

**DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
BOARD OF DIRECTORS**

The fourth meeting of the Dorset County Hospital NHS Foundation Trust Board of Directors will be held at 9.30am on Tuesday, 11 January 2011 in the **Town Hall, Corn Exchange, High East Street, Dorchester, DT1 1HF**

There will be an opportunity for members of the Council of Governors to talk informally with the directors before Part 2 of the meeting.

If you are unable to attend, please notify Annaliese Wykes, 01305 254645

DR JEFFREY ELLWOOD
Chairman

AGENDA - PART 1

- | | | |
|----|---|-----------------|
| 1. | Apologies for Absence | <i>Chairman</i> |
| 2. | Declaration of Interests | <i>Chairman</i> |
| 3. | Chairman's Remarks | <i>Chairman</i> |
| 4. | Part 1 Minutes of the Board Meeting: 07 December 2010 | <i>Chairman</i> |
| 5. | Matters Arising | <i>Chairman</i> |

QUALITY AND PERFORMANCE

- | | | |
|----|--|----------------------------|
| 6. | For information Patient experience | <i>CEO</i> |
| 7. | For scrutiny Integrated Operations report:
- quality/patient experience
- finance
- performance
- workforce | <i>Executives</i> |
| 8. | For information Patient and Public Engagement Report | <i>Director of Nursing</i> |
| 9. | For information Cancer Action Plan | <i>Director of Nursing</i> |

DECISION PAPERS

- | | | |
|-----|---|--|
| 10. | For scrutiny Board Assurance Framework | |
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COMMITTEE/SEMINAR MINUTES/REPORTS

- | | | |
|-----|--|--|
| 11. | For information : Draft Finance & Performance Minutes | <i>Director of Finance and Resources</i> |
| | Draft Finance & Performance ToR | <i>Director of Finance and Resources</i> |
| | Draft Healthcare Assurance Minutes | <i>CEO</i> |

12. Questions from the Council of Governors *Chairman*
13. Date and Time of Next Meeting: Tuesday, 01 February 2011 at 0930 in the **Seminar Room, Children's Centre, Dorset County Hospital**
14. Withdrawal of Press and Public - to move that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

NB A glossary of abbreviations that may be used in Board of Directors papers will be found at the back of the Part 1 papers.

Items on part 2

Confidential minutes of 07 December 2010 for approval

Matters Arising: 07 December 2010

Vital Pac business case – commercial in confidence

AGENDA – PART 2

15. **For approval** Minutes of part 2 Board meeting: 07/12/10 *Chairman*
16. **For discussion** Matters Arising - Board meeting: 07/12/10 *Chairman*
17. **For approval** Vital Pac Business Case *Director of Finance and Resources*

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

TRUST BOARD MINUTES

PUBLIC

Minutes of Dorset County Hospital NHS Foundation Trust's fourth public meeting held on Tuesday, 07 December 2010 in the Board room, Trust HQ, Dorset County Hospital

PRESENT:	Dr J Ellwood	Chairman
	Mr R Knight	Vice-Chairman
	Ms P Turnbull	Non-Executive Director
	Mr P Knell	Non-Executive Director
	Mrs T Peters	Non-Executive Director
	Dr P Camm	Non-Executive Director
	Mrs J Reid	Non-Executive Director
	Mrs J O'Callaghan	Chief Executive
	Ms A Tong	Director of Nursing and Operations
	Mr B Boa	Director of Finance and Resources
	Dr N Hateboer	Medical Director
	Mr M Power	Director of Workforce and HR
IN ATTENDANCE:	Miss A Wykes	PA to the Chief Executive (Minutes)
	Mrs A Ryder	Named Nurse for Safeguarding/Lead Nurse for Paediatrics (for item 240/10)

The Chairman welcomed Mrs Reid, Non-Executive Director, to her first Board meeting.

235/10 APOLOGIES FOR ABSENCE

There were no apologies for absence.

236/10 DECLARATION OF INTERESTS

No declarations of interest were made.

237/10 CHAIRMAN'S REMARKS

The Chairman reported that some members of the Board were meeting Monitor on 08 December 2010 for a regular monthly review.

Board members were advised that the Trust Long Service Awards were being held on 13 December 2010 and all were welcome to attend.

The CEO's objectives for 2010/11, which had been included with the Board papers, were **agreed** by the Board. CEO objectives for 2011/12 will be established when the annual plan has been approved.

238/10 MINUTES OF BOARD MEETING: 02 NOVEMBER 2010

Page 2, Operational Performance, Mr Knell commented that the Board's significant concern over failure to meet the cancer targets had not been effectively recorded in the minutes. The Chairman

drew the Board's attention to the paragraph at the end of the performance report which related to all the targets discussed, including that for cancer viz:

'The Board noted the action being taken but expressed significant concern at the Trust missing these targets and asked the Executive team to take all possible actions required to rectify the situation.' In the Chairman's opinion, this did express the concerns of the Board.

Page 4, 218/10: Board Governance Arrangements, final paragraph to read: "and delegated responsibility to refine the paper....".

Page 4, 219/10: Stroke Services Action Plan, third sentence to read: "The Board will **actively monitor** progress of the action plan".

The Chairman was **authorised**, by the Board, to sign these as a true record of the meeting following completion of the amendments as above.

239/10 MATTERS ARISING: 02 NOVEMBER 2010

PATIENT RECORDABLE OUTCOME MEASURES (PROMs)

The Director of Nursing and Operations advised the Board that while national PROMs data is available there is no Trust-specific report available. A comparison of the PROMs questionnaire return rate now compared to six months ago is being made and conclusions will be provided through the quality report, as will any Trust specific data.

COST IMPROVEMENT PROGRAMME (CIP)

The Director of Finance reported to the Board that CIP phasing details were now included in the finance report to allow the Board to monitor progress.

240/10 SAFEGUARDING CHILDREN REPORT

Mrs Ryder gave an overview of the work of the Trust's safeguarding children department in 2010, which included a number of serious case reviews, case contacts, case conferences and audits.

Future challenges for the department include:

- keeping up with national and local changes
- the volume of activity
- the number of significant cases (reviews)
- the increased external monitoring – impact of audits and quality monitoring
- training – online and new requirements
- DNA management
- Paediatric Nurses in outpatients
- think child beyond paediatrics

The Board expressed its appreciation of the work of the safeguarding children department and **asked** Mrs Ryder to convey it's appreciation to all those involved.

It was **agreed** that a Non-Executive Director would be nominated to join the Safeguarding Children Committee (***BAP**).

241/10 PATIENT EXPERIENCE

The CEO read out details (anonymised) details of a patient's experience following a diagnosis of mouth cancer. The main concern and issue was the complete lack of communication between hospitals and within individual departments. The CEO then shared (anonymised) details of a patient in orthopaedics who had had a very positive experience with all the departments which had contributed to care.

The Trust's Learning from Patients Group looks at themes and trends arising from complaints and takes appropriate action e.g. training. The Board agreed that good patient experience starts with the Board setting the right standards and values for staff to follow and that this regular item on the agenda assists in demonstrating the Board's determination to ensure our patients receive the best possible care.

242/10 OPERATIONAL REPORT

In introducing the new integrated operational report, the format of which will form the basis of future reporting, the CEO informed the Board that the Trust had had an unannounced visit from the Care Quality Commission (CQC) on 01 December 2010. Representatives visited a number of wards and found no significant issues, which was a source of significant reassurance for the Board. Formal feedback from the visit is due soon.

The CEO then identified to the Board the current key issues facing the Trust:

- achieving the Monitor cancer -targets
- refinancing by means of a loan from FTFF
- bedding in the new organisation
- the Monitor review meeting 08 December 2010

The CEO invited the Director of Finance to highlight for the Board the financial headlines.

Financial Report

The Trust's financial headlines were:

- the Trust is still forecasting a £3.5m deficit at the end of 2010/11 and a surplus position in 2011/12.
- a surplus was made in October for the first time in the year.
- the Trust is £700k ahead of plan for the Cost Improvement Programme (CIP) 2010/11 but needs to secure recurrent savings to allow continued progress in 2011/12.
- a proposal, comprising of three elements, has been made to the Foundation Trust Financing Facility (FTFF) about the possibility of a loan,
 - receive cash in advance of future asset sales
 - a capital loan secured against the Trust's capital programme
 - a Working Capital Facilitythis proposal will be discussed on 13 December and, if successful, the loan should be in place by January 2011.
- a Financial Risk Rating of 2 was maintained for October.

The Board **asked** the DoF to convey it's thanks to the finance team for their efforts.

Performance Report

The CEO led the discussion on the key operational issues identified in Section B of the performance overview papers.

- **cancer targets:** These are still not being met. An action plan has been developed and delivery of the plan will mean the Trust reaches the targets. However a breach of authorisation is considered by the Trust to be such an important risk, that Cancer targets have been added to the Risk Register.
- **c-difficile:** an aggregated risk assessment on an outbreak of c-difficile on Barnes Ward had been presented to the Executive meeting and had raised issues such as a lack of cleaners, lack of supervision and patient mix. The shortfall of cleaners and patient mix has now been addressed and work is in progress to improve supervision.
- **18 week target:** to meet the target, the Trust will need to undertake additional activity. The Board therefore **agreed** to not to do this until appropriate agreement is reached with the Primary Care Trust (PCT).
- **Cancelled operations:** the numbers of cancelled operations have been monitored over the last six weeks to reduce levels by working towards an estimated date of discharges and looking at reasons if the discharge does not occur on the specified date.
- **Stroke:** there continues to be an unacceptable performance for stroke patients despite the operational process for stroke patients being changed as well as the stroke team leadership. However the action taken is expected to improve performance.
- **MRSA screening:** following agreement from Monitor, the way MRSA screening is reported has changed and as a result the Trust will now meet the target.
- **VTE:** there has been a slight improvement in VTE performance but significant improvement still has to be made. The CEO advised the Board that Wards now have traffic light ratings at entrances showing the performance on VTE, ward cleanliness and hand hygiene.
- **Thrombolysis:** the Trust has been excluded from reporting on this target due to the small numbers of patients involved. The CEO is meeting with the CEO of the South Western Ambulance Service Trust in January and will discuss a breach, which occurred due to lack of equipment on an ambulance.
- **Mixed sex accommodation:** the Trust has provided its exclusion criteria for mixed sex accommodation to the PCT and a meeting is being held at the Strategic Health Authority (SHA) on 08 December 2010 to agree criteria.
- **Spinal:** following a meeting of the Dorset Health Scrutiny Committee, the Trust is not required to go to public consultation about spinal services being hosted by another provider.
- **Delayed discharges:** a number of actions are being taken on delayed discharges including the PCT reviewing, on a weekly basis, patients who have been in hospital over 28 days and additional services will be provided to the Trust by social services. These actions are fully expected to improve the situation.

The Board had a robust discussion on the reasons for the continuing failure of the Trust to achieve the above targets, in particular that for stroke and for the max 62 day cancer wait, for with 3 failing quarters, the Trust was now in breach of its authorisation. The board **asked** the CEO to take whatever steps necessary to ensure immediate compliance. (*EAP)

Patient Safety Report

The Director of Nursing and Operations introduced the new patient safety report and the board went through the issues identified with the following comments:

- **cardiac arrests** – there are higher numbers than expected, improvements are being made to the management of deteriorating patients including purchase of the VitalPAC tool
- **Complaints** – there has been an increase with complaints and with compliments. An addition has been made to the Patient Advice and Liaison service (PALs) team to monitor and improve complaint response times.
- **Pressure Ulcers** – work is ongoing with Matrons as there appears to be an inconsistency in reporting of pressure ulcers.
- **MRSA** – with no HAI's for over 12 months, this is considered a good performance.
- **Cleaning audits** – peer audits are being completed and fifteen additional cleaners have been recruited.
- **Urinary Catheter audits** – as poor results have been found, audits are being re-introduced.
- **Nutrition score** – unannounced CQC visit found all patient notes reviewed had a Malnutrition Universal Screening Tool (MUST) assessment but overall results are 56%, which needs improvement.
- **National Patient Safety Agency (NPSA) alerts** – the number of Pharmacy alerts, which had passed the deadline for completion, have now been done. Two alerts are currently open: “Right Blood, Right Patient” (this has been added to the Risk Register) and “management of radiological findings” – action plans in both cases are in place.
- **Hand hygiene audits** – the audit tool for this has changed, which has seen a dramatic improvement in results on the ward where the new audit tool was piloted.

Workforce Report

The Director of HR introduced the workforce report and asked the Board to focus on the performance measures that appear in Section C1 and C2 of the report. The Board reviewed the issues with the following comments:

- workforce levels and costs are now on plan and in budget.
- progress on reducing temporary staff and vacancies are closely controlled.
- there are three areas of workforce underperformance:
 - **sickness absence** – 4.2%, risen from 3.8% and is above the NHS and South West average which is disappointing. Action continues.
 - **annual appraisal rate** – dipped from 60% in September to 58%. The Human Resources department is completing an action plan to discuss at an Executives' meeting with the aim of reaching 90% in the next six months>(*EAP)
 - **statutory and mandatory training** – the completion rate for this is low at 65%. A 'task and finish' group has been set up to look at how to increase active participation in training events.
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- a staff health and wellbeing strategy is being implemented in December and a discussion paper on staff engagement is being discussed by the Partnership Forum with the aim of establishing a staff engagement strategy in February/March 2011.
- the organisational restructure has now been completed and now requires bedding-in.
- an interim Divisional Manager for Medicine has been appointed and will begin at the Trust on 14 December until the end of March.

243/10 RISK REGISTER

The CEO presented to the Board the revised Risk Register. The Board **noted** the current red risks and the two red risks to be added: cancer targets and “Right Blood, Right Patient” (NPSA alert). The entire risk register is presented monthly to the Executive meeting for review, the red

and amber risks are presented monthly to the IGC and the Board receives details of the red risks on a 3 monthly basis.

244/10 BOARD ASSURANCE FRAMEWORK

The CEO introduced the draft of the new BAF and requested feedback from the Board. The BAF, which had been reviewed by Executives but had not yet been discussed at Board sub-committees, will form an essential part of the Trust Governance Processes. The Board **agreed** that the document, after feedback has been received, should be discussed at the Board Committees and presented to the Board in February (*BAP)

245/10 WINTER PLAN

The CEO explained that the plan looks at three main areas of potential operational pressure during the winter period (1) flu preparedness (there has been a poor staff uptake of the flu vaccination this year, which is a cause for concern), (2) management of norovirus and (3) winter pressures in totality (for example, critical care capacity). The Plan, which has been approved by the Executive Committee will also be placed on the Intranet and staff will be notified by e-mail.

The Board **noted** the detail of the plan.

246/10 INFECTION PREVENTION AND CONTROL QUARTERLY REPORT

The Director of Nursing and Operations introduced the report and invited the Board to comment. The ensuing discussion established that the main issues from this report, to be noted, were:

- no HAI bacteriaemias since September 2009
- the high levels of contaminated blood cultures through the emergency department have now been significantly reduced
- C-difficile rate has reduced dramatically since 2007/08. The surveillance database is now in test phase and is expected to improve infection control practices.

The Board expressed thanks to the infection control team for their continued vigilance.

247/10 QUALITY REPORT 2010/11 – SECOND DRAFT PLAN

The Board **received** for its information the second draft of the quality report, which includes quality priorities for 2010/11. The Director of Nursing and Operations explained that there was a stipulated format that the Trust was required to follow. The Board **noted** the second draft.

248/10 FEEDBACK FROM STRATEGY WORKSHOP

Both the CEO and the Vice Chairman reported back on the first Strategy Workshop held with both the Board and the Strategy Committee of the Council of Governors on the 4th November. It was decided as a first step to identify the Strengths, Weaknesses Opportunities and Threats facing the Trust, in a typical SWOT analysis process. The results have been recorded and will form part of the next strategic analysis session. The Board confirmed that further workshops and meetings will be held with Trust stakeholders to ensure as many views as possible are included in the final plan.

The Board expressed it's approval with the process and asked for an update at the February Meeting.

249/10 STANDING FINANCIAL INSTRUCTIONS/SCHEME OF DELEGATION

The Board **approved** the revised Standing Financial Instructions/Scheme of Delegation subject to any comments and amendments that the Audit Committee may decide to make at their meeting in January.

250/10 RESPONSIBLE OFFICER FOR REVALIDATION

The Board **approved** the appointment of the Trust's Medical Director as the Responsible Officer for Revalidation. The Medical Director explained that the key to this role was to have a group of first class appraisers who can complete the necessary tasks for revalidation at appraisals, which are then signed off by the Responsible Officer.

The Board **asked** the Medical Director to confirm that the necessary resources had been placed at his disposal, and he confirmed that they had.

251/10 REGISTER OF INTERESTS

The Board **received and noted** the register of interests for Board members and for Governors.

252/10 SUB-COMMITTEE MINUTES

The draft minutes of the Finance and Performance Committee, the Audit Committee and the Integrated Governance Committee were **received and noted** by the Board.

253/10 GOVERNORS QUESTIONS

There were no Governors' questions.

254/10 DATE AND TIME OF NEXT MEETING

Tuesday, 11 January 2011 at 0930 in the **Town Hall, Corn Exchange, High East Street, Dorchester, DT1 1HF**

(*BAP) = Board action point

(*EAP) = Executive action point

**DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
TRUST BOARD
BOARD PUBLIC ACTION LIST
07 DECEMBER 2010**

(Please note, the information in brackets relates to the minuted reference)

		LEAD ACTION	ACTION DUE BY
1.	<u>SAFEGUARDING CHILDREN COMMITTEE</u> Non-Executive Director to be nominated to sit on the committee (240/10)	Chairman	11 January (verbal)
2.	<u>ANNUAL REPORT AND ACCOUNTS</u> Provide a plan, by end of January, for production of next year's annual reports and accounts (135/10)	Chief Executive	03 February 2011 (verbal)

Operational report: 11 January 2011	
Subject	Operational report for November 2010
Purpose	To ensure the Board are aware of the Trust's performance and highlight key variances.
Responsible Executive	CEO
Author of attached Report	Executive Directors
Summary	<p><u>Financial Performance</u></p> <p>Financially, the cumulative position at the end of October is favourable with a deficit of £2.053k against a planned deficit of £3.288k. A key risk remains elective over performance against contract as there is no payment for activity over the threshold. The underlying cash liquidity position will remain a risk until loan financing is secured.</p> <p>Other financial risks include potential non delivery of the cost improvement programme, the non-recurrent impact of holding vacancies long term and an increasing elective backlog and the need for the resolution of the cancer drugs recharge issue with Poole Hospital</p> <p><u>Operational Performance</u></p> <p>Performance overall is satisfactory but key areas of concern remain:</p> <ul style="list-style-type: none"> • achieving cancer targets • reducing cancelled operations • reducing delayed discharges • maintaining 18 weeks • increasing time spent by stroke patients in the unit <p>A review of the 62 day cancer wait target for consultant screening service referral is in progress. A breach of this target for three consecutive quarters represents a significant breach of the Monitor compliance framework.</p> <p>VTE assessment compliance remains low and C Difficile rates are one over trajectory, year to date. Action plans are in place for each area.</p> <p><u>Patient Safety</u></p> <p>Stroke mortality for April to September 2010 is above</p>

expectation and the Trust is undertaking a stroke mortality review of all cases within this period.

An area of concern is the deterioration in the response time of the Trust to letters of complaint.

The system for reporting pressure ulcers has been changed to ensure that ulcer grades are recorded. There has been a significant increase in reported numbers although no Grade 3 or Grade 4 pressure ulcers have been identified.

The revised methodology for MRSA screening reporting discussed in December will be next month with December's data.

A new audit tool and renewed emphasis on hand hygiene was reported at an earlier Board meeting and this month shows a material improvement in hand hygiene rates.

Workforce

Substantive and temporary workforce capacity is continuing to reduce in line with efficiency targets and expenditure continues to be below the planned levels for this period with a fourth consecutive month of reduced expenditure.

Total workforce capacity and associated staff costs continue to reduce. Temporary workforce expenditure accounts for 7.5% of the total pay bill (down from 8.4% in October).

Current workforce measures show under-performance in three areas: sickness absence has increased from 4.2% to 4.4% (3.8% in September 2010) which is the highest level for this financial year, the annual staff appraisal rate reduced by 1.2% to 56.8% this month, and the percentage of staff having completed statutory and mandatory training fell by 10% to 55%.

Other Issues

Organisational Structure

Patricia Miller, Director of Operations took up post on 5 January 2011. Tess Drabble has agreed to act into the Divisional Manager for Medicine post pending appointment through the recruitment process that closed on 5 January 2011. All other key management posts have been appointed to and the newly formed Senior Management Team, consisting of Divisional Directors, Managers and Executive Directors met for the first time at the end of December 2010.

Spinal Services

NHS Dorset is running a competitive process for the provision of

	<p>spinal services. The Foundation Trust has provided every assistance to ensure that the service is safely transferred to a new provider. It has been agreed with NHS Dorset that every effort will be made to transfer the service by 1 April 2011. If this is not possible the Trust will work with a new provider as a sub contractor to manage the transition. As a last and final resort the Trust will consider an extension to the contract for a further two months.</p> <p><u>Care Quality Commission (CQC)</u></p> <p>The Foundation Trust has received informal feedback following an unannounced visit to the hospital by the Care Quality Commission. The feedback was positive and provides the highest quality independent assurance to the Board. The Trust is awaiting written feedback and this will be presented to the Trust Board.</p> <p><u>Business Continuity</u></p> <p>The adverse weather conditions in December have fully tested the Business continuity plans of the Trust. The Trust maintained good levels of service during the period of disruption and particular credit goes to staff that ensured continuity of care in difficult circumstances. Learning points are being gathered and included in the Trust Resilience plans which are currently being reviewed with the intention of presenting these to the Board in the near future.</p>
Paper Seen By	Executive Directors
Strategic Impact	Delivery of a sustainable financial position and delivery of performance to agreed contractual and regulatory standards.
Risk Evaluation	Potential breach of terms of authorisation for quality of services. Delivery of significant savings levels.
Impact on Care Quality Commission Registration	Potential non-compliance with registration requirements.
Legal Implications	Compliance with Monitor terms of authorisation.
Financial Implications	Compliance with Monitor terms of authorisation.
Recommendation	Focus management on delivery of performance standards and the turnaround plan.

Action Required by Board of Directors	<ul style="list-style-type: none">• To note performance against regulatory and contractual performance standards• To note the financial performance• To note significant under performance against cancer targets• To note that our financial risk rating is forecast 2• To note that the Trust continues to be non-compliant with Monitor's terms of authorisation.

FINANCE REPORT NOVEMBER 2010

1. OVERVIEW

	Plan YTD £m	Actual YTD £m	Var YTD £m	Plan FOT £m	Fcst FOT £m	Var FOT £m
Income	97.0	98.5	1.5	146.2	146.7	0.5
Expenditure	(100.3)	(100.6)	(0.3)	(149.7)	(150.2)	(0.5)
Surplus (Deficit)	(3.3)	(2.1)	1.2	(3.5)	(3.5)	0.0

The results for the 8 months are better than plan by £1.2m.

The key indicators of staff whole time equivalents (WTE), which had been broadly flat for the last 6 months, had fallen in October and have continued at this lower level in November. Pay costs have dropped marginally further in November due to a sustained decrease in agency spend which is encouraging. WTE in November are below the WTE budget figures with pay costs also below the budgeted pay, which can be explained by higher than planned vacancies across the Trust. The current holding of vacancies is not sustainable though as a recurrent recovery plan and fortuitous savings must be identified recurrently for removal from budgets in 2011/12.

The normalised cash flow key indicator shows that we are continuing to manage our limited cash resource well. Our Public Dividend Capital has been deferred from March 2010 to September 2011. The Trust has submitted an outline proposal for refinancing to the Foundation Trust Financing Facility (FTFF) and is working closely with the FTFF to develop a proposal that can be implemented early in 2011.

The current over performance for the first 8 months against the main NHS Contract for 2010/11, is an issue that needs to be closely monitored and controlled throughout the year, due to the upper threshold contained within the contract, because we will not be able to charge for activity above this threshold. In November, the Trust continued to breach the cumulative threshold and has currently lost £473k of income against work it has completed for the year to date.

In addition, the Trust has spent £1.5m on additional activity to clear the backlog for achieving the 18 weeks target. It is unclear how much more activity has to be provided above core capacity for the rest of the year and whether costs can be contained within the £3.5m budget, that has been set aside for backlog and sustainability investment and the cessation of backlog activity work since August 2010 has coincided with an increase in waiting lists.

We are managing closely the operational performance of the hospital on key targets:

- 4 hour A&E target delivered at 97.4%, against the 95% contracted target.

- Non admitted 18 weeks delivered at 97.4%, against the 95% contracted target.
- Admitted 18 weeks delivered at 91% against the 90% contracted target.

The year end forecast remains at a £3.5m deficit, mainly due to the risks of delivering the CIP savings programme, winter pressures and the uncertainty around 18 weeks delivery in terms of overachievement of the contract.

2. MONTH AND YEAR TO DATE

- 2.1 The cumulative position at the end of November is a deficit of £2,053k versus a planned deficit of £3,288k, a favourable position of £1,235k against plan (**Schedule A**).
- 2.2 In November month, we incurred a deficit of £303k against a planned deficit of £296k, an adverse performance of £7k (**Schedule A**).

The key drivers in November were as follows:

- a) **£171k** income (**Schedule A**) was lower than plan for the month mainly due to:
- Adverse: non clinical £50k lower than plan;
 - Adverse: Non Contracted Activity (NCA) £88k lower than plan;
 - Adverse: Work in Progress (WIP) £54k lower than plan;
 - Favourable: Private Patients £18k higher than plan;
- b) **£112k** operating expenditure was lower than plan for the month mainly due to:
- Pay costs £104k favourable to plan, mainly due to pay savings above target through non recurring vacancy control.
 - Non pay costs were £7k favourable to plan, the main movements were:
 - Adverse: £85k clinical supplies, in particular orthopaedic inpatient consumables and prosthesis;
 - Favourable: £105k due to lower drugs prescribing;
 - Adverse: other costs £13k

- 2.3 EBITDA was £59k adverse against plan for the month (**Schedule A**).

3. FORECAST OUTTURN

- 3.1 The outturn forecast is a **deficit of £3.5m**, which is as per the Annual Plan (**Schedule A**).
- 3.2 The costs for additional short term private providers and WLI capacity due to potential target breaches, and sustainability in Orthopaedics, have been included in the forecast at approximately £3.5m.

3.3 Directorate Identified risks & opportunities are detailed in **Schedule E**. The Key corporate risks are summarised in the Executive Summary.

4. CASH

4.1 At the end of November, the Trust held a cash balance of £7.9m (**Schedule C**). This was, however, driven by a deferment of the PDC dividend due in March 2010 of £1.3m and a PCT advance of £11.3m, the underlying position is therefore **£4.7m adverse**.

4.2 Creditor days were 34 days for November. There has been a increase in the November debtors at £775k over 60 days, compared to October £700k. The main reasons for the level of over 60 day debtors is slow payments of non contracted activity and contracts with Somerset and Hampshire PCTs.

4.3 The underlying cash liquidity position remains unsustainable in the long term, however, the Trust has approached the Foundation Trust Financing Facility to explore the possibility of a term loan against two years of capital programme and anticipated receipts from asset sales and the agreement of a working capital facility for a time limited period. The risk associated with this approach is diminished by the improvement in financial risk rating to a level 2 in October and the fact that this improvement has been maintained in this month.

5. CAPITAL

5.1 Capital expenditure for the 8 months was £2.4m, which is in line with plan.

5.2 The detailed Balance Sheet position is shown in **Schedule B**.

6. RECOVERY PLAN

6.1 The Programme Management Office (PMO) reports are reviewed weekly by the Chief Executive. The summary report is shown in **Schedule F**.

6.2 The Programme Management Office (PMO) has produced a financial recovery program for 2010/11 which includes 'plans in development' and 'stretch' targets that result in identified savings totalling £6.2m. The financial position presented in this report is based upon the assumption that savings of £6 million will be delivered this year.

6.3 Each programme is sponsored by an Executive lead. Each programme is supported by a work plan with a monthly phased plan of anticipated savings. **Schedule F** sets out the planned savings signed into the Programme Management Office, the most current risk based assessment of the forecast outturn for the year and the savings that were anticipated by the end of October 2010.

6.4 In total the savings plan is forecasting an overachievement against the full year plan of £201,000, this is £450,000 higher than the savings that have

been planned into the budget for this year, but are however driven by non recurring savings of £2,607,000 on vacancy management.

- 6.5 As at 30 November 2010 the total programme has realised £399,000 more than planned. This strong performance overall does, however, mask areas of underperformance in key projects. The Trust savings plan is currently reliant upon the savings realised as part of the vacancy management programme. The non-recurrent nature of these savings is a concern as the Trust moves to 2010/11.
- 6.6 Each Project sponsor and Project Manager are accountable to the Chief Executive and projects who are not achieving planned savings levels meet weekly with the Chief Executive and Executive sponsors to ensure appropriate mitigation is in place.
- 6.7 The Full year effect of savings has been identified in **Schedule F** to support the business planning process for 2010/11. The Trust anticipates that all savings in 2009/10 will deliver a full year effect next year and outline plans for next year are based on this assumption. **Schedule F** shows that the Trust must identify £3.6 million of recurrent savings through this year's schemes. The Service Planning process is the mechanism through which these recurrent savings must be identified and driven out.
- 6.8 The Trust directorates have driven the process to identify potential saving schemes for 2011/12 totalling £9.6 million (risk adjusted to £8.4m). These potential savings must now be incorporated into service plans for Board approval early in calendar year 2011.
- 6.9 The identified plans will require ongoing and focussed work to implement and achieve at these levels of savings.

INCOME AND EXPENDITURE SUMMARY	CURRENT MONTH					YEAR TO DATE					FULL YEAR FORECAST				
	Month : November 2010														
	Actual £000	Budget £000	Variance £000	Last Year £000	Variance £000	Actual £000	Budget £000	Variance £000	Last Year £000	Variance £000	Forecast £000	Budget £000	Variance £000	Last Year £000	Variance £000
INCOME															
Non PbR Clinical Income	2,848	2,811	37	2,827	22	22,607	22,486	121	22,458	149	32,850	33,729	(879)	33,883	(1,033)
PbR Income :															
Elective income	2,592	2,710	(118)	2,612	(21)	22,020	20,472	1,548	21,819	201	33,358	31,810	1,548	32,765	593
Non elective income	3,317	3,423	(106)	3,457	(140)	28,299	28,632	(333)	27,326	972	42,505	42,838	(333)	40,435	2,069
Outpatient income	1,755	1,703	52	1,611	144	13,321	13,116	205	13,049	272	19,749	19,545	205	19,488	262
A&E income	257	255	2	239	18	2,415	2,352	62	2,170	245	3,440	3,378	62	3,076	364
Total income at full tariff	10,769	10,902	(132)	10,746	23	88,662	87,059	1,603	86,822	1,840	131,902	131,299	603	129,647	2,255
PBR clawback	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total NHS Clinical income	10,769	10,902	(132)	10,746	23	88,662	87,059	1,603	86,822	1,840	131,902	131,299	603	129,647	2,255
Private patients	66	48	18	33	33	480	384	96	382	99	672	576	96	560	113
Other clinical income	44	50	(6)	36	7	335	376	(41)	386	(51)	506	547	(41)	594	(88)
Non-Clinical Income	1,093	1,143	(50)	1,428	(335)	9,037	9,204	(168)	9,674	(638)	13,594	13,762	(168)	14,702	(1,108)
TOTAL INCOME	11,971	12,142	(171)	12,244	(272)	98,514	97,024	1,491	97,264	1,250	146,675	146,184	491	145,503	1,172
EXPENDITURE															
Pay Costs	(7,722)	(7,826)	104	(7,788)	67	(62,643)	(62,495)	(148)	(63,326)	683	(93,692)	(93,312)	(379)	(93,890)	198
Drug Costs	(784)	(888)	105	(860)	76	(6,725)	(7,088)	363	(6,579)	(146)	(10,370)	(10,732)	363	(10,034)	(336)
Other Costs (excl. depreciation)	(3,129)	(3,031)	(97)	(2,775)	(354)	(26,013)	(25,408)	(605)	(23,993)	(2,020)	(38,112)	(37,506)	(605)	(37,369)	(743)
TOTAL EXPENDITURE	(11,634)	(11,745)	112	(11,423)	(211)	(95,381)	(94,990)	(391)	(93,898)	(1,483)	(142,173)	(141,551)	(622)	(141,293)	(880)
EBITDA	338	397	(59)	821	(483)	3,133	2,034	1,099	3,366	(233)	4,501	4,633	(132)	4,210	291
Profit / loss on asset disposals			0		0	1		1	(12)	14	1		1	57	(55)
Exceptional Income / Costs			0		0	(40)		(40)	(1,284)	1,244	(40)		(40)	(551)	511
Total Depreciation	(440)	(487)	47	(503)	63	(3,536)	(3,688)	152	(4,025)	489	(5,523)	(5,677)	154	(6,021)	498
PDC Dividend	(202)	(202)	(0)	(248)	46	(1,617)	(1,617)	(1)	(1,985)	368	(2,426)	(2,425)	(1)	(2,798)	372
Total interest receivable	4	2	2	3	1	29	14	15	29	1	31	20	11	46	(15)
Total interest payable on NHS Financing	(2)	(4)	3	(2)	0	(15)	(23)	8	(16)	1	(21)	(41)	20	(24)	3
Total interest payable on working cap facility			0		0			0		0			0		0
Total other interest payable	(1)	(1)	(0)	(1)	(0)	(8)	(8)	(0)	(8)	(0)	(26)	(12)	(14)	(11)	(14)
Net Surplus/(deficit)	(303)	(296)	(8)	70	(373)	(2,053)	(3,288)	1,235	(3,936)	1,883	(3,501)	(3,501)	(0)	(5,093)	1,591
ACTIVITY MEASURES															
Activity numbers															
Elective activity (number)	2,334	2,215	119	2,254	80	17,983	17,373	610	17,584	399	26,910	26,300	610	26,540	370
Non-elective activity (number)	1,791	1,650	141	1,652	139	14,459	13,634	825	13,694	765	21,117	20,292	825	20,285	832
Outpatient visits (number)	15,667	14,658	1,009	16,032	(365)	117,731	114,864	2,867	126,132	(8,401)	174,185	171,318	2,867	188,368	(14,183)
A&E attendances (number)	2,861	2,772	89	2,774	87	26,352	25,642	710	25,644	708	37,348	36,638	710	36,638	710
Ratios															
Surplus/(deficit) %	-2.5%	-2.4%	-0.1%	0.6%	-3.1%	-2.0%	-3.4%	1.3%	-2.7%	0.7%	-2.4%	-2.4%	0.0%	-3.5%	1.1%
EBITDA %	2.8%	3.3%	-0.4%	6.7%	-3.9%	3.2%	2.1%	1.1%	3.5%	-0.3%	3.1%	3.2%	-0.1%	2.9%	0.2%
EBITDA % of plan achieved	85.1%	100.0%	-14.9%	118.9%	-33.9%	154.0%	100.0%	54.0%	56.3%	97.7%	97.2%	100.0%	-2.8%	47.2%	49.9%
Dividend Cover (minimum > 1x)	1.7	2.0	(0.3)	3.3	-1.6	2.0	1.3	0.7	1.7	0.2	1.9	1.9	(0.1)	1.5	0.3
Interest Cover (minimum >3x)	-	-	0.0	-	0.0	-	-	0.0	-	0.0	-	-	0.0	-	0.0
Debt Service Cover (minimum > 2x)	-	-	0.0	-	0.0	-	-	0.0	-	0.0	-	-	0.0	-	0.0
Debt Service to Revenue (minimum < 3%)	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%	0.0%
Private Patient Cap (0.5% statutory)	0.6%	0.4%	0.2%	0.3%	0.3%	0.5%	0.4%	0.1%	0.4%	0.1%	0.5%	0.4%	0.1%	0.4%	0.1%

BALANCE SHEET Month : November 2010	CURRENT MONTH			FULL YEAR FORECAST		
	Actual	Budget	Variance	Forecast	Budget	Variance
	£000	£000	£000	£000	£000	£000
TOTAL FIXED ASSETS	80,596	81,501	(905)	79,424	79,878	(454)
CURRENT ASSETS						
Stocks & Work in Progress	2,657	2,495	162	2,495	2,495	0
NHS Trade Debtors	4,353	2,870	1,483	2,944	2,944	0
Non NHS Trade Debtors	352	617	(265)	617	617	0
Other Debtors						
Prepayments and Accrued Income	1,906	1,592	314	1,586	1,586	0
Cash at bank and in hand	7,887	346	7,542	1,137	1,179	(42)
Total Current Assets	17,155	7,920	9,235	8,779	8,821	(42)
Bank overdraft						
Trade Creditors	(4,345)	(4,768)	423	(4,809)	(4,775)	(34)
PDC dividend creditor	(1,713)	(404)	(1,309)	(1,309)		(1,309)
Capital Creditors	(400)	(300)	(100)	(300)	(300)	0
Interest payable creditor			0	0	0	0
Payments on Account	(11,304)	(5,500)	(5,804)	(3,700)	(5,500)	1,800
Other Creditors	(3,631)	(3,695)	64	(3,695)	(3,695)	0
Accruals	(1,804)	(1,342)	(462)	(1,342)	(1,342)	0
PFI Lease/Finance Lease	(186)	(205)	19	(186)	(206)	20
Deferred income	(45)	(36)	(9)	0	0	0
Total Current Liabilities	(23,429)	(16,250)	(7,179)	(15,341)	(15,818)	477
NET CURRENT ASSETS (LIABILITIES)	(6,274)	(8,330)	2,056	(6,562)	(6,997)	435
Long term Debtors	817	707	110	635	635	0
TOTAL ASSETS LESS CURRENT LIABILITIES	75,139	73,878	1,261	73,497	73,516	(19)
CREDITORS: Amounts falling due after more than one year	(1,495)		(1,495)	(1,427)		(1,427)
PROVISIONS FOR LIABILITIES AND CHARGES	(594)	(2,148)	1,554	(618)	(2,079)	1,461
TOTAL ASSETS EMPLOYED	73,050	71,730	1,320	71,452	71,437	15
LOANS						
NHS financing facility				0	0	0
Other financing facilities						
TOTAL LOANS	0	0	0	0	0	0
TAXPAYERS' EQUITY						
Public dividend capital	81,609	81,609	0	81,609	81,609	0
Income and expenditure reserve	(25,692)	(26,928)	1,236	(27,141)	(27,141)	0
Revaluation reserve	14,836	14,836	(0)	14,836	14,836	0
Donated asset reserve	2,297	2,213	84	2,148	2,133	15
Other Reserves (Government grant reserve etc)						
TOTAL TAXPAYERS EQUITY	73,050	71,730	1,320	71,452	71,437	15
TOTAL FUNDS EMPLOYED	73,050	71,730	1,320	71,452	71,437	15
Supplementary Information						
Working Capital Facility Unused		10,000	(10,000)		10,000	(10,000)
Total Headroom	7,887	10,346	(2,458)	1,137	11,179	(10,042)
Prudential Borrowing Limit - total	0	0	0	0	0	0
- available	1,800	28,900	(27,100)	1,800	28,900	(27,100)
KPI's :						
Stock (days)	21	19	1	19	19	(0)
NHS Trade Debtors (days)	12	8	4	8	8	(0)
Non NHS Trade Debtors (days)	9	15	(6)	16	15	0
Trade Creditors (days) excl. deferred income	34	37	(3)	36	36	0
Return on assets (%)	-0.1%	-0.1%	(0)	-1.3%	-1.3%	(0)
Maximum Debt / Assets Ratio	0.0%	0.0%	0	0.0%	0.0%	0
Liquidity ratio (days)	(22)	(4)	(18)	(23)	(2)	(21)

CASH FLOW Month : November 2010	CURRENT MONTH			FULL YEAR FORECAST		
	Actual	Budget	Variance	Forecast	Budget	Variance
	£000	£000	£000	£000	£000	£000
EBITDA	338	397	(59)	4,501	4,633	(132)
Excluding Non cash I&E items	(21)	(22)	1	(253)	(256)	3
Movement in working capital:						
Stocks & Work in Progress	(28)	0	(28)	(0)	(0)	0
Debtors	491	29	462	(62)	(62)	(0)
Creditors	(142)	(34)	(108)	1,159	2,804	(1,644)
CashFlow from Operations	637	370	267	5,346	7,119	(1,773)
Capital Expenditure						
Maintenance capex	(114)	(314)	200	(3,731)	(4,231)	500
Non maintenance capex			0			0
Cash receipt from asset sales	0	0	0	1,300	1,300	0
CF before Financing	523	56	467	2,915	4,188	(1,272)
Movement in LT debtors	(32)	18	(50)	216	216	0
Movement in LT Creditors	0		0	0		0
Interest paid on loans and leases	(2)	(4)	3	(32)	(41)	9
Interest received	4	2	2	34	20	14
Drawdown of loans and leases	0		0	0	0	0
Repayment of loans and leases	(11)		(11)	(100)		(100)
Public Dividend Capital received (repaid)	0		0	0		0
Dividends paid	0	0	0	(2,426)	(3,734)	1,308
Net cash outflow/inflow	483	72	412	607	649	(42)
Opening cash balance	7,404	274	7,130	530	530	0
Closing cash balance	7,887	346	7,542	1,137	1,179	(42)
Supplementary Information						
Book value of disposed assets			0	1,300	1,300	0
Profit/(Loss) on disposal of fixed assets			0	1		1
KPI's :						
Cash flow from operations as % of EBITDA	188.8%	93.2%	95.5%	118.8%	153.7%	(0)
Free cash flow as a % of revenue	4.4%	0.5%	3.9%	2.0%	2.9%	-0.9%
Principal Debt Service (£000)	(14)	(5)	(8)	(147)	(53)	(94)
Working capital facility (£000 used in period)	0	0	0	0	0	0

Budgetary Performance for the period ending November 2010

<u>Directorates</u>	<u>Annual Budget £'000</u>	<i>Year to Date</i>			<i>Cumulative Variance</i>		
		<u>Budget £'000</u>	<u>Expenditure £'000</u>	<u>Pay £'000</u>	<u>Non Pay £'000</u>	<u>Total Variance £'000</u>	<u>Total %</u>
<u>Clinical Directorates</u>							
Cancer Services	1,037	682	598	40	44	84	12.3%
Histopathology	1,556	1,028	903	112	12	124	12.1%
Diagnostic Services	13,744	9,072	9,012	12	48	60	1.2%
Maternal & Child Health	16,373	10,845	10,632	242	(29)	213	1.9%
Medical Services	10,112	6,675	6,744	(69)	0	(68)	(1.1%)
Emergency Care Services	5,979	3,964	3,794	166	4	170	4.2%
Surgical Services	12,708	8,446	8,594	(132)	(16)	(148)	(1.8%)
Musculoskeletal Services	11,380	7,701	8,089	(21)	(366)	(388)	(5.1%)
Ward Nursing	15,905	10,696	10,804	(66)	(41)	(107)	(1.0%)
Critical Care Services	12,468	8,280	8,468	(66)	(122)	(188)	(2.3%)
Cardiology	4,854	3,220	3,151	(15)	83	69	2.1%
Renal	7,618	5,059	5,054	33	(29)	5	0.1%
Sub Total Clinical	113,735	75,669	75,842	238	(411)	(173)	(0.2%)
<u>Support Directorates</u>							
Estates	3,955	2,547	2,370	14	163	176	6.9%
Pharmacy	1,931	1,288	1,282	13	(6)	7	0.5%
Support Services	6,182	4,137	3,924	131	81	213	5.1%
Access Services	898	599	564	36	(1)	35	5.6%
Sub Total Support	12,967	8,571	8,140	194	237	431	5.0%
<u>Corporate Directorates</u>							
Director of Nursing	4,626	3,008	2,977	13	18	31	1.0%
Finance & IT	5,606	3,720	3,676	47	(2)	44	1.2%
Headquarters	836	1,049	1,376	(47)	(280)	(327)	(53.0%)
Human Resources	1,954	1,321	1,193	39	90	128	9.8%
Sub Total Corporate	13,023	9,099	9,222	51	(175)	(123)	(1.4%)
<u>All Other Services</u>	1,827	1,652	2,178	(631)	105	(526)	(29.8%)
Total Budgetary Performance	141,552	94,990	95,382	(148)	(243)	(391)	(0.4%)

SECTION B PERFORMANCE OVERVIEW

1. PURPOSE

- 1.1 To advise the Board of the Trust's performance against the key performance standards and indicators.

2. BACKGROUND

- 2.1 The Trust's Annual Plan sets out the programme of work to be undertaken to ensure compliance with Monitor's Compliance Framework, National standards, indicators and local standards included in PCT commissioning contracts
- 2.2 Detailed results of achievement as at 30th November 2010 are presented in Appendix A: Monitor Compliance Indicators, Appendix B: Contract Standards, Appendix C: Quality Standards and Appendix D: CQUIN Standards, with the relevant exception reports contained in Appendix E:

3. KEY ISSUES

- 3.1 The Trust's key performance standards and targets for 2010-11 have been classified into the following four categories which reflect the source of the indicators (details of these are set out in Appendix A,B,C, D and E)
- Monitor Compliance Indicators (A)
 - Contract Standards (B)
 - Quality Standards (C)
 - CQUIN Standards (D)
 - Exception Reports (E) - FPC Only
- 3.2 During November 2010 the Trust under performed against agreed tolerance levels for 2010/11 for the following performance standards:
- **C.diff Post (post 72 hours)** – There were 3 reported cases during November 2010 against a planned trajectory of 3. This gives a year to date performance of 32 cases against a trajectory of 31.
 - **18 week referral to treatment 'admitted RTT position'** – During November 2010 the Trust's performance was **88.2%** against a national target of **90%**. This indicator is monitored under the acute services contract. It is predicted this indicator will continue to under achieve in December 2010.
 - **Cancelled Operations** (cancelled on the day) – There were **40** reported cancellations for non-clinical reasons for the month of November 2010. The main reasons were, ran out of theatre time (13), staff unavailability (11) and lack of beds (8). The YTD performance is 1.4% adversely above the required national tolerance level of **0.8%**.
 - **Delayed Discharges** – This indicator continues to be a challenge with performance for November 2010 at **4.1%** with the overall year to date position of **4.1%**, 0.6% adversely above the national tolerance level of 3.5%.

- **80% of stroke patients spending 90% of their time on a stroke ward -** Performance deteriorated again in November, with only **37.0%** of stroke patients recorded as spending 90% of their time on a stroke ward. The year to date position for the trust is **50.9%** and remains below the 80% national and 90% contractual tolerance levels agreed for 2010/11.
- **MRSA Screening -** Performance for November 2010 highlighted further improvement in performance with **100%** of individual elective patients screened. Screening rates are now calculated by comparing the admission numbers in the categories that should be screened verses number of screening tests carried out.
- **Cancer Target - 62 day wait (screening service RTT) –** Performance for October 2010 was much improved at **87.5%** but still below the required tolerance level of **90%**.

Within the NHS Dorset acute services contract, a penalty clause of 2% of actual annual outturn value of service line revenue is associated with the failure to achieve the required tolerance levels for any of the cancer targets.

- **Cancer Target - 62 day wait (RTT) –** Performance for October 2010 was **84.6%**, just below the required tolerance level of 85%.
- **Cancer Target – max 2 week wait for breast symptoms -** Performance for the month of October 2010 was **73.1%**, below the required national tolerance level of **93%**.
- **Venous Thromboembolism (VTE) Risk Assessment -** The threshold for this indicator is 95% and is monitored through the CQUIN element of the contract. Performance in November showed a significant improvement with **59%** of patients recorded as **having** a VTE risk assessment completed. **12%** were recorded as **NOT** having a VTE risk assessment completed and **29%** did not have the VTE flag field completed on the PAS system.
- **Ambulance Handover -** For the period April to November 2010, the Trust has reported **1139** handovers greater than **15** minutes, **95** greater than **30** minutes, **4** greater than **1** hour and **2** greater than **2** hours. There are additional investigations on-going concerning data validation and accurate times reported by ambulance crews.
- **Mortality -** The Hospital Standardised Mortality risk for the period of April to September 2010 was **90.5** with a rolling 12 months position of **100.8**, 100 being the normal position of relative risk. **Stroke Mortality** for April to September is **115.9** with a rolling 12 months position of **119.2**. The Trust should be aiming to achieve a position within the range of 90-100 for both.

For April to September 2010 year to date there have been 41 deaths with a diagnosis of stroke against an expected figure of 35. The medical notes for these patients are currently being reviewed by the clinical coding team and the medical director as part of an on-going investigation.

- **Proms Completed –** The percentage of completed PROMS questionnaires has significantly deteriorated in November 2010 for Groin Hernia & Varicose Veins to **47.1%**. There has been a slight improvement on October performance for Hips & Knees to **66.2%** for November but this is still much

lower than in the first few months of the financial year. *(See quality schedule for further detail).

- **Serious Untoward Incidents** –There have been **19** reported cases YTD with **1** reported case for November 2010. Outturn for financial year 09-10 was 11
- **Mixed Sex Accommodation** – **0** reported cases in the month of November 2010, with a year to date position of **32**. A formal agreement on the circumstances when mixed sex accommodation can be permitted is being finalised with NHS Dorset.

4. ACTIONS

4.1 Exception reports were provided to the finance and performance committee in Appendix E for the following areas;

- 18 Weeks RTT admitted (I)
- Cancelled operations (II)
- Delayed discharges (III)
- Stroke patients spending 90% of time on stroke ward (IV)
- Cancer targets (V)
- VTE Risk Assessment (VI)
- Ambulance Handover (VII)

5. FINANCIAL/OTHER IMPLICATIONS

5.1 Achieving NHS plan targets and milestones is an important feature of the Trust's overall performance and demonstrates our commitment to delivering quality care to patients. There are a number of specific performance indicators within the contract where NHS Dorset have the discretion to apply financial penalties in respect of underperformance as detailed in the 2010/11 Acute Services contract with NHS Dorset.

6. RECOMMENDATIONS

6.1 The Board is asked to receive the Performance Report and note the progress that has been made together with any actions that are planned.

Appendix A

Monitor Compliance Indicators.

Standards	Corporate Framework Element	Outturn 2009/10	Plan 2010/11	Actual Monthly Performance												Q1	Q2	Weighting	Quarter 1	Quarter 2			
				Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11								
c MRSA infections -Hosp Acq post 48Hrs	Quality Schedule / Monitor	4	2	0	0	0	0	0	0	0	0	0					0	0	1				
g C-difficile infections -Hosp Acq Post 72 Hrs	Quality Schedule / Monitor	58	45	5	4	5	2	2	4	7	3						14	8	1	1			
m Screening elective patients for MRSA (there is an exclusion criteria)	Quality Schedule / Monitor	65.2%	100%	84.0%	86.8%	87.0%	83.9%	86.5%	82.7%	86.9%	100.0%						86.0%	84.3%	0.5	0.5	0.5		
a % < 4 hours in A& E (Inc MIU's)	Monitor / Contract	99.4%	95.0%	98.8%	99.1%	98.3%	99.0%	98.1%	98.8%	97.4%	98.0%						98.7%	98.6%	0.5				
c All Cancers: Max 2wk OP wait	Monitor / Contract	94.2%	93.0%	99.3%	95.6%	96.5%	96.9%	96.6%	97.8%	93.4%							97.1%	97.1%	0.5		0.5		
d All Cancers: Max 2wk wait for breast symptoms	Monitor / Contract	97.7%	93.0%	94.5%	94.4%	95.1%	86.3%	90.6%	72.2%	73.1%							94.7%	84.3%					
e All Cancers: Max 31 Day Diagnosis to first treatment	Monitor / Contract	99.4%	96.0%	98.7%	100.0%	98.7%	100.0%	95.6%	93.8%	100.0%							99.1%	96.4%	0.5				
f All Cancers: Max 31 Day DTT for other subsequent treatment: Surgery	Monitor / Contract	97.1%	94.0%	90.9%	100.0%	100.0%	90.0%	100.0%	93.8%	95.2%							97.5%	95.7%	1				
g All Cancers: Max 31 Day DTT for other subsequent treatments: anti cancer drugs (Chemotherapy)	Monitor / Contract	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%					
i All Cancers: Max 62 Day RTT	Monitor / Contract	90.6%	85.0%	82.4%	92.6%	92.5%	91.0%	81.8%	83.9%	84.6%							88.8%	85.5%	1	1	1		
j All Cancers: Max 62 Day wait - Screening Service RTT	Monitor / Contract	90.2%	90.0%	66.7%	40.0%	60.0%	84.2%	77.8%	44.4%	87.5%							56.3%	73.0%					
z Thrombolysis 'call to needle' < 60 mins	Quality Schedule / Monitor	52.4%	68.0%	100.0%	100.0%	100.0%	33.3%	100.0%	100.0%	0.0%	100.0%						100.0%	50.0%	0.5				
Compliance with requirements regarding access to healthcare for people with a learning disability	Monitor		Compliant	Not meeting requirement														0.5		0.5	0.5		
																						3	2.5

NB:

Z The Thrombolysis target will not apply to Trusts having five cases or less in the quarter.

J Where an NHS Foundation trust has failed to meet the same national requirement for three or more consecutive quarters, the governance score for that breach will increase from 1.0 to 4.0, which, could lead to a significant breach of the authorisation and possible regulatory action

Appendix B

Contract Standards

	Standards	Corporate Framework Element	Outturn 2009/10	Plan 2010/11	Actual Monthly Performance											Cumulative YTD Actual	
					Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11		Mar-11
1	Patient Focus																
an	Safeguarding vulnerable adults	Contract		tbc					tbc								
ah	National Bowel Cancer Audit (NBOCAP)	Contract		tbc					tbc								
ai	National COPD Audit	Contract		tbc					tbc								
aj	National Lung Cancer Audit (LUCADA)	Contract		tbc					tbc								
ao	STEMI - ST elevated myocardial infarction - audit	Contract		tbc					tbc								
ap	TIA - Transient Ischaemic Attack - audit	Contract		tbc					tbc								
ak	National Vascular Database	Contract		tbc					tbc								
al	QUIP - Quality and Patient Safety Improvement Programme	Contract		tbc					tbc								
am	Radical Prostatectomy - performance of radical prostatectomy	Contract	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
aq	Hip and Knee replacement audit	Contract		Audit	Annual Audit												
ar	Neurology - inpatients with Parkinsons disease will have medication at appropriate times	Contract		Audit	Audit												
as	ED department alcohol use disorder identification tool (audit)	Contract		Audit	Audit (minimum of 1 staff member on duty in ED assessing use of alcohol and referring to appropriate services)												
2	Safety																
t	Medication Errors (actual)	Contract	9	8	4	3	5	1	0	2	1	5					21
bc	Maternal death after elective caesarian	Contract		tbc													
bd	Misplaced nasogastric or orogastric tube	Contract		tbc													
be	MRSA - root cause analysis within 28 days of MRSA bacteraemias	Contract		100.0%													
bf	Multidisciplinary "deterioration recognition group" with action plan to implement NICE guidance	Contract		tbc													
bq	Patient safety incident reporting	Contract		tbc													
bh	Intravenous administration of mis-selected concentrated potassium chloride	Contract		tbc													
bi	Suicide - inpatient suicide by use of non collapsible rails	Contract		0													
bj	Wrong Site Surgery	Contract		0													
3	Clinical Outcomes																
a	Emergency readmissions within 28 days of discharge (following elective admission)	Contract	3.1%	tbc	3.2%	3.0%	3.7%	3.8%	3.6%	2.8%	3.1%						3.3%
b	Emergency readmissions within 14 days of discharge (following elective admission)	Contract	2.3%	tbc	2.6%	2.2%	2.7%	2.7%	2.8%	2.1%	2.2%						2.5%
c	Emergency readmissions within 28 days of discharge (following emergency admission)	Contract	8.8%	tbc	9.8%	8.9%	7.8%	6.8%	8.0%	8.0%	8.3%						8.2%
d	Emergency readmissions within 14 days of discharge (following emergency admission)	Contract	6.3%	tbc	6.9%	5.6%	5.4%	5.2%	6.2%	5.9%	6.2%						5.9%
4	People management																
n	Workforce - evidence adherence to workforce related activities (clause 11 contract)	Contract		tbc													
5	Clinical Effectiveness																
u	Diabetes	Contract		tbc													
ae	Renal dialysis - Patients dialysed in most appropriate setting	Contract		tbc													
af	Retained instruments post operative	Contract		0													
ag	Retained swabs or metal work	Contract		tbc													
7	Activity																
a	A&E Attendances (PbR)	Contract	36,638	36,638	3,174	3,268	3,340	3,527	3,636	3,309	3,237	2,861					26,352
b	Elective IP (PbR Care Spell Level)	Contract	6,143	6,029	494	535	518	590	457	465	505	526					4,091
c	Day Case (PbR Care Spell Level)	Contract	20,397	20,271	1,686	1,711	1,837	1,774	1,664	1,616	1,729	1,873					13,892
n	sub total Elective (PbR Care Spell Level)	Contract	26,540	26,300	2,180	2,246	2,355	2,364	2,121	2,084	2,234	2,399					17,983
d	Other Non-Elective (PbR Care Spell Level)	Contract		3,211	368	459	435	462	457	427	437	431					3,476
	Non-Elective Long Stay (PbR Care Spell Level)	Contract		11,666	963	948	889	936	979	953	905	957					7,530
	Non-Elective Short Stay (PbR Care Spell Level)	Contract		5,415	446	471	424	426	410	446	427	403					3,453
	sub total Non-Elective (PbR Care Spell Level)	Contract	20,285	17,081	1,777	1,878	1,748	1,824	1,846	1,826	1,769	1,791					14,459
e	Outpatient Attendances (consultant led) - New (PbR Single Professional)	Contract		48,203	3,999	4,082	4,312	4,470	3,932	4,384	4,193	4,383					33,755
	Outpatient Attendances (consultant led) - New (PbR Multiple Professional)	Contract		2,432	262	201	225	245	230	251	250	241					1,905
	sub total Outpatient Attendances (consultant led) - New (PbR)	Contract	54,679	50,635	4,261	4,283	4,537	4,715	4,162	4,635	4,443	4,624					35,660
f	Outpatient Attendances (consultant led) - Follow Up (PbR Single Professional)	Contract		107,758	8,810	8,577	9,139	9,270	8,813	9,356	8,910	9,657					72,532
	Outpatient Attendances (consultant led) - Follow Up (PbR Multiple Professional)	Contract		4,664	450	456	423	376	404	518	485	543					3,655
	sub total Outpatient Attendances (consultant led) - Follow Up (PbR)	Contract	133,689	112,422	9,260	9,033	9,562	9,646	9,217	9,874	9,395	10,200					76,187
	Outpatient Procedures (PbR)	Contract		8,261	706	691	832	814	699	698	651	793					5,884
g	Elective IP (non-PbR Care Spell Level Inc RDA's)	Contract	62	36,487	2,977	3,004	3,010	3,108	3,012	2,996	2,874	3,030					24,011
h	Planned Same Day (non-PbR Care Spell Level)	Contract	266		0	0											
i	Regular day Attenders (non-PbR)	Contract	27,722		0	0											
o	sub total Elective Activity (non-PbR)	Contract	28,050		2,977	3,004	3,010	3,108	3,012	2,996	2,874	3,030					24,011
j	Non-Elective (non-PbR Care Spell Level)	Contract	191	143	16	14	15	19	18	12	18	29					141
k	Outpatient Attendances - New (non-PbR)	Contract	25,829	20,971	2,097	2,162	2,271	2,278	2,131	2,207	1,958	2,290					17,394
l	Outpatients Attendances - Follow Up (non-PbR)	Contract	73,491	69,587	7,086	6,753	7,466	7,594	7,162	7,154	6,856	7,379					57,450
m	Outpatient Procedures (non-PbR)	Contract		6,051	613	613	723	578	553	528	459	459					4,526
8	Productivity																
t	No of Consultant to consultant referrals for same condition	Contract		0													
u	Spinal Procedures outside of service specification	Contract		0													
v	Urgent and Emergency care - reduce the conversion rate of ED attendance to admission	Contract		-15% 2009/10													
9	Access																
a	% < 4 hours in A&E (Inc MIU's)	Monitor / Contract	99.4%	95.0%	98.8%	99.1%	98.3%	99.0%	98.1%	98.8%	97.4%	98.0%					98.5%
c	All Cancers: Max 2wk OP wait	Monitor / Contract	94.2%	93.0%	99.3%	95.6%	96.5%	96.9%	96.6%	97.8%	93.4%						97.1%
d	All Cancers: Max 2wk wait for breast symptoms	Monitor / Contract	97.7%	93.0%	94.5%	94.4%	95.1%	86.3%	90.6%	72.2%	73.1%						89.3%

Appendix B

Contract Standards

	Standards	Corporate Framework Element	Outturn 2009/10	Plan 2010/11	Actual Monthly Performance											Cumulative YTD Actual
					Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	
e	All Cancers: Max 31 Day Diagnosis to first treatment	Monitor / Contract	99.4%	96.0%	98.7%	100.0%	98.7%	100.0%	95.6%	93.8%	100.0%					97.7%
f	All Cancers: Max 31 Day DTT for other subsequent treatment: Surgery	Monitor / Contract	97.1%	94.0%	90.9%	100.0%	100.0%	90.0%	100.0%	93.8%	95.2%					96.6%
g	All Cancers: Max 31 Day DTT for other subsequent treatments: anti cancer drugs (Chemotherapy)	Monitor / Contract	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
i	All Cancers: Max 62 Day RTT	Monitor / Contract	90.6%	85.0%	82.4%	92.6%	92.5%	91.0%	81.8%	83.9%	84.6%					89.1%
j	All Cancers: Max 62 Day wait - Screening Service RTT	Monitor / Contract	90.2%	90.0%	66.7%	40.0%	60.0%	84.2%	77.8%	44.4%	87.5%					76.1%
k	All Cancers: Max 62 Day wait - Cons Upgrade to treatment	Contract		86.0%												
m	% treated < 18 weeks (Admitted) Mthly 18 wk RTT aggregate or Qtrly at specialty level.	Contract	91.9%	90.0%	84.9%	89.9%	92.8%	94.5%	96.0%	92.0%	89.2%	88.2%				91.4%
n	% treated < 18 weeks (Non-Admit) Mthly 18 wk RTT aggregate or Qtrly at specialty level	Contract	97.6%	95.0%	97.1%	97.3%	97.1%	97.8%	98.1%	97.5%	96.9%	97.2%				97.4%
ab	Max. 2 week wait for Chest Pain Clinic	Contract	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%
ap	Cancer - care of patients who died within 30 days of receiving systemic anti cancer therapy	Contract		tbc				tbc								
ar	Cardiology - inter hospital transfers will occur within 3 days	Contract		tbc				tbc								
as	Elective Admissions - reduce multiple elective admissions for same condition	Contract		0				tbc								
at	Emergency Admissions - GP referred emergency admissions admitted directly to ward, not via ED	Contract		tbc				tbc								
au	Emergency Department - Patients presenting at ED referred to primary care without treatment	Contract		tbc				tbc								
av	Emergency Department - Achievement of NHS South West ED trajectory	Contract		tbc				tbc								
aw	Trauma delays - remove delays in treating non-elective trauma and fractures	Contract		tbc				tbc								
ax	Wrong route Chemotherapy - wrong route of administration Chemotherapy	Contract		tbc				tbc								
ay	% Patients spending more than 90% on Stroke Unit 10/11	Contract	48.6%	90.0%	60.0%	50.0%	48.5%	57.7%	42.3%	67.9%	46.2%	37.0%				50.9%
az	Stroke care - % of high risk transient ischaemic attack (TIA) patients who are treated within 24 hours	Contract														
12	Transfer of and Discharge from Care															
d	All those being discharged their relatives and carers (where appropriate) have been involved in determining the date of discharge, where possible this should be discussed on admission	Contract		90%				Not available								
e	Where health and social care services will be delivering care to patients after discharge adequate notice (at least 24 hours) will be given of the need for the service to the relevant care provider.	Contract		90%				Not available								
f	All those requiring drugs on discharge will be supplied with those drugs in a timely manner for the clinically relevant period for up to 28 days	Contract		90%				Not available								
g	All fields on the discharge form must be completed appropriately and in full. Required fields are as defined in Dorset PCT ASC Schedule 1 – "Discharge Summary"	Contract		95%				Not available								
j	All patients to be given Healthy Lifestyle advice during their visit or episode of care relevant to their condition and ability.	Contract		100%				Not available								
l	Discharge from care (work to discharge from care standards, schedule 2 pt2. Audit results leading to 100% compliance of all standards	Contract		100%				Not available								
m	Discharge from care (Eligibility for continuing healthcare process. Implement common assessment framework)	Contract		tbc				Not available								
n	Outpatient attendances and investigation reports submitted to GP within 3 working days	Contract		tbc				Not available								
13	Data Quality															
q	Clostridium Difficile NHS database will include NHS number	Contract		100.0%				tbc								
r	Short Stay Admissions - reduce short stays following ED attendance	Contract		0				tbc								
16	Public Health															

Appendix C

Quality Standards

				Actual Monthly Performance												Cumulative YTD Actual
Standards	Corporate Framework Element	Outturn 2009/10	Plan 2010/11	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	
1	Patient Focus															
a	Total number of contacts (complaints)	Quality Schedule	505	tbc	88	53	65	17	29	31						283
ae	% of complaints acknowledged within 3 days	Quality Schedule	tbc	tbc	100%	100%	100%	100%	100%	100%						100%
b	% of informal complaints handled within 20 days	Quality Schedule	84%	90%	96%	97%	98%	94%	65%	94%						91%
c	% of formal complaints handled within 20 days	Quality Schedule	59%	70%	73%	83%	80%	90%	38%	59%						71%
d	% of complex complaints handled within 40 days	Quality Schedule	88%	85%	28%	33%	86%	71%	63%	100%						63%
e	Complaints - Nursing care	Quality Schedule	tbc	tbc	16	5	9	1	5	8						44
f	Complaints - Medical care	Quality Schedule	tbc	tbc	66	45	53	14	20	23						221
g	Complaints - Access	Quality Schedule	tbc	tbc	6	4	10	1	3	0						24
at	Complaints - Finance	Quality Schedule	tbc	tbc				1								1
au	Complaints - Trust HQ	Quality Schedule	tbc	tbc					1							1
h	Privacy & Dignity Results - positive response PATIENTS	Quality Schedule	67%	tbc	Annual Report - January											
i	Mixed Sex Accommodation - No of Incidents	Quality Schedule	2	0	2	1	8	8	3	7	3	0				32
j	Inpatient Survey Results	Quality Schedule	tbc	tbc	(Reporting 2009 CQC) - Annual											
k	Outpatient Survey Results	Quality Schedule	tbc	tbc	(Reporting 2009 CQC) - Annual											
l	Maternity Survey Results	Quality Schedule	tbc	tbc	(Reporting 2009 CQC) - Annual											
m	Local Patient Surveys	Quality Schedule	tbc	tbc	Six monthly local patient survey of 200 patients to be collated by audit											
n	Patient Response recommendation to Friend or Relative	Quality Schedule	tbc	tbc	Not available											
p	Heart Disease Audits	Quality Schedule	5	5	Non identified for 2010/11											
q	Assurance & Safety Audits	Quality Schedule	tbc	tbc	Non identified for 2010/11											
r	National Sentinel Audit of Stroke	Quality Schedule	60 cases	tbc	National Sentinel Stroke Clinical and Organisation Audit.											
s	Local Audits	Quality Schedule	tbc	tbc	Adult Inpatient Record audit and review of unplanned admissions from Day Surgery audit.											
t	National Audits	Quality Schedule	tbc	tbc	Issuing of EDS and discharge planning audit, End of Life audit and Inpatient Discharge details audit.											
u	Cancer Audits	Quality Schedule	tbc	tbc	Dorset Cancer Network CVC line audit											
v	Positive Feedback from Patients	Quality Schedule	tbc	tbc	38	49	13	50	86	45	27	27				335
y	Number of safeguard referrals to Adult Safeguarding Triage Team	Quality Schedule	tbc	tbc	3	1	5	8	3	3	2	2				27
ah	Safeguarding children (compliant with CQC standards)	Quality Schedule	tbc	tbc	tbc											
ad	% PROMS Completed	Quality Schedule	58%	tbc	74.7%	66.7%	66.2%	60.4%	55.6%	50.7%	60.5%	62.2%				62.7%
ai	% PROMS Completed - Primary Unilateral Hip or Knee Replacements	Quality Schedule	68%	tbc	81.0%	73.4%	73.6%	68.0%	68.5%	53.7%	59.0%	66.2%				67.9%
aj	% PROMS Completed - Groin Hernia Surgery and Varicose Vein Procedures	Quality Schedule	31%	tbc	50.0%	41.2%	33.3%	25.0%	29.6%	41.7%	65.0%	47.1%				41.6%
af	Patient Moves (more than twice by 1000 bed days)	Quality Schedule	tbc	tbc	Under investigation											
aq	Annual clinical audit plan and bi-annual report against progress	Quality Schedule	tbc	tbc	tbc											
2	Safety															
b	MRSA infections Total(Cumulative)	Quality Schedule	9	4	0	0	0	0	0	0	0	0				0
c	MRSA infections -Hosp Acq post 48Hrs	Quality Schedule / Monitor	4	2	0	0	0	0	0	0	0	0				0
f	C-difficile infections Total	Quality Schedule	119	tbc	11	7	12	6	4	11	11	11				73
g	C-difficile infections -Hosp Acq Post 72 Hrs	Quality Schedule / Monitor	58	45	5	4	5	2	2	4	7	3				32
l	Overall Ward Cleaning Score	Quality Schedule	tbc	tbc	89.6%	92.2%	88.6%	85.0%	90.3%	88.9%	89.5%	91.6%				89.5%
ay	Report on environmental cleaning score for the Trust	Quality Schedule	tbc	tbc	tbc											
az	PEAT assessment outcomes and actions	Quality Schedule	tbc	tbc	tbc											
m	Screening elective patients for MRSA (there is an exclusion criteria)	Quality Schedule / Monitor	65.2%	100%	84.0%	86.8%	87.0%	83.9%	86.5%	82.7%	86.9%	100.0%				85.4%
ag	Screening non-elective patients for MRSA (there is an exclusion criteria)	Quality Schedule	100%	100%	70.7%	80.8%	79.5%	62.3%	77.7%	81.2%	81.7%	85.8%				77.5%
at	Central Venous Catheter Infections	Quality Schedule	tbc	tbc	tbc											
au	The number of patients acquiring a surgical site infection following clean surgery	Quality Schedule	tbc	tbc	tbc											
av	Ventilator Associated Pneumonia	Quality Schedule	tbc	tbc	tbc											
o	No of Serious Untoward Incidents (SUIs reported to SHA)	Quality Schedule	11	10	2	5	2	3	2	3	1	1				19
u	% WHO Surgical Safety Checklist carried out of patients undergoing a surgical procedure	Quality Schedule	95.0%	tbc	Under development											
v	No of Falls Reported incidents	Quality Schedule	820	(-20% 08/09)	78	80	58	83	81	58	65	64				567
bb	Patient falls (annual audit of 10 sets of notes)	Quality Schedule	tbc	tbc	To be developed											
x	No of Bed Pressure Sores reported	Quality Schedule	41	(-20% 08/09)	1	4	4	5	3	0	3	7				27
y	No of Root Cause Analyses being carried out	Quality Schedule	66	tbc	2	4	1	4	5	5	2	4				27
ba	No of reported root cause analyses completed with action plans developed	Quality Schedule	tbc	tbc	tbc											
aa	Never Events' that occur within the trust (NPSA)	Quality Schedule	0	0	0	0	0	0	0	0	0	0				0
ab	Norovirus- beds closed (empty & occupied)	Quality Schedule	tbc	tbc	tbc											
ac	Patient Observation Audit (MEWS) [MEW's audit NICE audit tool 50 sets of patient notes]	Quality Schedule	tbc	tbc	95.0%			99.0%			97.0%					97.0%
ad	Malnutrition Universal Screening Tool (MUST)	Quality Schedule	tbc	tbc	44.0%			60.0%			59%			58%		55.3%
af	Global Trigger Tool (Number reviewed per month)	Quality Schedule	50 notes	tbc	Bi annual report reviewing outcomes						Bi annual report reviewing outcomes					
ag	NHSLA Standards (Compliance Level 2 NHSLA standards and status)	Quality Schedule	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2				
ah	NICE technology appraisal and guidance (% compliance with all NICE technology appraisals)	Quality Schedule	tbc	tbc	tbc											
ai	Nutritional care (% of patients having nutritional assessments completed)	Quality Schedule	tbc	tbc	tbc											
aj	Pressure Ulcers (Audit of 10 patients notes against standards set out in NICE guidance)	Quality Schedule	tbc	tbc	Bi Annual Audit of 10						Bi Annual Audit of 10					
ak	Patient Falls (Audit of 10 patients notes)	Quality Schedule	tbc	tbc	Bi Annual Audit of 10						Bi Annual Audit of 10					
al	Returns to theatre (Unplanned return to theatre during same inpatient admission)	Quality Schedule	tbc	tbc	tbc											
am	Safety Alerts (Number and type of safety alerts and Chief Medical Officer alerts outstanding)	Quality Schedule	tbc	tbc	tbc											
bc	Safety Alerts - DoH Chief Medical Officer alerts outstanding	Quality Schedule	tbc	tbc	tbc											
bd	Safety Alerts - Number of CAS alerts received and actioned	Quality Schedule	tbc	tbc	12	19	19	15	8	15	15	14				117
be	Safety Alerts - Number of outstanding beyond require implementation date	Quality Schedule	tbc	tbc	8	8	8	8	11	11	4	2				60
an	Serious Untoward Incidents (Number of SUIs declared and anonymised investigation)	Quality Schedule	tbc	tbc	2	5	2	3	2	3	1	1				19

Appendix C

Quality Standards

		Actual Monthly Performance														Cumulative YTD Actual
Standards	Corporate Framework Element	Outturn 2009/10	Plan 2010/11	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	
ao	Adverse Incidents (Number of patient safety incidents)	Quality Schedule	tbc				tbc									
ap	Caesarean section rates (% of caesarean section rates)	Quality Schedule		Max 22.1%			tbc									
aq	Cleaning/decontamination audits (Environment cleaning audits/PEAT assessment outcomes)	Quality Schedule		tbc			tbc									
ar	Crash Calls (Number of crash calls) - Cardio-respiratory arrest	Quality Schedule		tbc	16	13	15	16	10	12	15	13				110
as	Emergency plans and business continuity plans	Quality Schedule		tbc			tbc									
aw	Medicines Report (Medicines Quality Scorecard)	Quality Schedule		tbc			tbc									
3	Clinical Outcomes															
f	Hospital Standardised Mortality Ratio (HSMR) - Rolling 12 months [Relative Risk]	Quality Schedule	96.8	tbc	105.1	104.4	104.5	105.3	104.6	100.8						104.1
4	People management															
c	Sickness %	Quality Schedule		4.0%	3.96%	3.59%	3.77%	3.61%	3.77%	4.20%	4.39%					3.9%
d	Rolling Sickness %	Quality Schedule		4.0%	4.38%	4.35%	4.31%	4.23%	4.20%	4.21%	4.19%					4.3%
e	Sickness Cost	Quality Schedule		tbc	£187,552	£167,650	£181,716	£175,843	£189,809	£212,655	£234,025					£192,750
f	Rolling Turnover %	Quality Schedule		tbc	10.9%	11.4%	11.4%	11.5%	11.4%	11.4%	11.4%	10.3%				11.2%
g	Appraisals	Quality Schedule		100%	62.0%	61.0%	61.0%	63.0%	61.0%	60.0%	58.0%	56.8%				60.3%
i	Percentage of staff undertaking mandatory training	Quality Schedule		tbc	N/A	N/A	N/A	N/A	N/A	69.0%	65.0%	55.0%				63.0%
k	Percentage of staff with professional registration checks	Quality Schedule		tbc								98.0%				98.0%
l	Medical devices (Bi-annual report on staff training and register of medical devices)	Quality Schedule		tbc			tbc									
m	Percentage of relevant staff with CRB checks	Quality Schedule		tbc								98.0%				98.0%
5	Clinical Effectiveness															
a	Number of Technological Appraisals	Quality Schedule		tbc			tbc									
b	Number of Technological Appraisals Compliant	Quality Schedule		tbc			tbc									
8	Productivity															
f	Cancelled Operation rates for non clinical reasons	Quality Schedule	1.5%	0.8%	2.4%	1.2%	2.3%	1.8%	3.2%	2.4%	3.0%	1.6%				2.2%
s	Delayed Transfers of Care	Quality Schedule	3.7%	3.5%	4.1%	4.4%	2.9%	4.2%	4.5%	4.0%	4.1%					4.1%
9	Access															
w	% GUM < 48 hours Offered	Quality Schedule	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%
z	Thrombolysis 'call to needle' < 60 mins	Quality Schedule / Monitor	52.4%	68.0%	100.0%	100.0%	100.0%	33.3%	100.0%	100.0%	0.0%	100.0%				62.5%
ad	Choose & Book - Slot Unavailability Rate	Quality Schedule	14.4%	10.0%	5.8%	5.6%	9.6%	7.9%	8.7%	8.5%	8.6%	5.4%				7.5%
ak	Delayed Ambulance Handovers (over 15 minutes)	Quality Schedule	10.6	0	11.0%	10.1%	14.2%	11.4%	10.6%	11.5%	15.4%	10.5%				11.8%
al	Delayed Ambulance Handovers (over 30 minutes)	Quality Schedule		0	1.3%	0.7%	0.7%	1.0%	1.6%	0.6%	0.9%	1.1%				1.0%
13	Data Quality															
h	% of SUS data altered after 5 operational days and reconciliation point	Quality Schedule		tbc												
p	Discharge audit report	Quality Schedule		tbc												
17	CQIIN															
a	Reduce avoidable death, disability and chronic ill health from Venous thromboembolism (VTE) (% of all adults inpatients who have had a VTE risk assessment on admission to hospital using the national tool)	Quality Schedule / CQIIN		95.0%			18.5%	19.7%	15.6%	16.8%	29.7%	59.0%				26.6%
18	Programme Specific Reports															
g	Programme Specific reports - Planned Care and Long Term Conditions	Quality Schedule		tbc												
h	Programme Specific reports - Urgent and Emergency Care	Quality Schedule		tbc												
i	Programme Specific reports - Staying Healthy	Quality Schedule		tbc												
j	Programme Specific reports - End of Life Care	Quality Schedule		tbc												
k	Programme Specific reports - Maternity, Newborn, Children and Young People	Quality Schedule		tbc												
l	Programme Specific reports - Mental Health	Quality Schedule		tbc												

Appendix D

CQUIN Standards

	Standards	Corporate Framework Element	Outturn 2009/10	Plan 2010/11	Actual Monthly Performance												Cumulative YTD Actual
					Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	
17	CQUIN																
a	Reduce avoidable death, disability and chronic ill health from Venous thromboembolism (VTE) (% of all adults inpatients who have had a VTE risk assessment on admission to hospital using the national tool)	Quality Schedule / CQUIN		95.0%			18.5%	19.7%	15.6%	16.8%	29.7%	59.0%					26.6%
b	Improve responsiveness to the personal needs of patients (responsiveness to personal needs calculated from 5 survey questions)	CQUIN		% improvement on 2009 to be agreed	To be developed												
c	Optimise elective care pathways for the management of chest pain (develop diagnostic capacity in order to implement the NHS Dorset's chest pain pathway to deliver a reduction in elective angiogram activity)	CQUIN		2009/10 outturn for elective angiogram activity	To be developed												
d	Optimise elective care pathways (reduce repeat outpatient numbers / increase patients discharged at first outpatient appointment to national average)	CQUIN		national average - 31.18%	To be developed												
e	Optimise elective care pathways (Improve the average length of stay for patients to the national median level)	CQUIN		national median level - 5.5	To be developed												
f	Reduction in admissions to hospital (reduce activity / referrals by 3% total over one year)	CQUIN		3% reduction	To be developed												

Patient Safety report

The patient safety report indicates the Trust position up to the end of November 2010

Note: Each section includes indicates in the right hand section of each header. A RAG process (Red, Amber, Green) shows the current situation of this section. An upward arrow shows an improvement from the previous month, a downward arrow shows deterioration from the previous month. A horizontal arrow denotes no change from the previous month.

1. Mortality (Hospital Standardised Mortality Ratio)

The HSMR for period April to September 2010 was 90.5 with a rolling 12 month position of 101 (See graph below), 100 being the normal position of relative risk. Stroke mortality for April to September 2010 is 115.9, with a rolling 12 month positions of 119.2. The National expected position should be achieving within the range of 90 to 100 for both.

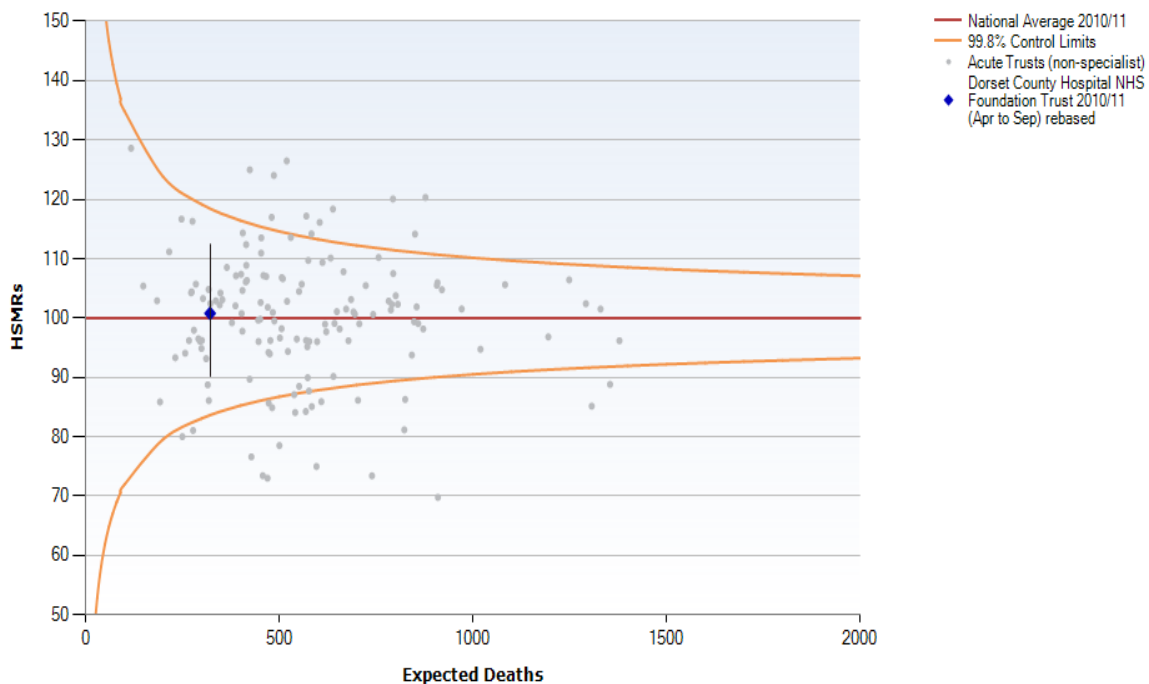
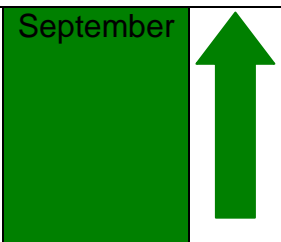


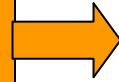
Table 1 - Benchmarking, April to September 2010, including day cases

	Total
Dorset County Hospital	90.5
Royal Bournemouth and Christchurch Hospitals	90.3
Yeovil Hospital	104.8
Salisbury Hospital	94
Poole Hospital	100.9

2. Incident reporting

There is a rise in the number of actual medication errors; these will be reviewed at the next Safer Medicine Practice Committee to see what actions are required.

November



No trends have been identified with the SUIs reported.

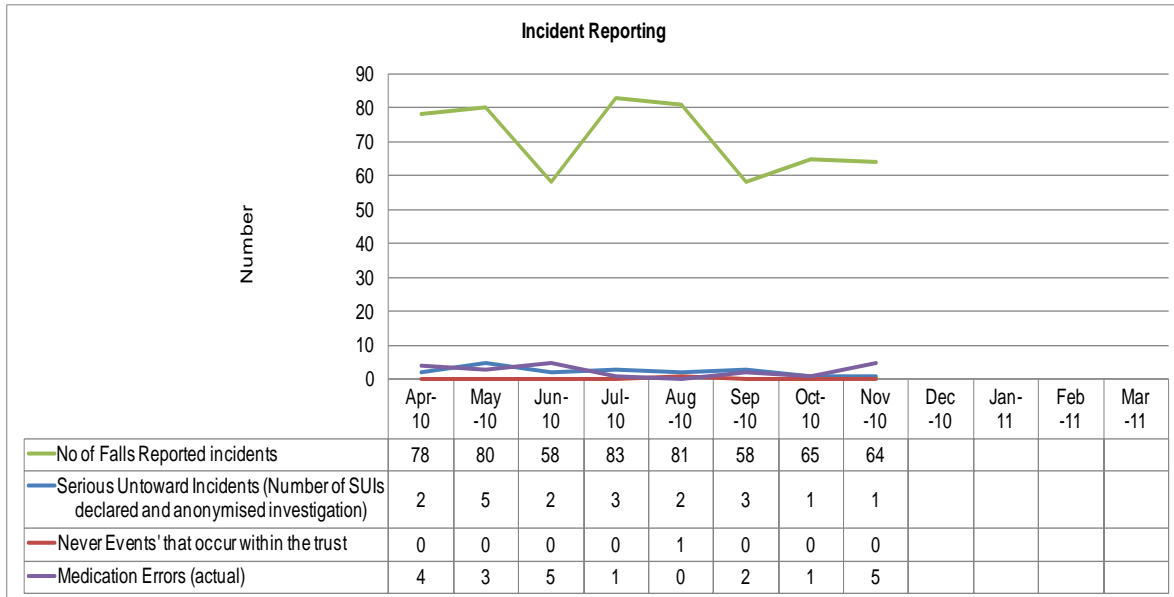


Table 2 - Reported incidents in November 2010

	Medicine	Surgery	Family	Clinical and Scientific	Other	Total
Serious Untoward incidents	1					1
Never Events						
Patient Falls	41	22			1	64
Medication Error (actual and near misses)	21	4	6	9	1	41
All other incidents	87	114	25	23	24	273
Total	150	140	31	32	26	379

3. Cardiac Arrests

The cardiac arrest data included all calls to the emergency line 2222 and calls that were related to a cardio-respiratory arrest.

November



The fall from 30 cardiac arrest calls in October to 21 calls in November is part of the normal fluctuation throughout the year and is not significant. The average number of calls per month to date is 24 (in the range 14 to 37). The monthly average for 2009-10 was 25.66.

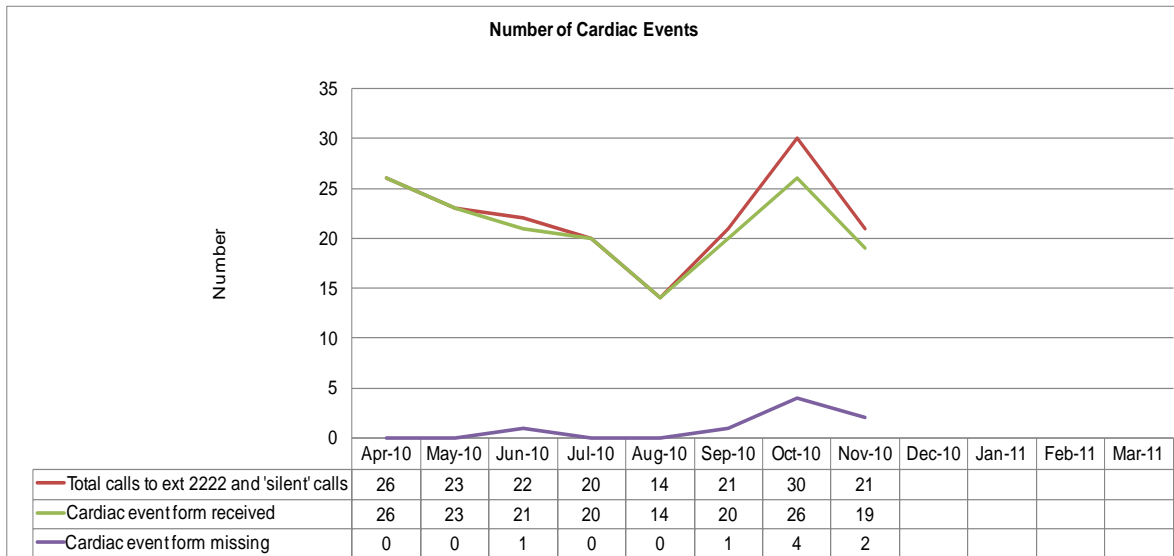
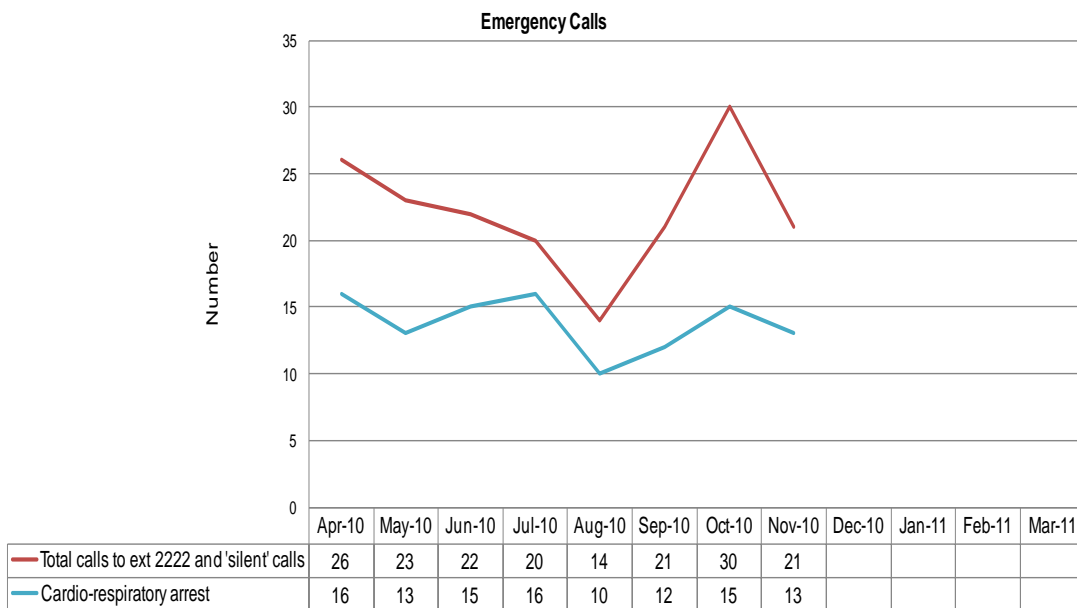


Table 3 - Emergency Calls in November 2010

	Medicine	Surgery	Family	Total
Total calls to 2222	12	8	1	21
Cardio-respiratory arrest calls	11	2	1	13



4. Complaints

Over the month of October, the recurring themes related to communication, including a request to review literature sent out for the breast clinic, and access to hospital services, which includes changes to appointments/procedure dates. Actions are being taken by the areas involved.

October



Directorate	Informal contacts	Formal and complex contacts
	1/11/10-30/11/10	1/11/10-30/11/10
ACCESS/ Administration	3	0
Clinical and Scientific	2	3
Governance	0	0
Family Services	2	3
Medical Services	16	9
Surgical Services	15	8
Estate	0	0
Finance	2	0
Human Resources	0	0
Infection control	0	0
Trust HQ	0	0
Other(inc PCT and Hospedia)	0	0
Ambulance Service	0	0
Grand Total	40	23

Table 4 - Complaints received and overdue responses October 2010

	Medicine	Surgery	Family	Clinical & Scientific	Total
Complaints received, formal and complex.	7	9	7	0	23
Formal complaints responded to within 20 days or as agreed with the complainant	3	5	4	n/a	12
Complex complaints responded to within 40 days	1	2	2	n/a	5
Informal complaints responded to within 20 days	5	11	2	0	18
Number of overdue responses at end of month – November 2010	0	4	1	0	5
Active (open) complaints at end of month – November 2010	4	11	1	1	17

5. Pressure Ulcers (Hospital Acquired)

The system for reporting pressure ulcers has been changed to ensure that the ulcer grades are recorded within the Datix report. Nursing staff have been reminded to submit incident forms, which will explain the increase in reporting.

November

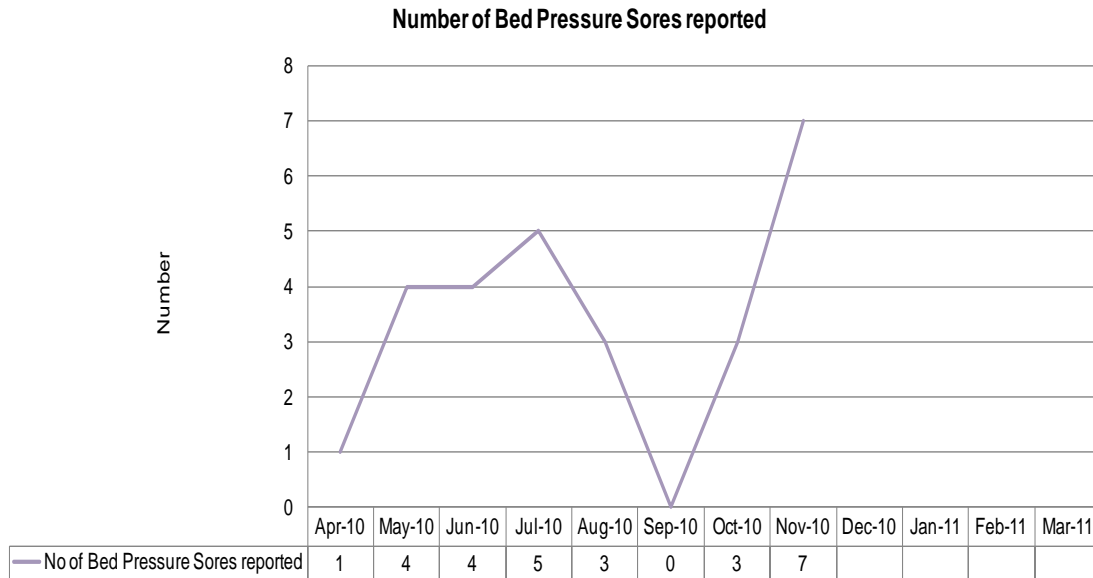


Table 5 - Hospital Acquired Pressure ulcers by division – November 2010

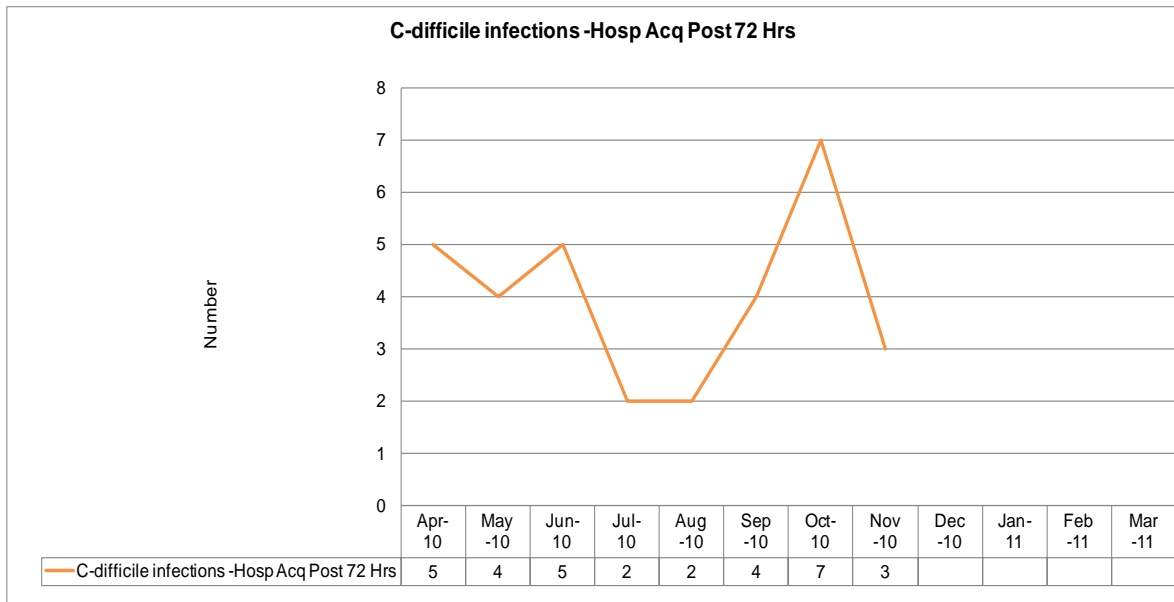
	Medicine	Surgery	Family	Total
Pressure Ulcers Grade 1		1		1
Pressure Ulcers Grade 2	4	1		5
Pressure Ulcers Grade 3				
Pressure Ulcers Grade 4				
Graded not reported	1			1
Total number of pressure ulcers	5	2	0	7

6. Infection Control

6.1 Clostridium Difficile

There are 3 cases reported during month of November against monthly trajectory of 3.

November



6.2 MRSA Bacteraemia

There have been no hospital acquired MRSA bacteraemia (pre 48 hours) since September 2009.

November



6.3 MRSA Screening

MRSA screening indicator measures the percentage of patients screened for MRSA as identified within national guidelines. Performance for November was 89% against national requirement of 100%. National MRSA screening rates are calculated by comparing numbers of admission within categories that should be screened with the number of screening tests carried out. Performance when calculated using this methodology would result in 100%.

November

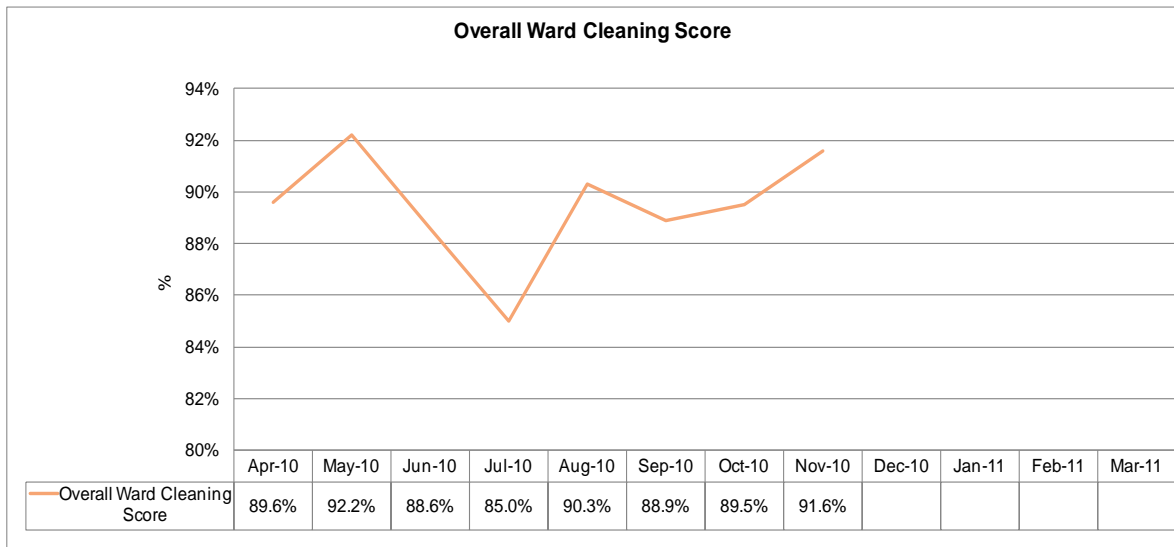


7. Infection Control Audits

7.1 Cleaning Audits

The overall score is made up of the following audit scores, domestic cleaning, nurse cleaning and estates.

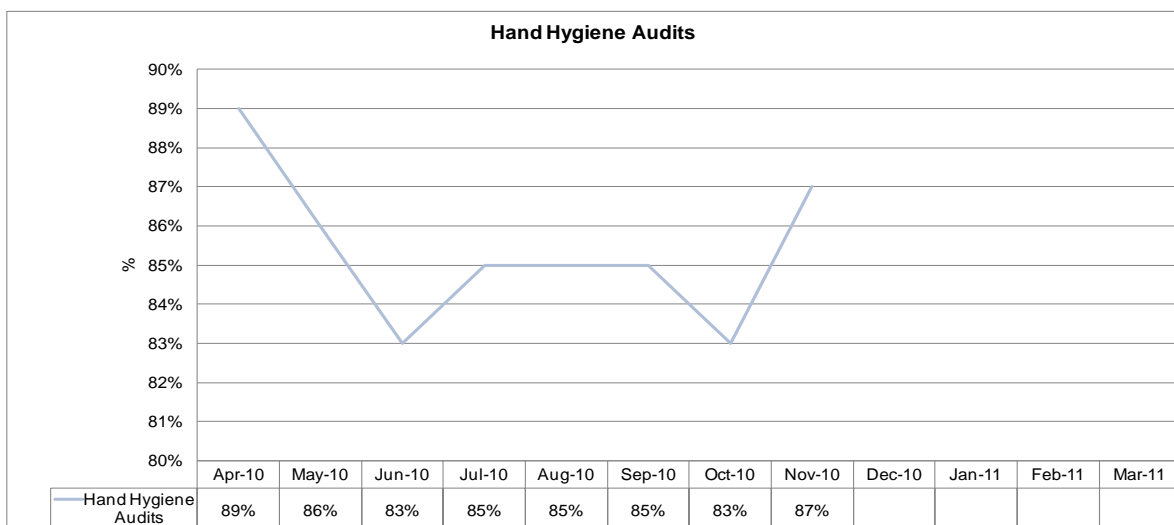
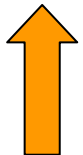
November



7.2 Hand Hygiene Audits

The method for auditing against hand hygiene standards has recently been changed to the IHI (Institute for Healthcare Improvement) Audit Tool; this audit tool undertakes a more detailed scrutiny of practice and therefore it is expected that the results will drop until the practice aligns to the revised audit standards.

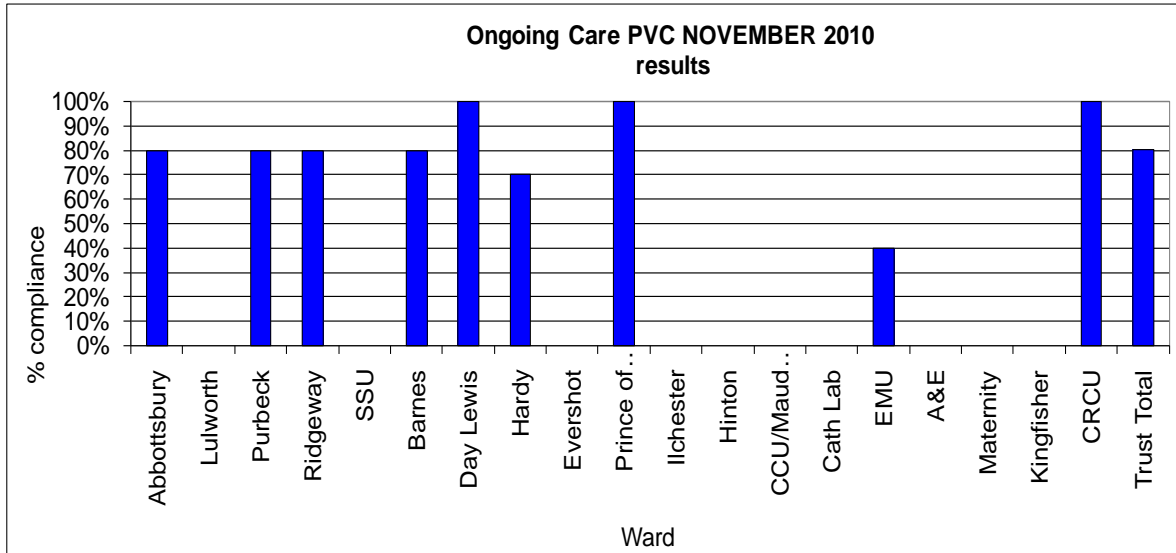
November



7.3 Peripheral Venous Cannula Audits

The focus has been to concentrate on PVC audits which have seen an improvement from September 76% to October 91% and decreased to 80% in November.

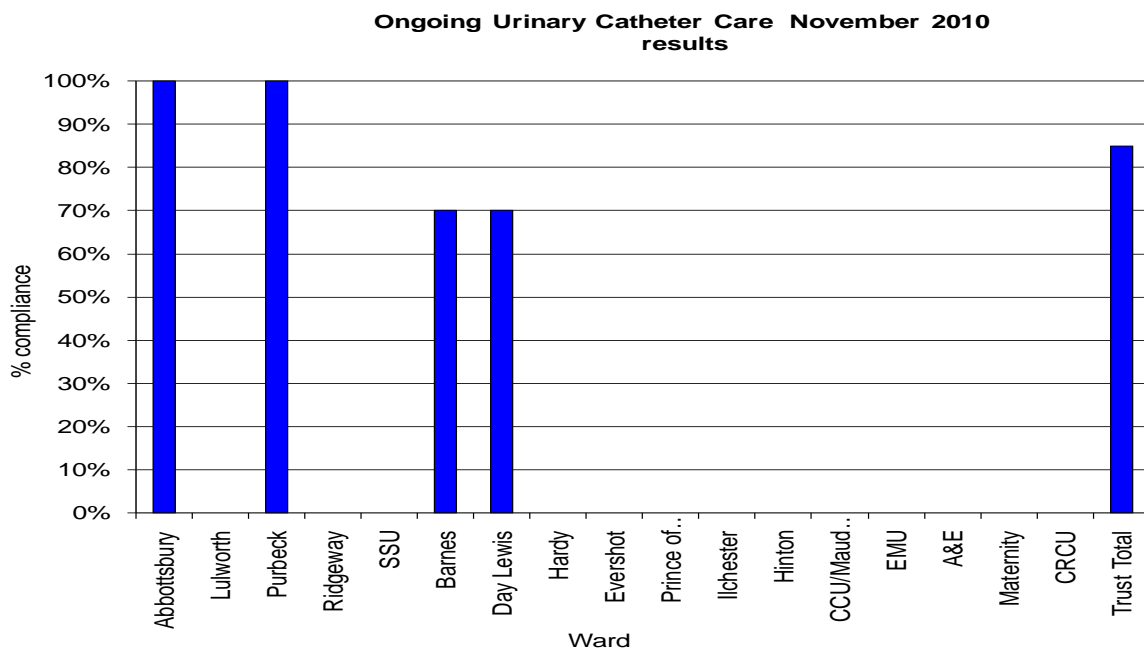
November



7.4 Urinary Catheter Audits

There has been a reduction of wards reporting in October with only one ward carrying out Urinary Catheter audits. This is being addressed with the divisional matrons. There has been an increase in reporting to four wards during November.

November



8. Nutritional Assessments


The results for staff completing MUST (Malnutrition Assessment Scoring Tool) has been lower than our acceptable level and so this audit is being conducted on a monthly basis until the standard improves.	November	
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Table 6 - Results for MUST audit - November 2010

	Step 1 BMI Score	Step 2 Weight Loss Score	Step 3 Acute Disease Effect Score	MUST Score (step 1 +2+3)
All Wards	61%	61%	59%	58%
Abbotsbury	40%	40%	40%	40%
Barnes	100%	100%	100%	100%
CCU	60%	60%	60%	60%
Day Lewis	40%	40%	40%	40%
EMU	100%	100%	100%	100%
Hardy	80%	80%	80%	80%
Hinton	60%	60%	60%	60%
Ilchester	20%	20%	20%	20%
ITU/HDU	100%	100%	75%	75%
Lulworth	40%	40%	40%	40%
Maud Alexander	40%	40%	40%	40%
Prince of Wales	80%	80%	80%	80%
Purbeck	100%	100%	100%	80%
Ridgeway	60%	60%	60%	60%
SSU	0%	0%	0%	0%

	Step 1 BMI Score	Step 2 Weight Loss Score	Step 3 Acute Disease Effect Score	MUST Score (step 1 +2+3)
Surgery Division	48%	48%	48%	44%
Medicine Division	68%	68%	66%	66%

9. National Patient Safety Agency

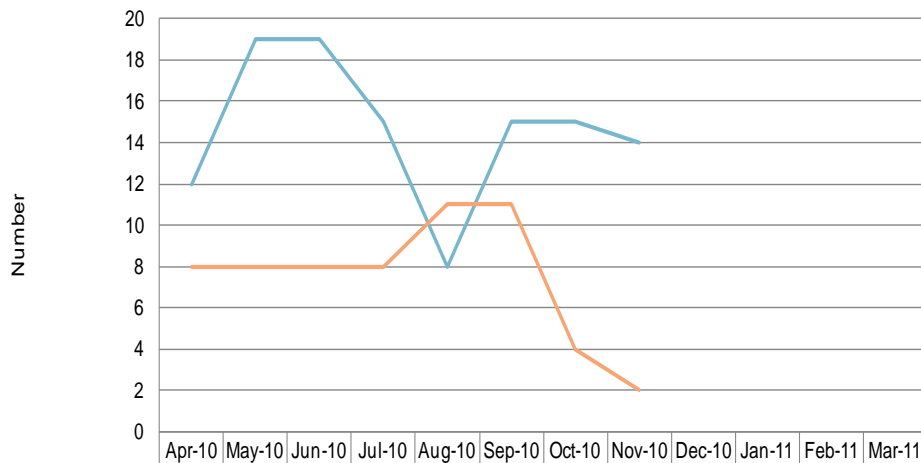
Two alerts are outstanding at the end of November.

The Management of Radiological Findings will remain open until June 2011 approximately whilst the Medical Director Chairs a Working Group which will ensure all actions are closed. The final alert is on the subject of Right Blood, Right Patient, which is due to be finalised in January 2011, and is now recorded on the risk register, with the Transfusion Nurse Practitioner.

November



National Patient Safety Agency



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
— Safety Alerts - Number of CAS alerts received and actioned	12	19	19	15	8	15	15	14				
— Safety Alerts - Number of outstanding beyond require implementation date	8	8	8	8	11	11	4	2				

SECTION D: WORKFORCE OVERVIEW

1.0 PURPOSE

1.1 The purpose of this section of the Operational Report is to provide data and commentary relating to the key workforce performance measures, to date 30 Nov 10, and details of the key actions being taken in the areas of under-performance, namely sickness absence, staff appraisal, and essential skills training.

1.2 Main headings are:

- Key Workforce Performance Measures.
- Under-Performance - Key Actions.
- Recommendation.

2.0 KEY WORKFORCE PERFORMANCE MEASURES

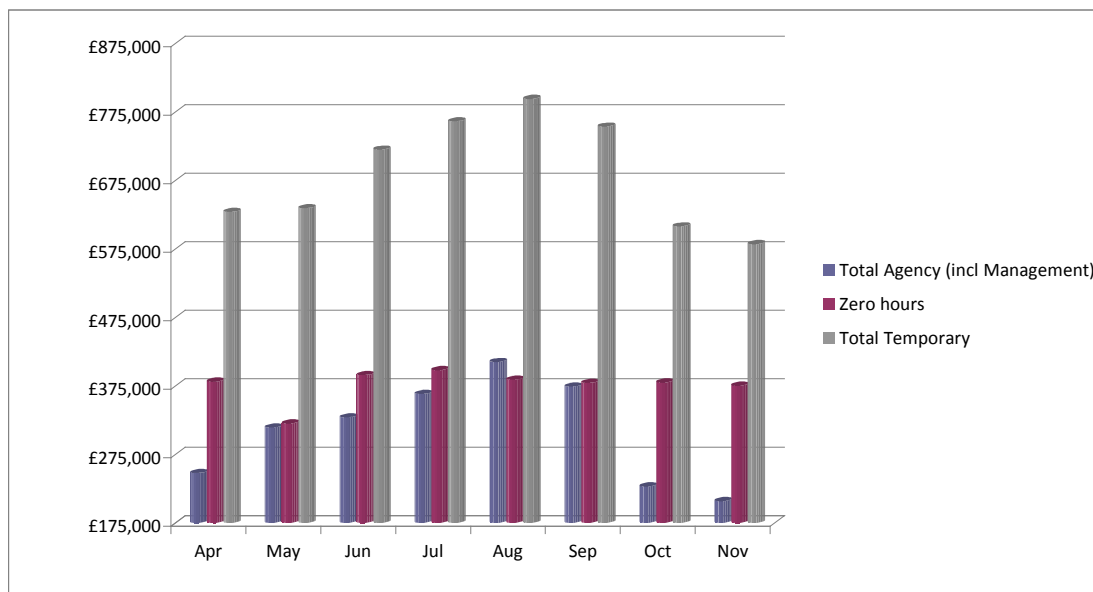
2.1 **Appendix D1** presents, in 'Dashboard' format, current data and trend analysis relating to the key performance measures detailed within the Workforce Scorecard, at **Appendix D2**. With the exception of the Sickness Absence Rate and Workforce Skill Mix data (which are reported one month in arrears), the data relate to Nov 10 (Month 8).

2.2 Full definitions relating to all workforce performance measures are provided at **Appendix D3**.

2.3 Headline commentary is as follows:

Workforce Capacity and Cost

- Marginal in-month reduction in substantive workforce capacity of 0.8 FTE.
- Between Oct - Nov temporary workforce capacity (i.e. bank and agency staff) reduced by 8.2 FTE and currently represents 6.5% of total workforce capacity (compared with 6.9% in Oct).
- Total workforce capacity (i.e. substantive plus temporary) reduced by 9.0 FTE in-month, and by 56.6 FTE against the Apr 10 baseline.
- In-month total expenditure on temporary staff reduced by £36k, which is £47k below the Apr 10 baseline. Current expenditure represents the lowest level for this financial year. The year to date cumulative temporary workforce expenditure is £5.5 million, which represents 7.5% of the overall pay bill for the same period (compared with 8.4% in Oct).
- The average monthly run rate for temporary workforce expenditure has further reduced from £701k in Oct, to £686k in Nov (the second successive month in which expenditure has reduced).
- The table below shows the year to date expenditure on temporary workforce, by type, i.e. Agency, Bank (zero hours), and Total.



- A reduction in total workforce cost was achieved for the fourth successive month.
- Both total workforce capacity and total workforce cost remain below their budgeted levels for the year to date.

Workforce Efficiency

- The current sickness absence rate is 4.4%, representing an increase of 0.2% between Sep - Oct and 0.4% against the Apr 10 baseline. This deterioration means that sickness levels are again at their highest for this financial year, and marginally above the 4% NHS average.
- The turnover rate remains broadly static, at 10.3%, and gives no cause for concern.
- The unit labour cost (i.e. indicative gross cost per employee) for Nov is £39.39k. This represents a further small in-month decrease of £0.16k, and a decrease of £0.26k against the Apr 10 baseline. Initial benchmarking using data from the Health and Social Care Information Centre shows consistency with other similar-sized acute Foundation Trusts, nationally.

Workforce Skill Mix

- The number of professionally qualified (non-medical) clinical workforce equates to 72.5% of the total non-medical clinical workforce. This represents a ratio of approximately two thirds qualified (or trained) to one third non-qualified (or untrained), which is consistent with other similar-sized acute trusts, nationally.
- Data relating to the percentages of staff at the various career framework levels are intended to provide a broad indication of skill mix across the workforce. For all levels, there continues to be no significant movement in the year, to date. The Workforce and HR directorate is reviewing the Trust's current workforce plan and will be working with Divisions to produce an updated 11/12 plan by 31 Mar 11. This process will include further analysis of skill mix at staff group and specialty/ department level.

Workforce Management

- At 99.7%, workforce stability is at its highest level this year.
- The annual appraisal rate considers what percentage of the substantive workforce remains in date for annual appraisal. Ideally, every member of staff should always be 'current' with respect to

appraisal, although allowance needs to be made for staff who may be absent on maternity leave, or through long term ill health. Therefore, a compliance rate of c. 85-90% is considered to be a realistic target. In-month, the overall recorded compliance rate has reduced by 1.2%, from 58% to 56.8%. This under-performance represents a further area of concern.

- The Trust's essential skills compliance (i.e. the proportion of staff remaining in date for all elements of 'essential' training) is reported to be 55%, which represents an in-month reduction of 10%. Although this figure cannot be fully verified, since the accuracy of recording and reporting of all training being undertaken is recognised in itself as an area that must be addressed, it is clear that the essential skills compliance rate must improve.

Benchmarking

- An aim for future workforce performance reports is to include benchmarking data for a range of key measures. Ideally, any such comparative data should relate to other foundation trusts of a similar size to DCH. Initial research has revealed a shortfall in the availability of timely and relevant information. In order to address this, the Workforce and HR directorate has initiated the task of collating and maintaining contemporary data from 15 foundation trusts. Anticipating a positive response to this initiative, benchmarking information will be updated monthly, and shared amongst participating trusts.

3.0 UNDER-PERFORMANCE – KEY ACTIONS

Sickness absence

3.1 Reducing sickness absence, and maintaining low levels of absence, within all areas of the Trust, remains a priority for the Workforce Managers, who will continue to support line managers and supervisors in proactively managing cases involving both short and long term absence amongst staff. This includes close case management of long term sickness issues, undertaking return to work interviews, robust management of repetitive short term absence and the application of appropriate formal sanctions.

3.2 Sickness absence data is comprehensive and provides, at ward/department level, both the in-month and rolling annual average rates, together with the total number of days lost. This data is being used to highlight 'hot spots' and trends, and therefore to inform the requirement for appropriate additional actions and interventions to address particular underlying causes.

Appraisal

3.3 In response to the apparent worsening position, with respect to annual appraisal compliance, a number of key initiatives are being taken. These interventions are detailed within the action plan at **Appendix D4**. Implemented on 6 Dec, the action plan aims to significantly improve performance before the end of this financial year.

Essential Skills Compliance

3.4 For the second successive month, essential skills compliance has failed to improve and, indeed, has worsened. This position is, in part, attributable to a high rate of non-attendance at scheduled and recorded training sessions. The records held centrally by the Education Centre indicate a 16% failure to attend rate at essential training during the month of November, alone. This rate is likely to be higher if training organised by individual departments is also taken into account (since non-attendance here is not recorded).

3.5 This issue further confirms the need to review and improve the way in which essential skills training is delivered and recorded, and to ensure all staff fully understand the essential skills training they are mandated to undertake, and at what frequency it must be undertaken (e.g. at induction only; annually; three-yearly). To this end, a task and finish group, headed by the Associate Director of

Education, has been established. The initial focus of the group has been to revise and simplify the existing essential skills matrix, and to strengthen the associated Trust policy. The continuing emphasis of the group's activity will be to:

- increase staff awareness of their responsibility to complete their requisite essential skills training;
- clarify the consequences for individuals and line managers when training is not undertaken;
- improve access to, and delivery of, essential skills training;
- improve the accuracy of recording and quality of reporting data.

Significant improvement is required within the remaining quarter of this financial year, and a full action plan will be included within the next Workforce Performance report.

4.0 Recommendation

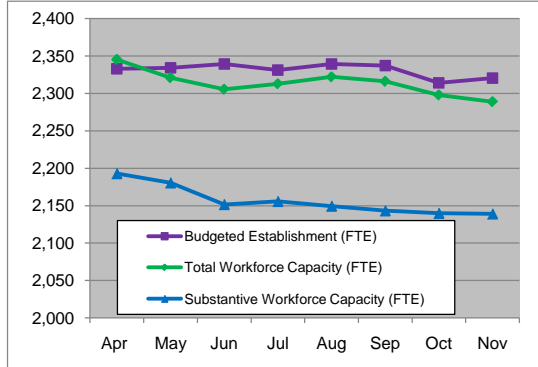
4.1 The Committee is asked to note the Month 8 position, in particular the actions being taken to address the three areas of under-performance.

Appendices:

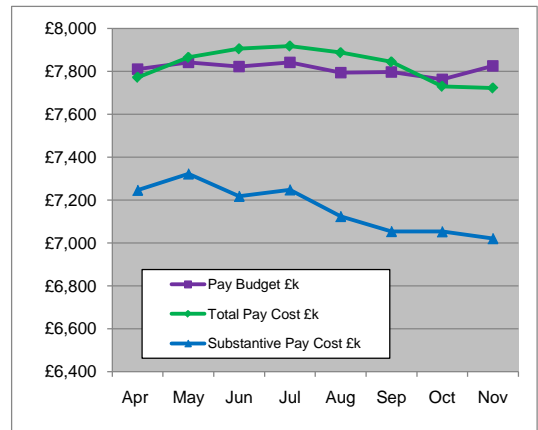
- D1 Workforce Dashboard - Nov 10 (Month 8)
- D2 Workforce Scorecard – Nov 10 (Month 8)
- D3 Workforce Performance Measures - Definitions
- D4 Staff Appraisal Action Plan

WORKFORCE CAPACITY & COST

Workforce Capacity			
FTE	Apr-10 Baseline	Nov-10 M8	Movement from Baseline
Total Substantive	2,192.9	2,139.1	-53.8
Total Temporary	152.4	149.6	-2.8
Total Trust Capacity	2,345.3	2,288.7	-56.6
Substantive by Division			
Surgery	NA	619.6	NA
Medicine	NA	630.9	NA
Clinical & Scientific	NA	253.1	NA
Family Services	NA	270.8	NA
Support Services *	NA	364.7	NA
Temporary by Division			
Surgery	NA	45.0	NA
Medicine	NA	55.9	NA
Clinical & Scientific	NA	3.1	NA
Family Services	NA	11.8	NA
Support Services *	NA	33.8	NA

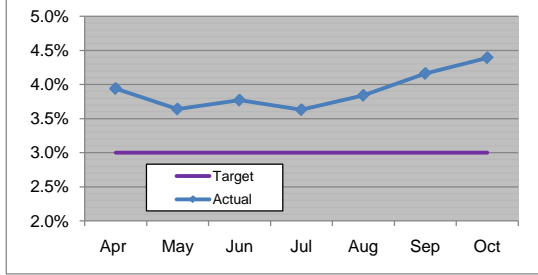


Workforce Cost

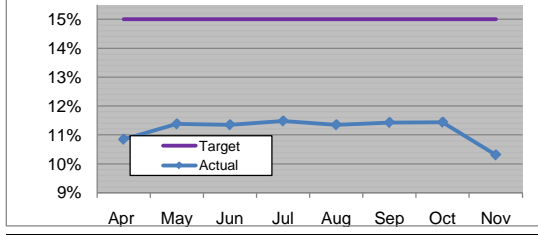


WORKFORCE EFFICIENCY

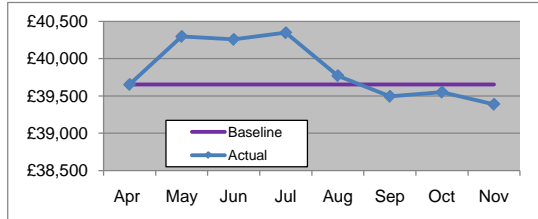
Sickness Absence Rate			
Division	Oct-10 M7	Variance against Target	Movement from Baseline
Surgery	3.9%	0.9%	-0.1%
Medicine	4.8%	1.8%	0.1%
Clinical & Scientific	4.0%	1.0%	0.8%
Family Services	4.8%	1.8%	2.6%
Support Services *	4.1%	1.1%	-0.1%
Total %	4.4%	1.4%	0.5%



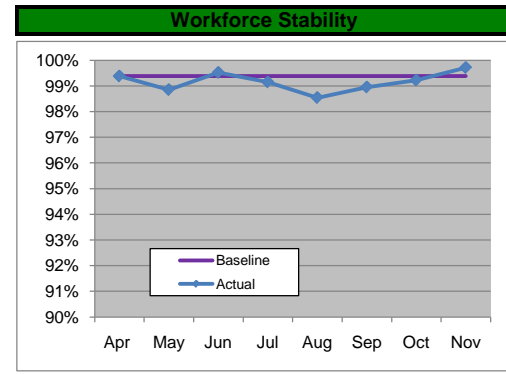
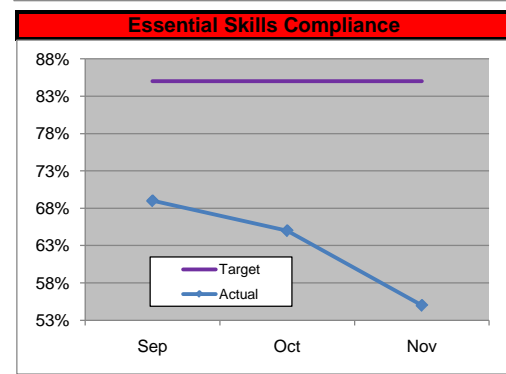
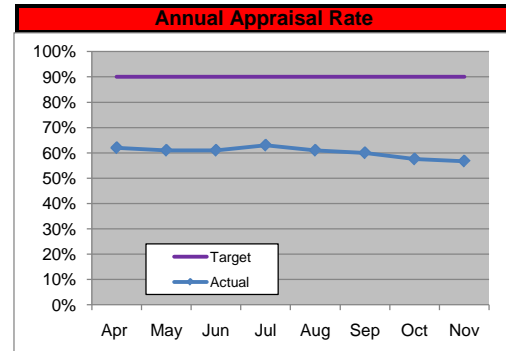
Turnover Rate			
Division	Nov-10 M8	Variance against Target	Movement from Baseline
Surgery	9.9%	-5.1%	1.2%
Medicine	11.2%	-3.8%	-0.8%
Clinical & Scientific	9.2%	-5.8%	-0.5%
Family Services	9.9%	-5.1%	1.6%
Support Services *	11.0%	-4.0%	0.4%
Total %	10.3%	-4.7%	0.6%



Unit Labour Cost	
Nov-10 M8	Movement from Baseline
£39,386.65	-\$265.86



WORKFORCE MANAGEMENT



* Support Services: Estates; Facilities; Finance; HR; Dir. Nursing; Trust HQ; Access; Research

Appendix D2: Workforce Scorecard Nov 10 (Month 8)

Domain	Measure	Month								In Month Change	Variance against Baseline
		Apr 10 (Baseline)	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10		
Workforce Capacity and Cost	Substantive Workforce Capacity (FTE)	2192.9	2180.5	2151.7	2155.8	2149.5	2143.3	2139.9	2139.1	- 0.8	- 53.8
	Temporary Workforce Capacity (FTE)	152.4	140.3	153.8	156.9	172.4	172.7	157.8	149.6	- 8.2	- 2.8
	Total Workforce Capacity (FTE)	2345.3	2320.8	2305.5	2312.7	2321.9	2316.0	2297.7	2288.7	- 9.0	- 56.6
	Total Workforce Cost	£7,772k	£7,865k	£7,905k	£7,918k	£7,887k	£7,844k	£7,730k	£7,722k	- £8k	- £50 k
Workforce Efficiency	Sickness Absence Rate	4.0%	3.6%	3.8%	3.6%	3.8%	4.2%	4.4%	Not Yet Available	+ 0.2% (Sep - Oct)	+ 0.4%
	Turnover Rate	10.9%	11.4%	11.5%	11.4%	11.4%	11.4%	11.4%	10.3%	- 1.1	- 0.6%
	Unit Labour Cost	£39.65k	£40.30k	£40.26k	£40.35k	£39.77k	£39.49k	£39.55k	£39.39k	-£0.16k	-£0.26k
Workforce Skill Mix	Professionally Qualified Clinical Workforce	68.5%	68.5%	68.7%	68.6%	68.8%	68.8%	72.5%	Not Yet Available	+ 3.7% (Sep - Oct)	+ 4.0%
	Staff at Career Framework Level 6 and above	32.0%	32.2%	32.3%	32.2%	31.8%	31.9%	32.1%	Not Yet Available	+ 0.2% (Sep - Oct)	+ 0.1%
	Staff at Career Framework Level 5	22.8%	22.6%	22.7%	22.6%	22.8%	22.5%	22.8%	Not Yet Available	+ 0.4% (Sep - Oct)	Nil
	Staff at Career Framework Levels 1 to 4	45.2%	45.2%	45.1%	45.2%	45.5%	45.6%	45.0%	Not Yet Available	- 0.6% (Sep - Oct)	- 0.2%
Workforce Management	Workforce Stability	99.4%	98.8%	99.5%	99.1%	98.5%	98.9%	99.4%	99.7%	+ 0.3%	- 0.3%
	Annual Appraisal Rate	62.0%	61.0%	61.0%	63.0%	61.0%	60.0%	58.0%	56.8%	- 1.2%	- 5.2%
	Essential Skills Compliance	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	69.0%	65.0%	55.0%	- 10.0%	Not Yet Available

Appendix D3: WORKFORCE PERFORMANCE MEASURES - DEFINITIONS

WORKFORCE CAPACITY AND COST: Support Trust financial health by optimising workforce costs and delivering the Workforce Plan

Measure	Definition	Rationale	Data Source	Target/Baseline
Substantive Workforce Capacity	Total of all NHS staff directly employed, expressed as FTE.	Substantive staff represent the greatest proportion of the overall workforce. In order to maintain financial health and effectively deliver services, substantive staff numbers must reflect the provisions of the divisional workforce plans and budgeted establishments.	Extracted from Electronic Staff Record (ESR) database, which records all movements in workforce numbers, including new joiners, leavers, internal transfers, and changes in hours.	Target derived from overall workforce plan assumptions.
Temporary Workforce Capacity	Total expenditure on all bank and agency usage, converted to indicative FTE (may also be expressed as a percentage of Total Workforce Capacity).	Whilst immediate access to temporary workforce is important to enable the Trust to respond quickly and flexibly to patient needs, such flexibility comes at a higher cost, compared to the use of substantive staff. As a general principle, reliance on temporary workforce must be reduced as much as possible, through (for example) improved retention, effective management of sickness absence, and effective management of rotas and skill mix.	Based upon Finance data relating to total expenditure on all bank and agency staff, converted to FTE.	Target to be established, but most trusts aim to contain Temporary Capacity to within 3 - 4% of Total Capacity.
Total Workforce Capacity	Total of combined Substantive Workforce and Temporary Workforce Capacity, expressed as FTE.	Total Workforce Capacity should be contained within the profiles detailed within workforce plans, the delivery of which is a key success criterion in the achievement of the Trust's financial targets.	Combination of ESR and Finance data.	Target derived from overall workforce plan assumptions.
Total Workforce Cost	The total cost of all elements of the workforce employed (i.e. all substantive, bank and agency staff), expressed as £k.	The Trust's workforce accounts for approximately 70% of its total expenditure. Therefore, it is imperative that total workforce cost is contained within the agreed financial envelope reflected by workforce plans and budgeted establishments (financial planning assumptions will take account of additional inflationary pressures on workforce costs, such as annual incremental rises and national uplifts to pay).	Finance data.	Target derived from overall workforce plan and finance assumptions.

WORKFORCE EFFICIENCY: Improve quality of patient care by increasing workforce efficiency and productivity

Measure	Definition	Rationale	Data Source	Target/Baseline
Sickness Absence Rate	Total working time lost to sickness absence in previous 12 months, expressed as a percentage of total working time available in the same period.	In addition to the direct financial costs of sickness absence, through the use of temporary staff or overtime, there are also indirect effects, including increased work pressure on colleagues, disruption to services (and therefore patient care), loss of productivity, and impact on staff morale and job satisfaction. Therefore, the need to reduce sickness absence to the lowest level possible is compelling.	ESR data.	Target: 3.0% or below.
Turnover Rate	Number of staff leaving the organisation in the previous 12 months, expressed as a percentage of the average Substantive Workforce employed in the same period.	Some turnover is essential in enabling the organisation to 'refresh' the workforce and to provide opportunities for career progression. However, excessive turnover incurs costs relating to recruitment, training, temporary cover, and reduced productivity (through the use of less experienced staff). Costs will be increased in those areas where the demand for staff exceeds supply. High turnover may also be an indicator of poor employment relations.	ESR data.	Target: 10 - 15%.
Unit Labour Cost	Cost of Total Workforce Capacity (£), divided by Total Workforce Capacity (FTE), expressed as £k.	As an indicative cost per employee, this measure is a useful additional indicator of the extent to which the Trust is containing its overall workforce costs, since it will be affected by a range of influences, including the use of bank and agency staff, premium payments, pay grades, and skill mix. The value of this measure will be in the consideration of trend analysis.	Finance data (£) ESR data (FTE)	Baseline: Apr 10.
Workforce Productivity	Total value (£) of all Activity delivered within a given period, divided by the Total Workforce Capacity (FTE) for the period, expressed as £k. (i.e. indicative average revenue per employee)	This measure provides an indicative average revenue per employee. Increasing workforce productivity is essential in enabling the Trust to improve service quality and patient care, and meet its financial targets. Similar to Unit Staff Cost, the value of this measure will be in the consideration of trend analysis.	Finance data (Activity) data (FTE)	ESR Baseline to be established.

WORKFORCE SKILL MIX: Adapt the skill mix of the organisation to maintain a more capable and cost effective workforce

Measure	Definition	Rationale	Data Source	Target/Baseline
% Professionally Qualified Clinical Workforce	Proportion of Professionally Qualified Clinical Staff (Nursing and Midwifery, Allied Health Professionals, Healthcare Scientists) expressed as % of total Substantive Clinical Workforce. (N.B: Qualified Staff in the above Professional Groups are assumed to be at Career Framework Level 5, or above).	When making changes to the overall Skill Mix, it is important that patient services continue to be improved. Therefore, an appropriate ratio of qualified (trained) staff to non-qualified (untrained) staff needs to be retained (notwithstanding that ratios will vary depending upon type of service, patient acuity, etc).	ESR data.	Target to be established, but an overall percentage of c.60% is likely to be appropriate.
% Staff at Career Framework Level 6 and above	Proportion of Substantive Workforce at Level 6 and above of the NHS Career Framework.	An essential starting point when considering role redesign is to examine Skill Mix. The NHS Careers Framework enables analysis of services by skill level and cost. The current Skill Mix profile highlights opportunities to increase our workforce capacity, improve productivity and reduce costs. For example, overall productivity will be increased by enabling experienced qualified nursing staff at level 5 to take on additional responsibilities and progress to nurse specialist and advanced practitioner roles at levels 6, 7 and 8, thereby releasing more productive time for medical staff. Similarly, devolving some tasks and functions currently undertaken at level 5 to staff employed at level 4, will allow qualified nursing staff to more effectively deploy their core skills, whilst level 3 staff will be enabled to progress upwards to undertake tasks at level 4. In addition to increasing productivity, implementing role redesign following a Skill Mix review should have a positive effect on staff, who will feel more valued and motivated, and will therefore deliver better patient care.	ESR data.	Target to be established.
% Staff at Career Framework Level 5	Proportion of Substantive Workforce at Level 5 of the NHS Career Framework.		ESR data.	Target to be established.
% Staff at Career Framework Levels 1 to 4	Proportion of Substantive Workforce at Levels 1 to 4 of the NHS Career Framework.		ESR data.	Target to be established.

WORKFORCE MANAGEMENT: Maintain efficient and effective HRM interventions to supply and develop the future workforce and retain the best staff

Measure	Definition	Rationale	Data Source	Target/Baseline
Workforce Stability	Proportion (%) of Substantive Workforce that remains in post for one year, or more.	Stability is a useful indicator of employment relations and staff satisfaction. Generally, where a new employee is dissatisfied with their employer, they will leave the organisation shortly after joining the organisation (however, this is also likely to be dependent upon prevailing labour market conditions). Given the costs associated with the attraction and recruitment of staff, a high level of stability is desirable.	ESR data.	Target: 85%.
Annual Appraisal Rate	Proportion (%) of Substantive Workforce that has received a performance appraisal within the last twelve month period.	All staff should receive an annual appraisal, such that performance objectives can be agreed and delivery against objectives is assessed. Personal objectives should be aligned to the delivery of specialty/department objectives, and overall Trust goals. Annual appraisal also provides an opportunity for individuals to discuss their personal development needs and objectives, and career aspirations.	Workforce and HR directorate records.	Target: 90%.
Essential Skills Compliance	Percentage of substantive staff receiving required essential skills training within the prescribed timescales.	To ensure the safety of patients and staff, it is essential that all staff receive the essential skills training that is applicable to their roles and responsibilities. This is also an important aspect of the promotion of staff health and well-being at work.	Training Records.	Target: 90%.

Appendix D4: Staff Appraisal Action Plan

Lead for Action Plan:	Jane Ridgway, Head of Operational HR Services
Reviewing Group:	Workforce Managers
Date Action Plan Initiated:	6 December 2010

Issue identified:

The Trust's current appraisal rate is 56.8%; this has deteriorated from 58% in Oct 10 and 60% in Sep 10. Ideally, every member of staff should always be 'current' with respect to appraisal, although allowance needs to be made for staff who may be absent on maternity leave, or through long term ill health. Therefore, a compliance rate of c. 85-90% is a realistic target, which makes the Trust's current compliance unacceptable. For several months now ongoing work has been undertaken by the Workforce and HR directorate including the following:

- Workforce Managers encourage ward/departmental managers to establish action plans to address gaps in compliance;
- comprehensive training is provided for all staff who have a responsibility to undertake annual appraisals;
- presentations have been made to Ward Sisters and Heads of Departments setting out the benefits of appraisal;
- Workforce Managers alert line managers of staff approaching a KSF gateway, on a monthly basis: this also serves as a reminder to conduct appraisals.

Clearly the current strategy is failing and further actions and interventions are required to ensure compliance is significantly improved. Key actions and interventions are as follows:

Action	Responsibility	Target Date	Progress	Review Date
All line managers to be sent an email (copied to their line manager and relevant exec) detailing the appraisal status for their staff: Red = never had or >12 months since last appraisal Amber = >6 months but < 12 months since last appraisal Green = <6 months since last appraisal.	Workforce Managers	13/12/10	Completed	14/12/10
All staff identified as 'red' to have date booked for an appraisal by 07/01/11 and details confirmed with Workforce Manager and relevant executive director.	Workforce Managers	7/01/11		10/01/11
All staff identified as 'red' to have had an appraisal by 31/03/11.	Line Managers	31/03/11		10/01/11

Action	Responsibility	Target Date	Progress	Review Date
Appraisal session to be delivered at HODs meeting to highlight the importance of appraisal, the expectations of line managers and the consequence of those expectations not being met.	Head of Operational HR Services	01/11		10/01/11
New simplified KSF and appraisal process to be reviewed.	Workforce Team	8/12/10	Completed – 2 options for implementation to be put into proposal to discuss at Jan HoDs meeting.	14/12/10
Appraisal policy and documentation to be reviewed in line with above and re-launched if required.	Workforce Team	14/01/11		10/01/11
New Medical Appraisal Policy to be implemented.	Medical Workforce Manager	31/01/11		10/01/11
Appraisal rate to be monitored monthly against an end of month target of: <ul style="list-style-type: none"> ▪ 60% Jan ▪ 65% Feb ▪ 70% Mar ▪ 75% Apr ▪ 80% May ▪ 85% Jun ▪ 90% Jul. 	Head of Operational HR Services	01/11 and ongoing		10/01/11
Appraisal rate to be communicated to line managers monthly and included in monthly Workforce Performance reports to the Trust Board.	Head of Operational HR Services	01/11 and ongoing		10/01/11
Divisional appraisal rates to be monitored monthly through performance framework.	Executive Team	01/11 and ongoing		10/01/11
Disciplinary Policy/Performance Management Policy to be invoked against line managers whose departmental appraisal rates are < targets identified above.	Head of Operational HR Services (with the	01/11 and ongoing		10/01/11

Action	Responsibility	Target Date	Progress	Review Date
	support of the Executive Team)			
Disciplinary Policy to be invoked against employees who refuse to have an appraisal or do not co-operate with the appraisal process.	Line Managers	01/11 and ongoing		10/01/11
Appraisal training to be reviewed to ensure line managers are aware that non achievement of staff appraisal will impact on their own achievement of their KSF relating to People Management and could result in them not progressing through the gateways.	Workforce Managers	01/11 and ongoing		10/01/11
Line managers who are not achieving the Trust appraisal targets will be stopped from moving through a gateway.	Head of Operational HR Services (with the support of the Executive Team)	01/11 and ongoing		10/01/11
Postal appraisals to be completed for locum and bank staff.	Workforce Resourcing Manager	31/03/11		10/01/11

Report to Board of Directors January 2011	
Subject	Patient and Public Engagement report (Quarter 3 2010/11)
Purpose	This report is to inform the Board of the work of the patient and public engagement team.
Responsible Executive	Alison Tong, Director of Nursing
Author of attached Report	Pam O'Shea, Patient and Public Engagement Lead
Summary	The report covers all aspects of engagement and feedback including PALS and complaints. This is a regular quarterly report.
Paper Seen By	Alison Tong, Director of Nursing
Strategic Impact	Engagement with the public and responding to complaints and feedback is of strategic importance in building a positive reputation of the Trust.
Risk Evaluation	Low
Legal Implications	None specifically related to this report.
Financial Implications	None specifically related to this report.
Recommendation	No recommendations
Action Required by Board of Directors	The Trust Board is requested to receive the report for information.

PATIENT AND PUBLIC ENGAGEMENT REPORT

Quarter 3 – 1 October 2010 to 31 December 2010

1.0 INTRODUCTION

1.1 The purpose of this report is to summarise the activity taking place in areas which impact on the patient experience. This includes the monitoring and reviewing of our services as a result of feedback and the actions required to improve the experience of the patient when using services at the Trust.

2.0 COMPLAINTS, CONCERNS, COMMENTS and COMPLIMENTS

2.1 The Trust strives to engage with and learn from patients and their carers. Feedback is obtained in a number of ways including complaints and compliments. All feedback is recorded and actions taken to improve the situation for further users of the service. Whilst positive feedback is always welcomed and encouraged, negative feedback should also be encouraged as it is important to have a balanced view from our patients and visitors.

2.2 In analysing the feedback for this quarter and comparing with the previous quarter, there are a number of key findings. In many instances the negative feedback related to generic issues which upon investigation showed the complaint to be unfounded. There were understandable reasons as to how and why events occurred, however poor communication or indeed a lack of communication at the time of the event, had resulted in patients believing that mistakes or omissions had occurred.

2.3 As a result of reviewing all the contacts this department received it is clear that there are key issues within the Trust that continue to have a negative impact on the patient experience. A recurring theme over the last two quarters is the number of cancelled or rearranged outpatient appointments or operations. Patients have reported feelings of complete disregard for them as individuals and the efforts they have gone to either at home or at work, to fit in with the Trusts requirements. In many instances they are given very short notice of the changes, not given an explanation as to why this change has occurred or not given a new date at the time of the cancellation. Patients are very concerned that they will be lost in the system or forgotten about and particularly with operation dates, that there will be a detrimental effect on the overall outcome of their surgery if it is delayed. One example of a short notice cancellation of an outpatient appointment relates to a patient who had travelled from Portland and arrived in the hospital car park for their appointment. They were then contacted by a family member advising that a message had been left on the home answer phone 15 minutes before the appointment time, cancelling the appointment.

2.4 In other cases, it is not necessarily the number of complaints that are received, but the impact of an incident or event for that person and therefore

how this is handled. In this quarter two patients have alleged they have lost their eyesight due to decisions taken by clinical staff. The complaint was investigated through the complaints procedure and as the investigation progressed, it was clear that there were shortcomings in the clinical care provided. The complaints process does not facilitate an independent review of whether the clinical care was appropriate or not. Further work is being undertaken to ensure the right person with the necessary knowledge and skills is appointed to investigate, which should avoid delayed responses and adding to the distress already caused.

- 2.5 In such complex cases, it also highlighted that although there is a complaints process and a being open policy which links to the litigation process, appropriate action was not taken. It is clear that further work is required with investigating staff outlining their responsibilities in linking these processes together to make it as seamless as possible for the affected person.
- 2.6 During quarter 2 there was a reduction of contacts received from pain clinic patients. Over quarter 3, the department has seen a steady rise in contacts from patients or their carers expressing concerns about the delay in appointments for treatment. These patients are already aware that the Trust is working with NHS Dorset on the changes to the patient pathways, however, given the pain they are experiencing, they do not feel that the intended improvements are taking place as quickly as they expected or meeting their needs.
- 2.7 It is encouraging to note that there has been a reduced number of complaints relating to nursing care on the wards. The general feedback is that the standard of care being provided is good. In this quarter there has been a significant reduction of complaints relating to Ridgeway Ward, this is believed to be aligned to the change in case mix of patients cared for on the ward and the improved knowledge and skills of the staff.
- 2.8 Although overall for this quarter there has been a significant decrease in the number of formal complaints received by the Trust (77 as opposed to 104 for quarter 2), there have been an increase in complainants contacting the Parliamentary and Health Service Ombudsman requesting a review. The reasons for this can be twofold. Firstly, the contact does not feel we have responded effectively to their concerns, which is a significant concern and secondly, we are actively providing the contact details to complainants. To date the Ombudsman has not actively investigated any of the complaints received about this organisation. This indicates that complaints being investigated and responded to are meeting the standard set out by the Ombudsman, however there is further learning to be gained from the patients who feel that their issues have not been addressed, hence why they have sought the Ombudsman's opinion.

3.0 REALTIME PATIENT FEEDBACK

- 3.1 There has been considerable interest amongst both staff and service users in the Trust acquiring a real time feedback system to capture patient experience.

Demonstrations of products from four companies have been planned for 27th January 2011, following which a paper will be prepared for the Executive to consider the implications and costs associated with the introduction of such a system within the Trust.

4.0 PATIENT INFORMATION LEAFLETS

- 4.1 Two members of hospital staff have completed training in the production of 'easy read' information. An easy read complaints leaflet has been developed for people using the Trusts services and is currently being finalised.
- 4.2 The development of easy read information is time consuming and is not the only method for delivering information. Therefore careful consideration will be given to decide which patient information needs to be available in an easy read format.
- 4.3 It has been agreed that easy read information developed by Dorset County Council, the Dorset Community Health Services and the DCHFT will be shared to avoid duplication.

5.0 PATIENT PROPERTY POLICY

- 5.1 In response to continued concerns regarding the handling of patient property and the costs incurred by the Trust in replacing lost property, a patient property policy has been developed setting out clear responsibilities for both staff and patients. This will be launched across the Trust in the next quarter.

6.0 ENGAGEMENT

LINKs

- 6.1 Regular contact continues with the LINKs facilitator. Dorset LINK will be launching a project which will review malnutrition awareness and assessment in Health and Social Care services in Dorset. This project is supported by the Care Quality Commission and as part of the review, will involve 'enter and view' teams to the hospital. An initial meeting is taking place in January 2011 following which further information regarding the planned work will be available.

West Dorset Older Peoples Health and Care Services Group

- 6.2 Age UK have recently published their findings, "Hungry to be Heard", raising awareness of malnutrition in older people, which is estimated to cost the NHS at least £7.3 billion a year. Assurances are being sought by the group on how the Trust is addressing this issue and this will be discussed at the next meeting.

The Independent Carer's Forum

- 6.3 The independent carer's forum supports the wellbeing of carers for people with mental health issues. In response to improving the experience of both carers and service users with mental health issues, the group have developed a 'rethink' card which will act as a prompt to staff within the hospital and the general public outside the hospital to raise awareness and adapt their approach to the person's individual needs. It is planned to launch the card within the hospital early next year and the project will then be rolled out nationally.

Clinical Audit Committee

- 6.4 The Healthcare Quality Improvement Partnership (HQIP) released a guidance document 'PPE in Clinical Audit'. The document contains six standards which are currently under review by members of the Clinical audit Committee.

7.0 RECOMMENDATIONS

- 7.1 The Trust Board are requested to note the report.

Patient Survey Report

Quarter 3 – 1 October 2010 to 31 December 2010

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to outline surveys which have taken place during the quarter within the Trust. The report summarises the results of these surveys and the actions taken as a result.

2.0 PATIENT SURVEYS

2.1 Picker National Maternity Survey

The National Picker Institute survey into maternity services has now been published. Overall the results for DCHFT maternity services were exceptionally positive. Christine Voce, Head of Midwifery will be reporting the findings of the survey as part of the Maternity Annual Review at the February 2011 Trust Board meeting.

2.2 GUM Patient Satisfaction Survey

All patients attending the GUM service in the week commencing the 18th October 2010 were surveyed as part of the service's annual patient satisfaction survey. There were 143 surveys returned and overall the patients reported an extremely high level of satisfaction with all aspects of the care they received from all staff in the GUM clinic.

In particular, 98-100% of patients felt that

- they were treated with respect, that their privacy was maintained (a testimony to the staff, given the highly personal nature of the specialty)
- they were listened to and their views were respected
- they were given information in a way they could understand
- they felt involved in decisions about their care.

2.3 Paediatric Liaison Service

Questionnaires were sent to 33 parents/carers who had used the Paediatric Liaison Service in the past twelve months. Ten questionnaires were returned giving a response rate of 30%. Overall the responses were positive about the support and service provided.

2.4 National Cancer Survey

The National Cancer Survey is now closed. The overall national response rate was 67% and the final response rate for DCHFT was 75%. The findings of the survey are due to be published shortly.

2.5 Picker National Inpatient Survey

The annual inpatient survey has now closed. The Trust has had a 52% response rate and the final report is awaited, initial findings are generally available between February – May.

2.6 Patient Satisfaction Survey for Ridgeway and Purbeck Ward

As a result of negative feedback from a number of patients who had been on an orthopaedic ward, this survey was undertaken. It is now complete and the final report will be available in January 2011.

2.7 Inpatient Questionnaire related to Discharge

As part of CQUIN requirements, 200 patients have again been surveyed about their discharge experience from DCHFT. There has been a 47% response rate to this survey and the final report will be available in January 2011.

A number of other surveys remain ongoing and a survey is currently being designed in easy read format for people with learning disabilities who have used hospital services both as an inpatient and outpatient.

3.0 STANDARD QUESTIONS

3.1 It has been agreed that all future surveys taking place within the Trust will include the following questions:

- Would you recommend this service to a friend or member of your family?
- Were you treated with dignity and respect?
- Did your treatment meet your expectations?

3.2 Respondents will also be asked to expand on their response to each question.

4.0 FUTURE DEVELOPMENTS

4.1 It is recognised that feedback from patients is very useful for improvement and redesign of services in addition to providing benchmarking between services and organisations. At present there are numerous surveys taking place throughout the Trust. However these tend to be isolated to particular

clinical services and do not always occur in areas in which there may be concerns.

- 4.2 A review of surveys also shows that the emphasis tends to be on patient satisfaction rather than the patient's experience. Therefore valuable information is not being captured which could if known assist the staff to improve the overall experience for those attending the hospital.
- 4.2 In recognising the limitations of the current survey system within the Trust, the introduction of a 'Realtime' feedback measurement system is currently being considered. The introduction of such a system could enhance the current surveys and provide a valuable insight into patient experience.

5.0 RECOMMENDATIONS

The Trust Board are requested to note the report

Background

The Trust has not achieved the 62 day screening target since Feb 2010 – initially this was mostly due to bowel screening patients choosing to delay investigations. Since July 2010, there has been an increase in referrals from the Breast Screening Service, coupled with a shortage of capacity. This will result in failure in Q2. The situation is being carefully managed to improve performance for Q3.

Capacity problems have also impacted upon Q2 performance in the 14 day Breast symptomatic standard and the 62 day referral to treatment target for patients referred by their GP suspicious of cancer. The actions below will focus on improving performance across all cancer targets and should improve performance for Q3 (with the exception of screening, as above).

Issue causing concern	Action required	Lead	Deadline	Comment
<u>Breast Screening</u> Inadequate capacity for localisations and pressure on Radiology service	1. Digital Mammographic equipment and replacement Ultrasound Scanner to be purchased to improve recruitment prospects and enable better links with Poole when cover required. 2. Short term plan to increase localisation and clinic capacity agreed. Poole capacity made available – potential breaches avoided.	Sue Green Sue Green/Matthew Sharpe/	12/11/10	1. Visa problems for locum prevented 16 Nov start. Replacement starts 15 Dec for 6 months. Poole radiologists providing cover for leave on private basis. Business cases to be considered by Board 2. Pts booked for localisation at Poole prior to surgery during Nov leave – no BSU breaches expected. 3. Surge in demand has relented
Bowel Screening capacity – wait for colonoscopy 5 weeks and breaches occurring due to	Additional capacity to be organised by screening centre	Dr Sally Parry (Dorset lead, Poole)	30/11/10	Dates of availability at DCH notified to Poole

patient choice to delay				
Histopathology reporting delays – some delays have caused breaches. Also, general unpredictability of Turn around Times yields uncertainty in planning remainder of pathway (eg results clinics)	<ol style="list-style-type: none"> 1. Establish clear mechanism for prioritising reports for patients in danger of breaching 2. Agree service level and Turn Around Times achievable within current resources 	Dr D'Arrigo/Execs	12/11/10	
Inadequate information systems to give timely and robust monitoring reports of performance and potential breaches	<ol style="list-style-type: none"> 1. Fully implement Cancer Register for waiting times and roll out reporting features to Directorates/KPI as required (as planned) 	Matthew Sharpe	12/11/10	1. SCR implemented. Desktop dashboard rolled out from 06/12
	<ol style="list-style-type: none"> 2. Ensure Cancer Register fully embedded with Trust and national reporting systems – further work on interface between PAS and SCR required to make best use of functionality. 	Matthew Sharpe/Shelley McIndoe	30/11/10	2. Oct data validated and ready for upload from SCR - report 06/12. Somerset not scheduling development of HL7 interfaces. DCH flagging with other users of SCR to seek prioritisation
	<ol style="list-style-type: none"> 3. Clarify escalation routes for all involved in cancer pathway 	Matthew Sharpe	12/11/10	3. Clarified and working well
	<ol style="list-style-type: none"> 4. Ensure information on TCI cancellations shared 	Matthew Sharpe/Catherin	01/11/10	4. Mechanism in place –cancer pts rarely cancelled

	with relevant staff. 5. Report potential breaches to DMs /KPI on a weekly basis	e Aitken Matthew Sharpe	06/12/10	5. SCR generated reports from 06/12 (ensuring process and data thoroughly validated)
Delays in Urology Diagnostic pathway	1. Escalate where TUB waits exceed 2 weeks 2. Continue to review pathway to reduce impact of serial investigations on CWT performance	Urology MDT Urology MDT	Immediate 30/11/10	1. Patients expedited where waits > 2 weeks 2. Plans for one stop Prostate Assessment clinic in place but clarity re funding required
Lack of OPA capacity to review treatment options (Oncology and Max Fax(skin))	Escalate lack of capacity to Poole management to ensure all available capacity reviewed	Matthew Sharpe	Immediate	Previous problems resolved – escalation in place

BOARD ASSURANCE FRAMEWORK

2010/11

Version 3
December 2010 (following Board Review)

Corporate Objective 1: Ensure Mitigation Plans for all Key Risks

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gap in Assurance		Description	Responsibility	Deadline
BAF1	The Board is not fully informed of the risks associated with the achievement of the corporate objectives	12 (3x4)	RM1	Quarterly review of the Assurance Framework by the Board	Chief Executive	Annual review of the Assurance Framework by Internal and External Audit	5	Internal review and collation of evidence	8 (2x4)	Annual review of process as required by NHSLA	Head of Risk Management	May 2011
			RM2	Statement of Internal Control	Chief Executive	Annual Report to the Board. Review by Internal and external audit	5	None identified				
			RM3	Board members are involved in the development of the corporate objectives (linked to the Board Strategy) on an annual basis	Chief Executive	Board Minutes	4	None identified				
BAF2	The Corporate Risk Register is inadequately populated and the Board ill-informed	12 (3x4)	RM4	Quarterly review of the Corporate Risk Register by the Board	Director of Nursing	Annual review of the Corporate Risk Register by Internal and External Audit	5	Internal review and collation of evidence	8 (2x4)	Annual review of process as required by NHSLA	Head of Risk Management	May 2011

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gap in Assurance		Description	Responsibility	Deadline
			RM5	Adherence to the NHSLA Risk Management Standards	Director of Nursing	Achievement of CNST level 2 external report	5	None identified				
			RM6	Monthly review of Risk Register by the Risk Management Committee	Director of Nursing	Risk Management Committee minutes	4	None identified				
			RM7	Quarterly review by the Integrated Governance Committee	Chief Executive	Integrated Governance Committee minutes. Audit Committee minutes.	5	Senior Management Team not involved in review of risk register	Monthly review of red risks and escalation of areas of concern	Director of Nursing & Quality	Monthly process	

Corporate Objective 2: **Strengthen Relationships with Key Commissioners / Agencies**

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gap in Assurance		Description	Responsibility	Deadline
BAF 3	The Trust fails to develop strategic partnerships with General Practice Consortia	9 (3x3)	GOV1	To be developed as Consortia are established. Communication plan with an agreed approach for liaising with general practitioners	Chief Executive	Executive Team minutes	3	None Identified	9 (3x3)	Shadow Consortia in April 2011. Formal links to be established then.	Chief Executive	
				Divisional Director reports to the Senior Management Team	Chief Executive	SMT minutes						

BAF 4	The Trust fails to maintain effective commissioner/provider relationships with main commissioner	9 (3x3)	GOV2	Board to Board meetings	Chief Executive	Minutes	4		6 (2x3)	Development of 2011/12 Contract	Director of Operations	31 May 2011
				Monthly Contract Management Meetings with Commissioners (quality and performance)	Director of Operations, Director of Finance and Director of Nursing & Quality	Minutes of Monthly Contract Monitoring Meeting with Commissioner	5	Two commissioning bodies are not attending contract review meetings		Request formal input from commissioners (excluding Dorset Healthcare)		
				One to one meetings between individual Directors and their opposite numbers within the PCT commissioners	Executive Directors	Reports to SMT	3	None identified				

Corporate Objective 3: **Achieve Recovery Plan Targets**

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gap		
			ID	Control	Exec Lead	Source	Score	Gap in Assurance		Description	Responsibility	Deadline
BAF 5	The trust fails to achieve its forecast outturn	12 (3x4)	FIN 1	Finance and Performance Committee	Director of Finance and Resources	Monthly Board and sub committee papers	3	Internal Audit Report: Financial Reporting and Budgetary control	6 (2x3)	None identified		
BAF 6	The Trust fails to deliver Cost Improvement Programme	9 (3x3)	FIN 2	Weekly Programme Management Office Report	Chief Executive	Monthly Board and sub committee papers	4	Internal Audit Report: Turnaround Plan	6 (3x2)	Implementation of internal Project Management Office Structure	Chief Executive	1 Jan 2011
				Divisional Reports to the Executive Team	Chief Executive	Minutes		None identified				
				Monthly review by external regulator, Monitor	Chief Executive	Monitor's report						

BAF 7	The Trust over performs against 2010/11 contract	16 (4x4)	FIN 3	Monthly Contract Monitoring Report Meeting with Commissioner	Director of Operations	Monthly Board and sub committee papers	3	None Identified	9 (3x3)			
				Weekly Scorecard		KPI and Executive team minutes						
BAF 8	The liquidity position of the Trust	20 (5x4)	FIN 4	Weekly Cash flow reporting	Director of Finance and resources	Monthly Board and sub committee papers	3	Weekly cash flow monitoring to Monitor and Monthly Review with Monitor	20 (5x4)*	The Trust agrees a loan with the Foundation Trust Financing Facility	Director of Finance and Resources	1 Jan 2011
BAF 9	The Trust under invests in Capital	10 (5x2)	FIN 5	Monthly Financial Report	Director of Finance and Resources	Monthly Board and sub committee papers	3	Annual ERIC data submissions	10 (5x2)	2011/12 Service Planning to incorporate Capital requirements	Director of Finance and resources	31 Mar 2011
				Risk event reporting and risk assessment escalation	Director of Nursing & Quality	Quarterly reports to Assurance Committee	3	None identified				

BAF 10	Diminishing NHS Funding	20 (5x4)	FIN 6	Quality, Innovation, Prevention and Productivity Plan	Chief Executive (Pan Dorset)	Board Reporting PMO reporting	3	2011/12 Service Plans	20 (5x4)*	Development of 3-5 year Strategic Plan and Medium Term Financial Strategy	Chief Executive Director of Finance and Resources	31 Mar 2011
				The recovery plan	Chief Executive	Monthly operational report to the Board	3	Capacity to deliver the efficiencies and pathway changes identified in the pan Dorset QUIPP Plan		Divisional Service Plans	Director of Operations	
				The Cost Improvement Plan	Director of Finance and Resources	Monthly operational report to the Board	3			Divisional Service Plans	Director of Operations	
				Interim Trust Priorities for 2010/11	Chief Executive	Board papers	3	Internal audit report: governance	9 (3x3)	Trust Strategic Plan	Chief Executive	31 May 2011
				Trust Governance structure	Chief Executive							
				Organisational structure	Director of Human Resources & Workforce							

Corporate Objective 4:

Meet or Exceed Quality Standards and Performance Targets

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gaps in Assurance		Description	Responsibility	Deadline
BAF 11	Failure to Engage clinical teams in patient safety and quality standards	12 (3x4)	QU 6	Trust quality standards are explicit in the organisation and performance methodology in place.	Director of Nursing and Quality	Monthly performance data to SMT and trust board reports.	3	Annual reviews/ audits/ inspections of specific areas of practice	9 (3x3)	Database of all inspections/ reviews/ audits Ensure preparedness for reviews/ inspections/ external audits.	Deputy Director of Nursing	In line with requirements of individual reviews
				Monthly Senior management team (SMT) meetings where performance data is reported	Chief Executive	Actions plans to address shortfalls in performance in place and monitored. Minutes of meetings. Performance Reports. Communication Strategy.	3	Clinical Leadership Forum	9 (3x3)	Establish Clinical Leadership Forum	Director of Human Resources & Workforce	March 2011
				Patient safety first leadership walkabouts	Chief Executive	Reports on trends and resulting actions to	4	Staff engagement strategy	9 (3x3)	Produce Staff Engagement Strategy	Director of Human Resources & Workforce	

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gaps in Assurance		Description	Responsibility	Deadline
				by the executive team.		Health assurance Committee. Database to manage remedial action. Reports from National Programme Office.						
				Areas of excellence in practice are recognised locally or nationally.	Director of Nursing & Medical Director	Excellence Award Scheme	3	None identified.	4 (2x2)			
BAF 12	Care quality Commission registration status	16 (4x4)	QU 7	Health Assurance Committee scrutiny of the CQC registration status and evidence to support compliance	Director of Nursing and Quality	Annual compliance report to health assurance committee. Assurance Committee minutes. Patient Survey results.	3	None identified.	12 (4x3)			
				Performance accelerator tool act as the repository for evidence to		Quarterly updates on compliance from performance accelerator to	3					

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gaps in Assurance		Description	Responsibility	Deadline
				support achievement of the required standards.		health assurance committee.						
BAF 13	Failure to meet the Operating Framework and contract, adversely impacting on the Trust's Terms of Authorisation	16 (4x4)	QU 8	Review by Monitor. Weekly and monthly executive scrutiny.	Chief Executive	Reports to the Board for scrutiny including exception reports on all areas of poor performance.	5	Self certification on quality governance not declared.	12 (4x3)	Process for Board responsibility to self assure on all significant risks reviewed.	Chief Executive	
BAF 14	Poor productivity and efficiency leading to poor use of resources and low national ranking	16 (4x4)	QU 9	Improved governance arrangements. Improved performance framework. Better clinical engagement in management process.	Chief Executive	Monthly meetings with Divisional leads. Reports to the Board on Key Performance Indicators (KPIs).	3		14 (4x3)			
BAF 15	Failure to listen to patients and improve	12 (4x3)	QU 10	National Patient Survey. Learning from Patients	Director of Nursing	Reports to the Board on Complaints, PALS contacts and legal				To develop local standards in all key areas and continue	Director of Nursing	

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gaps in Assurance		Description	Responsibility	Deadline
	patients' experience			Steering Committee. Local surveys.		claims.				to benchmark.		

Corporate Objective 5: **Implement new Comprehensive Governance Structure**

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurances to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gap in Assurance		Description	Responsibility	Deadline
BAF 16	Current reporting and sub-committee arrangements not providing robust scrutiny	12 (3x4)	GOV3	New governance arrangements agreed	CEO	Board papers	3	Board Secretary	9 (3x3)	Develop job description and person specification for Board Secretary	Chief Executive	May 2011
			GOV4	Terms of Reference agreed for all committees	CEO	Risk Strategy	3	Review of sub-committees required		Review of Sub-Committees	Chief Executive	May 2011
			GOV5	Board sub-committee reports to the Board	CEO	Monthly Board papers	3	None identified				
			GOV6	Annual review of Board Performance	CEO	Review report. Maturity Matrix. External view of ICOSA on Board performance	4			Review annually		June 2011
BAF 17	Poor data quality reporting therefore Board not getting accurate, timely information		GOV7	Standard templates for reporting.	Board Secretary	Board papers	3	None identified				
			GOV8	Increased quality and safety reporting to Board	Director of Nursing	Board papers	3					
			GOV9	Programme of	CEO	Board papers	3	None				

				Board reporting Developed				identified				
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Corporate Objective 6: **Implement Clinically-Led Business Unit Structure**

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gap in Assurance		Description	Responsibility	Deadline
BAF 18	Failure to appoint to key Divisional Leadership roles, thereby delaying or preventing implementation.	9 (3x3)	WHR5	Development and implementation of organisational restructure plan, including full and effective staff consultation programme, and robust recruitment and selection process.	Director of Workforce and HR	Comprehensive records of staff consultation programme, including feedback, and recruitment and selection process. Reports to Trust Board.	3	None Identified	3 (1x3)			
BAF 19	Failure to effectively invest in the support and development of individuals appointed to Divisional Leadership roles.	9 (3x3)	WHR6	Scoping of a support programme for clinical leaders and service managers to develop the skills and behaviours required to successfully lead and manage their divisions/ business units.	Director of Workforce and HR	Quality & Performance Reports. Leadership walk rounds. Staff Survey. Investment in training and development.	3	None identified	9 (3x3)			

Corporate Objective 7: **Restore Confidence and Reputation with Key Stakeholders and Community**

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Control Enhancement		
			ID	Control	Exec Lead	Source	Score	Gap/Future Assurance		Description	Responsibility	Deadline
BAF 20	Stakeholders unaware of progress and achievement of Trust	9 (3x3)	GOV 10	Board meetings are held in public	CEO	Board papers	5	None identified	4 (2x2)			
			GOV 11	Council of Governors participate in consultative exercises, the development of strategy and hold meetings within localities	CEO	Minutes of the Board of Governors meetings.	5					
			GOV 12	Regular publications for staff, governors and local community	CEO	Foundation Focus, Ward Round	3					
			GOV 13	Contract and quality review meetings with Commis-	Director of Nursing	Contract and Quality review minutes	5					

				tioners								
			GOV 14	Positive reporting in local media	CEO	Press cuttings	4					

Corporate Objective 8:

Develop a five year Strategy to ensure a Viable and Sustainable Future

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurances to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gaps in Assurance		Description	Responsibility	Deadline
BAF 21	Lack of clear long term direction for the Trust	12 (3x4)	GOV 15	Planning process in place for strategy development	CEO	Board of Governors involvement	2	None identified	8 (2x4)			
			GOV 16	Workshops arranged for Board, Governors, staff, PCTs and stakeholders	CEO	Report on outcome from Workshops. Plan agreed with Governors	3					
			GOV 17	Consultation document prepared by 31 st March 2011	CEO	Consultation document	3	Yes		Consultation exercise	CEO	March 2011
			GOV 18	Trust Strategy document signed off by Board	CEO	Board papers						
			GOV 19	Implementation plans in place monitored by the Board	CEO	Quarterly reports to the Board	4	Yes		Set up regular reports to the Board	CEO	May/June 2011
			GOV 20	Annual Plan Developed	CEO	Plan approved by the Board	4					

Risk ID	Principal Risks	Inherent Risk (LxC)	Key Controls			Control Assurances			Actual Risk (LxC)	Assurance to address Gaps		
			ID	Control	Exec Lead	Source	Score	Gaps in Assurances		Description	Responsibility	Deadline
BAF 22	Failure to effectively consult with and involve elected staff bodies in key business decisions and initiatives involving and affecting staff.	6 (2x3)	WHR 7	Regular, bi-monthly meetings of recognised collective bargaining bodies (Staff Partnership Forum and Local Negotiating Committee), chaired by Director of Workforce and HR.	Director of Workforce and HR	Updated and comprehensive terms of reference for recognised collective bargaining bodies (Staff Partnership Forum and Local Negotiating Committee).	5	None Identified	3 (1x3)	Development and implementation of Staff Engagement Strategy.	Director of Workforce and HR	Mar 11
				Staff Survey.		Minuted records of all meetings of Staff Partnership Forum, and Local Negotiating Committee.				5		

			WHR 13	Recognition of noteworthy contribution and successes in weekly Chief Executive briefing.			3			Development and implementation of Staff Engagement Strategy.	Director of Workforce and HR	Mar 11
BAF 25	Failure to improve staff health and well-being at work.	9 (3x3)	WHR 14	Staff Health and Well-being at Work steering group oversees associated interventions and initiatives.	Records of meetings conducted and actions taken.	4	In response to Boorman Report recommendations, need to raise awareness of staff health and well-being issues.	6 (2x3)	Implementation of Staff Health and Well-being Strategy, to incorporate Boorman recommendations.	Director of Workforce and HR	Dec 10	

Key: RM Risk Management
 FIN Finance and Performance
 QU Quality
 GOV Governance
 WHR Workforce & Human Resources

Score: 1 Limited Assurance
 2 Fair Internal Assurance
 3 Good Internal Assurance
 4 External Assurance
 5 Positive External Assurance

* To be added to the Corporate Risk Register during the next review.

Finance & Performance Committee DRAFT Minutes

30th November 2010

(Meeting No 15)

Present:	Peta Turnbull (PT) Bill Boa (BB) Peter Camm (PC) Jeffrey Ellwood (JE) Peter Knell (PK) Roderick Knight (RK) Jean O'Callaghan (JO) Tracey Peters (TP) Mark Power (MP)	Chairman & NED Director of Finance/Resources Non-Executive Director Chairman Non-Executive Director Non-Executive Director Chief Executive Non-Executive Director HR Director
In attendance:	Colin Dann (CD) Jo Bowkett (JB)	Council of Governors rep Council of Governors rep
Minutes:	Rachel Lovett (RL)	Minute Taker

NO	ITEM	Action
66/10	Apologies for Absence Apologies were received from Alison Tong and Nick Hateboer.	
67/10	Minutes of the Meeting 26th October 2010 The two following corrections were made to the minutes:- P4 – item 60/10 final paragraph to read “The Committee felt that more information was needed before any principle approval could be given. An improved” P7 – item 63/10 ‘questions’ amend to read “PK was concerned that the issue of diabetes had only arisen as a result of the national audit and the possible implications for other areas of care that could be similarly overlooked. It was therefore important to understand why the gap in awareness had occurred and to be assured that any deficiencies addressed. AT outlined the impending changes to the Board performance reporting framework and confirmed that, under the new framework, the deficiencies in the diabetes service would have been apparent to	

	<p>the Board.”</p> <p>Subject to these amendments, the minutes were approved.</p>	
68/10	Matters Arising from 26th October 2010	
68.1	<p><u>AL1 Action List – Delayed Discharges</u> This remains an issue. JO has met with the PCT and DCC on an individual basis, and the joint meeting will be taking place early in December. The need to have agreement of the winter plan which incorporates winter pressures at this meeting was stressed. Feedback will be given to the January meeting.</p>	JO
68.2	<p><u>AL2 – ToR for Finance Committee</u> These remain in draft form and need to be authorised. JE and JO have delegated powers to do so. Discussion had taken place about the future role of this Committee. JO agreed to check the current status and report back.</p>	JO
68.3	<p><u>AL3 Action List - Finance Report - Turnaround Office update</u> External interviews will be taking place on 6th December and short-term assistance has been arranged for the interim.</p>	
68.4	<p><u>AL4 Update on Service Line Reporting</u> It was noted that the Audit Committee will be ensuring that the recommendations made by Price Waterhouse are implemented. PT asked for the item to remain on the Action List.</p>	RL
68.5	<p><u>AL 5 Finance Report - Cancer Drugs</u> BB confirmed that this had not been resolved and is still being pursued. The potential risk to the Trust is £390,000. He explained the potential arguments that may be made against us, but was clear on our stance. Payments to Poole are being held back until resolution. It may be in the future that the cancer budget currently held by Poole is split between other providers. Keep Committee informed of the position.</p>	BB
68.6	<p><u>AL6 Action List – Performance Report</u> <i>VTE</i> - JO reported that the traffic lights were up on the wards, but were not as visible as she would like. <i>Proms</i> – the detailed report has not yet been received. Keep item on Action List.</p>	RL
68.7	<p><u>AL7 Summary Contract Brief</u> Work is continuing on a schedule to show potential penalties in next year’s contract. The assumption for this year remains that none will be incurred due to the block contract. BB wanted the operational directorates to see the schedule first, to raise awareness and ownership of the issues. It will then come to the January meeting.</p>	BB/RL

68.8	<p><u>AL8 Finance Report</u> <i>CIP</i> –this is included within the finance report and will be discussed then. <i>Nursing Bank Staff</i> – MP confirmed that new instructions have been issued, particularly relating to weekends, which has already had an impact. He acknowledged the hard work of AT and the nurses.</p>	RL
68.9	<p><u>AL9 Medical Records Business Case</u> – Agenda item</p>	
68.10	<p><u>AL10 Infection Control Database</u> It was unclear if this system was now live. A presentation had been made to the Infection Control Meeting and the feedback was that the system was really good and easy to use. PT asked if this could be kept of the Action List to ensure completion.</p>	
68.11	<p><u>AL11 Loan Application</u> – Agenda item</p>	
68.12	<p><u>AL12 Performance Report</u> <i>Medication Errors</i> – it was noted that this has been included in the patient safety report to the Trust Board.</p>	
69/10	<p>FINANCE</p> <p>Finance Report for Period ending October 2010</p> <p>BB proposed to give a brief overview of the current financial position to allow time for more in depth discussion of the schedules.</p> <p>The following points were highlighted:-</p> <ul style="list-style-type: none"> ▪ <u>Income</u> – is £1.7m ahead of plan in total ▪ <u>Elective Performance</u> – whilst this is reducing, in month 7 the Trust lost £50k due to breaching the upper threshold. ▪ <u>Expenditure</u> – this is continuing to fall, due to reduced agency/bank spend and posts being removed from budgets. As a consequence the risk rating has been maintained at 2 for the second month. Month 7 also showed a surplus which was planned, however no financial winter contingencies have been made. ▪ <u>Activity</u> – there remains issues surrounding orthopaedics ▪ <u>Cash</u> – the underlying cash liquidity position is of most concern to us and Monitor (but will be addressed with the loan). ▪ <u>Poole Cancer Drugs Recharge</u> – as already discussed, this is a risk to the Trust. <p>Members were then given the opportunity to ask questions and go through the schedules attached to the finance report. Those schedules particularly discussed were:-</p>	

	<p><u>Schedule A – Income and Expenditure</u> BB reported that the PCT have been informed of the Trust's priority to hit its financial targets. This may have an adverse implication on the 18 week targets. Assurances were sought that the Trust was still on track to make the £3 ½ m target.</p> <p><u>Schedule D – Expenditure</u> TP asked where the Poole deficit was shown. BB would clarify.</p> <p><u>Schedule R - CIP</u> BB explained the headings in detail and confirmed that Projects are managed on a weekly basis but that there are two areas of concern – theatre services and outpatients. It has proved difficult to achieve full engagement from the PCT in the outpatient project. Ophthalmology was discussed and BB confirmed that the Trust is seeking an expert to appraise the service and offer advice. Meanwhile the PCT has Issued an open tender for ophthalmic services for the community. This is a recent event of which the Trust has received no formal notice. This is likely to result in the removal of funds from our budget. JE expressed disappointment that Consultant and Medical Job Planning was showing no savings. MP stressed that work is taking place, but that more needs to be done.</p> <p>PK asked if a risk register could be included for the CIP schedule. BB agreed to add this to the F&P Committee Finance Report.</p> <p>Finally JE asked for Schedule Q ‘Risks’ to go to the Trust Board as it was very helpful.</p>	<p>BB</p> <p>BB</p> <p>BB/AW</p>
<p>70/10</p>	<p>Medical Records Business Case</p> <p>Patrick Rimmer (PR) and Rosie Samways (RS) were welcomed to the meeting.</p> <p>In addition to Enclosure D a detailed set of costings were tabled. BB explained the concept of how the costs were calculated for each of the four options, but was aware that PK felt that the costs were not on a like for like basis.</p> <p>This complex matter was discussed, with agreement being reached that option 4 was probably the best option. There was some debate about whether the re-fit costs could come out of capital rather than revenue funds. TP asked about the lease assignment and was assured by PR that the Trust had received legal opinion that there were no undue concerns about it.</p> <p>In light of the fact that Thales are keen to strike a deal by the end of December BB was asked to give a presentation</p>	

	<p>to the December Trust Board on how this could be afforded, clarifying the implications on financial years 2010/11 and 2011/12 (this would be in part 2 of the meeting). JE stressed that this must not put the Trust's recovery plan into jeopardy.</p>	<p>BB/AW</p>
<p>71/10</p>	<p>Loan Application</p> <p>The letter to Nick Rose was noted by the Committee, and will be discussed further by the Department of Health on 13th December. The Committee were happy with the Loan Application and congratulated BB.</p> <p>It was agreed to make reference to this when Monitor visit on 8th December.</p> <p><u>Questions</u> PC asked about public dividends and BB confirmed that 3 are due in the next financial year, but this affects cash not income and expenditure as the dividends have been provided for.</p>	<p>JE/BB</p>
<p>72/10</p>	<p>WORKFORCE</p> <p>Workforce Report</p> <p>MP highlighted the following points from his report:-</p> <p>Workforce Capacity and Cost:</p> <ul style="list-style-type: none"> ▪ Substantive workforce capacity - continues to reduce and is at lowest level since Apr 10. ▪ Temporary workforce capacity - continues to reduce, but remains above the Apr 10 level. ▪ Total workforce capacity - remains below budgeted establishment. ▪ Temporary workforce expenditure - continues to reduce and is at lowest level since Apr 10. Expenditure on temporary workforce represents 8.4% of total workforce costs. Focus maintained on further reducing reliance upon high cost agency staff. ▪ Total pay costs - now below the annual pay budget for the first time since Apr 10. <p>Areas of under-performance:</p> <ul style="list-style-type: none"> ▪ Sickness absence rate - increased by 0.4% to 4.2%, which is 	

	<p>the highest level for this financial year, and marginally above the 4% NHS average. Actions being taken to address.</p> <ul style="list-style-type: none"> ▪ Annual appraisal rate - reduced by 2%, from 60% to 58%, which is unacceptably low. Actions being taken to address. ▪ Statutory and Mandatory Training compliance rate - remains unacceptably low at c.65%. Actions being taken to address. <p>Other Workforce issues:</p> <ul style="list-style-type: none"> ▪ Organisation Restructure - All key divisional leadership roles are now recruited to, with the exception of Divisional Manager for Medicine. Contingency actions being taken. ▪ Staff Health and Well-being - Staff Health and Well-being Strategy will be implemented in Dec 10. Strategy will build upon current initiatives and good practice to further improve health and well-being within the workplace. ▪ Staff Engagement - Work has started on the development and implementation of a Staff Engagement Strategy. The Strategy will aim to improve staff engagement in a number of key areas, including shared values; communication; partnership working; leadership and people management, and recognition and reward. <p><u>Questions and Observations</u></p> <p>Increased sickness – was this as a result of tighter rules for booking nurse bank staff. MP felt that it was too early to say, but that this had resulted in a degree of tension in some areas. Whilst it is important to continue to drive down sickness absence, this must not be to the detriment of quality and patient safety. The Executive Team will be monitoring this issue.</p> <p>Staff Engagement Strategy – JO supports the Trust adopting the core values associated with the NHS Constitution, which should be promoted throughout the organisation.</p> <p>Leadership and management development – important with respect to staff engagement, and needs to be a key consideration within a future learning and development strategy.</p> <p>Annual Appraisal – work needs to be done to improve the current level of compliance. JB felt that staff needed to realise that it was beneficial personally as well as to the organisation. This led to a wider discussion about when appraisal is carried out, what other support is offered to staff throughout the year, and if the onerous could be put on individuals to link appraisal to the gateways (increments).</p>	
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	<p>Statutory and Mandatory Training – MP has set up a ‘task and finish group’ to look at the appropriateness and relevance of mandatory training, and how it can most effectively be delivered and recorded. One outcome will be a revised Statutory and Mandatory Training matrix.</p> <p>PT thanked MP for his very helpful and logical report.</p>	
<p>73/10</p>	<p>PERFORMANCE</p> <p>Performance Report</p> <p>BB presented this report in AT’s absence. He highlighted the following underperformance areas:-</p> <p><u>C. Diff</u> – This breach involved but was not limited to insufficient housekeeping staff on Barnes Ward which has now been rectified.</p> <p><u>18 week referral</u> – it was agreed to focus on ENT and oral surgery.</p> <p><u>Cancelled Operations</u> – BB explained the work being undertaken to show the flow of patients in the hospital, in particular when they are discharged and how many go through the discharge lounge. At present 70% of patients are discharged after mid-day. However now that this information is being published it is having a positive impact. JB added that most complaints that she receives are about the long waits for patients in the discharge lounge. JE was assured that there is a quick way to obtain essential equipment.</p> <p><u>Delayed Discharges</u> – as reported last month the PCT are facilitating delayed discharges over 30 days.</p> <p><u>Stroke Patients</u> – JO has since had another positive meeting and still expects improvements. If however no improvements are forthcoming she will change tack. This was very disappointing.</p> <p><u>MRSA</u> – BB confirmed that the Trust would be adopting the national MRSA screening rates calculation. This improves compliance to 100%. We will continue to report figures based on the existing method internally. The PCT have agreed with this course of action.</p> <p><u>Cancer Targets (Screening)</u> – While progress is being made this remains challenging. The position regarding recording 3 successive failures of a national requirement and incurring a breach of authorisation was noted. The problem is with breast</p>	

Draft Committee terms of reference

Dorset County Hospital NHS Foundation Trust Finance and Performance Committee

Draft Terms of Reference

1 Authority

- 1.1 The Board of Directors hereby resolves to establish a Finance and Performance Committee of the Trust under section 5 of the Standing Orders.
- 1.2 The Finance and Performance Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the committee.

2 Purpose

- 2.1 The committee will provide a forum, outside of the monthly public Board meeting, where time and attention can be devoted to discussion of the significant financial and performance issues facing the Trust.
- 2.2 The Committee will assess performance metrics that measure and monitor achievement of regulatory and contractual obligations ensuring we meet the terms of our authorisation as a Foundation Trust. The Committee will work closely with the Health Care and Quality Assurance Committee who, amongst other areas, will assess related metrics of a non-contractual nature.
- 2.3 The purpose of the Finance and Performance Committee is to provide additional assurance to the Board and not to replace or remove the requirement for the Board to monitor the financial and strategic performance of the Trust. It will provide intense scrutiny of financial and performance issues and make recommendations to the Trust Board to assist in decision making. Specific areas that the Finance and Performance Committee will scrutinise, review and monitor are:
 - Financial Planning
 - Financial performance to ensure the Board receives the best practice financial management and reporting
 - Activity performance
 - Financial reporting
 - Cash and Treasury management
 - Promote the financial awareness of all staff especially management and budget holders
 - Business case assessment and scrutiny (including post project review and monitoring)
 - Commercial approach to contract pricing, delivery and performance including assessment of financial results through Service Line Reporting and Service Line Management

- Investment and disinvestments,
- Tracking progress against and supporting delivery of efficiency and cost reduction programmes

3 Membership and Attendance

3.1 The membership of the Finance and Performance Committee shall be as follows:

- Non-Executive Directors one of which will be appointed by the Board to chair the Committee
- Chief Executive
- Director of Finance and Resources who will act as Executive Lead to the Committee
- Director of Operations
- Director of Human Resources and Workforce

3.2 All other Directors will be required to attend in an ex-officio capacity.

3.3 Other individuals may be invited to attend for all or part of any meeting, as and when required to do so.

4 Quorum

4.1 A quorum of the Committee shall be at least three Non-Executive Directors and three Executive Directors.

4.2 If the Chair is not present the Non-Executive Directors will choose one of their number to preside at that meeting.

5 Accountability

5.1 The Finance and Performance Committee is a committee of the Board of Directors and is accountable to and reports to the Board.

5.2 The Committee is an advisory Committee with no Executive powers; however, it can make recommendations to the Trust Board following robust debate and scrutiny of financial activity and performance.

5.3 Minutes of each meeting will be produced and approved by the subsequent meeting. Draft minutes of the Finance Committee will be reported to the full Board, unless there are matters which the Committee and Board Chairman agree should be received in private, at the next Board meeting following each Committee meeting.

5.4 The Committee will have an annual review of effectiveness.

5.5 The Committee may take sensitive issues under a part 2 agenda.

6 Meetings and Conduct of Business

Frequency

6.1 The Committee will meet monthly

Calling of additional meetings

6.2 Additional meetings may be called by the Chair of the Committee.

7 Agenda

7.1 The following standing items will appear on each agenda:

- Attendance and apologies for absence
- Declarations of interest of members of the Committee and other Directors present
- Minutes of the previous meeting and matters arising
- Finance Report for the Month
- Performance Report for the Month
- Workforce Report for the month

8 Duties of the Finance and Performance Committee

8.1 The Committee will review and challenge financial plans and positions and will review the use of resources to seek assurance that value for money is achieved.

8.2 The Committee will assist the Audit Committee and Board of Directors in scrutinising standards of financial management and accountability for the use of public funds.

8.3 The Committee will specifically:

- Consider and recommend to the Board of Directors the Annual Plan and budget of the Trust
- Consider and recommend to the Board of Directors the monthly Finance and the monthly Performance report
- Consider and recommend to the Board of Directors the monthly Service Line Reporting Reports
- Consider and recommend to the Board of Directors the monthly programme office report on savings and efficiencies
- Consider, scrutinise and recommend to the Board any Business cases within the delegated limits of the Board of Directors
- Monitor delivery of the Trust's annual capital programme
- To receive budget setting timeframes and processes
- To assess the Trusts pricing policy and associated performance against contracts through Service Line Reporting

9 Other Matters

9.1 The Committee shall be supported administratively by the Director of Finance and Resources whose duties will include:

- Agreement of the agenda with the Chair of the Committee
- Ensuring that Minutes and agenda items are managed in a timely fashion
- Advising the Committee on pertinent matters

10 Review

10.1 On an annual basis, the Committee will review its effectiveness and examine its future working arrangements to ensure that it remains fit for purpose and provides the Board with assurance that the financial information reported is accurate and acknowledges appropriate risk.

DRAFT

Integrated Governance Committee DRAFT Minutes

30th November 2010 (Meeting 22)

Present:	Roderick Knight (RK) Bill Boa (BB) Jean O'Callaghan (JO) Peter Camm (PC) Jeffery Ellwood (JE) Peter Knell (PK) Tracey Peters (TP) Alison Tong (AT) Peta Turnbull (PT)	Chairman and NED Director of Finance/Resources Chief Executive Non-Executive Director Chairman Non-Executive Director Non-Executive Director Director of Nursing/Operations Non-Executive Director
In attendance:	Suzanne Slight (SS) Vanessa Read (VR) Jane Ridgway (JR) Jo Bowkett (JB) Colin Dann (CD)	Head of Risk Management Deputy Director of Nursing Head of Operational HR Services Council of Governors rep Council of Governors rep
Minutes:	Rachel Lovett	Minute Taker

RK welcomed everyone to the meeting. He apologised for the short Agenda, but hoped that it would be a good meeting. Regarding item 6 Directorate Annual Report from Pathology, he asked JO to take this matter further as despite being chased no report has been received. This was unacceptable.

NO	ITEM	Action
117/10	<p>Apologies for Absence</p> <p>Apologies were received from Nick Hateboer, Mark Power, David Reason and Patrick Jeffery.</p>	
118/10	<p>Minutes of the Meeting 26th October 2010</p> <p>Subject to:-</p> <p>adding "Peter Knell" as an attendee; amending Fran Leaper's initials to read "FL" and changing the number of the last item to "116"</p> <p>the minutes were approved.</p>	

119/10	Action List and Matters Arising from 26th October 2010	
	Action List	
119.1	<p><u>AL1 Clinical Audit Committee</u> Joint Audit follow-up – this is outstanding and AT will report at the January meeting.</p> <p><i>Process for Referring Issues</i> - JO hoped that the new structure makes clear the escalation process.</p> <p>ITEM CLOSED</p> <p><i>IT Problems</i> - BB met with clinical audit. They have outlined a specification and are receiving advice.</p> <p>ITEM CLOSED</p> <p>Self Assessment Questions – RK had completed this task.</p>	AT
119.2	<p><u>AL2 Research Strategy Committee and Annual Report</u> For verbal report at January meeting as NH absent.</p>	NH
119.3	<p><u>AL3 Safeguarding Adults – Feedback from Away Day</u> AT reported on a morning session which had taken place, with a Committee meeting in the afternoon. There was a lack of agreed purpose for the Committee and key work streams need to be agreed. However the new independent chair is good and is in the process of meeting individual members. Feedback on the whole safeguarding process is needed to become simpler, and incorporate lessons learnt from the children’s safeguarding committee. Whilst there is correlation between adult and child safeguarding issues, there is no proposal to join the two committees at this point in time. VR felt that there remains confusion about what was a safeguarding issue, and that the organisation needed clarity.</p> <p>ITEM CLOSED</p>	
119.4	<u>AL4 Risk Register</u> - Agenda item	
119.5	<p><u>AL5 Medical Devices Committee</u> BB had met with this Committee to discuss its role, terms of reference etc. JO hoped that the wider issues of attendance would be resolved once the review of sub-committees had taken place. This involved acknowledging time commitments of clinical staff and streamlining numbers on Committees.</p> <p>ITEM CLOSED</p>	

119.6	<p><u>AL6 Business Continuity Committee</u> AT reported that Wayne Darch is due to start work here next week on 6 month secondment as resilience specialist. He currently works at Great Western Ambulance.</p> <p>Once he is in post, an action plan will be drawn up combining elements of emergency planning, continuity planning and Olympic preparedness. The plans will come to this Committee before Board sign off (February).</p>	<p>JO/AT <i>RL</i></p>
119.7	<p><u>AL7 Same Sex Accommodation</u> Exclusion criteria have been submitted to NHS Dorset, this item relates to the criteria submitted whereby a breach is acceptable. No feedback has been received, however there is concern around the country about this issue and there is a meeting next week at the SHA. There are particular issues in endoscopy and day care facilities with compliance. There should not be issues in the general wards.</p> <p>AT will keep this Committee informed if there is anything further to report.</p>	<p>AT</p>
119.8	<p><u>AL8 Quality Accounts – Prioritisation 2010/11</u> No comments had been received following the last meeting. Previous comments have been incorporated into the document which is going to this month's Trust Board.</p> <p>ITEM CLOSED</p>	
119.9	<p><u>AL9 Directorate Annual Report – Surgery</u> All issues have been picked up.</p> <p>ITEM CLOSED</p> <p><i>Child Protection Report</i> – this related to data being unavailable for this particular directorate. MP would be asked for an update at the next meeting.</p>	<p>MP</p>
119.10	<p><u>AL10 Referral of items to Trust Board –</u> This has been done.</p> <p>ITEM CLOSED</p>	
119.11	<p><u>AL11 Any Other Business – IGC Meetings</u> The points raised have been discussed.</p> <p>ITEM CLOSED</p>	
	INTERNAL CONTROL, RISK MANAGEMENT & ASSURANCE	

	<p>positive response and showed confidence in the way in which the incident was handled. She confirmed that the recommendation has now been implemented.</p> <p>RK felt that the letter was complimentary and asked SS to pass on the Committee’s appreciation to Sue Green for dealing with the matter so well.</p>	<p>SS</p>
122/10	<p>EXTERNAL VALIDATION & ASSESSMENT</p> <p>Exception Reports from Sub- Committees</p>	
122.1	<p><u>Care Quality Commission; Quality and Risk Profile (QRP)</u></p> <p>Vanessa presented this new item. The current report is based upon the November update. The information is collated from various regulatory sources. The summary shows only 1 red flag relating to safeguarding and safety. The report has been seen by the Executive Team who asked for the report to focus on red and amber indicators. The overall theme relates to poor communication, which is an acknowledged issue. VR confirmed that she is asking for further details surrounding the negative comments.</p> <p>She proposed to assigning an Executive Lead to each action and create an action list from that.</p> <p>Discussion took place regarding:-</p> <ul style="list-style-type: none"> ○ the lack of actual numbers allocated to comments ○ the NHS Choices website (where anyone can make any comment, although slanderous and vexatious ones can be removed) ○ the consequences of the report, which could alert the CQC to intervene ○ the negative staff comments, although it was pointed out that this was reflecting the position a year ago. <p>The pros and cons of undertaking a staff attitude survey were noted. MP would be asked to consider further.</p> <p>AT added that whilst the report had a number of areas for improvement, there were no surprises. It was agreed that the Committee should accept the report as being reasonably accurate, and address those areas to make improvements.</p> <p>It was agreed that this report would become a quarterly regular item on the IGC Agenda, but that the report would only show new red or amber risks, with a dashboard to show trends. It would go to the Trust Board half-yearly.</p>	<p>MP</p> <p>VR/RL</p> <p>AW</p>

122.2	<p><u>Directorate Annual Report - Pathology</u></p> <p>Not received - JO to take further.</p>	JO
123/10	<p>Referral of Items for Board of Directors</p> <p>There were no items for referral to the Trust Board.</p>	
124/10	<p>Any Other Business</p> <p><u>Board Assurance Framework</u> JE asked when the Trust Board would receive an up-date. JO confirmed that this was in next month's Board papers.</p> <p><u>Future Meetings of IGC</u> In light of conversations with JO, RK asked if this should be the last IGC meeting. JO who is away for the next meeting, asked that the new Committee start from February 2011.</p> <p>RK wished members of the Committee a Very Happy Christmas.</p>	
125/10	<p>Date and Time of Next Meeting</p> <p>4th January 2011</p>	

Meeting ended at 2.20