A meeting of the Board of Directors will be held on **Friday 12 July 2013** at 8.30am in the **Committee Room, Trust Management Suite, Royal Bournemouth Hospital**.

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

Karen Flaherty  
TRUST SECRETARY

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**A G E N D A**

1. **APOLOGIES FOR ABSENCE**  

2. **MINUTES OF THE PREVIOUS MEETING 8.30 – 8.35am**  
   (a) To approve the draft minutes of the meeting held on 14 June 2013
   (b) To provide updates to the Actions Log

3. **MATTERS ARISING 8.35 – 8.40am**  
   (a) Update on Breast Cancer Service Patient Recall (53/13(d) and 66/13(a))

4. **QUALITY 8.40 – 8.55am**  
   (a) Patient Story
   (b) CQC Quality and Risk Profile
   (c) DSSA Compliance

5. **PERFORMANCE 8.55 – 9.40am**  
   (a) Performance Report
   (b) Monitor Quarter 4 Results
   (c) Financial Performance
   (d) Appraisal and Revalidation Update

6. **STRATEGY 9.40 – 9.50am**  
   (a) Proposed merger between Poole Hospital and RBCH

7. **DECISION 9.50 – 10.00am**  
   (a) Board Objectives
   (b) Sustainable Development Policy
   (c) Responsible Officer Appointment (Revalidation)

8. **DISCUSSION 10.00 - 10.10am**  
   (a) NHS England Urgent and Emergency Care Review

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Karen Flaherty  
TRUST SECRETARY
Engagement Exercise

9. **INFORMATION 10.10 – 10.15am**
   (a) Stroke Briefing Paper  
      *Helen Lingham*  
      To Follow
   (b) Core Brief (June)  
      *Tony Spotswood*  
      N
   (c) Communications Update (inc RAAI June)  
      *Richard Renaut*  
      O
   (d) Board of Directors Forward Programme  
      *Karen Flaherty*  
      P

10. **NEXT MEETING**
    Friday 13 September 2013 at 8.30am in the Committee Room, Royal Bournemouth Hospital
    *Performance reports will be distributed in to the Board of Directors in August and a date has been reserved in the event that it is necessary for the Board of Directors to meet informally to discuss any matters.*

11. **ANY OTHER BUSINESS**
    Key Points for Communication

12. **COMMENTS AND QUESTIONS FROM THE GOVERNORS 10.15 – 10.30am**
    Board Members will be available for 10-15 minutes after the end of the Part I meeting to take comments or questions from the Governors on items received or considered by the Board of Directors at the meeting.

13. **EXCLUSION OF PRESS AND PUBLIC AND OTHERS**
    To resolve that under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act 1960, representatives of the press, members of the public and others not invited to attend be excluded on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted.
Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Board of Directors held on Friday 14 June 2013 in the Committee Room, Royal Bournemouth Hospital

Present: Jane Stichbury (JS) Chairman (in the chair)
Tony Spotswood (TS) Chief Executive
Karen Allman (KA) Director of Human Resources
Mary Armitage (MA) Medical Director
David Bennett (DB) Non-Executive Director
Brian Ford (BF) Non-Executive Director
Stuart Hunter (SH) Director of Finance
Steven Peacock (SP) Non-Executive Director
Alex Pike (AP) Non-Executive Director
Richard Renault (RR) Director of Service Development
Paula Shobbrook (PS) Director of Nursing and Midwifery
Ken Tullett (KT) Non-Executive Director

In attendance: Karen Flaherty (KF) Trust Secretary
Peter Gill (PG) Director of Informatics
Donna Parker (DP) Deputy Chief Operating Officer
Morwenna Hitchens (MH) Specialty Registrar, Palliative Medicine
Tracey Hall (TH) Head of Communications
Dily Ruffer (DR) Governor Co-ordinator
Judith Adda (JA) Public Governor
Mike Allen (MAli) Public Governor
Jayne Baker (JB) Public Governor
David Bellamy (DBel) Public Governor
Sue Bungey (SB) Public Governor
Sharon Carr-Brown (SCB) Public Governor
Derek Chaffey (DC) Public Governor
Mike Desforges (MD) Public Governor
Derek Dundas (DD) Public Governor
Eric Fisher (EF) Public Governor
Lee Foord (LF) Appointed Governor
Doreen Holford (DH) Public Governor
Richard Owen (RO) Staff Governor
David Triplow (DT) Public Governor
Katie Clark (KC) Reporter, Bournemouth Daily Echo
Margaret Neville (MN) Chairman, Friends of the Eye Unit
Rae Stollard (RS) Councillor, Bournemouth Borough Council

Apologies: Helen Lingham (HL) Chief Operating Officer
Ian Metcalfe (IM) Non-Executive Director

64/13 MINUTES OF THE MEETING HELD ON 10 May 2013 (Appendix A)

The minutes of the meeting were taken as read and, subject to a minor change to the wording in the section reporting the patient story (53/13(a)) suggested by KA, were accepted as a true record of the meeting.

KF
 ACTIONS LOG (Appendix B)

(a) Stroke Performance

DP provided an update on the three strands of the work which were ongoing regarding the Stroke Unit:

- the continuation of teamworking with new initiatives including daily meetings with social services and some further work on the outreach model;
- the 7 day services workstream which was looking into the issues around consultant and medical cover Trust-wide including the recommendations made in relation to the Stroke Unit; and
- the work around discharge planning and the locality services model with community and social services, which was again Trust-wide.

She added that HL was preparing a full written response to the questions which had been raised by Governors and this would be circulated once complete.

In response to a question from SP, TS confirmed that although the Trust may not have an agreement on the issues, there was now visibility on the issues. JS requested a formal report to update the Board in October/November with interim report in September. TS agreed that an update should be provided at each meeting.

 HL

 MATTERS ARISING

(a) Update on Breast Cancer Service Patient Recall (53/13(d))

PS provided an update on the patient recall for the breast cancer service. She reported that all the patients seen by the individual doctor concerned had now been invited back for a further outpatient review. She highlighted the number of clinics which had taken place and thanked the radiologists at Poole Hospital and all the staff involved for their support.

She noted that feedback from the patients had been generally positive and they had commented on the openness demonstrated by the Trust and the assurance provided from having been called back for review. PS added that this process was still ongoing and that the case notes of other patients seen by the doctor on different pathways, which may have involved further testing or review by other members of the multidisciplinary team, were also being risk assessed by consultants at the Trust. She further added that additional clinics had been arranged for a review for some of these patients, and those patients from the initial cohort who had been unable to attend. PS confirmed that she would provide full report once the review had been completed.
PS also reported that General Medical Council process was in progress and the Trust’s own review with the external support provided by the Royal College of Surgeons was being arranged.

JS thanked PS for the detailed update.

(b) **Update following Presentation on Stroke Performance (54/13(c))**

DP had provided the update earlier in the meeting.

(c) **Long-Term Conditions (57/13(a))**

RR reported that Help and Care, a local charity, had been successful in its bid for the self-care for long-term conditions and the Trust was one of partners along with the other foundation trusts in Dorset, Boots, BH Live and Know Your Own Health, the IT provider. He noted that it had been a very competitive tender process, with NHS Direct and a large international healthcare provider having submitted bids. The Board congratulated the team on this success and the innovative partnership approach adopted.

67/13 **QUALITY**

(a) **Patient Story (Verbal)**

PS introduced a film which had been made to illustrate the Trust’s response to a serious incident following the admission of a patient to Ward 4 with dehydration who was disoriented and aggressive as a result of this. She noted that the patient had fallen and fractured her hip and then been transferred to Poole Hospital to have the fracture operated on which had lengthened the patient’s stay in hospital. She highlighted that there were many patients in the hospital who were frail and elderly with acute needs and who were a high risk for falls. She reported that the film had been presented at a conference in South West and demonstrated how Wilf Williams, the Clinical Leader on Ward 4, utilised information from the Ward scorecard to make improvements around falls prevention.

The Board viewed the film. PS highlighted how the Ward scorecard had helped identify the issue and enabled the staff to monitor the impact of the changes which had been made.

In response to a question from KT, MA explained that the transfer to Poole Hospital of the small number of patients who fractured their hips at the Hospital was the best option for the patients from a clinical perspective.
(b) **Quality Impact Assessment Report (Appendix C)**

PS presented to the report. She emphasised how she wanted to provide reassurance to the Board around the review of the quality impact of the transformation programme and cost improvement plans (CIPs).

PS explained:
- if the business cases or projects were found to have a negative impact on quality then these will not be approved;
- the range of metrics used to assess quality;
- that there was a quality impact assessment section in monthly Directorate reports to the Trust Management Board and the Board;
- that she and MA had conducted the review process for 2013-14 and this had been reviewed in detail at the Healthcare Assurance Committee (HAC);
- 11 out of 145 business cases reviewed had been rejected and would not proceed, with the majority of those approved maintaining quality and the others having a positive impact on quality;
- that the process had been reviewed by PricewaterhouseCoopers who had confirmed it was robust; and
- the review was not an assessment of the credibility or likelihood of achieving the CIPs.

RR clarified that the 145 schemes covered three years of the CIPs and those rejected were in years 2 and 3 which would allow time to review and work on these plans. RR and SH noted their support for the process which protected quality. SH highlighted the risk that this presented to the ability of the Trust to identify CIPs which would mean that the Trust would also need to look at prioritising spending as an alternative to transformation programmes to make the necessary savings, particularly in the light of the transformation savings which the Trust had already achieved to date. SP commented that this demonstrated how important this process was.

SP asked whether a post-implementation review of these business cases was carried out to check that there had been no impact on quality in line with expectations. MA responded that the metrics used to monitor the quality impacts should pick up any negative impact on quality very quickly. She added that the Trust had to be prepared to change its mind if this was the case. SP acknowledged that this could be difficult culturally and the Board needed to support this.

JS endorsed the process which had been fully considered at HAC and received PricewaterhouseCoopers’ support, even though they
had challenged the Trust on these processes in the past. She noted SH’s warning but emphasised that this would not detract from the Trust’s focus on quality.

PERFORMANCE

(a) Performance Report (Appendix D)

DP presented the report, highlighting that:

- the new performance dashboard was included in the performance report and work was continuing on the Directorate level reports;
- it was a mixed picture on April in terms of performance;
- there had been a dip in performance on the Emergency Department (ED) 4 hour target but the position in May was much improved and the Trust looked like it would meet the target in the first quarter;
- the emergency pressures had continued in early June with an increase in admissions but also a slowdown in discharges;
- there had been no cancellations of operations in May due to the emergency pressures;
- there were no cases of MRSA year to date;
- there had been two C Difficile cases in each of April and May against a trajectory of three for the year to date which meant that the trajectory was likely to very challenging over the summer;
- the 18 week referral to treatment times remained challenging in General Surgery and Urology due to the number of referrals but Orthopaedics and Gynaecology had returned to above the threshold performance in May;
- the upward trend in fast track referrals had continued with 100 more referrals each month than at the same time last year and this very fast pathway created pressure for the Trust;
- although performance on fast track referrals was improving in May there was still pressure on Urology for 62 day cancer referrals and the Trust would be appointing an additional Urology consultant and had locum in place while recruiting to this position;
- the Trust was also looking at where diagnostic tests took place on the patient pathway and having a cancer specialist working with the team and was continuing to discuss with GPs how patient choice could be better managed;
- on Stroke performance there had been an improvement in TIA for high and low risk patients and the position on direct admission to the Stroke Unit and the time spent on the Stroke Unit was stable but remained below target;
- where there delays in direct admission to the Stroke Unit there were often reasons for this - seven patients had an
unclear/complex diagnosis and two were appropriately managed elsewhere due to a poor prognosis;

- those patients not achieving a 90% stay on the Stroke Unit included those with a poor prognosis and seven who were moved due to no longer requiring acute care but could not be discharged;
- staff sickness levels had dropped in May; and
- performance on appraisals was starting to increase.

TS highlighted that although there had been 50% increase in fast track referrals locally there had not been a corresponding increase in cancer amongst the local population. AP asked whether high profile campaigns were causing an increase in referrals due to raised awareness. MA agreed that raising awareness in the groups that the campaigns were designed to reach was a good thing but these also increased concerns among the “worried well”. The Board discussed how to assess the effectiveness of the fast track referrals process for patients.

In response to a question from KT, DP noted that referrals to Urology constituted the largest percentage of fast track referrals and many patients were choosing to wait. KT suggested that it would be useful to see this information in the performance report.

JS commended the Trust’s performance on sickness in context of the levels of activity. BF agreed, noting that there had been an outstanding performance in some areas.

PS presented those elements of the dashboard relating to Quality:
- there had been two serious incidents in April not four as had been shown in the report in the papers;
- out of the 522 patients surveyed in April, 88% received harm-free care and the majority of harms recorded were those patients admitted with community-acquired pressure ulcers;
- patients admitted with underlying pressure damage had an increased recovery time and the pressure ulcers could get worse while they were with the Trust as had happened in one case;
- the Trust was working with a group in the community and had had conversations with NHS Dorset Clinical Commissioning Group to help reduce the number of community-acquired pressure ulcers but many of the patients with community-acquired pressure ulcers were coming from home rather than private or community providers;
- the Friends and Family Test score in ED was 58 and for inpatients was 78 (net promoter score not a percentage);
- the response rate in ED was 8% which was below the Department of Health’s target of 15% as target but the

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HL
Trust had been congratulated on being one of the best in country by achieving this level of responses;

- the Trust’s performance on the Friends and Family Test would be published on NHS Choices in July;
- volunteers were working in ED to ensure cards were completed and post boxes for the cards had been installed but this was resource intensive;
- BF asked whether there were any concerns about publishing this and PS confirmed that's till intending to publish this in July;
- ED was highlighted as a challenge early on as patients tended to want to leave immediately after receiving treatment and therefore the Trust had focussed on one question rather than a number of question and other hospitals were using tokens;
- the delayed transfers of care clearly evidenced the pressure on the Trust and the number of patients who were in the Hospital due to a lack of provision for caring for them in the community; and
- the data on 30 day readmissions demonstrated an improvement in performance against the position last year.

AP asked how the Trust could better understand what harms were attributable to the Trust and those which were community-acquired in order to help improve its performance as 12% of patients did not receive harm-free care which was a significant number of patients. PS agreed and explained that the Trust did disaggregate the data and the Board would be reviewing some more detailed information in the private session of the meeting. She noted that all the information was provided to the Ward and validated against incidents and complaints so that they have data and can respond in terms of actions.

SP noted the information on mandatory training compliance and asked what this meant. KA responded that 80% of staff were up to date with mandatory training and detailed information was available from an individual level up. She noted that this was against a target of 95% and Trust had steadily increased its performance. She added that there was additional granularity below this which the Board could review as the scorecard was developed.

DB questioned why emergency pressures were continuing despite the emphasis on discussing ways to address this with partners and having action plans in place. TS acknowledged the comments but noted the importance of improving the performance outside the Trust in response to this issue which is why the Trust was discussing this with NHS Dorset Clinical Commissioning Group. He noted that the Trust was working to move patients to community beds and improve end of life care so patients had alternatives to dying in an acute hospital setting. The Board
discussed how the Trust had increased provision in response to current pressures but any further increase at this site would require major construction.

SH noted that the average length of stay had increased and asked whether this was a reflection of the Trust's efficiency. DP replied that this was due to a number of factors including acuity and discharge and agreed to provide more information. SH also asked whether the increase in GP outpatient referrals was likely to lead to an increase activity in the coming months.

AP indicated that the Board needed to understand how it can support the Trust more with these ongoing systemic issues. She noted that there was greater transparency and clarity than ever in terms of reporting and the Board should use this to support the team even if it was highlighting issues. JS concurred that the information should not be used to criticise performance and that the reporting had been very informative.

(b) Financial Performance (Appendix E)

SH presented the report, noting the positive performance overall. However, he highlighted that the Trust was behind plan on its transformation programme in April and the position in May looked significantly worse. He reported that the Finance Committee were now focusing on individual Directorates to address potential issues at an early stage.

He reported that the Trust had received £340,000 above the level of the commissioning contract to support emergency pressures but he acknowledged DB’s point earlier in the meeting about the delivery of agreed actions. He also noted the need to be mindful of expenditure and not commit to unnecessary expenditure.

69/13

STRATEGY

(a) Proposed Merger between Poole Hospital and RBCH (Appendix F)

TS reported on the independent hearings with the Competition Commission (CC) which had taken place on 11 June 2013 attended by each Trust. He updated the Board on the content of the CC’s current working papers and its emerging thinking:

- market definition and how far patients were prepared to travel and the delineation of services;
- maternity services provided by the Trust provided a competitive constraint on Poole Hospital but not the reverse;
- specialised services which included services that neither Trust provided which was slightly concerning;
- in relation to the counterfactual that the Monitor test on
special administration did not meet CC test of an organisation failing; and
• elective services, which was the focus of much of discussion with the Trust, where the overlap between the Trusts equated to £52 million in revenue on the CC’s analysis but was reduced to £40 million when overlaps in radiotherapy, oral maxillofacial surgery, haematology and pain management which did not exist were removed and to £25 million when sub-specialisation and services provided on a shared consultant basis were taken into account.

He noted that the Trust had calculated the value of the benefits of the merger in relation to five key clinical areas which had a combined revenue of £114 million, £88 million of savings over 5 years and £50 million of investment in terms of maternity and haematology. He highlighted the differential between the value of the benefits and the perceived reduction in competition.

TS commented that hearing itself had been relatively benign and indicated to the Trust that the CC may have made up its mind although the CC had assured the Trust that this was not the case. He reported that the CC’s provisional findings would be published at the beginning of July and may be available by the date of the Board meeting in July, the final report would be published on 26 August and, depending on the content of the report on the provisional findings, there may be a remedies hearing in the summer. He noted the Poole Hospital had had a similar experience at its hearing but the focus there had been on maternity services and the counterfactual.

TS reported that Mary Sherry who was designate Director of Integration and Benefits Realisation on the Proposed Board had accepted a post in Moorfields Eye Hospital NHS Foundation Trust and both Trusts would now look at how the role would be fulfilled in the new organisation. He also noted that work which would be taking place in July on the CIPs for the new organisation. He advised that if a shortfall was identified then the Trusts may need to have discussions with the commissioners. He stressed how difficult it was to drive through efficiencies with current levels of activity as SH had noted earlier in the meeting.

BF asked how the Trust would deal with situation if the CC’s ruling was based on incorrect information. TS replied that the CC had confirmed that they had not yet reflected the corrections the Trust had provided over a number of weeks in advance of the hearing. However, he noted that this would not form the basis for an appeal. MA agreed noting that this could be viewed as a matter of interpretation and may not be material to the final decision.

JS commented on the amount of work being done by the Executive Directors and many others to support this process and
the Trust’s commitment to the aim to improve standards of care for local people and financial resilience through the merger.

70/13 DECISION

(a) Governor Scrutiny Committee Report “The Hospital at Night (Appendix G)

PS presented the report to the Board, requesting that the Board receive the report at this stage with the recommendations to be considered by the Executive Directors. She noted that the chairman of the Governor Scrutiny Committee, SCB, was present and she would ask her to comment on the report.

PS highlighted that:

- there had been positive comments from staff and patients, particularly on the quality of care but also comments about nurse staffing during busy times at night;
- the majority of patients said call bells were answered in a reasonable time but the Trust is conducting surveys of responses to call bells and recognised that patients in escalation beds did not have call bells but patients in these beds were risk assessed and the Trust was also working on addressing this;
- nurse staffing had been reviewed and special nurses were brought into areas of increased dependency and complied with the Royal College of Nursing guidance on staffing levels and she believed these were at the correct level;
- additional staff had been brought into the Acute Medical Unit (AMU) and staff had commented that this had been a great improvement;
- the majority of staff had had appraisals completed and felt that they could raise any concerns which was very positive in the context of the Francis Report;
- issues were raised in the report around medical staff and Clinical Site Team; and
- she did not agree with the recommendation about the numbers of healthcare assistants given the work which had been done around the nurse staffing template to ensure the Trust had the correct numbers of nursing staff.

PS was pleased to receive the report and thanked the members of the Governor Scrutiny Committee and other Governors who came into the hospital at night. She also noted that she would pass on the comments to staff as requested.

SCB noted the recommendation around the timely administration of medication and how nursing staff had felt very strongly about the need for planning during the day for the night by ensuring equipment and medication was available. She noted that patients
were very happy with the care received and the need to focus on the issues which had been raised. DBel highlighted the need to improve the food facilities for night staff.

TS congratulated the team and authors for their very thorough work. He noted that the Trust had done similar work with the Clinical Site Team and this work had echoed the issues the Governors had heard. He highlighted the trend to ask patients about staffing levels and the risk associated with this due to the constraints within the funding envelope and the importance therefore of having a methodology for assessing requests for more staff.

RR noted that the report had provided a balanced view but there were still points which made for some uncomfortable reading. He added that the Trust was reviewing the work left at the end of the day for night staff on a ward by ward basis as these systematic changes may assist the Trust in delivering improvements within its existing resources.

PG noted that the report was also very reassuring but also questioned the partial take-up of the consultant/patient work list outside the Medical Wards which may be having an impact on the work left for staff at night. PS noted that the feedback from the teams which use the work list was very positive.

MA referred to how the information in the report triangulated with other data around the pressures on medical staff with doctors feeling isolated and delays in responding to nursing staff. She added that these issues were being picked up with the seven day working workstream. She also highlighted that outliers had been picked up in the report and the Trust was also considering how to address this issue with current activity levels.

KA added that the Trust had increased the number of nurse prescribers. She also noted the comments in the report about staff noise which could be addressed through customer care training as this was different to potential disruption by patients moving beds.

In response to a question from SP about staffing templates, PS responded that the two areas highlighted in the report, AMU and the Stroke Unit, had not been part of the original Nurse Staffing Review but this review had now been completed in AMU and she was currently conducting the review for the Stroke Unit. SP asked whether a similar review would be conducted for medical staff. TS replied that the Trust did not have the full allocation of junior doctors due to vacancies and sickness. He added that more junior doctors would join the Trust in August but there were difficult decisions about where to focus the Trust’s resources in relation to staffing.
KT commented that the Trust was fortunate to have Governors who could carry out this work. He added that the rest areas for staff were generally good and charitable funding had been used to improve this but if there was scope to do more than this could be done relatively quickly.

JS recognised the positive comments on the report and the Governors' commitment to the services and the patients at the Hospital. She underlined the need for Executive Directors to review the report and to respond to the Council of Governors. She added that while there was a great deal of assurance and positive comments in the report, the Trust needed to address the negative comments and the issues which had been highlighted. She concluded by thanking the Governors for the work which had gone into this report.

71/13  DISCUSSION

(a)  Monitor's Enforcement Guidance (Appendix H)

TS presented the guidance and noted its relevance to the Trust in understanding Monitor's approach in the context of local issues in relation to Poole Hospital. He noted that this guidance would inevitably be used given the number of trusts which were experiencing difficulties.

RR emphasised the work which had been done on quality governance more recently and the well-established performance monitoring and reporting. He noted the assurance which this provided on core areas.

The Board briefly discussed the due diligence work which KPMG would be performing in relation to the application to Monitor. SP noted that the Audit Committee would be reviewing the scope of this work and the assurance provided.

72/13  INFORMATION

(a)  Monitor Consultations on Procurement, Patient Choice and Competition Regulations (Appendix I)

RR noted that this was one of a raft of current consultation papers issued by Monitor. He highlighted that this was extremely relevant to the work around merger and ensuring services were financially viable. He highlighted the risks relating to anti-competitive behaviour.
(b) **Monitor’s Designation Framework for Commissioner Requested Services/Location Specific Services (Appendix J)**

This report was noted for information.

(c) **Appointment of New Medical Director (Appendix K)**

TS reminded the Board of MA’s decision to retire in September 2013. He presented the paper, acknowledging that it was unclear whether appointment would be for seven months or three years due to the uncertainty around the merger and how this had been a factor for individuals considering the role. He reported that three expressions of interest in the role had been received and following discussions with these individuals and with senior clinical staff Basil Fozard had applied for the role. TS noted that Basil Fozard was currently away but would be interviewed by TS, JS, KA and a Non-Executive Director with a view to appointing a Medical Director prior to MA’s departure. He mentioned that discussions were ongoing as to whether it would be more appropriate for a surgeon or physician to chair some of the groups normally chaired by the Medical Director, such as Therapeutics and Medicine.

(d) **Core Brief (Appendix L)**

This was noted for information.

(e) **Communications Update (Appendix M)**

The report was noted for information.

(f) **Board of Directors Forward Programme (Appendix N)**

The report was noted for information.

73/13

**DATE OF NEXT MEETING**

Friday 12 July 2013 at 8.30am, Committee Room, Royal Bournemouth Hospital

74/13

**ANY OTHER BUSINESS**

JS reported that TS had written to the Daily Mail in response to a letter from a patient which had been published. She noted that the clinical team did not recognise what the patient had said as normal practice and no formal complaint had been received. TS had requested that a letter from the Trust was passed to the individual so that they can make contact with the Trust to discuss what had happened.

KT also noted that raffle tickets were available for the Charity Jazz & Swing Concert at Highcliffe Castle on 14 July 2013.
Key Communications points for staff

1. Update on breast cancer service patient recall
2. Performance and SH's comments around delivering transformation savings
3. The findings in the Governor Scrutiny Committee report

QUESTIONS FROM GOVERNORS

1. DBel asked about the level of readmissions within 30 days, which totalled 460 in April, and whether the Trust understood what was behind this figure. RR responded that readmissions for any purpose were included in the data and this may be unrelated to the patient's first stay in hospital. He added that this was a raw measure which has not been used as a national quality improvement measure. He explained that the strongest correlation was to the patient's age and Medical specialty.
2. SCB asked whether the additional data relating to the safety thermometer could be incorporated in the public part of the meeting.
3. RO asked what impact the CC's decision would have on back office functions as some had already merged and some had plans to merge. TS responded that the back office services at both Trusts were likely to come together regardless of merger although some of reporting functions in Finance were unlikely to merge.
4. DC asked about the GP-led unit and the use of space at Christchurch Hospital and in nursing homes for patients and whether a GP-led unit could be incorporated in the plans. JS replied that a briefing note was being prepared which would provide absolute clarity on these issues. TS added that the building work and demolition work had already commenced and the Board of Directors would be considering the business case relating to the nursing home later in the meeting. He further added that it was not appropriate for the Trust as an acute trust to be providing this type of care to patients which would be better provided in a community hospital or nursing home setting.
5. JA asked whether the Trust provided additional training for staff around the communication of results following tests for cancer. DP noted that staff received advanced communication training and there were very few members of staff who had not received this training.
6. JA asked about the warnings around financial sustainability and earlier in the meeting and whether the Trust had strategic plans in place. SH replied that the plans for merger were designed to address this and the Board had also considered alternatives to merging. JS added that the objectives for the Board were to ensure that the Trust delivered an excellent service and was financial sustainable.

There being no further business the meeting was declared closed.
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS
NHS FOUNDATION TRUST

Actions carried forward from a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Board of Directors held on Friday 14 June 2013.

64/13 MINUTES OF THE MEETING HELD ON 10 May 2013 (Appendix A)

The minutes of the meeting were taken as read and, subject to a minor change to the wording in the section reporting the patient story (53/13(a)) suggested by KA, were accepted as a true record of the meeting.

65/13 ACTIONS LOG

(a) Stroke Performance

JS requested a formal report to update the Board in October/November with interim report in September. TS agreed that an update should be provided at each meeting.

68/13 PERFORMANCE

(a) Performance Report (Appendix D)

In response to a question from KT, DP noted that referrals to Urology constituted the largest percentage of fast track referrals and many patients were choosing to wait. KT suggested that it would be useful to see this information in the performance report.

SH noted that the average length of stay had increased and asked whether this was a reflection of the Trust’s efficiency. DP replied that this was due to a number of factors including acuity and discharge and agreed to provide more information. SH also asked whether the increase in GP outpatient referrals was likely to lead to an increase activity in the coming months.
DECISION

(a) Governor Scrutiny Committee Report “The Hospital at Night (Appendix G)

JS recognised the positive comments on the report and the Governors' commitment to the services and the patients at the Hospital. She underlined the need for Executive Directors to review the report and to respond to the Council of Governors.

PS Included on CoG agenda for 29 July 2013
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<td><strong>Author of Paper:</strong></td>
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</table>
| **Details of previous discussion and/or dissemination:** | Healthcare Assurance Committee, 27th June 2013  
 TMB, 5th July 2013 |
| **Key Purpose** | Assurance | Performance |
| **Action required by Board of Directors** | To Note the Report |

**Executive Summary:**
The CQC last updated the Quality and Risk Profile for RBCH FT on the 6th June 2013 (report dated 31/05/13).
The enclosed paper provides background information on the data set which is used by the CQC, which notes where the Trust is rated ‘worse than expected’ within each domain.
The information assessed by the CQC is rated ‘green and yellow’, which provides positive assurance of the Trust’s compliance with the 16 Essential Standards of Quality and Patient Safety.

**Strategic Goals & Objectives**
- All

**Links to CQC Registration**
- All Essential Standards of Quality and Safety

**Links to Assurance Framework/Key Risks**
- All

**Type of Assurance**
- All  
  - External – CQC
1. **Introduction**

The Care Quality Commission's (CQC) quality and risk profiles (QRPs) bring together information about a care provider and estimate the risk of non-compliance against each of the 16 Essential Standards of Quality and Safety. The CQC published an update to the QRP for May 2013 (report dated 31/05/13). The previous QRP was published in March 2013.

2. **Summary**

The current risk ratings for the 16 standards are 'green' and 'low yellow' from the CQC data sources, which demonstrate a low risk of non-compliance.

3. **Overview of risk ratings**

The chart below provides an overview of the risk ratings for the past 6 months, with the overall trend demonstrating positive assurance of continued compliance.
4. **Detail of the risk ratings**

The QRP report notes 3 risk rating changes from the previous months report.

The changes are not significant and do not change the Trusts overall positive risk profile.

<table>
<thead>
<tr>
<th>Outcome</th>
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<tbody>
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<tr>
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<td>May 13</td>
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</tbody>
</table>
5. **Detail of the red risk estimates**

In total the CQC have used 692 individual data items to form the overall risk estimate for the 16 essential standards of quality and safety.

If the CQC does not have the information to make a judgement for an outcome then this is recoded as no data or insufficient data. Each item of data is individually coded by the CQC as either:

- Much worse than expected – RED RATED
- Worse than expected
- Tending towards worse than expected
- Similar to expected
- Tending towards better than expected
- Better than expected
- Much better than expected – GREEN RATED
<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Current Risk Estimate</th>
<th>Number of Items listed as Much Worse, Worse or Tending to be Worse than expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1 (R17) Respecting and involving people who use services</td>
<td>Low Yellow</td>
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<td>Outcome 2 (R18) Consent to care and treatment</td>
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<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Low Green</td>
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<td>Outcome 5 (R14) Meeting nutritional needs</td>
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<td>Outcome 6 (R24) Cooperating with other providers</td>
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<td>Outcome 7 (R11) Safeguarding people who use services from abuse</td>
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<td>Outcome 8 (R12) Cleanliness and infection control</td>
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<td>Outcome 9 (R13) Management of medicines</td>
<td>Low Yellow</td>
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<td>Outcome 10 (R15) Safety and suitability of premises</td>
<td>Low Green</td>
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<tr>
<td>Outcome 11 (R16) Safety of equipment</td>
<td>Low Green</td>
<td>0</td>
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<tr>
<td>Outcome 12 (R21) Requirements relating to workers</td>
<td>Low Green</td>
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<td>Outcome 13 (R22) Staffing</td>
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<td>Outcome 14 (R23) Supporting staff</td>
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<tr>
<td>Outcome 16 (R10) Monitoring the quality of service provision</td>
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<td>Outcome 17 (R19) Complaints</td>
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<tr>
<td>Outcome 21 (R20) Records</td>
<td>Low Green</td>
<td>2</td>
</tr>
</tbody>
</table>

The data sources rated as either: Much worse than expected; Worse than expected; Tending towards worse than expected are listed below. The data has been forwarded to CQC Outcome leads for review and comment. This is available as appendix A. It is noted that some of the data sources used by the CQC are historic, and there are no significant gaps identified from our internal review.

6. Recommendation

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

J Sims
Associate Director Clinical Governance
June 13
### Appendix A: Information from the CQC

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Item Description</th>
<th>Item Datasource</th>
<th>Period Start</th>
<th>Period End</th>
<th>Comparison</th>
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</thead>
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<tr>
<td>Outcome 1 (R17) Respecting and involving people who use services</td>
<td>The proportion of respondents to the adult inpatient survey who stated that they were not given any information about their treatment or condition while in the ED</td>
<td>Care Quality Commission, Survey of Adult Inpatients</td>
<td>01/06/12</td>
<td>31/08/12</td>
<td>Much worse than expected</td>
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<tr>
<td>Outcome 1 (R17) Respecting and involving people who use services</td>
<td>PEAT score for Social Spaces &amp; Facilities - is there a family visiting area? - Data for Royal Bournemouth Hospital</td>
<td>Information Centre for Health &amp; Social Care (IC), Patient Environment Action Team (PEAT)</td>
<td>03/01/12</td>
<td>30/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 1 (R17) Respecting and involving people who use services</td>
<td>Proportion of respondents who stated that the doctors or nurses did not listen to what they had to say. -</td>
<td>Care Quality Commission, A&amp;E Survey</td>
<td>01/01/12</td>
<td>31/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 21 (R20) Records</td>
<td>Proportion of secondary diagnoses recorded incorrectly -</td>
<td>Audit Commission, Payment by Results (PbR)</td>
<td>01/04/11</td>
<td>31/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Total 30 day mortality rates by Health Resources Group chapters: Q - Vascular system -</td>
<td>Information Centre for Health &amp; Social Care (IC), Hospital Episode Statistics (HES)</td>
<td>01/01/11</td>
<td>31/12/11</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Comparison of observed to expected number of in-hospital deaths during weekend emergency admissions with a Hospital Standardised Mortality Ratio (HSMR) diagnosis. -</td>
<td>Dr Foster Intelligence, Hospital Guide 2012</td>
<td>01/04/11</td>
<td>31/03/12</td>
<td>Much worse than expected</td>
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<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Number of emergency admissions which have a length of stay of 0 or 1 day and a vague diagnosis. -</td>
<td>Dr Foster Intelligence, Hospital Guide 2012</td>
<td>01/04/11</td>
<td>31/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Standardised in-hospital mortality rates by CCS diagnosis group: Cerebrovascular -</td>
<td>IC, HES</td>
<td>01/01/12</td>
<td>31/12/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Standardised in-hospital mortality rates by CCS diagnosis group: Neurology -</td>
<td>IC,HES</td>
<td>01/01/12</td>
<td>31/12/12</td>
<td>Much worse than expected</td>
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<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for emergency cases in CCS diagnosis group - Gynaecology -</td>
<td>IC,HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
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<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for emergency cases in CCS diagnosis group - Dermatology -</td>
<td>IC,HES</td>
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<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for emergency cases in CCS diagnosis group - Trauma and orthopaedics -</td>
<td>IC,HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
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<tr>
<td>Outcome 4 (R9) Care and welfare of people who use services</td>
<td>Proportion of eligible patients with an initial diagnosis of STEMI who receive primary angioplasty within 90 mins of arrival at the Heart Attack Centre.</td>
<td>National Institute for Clinical Outcomes Research, Myocardial Ischaemia National Audit Project</td>
<td>01/04/11</td>
<td>31/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 8 (R12) Cleanliness and infection control</td>
<td>PEAT score for Infection Control - proportion of Yes responses relating to hand wash facilities - Data for Christchurch Hospital</td>
<td>Information Centre for Health &amp; Social Care (IC), Patient Environment Action Team (PEAT)</td>
<td>03/01/12</td>
<td>30/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 8 (R12) Cleanliness and infection control</td>
<td>PEAT score for Infection Control - Does the Trusts/organisations hand hygiene policy promote the World Health Organisations approach to hand hygiene?</td>
<td>(IC), PEAT</td>
<td>03/01/12</td>
<td>30/03/12</td>
<td>Much worse than expected</td>
</tr>
<tr>
<td>Outcome 8</td>
<td>PEAT score for Infection Control - Does the Trust/organisation have a clear, documented policy around identification of isolation areas/areas of restricted access?</td>
<td>(IC), (PEAT)</td>
<td>03/01/12</td>
<td>30/03/12</td>
<td>Much worse than expected</td>
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<td>Outcome 1</td>
<td>The proportion of respondents to the adult inpatient survey who stated that the hospital staff did not take into account the family or home situation when planning their discharge.</td>
<td>Care Quality Commission, Survey of adult inpatients</td>
<td>01/06/12</td>
<td>31/08/12</td>
<td>Tending towards worse than expected</td>
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<td>Outcome 10</td>
<td>The proportion of respondents to the adult inpatient survey who stated that during their stay in hospital they had to use the same bathroom or shower area as patients of the opposite sex</td>
<td>Care Quality Commission, Survey of Adult Inpatients</td>
<td>01/06/12</td>
<td>31/08/12</td>
<td>Tending towards worse than expected</td>
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<td>Outcome 4</td>
<td>Proportion of respondents who stated that if they needed attention, they were not able to get a member of medical or nursing staff to help them.</td>
<td>Care Quality Commission, A&amp;E Survey</td>
<td>01/01/12</td>
<td>31/03/12</td>
<td>Tending towards worse than expected</td>
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<td>Outcome 4</td>
<td>Percentage of hip procedures undertaken using 10A ODEP rated acetabular implants (hip cup)</td>
<td>National Joint Registry, National Joint Registry</td>
<td>01/01/12</td>
<td>31/03/12</td>
<td>Tending towards worse than expected</td>
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<tr>
<td>Outcome 4</td>
<td>Standardised in-hospital mortality rates by CCS diagnosis group: Vascular</td>
<td>IC,HES</td>
<td>01/01/12</td>
<td>31/12/12</td>
<td>Tending towards worse than expected</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for elective cases in CCS diagnosis group - Cerebrovascular</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
<td>Tending towards worse than expected</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for elective cases in CCS diagnosis group - Paediatrics and congenital disorders</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
<td>Tending towards worse than expected</td>
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<tr>
<td>Outcome 4</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for elective cases in CCS diagnosis group - Orthodontics</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
<td>Tending towards worse than expected</td>
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<tr>
<td>Outcome 4</td>
<td>(R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for emergency cases in CCS diagnosis group - Endocrinology -</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
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<td>Outcome 4</td>
<td>(R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for emergency cases in CCS diagnosis group - Neurology -</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
</tr>
<tr>
<td>Outcome 1</td>
<td>(R17) Respecting and involving people who use services</td>
<td>The proportion of respondents to the adult inpatient survey who stated that they did not have enough privacy when discussing their condition or treatment. -</td>
<td>Care Quality Commission, Survey of Adult Inpatients</td>
<td>01/06/12</td>
<td>31/08/12</td>
</tr>
<tr>
<td>Outcome 1</td>
<td>(R17) Respecting and involving people who use services</td>
<td>Proportion of respondents who stated that if their family or someone close to them wanted to talk to a doctor, they did not have enough opportunity to do so. -</td>
<td>Care Quality Commission, A&amp;E Survey</td>
<td>01/01/12</td>
<td>31/03/12</td>
</tr>
<tr>
<td>Outcome 16</td>
<td>(R10) Assessing and monitoring the quality of service provision</td>
<td>Participation - did the eligible organisation take part in the Stroke Improvement National Audit Programme - Data for Royal Bournemouth Hospital</td>
<td>Royal College of Physicians, Stroke Improvement National Audit Programme</td>
<td>01/10/12</td>
<td>31/12/12</td>
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<tr>
<td>Outcome 21</td>
<td>(R20) Records</td>
<td>The Trust has in place a robust programme of internal and external data quality/clinical coding audit in line with the requirements of the Audit Commission and NHS Connecting for Health. -</td>
<td>Department of Health, Information Governance Toolkit</td>
<td>01/04/12</td>
<td>31/03/13</td>
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<tr>
<td>Outcome 4</td>
<td>(R9) Care and welfare of people who use services</td>
<td>Standardised in-hospital mortality rates by CCS diagnosis group: Cardiology -</td>
<td>IC, HES</td>
<td>01/01/12</td>
<td>31/12/12</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>(R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for elective cases in CCS diagnosis group - Dermatology -</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>(R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for elective cases in CCS diagnosis group - Musculoskeletal -</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
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<td>----------</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>(R9) Care and welfare of people who use services</td>
<td>Standardised emergency readmission ratio within 30 days of discharge for emergency cases in CCS diagnosis group - Musculoskeletal -</td>
<td>IC, HES</td>
<td>01/12/11</td>
<td>30/11/12</td>
</tr>
<tr>
<td>Outcome 5</td>
<td>(R14) Meeting nutritional needs</td>
<td>The proportion of respondents to the adult inpatient survey who stated that they were not offered a choice of food -</td>
<td>Care Quality Commission, Survey of Adult Inpatients</td>
<td>01/06/12</td>
<td>31/08/12</td>
</tr>
<tr>
<td>Outcome 5</td>
<td>(R14) Meeting nutritional needs</td>
<td>PEAT score for Food &amp; Hydration - Reviewed Dysphagia Diet Food Texture Descriptions? And has the Trust taken steps to apply the descriptions to its provision of texture modified foods - Data for Royal Bournemouth Hospital</td>
<td>Information Centre for Health &amp; Social Care (IC), Patient Environment Action Team (PEAT)</td>
<td>03/01/12</td>
<td>30/03/12</td>
</tr>
<tr>
<td>Outcome 5</td>
<td>(R14) Meeting nutritional needs</td>
<td>PEAT score for Food &amp; Hydration - Reviewed Dysphagia Diet Food Texture Descriptions? And has the Trust taken steps to apply the descriptions to its provision of texture modified foods - Data for Christchurch Hospital</td>
<td>Information Centre for Health &amp; Social Care (IC), Patient Environment Action Team (PEAT)</td>
<td>03/01/12</td>
<td>30/03/12</td>
</tr>
<tr>
<td>Outcome 7</td>
<td>(R11) Safeguarding people who use services from abuse</td>
<td>The proportion of respondents to the adult inpatient survey who stated that they felt threatened during their stay in hospital by other patients or visitors -</td>
<td>Care Quality Commission, Survey of Adult Inpatients</td>
<td>01/06/12</td>
<td>31/08/12</td>
</tr>
<tr>
<td>Outcome 8</td>
<td>(R12) Cleanliness and infection control</td>
<td>PEAT score for infection control - proportion of applicable wards with adequate hand decontamination provision - Data for Christchurch Hospital</td>
<td>IC, PEAT</td>
<td>03/01/12</td>
<td>30/03/12</td>
</tr>
<tr>
<td>Outcome 9</td>
<td>(R13) Management of medicines</td>
<td>Proportion of respondents who stated that a member of staff did not tell them about medication side effects to watch for. -</td>
<td>Care Quality Commission, A&amp;E Survey</td>
<td>01/01/12</td>
<td>31/03/12</td>
</tr>
<tr>
<td>BOARD OF DIRECTORS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meeting Date and Part:</strong></td>
<td>12 July 2013 Part I</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Subject:** | Public Compliance Statements  
1) Delivering Same Sex Accommodation (DSSA) Compliance statement  
2) Endorsement of the Learning Disabilities Charter |
| **Section:** | Quality performance |
| **Executive Director with overall responsibility:** | Paula Shobbrook Director of Nursing and Midwifery |
| **Author of Paper:** | Ellen Bull Deputy Director of Nursing and Midwifery |
| **Details of previous discussion and/or dissemination:** | Annual declaration for compliance DSSA |
| **Key Purpose:** | Patient Safety | Health & Safety | Performance | Strategy |
| | | | | x |
| **Action required by BoD:** | For Decision |
| **Executive Summary:** | The Board of Directors is asked to:  
• review and approve the Trusts recommended compliance statement for delivering same sex accommodation.  
• Endorse the Learning Disabilities Charter |
| **Strategic Goals & Objectives:** | Department of Health compliance document. |
| **Links to CQC Registration:** (Outcome reference) | CQC Outcome 1 and 4 |
| **Links to Assurance Framework/Key Risks:** | CQC Inpatient Survey- PCT contract/Reputational risk |
| **Type of Assurance:** | Internal | External |
| | | x |
1) **Delivering Same Sex Accommodation Compliance Statement**

The compliance statement on delivering same sex accommodation is reviewed annually. This is an obligation every Trust is required to complete. The statement is displayed publically on the website.

Delivering same sex accommodation has been a key objective for the Department of Health and all acute Trusts are obliged to be transparent in the compliance to this statement. This is monitored monthly by commissioners, where compliance and breaches are reported.

As a Trust, much work has been completed to deliver compliance on our wards. There are currently nationally agreed exceptions to the compliance, such as areas of intense high acuity such as high dependency areas and acute cardiac areas. The website’s current compliance statement is deemed correct.

The Board of Directors is asked to review the following compliance statement shown as depicted on the Trust website and accept the recommendation that this compliance statement is correct.

**Compliance Statement**

**Same sex accommodation – improving the patient experience**

The elimination of mixed sex sleeping accommodation, except where it is in the overall best interest of the patient or reflects their personal choice, is recognised by the Trust as a key factor in maintaining the privacy and dignity of patients cared for in the hospital. The Trust is able to provide single sex sleeping accommodation in all inpatient areas in line with the Department of Health’s requirements and the Board of Directors receives reasonable assurance through the provision of monthly performance reports. You can find out more about how we are improving the patient experience here [Patients and visitor page](#).

**Same sex accommodation – improving the patient experience**

We remain committed to limit mixed sex areas to essential high care areas only, such as critical care. Even in these areas there are strict guidelines to ensure that privacy and dignity are maintained for patients.

For a hospital to say that it has same-sex accommodation, it must provide sleeping areas and toilet and washing facilities that are for men or women only. This will mean different things in different hospitals. You could be:

- in a same-sex ward, where the whole ward is occupied by either men or women only
- in a single room, or
- in a mixed ward, where men and women are in separate bays or rooms.
Toilet and washing facilities should be easy to get to, not a long way from your bed. You shouldn’t have to go through accommodation or toilet, or washing facilities used by the opposite sex, to get to your own.

Our commitment to privacy and dignity is embodied in a ward level action plan, key elements of which are:

- Ensuring staff are wearing their identity badge
- Improving the use of curtains around beds
- Minimising noise at night
- Peer audits of privacy and dignity
- Introduced goals for answering call bells and telephones
- Improving the quality of gowns available for patients
- Improving privacy and dignity in diagnostic areas
- Ensuring patients are appropriately covered when being transferred around the hospital.

**Recommendation**

The Board of Directors are asked to review this compliance statement and accept the recommendation that it is current and correct for 2013-2014.

2) **Learning Disability Charter**

Learning Disability (LD) best practice is a Monitor requirement. The ‘Getting it right’ Charter (see appendix) describes a set of care criteria which demonstrates public commitment to the LD agenda. The patient experience and communications committee have reviewed and endorsed the adoption of this Charter, and the Board of Directors are also requested to review and endorse this.

**Recommendation**

The Board of Directors are asked to endorse the adoption of the Learning Disabilities ‘Getting it right’ Charter
All people with a learning disability have an equal right to healthcare.
All healthcare professionals have a duty to make reasonable adjustments to the treatment they provide to people with a learning disability.
All healthcare professionals should provide a high standard of care and treatment and value the lives of people with a learning disability.

By signing this charter, we pledge to:

- make sure that hospital passports are available and used
- make sure that all our staff understand and apply the principles of mental capacity laws
- appoint a learning disability liaison nurse in our hospital(s)
- make sure every eligible person with a learning disability can have an annual health check
- provide ongoing learning disability awareness training for all staff
- listen to, respect and involve families and carers
- provide practical support and information to families and carers
- provide information that is accessible for people with a learning disability
- display the Getting it right principles for everyone to see.

For guidance on implementing this pledge, please visit www.mencap.org.uk/gettingitright
<table>
<thead>
<tr>
<th>Executive Summary:</th>
<th>This report accompanies the Performance Indicator Matrix and outlines the Trust’s performance exceptions against key access and performance targets for the month of May 2013, as set out in the Monitor Compliance Framework, ‘Everyone Counts’ planning guidance and contractual requirements. The report now also incorporates the Trust’s new Balanced Dashboard for Quality, Performance, Productivity and Efficiency. Further work continues on the dashboard and ‘drill down’ elements to refine the reporting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goals &amp; Objectives:</td>
<td>Performance</td>
</tr>
<tr>
<td>Links to CQC Registration:</td>
<td>Section 2 – Outcome 4: Care and welfare of people who use services. Outcome - 6 Co-operating with others.</td>
</tr>
<tr>
<td>Links to Assurance Framework/Key Risks:</td>
<td>Performance</td>
</tr>
<tr>
<td>Type of Assurance:</td>
<td>Internal</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Performance Exception Report
2013/14 - July

1 Purpose of the Report

This report accompanies the Performance Indicator Matrix and outlines the Trust’s performance exceptions against key access and performance targets for the month of May 2013, as set out in Everyone counts: Planning for Patients 2013/14, the Monitor Compliance Framework and in our contracts.

2 Cancer

Performance against 62 Day Wait from Referral to 1st Treatment

The performance for April was 81.4%, below the threshold of 85%. Continued increase in Fast Track referrals, patient choice, complexity of pathways and capacity pressures in Urology have resulted in a number of 62 day breaches. This currently presents a risk to Quarter 1 compliance, and is being managed closely.

3 Stroke Indicators

Performance against Stroke Best Practice Tariff and Network indicators

<table>
<thead>
<tr>
<th>Stroke</th>
<th>Total Patients (May)</th>
<th>Number of Patients Failing Target (May)</th>
<th>May 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIA High Risk Patients</td>
<td>40</td>
<td>10</td>
<td>75.0%</td>
</tr>
<tr>
<td>TIA Low Risk Patients</td>
<td>33</td>
<td>3</td>
<td>90.9%</td>
</tr>
<tr>
<td>Alteplase (Thrombolysis)</td>
<td>5</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>90% Time Spent on Stroke Ward</td>
<td>52</td>
<td>20</td>
<td>61.5%</td>
</tr>
<tr>
<td>Direct Admission to Stroke Unit within 4 hours</td>
<td>48</td>
<td>23</td>
<td>52.1%</td>
</tr>
<tr>
<td>Brain Imaging – urgent within 1 hour</td>
<td>20</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>Brain Imaging – other within 24 hours</td>
<td>50</td>
<td>4</td>
<td>92.0%</td>
</tr>
</tbody>
</table>
Performance against the 90% time on the stroke unit was 61.5% for May compared to 61.8% in April. 20 patients failed the target for various reasons including:

- 7 patients no longer requiring acute care
- 3 due to complexity/a delay in diagnosis
- 2 palliative care patients appropriately managed on other wards.

52% of patients had a Direct Admission to the Stroke Unit within 4 Hours compared to 54% in April. Reasons for non compliance included:

- 7 unclear diagnosis on admission leading to delay in access to the unit
- 2 palliative care patients appropriately managed on other wards
- 1 incorrectly transferred

80% of patients received imaging within 1 hour compared to 94% in April. 4 patients failed the target, one of which was delayed due to an urgent MRI being performed on another patient. Three of the patients were scanned within 1 hour 37 minutes or less.

4 Venous Thromboembolism

Risk assessment for hospital-related venous thromboembolism (95%)

Following a long period exceeding compliance against the Trust’s 90% target, in April the Trust’s CQUIN target relating to VTE risk assessment increased to 95%. This change, combined with other service model changes, led to an underperformance in April and May. Immediate work has been undertaken to ensure risk assessments take place in areas where previously not required and in particular, around ensuring that a record of patient’s risk assessments are completed on the trust systems. The Trust’s Safety Thermometer indicates >99% compliance suggesting that data entry was a key factor in non-compliance. Other improvement work includes: ward based reporting and targeted action; awareness raising through a new training video which includes a patient story; and a pilot of real time pharmacy data inputting using IPADs on AMU.

5 Cancelled Operations

Patients not offered a date within 28 days of cancellation – contractual standard of 0 breaches

Patients not offered a date within 28 days of their cancelled elective operation (‘on the day’) was 1 in May compared to 4 in April. These breaches resulted predominantly from the impact of urgent care pressures, particularly on ITU capacity, which caused cancellations and difficulties in rebooking due to capacity.
6 Attendance

Sickness absence rate (4% current; 3% stretch)

Sickness improved in May with an absence rate of 3.26%, compared to 3.58% in April. The Trust cumulative absence rate is 3.74%, which continues to be below the current target of 4% although above the stretch target of 3%.

7 Appraisals

90% of appraisals completed within one year

The Trust achieved 72.3% compliance with the annual appraisal target in May, a slight improvement compared to 68.5% in April. This is anticipated to improve further in June resulting from targeted work by directorates.

8 Admitted RTT – Speciality Level

90% of patients on an admitted pathway treated within 18 weeks

Admitted RTT performance continued to be below threshold in General Surgery and Urology. These have been predominantly due to elective cancellations as a result of the urgent care pressures and the knock on impact of rebooking patients, as well as the impact of fast track referral pathways. The Trust, however, continues to achieve the RTT targets on aggregate.

9 Recommendation

The Board are requested to note the performance exceptions to the Trust’s compliance with the 2013/14 Monitor and ‘Everyone Counts’ planning guidance requirements.

HELEN LINGHAM
CHIEF OPERATING OFFICER
### 2013/14 PERFORMANCE INDICATOR MATRIX FOR BOARD OF DIRECTORS

#### Monitor Governance Targets & Indicators

| Area          | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|---------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
| Infection Control | MRSA Bacteraemias Number of hospital acquired MRSA cases - Monitor de-minimis | 6 | 1.0 | 0 | 0 | > 1 | <=1 |
|               | Clostridium difficile Number of hospital acquired C. Difficile cases        | 29 | 1.0 | 13 | 2 | 2 | <= trajectory | <= trajectory |
| Referral to Treatment | RTT Admitted 18 weeks from GP referral to 1st treatment – specialty level | 90% | 1.0 | 91.5% | 90.5% | 91.5% | <0% | >0% | >=90% |
|               | RTT Non Admitted 18 weeks from GP referral to 1st treatment – specialty level | 95% | 1.0 | 98.6% | 98.6% | 98.8% | <0% | >0% | >=95% |
|               | RTT Incomplete pathway 18 weeks from GP referral to 1st treatment – specialty level | 92% | 1.0 | 95.3% | 96.3% | 96.1% | <0% | >0% | >=92% |

#### Cancer

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | 2 week wait From referral to to date first seen - all urgent referrals    | 93% | 0.5 | 91.4% | 94.5% | 93.1% | 94.5% | <93% | >93% |
|      | 2 week wait From referral to to date first seen - for symptomatic breast patients | 93% | 0.5 | 93.1% | 100.0% | 92.0% | 100.0% | <93% | >93% |
|      | 31 day wait From diagnosis to first treatment                             | 96% | 0.5 | 97.1% | 97.1% | 97.0% | 96.6% | <96% | >96% |
|      | 31 day wait For second or subsequent treatment - Surgery                  | 94% | 1.0 | 100.0% | 100.0% | 100.0% | 100.0% | <94% | >94% |
|      | 31 day wait For second or subsequent treatment - anti cancer drug treatments | 98% | 1.0 | 100.0% | 100.0% | 100.0% | 100.0% | <98% | >98% |
|      | 31 day wait For second or subsequent treatment - radiotherapy             | 94% | 1.0 | 85.6% | 86.5% | 89.2% | 81.4% | <85% | >85% |
|      | 62 day wait For first treatment from urgent GP referral for suspected cancer | 85% | 1.0 | 100.0% | 100.0% | 100.0% | 100.0% | <90% | >90% |
|      | 62 day wait For first treatment from NHS cancer screening service referral | 90% | 1.0 | 96.8% | 94.0% | 98.3% | <95% | >95% |

#### A&E

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | 4 hr maximum waiting time From arrival to admission / transfer / discharge | 95% | 1.0 | 96.8% | 94.0% | 98.3% | <95% | >95% |

#### LD

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | Patients with a learning disability Compliance with requirements regarding access to healthcare | n/a | 0.5 | Yes | Yes | No | Yes | Yes |

#### Indicators within the Operating Framework / Key Contractual Priorities

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
| Stroke | TIA High Risk Patients High risk TIA cases investigated and treated within 24hrs | 60% | BPT | 47% | 61% | 40% | 61% | 75% | < 50% | 50% - 60% | > 60% |
|      | TIA Low Risk Patients % of patients seen, assessed & treated by stroke specialist < 7 days | 100% | BPT | 83% | 77% | 81% | 86% | 91% | < 80% | 80% - 90% | >90% |
|      | Brain Imaging – as per indications Patients with acute stroke meeting the indications receive brain imaging within 1 hr | 95% | BPT | 82% | 71% | 95% | 94% | 80% | < 80% | 80% - 90% | >90% |
|      | Brain Imaging – other stroke Other stroke patients receive brain imaging within 24 hrs | 100% | BPT | 95% | 91% | 92% | 90% | 92% | < 80% | 80% - 90% | >90% |
|      | Direct admission to stroke unit Percentage of patients with suspected stroke admitted to a specialist stroke unit within 4 hrs of arrival | 90% | BPT | 54% | 44% | 44% | 54% | 52% | < 80% | 80% - 90% | >90% |
|      | Alteplase (Thrombolysis) Percentage of appropriate patients receiving thrombolysis | 100% | BPT | 100% | 100% | 100% | 100% | < 80% | 80% - 90% | >90% |
|      | 90% time spent on stroke ward Percentage of patients spending 90% or more of their time on the stroke ward during their inpatient stay | 80% | BPT | 65% | 33% | 57% | 62% | 62% | < 70% | 70% - 80% | >80% |

#### MSA

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | Mixed Sex Accommodation No of patients breaching the mixed sex accommodation requirement | 0 | | 0 | 0 | 0 | 0 | > 0 | 0 | |

#### IC

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | MRSA Bacteraemias Number of hospital acquired MRSA cases - national stretch | 0 | | 0 | 0 | 0 | 0 | > 1 | 0 | |

#### Cancer

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | 62 day – Consultant upgrade Following a consultant’s decision to upgrade the patient priority | 90% | | 100.0% | 100.0% | 100.0% | 100.0% | < 90% | >90% |

#### VTE

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | Venous Thromboembolism Risk assessment of hospital-related venous thromboembolism | 95% | | 93.7% | 94.2% | 94.2% | 92.2% | 93.3% | <95% | 95% - 95.5% | >95.5% |

#### Diagnostics

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | Six week diagnostic tests Less than 1% of patients to wait longer than 6 wks for a diagnostic test | <1% | | 0.3% | 0.3% | 0.5% | 0.5% | 0.3% | >1% | 0.9% - 0.99% | <0.9 |

#### E.D. Quality Indicators

| Area | Indicator                                                                 | Measure                                                                 | Target | Monitor | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | RAG Thresholds |
|------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------|---------|--------|--------|--------|--------|--------|----------------|----------------|
|      | Patient Impact Indicator Achieve at least one of the Patient Impact Indicators | Y | Y | Y | Y | No | Yes | Yes |
|      | Timeliness Indicator Achieve at least one of the Timeliness Indicators     | Y | Y | Y | Y | No | Yes | Yes |
## Ambulance Handovers

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Monitor</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of breaches of the 30 minute handover standard</td>
<td>tbc</td>
<td>3.1%</td>
<td>2.6%</td>
<td>3.3%</td>
<td>1.1%</td>
<td>0.4%</td>
<td></td>
</tr>
</tbody>
</table>

## Elective cancelled operations

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Monitor</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancelled Ops on day of admission as % of elective admissions</td>
<td>&lt; 0.8%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>&gt;0.7%</td>
</tr>
</tbody>
</table>

## 28 day standard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Monitor</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients not offered a date within 28 days of cancellation</td>
<td>0</td>
<td>2.44%</td>
<td>2.41%</td>
<td>2.55%</td>
<td>4</td>
<td>1</td>
<td>&gt;5%</td>
</tr>
</tbody>
</table>

## Workforce

### Sickness absence

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Monitor</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
<th>RAG Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of monthly sickness</td>
<td>4%-3%</td>
<td>4.1%</td>
<td>3.5%</td>
<td>3.55%</td>
<td>3.58%</td>
<td>3.26%</td>
<td>&gt;4%</td>
<td>3%</td>
</tr>
<tr>
<td>Percentage of cumulative sickness (rolling 12 months)</td>
<td>4%-3%</td>
<td>3.76%</td>
<td>3.74%</td>
<td>3.72%</td>
<td>3.75%</td>
<td>3.74%</td>
<td>&gt;4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Appraisals

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Monitor</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
<th>RAG Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage compliance with annual appraisals</td>
<td>90%</td>
<td>74.71%</td>
<td>73.14%</td>
<td>70.58%</td>
<td>86.51%</td>
<td>72.46%</td>
<td>&gt;70%</td>
<td>70%</td>
</tr>
</tbody>
</table>
• Trust Balanced Dashboard
• Quality, Performance, Productivity and Efficiency
• Reporting Month: May 2013
### Quality

<table>
<thead>
<tr>
<th>KPI</th>
<th>Units</th>
<th>Actual</th>
<th>Plan</th>
<th>Last Month</th>
<th>Last Year</th>
<th>Rolling 12 Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR* Index</td>
<td>Index</td>
<td>TBC</td>
<td>100</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>No. of Deaths*</td>
<td>No.</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>% Harm Free Care</td>
<td>%</td>
<td>98.6%</td>
<td>95.0%</td>
<td>88.5%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Theatre session utilisation</td>
<td>%</td>
<td>87.2%</td>
<td>85.0%</td>
<td>85.1%</td>
<td>87.6%</td>
<td></td>
</tr>
<tr>
<td>Serious incidents</td>
<td>No.</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Friends &amp; Family Test</td>
<td>Score</td>
<td>68</td>
<td>TBC</td>
<td>58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Friends &amp; Family Test</td>
<td>Score</td>
<td>78</td>
<td>TBC</td>
<td>78</td>
<td></td>
<td></td>
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<tr>
<td>Delayed Transfers of Care</td>
<td>No.</td>
<td>9</td>
<td>TBC</td>
<td>14</td>
<td>16</td>
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<tr>
<td>30 day readmissions</td>
<td>No.</td>
<td>455</td>
<td>TBC</td>
<td>463</td>
<td>618</td>
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</table>

### Productivity & Workforce

<table>
<thead>
<tr>
<th>KPI</th>
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<th>Plan</th>
<th>Last Month</th>
<th>Last Year</th>
<th>Rolling 12 Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outliers</td>
<td>No.</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Average length of Stay</td>
<td>Days</td>
<td>4.4</td>
<td>4.7</td>
<td>4.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatre session utilisation</td>
<td>%</td>
<td>87.2%</td>
<td>85.0%</td>
<td>85.1%</td>
<td>87.6%</td>
<td></td>
</tr>
<tr>
<td>Outpatient New-to-Follow-Up ratio</td>
<td>Ratio</td>
<td>0.66</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness absence</td>
<td>%</td>
<td>3.3%</td>
<td>3.0%</td>
<td>3.6%</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Vacancy</td>
<td>%</td>
<td>5.9%</td>
<td>5.6%</td>
<td>6.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisals</td>
<td>%</td>
<td>72%</td>
<td>90%</td>
<td>69%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>Mandatory training compliance</td>
<td>%</td>
<td>80%</td>
<td>80%</td>
<td>72%</td>
<td></td>
<td></td>
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</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>KPI</th>
<th>Units</th>
<th>Actual</th>
<th>Plan</th>
<th>Last Month</th>
<th>Last Year</th>
<th>Rolling 12 Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Bacteraemias</td>
<td>No.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>No.</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>RTT metrics (below plan)</td>
<td>No.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cancer metrics (below plan)*</td>
<td>No.</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Stroke metrics (below plan)</td>
<td>No.</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>A&amp;E 4 hr maximum waiting time</td>
<td>%</td>
<td>98.3%</td>
<td>95.0%</td>
<td>94.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP OP Referrals</td>
<td>No.</td>
<td>5,611</td>
<td>5,513</td>
<td>5,375</td>
<td>5,513</td>
<td></td>
</tr>
<tr>
<td>Risk ratings</td>
<td>Rating</td>
<td>3.2</td>
<td>3.0</td>
<td>3.7</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Surplus</td>
<td>£000s</td>
<td>£ 86</td>
<td>£ 284</td>
<td>£ 346</td>
<td>£ 189</td>
<td></td>
</tr>
<tr>
<td>Transformational plans</td>
<td>£000s</td>
<td>£ 653</td>
<td>£ 862</td>
<td>£ 632</td>
<td>£ 611</td>
<td></td>
</tr>
</tbody>
</table>

### Activity & Finance

<table>
<thead>
<tr>
<th>KPI</th>
<th>Units</th>
<th>Actual</th>
<th>Plan</th>
<th>Last Month</th>
<th>Last Year</th>
<th>Rolling 12 Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Attendances</td>
<td>No.</td>
<td>7,327</td>
<td>6,812</td>
<td>6,731</td>
<td>5,940</td>
<td></td>
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<tr>
<td>Elective admissions</td>
<td>No.</td>
<td>5,562</td>
<td>5,145</td>
<td>5,348</td>
<td>5,544</td>
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</tr>
<tr>
<td>Non-elective admissions</td>
<td>No.</td>
<td>2,365</td>
<td>2,341</td>
<td>2,374</td>
<td>2,964</td>
<td></td>
</tr>
<tr>
<td>GP OP Referrals</td>
<td>No.</td>
<td>5,611</td>
<td>5,513</td>
<td>5,375</td>
<td>5,513</td>
<td></td>
</tr>
<tr>
<td>Risk ratings</td>
<td>Rating</td>
<td>3.2</td>
<td>3.0</td>
<td>3.7</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Surplus</td>
<td>£000s</td>
<td>£ 86</td>
<td>£ 284</td>
<td>£ 346</td>
<td>£ 189</td>
<td></td>
</tr>
<tr>
<td>Transformational plans</td>
<td>£000s</td>
<td>£ 653</td>
<td>£ 862</td>
<td>£ 632</td>
<td>£ 611</td>
<td></td>
</tr>
</tbody>
</table>

*Metric reported 1 month in arrears in monthly views; quarterly values are unadjusted

---

Report produced: 04/07/2013 12:58:00
## BOARD OF DIRECTORS

### Meeting Date and Part:
12 July 2013  Part 1

### Subject:
Monitor Quarter 4 Report 2012/13

### Section:
Performance

### Executive Director with overall responsibility
Helen Lingham, Chief Operating Officer

### Author of Paper:
Helen Lingham, Chief Operating Officer

### Details of previous discussion and/or dissemination:

<table>
<thead>
<tr>
<th>Key Purpose:</th>
<th>Patient Safety</th>
<th>Health &amp; Safety</th>
<th>Performance</th>
<th>Strategy</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

### Action required by BOD:
Information

### Executive Summary:
To present the Monitor Quarter 4 Results

### Strategic Goals & Objectives:
Linked to Board objectives for year

### Links to CQC Registration:
(Outcome reference) Outcome 16

### Links to Assurance Framework/Key Risks:

<table>
<thead>
<tr>
<th>Type of Assurance:</th>
<th>Internal</th>
<th>External</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
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</tbody>
</table>
Monitor Quarter 4 Results 2012/13

1 Summary

I am pleased to confirm we have received formal notification from Monitor regarding Q4 performance as follows:

- Financial risk rating - 3
- Governance risk rating – Green


2 Recommendation

The Board of Directors is asked to note the above for information.

HELEN LINGHAM
CHIEF OPERATING OFFICER
<table>
<thead>
<tr>
<th><strong>BOARD OF DIRECTORS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting Date and Part:</strong></td>
</tr>
<tr>
<td><strong>Subject:</strong></td>
</tr>
<tr>
<td><strong>Section:</strong></td>
</tr>
<tr>
<td><strong>Executive Director with overall responsibility:</strong></td>
</tr>
<tr>
<td><strong>Author of Paper:</strong></td>
</tr>
<tr>
<td><strong>Details of previous discussion and/or dissemination:</strong></td>
</tr>
<tr>
<td><strong>Key Purpose:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Action required by BOD:</strong></td>
</tr>
<tr>
<td><strong>Executive Summary:</strong></td>
</tr>
<tr>
<td><strong>Strategic Goals &amp; Objectives:</strong></td>
</tr>
<tr>
<td><strong>Links to CQC Registration:</strong> (Outcome reference)</td>
</tr>
<tr>
<td><strong>Links to Assurance Framework/Key Risks:</strong></td>
</tr>
<tr>
<td><strong>Type of Assurance:</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
1. **Introduction**

This report summarises the Trust’s financial performance for the period to 31 May 2013. A financial overview is attached at Annex A.

2. **Overview**

The Trust is planning a cumulative surplus for the year of £1.25 million, representing a small proportion (half a percent) of the Trust’s £250 million turnover. This demonstrates sound and prudent financial planning, allowing the capacity to invest in future years.

This budget plan includes, however, a further 4% efficiency requirement in order to cover the many cost pressures experienced by the acute sector. As indicated in previous reports, the achievement of these further efficiencies becomes more difficult in time as the Trust has transformed services over many years and benchmarks well at 91% on the reference cost indicator.

The current under delivery of savings against plan demonstrates quite how difficult this is becoming, particularly when combined with the nationally recognised pressures in relation to emergency demand. These two issues together are driving the current adverse variance against plan.

3. **Key Financials**

**Net Surplus**

The in month deficit of £87,000 has reduced the year to date net surplus to £260,000, against a budgeted surplus of £526,000. This represents an adverse variance to plan of £266,000.

**Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)**

The EBITDA ratio is one of the key performance indicators the Foundation Trust is monitored against. As at 31 May the Trust returned 5.4% against a plan of 6.3%. The forecast for the year is a return of 5.5%.

**Transformation Programme**

The Trust has a strong track record of delivering significant efficiency savings, and as a result, has a Reference Cost Index of 91. This means that the Trust provides a mix of services at lower than the national average cost, indicated by an index of 100.

It is recognised, however, that to continue to deliver such levels is becoming ever more difficult as a single organisation. As a result, all transformation schemes are subject to a comprehensive Quality Impact Assessment. The process of monitoring these plans has been enhanced further in 2013, with a monthly mechanism to measure whether there is any potential adverse effect on the quality of the service provided.
The savings requirement for 2013/14 is £10.3 million, with savings recorded during April and May amounting to £1.285 million against a target of £1.467 million. Whilst it is expected that further schemes will come on stream throughout the year, some concerns are apparent within a small number of directorates.

**Capital expenditure**

Capital expenditure to date totals £701,000 against a plan of £598,000. A number of schemes have commenced ahead of plan, which is driving this current over commitment. The Trust is planning total capital expenditure of £9.475 million during 2013/14.

4. **Financial Risk Rating**

The Trust's overall financial risk rating as at 31 May was a rating of 3. This is in line with the planned rating for the year, however this is a reduction from the rating of 4 reported for April due to the pressures reported below. The best possible (lowest risk) rating is a rating of 5.

5. **Activity**

During the first two months of the financial year activity has exceeded budgeted levels by an aggregate 3.8%, continuing the upward trend seen throughout 2012/13. Elective activity is currently 6% above budget; Outpatients and Non Elective activity is 3% above budget, and Emergency Department Attendances are 5% above budget.

This increased demand is placing pressure on expenditure budgets, particularly due to the increased costs associated with using a flexible workforce to undertake this additional activity.

6. **Income and Expenditure**

During April and May, the Trust earned income of £41.9 million against a budget of £41.4 million, being a favourable variance of £0.5 million. Expenditure during the same period totalled £41.7 million against a budget of £40.9 million, being an adverse variance of £0.8 million.

These variances are attributable to a range of additional activities that the Trust has resourced and implemented to support the unprecedented level of emergency demand that has been recognised at a national level. This includes a necessity to maintain a significant flexible workforce outside of the baseline establishment, for which there is an associated premium.

Whilst additional income has been agreed with the Dorset Clinical Commissioning Group in relation to these activities, the level of confirmed income is not sufficient to cover the additional costs experienced against these schemes, leaving the Trust with an unfunded cost pressure.
7. Workforce

Unfilled vacancies within clinical directorates year to date stand at 44 Whole Time Equivalents, equating to a vacancy rate of 1.5%. Recorded sickness reduced in month from 3.58% in April to 3.26% in May, reducing the rolling twelve month cumulative sickness level to 3.74%.

8. Recommendation

The Trust is planning the delivery of all financial duties, with a planned surplus of £1.25 million demonstrating that financial budgetary control is well embedded within the day to day activities of the organisation.

It is recognised, however, that to continue to deliver the level of savings required is becoming ever more difficult as a single organisation. As a result, directorate savings plans require close monitoring to ensure that the current shortfall is progressed promptly.

Members are asked to note the Trust’s financial performance for the period to 31 May 2013.

Pete Papworth
Deputy Director of Finance
June 2013
### Annex A

#### Financial Performance for the Period to 31 May 2013

**THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST**

#### Key Financials

<table>
<thead>
<tr>
<th>YTD Actual £'000</th>
<th>2012/13</th>
<th>2013/14 Year to Date</th>
<th>2013/14 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NET SURPLUS/ (DEFICIT)</strong></td>
<td>300</td>
<td>526</td>
<td>260</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>2,567</td>
<td>2,608</td>
<td>2,274</td>
</tr>
<tr>
<td><strong>TRANSFORMATION PROGRAMME</strong></td>
<td>1,097</td>
<td>1,467</td>
<td>1,285</td>
</tr>
<tr>
<td><strong>CAPITAL EXPENDITURE</strong></td>
<td>1,003</td>
<td>598</td>
<td>701</td>
</tr>
</tbody>
</table>

#### Financial Risk Rating

<table>
<thead>
<tr>
<th>YTD Actual Metric</th>
<th>2012/13</th>
<th>2013/14 Year to Date</th>
<th>2013/14 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EBITDA Margin %</strong></td>
<td>6.4%</td>
<td>6.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td><strong>EBITDA Achievement of Plan %</strong></td>
<td>98.5%</td>
<td>100.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td><strong>Net Return after Financing %</strong></td>
<td>0.6%</td>
<td>1.5%</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>I&amp;E Surplus Margin %</strong></td>
<td>0.5%</td>
<td>1.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Liquidity Days</strong></td>
<td>53.1</td>
<td>57.6</td>
<td>57.8</td>
</tr>
<tr>
<td><strong>FINANCIAL RISK RATING</strong></td>
<td>3.2</td>
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<td></td>
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</table>

### Activity

<table>
<thead>
<tr>
<th>YTD Actual Number</th>
<th>2012/13</th>
<th>2013/14 Year to Date</th>
<th>2013/14 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective</strong></td>
<td>9,923</td>
<td>10,292</td>
<td>10,925</td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td>52,063</td>
<td>45,655</td>
<td>47,043</td>
</tr>
<tr>
<td><strong>Non Elective</strong></td>
<td>5,372</td>
<td>4,606</td>
<td>4,739</td>
</tr>
<tr>
<td><strong>Emergency Department Attendances</strong></td>
<td>11,231</td>
<td>13,404</td>
<td>14,058</td>
</tr>
<tr>
<td><strong>TOTAL PbR ACTIVITY</strong></td>
<td>78,589</td>
<td>73,956</td>
<td>76,765</td>
</tr>
</tbody>
</table>

### Income

<table>
<thead>
<tr>
<th>YTD Actual £'000</th>
<th>2012/13</th>
<th>2013/14 Year to Date</th>
<th>2013/14 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective</strong></td>
<td>11,502</td>
<td>12,080</td>
<td>12,094</td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td>5,255</td>
<td>5,257</td>
<td>5,230</td>
</tr>
<tr>
<td><strong>Non Pay Expenditure</strong></td>
<td>3,868</td>
<td>3,969</td>
<td>4,129</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>40,017</td>
<td>41,421</td>
<td>41,943</td>
</tr>
</tbody>
</table>

### Expenditure

<table>
<thead>
<tr>
<th>YTD Actual £'000</th>
<th>2012/13</th>
<th>2013/14 Year to Date</th>
<th>2013/14 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay</strong></td>
<td>23,137</td>
<td>24,339</td>
<td>24,758</td>
</tr>
<tr>
<td><strong>Clinical Supplies</strong></td>
<td>5,255</td>
<td>5,257</td>
<td>5,230</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td>3,868</td>
<td>3,969</td>
<td>4,129</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>6,188</td>
<td>8,561</td>
<td>8,588</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td>261</td>
<td>305</td>
<td>332</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td>39,717</td>
<td>40,895</td>
<td>41,683</td>
</tr>
</tbody>
</table>

### Statement of Financial Position

<table>
<thead>
<tr>
<th>YTD Actual £'000</th>
<th>2012/13</th>
<th>2013/14 Year to Date</th>
<th>2013/14 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non Current Assets</strong></td>
<td>148,507</td>
<td>144,446</td>
<td>144,403</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td>64,745</td>
<td>68,558</td>
<td>67,361</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td>(28,039)</td>
<td>(26,508)</td>
<td>(25,192)</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>182,006</td>
<td>183,748</td>
<td>183,818</td>
</tr>
<tr>
<td><strong>Public Dividend Capital</strong></td>
<td>78,674</td>
<td>78,674</td>
<td>78,674</td>
</tr>
<tr>
<td><strong>Reserve</strong></td>
<td>68,498</td>
<td>64,488</td>
<td>64,485</td>
</tr>
<tr>
<td><strong>Income and Expenditure Reserve</strong></td>
<td>34,834</td>
<td>40,586</td>
<td>40,659</td>
</tr>
<tr>
<td><strong>TOTAL TAXPAYERS EQUITY</strong></td>
<td>182,006</td>
<td>183,748</td>
<td>183,818</td>
</tr>
</tbody>
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### Workforce

<table>
<thead>
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<th>2013/14 Year to Date</th>
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## Board of Directors

### Meeting Date and Part:
12 July 2013 Part I

### Subject:
Appraisal and Revalidation Update

### Section:
Performance

### Executive Director with overall responsibility
Mary Armitage, Medical Director

### Author of Paper:
Mark Goodwin, Associate Medical Director

### Details of previous discussion and/or dissemination:
Trust Management Board

### Key Purpose:

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<th>Patient Safety</th>
<th>Health &amp; Safety</th>
<th>Performance</th>
<th>Strategy</th>
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### Action required by BoD:
For Information

### Executive Summary:
A presentation will be provided at the meeting on the appraisal and revalidation process for doctors. Guidance has been produced by regulatory authorities entitled Effective governance to support medical revalidation - A handbook for boards and governing bodies which is attached to provide useful background information in advance of the presentation.

### Strategic Goals & Objectives:
To offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care

### Links to CQC Registration:
(Outcome reference)
- Outcome 4: Care and welfare of people who use services
- Outcome 12: Requirements relating to workers
- Outcome 14: Supporting workers

### Links to Assurance Framework/Key Risks:

### Type of Assurance:

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Effective governance to support medical revalidation
A handbook for boards and governing bodies
This document sets out a view of the core elements of effective local governance of the systems that support revalidation. It has been produced collaboratively by the following organisations, in recognition of the important potential role of medical revalidation in driving improvement in healthcare quality and safety across the United Kingdom:

- the Care Quality Commission
- the General Medical Council
- the Government Procurement Service
- Healthcare Improvement Scotland
- Healthcare Inspectorate Wales
- Monitor
- the Regulation and Quality Improvement Authority.
Quality in healthcare embraces many factors that need to mesh together to deliver safe and effective patient care. In any setting, the integration of the responsibilities of organisations providing healthcare with those of individual professionals working within them is fundamental to achieving quality and safety objectives. It follows that effective local governance and quality assurance of the systems supporting medical revalidation make an essential contribution to the improvement of quality and safety for patients. It also follows that there is a paramount need for close co-operation between the agencies that set and monitor standards for those systems.

The introduction of medical revalidation in the United Kingdom (UK) from 3 December 2012 provides a further lever for healthcare improvement. Medical revalidation reinforces the duty of healthcare organisations to create an environment where doctors can meet their professional obligations. It also requires doctors to take part in organisational processes such as annual appraisal and clinical governance.

Although as regulatory authorities we each operate within different legal and methodological frameworks, we share similar objectives and values. These centre on the prime importance of paying continuous attention to the issues that underpin quality and safety for patients.

Medical revalidation can be expected to feature in our future regulatory programmes, and we will each use the handbook to support our statutory roles, acknowledging that these are not identical across the UK.

In collaborating over recent months to produce this short handbook, we recognise the importance of medical revalidation as a tool for improvement. The handbook is particularly intended to help boards and governing bodies in the initial phase of medical revalidation. Its contents will be kept under review as medical revalidation and systems regulation policies develop.

Foreword

There is an ever growing focus on the quality of healthcare services across the United Kingdom and throughout the world. Increasing demand, changes in public expectations and developing technology are leading all healthcare systems to look closely at how to ensure safety and quality for patients, in the face of significant pressure on available resources.
“It follows that effective local governance and quality assurance of the systems supporting medical revalidation make an essential contribution to the improvement of quality and safety for patients.”
Purpose and use of this handbook

The core elements of effective governance* set out in this handbook aim to help healthcare provider organisations (via their boards, governing bodies and responsible officers) evaluate the robustness and effectiveness of local systems supporting quality patient care and medical revalidation.

These elements are not new, and so are not additional to existing governance processes. The handbook is intended to serve as a reminder, and to help structure local evaluation. All boards and governing bodies overseeing medical care and treatment of patients should take account of the contents of the handbook when evaluating their own organisation’s arrangements, however there is no specific requirement to report against it.

Appendix 1 provides a list of questions that you may wish to use on an ongoing basis at future board/governing body meetings in order to demonstrate sound governance, governance reporting and systems evaluation within your organisation. These should be read alongside the core elements.

A separate version of appendix 1, which can be used as a checklist, is available on the General Medical Council (GMC) website.

In preparing for future inspection, assessment or audit work, boards or governing bodies may find it useful to record how this document, alongside other relevant guidance issued by regulators and quality improvement bodies, has been used in practice.

Appendix 2 summarises our respective roles and responsibilities.

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* Incorporating clinical governance and medical appraisal
Our guiding principles

These guiding principles will underpin the regulatory and quality improvement activities of our organisations. They are consistent with the objective of clarifying roles and responsibilities in the delivery of high quality services:

- responsibility for the quality and safety of services rests first and foremost with healthcare provider organisations and the individual professionals working within them;

- healthcare provider organisations should put in place governance systems that consistently promote and protect the interests of patients and service users – including creating an environment in which healthcare professionals can meet their professional obligations;

- in fulfilling their professional obligations, healthcare professionals should comply with the values and principles expected of their profession and participate fully in the systems and processes put in place by their organisations to improve quality and protect patients;

- quality improvement, government procurement and regulatory agencies’ purpose is to help improve the quality of care. They do this through a range of activities which include:
  
  - monitoring and, where relevant, enforcing compliance with standards or contracts;
  
  - sharing information and intelligence;
  
  - driving improvement through building capacity and promoting learning;
  
  - acting decisively to protect the public where evidence of risks to health or wellbeing emerge.
Medical revalidation and governance

Medical revalidation bears on all organisations in which doctors work*, on clinical leaders and on doctors themselves. Its introduction from 3 December 2012 reinforces the interdependent responsibilities of healthcare organisations and individual professionals. Medical revalidation places new statutory duties on all of these organisations and individuals, and will over time provide additional assurance that doctors in the UK are fit to practise. This additional assurance for patients and the public derives from doctors practising in well structured, managed and governed systems.

Medical revalidation also provides a powerful lever on organisations to drive improvements in the quality of patient care and treatment, and further underscores the paramount importance of robust systems for clinical governance, including appraisal and local quality assurance.

The majority of systems, processes and responsibilities that underpin medical revalidation are essential requirements of high quality health services for patients - they are not new or additional for medical regulation. It is important that people can be confident that the arrangements put in place can be relied upon.

Within this new system:

- organisations appoint a senior doctor (a responsible officer – RO) to oversee systems for governance and appraisal for doctors, for dealing with practice concerns about doctors and for advising the GMC about doctors’ fitness to practise;

- organisations are also responsible for providing resources to support ROs in their role. Their local governance arrangements should incorporate constructive challenge around the way services are delivered and monitored;

- ROs must assure themselves that the quality of their systems supports the evaluation of doctors’ fitness to practise in a fair and consistent way;

- individual doctors must demonstrate they continue to meet the values and principles expected of the profession set out in the GMC’s core guidance Good medical practice. This is achieved by doctors reflecting on a portfolio of information and evidence at annual appraisal of the doctor’s whole practice.

* Includes locum agencies and Government Procurement Services
“All boards and governing bodies overseeing medical care and treatment of patients should take account of the contents of the handbook.”
The core elements of effective governance

These core elements are intended to apply in respect of all organisations where doctors with a licence to practise work, including where those doctors do not undertake any direct clinical activity or they are employed by another body. Boards and governing bodies should embed these core elements in local systems, and use them to monitor governance in the key areas where organisations deliver care and treatment of patients.

1. There is corporate or organisation-wide commitment to creating an environment that fosters good professional practice

Well led and committed governing bodies will place high quality patient care and workforce quality at the centre of their business. Their organisations will provide sufficient, well planned and managed resources to support that objective. Risks to the systems supporting the provision of safe and effective patient care will be identified and managed. These systems in turn support medical revalidation, including appraisal and development of supporting information for appraisal.

2. Local governance is in place and monitored

Local governance should ensure that healthcare and other regulatory requirements and standards are met, and statutory and other relevant guidance is followed.

3. Equality and diversity considerations are integrated into all of the organisation’s medical revalidation policies and practices

Fair and non-discriminatory policies and practices should be in place to support quality patient care and medical revalidation. These should be actively monitored and regularly reviewed. Equality and diversity issues which may impact on medical revalidation should be identified and addressed in accordance with good practice.

4. Ongoing compliance with regulatory requirements and standards creates an environment where professionals can flourish

Organisations and ROs must act in accordance with their responsibilities, eg under the Medical Profession (Responsible Officer) Regulations 2010,* as read with the General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012† or as set down in guidance or their job descriptions.

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ROs should be appropriately trained to undertake their responsibilities, and should regularly participate in local RO network activities that provide shared learning opportunities and aid consistency of approach.

Information systems and records (eg for complaints and compliments and to access staff, patient† and public feedback) will provide accurate, valid, timely, reliable and relevant information to support workers in delivering high quality patient care and to support doctors in their revalidation. Information should be considered and acted upon where appropriate. All records should be accurately maintained.

The organisation should have in place mechanisms to assure that the medical workforce (whether employed, contracted, doctors in training, working with practising privileges, hired or volunteer) is planned, recruited and suitably skilled, competent and knowledgeable to undertake their duties professionally.

5. Medical appraisal takes place in accordance with GMC guidance and organisational requirements

ROs should ensure that all doctors are familiar with appraisal arrangements and that all doctors participate in annual appraisal. Appraisal must cover a doctor's whole practice, and take account of all relevant information relating to the doctor's fitness to practise.

Medical appraisal should be focused on the GMC's Good medical practice.

The Good Medical Practice Framework for appraisal and revalidation and Supporting Information for Revalidation guidance set out the approach to medical appraisal, as well as the information to be considered. ROs' fitness to practise advice (revalidation recommendations) to the GMC is based on this process and on information from governance systems. Organisations should ensure they are making reasonable arrangements to support doctors in collecting supporting information for appraisal and revalidation, and to share with them information gathered to support service quality and delivery.‡

Any areas for development in a doctor's practice should be identified and addressed in a targeted way, and concerns about a doctor's fitness to practise referred to the GMC where appropriate. Specialty or other central or local (regional) advice should be taken where appropriate. Examples of such advice include that on training and appraisal provided by the Medical Royal Colleges and Faculties, and on fitness to practise provided via the GMC's Employer Liaison Service.

The appraisal system for doctors should be subject to appropriate quality assurance measures. Appraisers should be appropriately trained and their performance as appraisers monitored and evaluated.

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† ‘Patient’ includes the public/clients/customers as appropriate

‡ For example, quality data, performance data, audits, compliments, complaints and significant events
“Well led and committed governing bodies will place high quality patient care and workforce quality at the centre of their business.”
This appendix provides list of questions that are relevant in the context of ongoing evaluating, demonstrating and reporting on governance of local systems and processes supporting patient safety and medical revalidation.

These questions draw on well established principles that support quality improvement and medical revalidation objectives. They take account of the clinical governance and appraisal criteria followed in the various assessments of readiness to begin medical revalidation undertaken across the UK, for example the Organisational Readiness Self Assessment used in England, however there is no specific requirement to report against them.

A separate version of this appendix, which can be used as a checklist, is available on the GMC website (www.gmc-uk.org).

1. There is corporate or organisation-wide commitment to creating an environment that fosters good professional practice

How does your organisation:

- know that the governance of systems supporting the provision of quality patient care and medical revalidation objectives is appropriately supported, managed and assured?

- ensure the adequacy of resources to support all healthcare workers in fulfilling their professional responsibilities, eg in relation to staff induction, appraisal, Continuing Professional Development (CPD) and revalidation of doctors?

In what way:

- does the organisation’s governance strategy proactively support the provision of quality patient care and medical revalidation objectives?

- might reporting around quality patient care and medical revalidation objectives to the board/governing body be improved?

How transparent are the board/governing body’s governance activities?

How does the board/governing body regularly review data relating to revalidation and clinical practice?

2. Local governance is in place and monitored

How does your organisation ensure:

- all information systems for monitoring the conduct and performance of doctors working in your organisation are operating effectively?

- the performance of locums, doctors in training and temporarily appointed doctors is monitored and reported in a way that contributes constructively to their revalidation?
4. **Ongoing compliance with regulatory requirements and standards** creates an environment where professionals can flourish

In what ways does your organisation:

- ensure ongoing familiarity with the organisational and professional responsibilities set down in regulations and guidance?
- take patient and public views, complaints and compliments into account to support governance and quality improvement?
- know that relevant data are collected and distributed to doctors, including for doctors working in a range of, or remote, practice settings, in a way that supports their revalidation?
- monitor the quality of data supporting your RO in their role, including making revalidation recommendations to the GMC?

What was the outcome of your last review of data needs to support quality improvement and monitoring?

How does your organisation:

- ensure the identity, qualifications, references and experience of your doctors?
monitor the conduct and performance of doctors, including temporarily appointed doctors, locums and doctors in training, and ensure any issues arising are addressed?

manage admission to the performers list, if relevant?

know that the arrangements to grant and monitor practising privileges for medical practitioners are robust?

5. Medical appraisal takes place in accordance with GMC guidance and organisational requirements

What is the practical effect of the integration of your organisation's appraisal policy with other governance arrangements?

How does your organisation:

know that all doctors requiring annual appraisal have participated?

manage the situation where doctors requiring appraisal have not been appraised?

know all doctors are familiar with your organisation's appraisal policy and system?

How does your organisation ensure:

the focus of appraisal is on the GMC's Good medical practice and other relevant guidance?

appraisers are appropriately trained to conduct appraisals?

adequate resources are available to support doctors' appraisal, revalidation and CPD?

the quality and completeness of information supporting appraisal?

How does your organisation:

manage and monitor the performance of its appraisers in their role?

monitor the quality and robustness of appraisals and appraisal outputs?

review the annual appraisal process and put consequential learning into effect?

monitor the outcomes of doctors' participation in CPD?

How does your governance hierarchy oversee appraisal, and consider whether it is delivering anticipated benefits?
Roles of the organisations producing this handbook

Care Quality Commission, England
(www.cqc.org.uk)

The Care Quality Commission (CQC) is the independent regulator of healthcare and adult social care services in England. CQC also protects the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, CQC focuses on:

- identifying risks to the quality and safety of people's care;
- acting swiftly to help eliminate poor quality care;
- making sure care is centred on people's needs and protects their rights.

By law, all providers of care services in England are responsible for making sure that their services meet national standards of quality and safety set by Government. CQC registers providers and can use a range of powers to take action to drive improvement when a service is not meeting the standards.

CQC uses inspections and information from other organisations to monitor whether care services are meeting the standards, as well as the views and experiences of people who use services, which are at the centre of CQC's work.

General Medical Council, UK
(www.gmc-uk.org)

The General Medical Council (GMC) is the independent regulator for doctors in the UK. Its role is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. GMC has four main functions under the Medical Act 1983:

- keeping up-to-date registers of qualified doctors;
- fostering good medical practice;
- promoting high standards of medical education and training;
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Revalidation provides a further lever to drive improvements in medical practice.

GMC controls entry to the medical register and sets the standards for medical schools and postgraduate education and training. GMC also determines the principles and values that underpin good medical practice and takes firm but fair action where those standards have not been met.
GMC has strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, GMC acts to protect patients from harm - if necessary, by removing the doctor from the register and removing their right to practise medicine.

The introduction of medical revalidation across the UK in early December 2012 provides a new way of regulating licensed doctors that will give extra confidence to patients that their doctors are up to date and fit to practise. Only licensed doctors have to revalidate, usually every five years, by having annual appraisals based on the GMC’s core guidance for doctors, Good medical practice. The majority of licensed doctors are expected to be revalidated for the first time by the end of March 2016.

Government Procurement Service, UK (www.gps.cabinetoffice.gov.uk)

Government Procurement Service (GPS) is an executive agency of the Cabinet Office with the overall priority of providing procurement savings across central government and the UK public sector including local government, health, education, devolved administrations, emergency services, defence and not for profit organisations.

The GPS centralisation programme drives value in the purchase of services via a system of framework agreements. One such agreement negotiated by the GPS is for supply of hospital medical locum doctors for short durations. This aims to deliver savings in the NHS while enhancing the safety and quality of services for users and patients. The agreement provides NHS bodies with a regulated means of providing continuity of patient care and core hospital services in a wide range of situations eg while permanent doctors are on annual leave, sick, or are attending interviews or training, or to provide additional resource at peak periods or cover unfilled vacancies.

Operation of the agreement is monitored and audited by GPS via its Health Assurance Team whose objective is to ensure that all workers supplied to the NHS under the framework are of high quality and do not present a risk to patient safety.

Healthcare Improvement Scotland (www.healthcareimprovementscotland.org)

Healthcare Improvement Scotland (HIS) is a health body with the vision to deliver excellence in improving the quality of the care and experience of every person in Scotland every time they access healthcare. The focus and key responsibility of HIS is to:

♦ help NHS Scotland and independent healthcare providers deliver high quality, evidence-based, safe, effective and person-centred care;

♦ scrutinise services to provide public assurance about the quality and safety of that care.

HIS activities are organised with patient focus and public involvement at their heart. They encompass all three areas of an integrated cycle of improvement, involving:
Healthcare Inspectorate Wales
(www.hiw.org.uk)

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all healthcare in Wales, and has a primary focus on:

- making a significant contribution to improving the safety and quality of healthcare services in Wales;
- improving citizens’ experience of healthcare in Wales whether as a patient, service user, carer, relative or employee;
- strengthening the voice of patients and the public in the way health services are reviewed;
- ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW’s core role is to review and inspect NHS and independent healthcare organisations and to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and of good quality. Services are reviewed against published standards, policies, guidance and regulations. HIW seeks to identify and support both the improvement of services and the actions needed to achieve this.

If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services, to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

Monitor, England
(www.monitor-nhsft.gov.uk)

Under the Health and Social Care Act 2012 Monitor becomes the sector regulator for health, with a main duty to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services which are economic, efficient and effective, and which maintain or improve the quality of those services.

In carrying out its sector regulator role, Monitor will licence providers of NHS services in England and exercise functions in three areas:

- publishing the national tariff, including setting the prices and/or setting the rules for determining prices for NHS funded care;
- enabling integrated care and preventing anti-competitive behaviour where this is in the best interests of people who use healthcare;
Monitor continues to assess NHS trusts for foundation trust status, and to ensure that they are financially viable and well led, so they can deliver sustainable quality care. Monitor will also, subject to consultation, continue to oversee the governance of NHS foundation trusts. If an NHS foundation trust’s governance is such that it will fail to meet the conditions of its licence, Monitor will be able to intervene to address the governance failings.

**Regulation and Quality Improvement Authority, Northern Ireland**
(www.rqia.org.uk)

The Regulation and Quality Improvement Authority, Northern Ireland (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

RQIA’s main functions are to:

- inspect the quality of services provided by Health and Social Care Services (HSC) bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies;

- regulate (register and inspect) a wide range of services delivered by HSC bodies and by the independent sector. The regulation of services is based on minimum care standards to ensure that service users know the quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality;

- undertake a range of responsibilities for people with a mental illness and those with a learning disability. These include preventing ill treatment, remedying any deficiency in care or treatment, terminating improper detention in a hospital or guardianship and preventing or redressing loss or damage to a patient’s property.
# BOARD OF DIRECTORS

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<td>Proposed merger of The Royal Bournemouth and Christchurch Hospitals NHS FT and Poole Hospital NHS FT</td>
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<td>Section:</td>
<td>Strategy</td>
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<tr>
<td>Executive with Overall Responsibility</td>
<td>Tony Spotswood, Chief Executive</td>
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<td>Author of Paper:</td>
<td>Tony Spotswood, Chief Executive</td>
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<td>Patient Safety</td>
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<td>To note progress</td>
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<td>To update the Board on current work regarding the proposed merger</td>
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The proposed merger of The Royal Bournemouth and Christchurch Hospitals NHS FT and Poole Hospital NHS FT

The Competition Commission (CC) are due to release their provisional findings on the proposed merger in early July. It is also anticipated that the Trusts will receive an initial paper setting out the principles underpinning possible remedies together with their initial thoughts on remedies during this period. The Trusts will have 21 days to respond to the provisional findings and 14 days to respond to the notice on remedies. It is envisaged that a response hearing will be held in late July and provide an opportunity to discuss possible remedies.

I will brief the Board in further detail on those specialties the CC are likely to highlight as impacted on by the merger. There continues to be an on-going dialogue to clarify the CC’s understanding of which specialties the Trust do and do not provide.

The remedies approach favoured by the CC is likely to be structural rather than behavioural. From the perspective of the CC structural remedies will be concentrated towards reinstating competition where there is a perceived significant lessening of competition or overlap, or could alternatively be designed to open the way for new providers to enter the market. Behavioural remedies are more concentrated towards the regulation of quality and correcting market flows though the provision of information.

A further aspect of the remedy process that has come to light is the potential for the CC to adopt a fix it first approach, before sanctioning the merger. This approach is taken where the CC are seeking assurance that the remedy will have traction. Such remedies are likely to be subject to public consultation and could, following this, require structural or physical changes to service. Conceivably such an approach could add a further year or more to the approval process.

To put this into perspective, this could extend the competition regulator assessment process for this merger from 18 months to two and a half years. Under such circumstances we also need to consider whether the Monitor process would add further time. Such delays are likely to have a profound impact not only on this merger but also necessitate action to review and revise the whole competition regulatory assessment process.

One remedy open to the CC is prohibition of the merger and this remains a possibility. Likely structural remedies could include:

- consideration of the potential for the Trusts to divest ourselves of services (likely to require consultation)
- the potential opening up of the Trusts facilities, for new providers to compete.
- The potential for the CCGs to be asked to tender services.
The Trusts will need to consider carefully whether any such remedies are workable or desirable. Indeed, the financial challenges facing many Trusts, including our own, allied to the need for greater critical mass to protect the quality of services are likely to obviate against such remedies.

The concerns the CC are likely to have with regard to behavioural remedies relate to the complexity of maintaining such arrangements and the confidence in Commissioners being able to enforce them.

A further update will be provided at the Board meeting.

Tony Spotswood  
Chief Executive
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<th>12 July 2013 Part I</th>
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<td>Board Objectives</td>
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<td>Decision</td>
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<td>Tony Spotswood, Chief Executive</td>
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<td>Karen Flaherty, Trust Secretary</td>
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<td>Action required by BoD:</td>
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<td>Executive Summary:</td>
<td>The Board's objectives for 2013-14 are set out in the attached paper for formal adoption by the Board, having previously been agreed as part of the Trust’s Strategic Plan for 2013-16</td>
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<td>Risks to all the Trust’s strategic objectives are recorded in the Assurance Framework</td>
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BOARD OBJECTIVES 2013-14

In its Strategic Plan for 2013-2016, which was submitted to Monitor at the end of May, the objectives were agreed and the key milestones for delivery of the 2013-14 were also set out. These have been set out overleaf.

During its review of the Board’s objectives in 2012-13, the Board of Directors agreed that its objectives for 2013-14 should reflect those in the annual plan and the Board should use the performance against these objectives to review its own performance at the end of the financial year as well as monitoring delivery of the Trust’s Strategic Plan throughout the year.

There are some objectives which will require cooperation with commissioners and other healthcare providers including:

- Deliver the Trust’s quality and safety programmes such as “Harm Free Care”
- Improve the whole system approach to urgent and emergency care
- To deliver care ‘Closer to Home’ in a variety of community settings
- Improved inpatient flow and throughput along the whole pathway
- Further develop our services especially around long-term condition (LTC) self-management and the health promoting hospital.
- Develop models of care and reconfiguration where necessary, to achieve centres of excellence
- Undertake a “listening” exercise with the local public and GPs to understand what they most value, and what they wish to protect and what to change
- Develop the business case for merger with Poole Hospital NHS Foundation Trust
- Develop partnerships with GPs and others to deliver integrated care
- To significantly develop the Christchurch Hospital site

Also, the objectives are part of a three year strategic plan and delivery of the objectives in full may continue through the entire period of the current strategic plan and beyond this, in particular in relation to the objectives relating to the merger and the system-wide approach to urgent and emergency care.

The Board of Directors also agreed the following quality improvement priorities for 2013-14 following having consulted consultation with local stakeholders (including governors):

- Reducing Harm from Inpatient Falls
- Reducing Harm from Hospital Acquired Pressure Ulcers
- Reducing Urinary Tract Infections caused by catheters
- Reducing Hospital Acquired Venous Thromboembolism (VTE blood clots).

These quality priorities were published in the Quality Report in the Annual Report and Accounts for 2012/13 and have also been reflected in the Strategic Plan for 2013-14.
<table>
<thead>
<tr>
<th>Strategic Goals</th>
<th>Objectives</th>
<th>Key milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1</strong>: To offer patient-centred services through the provision of high</td>
<td>Deliver the Trust's quality and safety programmes such as “Harm Free Care”</td>
<td>Embed safety express safety thermometer tool and ward to board reporting</td>
</tr>
<tr>
<td>quality, responsive, accessible, safe, effective and timely care.</td>
<td>Improve the whole system approach to urgent and emergency care</td>
<td>Achieve at least 95% harm free care across all 4 harms (falls, UTI, VTE, pressure ulcers)</td>
</tr>
<tr>
<td></td>
<td>To deliver care ‘Closer to Home’ in a variety of community settings</td>
<td>Introduction of an electronic National Early Warning System (eNEWS)</td>
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<td></td>
<td></td>
<td>Implement “Time To Lead” programme for ward clinical leaders</td>
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<td></td>
<td></td>
<td>Reduction in emergency re-admissions through audit, adoption of best practice and post discharge support</td>
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<tr>
<td></td>
<td></td>
<td>The implementation of a new improved model of Emergency Department cover with increased medical cover</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and specialist nursing and Allied Health Professional input</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The development of an integrated emergency response with local partners. Agreed action plan and funding</td>
</tr>
<tr>
<td></td>
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<td>with partners and KPIs</td>
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<tr>
<td></td>
<td></td>
<td>The establishment of close working models with GPs and nursing homes to support the management of</td>
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<tr>
<td></td>
<td></td>
<td>patients in community settings</td>
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<tr>
<td></td>
<td></td>
<td>The delivery a proportion of Phlebotomy services</td>
</tr>
<tr>
<td>Board Objectives Decision</td>
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<td>--------------------------</td>
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<tr>
<td><strong>Goal 2:</strong> To promote and improve the quality of life of our patients</td>
<td></td>
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<tr>
<td>Improved inpatient flow and throughput along the whole pathway in community settings</td>
<td></td>
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<tr>
<td>Further develop our services especially around long-term condition (LTC) self-management and the health promoting hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver agreed CQUIN targets including respiratory discharge care bundle, knee replacement PROMs, VTE and improvements in dementia diagnosis</td>
<td></td>
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<tr>
<td>Qualification as a ‘Health Promoting Hospital’</td>
<td></td>
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<tr>
<td>Development of bid for long-term conditions self-care support services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly progress reporting against CQUIN action plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal 3:</strong> To strive towards excellence in the services and care we provide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver and exceed regulatory requirements</td>
<td></td>
<td></td>
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<tr>
<td>Develop models of care and reconfiguration where necessary, to achieve centres of excellence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve all governance targets, in all quarters</td>
<td></td>
<td></td>
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<tr>
<td>CQC Essential Standards compliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific Plans for Centres of Excellence &amp; Clinical Strategy as part of Merger Integrated Business Plan (IBP) by Q1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The development of plans for the review and reconfiguration of the inpatient Haematology service</td>
<td></td>
<td></td>
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<tr>
<td>To undertake a review of the Acute Surgical service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and action plan to close gaps by Q1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Goal 4: To be the provider of choice for local patients and GPs. | Undertake a “listening” exercise with the local public and GPs to understand what they most value, and what they wish to protect and what to change  
Improve patient experience through enhanced engagement  
To significantly develop the Christchurch Hospital site  
To actively participate in AQP tenders as appropriate to both maintain and grow services | Secure specialist commissioning goals and successful service delivery  
Structured approach using independent facilitation Q1-Q2, to report and inform Trust plans  
Implement Friends and Family Test in all clinical areas by Q3  
Regular reporting and achievement of targets for Friends and Family test  
The finalisation of plans and commencement of work on the redevelopment of Christchurch Hospital  
To qualify as a provider for AQP Endoscopy and Dermatology services |
|---|---|---|
| Goal 5: To listen to, support, motivate and develop our staff. | To build upon the initial work undertaken via a process of appreciative inquiry to inform organisational direction  
Further roll out of staff welfare schemes  
Achieve high levels of staff satisfaction (as measured by staff survey) | The completion of an organisational development strategy  
In place by Q2, with take up improving over the year. Includes Staff Welfare Advisor positions to support implementation  
Annual survey, with subsequent action plans from 2012/13 in Q2 and survey in Q3 |
<table>
<thead>
<tr>
<th>Goal 6: To work collaboratively with partner organisations to improve the health of local people.</th>
<th>Continue to improve sickness and appraisal rates To further develop and support the role of the Trust Governors</th>
<th>Ongoing actions with 3.5% sickness and 90% appraisal targets. Implementation of Membership Development strategy and wider work plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop the business case for merger with Poole Hospital NHS Foundation Trust Develop partnerships with GPs and others to deliver integrated care Continue to exceed our carbon reduction targets</td>
<td>Submit evidence to the Competition Commission and complete by June 2013 Complete IBP case and submit to Monitor September 2013 Submission of joint partnership bid to provide self-care support services for patients with long-term conditions The development of a formal vascular network with Dorset County and Salisbury Hospitals, including interventional radiology To implement the following carbon reduction plans: - Sustainable Procurement Policy - Climate Change Risk Mitigation Plan - Waste Management Strategy</td>
</tr>
<tr>
<td>Goal 7: To maintain financial stability enabling the Trust to invest in and develop services for patients.</td>
<td>Delivery of the transformation plan savings of £9.8m Deliver the capital plan investments to improve services</td>
<td>Quarterly delivery against plan Ongoing monitoring each quarter against plan</td>
</tr>
<tr>
<td>Develop a private patient strategy</td>
<td>Agree plan and actions of implementation strategy</td>
<td></td>
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<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>To revise the Trust’s charity support structure towards an independent charity</td>
<td>The development of an independent charity</td>
<td></td>
</tr>
</tbody>
</table>


**BOARD OF DIRECTORS**

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>12th July 2013 – Part I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Sustainable Development Policy</td>
</tr>
<tr>
<td>Section:</td>
<td>Decision</td>
</tr>
<tr>
<td>Executive Director with overall responsibility:</td>
<td>Richard Renaut, Director of Service Development</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Laura Dale, Sustainability Manager</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>Carbon Group Meeting</td>
</tr>
<tr>
<td>Key Purpose:</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>Action required by Board of Directors:</td>
<td>Decision</td>
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</table>

**Executive Summary:**

Draft Policy for ratification by Board of Directors

The Trust takes the international requirement for action to prevent future climate change very seriously. It recognises that it has a social responsibility to reduce its environmental impact and associated carbon emissions.

This policy sets out the Trust’s aims, responsibilities and arrangements for the development and embedding of sustainability within the Trust.

Attached as an Annex is the Trust Annual Sustainability Report (included within the RBCH Annual Report). This report provides a summary of performance and sustainability achievements in 2012/13.

**Strategic Goals & Objectives:**

To achieve a 10% overall carbon reduction by April 2016 (from 2007/08 baseline)

**Links to CQC Registration:**

(Outcome reference) N/A

**Links to Assurance Framework/Key Risks:**

N/A

**Type of Assurance:**

<table>
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<tr>
<th>Internal</th>
<th>External</th>
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# Sustainable Development Policy

- **Approval Committee**: None
- **Version**: 1.0
- **Issue Date**: June 2013
- **Review Date**: June 2014
- **Document Author(s)**: Laura Dale, Sustainability Manager

## Version Control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Section</th>
<th>Principle Amendment Changes</th>
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<tr>
<td>1.0</td>
<td>March 2013</td>
<td>Laura Dale</td>
<td>ALL</td>
<td>Draft for discussion at Carbon Group Meeting</td>
</tr>
</tbody>
</table>
## Contents

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<tr>
<td>11.0 Consultation</td>
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1.0 Introduction

The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (the Trust) takes the international requirement for action to prevent future climate change very seriously. It recognises that it has a social responsibility to reduce its environmental impact and associated carbon emissions.

The goal of sustainable development is to “Meet the needs of the present without compromising the ability of future generations to meet their own needs”, as defined by the 1987 Brundtland Report. This requires consideration of the three pillars of sustainability; economy, society and environment.

In practice this means the Trust will consider the use of resources in its day to day operations so that it optimises the use of renewable resources where practical and preserves finite resources as much as possible. Therefore the Trust must make sure that its use of utilities, transport requirements, purchasing decisions and production of waste is as effective as possible.

To achieve this there is an increasing focus on carbon emissions that arise from these sources, and the NHS has set an overall carbon reduction target for NHS Trusts to achieve, of a 10% reduction by April 2016 (from 2007/08 baseline year). The Trust has adopted a series of carbon reduction targets in support of the NHS target to reduce emissions by 10% by 2015/16.

The key areas for action are waste, energy, water and carbon management, travel and transport, procurement and food, green spaces, buildings and site design, organisational and workforce development, partnership and networks, governance, IT and finance.

This policy sets out the Trust’s aims, responsibilities and arrangements for the development and embedding of sustainability within the Trust.
2.0 Scope
The policy will apply to all staff, contractors and stakeholders of the Trust and is to be considered in all activities and services of the organisation.

3.0 Objective / Policy Statement
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (the Trust) is committed to continual improvement in the minimising the impact of its activities on the environment, and in doing so reinforces its commitment to Good Corporate Citizenship.

The Trust will therefore ensure:
- It complies with all relevant environmental legislation and other requirements to which the Trust subscribes;
- It effectively manages the risk of climate change in the delivery of its health services
- It has in place an effective plan to deliver carbon reduction, in response to the NHS Carbon Reduction Strategy for England, including through direct energy consumption, procurement, transport, waste and water.
- It will continue to work in partnership with key stakeholders under Local Strategic Partnerships to ensure that collaboration aids the integration of this agenda
- It ensures that staff, patients, visitors and suppliers/ contractors are able to effectively engage with, and support, the Trust’s carbon reduction plan
- It regularly reviews and reports on progress against the Good Corporate Citizenship (GCC) Assessment Model and key actions within the Sustainability & GCC Action Plan

4.0 Duties & Responsibilities
Chief Executive
The Chief Executive has overall responsibility and accountability for ensuring that the Trust is meeting its obligations to endorse sustainability and adapt to and mitigate climate change.

Director of Service Development
The Director of Service Development will be the ‘Lead Director (Sustainability)’ and have Board level responsibility to provide strategic direction, as delegated by the Chief Executive, to deliver the Sustainable Management Plan and its associated action plan.

The Lead Director will provide the necessary corporate support and report sign off.

The Carbon Group
The Carbon Group have responsibility for ensuring the effectiveness of policies on corporate social responsibility, workplace diversity and equal opportunity, and oversee, monitor and report on the environmental performance of the Trust. Key responsibilities include:
- Assist in the integration & dissemination of the NHS Carbon Reduction Strategy and subsequent Sustainability strategies across the Trust and to lead on the associated work streams.
• Review the effectiveness of policies and initiatives designed to deliver environmentally sustainable and best-practice solutions.
• Promote Sustainability across the Trust and influence how this is included in the business and activity of the Trust as a whole.
• Agree Trust draft strategies and policies relating to Sustainability and environmental issues prior to submission to the Trust Board for ratification.
• Agree the Business Case(s) for any bids to be taken to Review Panel in relation to sustainability issues.
• Agree and co-ordinate any action plan for staff engagement relating to Sustainability and the environment, including where relevant appropriate training.
• Monitor the performance of associated work streams e.g. Sustainability & GCC Action Plan.
• Allocate responsibility for individual work streams.
• Assist the Trust Board in its oversight of the Trust's compliance with applicable legal and regulatory requirements in relation to environmental matters and socially responsible initiatives

Trust Directors
All Directors have a responsibility for ensuring that the policy is implemented within their directorates.

Departmental Managers/ Team Leaders
All Departmental Managers and Team Leaders have a responsibility for ensuring that all their staff are aware of the policy and their contribution towards sustainable development.

Sustainability Manager
The Sustainability Manager is responsible for facilitating the embedding of sustainable development across the Trusts activities. The Sustainability Manager is also responsible for the development, implementation and communication of the policy.

All Staff
All staff have a responsibility to cooperate with the implementation, monitoring and reviewing of this policy. All staff must be aware and minimise the impact that their work and services have on the environment as work towards embedding the wider agenda of sustainability into the operations.

Environmental Champions
The Environmental Champions have a responsibility for cascading information to their department or ward and provide local support regarding practical actions that can help to aid the Trust in their Sustainable Development objectives.

5.0 Implementation
Implementation of the Policy will be carried out through the Sustainability and Good Corporate Citizenship Action Plan. The Sustainability Manager will facilitate and coordinate the implementation of the plan and the Carbon Group and its members will drive the delivery of the action plan.
6.0 Training and Awareness

Training and awareness will be provided to ensure that all staff understand their requirements and responsibilities in terms of helping the Trust achieve their carbon reduction targets, embed sustainability within the organisation and meet legislative requirements and best practice.

A comprehensive Carbon Engagement and Communications Strategy has been developed to fully engage and encourage support for carbon reduction from staff, patients, visitors, suppliers and the wider community.

7.0 Process for Monitoring Compliance with the Policy

- Trust performance against the Sustainable Development Policy and associated action plans will be reviewed quarterly by the Carbon Group.
- Annual Sustainability reports will be produced to demonstrate Trust performance against targets and presented to the Board.
- The Good Corporate Citizenship Assessment Model will be reviewed every six months to measure, monitor and review the Trusts performance

8.0 Approval, Implementation & Review

<table>
<thead>
<tr>
<th>Action: Consultation of Sustainable Development Policy</th>
<th>By Whom: Carbon Group</th>
<th>By When: March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval of Policy</td>
<td>Trust Board</td>
<td>June 2013</td>
</tr>
<tr>
<td>Publication of Policy on intranet</td>
<td>Sustainability Manager</td>
<td>July 2013</td>
</tr>
<tr>
<td>All staff made aware of policy and its content</td>
<td>Departmental Managers</td>
<td>July 2013</td>
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<tr>
<td></td>
<td>Sustainability Manager</td>
<td></td>
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<tr>
<td>Monitoring of implementation of policy</td>
<td>Carbon Group</td>
<td>Ongoing</td>
</tr>
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<td></td>
<td>Trust Board</td>
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</tbody>
</table>

This policy shall be reviewed by June 2014 or when any changes in sustainability practice or legislation occur.

9.0 References

- Saving Carbon, Improving Healthcare
- NHS Carbon Reduction Strategy
- NHS Good Corporate Citizenship
- Applicable Environmental Legislation
10.0 Associated Policies
Under Arching Policies/ Documents:
- RBCH Sustainable Management Plan
- Environmental Policy (to be actioned)
- Sustainable Procurement Policy (to be actioned)
- Sustainable Food Policy Statement (draft)
- Carbon Engagement and Communication Plan (draft)

Associated Policies
- Health & Safety Policy
- Health & Wellbeing Policy
- Equality & Diversity Policy
- Waste Management Policy

11.0 Consultation

| Those listed opposite have been consulted and comments/actions incorporated as required. | March 2013  
Initial draft to Carbon Group for discussion |
| (Author to ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval) | April 2013  
Carbon Group agreed Sustainable Development Policy subject to Board Approval |
**Annual Sustainability Report 2012/13**

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. In support of this target, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) has developed a Sustainable Management Plan (SMP). This was signed by the RBCH Board of Directors in January 2011. The SMP affirms the Trust’s objectives and targets for reducing carbon emissions, and enables the Trust to contribute to the NHS aim of becoming a low carbon, sustainable provider of high quality healthcare.

The Trust is committed to continually improve on minimising the impact of its activities on the environment, and in doing so reinforcing its commitments to both the Good Corporate Citizenship Model and cost improvement.

To achieve this there is an increasing focus on carbon emissions that arise from these sources, and the NHS has set an overall carbon reduction target for NHS Trusts to achieve, of a 10% reduction by April 2016 (from 2007/08 baseline year). The Trust has adopted a series of carbon reduction targets in support of the NHS target to reduce emissions by 10% by 2015/16.

The key areas for action are energy, water & carbon management, sustainable procurement & food, low carbon travel, transport and access, waste reduction & recycling, green spaces, staff engagement & communication, buildings and site design, organisational and workforce development, partnership and networks, governance, IT and finance.

The Trust regularly reviews and reports on progress against the Good Corporate Citizenship Assessment Model and key actions within an accompanying Sustainable Management Action Plan.

Monitoring, reviewing and reporting of energy and carbon management are carried out quarterly via the Carbon Management Group. Richard Renaut, Director of Service Development, is the Board Level Lead for Sustainability. A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

**Summary Performance:**
RBCH has been progressing with energy and carbon management over the last couple of years. Sustainability achievements in 2012/13 include:

**Energy, Water and Carbon Management:**
The trust has been investing in energy efficient lighting across the Hospital sites. LED lights have been installed in 1 ward environment, main corridors, a number of office areas, accommodation refurbishments, and in all car parks at Royal Bournemouth Hospital.

The Trust has also initiated an Energy Performance Contract energy reduction scheme with the aim of reducing utilities consumption by 25% through various infrastructure changes. The Trust will work on this initiative in partnership with British Gas, and an investment grade audit has been commissioned.

**Sustainable Procurement and Food:**
The Trust recognises its responsibility to carry out its procurement activities in an environmentally and socially responsible manner, and the considerable influence we have in using our buying power to encourage healthy and sustainable food production and consumption. In such, the Catering Department has developed a Health & Sustainable Food Policy Statement.

A food waste digester has also been installed within the kitchen at Royal Bournemouth Hospital. The waste digester replaced the waste disposal maceration unit within the kitchen, and the digester works by the use of enzymes that break down the food into a soluble form that can be
dealt with by normal sewage treatment systems. This installation of the waste digester will save the trust money through avoided water costs and maintenance costs associated with maceration. It improves the carbon footprint of the Trust through reduced water consumption and it demonstrates a positive environmental commitment & best practice to refrain from maceration.

The Purchasing & Commercial Services Department also ensure that all suppliers are asked to provide information on environmental performance during the pre-qualification questionnaires process.

**Low Carbon Travel, Transport and Access:**
The Catering Department have recently invested in an electric van for the delivery of meals between Royal Bournemouth Hospital and Christchurch Hospital. The electric van will help the Trust in reducing its travel related carbon footprint and supporting a sustainable future, whilst still providing the ability to deliver the food service. The vehicle will be charged at Royal Bournemouth Hospital by utilising the renewable energy generated from the 3 Solar PV Installations on site.

Members of staff who regularly drive Trust vehicles or the pool cars were also identified and sent on the Energy Savings Trust Smart Driving Course. This training helps drivers to become more efficient drivers and can save organisations up to 15% on fuel costs.

**Waste Reduction & Recycling:**
The Trust has piloted robust recycling facilities within the Education Centre at Royal Bournemouth Hospital, with the provision of co-mingled recycling bins and food waste bins. All co-mingled recycling is processed by our waste contractor and all food waste is composted. This pilot has been well received and the Trust is now in the process of introducing commingled recycling in all areas across the Trust. Battery recycling facilities have also been rolled out across the Trust.

The installation of Dyson Air blade hand driers in non-clinical washrooms has also been carried out at Royal Bournemouth Hospital. Great savings can be achieved through the installation of these items through the avoided cost in paper towel purchasing and disposal.

**Buildings and Site Design:**
In developing its services and facilities, the Trust will aim to meet the BREEAM performance benchmarks (including ‘BREEAM Excellent’ for new build developments) in respect of the specification, design, construction and use of our buildings. The BREEAM measures include aspects related to energy and water use, the internal environment (health and well-being), pollution, transport, materials, waste, ecology and management processes.

**Green Spaces:**
The Estates team have carried out a number of improvements to encourage wildlife and enhance biodiversity around the Hospital sites. Around 30 bird boxed have been installed, covered duck houses provide around the lake, log piles have been formed to encourage biodiversity and a wildflower site has also been trialled to encourage nectar feeding bees and other insects. The Trust has also been trialling green pest control in the form of a Harris Hawk.

**Staff Engagement & Communications:**
The Trust is committed in ensuring that staff, patients, visitors and suppliers/contractors are able to effectively engage with, and support, the Trust’s carbon reduction plan. The Trust have been the second NHS organisation to take part in the Green Impact Scheme, an environmental accreditation and awareness scheme run by the National Union of Students. The Trust currently has 17 teams signed up to the scheme, and an awards ceremony will be held in July to reward staff on their sustainable actions. Regular articles about sustainability and energy awareness are included within the staff magazines, as well as regular awareness raising events, such as a recent week-long schedule of events in support of the National Climate Week campaign, and support of the annual NHS Sustainability Day.
Organisational and Workforce Development:
A range of initiatives associated with health improvement and promoting the health of staff, patients and the public are led and overseen by the Trust Health & Wellbeing Group

Partnership & Networks:
The Trust continues to work in partnership with key stakeholders under Local Strategic Partnerships to ensure the collaboration aids the integration of the sustainability agenda.

Governance:
Performance against targets is reported quarterly to the Carbon Group. RBCH has a target to achieve a carbon reduction of 10% by 2015/16, which it is on target to achieve. A Trust Sustainable Development Policy has also been signed off on behalf of the Trust by the Carbon Group. The Trust also routinely reports on energy consumption through the Department of Health’s “Estates Returns Information Collection mechanism” (ERIC).

IT & Finance:
The Trust has introduced sustainability criteria for completion as part of all business cases, and the IT department have recently completed the rolling out of the PC Power Management software, aimed at reducing energy consumption through computers being left on unnecessarily.

Future Priorities and Targets for 2013/14:
- Update the RBCH Sustainable Management Plan and Action Plan.
- Catering Department to achieve the Bronze Food for Life Catering Mark to show case all work done regarding local, healthy & sustainable food.
- Sustainable Procurement Policy and associated Action Plan
- Waste Management Strategy
- Conduct staff and patient travel survey
- Explore potential of collaboration with neighbouring companies to reduce congestion around sites during peak times.
- Expansion of Green Impact scheme
- Further utilisation of electric vehicles for cross site travel
- Climate change risk mitigation plan
Performance Data:

<table>
<thead>
<tr>
<th>Non-Financial Indicators (tonnes CO$_{2e}$)</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
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<tbody>
<tr>
<td>Total Gross Emissions:</td>
<td>13,307</td>
<td>12,584</td>
<td>11,737</td>
<td>12,371</td>
<td>11,626</td>
<td>12,572</td>
</tr>
<tr>
<td>Gross Emissions scope 1 (Gas/oil/fleet vehicles/refrigerant losses)</td>
<td>5,340</td>
<td>4,949</td>
<td>4,401</td>
<td>4,630</td>
<td>4,166</td>
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<td>Gross Emissions scope 2 (Electricity)</td>
<td>7,511</td>
<td>7,172</td>
<td>6,876</td>
<td>7,247</td>
<td>7,142</td>
<td>8,161</td>
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<td>Gross Emissions scope 3 (waste/water)</td>
<td>456</td>
<td>463</td>
<td>460</td>
<td>494</td>
<td>318</td>
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<th>Related Energy consumption (MWh)</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
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<tbody>
<tr>
<td>Electricity: Non-renewable</td>
<td>9,823</td>
<td>9,704</td>
<td>10,332</td>
<td>11,215</td>
<td>11,053</td>
<td>11,275</td>
</tr>
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<td>Electricity: Renewable</td>
<td>4,072</td>
<td>3,889</td>
<td>3,857</td>
<td>3,738</td>
<td>3,684</td>
<td>3,758</td>
</tr>
<tr>
<td>Gas</td>
<td>28,457</td>
<td>25,435</td>
<td>22,371</td>
<td>23,566</td>
<td>21,512</td>
<td>21,480</td>
</tr>
<tr>
<td>Oil</td>
<td>0</td>
<td>356</td>
<td>556</td>
<td>162</td>
<td>246</td>
<td>194</td>
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<tr>
<td>LPHW</td>
<td>1,535</td>
<td>6,629</td>
<td>10,104</td>
<td>7,903</td>
<td>5,125</td>
<td>6,696</td>
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<table>
<thead>
<tr>
<th>Financial Indicators (£1,000’s)</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
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<tbody>
<tr>
<td>Expenditure on energy</td>
<td>1,545</td>
<td>2,344</td>
<td>2,003</td>
<td>2,035</td>
<td>2,225</td>
<td>2,675</td>
</tr>
<tr>
<td>CRC Gross expenditure</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>143</td>
<td>149</td>
</tr>
<tr>
<td>Expenditure on official business travel</td>
<td>-</td>
<td>428</td>
<td>448</td>
<td>391</td>
<td>324</td>
<td>389</td>
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<table>
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<tr>
<th>Energy consumption (MWh) per GIA floor area:</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
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<tbody>
<tr>
<td>Carbon emissions (Kg CO$_{2e}$) per Patient:</td>
<td>21.3</td>
<td>19.0</td>
<td>16.7</td>
<td>17.6</td>
<td>15.7</td>
<td>16.3</td>
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Performance commentary:

RBCH energy costs have increased by 20% in 2012/13. These increases are largely due to the rising cost of utilities, but also due to increased utilities consumption in response to a significantly colder winter in the 2012/13 year compared to the mild weather the previous year. A slight increase in electrical consumption has also been observed, and this is due to additional electrical load through new equipment installed in 2012/13.

Although total energy consumption relative to floor area has increased in 2012/13 compared to the previous year, it has still reduced in comparison to 2010/11, and has reduced by 24% from the 2007/08 baseline year.

The Trust’s gross carbon emissions have also risen in 2012/13. Although a decrease in scope 3 emissions has been observed, due to 526 tonnes of waste being diverted from landfill and sent to an energy recovery facility, an increase in scope 1 & 2 emissions has occurred. Gross carbon emissions have reduced by 5% from 2007/08 baseline year, and carbon emissions per patient have reduced by 23% since the baseline year. It is believed with the commencing of the EnPC in 2013 that the Trust will remain on target to achieve its carbon reduction targets outlined in the Sustainable Management Plan.

RBCH purchase 25% of its electricity supply from renewable sources. Renewable energy represents approximately 8.4% of total energy use. In addition, RBCH generates 15% of our energy onsite, through the 3 solar PV installations and Low Pressure Hot Water which is produced as a by-product of on-site incineration and used to subsidise the Royal Bournemouth Hospital heating systems.
### Non-Financial Indicators (tonnes)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total Waste</td>
<td>1,369</td>
<td>1,286</td>
<td>1,257</td>
<td>1,482</td>
<td>1,503</td>
<td>1,258</td>
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<tr>
<td>High Temp Disposal Waste</td>
<td>615</td>
<td>565</td>
<td>610</td>
<td>517</td>
<td>469</td>
<td>486</td>
</tr>
<tr>
<td>Landfill</td>
<td>701</td>
<td>707</td>
<td>642</td>
<td>827</td>
<td>299</td>
<td>0</td>
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<tr>
<td>Recycled/ Reused</td>
<td>123</td>
<td>17</td>
<td>88</td>
<td>181</td>
<td>444</td>
<td>247</td>
</tr>
<tr>
<td>Energy Recovery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>284</td>
<td>526</td>
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### Financial Indicators (£1,000's)

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</thead>
<tbody>
<tr>
<td>Total waste cost</td>
<td>318</td>
<td>325</td>
<td>367</td>
<td>333</td>
<td>336</td>
<td>320</td>
</tr>
<tr>
<td>High Temp Disposal Waste</td>
<td>256</td>
<td>238</td>
<td>288</td>
<td>258</td>
<td>221</td>
<td>237</td>
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<tr>
<td>Landfill</td>
<td>62</td>
<td>77</td>
<td>73</td>
<td>72</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>Recycled/ Reused</td>
<td>26</td>
<td>3</td>
<td>9</td>
<td>28</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>Energy Recovery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>31</td>
<td>65</td>
</tr>
</tbody>
</table>

### Performance commentary:

In 2012/13 the Trusts preferred waste contractor collected a total 773 tonnes of non-hazardous waste. Of this, zero tonnes went to landfill, 526 tonnes went to an energy recovery facility and 247 tonnes was recycled, which included mixed recycling (38 tonnes); baled cardboard (103 tonnes); and separate food waste collections (60 tonnes). In addition to the general recycling, various unwanted materials were collected for reuse or recycling, including curtains and bedding that were sent to Medical Aid International to be utilised in third world countries.
### Water:

<table>
<thead>
<tr>
<th>Non-Financial Indicators (000's m³)</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
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<tr>
<td>Water consumption</td>
<td>130</td>
<td>138</td>
<td>143</td>
<td>142</td>
<td>140</td>
<td>141</td>
</tr>
<tr>
<td>Sewerage</td>
<td>112</td>
<td>118</td>
<td>117</td>
<td>124</td>
<td>122</td>
<td>122</td>
</tr>
<tr>
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<tr>
<td>Water supply costs</td>
<td>115</td>
<td>121</td>
<td>121</td>
<td>140</td>
<td>147</td>
<td>155</td>
</tr>
<tr>
<td>Sewerage costs</td>
<td>144</td>
<td>147</td>
<td>151</td>
<td>168</td>
<td>164</td>
<td>181</td>
</tr>
<tr>
<td>Water usage per GIA (floor area)</td>
<td>1.47</td>
<td>1.57</td>
<td>1.34</td>
<td>1.33</td>
<td>1.31</td>
<td>1.32</td>
</tr>
</tbody>
</table>

**Commentary:**

RBCH water consumption increased by 883 cubic meters (0.6%) in 2012/13 compared to the previous year.

Although RBCH water consumption has increased since 2007/08, water consumption per square metre of gross internal floor area has decreased by 10% in 2012/13 from the baseline year (2007/08).
### BOARD OF DIRECTORS

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>12 July 2013 Part I</th>
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<tbody>
<tr>
<td>Subject:</td>
<td>NHS England Urgent and Emergency Care Review</td>
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<tr>
<td>Section:</td>
<td>Discussion</td>
</tr>
<tr>
<td>Executive Director with overall responsibility</td>
<td>Tony Spotswood, Chief Executive</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Tony Spotswood, Chief Executive</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>Trust Management Board</td>
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<tr>
<td>Key Purpose:</td>
<td>Patient Safety</td>
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<tr>
<td></td>
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<tr>
<td>Action required by BoD:</td>
<td>For Discussion</td>
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### Executive Summary:
NHS England is undertaking a review into the way the NHS responds to and receives emergency patients with the aim of developing a national framework to help clinical commissioning groups ensure high-quality, consistent standards of care across the country. NHS England has written to the chief executives and medical directors at all NHS trusts and foundation trusts asking them to share their views using an online questionnaire.

### Strategic Goals & Objectives:
To offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care

### Links to CQC Registration:
(Outcome reference) Outcome 4: Care and welfare of people who use services Outcome 6: Cooperating with other providers

### Links to Assurance Framework/Key Risks:

<table>
<thead>
<tr>
<th>Type of Assurance:</th>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
</table>

To: Chief Executives – NHS trusts and foundation trusts
    Medical Directors – NHS trusts and foundation trusts
Cc: Dr David Bennett, Chief Executive – Monitor
    David Flory CBE, Chief Executive – NHS Trust Development Authority
    David Behan, Chief Executive – Care Quality Commission

Dear Colleague,

Re: Urgent and Emergency Care Review

We are writing to seek your views on an important piece of work to shape the future of urgent and emergency care services in England.

In January this year the national Medical Director, Professor Sir Bruce Keogh, announced a review into the way the NHS responds to and receives emergency patients, called the Urgent and Emergency Care Review which was outlined as a priority for NHS England in its planning guidance for clinical commissioning groups called Everyone Counts.

The aim of the review is to develop a national framework to help clinical commissioning groups ensure high-quality, consistent standards of care across the country.

Over the last six months a steering group with representation from a patient and public organisation, provider and commissioning organisations and the wider clinical body, which is chaired by Professor Keith Willett, Director of Acute Episodes of Care, has worked to develop an evidence base for change and emerging principles.

NHS England is committed to an evidence-based approach to change and the evidence base drafted by the steering group has identified a number of areas for improvement within the current system of urgent and emergency care in England, including:

- More and more people are using the urgent and emergency care system;
- Overall fragmentation of the system means that many patients may not be able to access the most appropriate urgent or emergency care service to suit their needs;
- There is significant variation in patient experience across urgent and emergency care;

High quality care for all, now and for future generations
• Demographic change in the national population means that more and more patients need support managing long-term conditions;
• Emergency admissions are rising and there is a variation in outcomes for these patients.

Using this evidence base **four emerging principles** have also been drafted which outline the case for change, for a system that:

• Provides consistently high quality and safe care, across all seven days of the week;
• Is simple and guides good choices by patients and clinicians;
• Provides the right care in the right place, by those with the right skills, the first time;
• Is efficient in the delivery of care and services.

Using these principles the steering group has developed some system design objectives which any new system should be shaped around, as well as some possible implementation solutions.

These are not agreed solutions at this stage, but have been presented to stimulate debate and help explain what a future system might look like. We are seeking your comments to ensure that the evidence base and principles are scrutinised and clinically sound. Your comments will be used to develop a national framework for commissioning of urgent and emergency care. Clinical commissioning groups will then be able to use this framework to commission local urgent and emergency care services.

We would be grateful if you could take the time to read both documents and complete the **short online questionnaire** to give us your feedback. This engagement period will take place between 17 June and 11 August 2013.

We hope you can take this opportunity to help us shape the future of urgent and emergency care.

Yours sincerely,

Professor Keith Willett
Domain Director for
Acute Episodes of Care
NHS England

Sir Bruce Keogh
Medical Director
NHS England
High quality care for all, now and for future generations: transforming urgent and emergency care services in England –
the Evidence Base from the Urgent and Emergency Care Review
This document supports an engagement exercise on the evidence base and emerging principles developed through the Urgent and Emergency Care Review.
High quality care for all, now and for future generations: transforming urgent and emergency care services in England –

the Evidence Base from the Urgent and Emergency Care Review

First published: June 2013

Prepared by: Urgent and Emergency Care Review Team
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Foreword

'High quality care for all, now and for future generations'

By Sir David Nicholson
Chief Executive, NHS England

This is the first in a series of initiatives to challenge our thinking on the future of health and care and how we organise NHS services so we can provide high quality care to every patient, every time it is needed, sustainably. It is our responsibility to ensure that the NHS is here for our children and their children.

How do we want the NHS to be in the future? This is a question for us as citizens and patients, and for the communities in which we live. It is a question for everybody who works in health and care. The NHS belongs to us all, and it is for all of us to shape its future.

In July, to mark the 65th anniversary of the founding of the NHS, we will be publishing 'The NHS belongs to us all: a call to action' which will invite everybody to take part in a series of local and national conversations about the long term future of health and care services. We live in a time of financial constraint and rising demand for health services and we need to ask some big questions: what is the future shape of care services? How can we support citizens and patients to take more control of their health and care? How can we transform the patient experience?

We will be asking people how the NHS should develop and expand primary care services and which NHS services should be planned and paid for centrally because they are highly specialised. We want to start a debate about how the internet and digital technology can transform both NHS services and every patient’s experience of accessing the right care.

Working with NHS staff we’ll be studying the role of commissioning; how our services are organised and paid for locally and what levers exist in this area for improving quality and financial efficiency. We’ll be looking at the role of our hospitals in the future and developing ideas for how they can become beacons of excellence, where patients can expect to get the most effective and advanced treatments.

The Urgent and Emergency Care Review opens a key conversation: how can our A&E services deliver the best outcomes for patients and for our communities in the future?

Our A&E departments are under considerable pressure: staff are saving lives and helping people recover from injury using the best clinical expertise and technologies in the world. In some cases, such as heart attack and stroke, we have learnt that patients get better outcomes by going straight to specialist centres and not to A&E. We also know that some people who present at A&E, and who we treat there, would have more appropriate care and a better patient experience if they were seen in a primary or community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery.
One of the issues we are dealing with is the fact that patients find it hard to navigate between primary care, our hospitals and social care services. In many cases some of our most vulnerable patients need careful management and input from a number of different agencies and sometimes they, or their carers, are just not able to understand and work with this range of services, and find themselves in A&E as a last resort. This falls short of the high quality care we want to give every patient.

I want to thank everyone who takes part in this conversation. Every response will be used to build understanding and better solutions for patients.

Sir David Nicholson
Chief Executive, NHS England
Foreword

By Professor Sir Bruce Keogh
Medical Director, NHS England

Our NHS is founded on values that epitomise the social conscience of our country. Nowhere is this better reflected than in the Accident and Emergency department of a hospital which offers sanctuary, safety and hope for people when they need help unexpectedly.

Twenty years ago most A&E departments could treat most patients safely and effectively by the clinical standards of the day. But things have changed. The inexorable and accelerating advances in medical science mean that treatments improve and acceptable standards continuously evolve. This means there is now no A&E department in the country that can treat everything that comes through the door. In fact, most A&E departments can no longer offer the best treatments for the two major killers – serious heart attacks and stroke – because they now require a high level of specialist expertise and technology to offer the best chance of recovery.

So the way we offer emergency care needs to change to keep up with medical science and to ensure that everyone in the land, wherever they live, has the best chance of the best, most up-to-date care as close to home as is reasonably possible. Balancing the requirement for centralisation of some complex services for common, serious conditions against the provision of safe care close to home will require detailed thought and debate between clinical professionals, the public and politicians.

A debate based on good evidence where it exists, but which also recognises where evidence is weak or absent, will be an informed and productive debate and more likely to alight on innovative and effective principles and solutions. These may vary in different metropolitan and rural areas.

Last year, NHS England committed to reviewing the provision of urgent and emergency care as part of a drive to promote more extensive seven-day services in the NHS. We established an Urgent and Emergency Care Review to support this, and I am now pleased to present the evidence base which has emerged from the Review so far, along with some principles which I hope will help initiate the debate which is so urgently needed.

The current concerns around A&E performance should be seen as a stimulus and opportunity to improve the way we offer care between our hospitals, primary and community care and social services. Better integration and communication between these services could reduce unnecessary attendances at A&E and enable people in hospital to return home sooner. This in turn could free up hospital beds so patients who need admission from A&E would not be kept waiting so long.
I hope that you will work with us to develop and improve our evidence base for change, and help us to develop the principles and system design objectives on which we will build a stronger, more sustainable urgent and emergency care system for everyone.

Professor Sir Bruce Keogh
Medical Director, NHS England
Foreword

By Professor Keith Willet
National Director for Domain 3: Acute Episodes of Care, NHS England

What we all want is to be able to deliver the best service for patients and the public – one that not only meets, but often exceeds, the minimum standards. To get there we need the whole NHS system, in the community and in hospitals, to work seamlessly to deliver acute care at the time it is needed and with continuity where an acute episode is part of a long-term problem.

As the Chair of the Urgent and Emergency Care Review I, like Professor Sir Bruce, am very pleased to present our work so far. We are now looking to the expertise of professionals across the breadth of the NHS and to draw on the experiences of patients to help us develop new models of care that will be successful for the future.

There are no simple or easy solutions for improving the delivery of urgent and emergency care, and I would like to pay tribute to the way in which this Review’s Steering Group has grappled with the issues which the Review has brought up – which are many and complex.

We have developed an initial evidence base, and we have used this to generate emerging principles for change, some design objectives and some possible options for how these might be implemented. It is now time to present these to a wider audience for comment, challenge, and improvement.

We look forward to hearing your views on our work so far, and we will use this to help us as we move forward to the next phase of the Review – which will be to develop practical proposals and solutions to help us to deliver an urgent and emergency care system which is robust, efficient, and responsive to the needs of patients and the public for years to come.

It is my intention to continue this dialogue with NHS staff and patients throughout the review.

Professor Keith Willett
National Director for Domain 3: Acute Episodes of Care, NHS England
Executive summary
The evidence base sets out to review the urgent and emergency system in England and draw out evidence to illustrate the main challenges it currently faces. Starting with overall patient experience, this document goes on to highlight issues within each part of the urgent and emergency care system in order of the perceived levels of patient need that it addresses, these are:

- Self care and self management;
- Telephone care;
- Face to face care;
- 999 emergency services;
- A&E departments; and
- Emergency admissions to hospital.

Two final sections follow, one examines the capacity and sustainability of the current workforce, and the other outlines the potential of urgent and emergency care networks to create a whole-system approach capable of addressing many of the current issues. A number of key messages emerge from each section of the evidence base. These are listed below.

Key messages

Current services
- The number of GP consultations has risen over recent years and despite rapid expansion and usage of alternative urgent care services, attendances at A&E departments have not reduced. This indicates either unmet demand across the whole system or supply induced demand: increased uptake as a result of increased provision of services.
- Growth in the number of people using urgent and emergency care is leading to mounting costs and increased pressure on resources.
- Overall fragmentation of the system means that many patients may not able to access the most appropriate urgent or emergency care service to suit their needs, leading to duplication and over-use of the most expensive services, at significant cost to the NHS.

Patient experience
- There is significant variation in patient experience between GP practices. Data shows that some patients who have a good experience of their GP are less likely to use A&E departments.
- Patient experience of both the NHS Direct telephone service and pilots of NHS 111 has been found positive; however transition from nurse-led triage to calls answered by trained advisors, supported by experienced clinicians has led to some incidences of poor patient experience during the early implementation of NHS 111.
- The wide range of urgent care services available and lack of standardisation of services and labelling results in patient confusion over how to access the right healthcare quickly; this leads to duplication, delay, increased clinical risk and poor patient experience.
• There are variations in the way patient experience is monitored and acted upon in urgent care and this falls short of what is achieved in other parts of the NHS.
• Consistently positive patient experiences of ambulance services, and confusion surrounding other areas of healthcare, are factors that may have contributed to an increased use of the emergency (999) number and ambulance services by patients with non-urgent healthcare needs.
• A&E performance (operational and clinical), and therefore patient experience, varies significantly between trusts, with a few performing far worse than the rest. Additionally, there are signs that overcrowding of A&E departments is causing a deterioration of performance and impacting negatively on patient experience.

Self-care and self-management
• Self-care for minor ailments and self-management of long-term conditions are effective at improving quality of life and reducing dependency on urgent and emergency care services; however there is a lack of awareness surrounding how to access self help and the demographic groups most likely to benefit are least likely to be aware.
• There are a range of programmes available to support self-management of long-term conditions but provision and uptake of these is variable across the NHS.
• Variable management of long-term conditions in primary care may have contributed to a rise in the number of emergency admissions to hospital.
• Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions; however there is little public awareness of the range of services provided by pharmacists.

Telephone care
• Telephone advice can prevent many unnecessary attendances at NHS facilities. However it is sometimes difficult to accurately triage patients over the phone and, without clinical input, call handlers may sometimes over-triage if they cannot rule out a serious condition.
• Telephone consultations are becoming increasingly popular, are less resource-heavy for general practice than face-to-face consultations and their systematic use is linked to reduced use of A&E departments. However some patients lack confidence in telephone advice and are likely to pursue a second opinion inappropriately, leading to duplication of service provision, in some cases.

Face-to-face care
• Urgent access to GP appointments across England is variable. Additionally, in urban areas where demand is high and transient populations exist, many may use an A&E department as their first point of urgent and emergency care.
• Primary care can struggle to manage some patients with long-term conditions effectively, including those with mental health problems. This may lead to avoidable A&E attendances and emergency admissions to hospital.
• Most out-of-hours services work effectively to deliver a high standard of care to patients who need urgent care when their GP practices are closed. However there are variations in
the standard of care provided and commissioners are not always able to hold providers to account.

- The fragmentation and diverse nomenclature of urgent care services across England causes confusion amongst patients and healthcare professionals in terms of services offered. This can lead to patients presenting at services that may not best suit their needs.
- Urgent care services are characterised by variation and a lack of standardisation and clear information. This contrasts with the strong identity of A&E departments. Variation in acceptance and quality of care provided can result in delayed treatment or multiple contacts and a poor experience of care, as well as inefficient use of expertise and resources.

**999 emergency services and Accident and Emergency departments**

- Appropriate staffing is integral to an effective A&E department; however doctors in training are relied on heavily to provide the service due to insufficient numbers of senior emergency medicine trained doctors.
- Consultant-delivered care and senior clinical input improves patient outcomes in A&E departments; however the shortage of emergency medicine trained senior (middle grade and consultant) doctors is a problem for nearly all A&E departments and large variation in consultant ‘shop floor’ coverage is seen across England.
- Patients with mental health needs are a key challenge facing A&E departments but access to psychiatric support out-of-hours is poor for the majority of services.
- Crowding in A&E departments is a growing threat to patient safety and can have a significant impact on all patients. Timely access is required from supporting specialties to enable appropriate admission and transfer of patients to improve patient flow within A&E departments.
- To ensure high-quality and safe care in an A&E department, access to inpatient beds and support from other specialities in the hospital or rapid transfer to the right hospital is required.

**Emergency admissions to hospital**

- Growth in the number of emergency admissions to hospital has been associated with a large rise in short or zero stay admissions. The reasons for this are multifactorial but some studies have attributed it to a lack of early senior review, risk averse triage and A&E departments trying to avoid breaching the four hour standard.
- Reduced service provision, including fewer consultants working at weekends, is associated with England’s higher weekend mortality rate. Consistent services across all seven days of the week are required to provide high quality and safe care.
- There are clear recommendations from the Temple report that training needs to take place in a consultant delivered service yet this is not practised across the majority of hospital services.
Workforce
- National workforce analysis highlights a growth in the GP workforce in England however, local variation exists in unequal access to GPs between areas of high and low deprivation. Analysis highlights that the GP workforce is under with insufficient capacity to meet needs.
- The involvement of senior doctors 24 hours a day and consultant presence at times of peak activity seven days a week is required to ensure timely patient care and flow in an A&E department. Many A&E departments do not have the recommended number of emergency medicine consultants or middle grade doctors to support such a rota.

Urgent and emergency care networks
- Urgent and emergency care networks can improve patient outcomes and experience, however there is variation in the organisation, scope and functionality of networks across the country.
- There are wide variations in the way information is shared between providers of urgent and emergency care leading to potential duplication within the system causing delay and poor patient experience.
1. Introduction

The NHS should consistently provide safe and high quality urgent and emergency care 24 hours a day, seven days a week. Millions of people in England have non-life threatening short-term illnesses or health problems for which they need prompt and convenient treatment or advice. Others have pre-existing health problems which fluctuate or deteriorate. A much smaller number suffer from serious illness or have a major injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery. To meet these needs an improvement in information and advice and access to timely and appropriate urgent and emergency care, across the 24-hour period within the NHS, is required.

It is suggested that the current system of urgent and emergency care is unaffordable and unsustainable and consuming NHS resources at a greater rate every year. Urgent or unplanned care – when there is a need to access care quickly – leads to at least 100 million NHS calls or visits each year, which represents about one third of overall NHS activity and more than half of the costs. Growing numbers of frail elderly patients, increasing morbidities, more treatable illnesses and an increased public expectation of healthcare have all contributed to ever greater pressure on health and social care services. In urgent and emergency care, this has led to more people:

- using GP services
- using urgent care, walk-in centres and minor injury units;
- accessing the most expensive types of urgent and emergency care; and
- being admitted to hospital through emergency services.

Further to this, the fragmentation of the system is causing confusion amongst patients resulting in duplication of efforts for the same episode of care and inappropriate attendances and emergency admissions to hospital.

For emergency admissions, a patient admitted to hospital in an emergency has little choice about where or when they attend. The public expect that the NHS will provide them with a consistently high quality and safe service; this expectation should underpin the way that all services are commissioned and delivered. Whilst the NHS provides a high quality service for many patients admitted as an emergency, significant variations exist in patient outcomes and service arrangements both between hospitals and also within hospitals depending on whether the patient is admitted on a weekday or weekend.

References:

3. NHS Alliance (2012) A practical way forward for clinical commissioners; NHS Alliance on behalf of NHS Clinical Commissioners and sponsored by NHSCB.
4. Primary Care Foundation (2011) Breaking the mould without breaking the system.
Analysis demonstrates that in England patients admitted to hospital as an emergency at the weekend have a significantly increased risk of dying compared to those admitted on a weekday. Data shows that around 4,400 lives in England could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday. Figure 1 demonstrates the number of lives that could be saved in the different regions in England if there was no difference in weekend and weekday mortality rates.

**Figure 1: Number of lives that could be saved if there was no difference in weekend and weekday mortality rates**

Reduced service provision throughout hospitals, including fewer consultants working at weekends, is associated with this higher weekend mortality rate. This suggests that a change in workforce arrangements is required to ensure that the right number of experienced and highly qualified staff are always available, alongside a change in service arrangements across the whole system to ensure the availability of support services.

This review sets out to improve urgent and emergency care services within the whole system, in England, 24 hours a day, seven days of the week.

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12 National Confidential Enquiry into Patient Outcome and Death. (2007). Emergency admissions: A step in the right direction, NCEPOD
2. The Urgent and Emergency Care Review

Improving the quality and safety of urgent and emergency care is outlined as a priority in *Everyone Counts: Planning for Patients 2013/14.*

The aims of the review of urgent and emergency care in England are to:

- Put patients and the public first;
- Create consensus among clinicians on options for organising urgent and emergency care;
- Produce evidence to support proposed models of care, based on quality, workforce and economic considerations; and
- Create a climate in which Clinical Commissioning Groups can commission for change and improvement in their localities.

It is suggested that the current system of urgent and emergency care in England, is unsustainable and unaffordable and there is a need to review the way the NHS responds to and receives emergency patients. The review outlines the issues within the current system and has developed principles for the future delivery of urgent and emergency care. Subject to wider engagement on the evidence base for improvement and emerging principles for urgent and emergency care, the work will continue to develop a framework for commissioning these services. This will ultimately aim to address the current issues of sustainability, access challenges, patient experience and outcomes and the provision of urgent and emergency care across the whole system in England.

**Who was involved in the programme?**

The urgent and emergency care review is clinically-led. Professor Keith Willett, National Director for Domain 3: Acute Episodes of Care, NHS England, chairs an Urgent and Emergency Care Steering Group which has representation from clinicians and commissioners across the NHS, National Voices, and the wider clinical body.

The review aims to ensure that the needs of patients and the public are given primacy and are central to determining the priorities for patients when accessing care.

**Approach**

Development of the evidence base for change was undertaken through desk-top research and review of available data such as Hospital Episode Statistics (HES). Supporting evidence was drawn from national guidance and reports from the wider clinical body including the Primary Care Foundation, College of Emergency Medicine, Royal College of General Practitioners and other Royal Colleges, as well as opinion from the Steering Group members and through wider engagement with clinical commissioning groups and key stakeholders.

The evidence base and emerging principles for urgent and emergency care in England have been published for a period of wider engagement from 17 June to 11 August 2013.
3. **Current provision of urgent and emergency care services**

The most recent data available shows that there were:

- An estimated 438 million visits to a pharmacy in England for health related reasons in 2008/09\(^\text{15}\);
- More than 300 million GP consultations in 2008/09\(^\text{16}\);
- Approximately 24 million calls to NHS urgent and emergency care telephone services
  - 8.49 million calls to emergency 999 services in 2011/12\(^\text{17}\);
  - 4.4 million calls to NHS Direct in 2011/12\(^\text{18}\);
  - 2.7 million calls to NHS 111 in 2012/13\(^\text{19}\);
  - 8.6 million calls to GP out-of-hours services in 2007/08\(^\text{20}\);
- 6.71 million emergency ambulance journeys in 2011/12\(^\text{21}\);
- 21.7 million attendances at A&E departments, minor injury units and urgent care centres in 2012/13\(^\text{22}\); and
- 5.2 million emergency admissions to England’s hospitals in 2012/13\(^\text{23}\).

### 3.1 Increasing demand and costs of urgent and emergency care

#### Consultations and attendances

In England, the average number of GP consultations per patient rose from 3.9 to 5.5 per year between 1995 and 2008\(^\text{24}\). This increased pressure on primary care means that some patients may have found it more difficult to access their GP quickly, leading to a rising demand for other urgent and emergency care services\(^\text{25}\).

In A&E departments this has led to increasing numbers of patients with less urgent healthcare needs adding to the number of those with life-threatening conditions. To tackle this, in the last decade there has been a huge growth in spending on unplanned care services across England, designed to provide the public with quick access to a clinician when urgent care needs arise\(^\text{26}\). This means that most A&E departments are now able to stream patients to an alternative urgent care facility when appropriate. Despite this, attendances at major and single specialty

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\(^{15}\) Based on an estimate by the Department of Health that 1.2m people visit their pharmacy each day for health related reasons – source: Department of Health (2008) Pharmacy in England
\(^{19}\) Department of Health (2013) National MDS NHS 111 Statistics
\(^{24}\) The Information Centre for Health and Social Care (2009) Final Report to the NHS Information Centre and Department of Health Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database
\(^{25}\) The Information Centre for Health and Social Care (2011) GP Patient Survey respondent demographics - Comparing A&E attendances with results from the GP Patient Survey
A&E departments have continued to increase by about 18 per cent between 2003 and 2011 (or about 2 per cent a year). In comparison, attendances at walk in centres and minor injury centres have increased by around 12 per cent per year since data was recorded.\(^{27}\)

Attendance to an A&E department often reflects the availability or awareness of alternative sources of help. Patients know what an A&E department does and that its services are available 24 hours a day, seven days a week. This is in contrast to other components of the urgent and emergency care system, which offer less consistent responses and are less well understood by patients. This indicates that some patients may default to A&E departments when they are unsure about which service is most appropriate to their needs.

Since 2003/04 when the A&E attendance statistics began to include figures from walk in centres and minor injury units\(^{28}\) there has been significant variation in the services offered and a steady increase in combined attendance numbers. Attendances to A&E departments, minor injury units and walk in centres combined altogether rose by more than 50 per cent in the ten years from 2001 to 2011\(^{29,30}\). One interpretation of this is that the new services are meeting a previously unmet need. Alternatively, it could be that the increased provision has led to supply induced demand and therefore increased uptake, or failure demand caused by a failure to do something earlier on in the urgent and emergency care pathway or system.

**Figure 2: Unplanned care attendances 1987 – 2011**

![Graph showing unplanned care attendances 1987-2011](image)

Source: Department of Health*\(^{31}\)

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27 Department of Health (2011) Timeseries A&E Attendance data
28 Fernandes, A. (2011) Guidance for commissioning integrated urgent and emergency care: a whole system approach; Royal College of General Practitioners Centre for Commissioning
29 Department of Health (2011) Timeseries A&E Attendance data
31 *data for minor A&E/MIUs and Walk in Centres was not collected before 2002-03 and figures are included under major and single specialty A&E departments
**Key message**

The number of GP consultations has risen over recent years and, despite rapid expansion and usage of alternative urgent care services, attendances at A&E departments have not reduced. This indicates either unmet demand across the whole system or supply induced demand: increased uptake as a result of increased provision of services.

**Rising costs**

The average cost of accessing urgent and emergency care varies considerably depending on how and where it is accessed, ranging from lower cost services such as NHS Direct to the highest level of urgency with 999 services and hospital admissions.

The total cost of A&E services varies due to changes in definitions and the way information has been collected, making it difficult to estimate the costs associated with the rise in urgent care. However spending on major A&E services in England is thought to be between £760m and £1.5bn per year, with the average cost of an attendance thought to be about £68.\(^{32,33,34,35,36,37}\)

Rising costs across urgent and emergency care services can be associated with fragmentation of the current system of urgent and emergency care. This fragmentation leads to confusion among patients about how and where to access the care they need\(^ {38}\), and many people are unable to navigate to the level of care appropriate to their condition, leading to multiple calls or attendances and unnecessary use of A&E or ambulance services\(^ {39}\). It is estimated that around three-quarters of A&E attendances relate to serious or life-threatening conditions and about one quarter could have been treated elsewhere\(^ {40,41,42}\). However there is variation between different A&E departments, with deprived urban areas having the highest proportion of patients who did not require hospital treatment\(^ {43}\). This suggests that NHS resources are being used inefficiently because more people are accessing:

- urgent and emergency care in several places for a single episode of care, often referred on by health professionals\(^ {44}\); and
- more expensive areas of urgent and emergency care than necessary.

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32 Foundation Trust Network (October 2012) Briefing on Driving Improvement in A&E Service
34 Fernandes, A. (2011) Guidance for commissioning integrated urgent and emergency care: a whole system approach; Royal College of General Practitioners Centre for Commissioning
38 NHS Alliance (2012) A practical way forward for clinical commissioners; NHS Alliance on behalf of NHS Clinical Commissioners and sponsored by NHSCB
40 Cooperative Pharmacy (2011) Reducing needless A&E visits could save NHS millions
41 NHS Networks (2011) New Choose Well Campaign
42 Self Care Forum (2012) Over 2 million unnecessary A&E visits “wasted”
44 RCGP, RCN, RCPCH & CEM (2012) Right care, right place, first time?: Joint Statement by the Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN), Royal College of Paediatrics and Child Health (RCPCH) and the College of Emergency Medicine (CEM) on the urgent and emergency care of children and young people
Key messages
Growth in the number of people using urgent and emergency care is leading to mounting costs and increased pressure on resources.

Overall fragmentation of the system and inconsistent service provision means that many patients may not be able to access the most appropriate urgent or emergency care service to suit their needs, leading to duplication and over-use of the most expensive services, at significant cost to the NHS.

Increasing emergency admissions to hospital
Emergency admissions to hospital in England are also increasing, with a rise of 40 per cent between 2003/04 and 2010/11 (this includes short-stay and zero length of stay admissions). A 2010 review of trends in emergency admissions between 2004 and 2009 found that, in 2009, emergency admissions to hospital cost the NHS about £11bn and were increasing at a rate of about £83 million per annum. Activity has risen at a much greater rate than the national population over the same period, indicating that population growth plays a minor role in the increase in emergency admissions (figure 3).

Figure 3: Trends in admissions through A&E compared to population (England)

Sources: Office for National Statistics (Population Estimates) and Department of Health (A&E Admissions)

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46 Department of Health (2011) Emergency Admissions through A&E; Datasets 03/04 Q1 to 2010/11 Q4
There are various factors that have contributed to the rise in emergency admissions including:

- a rise in the proportion of older adults within the population;
- a rise in the number of people living with long-term conditions and acute exacerbations of these conditions;
- an increase in short-stay admissions; and
- an increase in emergency re-admissions (see section 10).

The evidence base for improving urgent and emergency care in England sets out to review the evidence in different service areas, ranging across patients’ perceived levels of need, in terms of a patient’s level of anxiety or perception of the seriousness of their complaint. These are as follows:

- Self care and self management;
- Telephone care;
- Face to face care;
- 999 emergency services;
- A&E departments; and
- Emergency admissions to hospital.
4. Patient experience

In 2012, NHS England set out its aims to deliver a patient-centred, customer-focused NHS. The Government’s mandate to NHS England for 2013-2015 states that the quality of care is as important as quality of treatment, but the public are less confident about consistency of care provision than they are about treatment. In urgent and emergency care, quality of care can significantly impact the way patients choose to access services, with many choosing not to use the services most appropriate to their needs. This causes duplication and a poorer experience for many patients.

Patient experience is difficult to capture for this type of healthcare. For example, 22 per cent of patients in A&E departments are under 16 years and 20 per cent are over 65 years. Many patients cannot communicate easily, are in pain or experience fear or stress, and have different expectations of care from those in less acute settings. While it is possible to implement systems to measure patient experience in groups such as children using urgent and emergency care services, a review of survey a review of national surveys within the NHS found that the voice of under-16 year olds is not included in most national surveys. In the 2004 Inpatient Surveys, in which they were included, children and young people were significantly less likely to than adults to feel confidence and trust in their doctors or that they were treated with dignity.

Patient experience of general practice

The NHS and Social Care Services Surveys show that overall satisfaction with GP services has traditionally been high (although it has declined slightly from a high of 80 per cent in 2009 to 74 per cent in 2012). However the 2011-12 GP patient survey shows that there was significant variation between GP services and across different geographic areas. Practices in London and those located in more deprived areas were much more likely to under-perform on both clinical outcome measures and patient experience.

A recent study of patients accessing their GPs over the telephone found that the two factors most likely to affect patient experience were speed of access and continuity of care. In the study of 1,328 patients across 15 practices, patients who said they were ‘very unsatisfied’ waited an average of 129 minutes to speak to a GP, whilst those who were ‘very satisfied’ waited an average of 46 minutes. Of those who were very unsatisfied, only 38 per cent spoke to their usual GP whereas, of those who were very satisfied, 73 per cent spoke to their usual GP.

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49 RCPCH and Picker Institute (2012) Patient Reported Experience Measure (PREM) for urgent and emergency care, Royal College of Paediatric and Child Health and the Picker Institute
50 Hargreaves, D. and Viner, R. M. “Children’s and young people’s experience of the National Health Service in England: a review of national surveys 2001-2011” Archives of Disease in Childhood 2011: 10.1136
51 The King’s Fund (2012) Satisfaction with NHS and social care services – results; the King’s Fund, London UK
52 The King’s Fund (2012) Data briefing: improving GP services in England: exploring the association between quality of care and experience of patients; King’s Fund, London UK
GP. Most of the time, patients report good access to their GP, but there are variations in access between practices and across geographic areas\(^{54}\).

A 2012 King’s Fund study found that patient satisfaction with access to general practice consistently showed a strong association with clinical quality. Evidence suggests that patient experience of GP services, particularly when related to ease of access, affects uptake and interaction with primary care. This affects the way in which patients choose to access health care because patients that are not satisfied with their GP practice are more likely to:

- resort to using urgent and emergency care services for primary care needs; or
- only seek help when they become acutely ill, increasing the risk of emergency admission\(^{55}\).

Analyses of GP patient survey data have found a correlation between the ability of patients to access their GP quickly and overall satisfaction with their GP surgery. There is also an inverse correlation between these variables and how frequently a patient is likely to use A&E services (figure 4).

**Figure 4: the relationship between A&E attendances and results from the 2011-12 GP Patient Survey (GPPS)**

![Graph showing the relationship between A&E attendances and patient satisfaction](source.png)

Source: Health and Social Care Information Centre

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\(^{54}\) Goodwin et al (2011) Improving the quality of care in general practice: Report of an independent inquiry commissioned by The King’s Fund; The King’s Fund, London

\(^{55}\) The King’s Fund (2012) Data briefing: improving GP services in England: exploring the association between quality of care and experience of patients; King’s Fund, London UK
There is insufficient evidence to demonstrate a causal link between these factors. However, a recent analysis concluded that a patient’s experience of GP services, particularly regarding ease of access, is likely to be a factor in the way patients interact with other areas of healthcare. Variables such as levels of deprivation, proximity to A&E services and numbers of patients with long-term conditions, will also influence the proportion of patients accessing A&E services. Analyses of A&E attendances and levels of multiple deprivation statistics show that patients living in areas with high levels of deprivation are more likely to use A&E services.

Key message
There is significant variation in patient experience between GP practices. Data shows that some patients who have a good experience of their GP are less likely to use A&E departments.

Patient experience of telephone services
The NHS Direct telephone number provided the public with access to healthcare advice over the telephone and, if necessary, directed them to the NHS service most appropriate to their health needs. Public satisfaction with this service in 2012 was high: 90 per cent of those using the telephone service said they were satisfied with the way the call was handled, and 90 per cent followed the advice the service gave them. However, a major criticism of the NHS Direct number was the length of time patients could wait to be called back for medical advice or referral. A report by the National Audit Office also concluded that advice given by NHS Direct staff could vary under similar circumstances and generally call handlers erred on the side of caution. Although many patients were advised to self-care when they would have otherwise visited their GP, the service did not appear to have an influence on the number of people using urgent and emergency services.

In 2013, the NHS Direct telephone number was replaced by NHS 111. The objective of the new service is to transform the delivery of urgent and emergency care by directing patients to the “right service, first time”, with clinical assessment and referral taking place within the same phone call. The service also encourages different providers of urgent and emergency care to come together to consider the way in which the current system works and furthermore, tackle any deficits. It is envisaged that NHS 111 will use fewer clinicians to the previous NHS Direct telephone number, with the majority of call handlers relying on the support of NHS Pathways – an electronic clinical assessment system which enables callers to any service to have their clinical need assessed by the call handler they speak to, and then be referred directly to the most appropriate provider in their local area. NHS Pathways has developed a shared NHS view on how to manage risk for issues that initially present on the phone. This has been achieved through extensive piloting and constant review from an independent National Clinical Governance Group chaired by the Royal College of General Practitioners and including

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56 The King’s Fund (2012) Data briefing: improving GP services in England: exploring the association between quality of care and experience of patients; King’s Fund, London UK
57 Department of Health A&E statistics comparison with Office of National Statistics data on levels of multiple deprivation.
58 NHS Direct (2012) NHS Direct facts and figures
61 Ibid
representatives from the College of Emergency Medicine, the British Medical Association and other organisations involved in the delivery of urgent and emergency care.

An evaluation of three pilot sites in 2012 found that patient satisfaction with the NHS 111 service was very high, but using the service did not improve overall patient experience, or reduce the use of other urgent and emergency care services\textsuperscript{63}. Additionally some concerns were raised by a number of NHS 111 providers, particularly in those areas that went ‘live’ in March 2013 when some patients experienced long delays before they were advised or referred, due to operational failures to provide adequate staffing for the service and call volumes\textsuperscript{64}.

\textbf{Key message}

Patient experience of both the NHS Direct telephone service and pilots of NHS 111 has been found positive; however transition from nurse-led triage to calls answered by trained advisors, supported by experienced clinicians has led to some incidences of poor patient experience during the early implementation of NHS 111.

\textbf{Fragmentation of urgent care services}

Urgent care services are highly fragmented and difficult to navigate causing many patients to experience difficulty choosing the service most appropriate to their needs\textsuperscript{65,66,67}. Variations in opening hours, clinical expertise, access to diagnostics and nomenclature can lead to confusion and referrals to a number of urgent care services within the same episode of care. This increases cost, delay and clinical risk and leads to poor patient experience\textsuperscript{68}. The Primary Care Foundation’s review of urgent care in 2011 found that\textsuperscript{69}:

- There was significant variation in the case mix that urgent care centres provide for, with some seeing minor illnesses only, some minor injuries only and some seeing both. In some services this could depend on whether or not the right member of staff happened to be working at that time or not;
- There were no standard operating hours for urgent care centres: with, for example, some open 24/7, some only open on weekday daytimes and some only open out-of-hours; and
- An increasing number were situated in or close to the acute hospital, but many others remain distant, which made streaming of patients attending A&E departments much more difficult.

The lack of standardisation and inconsistent terminology of service names leads to fundamental misconceptions amongst patients regarding the types of services offered by urgent care, resulting in widespread patient confusion\textsuperscript{70} and frustration with selecting these services. Furthermore, this can lead to patients accessing a higher acuity service.

\textsuperscript{63} Turner, J et al (2012) Evaluation of NHS 111 pilot sites; University of Sheffield
\textsuperscript{64} BMA (2013) GPs implore government to delay NHS 111; British Medical Association, 28 March 2013
\textsuperscript{65} The King’s Fund (2011) Managing urgent activity – urgent care
\textsuperscript{67} Primary Care Foundation (2011). Breaking the mould without breaking the system. Primary Care Foundation.
\textsuperscript{68} Primary Care Foundation (2011). Breaking the mould without breaking the system. Primary Care Foundation.
\textsuperscript{69} Primary Care Foundation (2011). Breaking the mould without breaking the system. Primary Care Foundation.
Key message
The wide range of urgent care services available and lack of standardisation of services and labelling results in patient confusion over how to access the right healthcare quickly; this leads to duplication, delay, increased clinical risk and poor patient experience.

In 2012, NHS England made ‘listening to patients’ one of the key principles behind planning clinically-led commissioning. Capturing feedback regularly, consistently and accurately then acting on that information to improve patient experience is expected of all NHS services. The clinical quality indicators, introduced as part of the Operating Framework for the NHS in England 2011/2012, require A&E departments to assess the experience of patients and describe improvements made to the service as a result. This helps provide A&E departments with the tools and intelligence required to sustain high quality patient experience. However there is currently no equivalent requirement for urgent care centres, minor injury units, walk-in centres or GP out-of-hours services. This means that these services lack consistency and regularity in their arrangements for capturing patient feedback. In a 2012 study, the Primary Care Foundation found that, in some cases, there had been a long gap since the last survey had been conducted; in others, the questions had been changed so that it was impossible to compare results to find out whether recent changes had improved the experience of patients.

The absence of a consistent mechanism for feedback means that it is difficult to assess the standard of patient experience across all urgent and emergency care services. It also means that many urgent care centres may not understand where they are falling short of patient expectations.

Key message
There are variations in the way patient experience is monitored and acted upon in urgent care and this falls short of what is achieved in other parts of the NHS.

Patient experience of ‘999’ emergency services
Patient experiences of ‘999’ emergency services are consistently positive and patients have a high level of trust and confidence in ambulance staff who attend to them. A 2008 Care Quality Commission (CQC) survey of category C patients (those with ‘non urgent or life-threatening conditions’) calling ‘999’ found that experiences of using the service were overwhelmingly positive, with 98 per cent of patients rating the service as good or better. This compares with 74 per cent patient satisfaction with GPs and 61 per cent satisfaction with NHS services overall. The differences in patient experience found in the survey may go some way to explaining why many people with non-urgent or life-threatening conditions seek help from ‘999’ emergency services.

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72 Primary Care Foundation (2012) Urgent care: what works best – review of urgent care centres; a discussion paper form the Primary Care Foundation
74 Primary Care Foundation (2012) Urgent care: what works best – review of urgent care centres; a discussion paper form the Primary Care Foundation
75 Primary Care Foundation (2012) Urgent care: what works best – review of urgent care centres; a discussion paper form the Primary Care Foundation
76 CQC (2009) National NHS patient survey programme: Survey of Category C ambulance service users 2008; Care Quality Commission
77 The King’s Fund (2012) Satisfaction with NHS and social care services – results;
A recent qualitative study of patients who use ‘999’ emergency services for primary care needs found that many people used ambulance services because they were not aware of, or confused by the alternative offerings. The 2008 CQC survey found that only 31 per cent of callers considered calling another service, suggesting that there is an inherent over-reliance on ‘999’ emergency services and the public are reluctant to use alternatives.

**Key message**
Consistently positive patient experiences of ambulance services, and confusion surrounding other areas of healthcare, are factors that may have contributed to an increased use of the emergency (999) number and ambulance services by patients with non-urgent healthcare needs.

**Patient satisfaction in A&E departments**
Accident and Emergency departments are understood and trusted by the public; they provide 24/7 access to anyone using the service. However, the 2012 national NHS patient survey for A&E departments indicated that overall patient satisfaction with A&E services had decreased slightly over the last decade.

**Figure 5: Patient satisfaction with A&E departments**

Source: National NHS Patient Survey Programme: Accident and Emergency Department Survey 2012

Most of the overall downward trend is a result of a marked decrease in patient satisfaction with access and waiting. In 2012/13, thirty-three per cent of respondents said they waited more

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79 CQC (2009) National NHS patient survey programme: Survey of Category C ambulance service users 2008; Care Quality Commission
than half an hour before they were first seen by a doctor or nurse – up from 24 per cent in 2004 and 29 per cent in 2008. This is despite the number of patients waiting more than four hours from the time of arrival to admission or discharge falling dramatically over that period. Fifty-nine per cent of patients in 2012/13 said they had not been told how long they would have to wait to be treated – an increase of six per cent since 2008.

Recent data shows that the number of patients waiting more than four hours from the time of arrival at an A&E department to admission or discharge increased from 1.73 per cent to 4.1 per cent between 2009/10 and 2012/13. In addition to sick or anxious patients’ negative experience of long waits for treatment or discharge, overcrowding is thought to be a key factor affecting patient experience in A&E departments because it leads to delayed treatment, impediment of pain management and poorer clinical outcomes (see section 8.3). The 2012 national NHS patient survey for A&E departments found that 17 per cent of patients thought hospital staff did not do everything they could to help them control their pain, which was a rise of four per cent from 2008. There were also variations between A&E providers in terms of overall patient experience. Findings highlighted that 30 trusts performed consistently above average. Foundation Trust and Teaching Hospital status and proportion of white inpatients were positively associated with performance. Six trusts in England were below average on each domain and these were located in London and were not foundation trusts. They were also found to have the highest deprivation scores and the lowest percentage of white inpatients.

**Key message**
A&E performance (operational and clinical), and therefore patient experience, varies significantly between trusts, with a few performing far worse than the rest. Additionally, there are signs that overcrowding of A&E departments is causing a deterioration of performance and impacting negatively on patient experience.

**Meeting patients’ expectations in hospital**
Patients want the highest standard of care and their experience can be enhanced by consultant involvement – their stay in hospital may be shortened and their clinical outcome improved. Studies have also found that patient experience is a good indicator for the quality of services and it is therefore becoming an increasingly important measure of the quality of hospital care.

A recent study of patient ratings of all NHS acute hospital trusts, submitted on NHS Choices, found that hospitals with better patient ratings tend to have lower mortality rates and lower re-admission rates. Findings showed that the top quartile of hospitals compared to the bottom quartile had five percent lower mortality rates and 11 percent lower re-admission rates.

81 Department of Health weekly A&E SitReps 2003/04 – 2012/13
82 Collins et al (2010) Adverse effects of overcrowding on patient experience and care; Emergency Nurse; Volume 18, no 8, pp34-39
84 Raleigh et al, An analysis of patient experience across acute care surveys in English NHS Trusts, 2012
It is recognised that patient experience is a far from perfect indicator but findings do certainly show a general trend that where patients rate a hospital highly the clinical quality of hospital care is also good.

5. Self-care and self-management

Self-care for minor ailments and self-management of long-term conditions play a crucial role in influencing the level of demand for urgent and emergency care. It is thought that about 80 per cent of health problems are treated or managed at home, without resorting to the use of NHS services. Because the number of minor ailments and long-term conditions dealt with through self-care and self-management is very large, minor changes in behaviour have significant potential to affect demand for formal health care, including urgent and emergency services. Improving access and encouraging the use of support for self-care of minor ailments could help to free capacity in primary care and prevent unnecessary use of urgent and emergency care services. The treatment of minor ailments within primary care accounts for about 20 per cent of total available GP workload and is estimated to cost the NHS about £2bn.

There has been rapid growth in the use of online health tools over the last ten years and there is an increasingly wide variety of options available to patients. Recent estimates have found, for instance, that there are over 40,000 medical applications available for download on tablets and smartphones and so far the market is unregulated for both doctors and patients. A study into NHS Direct’s online symptom checker found that most users were young (71 per cent under 45 years old) and most were female (67 per cent) which indicates wide use for this cohort of patients. Although, approximately 44 per cent of users sought consultation with a health professional after using the NHS Direct website symptom checker and most of those who did not, fell into the younger age group categories.

Evidence suggests that if more members of the public are supported to undertake self-care and self-management, fewer patients will access unscheduled care within the same episode of care. There is, however, some inconsistency in the level to which health professionals are thought to recommend and support self-care and self-management and it is suggested that many people do not have the necessary confidence, or health literacy, to treat or manage their condition themselves.

89 Self Help Forum (2013) Self Care: the story so far
90 Bower, C (2012) Will medical apps be to healthcare what ATMs are to banking?: British medical journal online: http://blogs.bmj.com/bmj-journals-development-blog/2012/08/02/will-medical-apps-be-to-healthcare-what-atms-are-to-banking/
91 Powell et al (2011) The Characteristics and Motivations of Online Health Information Seekers: Cross-Sectional Survey and Qualitative Interview Study; Journal of Medical Internet Research; no. 13(1)
95 Department of Heath (2007) Self Care: A National View in 2007 Compared to 2004-05; Department of Health
The extent to which a patient is actively involved in their own care is strongly linked to health outcomes. Research shows that, by supporting self-care, the NHS can improve health outcomes and increase patient satisfaction. However, self-care requires the ability to:

- assess one’s own health care needs;
- acquire an understanding of the options available; and
- select and access the most appropriate option.

Previous research has demonstrated that some people with minor ailments abandon self-care earlier than they need to, and depend too highly on support from formal healthcare services because they do not have the confidence or knowledge necessary.

It is possible for patients to be educated to manage their own condition, reducing the likelihood of future exacerbations and hospital admission, through contact with the NHS. Although there is limited evidence to demonstrate that this is cost-effective across the health economy, self-management programmes have been shown to improve patient experience, adherence to treatment and medication and reduce emergency admissions to hospital. Approximately 80 to 90 per cent of patients with long-term conditions, as well as their carers, can be supported to actively manage their own health. Some people with long-term conditions consistently say that they want more access to information and support to help them understand and manage their condition. This suggests that there is significant scope for the NHS to improve health literacy and help people manage and prevent their own illness and injury through improved self-care and self-management. However, analyses of self-management courses have found that their impact is also somewhat limited because they are dominated by the most affluent and educated patient groups with long-term conditions, who already consider themselves to be effective self-managers. The vast majority of patients with long-term conditions are not aware of self-care and self-management support options and there is sometimes a lack of awareness surrounding how to access the necessary resources.

Key message
Self-care for minor ailments and self-management of long-term conditions are effective at improving quality of life and reducing dependency on urgent and emergency care services; however there is a lack of awareness surrounding how to access self help and the demographic groups most likely to benefit are least likely to be aware.

There are a number of well established self-management programmes designed to give patients better access to the necessary tools and information to manage long-term conditions.

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97 Self Help Forum (2013) Self Care: the story so far
98 Imison et al (2011) Transforming our health care system: Ten priorities for commissioners; The King’s Fund, London UK
100 Department of Heath (2012) Long Term Conditions Compendium of Information - Third Edition; Department of Health guidance
101 Department of Heath (2005) Self Care – A Real Choice: Self Care Support – A Practical Option; Department of Health
102 RCGP (2012) Making integrated out of hospital care a reality; Royal College of General Practitioner and NHS Confederation
105 Department of Heath (2007) Self Care: A National View in 2007 Compared to 2004-05; Department of Health
effectively. For example, the Expert Patient Programme (EPP) consists of courses aimed at educating patients and enabling them to take control of and manage their long-term conditions\textsuperscript{106}. The Department of Health found that courses can be effective at improving patient outcomes and also reducing their subsequent utilisation of formal health services, with a seven per cent decrease in GP consultations and a 16 per cent reduction in A&E attendances\textsuperscript{107}. However self-management programmes based on the EPP model are normally aimed directly at patients and can struggle to recruit sufficient numbers to have widespread impact. This is because they are limited by the numbers of patients able or willing to access and engage with them\textsuperscript{108,109,110}.

Peer support groups offer a forum for patients with long-term conditions, where a communication exchange can take place and where more experienced patients can offer advice on the choices and journey a new patient may take\textsuperscript{111}. Although peer support groups are widespread, and are thought to be very effective, research into their impact on the wider health economy is limited\textsuperscript{112}. Health coaching, where a patient is supported by a health worker to help them achieve their personal goals, is shown to reduce patient’s use of acute services, with a number of studies also demonstrating that the approach can also offer value for money\textsuperscript{113}.

There have been attempts to embed self-management support into primary care due to GPs’ knowledge of the needs of their patients. Continuity of care means that self-management support can take place over a long period of time and be delivered according to the need of the individual. However, competing clinical priorities and limited time, can sometimes mean that self-management support is difficult to achieve within the current primary care framework\textsuperscript{114}. Despite the range of programmes available, the provision of self-management support is variable. For example, only 43 per cent of people in England who had a heart attack, bypass surgery, or an angioplasty took part in cardiac rehabilitation, despite evidence that this can reduce mortality and improve quality of care\textsuperscript{115}. Additionally, less than 50 per cent of people with diabetes were given the opportunity to discuss their own goals for self-management\textsuperscript{116,117}.


\textsuperscript{107} Phillips et al (2010) Self care reduces costs and improves health - the evidence


\textsuperscript{111} NHS Kidney Care (2013) You’re not alone: Peer support for people with long term conditions

\textsuperscript{112} Greenhalgh, T (2009) Chronic illness: beyond the expert patient; BMJ, Volume 338, pp629-631

\textsuperscript{113} Huffman MH. Health coaching: a fresh approach for improving health outcomes and reducing costs. AAOHN J 2010;58(6):245-250

\textsuperscript{114} Kennedy, A (2013) Implementation of self management support for long term conditions in routine primary care settings: cluster randomised controlled trial; BMJ, Volume 346

\textsuperscript{115} Richmond Group (2012) From vision to action: Making patient-centred care a reality; The King’s Fund, London

\textsuperscript{116} Richmond Group (2012) From vision to action: Making patient-centred care a reality; The King’s Fund, London

\textsuperscript{117} Royal College of General Practitioners (2011) Care Planning: Improving the Lives of People with Long Term Conditions; Royal College of General Practitioners: Clinical Innovation and Research Centre
Key message
There are a range of programmes available to support self-management of long-term conditions but provision and uptake of these is variable across the NHS.

The effect of the growing frail elderly population and increasing morbidity necessitates a change in focus in healthcare from treatment of episodic periods of illness towards management of long-term conditions. The Department of Health estimates there to be around 15 million people in England with at least one long-term condition and this is set to rise by a further 23 per cent over the next 25 years. Good self-management is proven to be an effective way of reducing A&E attendances and emergency admissions to hospital amongst people with long-term conditions.

Evidence suggests that care planning can improve a patient’s ability to self-manage and reduce emergency admissions to hospital for patients with long-term conditions that are prone to rapid deterioration. A care plan enables identification of the issues related to a patient’s condition and helps them develop ways to self-care; improving their quality of life and reducing the likelihood of their condition deteriorating. However patient survey data found that only about 12 per cent of patients with long-term conditions report that they had been told they had a care plan. A recent qualitative study of patients with long-term conditions found that patients generally received some elements of care planning but a structured, comprehensive process was not evident. In the ten years from 2001 to 2011 the number of emergency admissions to hospital for conditions that could be successfully managed in primary care in England increased by an estimated 40 per cent. They now account for approximately one in every six emergency admissions to hospital in England and cost around £1.42bn a year.

Key message
Variable management of long-term conditions in primary care may have contributed to a rise in the number of emergency admissions to hospital.

It is estimated that approximately 18 per cent (or 51 million) GP consultations per year concern minor ailments alone, which could largely have been dealt with through self-care with support

118 The King’s Fund (2011) The evolving role and nature of general practice in England
119 Department of Heath (2013) Long Term Conditions; Department of Health
120 Jacobs, S () Expert Patients Programme: A community interest company; NHS Trusts Association
121 Royal College of General Practitioners (2011) Care Planning: Improving the Lives of People with Long Term Conditions; Royal College of General Practitioners: Clinical Innovation and Research Centre
126 Ham et al (2012) Transforming the delivery of health and social care: the case for fundamental change; King’s Fund
127 Burt et al (2012) Prevalence and benefits of care plans and care planning for people with long-term conditions in England; Journal of health services research and policy; January 2012 vol. 17 no. suppl 1 64-71
130 Imison et al (2011) Transforming our health care system: Ten priorities for commissioners; The King’s Fund, London UK
131 The King’s Fund (2012) Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions
from community pharmacy services\textsuperscript{132}. These services can also be an important source of advice and support for patients managing long-term conditions. With approximately 10,500 community pharmacies across England, the widespread availability of services means they are usually easy to access, with 99 per cent of people in England able to get to their local pharmacy within 20 minutes by car and 96 per cent by walking or using public transport\textsuperscript{133}. Many community pharmacies have long opening hours, which means they can provide a source of medical advice or treatment for some patients when their GP surgery is closed, potentially reducing the need for them to use out-of-hours GP services\textsuperscript{134}. The traditional role of community pharmacies is to support patients in the safe use of over-the-counter and prescription medicines. More recently this role has expanded significantly to include: providing advice and treatment for common minor ailments, promoting healthier lifestyles, and supporting people with long-term health conditions\textsuperscript{135,136}. Increasingly, pharmacies are being encouraged to provide enhanced services designed to reduce the need for GP and urgent care services. Eighty-five per cent of pharmacies have a consultation room, which enables pharmacists to provide services traditionally delivered by GPs. These include:

- Minor Ailment Schemes, where pharmacists provide consultations for patients with common minor ailments; and
- The New Medicine Service, where a pharmacist supports patients with selected chronic conditions using new medicines.

Small-scale evaluations of minor ailment schemes have found that treatment of common conditions in a pharmacy setting can be cost effective and can release healthcare resources, particularly GP appointments\textsuperscript{137}. However, studies have found that a lack of awareness and public trust in the range of services provided by community pharmacists poses a barrier to increased uptake of the services. A 2010 survey found that only 23 per cent of pharmacy users considered pharmacies to be the best place from which to seek general health advice, with patients preferring to consult their GP\textsuperscript{138}. Research suggests that pharmacists still spend the majority of their time involved in activities associated with dispensing medicine and are less confident when it comes to providing other areas of healthcare\textsuperscript{139}.

\textbf{Key message}

Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions; however there is little public awareness of the range of services provided by pharmacists.

\textsuperscript{132} PAGB (2010) PAGB annual review: the campaign for real self-care; Proprietary Association of Great Britain
\textsuperscript{133} Fernandes, A (2011) Guidance for commissioning integrated urgent and emergency care: a ‘whole system’ approach
\textsuperscript{134} Pharmaceutical Services Negotiating Committee (2013)
\textsuperscript{136} Krska et al (2010) Views of the general public on the role of pharmacy in public health; Journal of pharmaceutical health services research; volume 1, issue 1, pp 33-38, March 2010
\textsuperscript{138} Krska et al (2010) Views of the general public on the role of pharmacy in public health;
6. Telephone consultations

When patients are unable to manage their condition through self-care or self-management, the quickest way to access urgent and emergency care is usually through a telephone call. Telephone services can help patients access healthcare quickly, enabling them to obtain reliable clinical advice and provide reassurance to reduce worry. Under the current system there are a number of different numbers available for patients to use including:

- 999 (see section 8);
- NHS Direct;
- NHS 111; and
- GP in-hours and out-of-hours services.

6.1 NHS Direct and NHS 111

NHS Direct was introduced in 1997 in order to provide “easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families”, and in the hope that the new service would also reduce or limit the demand on other areas of the NHS. Since the development of NHS Direct, the range of urgent and emergency care services available has increased the complexity of decision-making for patients. This has precipitated a number of policy initiatives highlighting the need for a single point of access to urgent and emergency care.

2013 brings the national implementation of NHS 111, replacing NHS Direct along with the telephone triage elements of other urgent and emergency care services such as GP out-of-hours services. NHS 111 uses a clinical triage system to assess symptoms for severity and, where appropriate, can give healthcare advice and support over the phone. Where this is not possible, NHS 111 utilises a directory of services to direct patients to the most appropriate NHS service.

Triage over the telephone can be very accurate in some cases however, sometimes it can be inaccurate, and can lead to more patients receiving the wrong care in the wrong place and duplication within the system because there is a lack of visual or other clues. Additionally, triage services are not always aware of the alternatives to A&E services. Telephone triage is dependent on a clinical triage system and may be more likely to be risk averse and direct patients to a higher acuity of care than necessary. There is less incidence of over-triage in Australia and North America where clinical input is offered early on in the process.

**Key message**

Telephone advice can prevent many unnecessary attendances at NHS facilities. However it is sometimes difficult to accurately triage patients over the phone and, without clinical input, call handlers may sometimes over-triage if they cannot rule out a serious condition.

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141 Turner et al (2012) Evaluation of NHS 111 pilot sites; The University of Sheffield
142 Department of Heath (2001), Raising Standards for Patients
143 Department of Heath (2001) Reforming Emergency Care
144 Department of Health (2005) Taking Healthcare to the patient
6.2 GP consultations and out-of-hours services

Telephone consultations have been used increasingly over the last few years in order to improve patient access to healthcare and optimise clinical time. Recent years have seen the proportion of GP consultations conducted over the telephone rise from three per cent in 1995 to 11 per cent in 2007.\(^{145,146}\) The move to telephone consultations has been driven by increased demand for healthcare and pressure on GPs to provide more flexible, faster access and out-of-hours services.\(^{147}\) Telephone consultations are conducted both in and out-of-hours.

Although there is some evidence to suggest that easier access to clinical advice through telephone consultations may also perpetuate a culture of seeking help for minor conditions,\(^{148}\) telephone consultations are particularly effective at providing fast, convenient and cost-effective follow-up care and helping patients to manage chronic or long-term conditions.\(^{149}\)

A 2009 study found that telephone consultations for patients seeking advice during normal working hours took, on average, half the time of face-to-face consultations (4.6 minutes compared to 9.7 minutes) and patient satisfaction appeared to differ little between consultation types.\(^{150}\) Some studies of GP out-of-hours services have shown that the elderly usually prefer face-to-face contact with a familiar doctor.\(^{151,152}\) There are also some risks that may arise from the lack of visual clues and medical history being available to clinicians, particularly for patients with urgent and life-threatening conditions.\(^{153,154}\) However, telephone consultations are popular with many patients. Additionally, telehealth devices for monitoring patients with long-term conditions have been found to be effective at reducing hospital admissions (by around 20 per cent), and effective at reducing mortality rates but not necessarily effective at reducing health costs – which were found to be equivocal.\(^{155}\)

Proven and tested systems exist in England, where telephone consultations are used routinely in general practice, whilst other developed systems include telephone assessment of all patients prior to attending the practice. The ‘Doctor First’ model is used in some practices across England and encourages an effective use of clinical time. The system enables all patients to have their first doctor contact over the telephone, which can result in either advice, referral to another care provider or being given an appointment to visit; the system has effectively freed up capacity, with up to 80 per cent of patients, being able to see a doctor on the same day as their telephone call. The ‘Doctor First’ model has demonstrated a cost saving of approximately £100k per practice through prevention of avoidable attendance and

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145 Campbell et al (2013) The effectiveness and cost-effectiveness of telephone triage of patients requesting same day consultations in general practice: study protocol for a cluster randomised controlled trial comparing nurse-led and GP-led management systems (ESTEEM); Trials volume 14
147 Patient.co.uk (2009) Telephone Consultations
152 Foster et al (2001) A qualitative study of older people’s views of out-of-hours services; British Journal of General Practice; 2001 September; 51(470); 719–723
admissions to hospital and a time saving of between five and ten hours per week\textsuperscript{156,157}. Additionally, a recent analysis of the GP patient survey, A&E attendance data and deprivation found that GP practices using systematic telephone consultations, such as the ‘Doctor First’ model, are associated with a 20 per cent lower A&E usage, irrespective of deprivation\textsuperscript{158}.

Telephone consultations require fewer resources and are a useful tool for the GP and patient. However, a recent qualitative study of out-of-hours care found that some patients often seek more information and help for their condition from other health services prior to a telephone consultation or immediately after, using the second interaction as a conformation of what has been discussed with them. This results in duplication within the system\textsuperscript{159}.

**Key message**

Telephone consultations are becoming increasingly popular, are less resource-heavy for general practice than face-to-face consultations and their systematic use is linked to reduced use of A&E departments. However some patients lack confidence in telephone advice and are sometimes more likely to pursue a second opinion inappropriately, leading to duplication of service provision, in some cases.

\textsuperscript{156} Dr Stephen Clay & Harry Longman. Transformation of Urgent Care: How evidence based GP Practice is Reducing Emergency Admissions

\textsuperscript{157} Productive Primary Care – Doctor First. http://www.productiveprimarycare.co.uk/doctor-first.aspx


7. **Face-to-face care**

There are many different routes that a patient can follow if they are seeking a face-to-face consultation, which over the last decade have included a large increase in nurse-led consultations. These include:

- Booking a GP appointment at the patient’s own practice;
- Attending a walk in centre, where the patient does not have to be registered (these have a range of nomenclature including: urgent care centres, minor injury units, or 8-8 centres); and
- Attending an A&E department.

In many cases patients prefer to see their own GP but default to the other options if they are not confident of an urgent appointment at a time convenient to them.

These multiple access points can cause confusion among patients over where they should seek help from and when, and it is common for the first point of contact to refer on to another. This often leads to duplication and added costs.

7.1 **Access to primary care**

General practice consultation activity levels have been steadily increasing over the last 10 years. Research has shown that the average patient has increased their number of GP consultations from 3.9 consultations per year in 1995 to 5.5 consultations in 2008.

There are important variations in access to GP services across England; the King’s Fund study into inequalities in GP access and improving care highlights that the availability of general practitioners is inequitable, ranging from fewer than 50 to more than 80 per 100,000 population. The study demonstrated that in rural areas, access was far more limited than it was in high population and urban areas, but also concluded that GPs in rural areas treated more patients wholly within the practice. Rural patients were less likely to attend an A&E department or an urgent care centre: this was likely to be due to reduced access to these services. Evidence suggests that in primary care, a higher continuity of care with a GP is associated with lower risk of admission. The report also highlighted demographic pressures, such as an ageing population which will impact on this further.

The GP Patient Survey: January – September 2012 highlighted that only one in five patients were able to get an appointment on the same day and around one in eight said they were not able to book ahead for their appointment, with the same amount saying they could not see their preferred clinician. Whilst most of these people accepted an alternative time, date or clinician, the survey showed that a small minority decided to go elsewhere for their treatment – nine per cent visited an A&E department, four per cent had a consultation over the phone and three per cent went to a pharmacist. Because of the volume of patients using GP surgeries

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160 RCGP, RCN, RCPCH & CEM (2012) Right care, right place, first time?: JOINT STATEMENT by the Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN), Royal College of Paediatrics and Child Health (RCPCH) and the College of Emergency Medicine (CEM) on the urgent & emergency care of children and young people

161 Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the Q Research database; The Information Centre, 2009

162 Purdy, S, Avoiding hospital admissions, 2010
daily, even a small proportion of patients choosing to go elsewhere can have a large impact on other urgent and emergency care services.

Furthermore, England’s urban areas contain increasingly transient populations, including migrants from other countries\textsuperscript{163}. These populations will include people who do not have a registered GP and who may not have any knowledge or experience of using the NHS. There are also large numbers of vulnerable and often inaccessible groups including drug and alcohol users and people with mental health problems\textsuperscript{164}. Unfortunately, many of the areas with this population mix are under-doctored, which creates further potential for these patients to access an A&E department as their first point of contact\textsuperscript{165}.

**Key message**

Urgent access to GP appointments across England is variable. Additionally, in urban areas where demand is high and transient populations exist, many may use an A&E department as their first point of urgent and emergency care.

Management of patients with long-term conditions in primary care plays a key role in preventing acute episodes of illness and resultant A&E attendances and emergency admissions to hospital. Evidence suggests that there is variation in the management of this cohort of patients within primary care services\textsuperscript{166}. This is illustrated by recent studies, which found:

- A fivefold variation among PCTs in emergency admissions to hospital rates for asthma patients aged under 18 years old\textsuperscript{167};
- Fifty-one per cent of people with type 2 diabetes and only 32 per cent of people with type 1 diabetes received the appropriate care according to NICE guidelines\textsuperscript{168}; and
- Significant variation in the ability of GPs to identify dementia early, preventing patients from being able to access help and support\textsuperscript{169}.

More than four million people in England with a long-term physical health condition also have a mental health problem, and many of them experience significantly poorer health outcomes and reduced quality of life as a result\textsuperscript{170}. For example an estimated three-quarters of people with depression or crippling anxiety disorders do not receive treatment in primary care\textsuperscript{171}. Although there has been major progress in providing evidence based treatments for depression (one of the most common conditions in primary care in the past few years) only 15 per cent of patients can access this care\textsuperscript{172}. Patients with a co-morbid mental health condition are likely to have poorer levels of self-care and experience exacerbations, resulting in increased use of urgent

\textsuperscript{163} Primary Care Foundation (2010). Primary Care and Emergency Departments. Primary Care Foundation.
\textsuperscript{164} Ibid.
\textsuperscript{165} Ibid.
\textsuperscript{166} Alshamsan, R (2010) Impact of pay for performance on inequalities in health care: systematic review; Journal of Health Services Research & Policy
\textsuperscript{153} Goodwin et al (2010) Managing people with long-term conditions; The King’s Fund, London UK
\textsuperscript{168} Ibid
\textsuperscript{169} Ibid
\textsuperscript{171} LSE (2012) How mental illness loses out in the NHS: a report by the Centre for Economic Performance’s Mental Health Policy Group
\textsuperscript{172} LSE (2012) How mental illness loses out in the NHS; a report by the Centre for Economic Performance’s Mental Health Policy Group

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and emergency care services\textsuperscript{173,174}. A 2012 King’s Fund report found that links between mental health professionals and primary care, where most people with mental health problems are supported, have been neglected in many areas\textsuperscript{175}. A report by the Schizophrenia Commission identified that:

- There is a lack of clarity around the role and responsibility of GPs regarding mental health conditions; and
- Primary care practitioners often lack the confidence to support patients with chronic mental health conditions\textsuperscript{176}.

**Key message**

Primary care can struggle to manage some patients with long-term conditions effectively, including those with mental health problems. This may lead to avoidable A&E attendances and emergency admissions to hospital.

Out-of-hours services provide primary care to patients who need to be seen quickly when their GP practice is closed. Since 2004 GP practices have been able to opt out of providing out-of-hours care and responsibility for commissioning these services has been transferred to local commissioning organisations. When this arrangement was introduced, nine out of ten GP practices decided to opt out of providing out-of-hours care, handing over provision to a range of different types of organisations.

These organisations operate independently of local GP (in-hours) services and are often orientated around large walk in centres, where face-to-face care can be provided centrally. The Urgent and Emergency Care Clinical Audit Toolkit states that all GP out-of-hours services are to be routinely monitored\textsuperscript{177}. A 2010 Department of Health study found that most GP out-of-hours services in England were good but standards varied unacceptably\textsuperscript{178}. Primary Care Foundation data supports this, showing large differences between geographic areas (the study compared areas covered by primary care trusts in 2010) in how quickly patients can access face-to-face care through out-of-hours services. In many areas, all emergency patients calling their out-of-hours service are seen face-to-face within one hour; however in at least four areas, the local providers were only able to comply with this standard in 60 per cent of cases\textsuperscript{179}. In an investigation into one out-of-hours provider, which had been delivering a poor standard of care, many of the issues were attributed to the local commissioners’ lack of ability to challenge services and enforce standards of care\textsuperscript{180}.

\begin{itemize}
  \item RCGP (2011) Primary Care Guidance: Treating Depression in people with Coronary Heart Disease (CHD);
  \item The Schizophrenia Commission (2012) The Abandoned Illness;
  \item Royal College of General Practitioners, Royal College of Paediatrics and Child Health and the College of Emergency Medicine (2010) Urgent and Emergency Care Clinical Audit Toolkit
  \item Colin-Thome et al (2010) General Practice Out-of-Hours Services: Project to consider and assess current arrangements; Department of Health
  \item Primary Care Foundation (2011) Out of Hours Services Benchmark
  \item Stern, R (2010) Improving out-of-hours care; GP Commissioning in association with NHS Alliance, article 19th November 2010;
\end{itemize}
Key message
Most out-of-hours services work effectively to deliver a high standard of care to patients who need urgent care when their GP practices are closed. However there are variations in the standard of care provided and commissioners are not always able to hold providers to account.

7.2 Urgent care walk-in services
Urgent care walk-in services were developed to have a ‘see and treat’ approach to less serious yet immediate illness or injury\(^\text{181}\). This approach was set up to address the problems associated with demand management and treatment waiting times in A&E\(^\text{182}\). However, in addition to the numerous names given to facilities providing urgent care there is significant variation in the care offered between them for different conditions and for patients of different age groups, and within services of the same name, across different geographies. This can be in respect of the services provided, clinical staffing, opening hours, protocols or overall quality of care\(^\text{183}\).

Currently, urgent care walk-in services across England range from large integrated care services that encompass a 24/7 urgent care centre, GP services in and out-of-hours, a dentist, a rapid response team and radiology services to a minor injuries unit that has variable access to essential healthcare professionals and diagnostics, and may not be available out-of-hours. These variations are confusing and can be overwhelming to an individual that needs urgent medical attention, causing services to be utilised in a way that may not best suit a patients needs.

The Primary Care Foundation categorised facilities that deliver urgent care into three main types\(^\text{184}\):

- Full case mix urgent care centres co-located with an emergency department
- Full case mix stand alone urgent care centres; and
- Restricted case mix urgent care centres.

This categorisation serves to further highlight the variation in urgent care services but also the different extent to which they rely on healthcare professionals and the public’s ability to access them appropriately in order to be effective in providing urgent care. Urgent care services are highly fragmented and generate confusion among patients\(^\text{185}\). The co-located urgent care centre relies on accurate triage by an ‘in house’ healthcare professional and arguably can provide effective services without the patient even knowing of its existence; whereas the stand alone and restricted case mix centres are entirely dependent on patients and ‘external’ healthcare professionals having knowledge of both their existence and their services. Evidence suggests that walk-in centres are not effective in reducing A&E department attendances except when they are co-located and integrated with A&E departments\(^\text{186}\).

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182 Primary Care Foundation (2010). Primary Care and Emergency Departments. Primary Care Foundation
184 The King’s Fund (2011) Managing urgent activity – urgent care
185 The King’s Fund (2013) Urgent and Emergency Care, A review or NHS South of England
In this respect, information to help patients choose the appropriate service for their medical condition is not easily accessible or available\textsuperscript{187}. This can lead to further complications in terms of patients not being seen by the appropriately skilled group that is most likely to be able to treat their condition safely because the patient may have made the wrong choice of service\textsuperscript{188}. A study found that an A&E department with a co-located urgent care service had a number of signs for urgent and emergency care but did not state or have assistance to explain what each of the services delivered\textsuperscript{189}.

The combined effect of the vast nomenclature of urgent care services, the diversity and variation of services provided at these facilities and a lack of information makes it difficult for patients to navigate to the right service for their urgent care need. Conversely, most people know that an A&E department will be open 24/7 and when faced with uncertainty about the service options available or their level of need, they know that A&E will provide a definitive point of care.

**Key message**

The fragmentation and diverse nomenclature of urgent care services across England causes confusion amongst patients and healthcare professionals in terms of services offered. This can lead to patients presenting at services that may not best suit their needs.

The variation in quality of care delivered within urgent care services can also influence where patients choose to attend when they require urgent care. Variation exists in the way clinical protocols are adhered to, and advice given to the patient. Nationally, there is no protocol or policy that exists for staff in urgent care services to follow-up patients that have used the service. This lack of follow-up care can lead to patients presenting to an A&E department due to a lack of sufficient information or the medical problem recurring. This can result in a duplication of resources by both urgent and emergency care services; inefficiency and reinforcing the patient perception that A&E departments are where definitive treatment will be given.

Variation also exists in access to different urgent care services. A review of urgent care centres\textsuperscript{190} found variation in acceptance criteria for treatment. Some services allowed patients to walk in, others only following streaming via the A&E department; some treated all routine cases within their ability, others treated only the urgent need and referred patients back to their GP. Evidence has demonstrated that a number of patients from vulnerable groups in the community are more likely to use A&E departments when the services may not best suit their needs due to a number of reasons that are linked to their social wellbeing and reduced access to services within primary care that address these issues\textsuperscript{191}. There is a danger that if these groups are turned away from emergency care or re-directed to use different services they may not receive any care at all\textsuperscript{192}. Therefore it is necessary to ensure primary care is able to provide individuals with the support they need, in order to reduce the number of acute episodes. In order to have a sustainable urgent and emergency care service, there needs to be

\textsuperscript{187} Primary Care Foundation (2010). Primary Care and Emergency Departments. Primary Care Foundation

\textsuperscript{188} Ibid.

\textsuperscript{173} Primary Care Foundation (2010). Primary Care and Emergency Departments. Primary Care Foundation


\textsuperscript{191} Primary Care Foundation (2010). Primary Care and Emergency Departments. Primary Care Foundation.

\textsuperscript{192} Primary Care Foundation (2010). Primary Care and Emergency Departments. Primary Care Foundation.
effective integration between a number of public service interdependencies\textsuperscript{193} in the community to support and promote the health and wellbeing of the public.

National Reporting and Learning System (NRLS) data illustrates that there are significant patient safety issues for children who attend minor injury units where the medical cover is provided by out-of-hours GPs. The incidents suggest that staff at minor injury units were sometimes unable to direct or transfer patients to the care service most appropriate to their needs. Examples of incidents reported can be summarised under themes including lack of equipment, inability to deal with child’s presenting condition, delay in ambulance transfer out of the minor injury unit for children, children presenting although the minor injury unit is closed, failure to recognise safeguarding issues and critically ill children.

**Extracts from NRLS data**

A poorly child arrived at a minor injury unit with an unidentified rash covering both legs and body. An emergency call was made to request an ambulance one minute after the patient arrived. The caller advised control that the case needed to be top priority. However no ambulance had arrived after 30 minutes and, with the child’s condition deteriorating, a second emergency call was made, this time control advised that the ambulance was one minute away.

An asthmatic teenager arrived at a minor injury unit at 1am. The patient was able to talk but struggling to breathe. The minor injury unit was closed at that time so the newly qualified nurse who met him was unable to offer treatment. The nurse did not know where to send him, being unsure that his symptoms were severe enough to warrant calling 999. The nurse said that this was one of a few similar incidents that took place while on duty overnight.

**Workforce capacity and skill mix**

The quality of patient care and experience is influenced by the clinical staff available and the seniority of staff available\textsuperscript{194}. The availability of staff is too often dependent on the time of the day. This variation occurs in urgent care services right across England, and such variation prompts patients to avoid these services and go directly to an A&E department, where they are assured that they will have access to the clinical staff and diagnostics needed, even if their situation is not life-threatening. Patients need reassurance from the urgent care services that when they present to the service, they will have access to the appropriate services and staff; this is not currently happening consistently. Some patients are not treated at the centre to which they present due to the variability of skills and capabilities of clinical staff as well as the availability of diagnostic tools for a restricted period\textsuperscript{195}; this can lead to a delay in the patient treatment pathway and is not the prompt service a patient should receive when they use an urgent care service.

Recent research has shown that urgent care centres that are able to see and treat patients within one consultation, rather than patients being seen by various people demonstrated improvement in the patient experience\textsuperscript{196}. The Primary Care Foundation recommend this approach, highlighting this method as beneficial in terms of patient safety as it reduces patient

\textsuperscript{193} Royal College of General Practitioners (RCGP) (2011). Guidance for commissioning integrated urgent and emergency care. A ‘whole system’ approach. RCGP.


waiting times, which can improve the patient experience. However, this approach is not commonly found in urgent care services across England. Instead, patients can be referred to a number of services which leads to an inefficient duplication of efforts and a negative impact on patient experience.

Additionally, a study into clinical pathways for children with a fever in urgent care found that patient contacts ranged from one to 13 across all services during their illness, despite the child’s episode of illness lasting only three days on average. Approximately half of repeat contacts (221 of 350) were initiated by the services themselves, rather than by parents.\(^\text{197}\)

**Key message**

Urgent care services are characterised by variation and a lack of standardisation and clear information. This contrasts with the strong identity of A&E departments. Variation in acceptance and quality of care provided can result in delayed treatment or multiple contacts and a poor experience of care, as well as inefficient use of expertise and resources.

\(^\text{197}\) Department of Health (2010) To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature)
8. 999 emergency services and accident and emergency departments

8.1 999 emergency calls

There has been a significant rise in the volume of calls to the 999 emergency service from 4.7 million in 2001/02 to over 8 million (2010/11)\textsuperscript{198}. Many calls relate to non life-threatening conditions and there is increasing concern that many calls to 999 services are based on fundamental misconceptions about the types of treatment other urgent-care options can provide\textsuperscript{199}.

Ambulance call outs are by far the most expensive way for patients to access urgent and emergency care. The cost of ambulance services in England is estimated to be about £1.1bn per year and is rising at about four per cent per annum\textsuperscript{200}. Although 999 emergency call outs are associated with only two per cent of urgent and emergency care cases, they are thought to be responsible for about 22 per cent of the commissioning costs\textsuperscript{201}.

The volume of calls and incidents resulting in a 999 emergency response has increased in the last ten years, and this will cause added pressure in the future as ambulance trusts attempt to reduce spending. Most 999 calls result in an emergency response and the rise in emergency calls reflects the rise in emergency responses (figure 6). There is increasing concern that the general NHS approach to triage, which is to assume seriousness, is leading to more emergency responses than necessary, at significant cost to the NHS\textsuperscript{202}.

\textsuperscript{198} Agnelo Fernandes (2011) Guidance for commissioning integrated urgent and emergency care: A 'whole system' approach
\textsuperscript{200} Fernandes, A. (2011) Guidance for commissioning integrated urgent and emergency care: a whole system approach; Royal College of General Practitioners Centre for Commissioning
\textsuperscript{201} PA Consulting Group (2008) Healthcare for London: Study of Unscheduled Care in 6 Primary Care Trusts, Central Report
\textsuperscript{202} H Snooks and J Nicholl (2007) Sorting patients: the weakest link in the emergency care system; Emergency Medicine Journal, 2007 February; 24(2): 74
Sending an ambulance to care for a patient who would be better treated elsewhere wastes valuable time as well as resources. To avoid this, NHS emergency dispatch staff are trained to give advice by telephone to deal with non-urgent cases. Patients may be advised on self-care, or to seek help from an alternative source, such as GP out-of-hours services or a minor injuries unit.

However, only a small number of calls are currently closed with telephone advice only: 3.7 per cent overall in England. The highest proportion is in the Isle of Wight and the lowest in the north east area. By comparison, in France, due to differences in the urgent and emergency care system including enhanced triage, only about 65 per cent of emergency calls actually receive an ambulance response.

Note: Department of Health recorded data from LAS for Oct to Dec 2012 shows a slightly higher figure c.5.8-7% - figures are inconsistent between www.data.gov.uk and http://transparency.dh.gov.uk/2012/06/19/ambqidownloads/

Figure 7: Emergency calls closed with telephone advice only

In many cases where an ambulance is sent out in England, it is later found that one was not required\textsuperscript{205}. Comparison of the number of cases resolved by telephone advice alone and the number of cases found not to require an ambulance by a responding team suggests that the former represents a small proportion of the possible number of cases that could either be dealt with remotely or by directing patients to more appropriate healthcare facilities.

National Reporting and Learning System data also demonstrates that incidents also occur where the wrong type of response is sent to a call, for example a technician crew is sent when a paramedic response was requested.

Extract from NRLS data

\textit{A patient needed to be transferred from one hospital to another in order to treat severe internal bleeding that had taken place overnight. A paramedic crew had been requested to oversee the transfer but a technician crew was sent. During the transfer, the patient experienced another bleed and went into cardiac arrest. On arrival at A&E, medical staff attempted to revive the patient using CPR but could not prevent the patient from dying.}

8.2 Pre-hospital emergency care

Many 999 calls relate to non-life threatening or non-serious conditions. This may be because of a perceived or actual lack of alternative options in the area, or because a patient’s symptoms are both worrying and unclear. While there are a range of alternatives to A&E departments for people with less serious conditions, the differences between the services offered and their hours of operation means that the public’s default position in a crisis is often to either call 999

\textsuperscript{205} HM Government, Data.gov.uk. Ambulance Services England – 2011-12. (http://www.data.gov.uk/dataset/ambulance-services-england-2011-12/resource/ed7cde68-a4e6-4a49-80dc-7b007f7f4e6a). Note, significant fluctuation between years in some areas; nonetheless, significant wasted resource indicated.
or to take the patient (or self-present) to their local A&E department. Numbers of emergency calls have risen steadily across all areas of England\textsuperscript{206}.

\textbf{Figure 8: Rise in emergency calls in England 2007 – 2012}

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\textit{Source: Ambulance Services England}

There have been attempts to develop pre-hospital services in England to enable patients to be treated at the scene or at home, and to therefore avoid unnecessary attendance at A&E departments. Despite these measures, however, a high proportion of emergency 999 calls still result in an attendance at hospital with patients who could receive treatment elsewhere.

The ambulance service in England, like that of the USA, was developed predominantly to transport emergency patients as quickly as possible to a facility where they can be treated by a more specialist team. In contrast, many other European and Scandinavian countries use a system whereby more care is delivered at the scene by medical or nursing staff\textsuperscript{207}.

In Sweden, for example, a registered nurse with specialist training to deliver advanced care in the field is present in all emergency ambulances\textsuperscript{208}. In France, some response units are staffed by a qualified physician, a nurse and/or an emergency medical technician. The physician may conduct a full set of observations, examinations and interventions on site, and may decide to admit the patient directly to hospital, bypassing an A&E department altogether. In such systems, the ambulance is likely to spend longer at the scene compared with the English ambulance service. However, there is a lack of evidence that this improves overall outcomes.


\textsuperscript{207} Dick WF. "Anglo-American vs. Franco-German emergency medical services system". Prehospital Disaster Medicine (2003) Jan-Mar;18

\textsuperscript{208} Sadock, J., Arnhiort, T, Malmquist, P. and Aujalay, N. “Emergency Medicine in Sweden”, American Academy of Emergency Medicine (2007);14:14,16-17. Check – this was a target for 2007
In England, many patients are treated at the site of the incident by ambulance teams. In 2011/12, 1,809,300 patients (21.3 per cent) received treatment in their homes or at the scene by ambulance staff and did not require onward transport. This included both category A patients (those with apparently life-threatening conditions) and less serious category C patients. Nonetheless, a relatively high number of cases (around 64 per cent in England overall) are transported by ambulance to an A&E department. Some degree of over-triage by ambulance services is expected – protocols are designed to err on the side of caution to ensure patient safety. A similar degree of over-triage might therefore be expected across different areas. However, while the average for England in the last quarter of 2011/12 was around 64 per cent, this figure rose to around 77 per cent in the north west and fell to 47 per cent in the south west (figure 9). This demonstrates significant variation in practice and scope for improvement in some areas.

Figure 9: Patients taken to A&E and those transported elsewhere or discharged at scene, October to December 2012

Source: Ambulance Services England

Some of this variation may be due to casemix and differences in the healthcare facilities available to ambulance crews in the different regions – for example, numbers of urgent care centres available in the area. However, it suggests that different protocols or practices, or uniform availability of alternative sources of care, could result in more patients either being treated at the scene, or transported to a more appropriate care setting. This would reduce the

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number of patients transported to an A&E department and allow more patients to remain in their homes, or to receive care in more appropriate settings.

8.3 Accident and emergency departments

Unlike some urgent care offerings, patients are guaranteed access to an A&E department 24 hours a day, seven days a week. The work of an A&E department is unbounded; it provides care for emergency conditions – illness, mental health problems and injury of all severities – of all types and for patients of all ages. There has not been a reduction in attendances to A&E departments over recent years – many of which are self-referral – despite a large growth in the availability of other options, placing greater demand on the service.

Due to the unplanned nature of patient attendance; A&E departments must be able to provide initial treatment for a broad spectrum of illnesses and should also have the required staffing and skills to treat illness and injury for all age groups.

In some hospitals, patients who have already seen by a GP, who has recommended hospital admission, bypass the A&E department and go directly to the acute medical or surgical unit or specialty inpatient beds. In some hospitals these patients are seen by an initial assessment team in case there is scope for rapid investigations, diagnosis and discharge. In other areas these patients are directed through the A&E department, with in-patient resources devoted to this stream of patients in A&E.

Proper staffing is the ‘single most important factor’ in providing a high quality, timely and clinically effective service to patients. There is a need to ensure a balanced workforce within an A&E department in order to provide a safe service. The UK’s historical model of staffing within A&E departments, which resulted in the majority of care being delivered by ‘inexperienced junior doctors’, is inappropriate. More recent studies of the performance of doctors in training highlight that they are seeing fewer patients than their predecessors and feel less confident in their clinical skills.

Key message
Appropriate staffing is integral to an effective A&E department; however doctors in training are relied on heavily to provide the service due to insufficient numbers of senior emergency medicine trained doctors.

Most A&E departments have an area set aside for children. A separate paediatric emergency department, with its own staff, is available in some larger A&E departments; however in most A&E departments there is a mix of both general and paediatric trained professionals seeing and assessing children. Skilled assessment by an experienced and trained professional, sometimes with a short period of observation, may be useful to differentiate a minor condition from a life-threatening condition. However, the CEMACH (The Confidential Enquiry into Maternal and Child Health) pilot study Why Children Die outlined that errors were repeated and

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210 Emergency Care Intensive Support Team, Effective approaches in urgent and emergency care, 2011
215 Ibid.
compounded by the fact that the principal assessment of a child was being performed by a junior doctor with no postgraduate training in paediatrics, in settings where there was no supervision by an experienced specialist paediatrician. The 2012 Services for Children in Emergency Departments document recommends that a consultant with sub-speciality training in paediatric emergency medicine be appointed for each emergency department with greater than 16,000 annual paediatric visits.

Furthermore, despite the majority of urgent care being delivered in the primary cares setting, an increasing number of older people are attending A&E departments – over the next 20 years, the number of people aged 85 and over is set to increase by two-thirds compared with a 10 per growth in overall population. This indicates a growth in older people accessing care from A&E departments. The last few years have seen an increase in the use of end-of-life pathways. Improvements in end-of life care can have a high impact on patient experience as well as the experience of family members and carers. Evidence suggests that, where these are absent or poorly scripted, uncertainty in the end-of-life pathway often results in A&E attendances or emergency admissions to hospital that are, in retrospect, deemed to be unnecessary.

The 2010 Temple report concluded that consultant-delivered care, as opposed to consultant-led or consultant-based care, was the only viable model for the future of medical care in the UK. This is because consultants “make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality”. The Temple report defines consultant-delivered care as “24 hour presence, or ready availability”.

There is evidence to suggest that consultant-delivered care in an A&E department improves outcomes for some patient groups. For example, the introduction of Major Trauma Networks in the capital with consultant-led resuscitation and assessment of severely injured patients saved 58 lives in London in the first year of operation. Other improved outcomes and benefits include:

- Enhanced and more timely clinical decision making;
- Increased supervision of more junior members of the team;
- Reduced numbers of serious untoward incidents;
- Less unplanned returns to the A&E department; and,
- Fewer misinterpreted x-rays that result in missed diagnoses.

Recent studies also found that consultant-delivered care in A&E departments contributed to cost savings and increased service efficiency. Additionally, a recent study highlighted that a

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217 Royal College of Paediatrics and Child Health. The role of the consultant paediatrician with sub-speciality training in paediatric emergency medicine. London: RCPCH, August 2008
218 Jay Banerjee et al Quality care for people with urgent and emergency care needs, 2012
220 Temple J. Time for training, 2010
221 The London Trauma Office
222 Positive impact of increased number of emergency consultants. Geelhoed GC, Geelhoed EA Arch Dis Child 2008;93:62-64
consultant based service offers many advantages that cannot be matched by either junior or middle grades\textsuperscript{224}.

Variation exists in the number of hours that consultants are present in A&E departments across the country. Additionally there is a variation in the number of consultants employed by A&E departments (see section 11). Internationally, comparing emergency medicine consultant staffing in England with similar models in Australasia and North America, the current consultant numbers in emergency medicine in England are less than half those that would be provided in similar departments in these regions\textsuperscript{225}. A recent study of A&E departments in the United Kingdom, of which nearly 60 per cent of respondents were in England, carried out by the College of Emergency Medicine\textsuperscript{226} highlighted the variation in consultant ‘shop-floor’ cover to help maintain quality and safety in A&E departments, with the situation worsening over the weekend. Seventy-seven per cent of responding UK A&E departments reported that they had at least one emergency medicine consultant present in the A&E department over 12 hours on weekdays, but only 17 per cent reported such presence for 16 hours. At weekends the number of A&E departments with consultant ‘shop-floor’ cover for at least 12 hours each day is just 30 per cent.

\textbf{Figure 10: Consultant ‘shop-floor’ coverage – hours per day in A&Es (UK)}

To ensure the delivery of high quality emergency medicine, the involvement and input of experienced and competent emergency medicine doctors 24 hours a day is required, as

\begin{itemize}
  \item Emergency Medicine Consultants Workforce Recommendations, The College of Emergency Medicine, April 2010
  \item College of Emergency Medicine (2013) The drive for quality; How to achieve safe, sustainable care in our Emergency Departments?
\end{itemize}
recommended by the College of Emergency Medicine\(^{227}\). Middle grade doctors (Specialty Registrars, Specialty Doctors and Trust Grades) provide the vital safety net of experienced medical care and supervision round the clock. However, A&E departments across the country struggle to provide this level of cover as vacancy rates at this grade are high both for the training grade registrars and other non-training grades (see section 11).

**Key message**

Consultant-delivered care and senior clinical input improves patient outcomes in A&E departments; however the shortage of emergency medicine trained senior (middle grade and consultant) doctors is a problem for nearly all A&E departments and large variation in consultant ‘shop floor’ coverage is seen across England.

The senior review of patients has a positive impact on patient outcomes. A study undertaken to assess the influence and effect of ‘real-time’ senior clinician supervision on patient disposition in a UK A&E department found that senior review of 556 patients reduced inpatient admissions (by 11.9 per cent) and reduced admissions to the acute medical unit specifically (by 21.2 per cent). Furthermore, inappropriate discharge was prevented in 9.4 per cent of cases, improving patient safety, and the appropriate use of outpatient facilities resulted in a rise of 34.6 per cent in outpatient appointments\(^{228}\).

An A&E department also requires designated nursing staff based on minimum levels to meet service requirements, however there is significant variation in nursing management across A&E departments. Several reports\(^{229,230}\) have highlighted high rates of nursing vacancy and inadequate skill mix within the A&E, which can lead to poorer outcomes for patients\(^ {231,232}\). Several reports\(^{233,234}\) highlight that where care has been found to be poor, the majority of care was delivered by unregistered staff with insufficient nurses to supervise them. It has been demonstrated\(^ {235}\) that as the percentage of healthcare assistants rises, combined with increased bed occupancy, mortality rates can rise.

**A&E attendances related to mental health issues**

Mental health disorders account directly for approximately five per cent of A&E attendances and most patients who frequently re-attend A&E departments do so because of an untreated mental health problem\(^ {236}\). However A&E attendances are usually defined by the presenting symptoms and not the underlying condition, which is often mental-health related. Alcohol

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\(^{228}\) White AL, Armstrong PAR, and Thakore S. “The impact of senior clinical review on patient disposition from the emergency department” *Emergency Medicine Journal, 2010;27:262-265*

\(^{229}\) Independent Enquiry into the care provided by Mid Staffordshire NHS Foundation Trust, Jan 2005-March 2009.

\(^{230}\) Care Quality Commission, October 2011: Investigation report: Barking, Havering and Redbridge University Hospital NHS Foundation Trust


\(^{233}\) The Patient Association (2010) *Listen to patients, speak up for change. Tinyurl.com/listen-patients*


\(^{236}\) Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of liaison mental health services to acute hospitals;
abuse, for instance is one of the most significant factors affecting demand for A&E services. Alcohol-related chronic conditions, intoxication and secondary effects of alcohol abuse such as injuries from alcohol-related violence contribute to approximately 35 per cent of A&E attendances\textsuperscript{237,238,239}. Dementia is an underlying factor in 42 per cent of emergency admissions for patients over 70 years old and these patients often find the pace and noise in A&E departments difficult to cope with\textsuperscript{240}.

Self-harm is one of the most common reasons for emergency care in England and Wales, accounting for around 200,000 visits to hospital each year\textsuperscript{241}. Research shows that attendance at an emergency department for self-harm is associated with future suicide, with one quarter of suicides preceded by acts of self-harm within the previous year\textsuperscript{242}. One study of suicides in north west England found that over 40 percent of people who had committed suicide had attended an A&E department in the year prior to their death, with the majority of attendances due to self-harm or requests for psychiatric help\textsuperscript{243}. Seventy-five per cent of suicides are completed by people not known to mental health services\textsuperscript{244}. The National Reporting and Learning System has identified a number of suicides that have taken place in emergency departments.

**Extract from NRLS data**

Patient attended A&E after it had been reported that they had attempted to throw themself under a moving car as a possible means of attempting self-harm. There were significant capacity issues within the department, with patients queuing in the ambulance corridor, which meant the senior nurse was unable to undertake immediate nurse triage. A visual assessment suggested that the patient did not need to move forward in the queue for nurse triage but, by the time the senior nurse was able to undertaken triage, the patient had left the department. The patient re-attended an hour and a half later after being found collapsed in the road after he had walked in front of an oncoming car. The patient sustained a cardiac arrest while in the department.

Often, patients requiring a mental health assessment experience long waits or are admitted to a general hospital unit while awaiting mental health assessment; this is inappropriate. The care of patients with mental health problems is of great concern across the emergency care pathway. There is a need to ensure that patients attending an A&E department who require a mental health assessment receive this within the same timescale as those who have other conditions. Delays to assessment should not be created by the need to manage a concomitant physical health problem. Evidence suggests that access to expert psychiatric support on weekdays between 09.00 and 17.00 is generally good but access at other times is often poor putting additional pressure on A&E departments to deliver clinical care and manage referrals.

\textsuperscript{238} Institute of Alcohol Studies (2009) The impact of alcohol on the NHS: IAS factsheet  
\textsuperscript{239} NHS Choices (2011) Drink causes a million hospital visits a year  
\textsuperscript{240} RCN (2010) Improving quality of care for people with dementia in general hospitals: essential guide; Royal College of Nursing supported by the Department of Health  
\textsuperscript{241} NIHR (2013) Multicentre study of Self-harm in England; National Institute of Health Research, Department of Health  
\textsuperscript{242} Mark Broadhurst & Paul Gill (2007) Repeated self-injury from a liaison psychiatry perspective; Advances in Psychiatric Treatment vol. 13, pp228–235  
\textsuperscript{243} Cruz, D (2010) Emergency department contact prior to suicide in mental health patients; Emergency Medicine Journal;28:467-471  
\textsuperscript{244} The National Confidential Inquiry (2006) Avoidable Deaths: Five year report of the national confidential inquiry into suicide and homicide by people with mental illness. Manchester: The University of Manchester;2006.
for patients with mental health needs. More appropriate provision, particularly out-of-hours, for these patients would be beneficial to both the patient and hospital system.

**Key message**
Patients with mental health needs are a key challenge facing A&E departments but access to psychiatric support out of hours is poor for the majority of services.

**The four hour standard**

Many reviews have examined A&E attendances and initiatives to reduce waiting times. Across England, compliance with the four hour standard is decreasing. Compliance means that 95 per cent of patients should be seen, treated and discharged within four hours. The latest available data (quarter 3, 2012/13) for the four-hour A&E standard in England show an increase in the number of patients waiting more than four hours from the time of arrival to admission, transfer or discharge, when compared with the previous quarter (quarter 2, 2012/13). Although this is consistent with seasonal variance in other recent years, it is the highest proportion since 2003/04.

During quarter 4 of 2012/13, a total of 310,000 patients across England waited more than four hours in A&E from the time of arrival to admission, transfer or discharge. This marked a 35 per cent increase over the previous quarter (quarter 3, 2012/13) and a 39 per cent increase over the same quarter of the previous year (quarter 4, 2011/12). Despite this increase, the total number of people attending A&E departments fell in each quarter of 2012/13 and quarter 4 of 2012/13 was down 0.65 per cent on the same period in 2011/12.

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245 Foundation Trust Network (October 2012) Briefing on Driving Improvement in A&E Service
247 Health Services and Research Delivery Programme (2005) Reducing attendance and waits in emergency departments: A systematic review of present innovations
248 The King’s Fund, How is the NHS performing?, 2013
Crowding and patient flow

Ensuring patient flow through an A&E department is a vital element of providing a high-quality and safe service. Crowding in A&E departments is associated with delays in assessment and treatment\textsuperscript{249,250,251}. Significantly, a study into the effects of overcrowding in A&E departments found a 30 per cent increase in ten day mortality rates in A&E departments during crowded periods\textsuperscript{252,253}.

A study of emergency admissions to hospital in Australia found that in-patient length of stay is also closely linked to the length of time patients had spent in A&E\textsuperscript{254}. The study found that patients spending between four and eight hours in A&E, on average, spent 1.9 days longer in hospital than those admitted within four hours. Patients spending between eight and 12 hours in the A&E department spent 2.9 days longer and those spending more than 12 hours in the A&E spent an average of 3.5 days longer in hospital.

\textsuperscript{249} Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust2006;184:213-6
\textsuperscript{250} Collis (2010) Adverse effects of overcrowding on patient experience and care; Emergency Nurse; Volume 18, no 8, pp34-39
\textsuperscript{251} Collins, J (2010) Adverse effects of overcrowding on patient experience and care; Emergency Nurse, Volume 18, Number 8, December 2010
\textsuperscript{252} Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust2006;184:213-6
\textsuperscript{253} Collis (2010) Adverse effects of overcrowding on patient experience and care; Emergency Nurse; Volume 18, no 8, pp34-39
\textsuperscript{254} Liew et al (2003) Emergency department length of stay independently predicts excess inpatient length of stay; MJA 2003; 179; 524-526
A study of the acute admissions timeline by the Primary Care Foundation found that many patients present at hospital towards the end of the day following a home visit from their GP, which typically takes place in the afternoon\(^{255}\). Length of stay in A&E departments is generally greater during this period when departments are busiest and staffing and support services are often reduced.

If patient flow is not addressed through the timely availability of senior staff, support services and available hospital beds, patient safety, privacy and dignity are compromised by overcrowded conditions. An 11-year study of factors influencing A&E waiting times, published in 2007, found that team working practices had a significant impact on the length of time patients had to wait between arrival in the department and admission to hospital or discharge. The study found that departments where clinicians and nursing staff routinely worked together in teams (not just in specific emergency events) were more effective at making quick clinical decisions\(^{256}\).

The safe delivery of care in an A&E department depends on timely access to diagnostics and investigations. Early access to diagnostics can also prevent unnecessary admission to hospital, therefore providing better outcomes for patients. Accident and emergency departments should have unrestricted access to imaging to allow immediate investigation of potentially life threatening conditions. Additionally, poor patient flow and department overcrowding\(^{257}\) can be associated with a lack of support from inpatient specialties and a lack of swift access to inpatient beds. This in turn often represents problems in outflow from the admissions units to longer-stay wards, and from longer-stay wards to community discharge.

NHS England has stated that all handovers between an ambulance and A&E Department must take place within 15 minutes, and crews should be ready to accept new calls within a further 15 minutes\(^{258}\). However, in 2012, 24 per cent of ambulance patients surveyed said they had to wait over 15 minutes with the ambulance crew before they could be handed over to A&E staff\(^{259}\). Five per cent said they had to wait over an hour to be handed over.

**Key message**
Crowding in A&E departments is a growing threat to patient safety and can have a significant impact on all patients. Timely access is required from supporting specialties to enable appropriate admission and transfer of patients to improve patient flow within A&E departments.

**Clinical Quality Indicators (CQIs)**
Clinical Quality Indicators (CQIs) were introduced by the Department of Health in April 2011 to balance the potentially adverse effects of over-focus on the four hour standard and encourage continuous improvement\(^{260}\). The introduction of CQIs aims to shift the focus away from waiting time targets towards a range of measures based on quality (including clinical outcomes, safety

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256 Mason et al (2006) What are the organisational factors that influence waiting times in Emergency Departments; Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)
260 Cooke, M (2013) Intelligent use of indicators and targets to improve emergency care; Emergency Medicine Journal
and patient experience) and is expected to encourage transparency and continuous improvement in A&E departments\textsuperscript{261}. The eight CQIs are:

- Ambulatory Care;
- Unplanned Re-attendance Rate;
- Total Time Spent in A&E;
- Left without Being Seen Rate;
- Service Experience;
- Time to Initial Assessment;
- Time to Treatment; and
- Consultant Sign-off.

A&E departments are encouraged to locally publish information on the A&E indicators in the form of a clinical dashboard that is available to patients and the public, other providers and local commissioners. The information gathered for the CQIs combine data with knowledge and observation of the underlying processes. They are expected to encourage discussion about how good the care provided is and how it can be improved, aid decision making processes, identify issues early and address areas where immediate, targeted decisions can benefit patients\textsuperscript{262}.

**Clinical decision/ observation areas**

Many A&E departments run clinical decision/ observation areas as part of the drive to improve patient care and view these facilities as an integral part of emergency medicine. Clinical decision/ observation areas maximise the use of available resources and are viewed as a better alternative for patients than an inpatient admission as they provide a period of observation or treatment, typically for four to twelve hours, for those patients with an expected recovery time or a short, defined period of active treatment for specific diagnoses\textsuperscript{263}. These areas also allow time to investigate and to safely rule out serious diagnoses, preventing both unsafe discharges and inpatient admissions. Significantly, research has shown that patient satisfaction increases with the presence of clinical decision/ observation units, with fewer problems associated with poor care, communication, emotional support and physical comfort\textsuperscript{264}. Overall, clinical decision/ observation areas can provide patients with shorter lengths of stay. These are most effective when they are ring-fenced areas exclusively managed by emergency medicine doctors and nurses with clear operational policies\textsuperscript{265}. However, not all A&E departments have access to such a facility and there is considerable variation in the way in which they function.

\textsuperscript{261} Ibid
\textsuperscript{262} Department of Health (2011) A&E Clinical Quality Indicators: Best Practice Guidance for Local Publication; Department of Health Urgent and Emergency Care
9. **Access to quality back up services**

Accident and emergency departments have evolved to become increasingly sophisticated, employing more specialist staff in greater numbers and requiring a more complex system of acute hospital services to support them. To ensure high-quality and safe care in an A&E department, access to inpatient beds, speciality clinical opinion and support from other specialities in the hospital is required. Patients waiting in an A&E department (often on hospital trolleys) due to a lack of inpatient beds is sub-optimal and evidence suggests that patients with prolonged ‘trolley times’ have longer lengths of stay in hospital once admitted with possible increased morbidity and mortality. Although improvements have been made, this still remains a problem in many hospitals.

Relationships with supporting specialties can be inconsistent. Therefore, the College of Emergency Medicine recommends that as a minimum an A&E department must have support from the ‘seven key specialities’: critical care, acute medicine, imaging, laboratory services (including blood bank), paediatrics, orthopaedics and general surgery. This should ensure timely assessment to senior clinical decision makers within inpatient teams, to improve the flow of the A&E department. Where these teams are not on-site there must be robust policies and procedures to ensure rapid access to a senior clinical decision maker, and transfer to an inpatient bed if required. The following extract from NRLS data illustrates why this is essential for ensuring patient safety:

**Extract from NRLS data**

*A patient attended A&E after vomiting blood and was seen to by the A&E registrar, medical registrar, anaesthetic registrar and two senior A&E nurses. The team needed to carry out an emergency endoscopy but was unable to locate anyone able to do this, despite attempting to contact the relevant personnel at their home. The patient continued to bleed and died in the A&E department due to no out-of-hours endoscopy service available.*

Recent work from the College of Emergency Medicine highlights that in spite of the College’s recommendations, there is no on-site supporting service that is universally available to all A&E departments, with the exception of anaesthesia and orthopaedics in major trauma centres. The supporting services most commonly available on site are acute medicine (86 per cent), critical care (87 per cent), anaesthesia (88 per cent), general radiology (87 per cent), general paediatrics (79 per cent) general surgery (84 per cent), care of the elderly (86 per cent) and orthopaedics (84 per cent). Additionally, only 10 per cent of A&E departments have a co-located urgent care centre, and 36 per cent have a co-located out of hours GP service.

Much of the evidence, both national and international, on treatment for emergency patients and where and when they should attend relates to urban environments. Rural and remote patients present a specific challenge due to the density of the population and the distances involved. The low-density population of rural areas means that healthcare facilities are spread far apart, and there may not be the critical mass necessary to provide a fully functional major acute

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266 HCL (2013) The Real Emergency in Emergency Departments: Is the chronic shortage of England’s A&E doctors reaching crisis point?; HCL workforce solutions
269 College of Emergency Medicine (2013) The drive for quality; How to achieve safe, sustainable care in our Emergency Departments?
hospital within the region. The distance to transport patients may mean a lengthy wait before treatment can be delivered.

A hub and spoke telehealth system, whereby remote facilities are linked up to a central hospital with specialist support on hand, may represent a possible solution to some of these problems. Telemedicine is a broad description of medical and healthcare services provided by means of telecommunications. Telemedicine can be used to:

- Support more types of services;
- Bring specialist services to more people in rural and remote areas;
- Enable better on-scene treatment for medical professionals on the move;
- Enable patients and clinicians to collaborate more effectively to monitor and treat chronic conditions;
- Enable more effective monitoring and treatment of patients with chronic conditions; and
- Enable remote rehabilitation monitoring.

In recent years, technological developments have rapidly increased the number of telemedicine options available to the NHS. Telemedicine is an emerging area that holds a great deal of promise for healthcare, with many studies finding that it can facilitate better communication between healthcare providers and improve patient outcomes. Additionally, international models such as those used by Kaiser Permanente of self-care and shared care use technology to emphasise prevention, early intervention and the active management of patients with the priority of keeping patients out of hospital. There have been numerous pilots using telemedicine in urgent and emergency care and a number of studies attempting to measure its clinical and cost effectiveness. However literature around telemedicine is often a confused picture, especially regarding its cost-effectiveness, due to the wide variety of different technologies and utilisation methods available.

There is broad agreement that telemedicine has significant potential for improving access to safe, high quality emergency medicine, particularly in rural and remote areas. Increased sub-specialisation in medicine means that acute specialists often have less familiarity with other areas of medicine, necessitating more effective communication and collaboration between clinicians, often based in different locations. This development in healthcare has had the greatest impact on hospitals in rural and remote areas because it is becoming increasingly difficult for them to provide the full spectrum of acute services required to treat emergency patients. Telemedicine can facilitate effective networking between providers

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270 Brownsell et al (2012) Barriers and challenges to implementing telehomecare for Long Term Conditions; University of Sheffield and Sheffield Teaching Hospitals NHS Trust


272 NHS Improvement (2011) Heart failure — patient pathways


274 Darkins, A (2012) Patient safety considerations in developing large telehealth networks; Clinical Risk, May 2012 vol. 18 no. 3 90-94


and allow patients to receive a wider range of clinical treatments in areas with less access to clinical expertise\textsuperscript{279}.

There are several documented examples of telemedicine working effectively to improve access to specialist clinical expertise in remote areas or where there is a local shortage of expertise. There is a considerable literary evidence to support the feasibility and effectiveness of telemedicine, particularly for specific applications such as stroke management, cardiology, neurology, burns and ophthalmology, where a high-degree of specialist expertise is often required. Most studies showed some potential for improving rapid evaluation and treatment of patients whilst reducing ambulance transfers and emergency admissions to hospital\textsuperscript{280,281,282}.

However, implementation of telemedicine systems tends to be piecemeal and barriers to implementation of telemedicine systems include\textsuperscript{283}.

- High cost of setup and maintenance of systems;
- A lack of systematic analysis of impact on wider healthcare costs; and
- Ethical and legal concerns surrounding patient confidentiality and physical indemnity.

Key message
To ensure high quality and safe care in an A&E department, access to inpatient beds and support from other specialties in the hospital or rapid transfer to the right hospital is required.

\textsuperscript{281} Wechsler et al (2013) Teleneurology applications; Neurology February 12, 2013 vol. 80 no. 7 670-676
\textsuperscript{282} Kulshrestha et al (2010) Journal of Telemedicine and Telecare, June 2010 vol. 16 no. 4 196-197
\textsuperscript{283} WHO (2010) Telemedicine – Opportunities for developments in Member States: report on the second global survey on ehealth; World Health Organization
10. Emergency admissions to hospital

Rising number of emergency admissions to hospital

With a significant rise in the number of acute hospital admissions, which represent around 65 per cent of all hospital bed days in England\textsuperscript{284}, there is a need to reduce unnecessary admissions, not only because of the high and rising costs associated with these, but because of the pressure and disruption that emergency admissions to hospital put on the elective health care system for example: increased waiting lists and cancellations. An emergency admission to hospital can also be known to be a disruptive and unsettling experience for patients, particularly the frail elderly, which exposes them to new clinical and psychological risks\textsuperscript{285}.

Evidence highlights that the majority of adult patients who are admitted to hospital with an acute illness seek professional help from primary care in the first instance. Those who attend an A&E department generally perceive their problem as more urgent or severe, or have an ambulance called on their behalf\textsuperscript{286}. For children, there is a continuing increase in very short-term admissions for those with common infections – 28 per cent over the last decade\textsuperscript{287} – and research suggests that this may be due to a systematic failure of both primary care and hospital care (by emergency departments and paediatricians) in the assessment of children with acute children that could be managed in the community, which can be attributed to the change in the GP contract and providing out-of-hours care and the introduction of the four-hour standards in A&E departments\textsuperscript{288}. Further research suggests that general practice and the paediatric community now have the opportunity to rise to this challenge and improve outcomes for children across the urgent and emergency care pathway\textsuperscript{289}.

There is variation across the country in the proportion of emergency admissions to hospital, with people from lower socio-economic groups being more at risk of emergency admission to hospital. Additionally, those who live in urban areas have higher rates of emergency hospital admission that those in rural areas\textsuperscript{290}. What is uncertain about this difference is whether it is due to better management of patients in the community in rural areas, demographic factors or because patients who live further from secondary care have more difficulty accessing services\textsuperscript{291}.

There are a number of factors that contribute to the rising number of emergency admissions to England’s hospitals. A growing frail elderly population means that many more people are living with a long-term condition without sufficient and systematic support to self-manage, many of whom are vulnerable to exacerbations resulting in hospital admission\textsuperscript{292}. The Department of

\textsuperscript{284} Purdy, S (2010) Avoiding hospital admissions
\textsuperscript{285} Imison, C et al (2012) Older people and emergency bed use: exploring variation; The King’s Fund, London
\textsuperscript{287} Powell, C. (2013) Do we need to change the way we deliver unscheduled care?; Archives of Disease in Childhood; 2013:98:5:319-320
\textsuperscript{289} Powell, C. (2013) Do we need to change the way we deliver unscheduled care?; Archives of Disease in Childhood; 2013:98:5:319-320
\textsuperscript{291} O’Donnell, 2000
\textsuperscript{292} The King’s Fund (2011) The evolving role and nature of general practice in England
Health estimates there to be around 15 million people in England with at least one long-term condition and this is set to rise by a further 23 per cent over the next 25 years\textsuperscript{293,294}. An estimated two-thirds of older people currently live with more than one long-term condition\textsuperscript{295}. This cohort is the biggest user of the NHS accounting for 50 per cent of all GP appointments and 70 per cent of all hospital admissions equating to about 70 per cent of the total spend\textsuperscript{296}.

Introduction of the four hour standard for discharge from A&E departments, increased use of clinical protocols and standards set by commissioners have helped improve patient outcomes but may have led to an increase in short-stay emergency admissions to hospital. Fifty per cent of emergency admissions to hospital are for stays of one day or less and short-stay admissions account for most of the total increase\textsuperscript{297}. It has also been suggested that some trusts will admit patients when they are close to breaching the four hour standard in A&E departments, resulting in an emergency admission lasting only a few hours\textsuperscript{298,299}. There was a demonstrable acceleration in the rise of short-stay admissions after the four hour standard was introduced; however much of this increase has also been attributed to more effective treatment and discharge\textsuperscript{300}. Many UK hospitals have introduced an acute medical admissions unit to facilitate an efficient emergency admission process and evidence demonstrates improved outcomes for patients such a reduction in waiting in an A&E department, length of hospital stay and mortality\textsuperscript{301,302}.

An association between the introduction of payment by results (PbR) in acute medicine and an increase in short-stay admissions was also found by the Nuffield Trust in their study of trends in emergency admissions to hospital between 2004 and 2009. The change from block contracts to PbR (Payment by Results) in acute medicine may have given hospitals a financial incentive to admit more patients\textsuperscript{303,304}. However the introduction of a 30 per cent tariff on admission activity in excess of 2008-09 levels, removed this incentive, but has not prevented emergency admissions to hospital increasing by about three per cent per year\textsuperscript{305}. For the majority of trusts, the cost of providing A&E services exceeds the income received from commissioners, which suggests other factors are driving the increase\textsuperscript{306}.

Other factors in the rise in short-stay admissions are thought to be an increased use of clinical protocols and lowering of clinical thresholds, leading to the admittance of less severe cases\textsuperscript{307,308,309}. The NHS has traditionally taken a risk averse approach to hospital admission

\textsuperscript{293} Department of Heath (2013) Long Term Conditions; Department of Health
\textsuperscript{294} Jacobs, S () Expert Patients Programme: A community interest company; NHS Trusts Association
\textsuperscript{296} Department of Health (2011) Millions of patients set to benefit from a modern NHS; Department of Health press release
\textsuperscript{297} The King’s Fund (2011) Emergency bed use: what the numbers tell us; King’s Fund, London UK
\textsuperscript{298} Information Centre for Health and Social Care (2009) Further Analysis of the Published 2007–08 A&E HES Data (Experimental Statistics)
\textsuperscript{305} Foundation Trust Network (October 2012) Briefing on Driving Improvement in A&E Services
\textsuperscript{306} Foundation Trust Network (October 2012) Briefing on Driving Improvement in A&E Services
as it is clinically appropriate to assume seriousness if there is any doubt over the diagnosis; however there is a suggestion that an increased threat of litigation in recent years has led to more defensive medicine\textsuperscript{310,311}. This may also contribute to avoidable admissions.

Evidence suggests that there is a correlation between clinician experience and the likelihood that they will admit inappropriately. Senior clinician availability to review emergency patients has been shown to decrease emergency admissions to hospital by 12 per cent\textsuperscript{312}. However wide variations have been found in admission rates between GPs working in out-of-hours services, and there is a suggestion that those with less experience of emergency medicine, may be more likely to assume seriousness and admit patients unnecessarily\textsuperscript{313}.

Good management of the transition to community or primary care after discharge is a significant factor in preventing hospital re-admissions\textsuperscript{314}. However there is concern that increased emergency admissions to hospital and an overall reduction in bed numbers has put pressure on hospitals to discharge patients rapidly and without adequate assessment or transfer to community services\textsuperscript{315}. This has led to an increase in re-admissions which puts further pressure on the system and costs the NHS £1.8bn per year\textsuperscript{316}. The number of episodes where patients are discharged by a hospital but readmitted within 30 days rose 51 per cent between 2003/04 and 2010/11 to 650,000, making up approximately 23 per cent of the total\textsuperscript{317}.

**Key message**

Growth in the number of emergency admissions to hospital has been associated with a large rise in short or zero stay admissions. The reasons for this are multifactorial but some studies have attributed it to a lack of early senior review, risk averse triage and A&E departments trying to avoid breaching the four hour standard.

**Outcomes for emergency admissions to hospital**

Recommendations from clinical evidence over a number of years have been resoundingly clear: early and consistent input by consultants improves patient outcomes. Early consultant involvement in the management of patients admitted as an emergency is one of the most important factors in patient care\textsuperscript{318} but too often working patterns are not set up to support this. Delays to both consultant reviews and a lack of senior involvement in patient care have been linked to poor outcomes, including mortality\textsuperscript{319, 320, 321, 322, 323, 324, 325, 326, 327, 328}.

\textsuperscript{308} H Snooks and J Nicholl (2007) Sorting patients: the weakest link in the emergency care system; Emergency Medicine Journal, 2007 February; 24(2): 74


\textsuperscript{310} H Snooks and J Nicholl (2007) Sorting patients: the weakest link in the emergency care system; Emergency Medicine Journal, 2007 February; 24(2): 74


\textsuperscript{312} Purdy, S (2010) Avoiding hospital Admissions: What does the research evidence say?; Kings Fund

\textsuperscript{313} Purdy, S (2010) Avoiding hospital Admissions: What does the research evidence say?; Kings Fund

\textsuperscript{314} SG2 Healthcare Intelligence (2011) Sg2 Service Kit: Reducing 30-day Hospital Readmissions

\textsuperscript{315} Dr Foster Intelligence (2012) Fit for the future? Doctor Foster Hospital Guide 2011

\textsuperscript{316} Dr Foster Intelligence (2012) Fit for the future? Doctor Foster Hospital Guide 2012

\textsuperscript{317} Department of Heath (2013) New data on emergency readmissions

\textsuperscript{318} National Confidential Enquiry into Patient Outcome and Death. (2007). Emergency admissions: A step in the right direction, NCEPOD

\textsuperscript{319} Nafsi et al. (2007). Audit of deaths less than a week after admission through an emergency department: how accurate was the ED diagnosis and were any deaths preventable? Emergency Medicine Journal. 24: 691 - 695

\textsuperscript{320} NCEPOD. (2009). Caring to the end? Review of patients who died within 4 days of hospital admission. NCEPOD

To provide consistent high quality hospital care, the NHS needs to ensure that the right consultants and teams are available seven days a week, and for some groups of patients, 24 hours a day. The Academy of Medical Royal Colleges recently published a report on the benefits of consultant delivered care across all services\textsuperscript{329}. These can be summarised as improved outcomes; efficient and effective use of resources; meeting patient expectations, improved patient experience and enhanced junior doctor training.

Consultants are the most skilled and experienced doctors. They are therefore able to make rapid and appropriate decisions to ensure patients receive the correct diagnostics and that they enter on the right pathway of care at an early stage. This leads to better patient outcomes including mortality. This is echoed in findings from numerous National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports published in the last twenty years linking improved outcomes with senior assessment and ongoing management of acutely ill patients\textsuperscript{330,331,332}, as well as recommendations from the Royal College of Physicians and Society of Acute Medicine\textsuperscript{333}. There is also mounting evidence demonstrating a variation in outcomes for patients depending on the time of day or day of the week that they are admitted to hospital as an emergency\textsuperscript{334,335,336,337,338,339,340}.

The 2011 Hospital Guide published by Dr Foster demonstrated the impact of senior staffing levels on mortality. Across England senior staffing levels were mapped at a trust level and compared to data on the number of beds and weekend mortality analysis. Findings showed that more senior staffing at the weekend is associated with a lower weekend mortality rate. This is demonstrated in figure 12. Data also shows that around 4,400 lives in England could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday.

\textsuperscript{322} NCEPOD (2007). Op. cit
\textsuperscript{323} Nafsi et al. (2007). Audit of deaths less than a week after admission through an emergency department: how accurate was the ED diagnosis and were any deaths preventable? Emergency Medicine Journal. 24: 691 - 695
\textsuperscript{325} NCEPOD (2007). Op. cit
\textsuperscript{329} Academy of Royal Colleges (2012) The Benefits of Consultant-delivered Care
\textsuperscript{330} National Confidential Enquiry into Patient Outcome and Death (2007) Emergency admissions: A step in the right direction, NCEPOD
\textsuperscript{332} NCEPOD. (2009). Caring to the end? Review of patients who died within 4 days of hospital admission. NCEPOD
\textsuperscript{333} Royal College of Physicians, London (2012) Acute Care Toolkit 4 - Delivering a 12 hour 7 day consultant led service on the Acute Medical Unit
\textsuperscript{335} Bell, M. D., Redelmeier, D. A. (2001). Mortality among patients admitted to hospitals on weekends compared with weekdays The New England Journal of Medicine 345: 9
\textsuperscript{338} National Confidential Enquiry into Patient Outcome and Death. (2007). Emergency admissions: A step in the right direction, NCEPOD
This variation in staffing is seen right across services in England. In the capital, improvements in heart attack, major arterial surgery, major trauma and stroke services have been made by providing consistent, consultant-delivered care, seven days a week and patient outcomes have improved. For example, since operating a consultant-delivered service seven days a week London’s heart attack centres now observe no difference in mortality rates between the week and at the weekend – demonstrating that where systems are in place to respond seven days a week, there is a direct effect on mortality rates. The potential impact on patient outcomes of developing and delivering consultant-delivered care, consistently across seven days a week across all emergency care in England, is significant.

As clinical leaders, consultants are also best placed to ensure the most efficient and effective use of resources. Consultants’ greater knowledge and experience and therefore rapid diagnosis leads to the most appropriate investigations and interventions first time. Their direct involvement in patient care consequently leads to a reduction in unnecessary admissions to hospital, lengths of stay and re-admission rates. This is of particular importance at present as the increasing number of patients with multiple medical conditions increase the difficulty of making generic treatment algorithms work.

Contributors to the Academy of Medical Royal Colleges’ report were also clear that greater consultant presence would not only improve patient care and experience but also improve the opportunities for learning and the quality of training for doctors, thereby improving safety now and creating a sustainable workforce for the future.

The implementation of the European Working Time Directive (EWTD) has resulted in shorter sessions of work for training grade junior doctors with complex rotas and more frequent handovers. The Collins and Temple reports both found that training grade doctors were often poorly supervised and sometimes expected to act beyond their competence.
**Key messages**

Reduced service provision, including fewer consultants working at weekends (in emergency medicine and acute in-patient specialties), is associated with England’s higher weekend mortality rate. Consistent services across all seven days of the week are required to provide high quality and safe care.

There are clear recommendations from the Temple report that training needs to take place in a consultant delivered service yet this is not practised across the majority of hospital services.
11. Urgent and emergency care workforce

The urgent and emergency care workforce faces mounting pressures across all specialties. General practice is the largest medical specialty group and GPs see more patients everyday than any other part of the NHS. There has been both a significant growth in the size of the NHS medical workforce and its shift from general practice towards secondary care. The number of GPs has grown by 29 per cent between 1995 and 2011 which was in line with total growth in NHS staff over the same time period. This is in contrast to the total number of consultants in other medical specialties which doubled over that period.

In 2011 there were 67.8 GPs per 100,000 population in England, compared to 58.1 in 2000. The Centre for Workforce Intelligence projects that this ratio will rise to 83-84 GPs per 100,000 population by 2030, if the 2015 target of 3,250 trainee places is achieved and maintained, although there is considerable uncertainty about the future GP workforce supply. It is suggested that the national picture also masks local variation such as unequal access to GPs between areas of high and low deprivation. Analysis of the available evidence on the demand for GP services points to a workforce under considerable strain. The existing GP workforce has insufficient capacity to meet current and expected patient needs.

With regard to urgent and emergency care out-of-hours services, a recent study looking at the changing workforce patterns highlighted examples of workforce and skill mix change. A wide range of new roles were observed for nurses and allied health professionals. Although there were differences in how these were deployed in different cases. The majority of examples were of non-medical professionals substituting for GPs in telephone triage and assessment; out-of-hours home visiting; face-to-face consultations with patients in treatment centres; prescribing medicines and admitting patients directly to hospital in an emergency.

Key message
National workforce analysis highlights a growth in the GP workforce in England however, local variation exists in unequal access to GPs between areas of high and low deprivation. Analysis highlights that the GP workforce is under with insufficient capacity to meet needs.

For A&E departments, whilst the demand for clinical involvement has increased, an insufficient number of doctors are choosing to specialise in emergency medicine because of concerns over the intensity and nature of the work, unsociable hours and working conditions. Recent drives to deliver consistent care seven days a week, together with a recognised need for consultant-delivered care mean that recruitment issues represent a serious threat to the sustainability of A&E services.

In 2011 and 2012, less than 50 per cent of ST4 posts for the A&E specialty were successfully filled. This has raised serious concerns over the supply of future consultants and the ability of A&E services to maintain current standards of care, which require consultant presence for 16 hours, seven days a week. In 2012 approximately 36 per cent of trusts already had

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344 Centre for Workforce Intelligence (2013) GP in-depth review: Preliminary findings
345 Centre for Workforce Intelligence (2013) GP in-depth review: Preliminary findings
347 NHS Employers Medical Workforce Forum notes (August 2012)
vacancies for consultants and 19 per cent had vacancies for middle-grade doctors\textsuperscript{348}. A more recent study\textsuperscript{349} of the breakdown of posts carried out by the College of Emergency Medicine shows a heavy reliance on locums to fill senior doctor positions across the UK (figure 13).

**Figure 13: Average breakdown of substantive, locum and vacant positions 2011/12 (UK)**

<table>
<thead>
<tr>
<th>Post Category</th>
<th>Av. Vacant posts (WTE)</th>
<th>Av. Locum in post (WTE)</th>
<th>Av. Substantive in post (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td></td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td>F2</td>
<td>3%</td>
<td></td>
<td>97%</td>
</tr>
<tr>
<td>GPVTS</td>
<td>4%</td>
<td></td>
<td>86%</td>
</tr>
<tr>
<td>CT1-CT3</td>
<td>5%</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>ST4-ST6</td>
<td>15%</td>
<td>12%</td>
<td>72%</td>
</tr>
<tr>
<td>Clinical Fellow/Trust Grade (Junior)</td>
<td>12%</td>
<td>11%</td>
<td>77%</td>
</tr>
<tr>
<td>Staff Grades/Specialty Doctors</td>
<td>12%</td>
<td>17%</td>
<td>71%</td>
</tr>
<tr>
<td>Consultants</td>
<td>8%</td>
<td>9%</td>
<td>83%</td>
</tr>
</tbody>
</table>

The average number of whole time equivalent (WTE) consultants per A&E department in 2011/12 was 7.4, compared to 3.8 in 2007/8. The average number of Higher Specialist Trainees (ST4-6) posts available has risen slightly in the same five year time period (2007-12), but the well-documented reduction in recruitment into ST4-6 posts has created significant vacancy or locum rates of 29 per cent for specialist trainees\textsuperscript{350}.

The recruitment shortage is set to compound the effects of the European Working Time Directive (EWTD), which limited the number of hours trainee doctors are allowed to work; effectively restricting the ability of hospitals to provide appropriate middle-grade cover, especially during out of hours periods\textsuperscript{351}. The inability of trusts to recruit doctors to substantive posts in A&E departments has already led to an increase in the use of locums to deliver services\textsuperscript{352,353}. Between 2008/09 and 2010/11 the average annual spend on medical locums in A&E departments rose by 30 per cent from £496,000 to £643,000. A recent report into the

\textsuperscript{348} HCL (2013) The Real Emergency in Emergency Departments: Is the chronic shortage of England's A&E doctors reaching crisis point?; HCL workforce solutions

\textsuperscript{349} College of Emergency Medicine (2013) The drive for quality; How to achieve safe, sustainable care in our Emergency Departments?

\textsuperscript{350} College of Emergency Medicine (2013) The drive for quality; How to achieve safe, sustainable care in our Emergency Departments?

\textsuperscript{351} Royal College of Physicians: Implementation of the European Working Time Directive by August 2004 for specialist registrars in acute hospital medicine, Commentary, Jan/Feb 2003, supplement no. 1

\textsuperscript{352} Broad, M (2010) Spending on locums rockets due to EWTD; hospital doctor news 12th November 2010

\textsuperscript{353} RCS Policy Unit (2010) Locum doctor costs in NHS Trusts in England: Results of a study from the Royal College of Surgeons of England

68
A shortage of doctors specialising in emergency medicine found that expenditure on locum staff for A&E is putting increasing pressure on acute trust resources.\textsuperscript{354}

**Key message**

The involvement of senior doctors 24 hours a day and consultant presence at times of peak activity seven days a week is required to ensure timely patient care and flow in an A&E department. Many A&E departments do not have the recommended number of emergency medicine consultants or middle grade doctors to support such a rota.

\textsuperscript{354} HCL (2013) The Real Emergency in Emergency Departments: Is the chronic shortage of England’s A&E doctors reaching crisis point?; HCL workforce solutions
12. Effective urgent and emergency care networks

Fragmented and diverse services present a confusing and complex picture to patients, who may find it extremely difficult to access care when they need it most. In addition, a lack of communication between these services may result in poor patient experience, duplication of effort (for example, history taking) and risk (for example, over-medication).

Linking services together into networks may result in an improved experience for patients, as well as a more efficient system overall. A review of urgent and emergency services by the Healthcare Commission found that the 33 per cent best performing areas worked together to provide care in an integrated way, as well as providing prompt access to services\textsuperscript{355}. Networks are also more likely to have linked reporting and patient information systems. This not only allows clinicians working in different locations to access detailed patient information, but also allows the collation of data for research purposes, driving improvement in treatment for the future\textsuperscript{356}.

Additionally, in a joint statement, the Royal Colleges of Physicians, GPs and Nursing, the College of Emergency Medicine and the British Geriatrics Society stressed the need for integration of services across primary, secondary, health and social care to provide the best care for frail older people. In particular, for A&E departments to be aligned with geriatricians and other services. It also stressed the need for GPs to provide early and targeted interventions in the community for older people with long term conditions. Such integration could reduce admission and re-admission rates and length of stay in hospitals\textsuperscript{357}.

Urgent and emergency care networks exist in some areas of England: in 2007, 96 out of the 152 (63 per cent) PCTs reported some network involvement in urgent and emergency care. Although guidance on their development was produced there was considerable variation in the organisation, scope, function and maturity of the networks\textsuperscript{358}. One third of networks identified themselves as informal and most had a focus on implementing change across organisational boundaries.

Additionally, information sharing across the urgent and emergency care pathway is of paramount importance as better integration across information systems can improve the handover and referral processes for patients as they move between care providers\textsuperscript{359}. However a 2011 study found that there was a lack of formal integration between providers of urgent and emergency care operating in the same area\textsuperscript{360}. A 2010 study of eight out-of-hours urgent and emergency care providers also found that, in some organisations, access to patient records was difficult, and incompatible or unsophisticated IT systems created barriers for passing on patient information to other providers\textsuperscript{361}. This meant there was a high probability


\textsuperscript{357} Royal College of Physicians, College of Emergency Medicine, the British Geriatrics Society, the Royal College of General Practitioners and the Royal College of Nursing, 2012. Joint statement on the emergency care of older people

\textsuperscript{358} University of Sheffield 2009. Medical Care Research Unit Final Report 2006-2010 http://www.shef.ac.uk/content/1/c6/05/91/04/final%20report.pdf

\textsuperscript{359} National Ambulance Commissioners Group (2010) Achieving integrated unscheduled care

\textsuperscript{360} Primary Care Foundation (2011), Breaking the mould without breaking the system. Primary Care Foundation.

that some services were not aware of a patient’s previous attendance elsewhere, forcing
patients to repeat their stories at several stages in the same pathway. This disorder within the
system compounds the issues of increased cost, poor patient experience, delay and clinical
risk caused by patient confusion.

**Key messages**

Urgent and emergency care networks can improve patient outcomes and experience, however
there is variation in the organisation, scope and functionality of networks across the country.

There are wide variations in the way information is shared between providers of urgent and
emergency care leading to potential duplication within the system causing delay and poor
patient experience.

There is clearly room to increase and improve the number and consistency of emergency and
urgent care networks in England, drawing on examples of good practice among other networks,
including those from other areas of medicine.

Stroke networks, for example, link together ambulance services, hyper-acute stroke units, local
stroke units and rehabilitation services. Ambulance crews take patients directly to the most
appropriate location and patients are likely to receive the best treatment, such as thrombolysis,
within the recommended time. Patients can then be sent to more local dedicated stroke units
closer to home, ideally within three days.\(^{362}\)

The trauma system in London also represents a well-developed network. It includes four
trauma networks, each centred on a major acute hospital. These centres are supported by a
number of trauma units located in A&E departments, where patients with less serious injuries
are treated. Ambulance protocols developed alongside the system mean that trauma patients
with severe injuries are taken directly to those centres that are best equipped to treat them. In
the unusual event of such patients being taken to another A&E department, they are
transferred directly. The development of specific trauma patient pathways has led to
significant improvements in outcomes.

A whole-system approach to commissioning more accessible, integrated and consistent
services is required to meet patients unscheduled care needs.

13. Conclusion

Urgent or unplanned care – when there is a need to access care quickly – leads to at least 100 million NHS calls or visits each year, which represents about one third of overall NHS activity and more than half the costs. Growing numbers of frail elderly patients, increasing morbidities, more treatable illnesses and an increased public expectation of healthcare have all contributed to ever greater pressure on health and social care services. This has led to greater pressure on the urgent and emergency care system and indications that the current system of urgent and emergency care is unaffordable and unsustainable and consuming NHS resources at a greater rate every year. Further to this, the widespread fragmentation and varied nomenclature of the system is causing confusion amongst patients resulting in an inability to navigate the system effectively, duplication of efforts and patients’ needs not being met in the right place, first time, by those with the right skills.

The evidence base for improving urgent and emergency care in England indicates that there is variation in access to primary care services across England leading to many patients accessing urgent and emergency care services for conditions that could be treated in primary care. There is also variation in the management of patients with long-term conditions by primary care services.

Although telephone consultations are becoming increasingly popular and are less resource-heavy for general practice than face-to-face consultations, some patients lack confidence in telephone advice and are likely to pursue a second opinion inappropriately, leading to duplication of service provision, in some cases. Additionally, it is sometimes difficult to accurately triage patients over the phone and, without clinical input, call handlers may be likely to over-triage if they cannot rule out a serious condition.

Fragmentation and variation in urgent care services emphasise the problems of patient confusion and limited ability to navigate the current system. This leads to poor patient experience, duplication of efforts and resources and in some cases, patients defaulting to the familiarity of an A&E department, despite this not being the most appropriate service for their needs.

Calls to 999 emergency services are rising and, while ambulances are not always sent to callers, with some calls resolved with telephone advice alone, many are dispatched only to find an ambulance was not required. Some patients may be discharged at the scene following treatment; others are taken to non-emergency care facilities. The majority, however, are transported to A&E departments. While all emergency patients attending A&E departments should be able to expect specialised care of the highest quality, these departments are under increasing pressure due to rising patient numbers.

363 NHS Alliance (2012) A practical way forward for clinical commissioners; NHS Alliance on behalf of NHS Clinical Commissioners and sponsored by NHSCB
364 Primary Care Foundation (2011) Breaking the mould without breaking the system
368 Fernandes, A. (2011) Guidance for commissioning integrated urgent and emergency care: a whole system approach; Royal College of General Practitioners Centre for Commissioning
Many patients presenting to A&E, or calling 999, do not need the specialised care offered at by these services, and would be better served elsewhere. They may be unaware of the options such as the NHS 111 services, which gives access to real time information about clinical services in order to locate an available service with the right skills. Additionally, feeling unwell and vulnerable, patients may go for the option they most closely identify with being able to provide care in a crisis, 24 hours a day. Whatever the reason, the current system is failing either to signpost patients to the appropriate level of care effectively, and, or in some cases to provide an obvious and easily-accessible alternative to A&E departments.

The public expect that the NHS will provide them with a consistently safe and high quality service; this expectation should underpin the way that all services are commissioned and delivered. Whilst the NHS provides a high quality service for many patients admitted as an emergency, significant variations exist in patient outcomes and service arrangements, both between hospitals and also within hospitals depending on whether the patient is admitted on a weekday or weekend. This variation is also true of access to high quality back up services and specialised services.

With rising demand and greater costs, the urgent and emergency care system is consuming resources at a greater rate each year. Fragmented and diverse services present a confusing and complex picture to patients, who may find it extremely difficult to access care when they need it most. There is a clear need to adopt a whole-system approach to commissioning more accessible, integrated and consistent urgent and emergency care services to meet patients unscheduled care needs.

374 National Confidential Enquiry into Patient Outcome and Death. (2007). Emergency admissions: A step in the right direction, NCEPOD
Glossary

Academy of Medical Royal Colleges: The Academy’s role is to promote, facilitate and where appropriate co-ordinate the work of the Medical Royal Colleges and their Faculties for the benefit of patients and healthcare. The Academy comprises the Presidents of the Medical Royal Colleges and Faculties who meet regularly to agree direction.

Acute medicine: That part of general (internal) medicine concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to, or from within, hospitals, requiring urgent or emergency care.

Acute trust: NHS acute trusts manage hospitals. Some are regional or national centres for specialist care; others are attached to universities and help to train health professionals. Some acute trusts also provide community services.

Algorithms: A step by step process for calculations used for data processing.

Ambulatory care-sensitive conditions (ACSCs): Conditions for which effective management and treatment should limit emergency admissions to hospital.

Arterial surgery: Surgery of the blood vessels which carry blood away from the heart.

Asthma: A common chronic inflammatory disease of the airways characterised by variable recurring symptoms, such as reversible airflow obstruction.

Blood bank: A cache or bank of blood or blood components, gathered as a result of blood donation, stored and preserved for later use in blood transfusion.

Cardiology: The medical specialty dealing with disorders of the heart.

Care Quality Commission (CQC): This is an organisation funded by the Government to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people’s own homes and elsewhere meets national standards of quality and safety.

Chronic condition: A health condition or disease that is persistent or otherwise long-lasting in its effects.

College of Emergency Medicine: A charity founded in 2010 which champion a culture of innovation, prevention and patient collaboration in medicine.

Confidential Enquiry into Maternal and Child Health (CEMACH): This organisation aims to improve the health of mothers, babies and children by carrying out confidential enquiries on a nationwide basis and by widely disseminating the findings and recommendations.

Critical care: A branch of medicine concerned with life support for critically ill patients.

Department of Health: The government department responsible for public health issues and which exists to improve the health and wellbeing of people in England.
**Diabetes:** A group of metabolic diseases in which a person has high blood sugar.

**Diagnosis:** The identification of the nature and cause of anything.

**Dr Foster:** The leading innovator in benchmarking public services and communicating information about services to the public.

**Elective care:** Scheduled care which does not involve a medical emergency.

**Emergency 999 service:** The official emergency UK telephone number for the caller to contact emergency services and for emergency assistance.

**Emergency admission:** An admission that is unpredictable and at short notice because of clinical need.

**Emergency department (ED):** Also know as accident and emergency (A&E), or casualty department, is a medical facility specialising in acute care for patients who present without prior appointment, either by their own means or by ambulance.

**Ethnic group:** Socially defined category based on common culture or nationality.

**European Working Time Directive (EWTD):** A collection of regulations concerning hours of work, designed to protect the health and safety of workers.

**Expert Patient Programme (EPP):** A self-management programme for people and carers living with long-term health conditions.

**Foundation Trust:** Part of the NHS and has gained a degree of financial and managerial independence from the Department of Health and local NHS strategic health authorities.

**Foundation Trust Network:** A membership organisation for the NHS public provider trusts, who represent every variety of trust.

**Frontline staff:** Staff who work directly with service users.

**General practitioner (GP):** A medical practitioner who treats acute and chronic illnesses and provides preventative care and health education to patients.

**Health literacy:** Method used to help people manage and prevent their own illness and injury better through self care and self management.

**Hyper-acute stroke unit (HASU):** Specific units created to deliver care for patients presenting with new onset of stroke symptoms.

**Hypertension:** A chronic medical condition in which the blood pressure in the arteries is elevated. Also known as high blood pressure.

**Information Centre for Health and Social Care (ICHSC):** A data information and technology resource for the health and social care system.
**Imaging:** The process used to create images of the human body for clinical purposes seeking to reveal, diagnose, or examine disease.

**Inpatient:** A patient who is admitted to the hospital and stays overnight for an indeterminate time.

**King’s Fund:** An independent charity working to improve health and healthcare in England, by helping to shape policy and practice through research and analysis.

**Laboratory services:** A facility that provides controlled conditions in which scientific research experiments and measurement may be performed.

**London Trauma Office:** An NHS department which oversees the management of the capital’s trauma system ensuring the delivery of a world class system.

**Major Trauma Networks:** NHS networks established nationally to specifically manage serious injuries.

**Minor injury units (MIU):** NHS units established to specifically treat non-serious injuries.

**Morbidity:** Refers to the disease state of the patient, or the incidence of illness in the population.

**Mortality rates:** Refers to the incidence of deaths in a population.

**National Audit Office:** A government agency responsible for scrutinising public spending on behalf of Parliament.

**National Confidential Enquiry into Patient Outcome and Death (NCEPOD):** A national organisation whose purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

**Neurology:** The medical specialty responsible dealing with disorders of the nervous system.

**NHS 111:** A three digit telephone service introduced to improve access to NHS urgent care services.

**NHS Choices:** Information from the National Health Service on conditions, treatments, local services and healthy living.

**NHS Constitution:** The constitution sets out rights for patients, public and staff, and outlines NHS commitments and responsibilities owed to one another to ensure that the NHS operates fairly and effectively.

**NHS Direct:** A website set up by the NHS to provide health advice and information to patients and the public.
**NHS Employers Medical Workforce Forum:** An organisation established to provide an authoritative voice of workforce leaders, experts in human resources, and negotiate fairly to get the best deal for patients.

**NHS England:** Established in April 2013, the main aim of NHS England is to improve the health outcomes for people in England.

**NHS Improvement:** This organisation is now closed. However, elements of its programmes of work have continued within NHS Improving Quality, which is hosted by NHS England.

**Ophthalmology:** Is the branch of medicine that deals with the anatomy, physiology and disease of the eye.

**Orthopaedics:** The branch of surgery concerned with the musculoskeletal system.

**Outpatient:** A patient who visits a hospital or associated facility for diagnosis or treatment who is not hospitalised for 24 hours or more.

**Paediatrics:** The branch of medicine that deals with the medical care of infants, children and adolescents.

**Paediatrician:** A medical practitioner who specialises in the medical care of infants, children and adolescents.

**Patient Association:** A national voluntary organisation run by an elected Council and independent of government and health service organisations.

**Payment by results (PbR):** A system developed by a government team responsible for the development and production of a national tariff and supporting guidance.

**Pharmacist:** Healthcare professionals who practice pharmacy, the field of health sciences focussing on the safe and effective medication use.

**Physician:** A professional who practices medicine.

**Pre-hospital care:** A term which covers a wide range of medical conditions, medical interventions, clinical providers and physical locations.

**Primary care:** The health care given by a health provider who typically acts as the principle point of consultation for patients within the healthcare system and coordinates other specialists that the patient may need.

**Primary Care Foundation:** Established in 2008 to support the development of best practice in primary and urgent care.

**Public health:** Helping people to stay healthy and protecting them from threats to their health.

**Registrar:** A new training grade used to train doctors up to the specialist level required to become a consultant.
Respiratory: The anatomical system that includes the lungs, airways and respiratory muscles.

Royal College of General Practitioners: A professional membership body for family doctors in the UK and overseas.

Royal College of Physicians (RCP): An independent membership organisation which supports and represents physicians and engages in physician development and raising standards in patient care.

Royal College of Surgeons (RCS): An independent membership organisation which provides support and training to enable surgeons to achieve and maintain the highest standards of patient care.

Secondary care: Healthcare services provided by medical specialists and other healthcare professionals who generally do not have first contact with patients.

See and treat: A system developed with the aim to reduce variation waiting times between patients, thereby reducing the maximum wait that some patients experience.

Self care: Personal health maintenance. Any activity of an individual, family or community, with the intention of improving or restoring health, or treating or preventing disease.

Self Help Forum: An online self help support forum community which allows the public to raise health related queries and concerns online.

Social care services: A provider of quality outcome support for care service providers and independent single assessments and reviews to the general public and local authorities.

Socio-economic group: A group of people who have the same social, economic or educational class.

Telemedicine: A broad description of medical and healthcare services provided by means of telecommunications.

Tertiary hospital: A hospital which provides specialised consultative care.

Thrombolysis: The breakdown of blood clots by pharmacological means.

Triage: The process of determining the priority of patients’ treatments based on the severity of their condition.

Trolley wait: A term used for patients who cannot be admitted due to a lack of bed capacity.

Ultrasound: A painless test that uses sound waves to create images of organs and structures inside the body.

Unplanned care: Healthcare which cannot reasonably be foreseen or planned in advance.

 Unscheduled care: A term used to describe any unplanned health or social care.
**Urgent care:** The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of the hospital emergency department.

**Walk-in centre:** A service that provides treatments for minor ailments.

**World Health Organisation (WHO):** An organisation which directs and coordinates authority for health within the United Nations system.

**X-ray:** Often used to produce images of the dense tissues inside the body, such as bone.
High quality care for all, now and for future generations: transforming urgent and emergency care services in England.

Emerging Principles from the Urgent and Emergency Care Review

June 2013
Structure of this document

Through the development of the evidence base for improving urgent and emergency care, the Urgent and Emergency Care Steering Group has identified four emerging principles for an improved urgent and emergency care system in England.

From these principles 12 ‘system design objectives’ have been outlined – these are the suggested outcomes which should be delivered by any future urgent and emergency care system.

The Urgent and Emergency Care Steering Group has also identified illustrative implementation options to show the types of solutions that Phase 2 of the Review may develop.

These are not agreed solutions at this stage, but have been presented to help explain what any future urgent and emergency care system might look like to stimulate debate.
Emerging principles for urgent and emergency care in England outline a system that:

1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week;

2. Is **simple** and guides good choices by patients and clinicians;

3. Provides the **right care** in the **right place**, by those with the **right skills**, the **first time**;

4. Is **efficient** in the delivery of care and services.
System design objectives (1):

1. Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.
2. Increase my or my family/carer’s awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition.
3. Increase my or my family/carer’s awareness of and publicise the benefits of ‘phone before you go’.
4. If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.
5. Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway.
6. Wherever appropriate, manage me where I present (including at home and over the telephone).
7. If it's not appropriate to manage me where I present (including at home and over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed.

8. Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised.

9. Information, critical for my care, is available to all those treating me.

10. Where I need wider support for my mental, physical and social needs ensure it is available.

11. Each of my clinical experiences should be part of programme to develop and train the clinical staff and ensure their competence and the future quality of the service are constantly developed.

12. The quality of my care should be measured in a way that reflects the urgency and complexity of my illness.
1. Provides **consistently high quality** and **safe** care, across all seven days of the week (1)

<table>
<thead>
<tr>
<th>System design objective</th>
<th>Possible implementation options:</th>
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| (4) If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team. | • Same day, every-day telephone, web or email contact to a primary care team integrated with patient’s own GP practice  
• A same-day, every-day appointment system for urgent care facilities  
• Direct access to community nurse specialists and hospital specialist teams for patients with long term conditions  
• GPs/Out-of-Hours teams to have easy direct access to same day opinion from hospital specialists 7/7 |
| (5) Improve my care, experience and outcomes by ensuring early senior clinical input in the urgent and emergency care pathway. | • 111 (advice and triage) services with greater clinical input, such as senior clinical input in telephone triage where hospital transfer is recommended or for complex enquiries  
• Urgent Care Centres staffed with a multi-disciplinary team with support of at least one GP or other registered medical practitioner  
• Senior emergency physicians present in all 999 ambulance receiving Emergency departments to ensure presence until midnight, and beyond this where acuity and patient numbers justify this  
• Ensure working patterns/careers are sustainable - rested, alert and safe practitioners ready to provide high quality care  
• Utilise specialist nurses, paramedics and other allied health practitioners at key decision points in care to optimise patient outcomes and experience  
• Specify clinical service modules of care for different patient groups (e.g. ill child, mental health, limb injuries, etc.) that are capable of assessing and either treating or transferring. These could be combined to create bespoke local emergency facilities based on a community’s needs |
1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week (2)

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| (6) Wherever appropriate, manage me where I present (including at home and over the telephone). | • Identify and commission joint primary and specialist care of complex patient groups in the community (e.g. diabetics)  
• Mobilisation of the appropriate level of decision making for the call/enquiry, and where appropriate, decision maker is sent to the home rather than taking the patient to the decision maker  
• Remote/rural areas to be supported by higher specification on-scene treatment options by paramedics, nurse specialists or doctors  
• Telemedicine support and on scene/home diagnostic testing  
• Direct referral of patients to responsive community support teams |
| (7) If it's not appropriate to manage me where I present (including at home and over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed. | • All urgent and emergency care facilities to be in formal networks  
• Each facility to have immediately available and capably skilled staff and plans for the safe care and/or transfer of all patient types  
• Bypass some Emergency facilities to specialist centres for stroke, heart attack, major trauma and specialist children’s services; those centres to have consistent network pathways and concentrate expertise to improve patient outcomes and efficiency  
• Inpatient service support for Emergency facilities is always available  
• Remote and rural areas to have intermediate facilities capable of stabilisation prior to transfer if network journey times are too lengthy |
| (8) Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised. | • Establish a code of conduct for non-NHS urgent and emergency care operators to ensure alignment with NHS operational and clinical governance and provide clarity of corporate responsibilities  
• Commission appropriate transportation for those in mental health crisis, which is sensitive to their holistic needs |
2. Is **simple** and guides good choices by patients and clinicians

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| (1) Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice. | • Simplified and standardised access points to the urgent and emergency care network and facilities  
• A single urgent and emergency care system for the public, but with a supporting, responsive, tiered clinical structure behind  
• Decision support from a patient’s own GP practice and hospital specialist nurse/team, seven days a week |
| (2) Increase my or my family/carer’s awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition. | • Increased patient, family/carer education to self-care and self-manage  
• 7 day continuity of care from a patient’s GP practice  
• 7 day access to community, mental health and hospital nurse specialists  
• 111 service fosters communication and co-ordination between different elements of the urgent care community, whilst developing an effective and expanding directory of services in every locality  
• 111 website and NHS Choices better linked to charity and other support groups and their information  
• Improve status and use of pharmacists |
| (3) Increase my or my family/carer’s awareness of and publicise the benefits of ‘phone before you go’. | • 111 service to have greater medical input - senior clinical input in telephone triage and advice  
• GP telephone consultations both in and out-of-hours |
| (12) The quality of my care should be measured in a way that reflects the urgency and complexity of my illness. | • Process and outcome measures and commissioning requirements should be sensitive to, and appropriate for the casemix, linked to the outcome and relate to the episode of care |
3. Provides the **right care in the right place**, by those with the **right skills**, the **first time** (1)

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| (5) Improve my care, experience and outcomes by ensuring early senior clinical input in the urgent and emergency care pathway. | • 111 (advice and triage) services with greater clinical input, such as senior clinical input in telephone triage where hospital transfer is recommended or for complex enquiries  
• Urgent Care Centres staffed with a multi-disciplinary team with support of at least one GP or other registered medical practitioner  
• Senior emergency physicians present in all 999 ambulance receiving Emergency departments to ensure presence until midnight, and beyond this where acuity and patient numbers justify this  
• Ensure working patterns/careers are sustainable - rested, alert and safe practitioners ready to provide high quality care  
• Utilise specialist nurses, paramedics and other allied health practitioners at key decision points in care to optimise patient outcomes and experience  
• Specify clinical service modules of care for different patient groups (e.g. ill child, mental health, limb injuries, etc.) that are capable of assessing and either treating or transferring. These could be combined to create bespoke local emergency facilities based on a community’s needs |
| (6) Wherever appropriate, treat me where I present – at home, on scene or over the telephone. | • Identify and commission joint primary and specialist care of complex patient groups in the community (e.g. diabetics)  
• Mobilisation of the appropriate level of decision making for the call/enquiry and, where appropriate, decision maker is sent to the home rather than taking the patient to the decision maker  
• Remote/rural areas to be supported by higher specification on-scene treatment options by paramedics, nurse specialists or doctors  
• Telemedicine support and on scene/home diagnostic testing  
• Direct referral of patients to responsive community support teams |
3. Provides the **right care** in the **right place**, by those with the **right skills**, the **first time** (2)

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| (7) If it's not appropriate to treat me where I present (home, on scene or over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre. | • All urgent and emergency care facilities to be in formal networks  
• Each facility to have immediately available and capably skilled staff and plans for the safe care and/or transfer of all patient types  
• Bypass some Emergency facilities to specialist centres for stroke, heart attack, major trauma and specialist children's services; those centres to have consistent network pathways and concentrate expertise to improve patient outcomes and efficiency  
• Inpatient service support for Emergency facilities is always available  
• Remote and rural areas to have intermediate facilities capable of stabilisation prior to transfer if network journey times are too lengthy |
| (10) Where I need wider support for my mental, physical and social needs ensure it is available. | • A directory of community and acute services available to all clinicians in the urgent and emergency care pathway, encompassing health and social care services  
• Rapid access to social care assessment and mental health liaison services |
| (11) Each of my clinical experiences should be part of programme to develop and train the clinical staff and ensure their competence and the future quality of the service are constantly developed. | • Regular integrated clinical governance meetings involving all contributors to the urgent and emergency care pathway with a focus on final outcomes  
• Ensure training is delivered effectively and that services are not over-reliant on trainees  
• Appropriate senior supervision of trainees |
4. Is **efficient** in the delivery of care and services

<table>
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| (1) Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice. | • Simplified and standardised access points to the urgent and emergency care network and facilities  
• A single urgent and emergency care system for the public, but with a supporting, responsive, tiered clinical structure behind  
• Decision support from a patient’s own GP practice and hospital specialist nurse/team, seven days a week |
| (8) Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised. | • Establish a code of conduct for non-NHS urgent and emergency care operators to ensure alignment with NHS clinical governance and provide clarity of corporate responsibilities |
| (9) Information, critical for my care, is to be available to all those treating me.       | • All patient records are to be accessible and shared amongst all urgent and emergency care providers |
APPENDIX M

Stroke Briefing Paper

REPORT

TO FOLLOW

Board of Directors Part I

12 July 2013
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<tr>
<td><strong>Type of Assurance</strong></td>
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</table>
For the first time ever, NHS organisations across Dorset have come together to launch The big ask, a unique survey asking for the views of people across Dorset and west Hampshire on a whole range of NHS services, including GPs, out of hours’ services, community services and hospital care. It’s called The big ask because it’s not just a simple tick box survey. There are some real thought provoking questions that will really help inform how local services are provided, and we want you, our staff and volunteers, to take part.

Some 12,000 people across Dorset and west Hampshire will be sent a postal survey, but anyone can take part online at www.bournemouth.ac.uk/thebigask. We will also be carrying out a range of focus groups. To ensure it is independent, the research is being carried out by the Market Research Group (MRG) at Bournemouth University.

The initiative runs over 12 weeks and is being supported by a proactive communication plan. A range of activities include local media coverage, website features and engagement using Twitter and Facebook. Over the next few weeks we will be covering topics such as choosing the appropriate NHS service, the changing NHS and local NHS services.

Make sure you have your say by completing the survey. You can also take part in conversations by following us on Twitter @RBCH_NHS and @HealthyDorset or on Facebook at www.facebook.com/HealthyDorset

We will feedback the findings and outcomes of the research later in the autumn.

If you would like a paper copy of the survey, please contact Ehren Milner on 01202 961379 or emilner@bournemouth.ac.uk. For paper copies to be placed in patient waiting areas, please contact the Communications Team on communications@rbch.nhs.uk or call 01202 704271.
Christchurch Hospital update

A new factsheet has been produced with an update on the plans for Christchurch Hospital, including estimated dates for when work will start and where. The factsheet can be downloaded from www.rbch.nhs.uk/christchurch. Alternatively contact communications@rbch.nhs.uk for a paper copy.

Open Day

The atrium of the Royal Bournemouth Hospital was abuzz with activity on 12 June as patients, the public and staff took part in the annual Open Day.

Visitors found out about the different services available at the Trust and got involved with the interactive displays that were hosted by a range of departments.

Director of Nursing and Midwifery Paula Shobbrook presented the Interactive Exhibitor Award to Maternity Services, whose stand explored midwifery through the ages. Midwife Julie Horn dressed up like Miranda Hart’s character Chummy from popular BBC1 drama Call the Midwife and mounted her bicycle while other members of the team talked to people about different birthing methods, and breastfeeding.

Thank you to everyone involved in the day.

Mayor of Bournemouth’s generous support

The Trust has expressed its thanks to the Mayor of Bournemouth, Councillor Phil Stanley-Watts, for a year of generous support.

The Mayor presented a cheque for £5,332 to the hospital Trust’s fundraising team, which will go towards the hospital’s Jigsaw Appeal.

Each year the Mayor of Bournemouth adopts local charities to support during their mayoral year. During his year Councillor Stanley-Watts chose four charities - the Jigsaw Appeal, Bournemouth Leukaemia Fund, The Jon Egging Trust and the Springbourne Family Centre, raising £21,329 in total.
Plans for the new Jigsaw Building have been submitted for consideration to Bournemouth Council. The plans can be viewed on www.bournemouth.gov.uk under planning application number 7-2013-5913-EE. Any comments should be submitted to the council in writing by 19 July.

Detailed feedback from hospital staff, patients and the public have been incorporated into the designs for the proposed new Women’s Health Unit and Cancer and Blood Disorders Unit.

Richard Renaut, Director of Service Development, said: “We’re really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.”

The proposed 2000m2 Jigsaw Building will be based at RBH between the Eye Unit and the Derwent Suite for Orthopaedics. It will be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

Subject to planning approval, initial work could start in October with a potential completion date of late 2014.

Over 350 walkers turned Bournemouth promenade into a sea of pink for this year’s Twilight Walk in support of the Trust’s Jigsaw Appeal.

The walk was started by the new Mayor of Bournemouth, Councillor Dr Rodney Cooper, and Mayoress Mrs Elaine Cooper. There were more participants than in 2012 and the walkers enjoyed fine weather and a party atmosphere.

Lindsey Sturman, Fundraising Manager of the Bournemouth Hospital Charity, said: “The Twilight Walk is an event we really look forward to and this year did not disappoint. We would like to say a big thank you to everybody who took part and also to those who helped make the event possible including our wonderful volunteers.”

The Bournemouth Hospital Charity is now on Twitter. Follow them @Bmthospcharity
Information Standard

The Trust has been awarded the Information Standard quality mark for the health and care information it produces for patients.

To achieve the Information Standard accreditation, the Trust underwent a rigorous two-day assessment of its patient information process by the Royal Society for Public Health, one of the organisations accredited to carry out the assessment. Achieving the accreditation means all information produced can now carry the Information Standard quality mark - a clear indication that it is accurate and reliable.

Patient information produced by the Trust ranges from leaflets detailing what exercises to do after surgery, to information about drugs a patient has been prescribed. More than 1,500 pieces of patient information have been reviewed and approved by the Trust’s Patient Information Group, which includes leaflets, website content and patient films. The information is reviewed at least every three years to ensure it is still relevant and correct.

Patient films

This month the Communications Team has been working with a production company to produce two new patient films. The films have focused on dementia and the Clinical Site Team and will be available on the Trust website in the summer.

The films are designed to give the public an insight into the workings of the hospitals and to let patients and relatives know what to expect before they attend and while they are here.

If you would be interested in producing a patient film for your department, please contact communications@rbch.nhs.uk

“Ortho App” available to download for iPhones and iPads

The Trust has launched its new Ortho App about orthopaedic procedures. The Ortho App is an interactive tool which covers the whole patient journey, from preparing to come into hospital to what should be done to aid recovery at home. It is now available to download from the Apple App Store.

Features include information on the Orthopaedics Department, a tick list of what items a patient should bring to hospital and films of post-operative physiotherapy exercises with an option to set a reminder on when to do them. It also contains generic information about the hospital, including travel details and maps.

The first procedures to feature on the app are shoulder arthroscopic subacromial decompressions (ASDs) and knee arthroscopies. More procedures will be added over the coming months.

Any feedback about the app will be taken into account when upgrades are made, and for the Android version.

The app can be downloaded by searching for “OrthoApp” on the Apple App Store. An information video on the app can be viewed from the latest news section on the RBCH website: www.rbch.nhs.uk/news
A-Z of services

We are currently updating the A-Z pages of the Trust website to ensure all departments and services have a web presence. Basic information, such as contact telephone numbers and an overview of your service, can be added first with additional information uploaded at a later date. If your department is not on the A-Z of services, please contact the Communications Team at communications@rbch.nhs.uk to discuss the information required.

Unicef approves Bournemouth Maternity Unit as ‘baby friendly’

The Royal Bournemouth Hospital’s Maternity Unit has earned Unicef Baby Friendly reaccreditation, recognising the support and care provided to mothers and babies.

The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF. The overarching aim is to ensure a high standard of care for pregnant women and all mothers in the postnatal period, supporting them in their chosen feeding method.

The Maternity Unit received full accreditation in 2011 after a four-year assessment process. Reaccreditation takes place every two years to ensure the standards of care are being maintained. Staff knowledge and skills were reassessed; with an 80% pass mark required in each of eight categories. The RBH Maternity Unit achieved 91% in two categories and 100% in the remaining six categories.

Liz Stacey, Breastfeeding Educator at RBH, said: “We are incredibly proud to have achieved reaccreditation. Given the high standards that need to be met, it is a fantastic achievement. It demonstrates the calibre of staff within the Maternity Unit and the excellent care that we give to mothers.”

Mothers were also interviewed as part of the process, both in the antenatal and postnatal period, to assess the standard of care and information that they receive. An 80% pass mark is again required in each category and the RBH Maternity Unit results were extremely high, with 92% in one category and 100% in all other categories.

HIV awareness - guidelines for healthcare workers

A set of guidelines have been written in conjunction with Body Positive Dorset, drawing on the experience of patients who have encountered situations within the hospital that they feel could have been handled better. All healthcare workers should familiarise themselves with the guidelines, and pass on to colleagues in their directorates and departments.

The key messages:
- no one should be refused treatment simply because of their HIV status
- protect confidentiality
- respect privacy. Only ask questions that are clinically relevant
- treat with dignity
- employ standard precautions for all patients. In particular HIV patients should not be placed at the end of theatre lists

The full guidelines will soon be available on the intranet.
<table>
<thead>
<tr>
<th><strong>BOARD OF DIRECTORS</strong></th>
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<tbody>
<tr>
<td><strong>Meeting Date and Part:</strong></td>
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<tr>
<td><strong>Subject:</strong></td>
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<tr>
<td><strong>Section:</strong></td>
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<tr>
<td><strong>Executive Director with overall responsibility:</strong></td>
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<tr>
<td><strong>Author of Paper:</strong></td>
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**Details of previous discussion and/or dissemination:**

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<th>Performance</th>
<th>Strategy</th>
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<td></td>
<td></td>
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<td>X</td>
<td>X</td>
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| **Action required by Board:** | To note the report |

**Executive Summary:**
The Communications Report provides a summary of key communication activities over the past month, including media KPIs, quarterly web statistics, and a summary of the Trust’s media coverage (Read All About It).

**Strategic Goals & Objectives:**

**Links to CQC Registration:**
(Outcome reference) Section 1, Outcome 1, Section 4, Outcome 13 and 14

**Links to Assurance Framework/Key Risks:**

| **Type of Assurance:** | Internal | External |
Communications activities
July 2013

1. Introduction

The following paper sets out:
- recent communication and fundraising activities
- media relations KPIs

2. Recent activities

- very successful open day and one of the busiest. Good, interactive stands, lots of visitors and ever-popular talks. One visitor from Jersey said: “More hospitals should do this”. There was a key focus on Health Promoting Hospitals
- launch of The big ask – first Dorset-wide listening exercise involving all health partners. Communications programme of editorials and use of social media on-going. Surveys have started to go to 12,000 representative members of the public in Dorset and west Hampshire. Members will receive the survey early August with FT Focus.
- Celebrities Dancing on Ice stars Chico and Kyran Bracken visited the hospital to meet staff and patients on wards 10 and 11 and announce the winner of the charity raffle – this was extremely popular with staff and patients and received good media coverage and raised funds for Bournemouth Hospital Charity.
- Staff Excellence Awards – all award categories have been judged and filming for the evening ceremony nearly complete. Date for the ceremony is Thursday 5 September.
- big increase in Twitter followers, including lots of patients tweeting their good experiences at the hospitals, which are sent on to the relevant department.
- new factsheet created for Christchurch Hospital developments which has been uploaded to website, sent to staff, patient areas, governors and press.
- filming for two new patient films complete. The films focus on dementia and the Clinical Site Team. Editing work now in progress.
- merger communication activities

3. Future activities

- Staff Excellence Awards ceremony planning
- merger communications
- patient film promotion
- developing social media plan
- developing the Bournemouth Hospital Charity fundraising strategy

4. Recommendation

The Board is asked to note the report.
### Media relations - Key Performance Measures 2013

*(this includes fundraising)*

<table>
<thead>
<tr>
<th>2013</th>
<th>No. of proactive news release distributed</th>
<th>% that received media coverage in that month</th>
<th>% of articles relating to releases/ media enquiries</th>
<th>Total number of pieces of coverage (includes adverts)</th>
<th>Total positive media coverage (all media)</th>
<th>Advertisings value (for print coverage) */ **</th>
<th>Total negative media coverage</th>
<th>Negative coverage rebutted i.e. avoided</th>
<th>Media enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June 2013</strong></td>
<td>15 (including Chico visit, Ortho App launch, Twilight Walk success, Mat Unit accreditation, Jigsaw plans, charity bike ride and League of Friends donation)</td>
<td>100%</td>
<td>79%</td>
<td>61</td>
<td>56</td>
<td>£91,865</td>
<td>1</td>
<td>0</td>
<td>14 (including filming for BBC programme, ED waiting times, merger, public health funerals, Jigsaw building, XCH update)</td>
</tr>
<tr>
<td><strong>May 2013</strong></td>
<td>12 (including virtual nurse, Open Day, Twilight Walk, Winter Heroes, bra donation, Eye Unit award, Health Minister visit and Information Standard)</td>
<td>92%</td>
<td>94%</td>
<td>67</td>
<td>40</td>
<td>£23,478</td>
<td>24</td>
<td>0</td>
<td>24 (including a number of enquiries and follow up questions about the recall of breast patients)</td>
</tr>
<tr>
<td><strong>April 2013</strong></td>
<td>10 (including patient legacy urology equipment, Health Promoting Hospitals, Open Day)</td>
<td>60%</td>
<td>40%</td>
<td>25</td>
<td>22</td>
<td>N/A need updated advertising rates</td>
<td>1</td>
<td>0</td>
<td>12 (including patient filming for BBC programme, weekend staffing levels, catering waste, merger, Jigsaw building)</td>
</tr>
</tbody>
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- * Any paid for adverts are not included i.e. advertorials
- ** Negative articles are not included
- Quarterly website statistics for **www.rbch.nhs.uk**

<table>
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<tr>
<th>Assessment</th>
<th>Performance Indicator</th>
<th>Sept-Dec 2012</th>
<th>Jan-March 2013</th>
<th>Apr-Jun 2013</th>
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</thead>
<tbody>
<tr>
<td><strong>Site marketing</strong></td>
<td>New visitors</td>
<td>41,239 visits (-3%)</td>
<td>45,792 visits (+11%)</td>
<td>49,103 visits (+7%)</td>
</tr>
<tr>
<td><strong>User commitment</strong></td>
<td>Returning visitors</td>
<td>27,005 visits (+8%)</td>
<td>31,537 visits (+16%)</td>
<td>33,736 visits (+7%)</td>
</tr>
<tr>
<td><strong>Information accessibility</strong></td>
<td>Average dwell time on website</td>
<td>3.59 minutes</td>
<td>2 minutes</td>
<td>2 minutes</td>
</tr>
<tr>
<td><strong>Search engine coverage</strong></td>
<td>Search traffic (from search engines)</td>
<td>51,560 visits (-2%)</td>
<td>55,010 visits (+7%)</td>
<td>59,034 visits (+7%)</td>
</tr>
<tr>
<td><strong>External interest</strong></td>
<td>Referral traffic (from other websites)</td>
<td>6,677 visits (-30%)</td>
<td>7,615 visits (+14%)</td>
<td>9,371 visits (+23%)</td>
</tr>
<tr>
<td><strong>Site Awareness</strong></td>
<td>Direct traffic (people visiting site directly)</td>
<td>10,006 visits (+99%)</td>
<td>15,002 visits (+50%)</td>
<td>18,693 visits (+25%)</td>
</tr>
</tbody>
</table>
June saw a reduction in the actual number of media enquiries received compared to May, but an increase in the range of topics enquired about by the press. There were also a number of requests for filming on site, as well as a request for a radio interview to promote the Trust’s Open Day.

June also saw an increase in the number of proactive press releases sent out and an excellent level of positive coverage across a range of media, including new publications and social media platforms. Positive coverage included a front page story about the plans for the Jigsaw Building being submitted to Bournemouth Council. Other published articles included the success of the Twilight Walk, the Maternity Unit being reaccredited by Unicef, a donation by the League of Friends which funded a rehab bike for Christchurch Hospital, and a charity bike ride by two of the Trust’s consultants.

Articles are published with the kind permission of the Daily Echo, Advertiser, the New Milton Advertiser and the Stour and Avon Magazine.

### Summary of media coverage:

<table>
<thead>
<tr>
<th>June 2013</th>
<th></th>
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<tbody>
<tr>
<td>Online</td>
<td>23</td>
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<tr>
<td>Print</td>
<td>37</td>
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<td>Radio</td>
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<td>Television</td>
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### June 2013 coverage

<table>
<thead>
<tr>
<th>Positive</th>
<th>56</th>
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</thead>
<tbody>
<tr>
<td>Negative</td>
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<td>OK</td>
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### June 2012

<table>
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<tr>
<td>8</td>
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<tr>
<td>Date</td>
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<td>------------</td>
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<tr>
<td>Publication</td>
<td>New Milton Advertiser</td>
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<tr>
<td>Title</td>
<td>Hospital eye unit in running for accolade</td>
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<tr>
<td>Information</td>
<td>A team of eye specialists at RBH has been nominated for a national award after receiving outstanding praise from patients.</td>
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<tr>
<td>Page number</td>
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<table>
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<tr>
<td>Publication</td>
<td><a href="http://www.seekernews.co.uk">www.seekernews.co.uk</a></td>
</tr>
<tr>
<td>Title</td>
<td>Post-surgery bras donated to Royal Bournemouth Hospital breast clinic</td>
</tr>
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</table>

**Hospital eye unit in running for accolade**

A TEAM of eye specialists at the Royal Bournemouth Hospital have been nominated for a national award after receiving outstanding praise from patients.

Medics from the eye unit are in the running for the Clinical Service of the Year title as part of the Macular Society’s Awards for Excellence. The accolades reward staff, teams or services which show exceptionally good practice for care of those with central vision loss.

Patient John Bright, who nominated the team, said: “I cannot praise all of the staff enough. They are courteous, helpful and efficient. In addition the waiting rooms are light, airy and clean.

“This eye unit is very well run and they deserve credit for it. They are really lovely helpful people.”

The team will be considered by a judging panel and winners will be announced at the society’s annual conference set to be held in London on September 28th.

Consultant Non Matthews, clinical lead of the eye unit, said: “All the staff are so pleased and proud to receive this nomination.

“We try very hard to deliver a friendly, efficient and caring service, with all members of the team contributing to the patient experience. We are delighted that this is being recognised with this nomination.”

**Post-surgery bras donated to Royal Bournemouth Hospital breast clinic**

A Bournemouth supermarket kindly donated 294 bras to the RBH breast clinic this week for women who have undergone breast surgery.

Staff from the Castlepoint branch of Asda visited the hospital on Thursday 20 May to hand over the bras to some of the theatre's breast care nurses.

Amanda Atkinson, specialist breast care nurse at RBH, said: “Asda has been very generous in donating a number of bras suitable for women who have undergone breast mastectomy surgery.

“It is important for ladies to feel comfortable and confident following surgery and we are very grateful for Asda’s support.”

A new Women's Health and Cancer Unit is planned at RBH as part of the proposed new Jigsaw building. It will be a centre of excellence to screen, diagnose and treat patients with breast and gynaecological cancer and for those undergoing complications in early pregnancy, including miscarriages.

To find out more about the Jigsaw building, call 01202 704000, email charity@rbh.nhs.uk or log on to www.bournemouthhospitalcharity.co.uk

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<thead>
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<th>Date</th>
<th>3 June 2013</th>
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<tbody>
<tr>
<td>Publication</td>
<td>Daily Mail</td>
</tr>
<tr>
<td>Title</td>
<td>Our part-time NHS</td>
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<tr>
<td>Information</td>
<td>Findings on recovery from surgery depending on which day of the week surgery takes place.</td>
</tr>
<tr>
<td>Page number</td>
<td>27</td>
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<tr>
<td>Article size</td>
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</table>
The outgoing Mayor of Bournemouth ended his reign by handing over a cheque for more than £20,000 to his four chosen charities.

A total of £22,329 was raised from a packed programme of shows, balls and lunches during Cllr Phil Stanley-Watts’ Mayoral year.

And the money will be split between his four selected good causes - the Bournemouth Leukaemia Fund, the Jigsaw Appeal for Women, the John Rigging Trust and the Springbourne Family Centre.

Handing over the cheques in the Mayor’s Parlour, Cllr Stanley-Watts said: “I know that you charities do such a lot for Bournemouth and I believe it’s important in these economic times to support charities as much as I can.

“The charities I picked this year I feel could go a long way to support different groups in the Bournemouth area.”

The Springbourne Family Centre supports vulnerable families in the Bournemouth area by offering a range of support services while the John Rigging Trust provides 10 selected young people with key inspirational days, accredited work skills and leadership training opportunities.

The Bournemouth Leukaemia Fund supports local research into the cause, diagnosis, natural history and treatment of patients while the Jigsaw Appeal for Women aims to build a brand new women’s health unit at the Royal Bournemouth Hospital.

Estelle Wilson, of the Bournemouth Leukaemia Fund, spoke for all four charities when she said: “I’d just like to say what a fun year we have had. It’s been really interesting and thank you for your support, we really appreciate it.”

Events during Cllr Stanley-Watts’ mayoral year included a black tie ball, quiz night, fashion show and duck race.

CONTACT ME:
Tel: 01202 411291
Email: melanie.vass@bournemouthecho.co.uk
Twitter: @MelVassEcho
RBCH “Ortho App” available to download for iPhones and iPads

TUESDAY, JUNE 4, 2013

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) has launched its new Ortho App about orthopaedic procedures.

This Ortho App is an interactive tool which covers the entire patient journey, from preparing to come into hospital to what should be done to aid recovery at home. It is now available to download from the Apple App Store.

Orthopaedic Pathway and Innovation Manager Lucy Hart with the new Ortho App.

Features include information on the RBCH Orthopaedics Department, a task list of what items a patient should bring to hospital and forms of post-operative physiotherapy exercises with an option to set a reminder on when to do them. It also contains generic information about the hospital, including travel details and maps.

The first procedures to feature on the App are shoulder arthroscopic subacromial decompressions (SHADOs) and knee arthroscopies. More procedures will be added over the coming months.

Lucy Hart, Orthopaedic Pathway and Innovation Manager at RBCH, came up with the idea for the Ortho App.

She said: “I’d sail in un-pre-assessments with patients and seen the vast amount of information that was given out. Often written information can be easily forgotten so we wanted something that was interactive, with more videos rather than static drawings.

“I really believe the App will improve a patient’s access to information in a format where they will be able to easily select the information they want.

“It will also encourage family and friends to get involved with a patient’s journey as they can download the App themselves and help their relative or friend to prepare for hospital and arrange them with their recovery at home.”

A former patient uses the new Ortho App.

Current and former patients are encouraged to download and test the app and provide further feedback as improvements will continue to be made over the coming months. After a period of testing and feedback from the public, future upgrades will be made and an android version will also be released.

Information regarding orthopaedic procedures and post-operative physiotherapy will still be available in paper format and online. The app can be downloaded by searching for “OrthoApp” on the Apple App Store. An information video on the app can be viewed from the latest news section on the RBCH website: www.rbch.nhs.uk/news.
Heartfelt thanks to Mayor of Bournemouth for charity cash

The Bournemouth Hospital Charity would like to express its thanks to the Mayor of Bournemouth, Councillor Phil Stanley-Watts, for a year of generous support. The Mayor presented a cheque for £8,343 to the hospital’s Trust’s Fastest Rising Star, which will go toward the hospital’s Jigsaw Appeal.

Each year the Mayor of Bournemouth assists local charities to support during their mayoral year. During his year Councillor Stanley-Watts chose four charities – the Jigsaw Appeal, Bournemouth Leukaemia Fund, The Jon Epstein Trial and the Springbourne Family Centre, raising £23,320 in total.

Bournemouth Hospital Charity’s Jigsaw Appeal is raising funds to transform the Women’s Health and Cancer Unit (WHAC) at the Royal Bournemouth Hospital and all proceeds raised by the Mayor will help to support this new unit. The Women’s Health Unit, which will treat around 17,000 local women every year, will be a centre of excellence to screen, diagnose and treat patients with breast and gynaecological cancer and for families undergoing complications in early pregnancy, including miscarriage.

Lindsey Sherman, Fundraising Manager of the Bournemouth Hospital Charity, said: “We were very lucky to have been chosen as one of the Mayor’s charities. The amount that was raised was excellent and we are very appreciative of all the hard work that went in to raising this fantastic amount. It has been a great opportunity for the charity.”

For more information on the Bournemouth Hospital Charity or the new Jigsaw Building, visit www.bournemouthhospitalcharity.co.uk or call 01202 704950.
<table>
<thead>
<tr>
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<td>Daily Echo</td>
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<tr>
<td>Title</td>
<td>Hospital gives excellent care</td>
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<tr>
<td>Information</td>
<td>Patient gives good comment on the care given by the Urology Department.</td>
</tr>
<tr>
<td>Page number</td>
<td>20</td>
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<tr>
<td>Value</td>
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**Article:**

RECENT reports on the NHS would suggest that it is hardly fit for purpose but I would like to show that is far from the truth. For the past 30 years I have been in and out of most of the hospitals in the area and whilst the admin may leave something to be desired the medical care has been almost without exception, excellent. My last operation was at the urology department in Royal Bournemouth Hospital under the care of Mr Wedderburn who I know has been praised before in your letters column.

The whole procedure was carried out by skilled and dedicated staff and has literally given me a new lease of life. I can only presume that we are blessed in this area with a standard of healthcare which others can only dream about. Yet another advantage of living in this beautiful part of the country.

ALAN LINGE, Shaftesbury Road, Poole
Staff in support for patients

SUPERMARKET staff have shown their support for breast cancer patients – in more ways than one – after donating 284 post surgery bras.

Department manager at Asda Castlepoint, Jacqui Barker, presented the bras to staff at the Royal Bournemouth Hospital’s cancer unit on Thursday.

The donation is part of the store’s annual Pickled Pink campaign to raise funds and awareness of breast cancer charities. Last year the store raised £7,527 for Breast Cancer Care and Breast Cancer Campaign which was the best fundraising performance in the area and helped the store win the Community Life Regional Champion award.

Boost for Jigsaw Appeal due to outgoing Mayor

The organisers of Royal Bournemouth Hospital’s Jigsaw Appeal have thanked the town’s departing mayor for a year of support.

Cllr Phil Stanley-Watts presented a cheque for £5,332 to the fundraising team before he handed over the chains of office to Cllr Rod Cooper.

The Jigsaw Appeal aims to transform the women’s health and cancer unit at the Bournemouth hospital. The new women’s health unit will treat around 17,600 local women a year.

Lindsey Sturman, fundraising manager of the Bournemouth Hospital Charity, said: “We were very lucky to have been chosen as one of the Mayor’s charities.

“The amount that was raised was excellent and we are very appreciative of all the hard work that went into raising this fantastic amount.

“It has been a great opportunity for the charity.”
HEALTH organisations across Dorset have joined forces with the Daily Echo to invite you to take part in The Big Ask – a unique survey which will help shape NHS services in the future.

We are asking for your views on a whole range of NHS services, from your local GP and out of hours’ services to community, mental health and hospital services.

The survey which goes live on Saturday will look into how well informed you are about the various services available locally, how you choose your health care and what services you use the most.

It will also ask how you think the NHS can provide information in the most effective way. Most importantly, it will seek your opinions on the NHS in Dorset – what you value the most and what can be improved.

Dr Forbes Watson, pictured left, chair of the NHS Dorset Clinical Commissioning Group says: “It’s called The Big Ask for a reason. We are not just asking you for tick box responses. This is an in-depth analysis of your views. Everyone has a view on the NHS but the big ask is whether you are prepared to provide us with some really thought provoking responses that will help shape services in the future.

“More than 750,000 people live in the region. This survey will ensure that patients and the public are at the heart of any decisions we make about the future of the NHS in the county. It will ensure we fully understand how people use our services and what they think our priorities should be.”

This is the first time that NHS organisations across the county have worked together on an exercise of this scale. It includes the major hospitals in Bournemouth, Christchurch, Dorchester and Poole working together with the newly-formed Dorset Clinical Commissioning Group, which represents the county’s 101 GP practices, and Dorset HealthCare, which provides community health services across a wide range of locations.

For more information about The Big Ask, visit bournemouthecho.co.uk/health

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Independent survey from university group

TO ensure the exercise is independent, The Big Ask is being carried out by Bournemouth University’s Market Research Group. More than 12,000 people will be sent the survey but anyone can take part.

You can complete the survey online at bournemouthecho.co.uk/theask or if you would like a paper copy please contact Ehren Milner at the Market Research Group on 01202 561379 or emilner@bournemouthecho.ac.uk. Closing date is September 9.

Feedback will be published in the autumn.
Take part in The big ask and help shape your local NHS

Health organisations across Dorset have come together to ask you to take part in The big ask - a unique survey which will help shape NHS services in the future.

We are asking for your views on a whole range of NHS services, from your local GP and out of hours' services to community, mental health and hospital services. The survey will look into how well informed you are about the various services available locally, how you choose your health care and what services you use the most. It will also ask how you think the NHS can provide information in the most effective way. Most importantly, it will seek your opinions on the NHS in Dorset - what you value the most and what can be improved.

Announcing the launch of the project, Dr Forbes Watson, Chair of the NHS Dorset Clinical Commissioning Group says: "It's called the big ask for a reason. We are not just asking you for tick box responses. This is an in-depth analysis of your views. Everyone has a view on the NHS but the big ask is whether you are prepared to provide us with some really thought provoking responses that will help shape services in the future.

"More than 750,000 people live in the region. This survey will ensure that patients and the public are at the heart of any decisions we make about the future of the NHS in the county. It will ensure we fully understand how people use our services and what they think our priorities should be."

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Dr Forbes Watson

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To ensure the exercise is independent it is being carried out by Bournemouth University's Market Research Group. More than 12,000 people will be sent the survey but anyone can take part.

"An ageing population, new treatments and rising expectations all require the NHS to continue to adapt and develop, but limited taxpayer funding makes the challenge greater each year," continues Dr Watson. "Ensuring that NHS care remains of the highest quality, accessible and up to date means we need to establish our priorities and make some

"It will seek opinions on the NHS in Dorset - asking people what they value the most and what can be improved."

Dr Forbes Watson
Date: 10 June 2013
Publication: www.bournemouthecho.co.uk
Title: Fundraisers step out in pink for Twilight Walk

Date: 10 June 2013
Publication: www.seekernews.co.uk
Title: Celebrities on Ice pair visit the Royal Bournemouth Hospital
Take part in 'the big ask' and help share your local NHS

Health organisations across Dorset have come together to ask you to take part in 'the big ask' – a unique survey which goes live on 5 June and will help shape local NHS services in the future.

We are asking for your views on a whole range of NHS services, from your local GP out of hours’ services to community, mental health and hospital services. The survey will look into how well informed you are about the various services available locally, how you choose your health care and what services you use the most. It will also ask you how you think the trust can provide information in the most effective way.

Most importantly, it will seek your opinions on the NHS in Dorset – what you value the most and what can be improved. Announcing the launch of the project, Dr Ferose Watson, Chair of the NHS Dorset Clinical Commissioning Group, says, “It’s called The big ask for a reason. We are not just asking you for brief box responses. This is an in-depth analysis of your views. Everyone has a view on the NHS, but the big ask is whether you are prepared to provide us with some really thoughtful responses that will help shape services in the future.”

“More than 750,000 people live in the region. This survey will ensure that patients and the public are at the heart of any decisions we make about the future of the NHS in the county. It will ensure we fully understand how people use our services and what they think our priorities should be.”

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To ensure the exercise is independent, it is being carried out by Bournemouth University’s Market Research Group. More than 12,000 people will be sent the survey but anyone can take part.

"An ageing population, new treatments and rising expectations all require the NHS to continue to adapt and develop, but limited taxpayer funding makes the challenge greater each year," continues Dr Watson. "Ensuring that NHS care remains of the highest quality, accessible and up to date means we need to establish our priorities and make some careful decisions over the next couple of years.

"That is why this survey is so important and we want as many people as possible to have their say," he adds.

Please take part in ‘the big ask’. You can complete the survey online at www.boomercard.co.uk/bigask or if you would like a paper copy please contact Ellen Minter at the Market Research Group on 01202 512578 or eminter@boomercard.co.uk. The survey will close on 19 September and the feedback will be published in the autumn.

You can also join us on Twitter @HealthyDorset or follow us on Facebook at www.facebook.com/HealthyDorset
Pink army walks to fight cancer threat

BORNEMOUTH’S famous promenade turned pink on Sunday as a dozens of fundraisers stepped out for charity.

More than 360 people wearing bright pink t-shirts completed the Twilight Walk along the seawall at sunset to raise money for a new women’s health unit at the Royal Bournemouth Hospital.

In previous years, the charity challenge has raised tens of thousands of pounds for the good cause.

Lindsey Sturman, the fundraising manager for Bournemouth Hospital Charity, said: “It was an absolutely brilliant evening.

“It was wonderful to see so many people supporting the charity. We had so many people it was like a sea of pink.”

The event, now in its third year, was originally open to women only.

However, everyone is now welcome to take part.

Lindsey said: “We even had dogs turning up in little pink t-shirts.

“Everyone has an aunt, a sister, a mother or a friend who may benefit from the unit, so everyone should be able to come along and fundraise.”

This year’s race was started by Bournemouth’s mayor, Councillor Rod Cooper.

“It was really lovely to have him come along,” said Lindsey.

“We’ve even got a date set for next year’s event – it will be on Friday, June 6, 2014.

The hope for women’s health unit will be based in the planned Jigsaw Building, based at the hospital.

The centre will screen, diagnose and treat breast and gynaecological cancer, as well as provide care for women undergoing complications in early pregnancy.

For more information about the appeal, visit the Jigsaw website: jigsawappeal.org.uk.

CONTACT ME

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Over 350 walkers turned Bournemouth promenade into a sea of pink for this year’s Twilight Walk in support of the Bournemouth hospital Charity’s Jigsaw Appeal.

The Mayor of Bournemouth starts the Twilight Walk along Bournemouth promenade.

The walk was started by the new Mayor of Bournemouth, Councillor Dr Rodney Gooper, and Mayor’s wife Elaine Gooper. Walkers enjoyed fine weather and a party atmosphere and with more participants than last year, the charity hopes to raise more funds for the planned Jigsaw building at the hospital.

Lindsey Sturman, Fundraising Manager of the Bournemouth Hospital Charity, said: “The Twilight Walk is an event we really look forward to and this year did not disappoint. It was a fantastic evening, with women, men, children and dogs all joined together to raise funds and awareness for the women across Dorset. We would like to say a big thank you to everybody who took part and also to those who helped make the event possible including our wonderful volunteers.

“We have already set the date for next year’s walk, which will take place on Friday, 9 June 2014, so please put the dates in your diaries so you don’t miss out on this wonderful event.”

The new Women’s Health and Cancer Unit at the Royal Bournemouth Hospital will be a centre of excellence to screen, diagnose and treat patients with breast and gynaecological cancer and for families undergoing complications in early pregnancy, including miscarriages.

You can still donate money towards the Twilight Walk appeal and all those who took part in the Twilight Walk are reminded to submit their sponsorship money to the Bournemouth Hospital Charity office. You can find out more at www.bournemouthhospitalcharity.co.uk, email charity@rbh.nhs.uk or call 01202 764280.
PLANS for the new Women’s Health Unit at the Royal Bournemouth Hospital have come a step closer to fruition. It has been announced this afternoon.

The proposals for the Jigsaw Building, which will also house the Cancer and Blood Disorders Unit, have been submitted to Bournemouth Borough Council planners.

The hospital Trust said “detailed feedback from hospital staff, patients and the public have been incorporated into the designs”.

Richard Rennau, director of service development at the hospital Trust, said: “We’re really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.”

The proposed 2,000sqm Jigsaw Building will be built at RBH between the Eye Unit and the Dorset Suite for Orthopaedics.

The Trust said it would be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital.

Subject to planning approval, initial work could start in October with a potential completion date of late 2014.

The plans for the Jigsaw Building can be viewed on the council website, www.bournemouth.gov.uk, under planning application number 7/2013-0913-EL.

Comments should be submitted to the council in writing by July 15.

Fundraising efforts through the Jigsaw Appeal charity, alongside NHS investment, have helped pay for the building.
Take key steps and improve wellbeing

Nicky Findley

AS The Big Ask survey gets under way, over the next 12 weeks we’ll be bringing you a series of features on health issues...

THIS week, Sam Crowe, assistant director of public health for Bournemouth, pictured below, tells us what wellbeing means and how we play the central role in our own health story.

"Most of us know that taking more exercise, drinking less alcohol, quitting smoking or eating a more balanced diet can affect your chances of living longer and remaining free from illness."

"Yet making these changes and sticking to them often prove notoriously difficult, and over time people may revert back to unhealthy behaviour."

"What is less known are the steps that people can take to improve their own wellbeing."

"Governments and psychologists are increasingly interested in measuring people’s wellbeing and understanding more about the links between wellbeing and health as the focus shifts from illness to wellness."

"Wellbeing sounds like a fluffy concept, but essentially it means feeling good and functioning well. Wellbeing is important, because it is thought that people with a high level of wellbeing may be less likely to take up unhealthy behaviours - it may be protective in some way. So just focusing on unhealthy behaviour and illness misses out the simple steps that people can take that can improve their wellbeing - and enjoyment and fulfilment in their life."

Many factors can affect an individual’s perception of wellbeing, but research consistently shows that five simple things can have the greatest effect on sense of wellbeing.

Connecting - with people around you, such as family, friends, colleagues and neighbours.

Being active - physical activity will improve mood as well as being good for you. It doesn’t have to be vigorous.

Taking notice - be curious and take time to notice the things around you. Be aware of what you’re feeling and reflect on your experiences.

Keep learning - whether something new or rediscovering old skills. Learning new things and achieving challenges will build your confidence and can be fun.

Giving - do something for other people. Whether volunteering, sharing or giving something back to your community.

Take part in The Big Ask, visit bournemouthecho.co.uk/health.

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Thanks go to stroke nurses

SINCE my stroke 11 years ago I have had numerous visits to both Royal Bournemouth Hospital and Christchurch Hospital. I have always received good care and treatment especially in the Endoscopy Department at the Royal Bournemouth and the Forest Dene Ward at Christchurch Hospital. I would like to thank the staff and especially the nurses for the kindness and consideration.

BARRY LYNCH,
Forest Way, Highcliffe

Women’s Health Unit Plans Submitted

Plans for the new Jigsaw Building at the Royal Bournemouth Hospital (RBH) have been submitted for consideration to Bournemouth Council.

Detailed feedback from hospital staff, patients and the public have been incorporated into the designs for the proposed new Women’s Health Unit and Cancer and Blood Disorders Unit.

Richard Renaut, Director of Service Development at the hospital Trust, said:

“We’re really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.

“We’re excited about the design and will continue to work with the public to get their views on the interior of the building and the garden area.”

The proposed 2000m2 Jigsaw Building will be based at RBH between the Eye Unit and the Derwent Suite for Orthopaedics. It will be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital.

Subject to planning approval, initial work could start in October with a potential completion date of late 2014.

The plans for the Jigsaw Building can be viewed on the council website: www.bournemouth.gov.uk under planning application number 7-2013-5913-EE. Comments should be submitted to the council in writing by 19 July.
Women's health unit closer to realisation

PLANS for the new women's health unit at the Royal Bournemouth Hospital have come a step closer to fruition.

The proposals for the Jigsaw Building, which will also house the Cancer and Blood Disorders Unit, have been submitted to Bournemouth Borough Council planners.

The hospital Trust said "detailed feedback from hospital staff, patients and the public have been incorporated into the designs".

Richard Renaut, director of service development at the hospital Trust, said: "We're really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.

“We're excited about the design and will continue to work with the public to get their views on the interior of the building and the garden area.”

The proposed 2,000sqm Jigsaw Building will be based at RHIB between the Rye Unit and the Derwent Suite for Orthopaedics.

The Trust said it would be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital.

Subject to planning approval, initial work could start in October with a potential completion date of late 2014.

The plans for the Jigsaw Building can be viewed on the council website, bournemouth.gov.uk, under planning application number 72013-5918-B.

Comments should be submitted to the council in writing by July 19.

Fundraising efforts through the Jigsaw Appeal charity, alongside NHS investment, have helped to pay for the building.

ARTIST'S IMPRESSION: Plans for the new Jigsaw Building and Richard Renaut, inset

Steven Smith

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Dialling 111 is real lifesaver

I WOULD like to thank the local NHS for the fantastic service shown to me when I became unwell recently.

The NHS 111 service, which has had some bad press recently, was brilliant and could not have been more helpful.

They arranged for a doctor to be waiting for me when I arrived at Bournemouth Hospital and within 10 minutes I was transferred to the Coronary Care Unit and had a temporary pacemaker fitted within 45 minutes. The treatment and care I received from Dr. Radman and his team could not be faulted.

I would like to thank all those who cared for me. The doctors, nurses and auxiliary staff of both the Coronary Care Unit and ward 21 were a credit to the NHS.

From the call to NHS 111 to my discharge my experience of the local NHS trust was exemplary. I would also like to thank my wife and son for their quick action in phoning NHS 111.

GEORGE FAULKNER,
Saxonhurst Road, Bournemouth

Care team was fantastic

WE read so much about how some of the NHS is so poor in all areas. Well my mother became ill and I decided to keep her at home. The NHS Bournemouth Intermediate Care team came in. They were here for six weeks and mum and I can say that all of the staff were five star.

They were fantastic and we were worry to see them go, but of course pleased mum recovered.

So take heart as the NHS is alive and well.

GILLIAN MACHIN
Petersfield Road, Bournemouth
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<th>Date</th>
<th>Publication</th>
<th>Title</th>
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<tr>
<td>13 June 2013</td>
<td><a href="http://www.jackradio.com">www.jackradio.com</a></td>
<td>A planning application has been submitted to the council.</td>
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<td>- Plans for a new centre of excellence at Bournemouth’s hospital have gone on show.</td>
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<td>- The so-called Jigsaw building will house specialist units for cancer, blood disorders and women’s health.</td>
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<td>- If the appeal goes the green light later this summer initial work could start in October with a potential completion date of late 2014.</td>
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<td>- Richard Ferrans, Director of Services Development at the hospital Trust, said: “We’re really pleased to get to the stage of the project, our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.”</td>
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<td>- The plans for the Jigsaw building can be viewed on the council’s website: <a href="http://www.bournemouth.gov.uk">www.bournemouth.gov.uk</a> under planning application number: 7-2013-3913-EEE. Comments should be submitted to the council in writing by 13 July.</td>
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Royal Bournemouth Hospital Open Day success

The attendances of the Bournemouth Hospital Open Day was about with activity yesterday as patients, the public and staff took part in the annual Open Day.

Visitors found out about different services on offer at the Trust and got involved with the interactive displays that were hosted by a team of volunteers.

Treasurer’s post open

BOURNEMOUTH: The League of Friends of Royal Bournemouth Hospital has a vacancy for a treasurer.

The post comes with out of pocket expenses refunded and free parking.

Ring 01202 496185.

Join in falls awareness

BOURNEMOUTH: Staff at Royal Bournemouth Hospital will be joined by other health experts to promote Falls Awareness Week from June 17 to 21.

Visitors to the main atrium can get useful tips and information on falls prevention. From 10am to 3pm on June 18, staff will be on hand to give demonstrations of exercises that improve bone health and free walking stick checks will also be available.

More information can be obtained from Age UK by calling 0800 199 85 65 or going to visit ageuk.org.uk
**Chico and Kyran skate along for hospital visit**

THE hospital clock turned to Chico time when the former X Factor star and rugby legend Kyran Bracken paid a visit to staff and patients in Bournemouth.

Chico and Kyran visited the Royal Bournemouth Hospital to learn more about the proposed new Jigsaw Building.

The duo are starring in the skating show Celebrities on Ice, taking place at the BIC in Bournemouth from June 14-16.

They donated two pairs of tickets for the show which were raffled off to staff to raise funds for the Bournemouth Hospital Charity.

They also gave away a number of tickets to patients at the hospital.

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**Date**  
14 June 2013

**Publication**  
Daily Echo

**Title**  
Chico and Kyran skate along for hospital visit

**Information**  
Former X Factor star and rugby legend visit patients at RBH.

**Page number**  
7

**Article size**  
Quarter of a page

**Value**  
£2525

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**Date**  
14 June 2013

**Publication**  
Seeker News

**Title**  
Thanks for the thousands

**Information**  
Cllr Phil Stanley-Watts saluted those who had raised funds for charities including the Jigsaw Appeal.

**Page number**  
5

**Article size**  
Eighth of a page

**Value**  
£140
Hospitals given seal of quality

Patients at the Royal Bournemouth and Christchurch hospitals can be assured the information they are receiving is of the highest quality after it was awarded the Information Standard quality mark for the health and care information it produces for patients.

The Information Standard is a certification scheme commissioned by NHS England which assesses whether the information an organisation produces is clear, accurate, evidence-based and up to date, and that a robust system is in place for the approval and recording of information.

To achieve the Information Standard accreditation, the Trust underwent a rigorous two-day assessment of its patient information process by the Royal Society for Public Health, one of the organisations accredited to carry out the assessment.

Richard Renaut, director of service development at RBCH, said: “The Trust’s priority is putting patients first and that is not limited to the care we provide face to face; it is also about the information we give to patients to take away or to prepare them before they come into hospital.”

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<td>RBCH has been given the Information Standard for its patient leaflets.</td>
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FROM WARD TO BOARD

Paula Shobbrook is Director of Nursing and Midwifery at the Royal Bournemouth and Christchurch hospitals and will carry out this role in the new merged organisation, if approved. Here Paula talks about how essential ward to Board reporting is to ensure quality of care for patients.

“My job is focused on providing the highest quality of patient care,” explains Paula. “Quite simply, we are judged by what happens at the bedside.”

And for Paula this means regularly getting back into her uniform and going out onto the wards.

As Director of Nursing and Midwifery, Paula sits on the hospital’s Board and having first-hand knowledge is crucial: “If we’re going to sit in a board meeting, making major decisions about patient care or what is happening in the hospital, this ‘ward to board’ connection is vitally important.”

Her interest in patient care started when she volunteered for the Red Cross as a youngster, and a colleague at the charity suggested she took up nursing as a career. Since then, she has built up a wealth of knowledge from working in various positions in the NHS.

Paula has an important role in leading the new organisation and retaining that connection with nurses at ward level. “I’m at the centre of making decisions about issues that matter, but it also allows me to keep in touch with life on the wards. This connection will be vital if the merger between the two foundation trusts is approved. Continuing to provide quality services locally is the driver behind merger. While the two organisations already provide excellent services, we want to retain that and together we can be even better.”

Patient feedback is important in helping any hospital provide high quality of care. “We carefully review feedback and if there are areas we need to improve we make sure we put it right. The merger is about ensuring we can continue to provide quality of care but also to improve and meet new standards.

“We need to be able to adapt and change so that we can provide the best care and services possible, and the proposed merger is another step towards meeting the challenges of the modern world.

“We already work very closely across Bournemouth, Poole and Christchurch hospitals with many services complementing each other. We will still have the same three hospitals, but the merger will allow us to address some of the challenges currently facing the NHS.

“For me, the most exciting part will be the chance to share and develop best practices from both trusts to continue to improve our services.”

You can also email us at communications@poole.nhs.uk and communications@rbch.nhs.uk
Falls Awareness Week at Royal Bournemouth Hospital

FALLS AWARENESS WEEK AT ROYAL Bournemouth Hospital

Friday June 14, 2013

Published in Community

Royal Bournemouth Hospital

Staff will be joined by other health professionals next week to educate people on how to reduce the number of falls in hospital and at home.

According to the National Osteoporosis Society, there were around 315,600 fractures nationwide caused by falling in 2011, with the number expected to increase. As part of Falls Awareness Week, the public can come along to the atrium at RBH from 12-21 June to get useful tips and information on falls prevention.

From 10am-3pm on 18 June, staff will be on hand to give demonstrations of exercises that improve bone health and free walking stick checks will also be available.

The Trust has implemented a number of initiatives to help in the prevention of falls. These include providing equipment for falls prevention in wards, advice on safe footwear and ensuring environmental changes to lessen the risk of falls, for example signage, coloured floor tiles and lighting. Any inpatient with a history of falls, or who is susceptible to osteoporosis, has their medication reviewed as this may be a contributing factor.

Audrey Redshaw, one of the falls leads at RBH, said: “Having a fall can have a huge impact on the patient and their family. It can destroy confidence and therefore independence. Reducing falls helps to maintain independence which is really important to our patients and something that we are really passionate about.”

09/06/13 CM 12 June 2013

“The Trust is committed to ensure we are doing our very best to reduce falls and we are always looking at new ways of achieving this.”

Useful information about preventing falls and bone health can be obtained from Age UK by calling 0800 109 55 55 or logging on to www.ageuk.org.uk.
Fear hospital merger may be in jeopardy

Katie Clark

ROYAL Bournemouth Hospital's chief executive has voiced fears the Competition Commission have already "made up their minds" over the proposed merger.

Following separate hearings between the Commission and both hospital trusts this week, Tony Spotwood said some misinformation over hospital services may lead to a negative response from the body appointed to review the first proposed merger of the NHS.

Speaking at a meeting of the Royal Bournemouth and Christchurch Hospital board of directors on Friday, Mr Spotwood said the commission had a series of working papers, which gave the Trust an indication of their "emerging thinking".

"They are building up an understanding which is not entirely accurate", he told directors.

He said much of the hearing was spent talking about the elective services the Trust provides.

Mr Spotwood disputed the Commission's perceived cost of the overlapped services, saying their £32million figure was in reality £40million, as they did not provide some of the services suggested.

"The hearing was quite benign and that gives us a sense that they had made up their minds", Mr Spotwood added.

"I think we are going to have a challenging time in persuading the Competition Commission that the merger ought to be approved.

"We will get their findings at the start of July and a formal report at the end of August.

"We will have a pretty good understanding from those provisional findings in July.

"The view from Poole was not dissimilar.

"Their hearing concentrated on maternity services to a large extent as well.

"We felt it was a hearing that was done in good grace."

In the same meeting, Stuart Hunter, director of finance and IT, gave a repeated warning about the tough financial future for the Trust.

Mr Spotwood was also quizzed about what would happen, should the merger not go ahead, as some back office services have already been brought together.

He said: "A lot of the back office services were likely to come together irrespective of whether we merge or not. There are a lot of services we could not really merge without a merger itself."

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Royal Bournemouth Hospital's chief executive has voiced fears the Competition Commission have already "made up their minds" over the proposed merger.

Following separate hearings between the Commission and both hospital trusts this week, Tony Spotwood said some misinformation over hospital services may lead to a negative response from the body appointed to review the first proposed merger of the NHS.

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"They are building up an understanding, which is not entirely accurate," he told directors.

He said much of the hearing was spent talking about the elective services the Trust provides.

Mr Spotwood disputed the Commission's perceived cost of the overlapped services, saying their £52million figure was in reality £60million, as they did not provide some of the services suggested.

"The hearing was quite benign and that gives us a sense that they had made up their minds," Mr Spotwood stated.

"I think we are going to have a challenging time in persuading the Competition Commission that the merger ought to be approved.

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Mr Spotwood was also quizzed about what would happen, should the merger not go ahead, as some back office services have already been thought together.

He said: "A lot of the back office services were likely to come together irrespective of whether we merge or not. There are a lot of services we could not easily merge without a merger.
AN NHS chief has maintained his support for a controversial proposed hospital trust merger despite a financial probe being launched.

Plans to merge the Royal Bournemouth and Christchurch Hospitals Trust (RBCHT) with Poole Hospital Foundation Trust (PHFT) are already being investigated by the Competition Commission.

But on Monday, health regulator Monitor also announced it was to look into the Poole Hospital Foundation Trust (PHFT) because it had forecast a significant financial pressure over the next three years, which raised questions over its sustainability.

However, Tony Spotswood, current head of the RBCHT and proposed head of the two trusts should they merge, was unperturbed by the news of the Monitor investigation.

"We have always believed that the merger is in the best interests of staff and patients in securing the future of hospital services in east Dorset," he said.

"Our hospitals already provide high quality services but the merger ensures these services are sustained. It also creates the potential to realise many benefits by bringing together skills, expertise and technology, and promoting safe and sustainable services. We will be able to provide even better services and better outcomes for our patients.

"Without the merger, it will become increasingly challenging to sustain high quality and strive for the savings we need to keep.

The trust did not comment on 'A&T' questions on if or how it had looked into the finances at PHF as part of its reaction to the financial probe was.

As reported by the A&T, the plan was to amalgamate the trusts first and then merged last year. Both came in for criticism when they failed to publicly release large quantities of data on their plans, even to Christchurch MP Christopher Copsey.

The merger then came under fire from the Office of Fair Trading (OFT) and Monitor, which suggested risks to competition between the two hospitals outweighed patient benefits.

The concerns were so great that both organisations referred the matter to the Competition Commission, which will have the final say.

Paul Stewart, Monitor regional director, said: "The PHFT has forecast a financial deficit and we are investigating at an early stage to find out more. Monitor has not yet reached a view as to whether there been any breach of the licence conditions.

"Patients expect to see their services run well and by investigating this early stage we can make sure that any issues are addressed quickly and effectively.

A Monitor spokesman was keen to stress its investigation into PHFT was completely separate from the one being carried out by the Competition Commission.

"Our investigation will be paying no heed to the proposed merger—it will be looked at as a separate entity," he said.

"It is an unusual situation because it will be the first investigation into a foundation trust that is going through the merger referral process.

He said should Monitor judge the PHFT had broken the rules its powers included forming an action plan with the trust or altering its licence to ensure patients got the best of the services. He could not put a deadline on when a ruling would be made.

"We are not interested in a short-term fix," he added. "When problems are identified we work with the trust to make sure the services they are providing are good quality and sustainable."

Monitor has also launched an investigation into the University Hospital Southampton (UHS) NHS Foundation Trust, which is used by many New Forest residents, over its persistent failure to reach accident and emergency targets.

Dr Michael Marsh, medical director at UHS, said: "Like many other large regional hospital trusts across the UK, we have been experiencing high demand for urgent care—regularly seeing more than 300 patients a day in our emergency department.

"During an extremely busy and prolonged winter which created a sustained period of pressure on our resources, this resulted in many more people waiting longer than we would want or normally expect.

"However, we have been working hard to reduce waits where it is clinically appropriate to do so and we will be working closely with our fellow healthcare providers, council of governors and Monitor over the coming weeks to ensure we continue to make progress in this area."
Bournemouth A&E waiting times are better than average

HOSPITAL bosses in Bournemouth have pledged to ensure high quality emergency care for patients amidst fears the system is heading for a crisis.

It follows a report that the NHS in England missed its A&E waiting time target in the first three months of the year as hospitals struggle to cope with rising demand amid pressures on funding and staffing levels.

But in Bournemouth the situation is better than the national average. Up to 266 people attend the hospital for emergency care on any one day. Of these around 85 per cent are seen within the four hour time limit.

Helen Lingham, chief operating officer at RBCH, said: “We are committed to making sure our patients receive the right care in the right place at the right time.”

But she added: “Although the four hour target is a priority for the Trust, it is not just about the statistics.

“It is a quality indicator to ensure that our patients receive prompt and appropriate treatment from the moment they come in to the moment they are discharged. All members of staff have a role to play in meeting this target and we continually strive to give all patients the best quality care.

“We also have an Acute Medical Unit so that patients who have been referred urgently to hospital by their GP can go directly to a medical ward and bypass ED. Patients admitted to AMU are assessed urgently and may be transferred to a specialist ward if appropriate.

“The increase in emergency patients coming in to our hospitals impacts on our ability to treat patients in the appropriate place and to ensure they are discharged effectively. For each patient that needs to be admitted, there needs to be a bed available in an appropriate place for their individual needs. A lot of work is taking place to ensure patient flow throughout the entire hospital, which is led from executive level.

“It is important to remember that for some patients it is clinically appropriate they spend longer in the Emergency Department to ensure high quality care.”
Unicef approves Bournemouth Maternity Unit as 'baby friendly'

The Royal Bournemouth Hospital's Maternity Unit has earned Unicef Baby Friendly reaccreditation, recognising the support and care provided to mothers and babies.

The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and Unicef. The overarching aim is to ensure a high standard of care for pregnant women and all mothers in the postnatal period, supporting them in their chosen feeding method.

The Maternity Unit received full accreditation in 2011 after a four-year assessment process. Recertification takes place every two years to ensure the standards of care are being maintained. Staff knowledge and skills were reassessed with an 80% pass mark required in each of eight categories. The RBH Maternity Unit achieved 91%, in two categories and 100% in the remaining six categories.

Liz Stacey, Breastfeeding Educator at RBH, said: "We are incredibly proud to have achieved reaccreditation. Given the high standards that need to be met, it is a testament to the excellent care that we give to mothers."

"The ultimate aim of the initiative is to increase the number of babies being breastfed as we know that breastfeeding has lifelong health benefits for both mother and baby. But we support all mothers, whichever their chosen method of feeding."

Mothers were also interviewed as part of the process, both in the antenatal and postnatal period, to assess the standard of care and information that they received. An 80% pass mark is again required in each category and the RBH Maternity Unit results were extremely high, with 92% in one category and 100% in all other categories.
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**Have your say on future of the NHS**

THE Big Ask is a large-scale survey where local people can give their views on the NHS in Dorset and is now available for you to complete.

The survey runs until September, so each week in the Daily Echo we will be featuring local health topics. This week, it’s the role of doctors and the newly-created Clinical Commissioning Groups.

Poole GP and member of NHS Dorset Clinical Commissioning Group (CCG) Dr Chris McCall, pictured above, explains how national changes in April affect the planning and delivery of local health services:

> “The recent changes to the NHS mean that GPs are at the heart of decision making. We are now able to have more of a say in how and where money is spent, as we see patients day in day out, we are able to influence spending decisions based on what we are hearing, allowing us to champion the needs of our local communities.

> “We’re responsible for certain services including planned hospital care, urgent and emergency services, mental health and community health services. Those which fall outside of our remit are the responsibility of other organisations such as NHS England or the local authorities, who now look after public health.

> “We work closely with all our partners and providers to make sure they deliver quality services. We’re split into 13 local areas, which are made up of GP member practices enabling each area to have a voice via their locality chair.

> “In addition we have six teams who work within Clinical Commissioning Programmes (CCPs) and focus on specific areas of work, for example cancer care, mental health or family health.

> “Our budget is around £900m. Although this may seem a lot, we need to make sure we spend it wisely.

> “Our providers have to deliver services, which meet local needs and are sustainable – something we monitor constantly.

> “To help us make sure services do meet local health care demands we need the involvement of local people, be it as part of the local health network, a Patient Participation Group or by involvement in initiatives such as this survey - The Big Ask.

> “By taking part you can help bring a unique insight on which services are planned and purchased.”

To have your say please visit bournemouth.gov.uk/health or Bournemouth.ac.uk/the big ask.

For further information on NHS Dorset CCG visit dorsetccg.nhs.uk

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Baby award

THE Royal Bournemouth Hospital’s Maternity Unit has earned Unicef Baby Friendly re-accreditation, recognising the support and care provided to mothers and babies.

The initiative is part of a joint programme by the World Health Organisation and UNICEF which aims to ensure a high standard of care for pregnant women and mothers.

Liz Stacey, breastfeeding educator at RBH, said: “We are incredibly proud to have achieved re-accreditation.

“The ultimate aim of the initiative is to increase the number of babies being breastfed as we know that breastfeeding has lifelong health benefits for both mother and baby.

“But we support all mothers, whatever their chosen method of feeding.”

The Maternity Unit received full accreditation in 2011 after a four-year assessment process.

Re-accreditation takes place every two years to ensure standards are being maintained.
Breast cancer worries eased

MORE patients could have been recalled to Royal Bournemouth Hospital following concerns over the way their breast cancer consultations were carried out.

In May, the Trust confirmed hundreds of women had been advised to return for repeat assessments after their initial examinations “potentially did not meet our usual high standards”.

The matter, which is now the subject of two investigations, was raised on Friday at the trust’s board of directors meeting.

Director of nursing, Paula Shobbrook, told the directors that all the patients seen by this doctor were invited back to clinics on May 3, 5, 6, 11, 17, 18 – which included some weekends.

The trust has also brought in external consultants to help with the assessments.

Ms Shobbrook said: “Our surgeons have also been incredibly helpful along with our radiologists, nurses and outpatients staff.

“The feedback from the patients has been positive. They have been pleased that we have been open with them.”

She said patients who were seen by the doctor through other “care pathways” have also been assessed.

“We have undertaken some further clinics and invited some further patients back for reassurance to look in depth at their cases.

“This is a briefing in progress, I feel comfortable with the work that has been done”, she added.

Initially a total of 272 women who attended the hospital’s breast clinic between January 2011 and July 2012 and were told there was no need for a follow-up appointment, were invited back for a further consultation.

But when the Daily Echo asked for updated figures on the number of patients recalled as part of the investigation, the Trust said these would not be available until the review is complete.

Hospital bosses say they have “no evidence” of any harm to the patients seen by this junior doctor.

The doctor, who no longer works at the hospital, is now being investigated by the General Medical Council and the Trust has asked the Royal College of Surgeons to help in a review.”
Charity making its last ever donations

A charity that supported respiratory patients in Poole and Bournemouth for more than two decades has made its final donations.

The Dorset Respiratory Group started out as the British Lung Foundation’s largest regional branch in 1982, with 500 members. It separated from the BLF three years later but was disbanded in March due to dwindling numbers.

The group’s chairman and treasurer, Ann and Rob Maskell, went to Poole Hospital to hand over nearly £15,000 to consultants Drs Simon Crowther, Mark Allenby and Suganya Mallawathani.

The money will be used to buy equipment for patients with cystic fibrosis and other respiratory illnesses such as chronic obstructive pulmonary disease.

“We came together with the goal of providing support for people with chronic respiratory disease in Dorset, and we unanimously agreed to disband the group in order to protect this legacy and bow out on a high,” said Ann.

She explained that patients were now given much more information.

“Gradually over the years, they haven’t needed our services and numbers are depleted from 600 in the early days to about 25 in the last year.

“We were paying out each month more than we were getting in.

“It was eating into the legacies we had been left.

“We decided it was very important that the money should be used to support people with respiratory problems.

“When we closed it was unanimous that the money would be equally divided between the thoracic departments of Poole and the Royal Bournemouth Hospitals.”

The equipment being bought by Poole includes two new electronic spirometers, which test and record lung function.

The team is also looking to buy two portable ventilator machines.

Dr Crowther said: “The group has donated a large amount of money over the last two decades which has helped us improve the care we provide to our patients and our patients’ experience.

“We are extremely grateful to all their members for their support.”
More patients recalled to Royal Bournemouth Hospital over breast cancer consultations

By Kate Clark
14:00 pm Thursday 20th June 2013

MORE patients could have been recalled to Royal Bournemouth Hospital following concerns over the way their breast cancer consultations were carried out.

In May, the Trust confirmed hundreds of women had been advised to return for repeat assessments after their initial examinations “powerfully did not meet our usual high standards”.

The matter, which is now the subject of two investigations, was raised on Friday at the trust’s board of directors meeting.

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The doctor, who no longer works at the hospital, is now being investigated by the General Medical Council and the Trust has asked the Royal College of Surgeons to help in a review.
Falling into place

By Steven Smith

The proposed 2,000sqm Jigsaw Building will be based at RBH between the Eye Unit and the Derwent Suite for Orthopaedics. The Trust said it would be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital. Subject to planning approval, initial work could start in October with a full completion date of late 2014.

The plans for the Jigsaw Building can be viewed on the council website, bournemouth.gov.uk, under planning application number 2013/00129.

Comments should be submitted to the council in writing by July 19.


Kind, friendly hospital staff

On my recent admission to A&E at Royal Bournemouth Hospital followed by a further admission to AMU the next day I would like to thank all the ambulance and medical staff for all their kindness and friendliness in making my stay so comfortable.

Too many people criticise the NHS, and not enough praise is given.

RAYNA PHILLIPS, Broadway, Southbourne, Bournemouth
A CARDIAC secretary from Royal Bournemouth Hospital who recently shaved her head for charity will be walking 62 miles from June 22 to 23 for the British Heart Foundation.

Janet Dryden, a serial-fundraiser from Northbourne, will be walking 100km through the day and night for the charity because her husband and mother both had lifesaving surgery.

Her husband Colin, 64, had a triple bypass 18 years ago and her mother has nine stents and keeps active with pier-to-pier walking.

Janet said: “Colin, my wing man now has a full metal jacket of eight stents which allow him to live a full and active life all thanks to the great doctors and their teams at Royal Bournemouth Hospital.

“He will be meeting me at every checkpoint along the route to provide support.”

She will walk the route from London to Brighton with fellow cardiac secretary Emma Watkins, with her 27-year-old daughter waiting at the finish.

Janet said: “It will be really tough but life is for living and I’m so grateful for my husband’s second chance.”

The cardiac nurse was sponsored to shave her head and this has helped contribute to the £1,000 target for the BHF.

Janet, who suffers from glaucoma, has also raised money for Guide Dogs for the Blind and skydived for Helen and Douglas House hospice. Visit justgiving.com/janetrdryden1 to donate.

Jenny Awford

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ALL SMILES: Colin Dryden, Janet Dryden (middle) and her mother
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## Jigsaw Building plans submitted to council

PLANS for the new Jigsaw Building at the Royal Bournemouth Hospital (RBH) have been submitted for consideration to Bournemouth Council. Detailed feedback from hospital staff, patients and the public have been incorporated into the designs for the proposed new Women’s Health Unit and Cancer and Blood Disorders Unit.

Richard Renaut, director of service development at the hospital Trust, said: “We’re really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received. “We’re excited about the design and will continue to work with the public to get their views on the interior of the building and the garden area.”

The proposed 2000m² Jigsaw Building will be based at RBH between the Eye Unit and the Derwent Suite for Orthopaedics. It will be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital. Subject to planning approval, initial work could start in October with a potential completion date of late 2014.

The plans for the Jigsaw Building can be viewed on the council website: [www.bournemouth.gov.uk](http://www.bournemouth.gov.uk) under planning application number 7-2013-5913-EE. Comments should be submitted to the council in writing by 19 July.
Generous donation gets people cycling at Christchurch Hospital

Patients who often feel short of breath can now make use of a specialist exercise bike bought with funds from the hospital’s League of Friends.

The £1,000 bike operates at a low intensity, meaning little pressure needs to be applied to get it moving, making it ideal for a wide range of patients. It will be used in pulmonary rehabilitation classes which take place at Christchurch Hospital, benefiting around 40 patients every week. The specially designed classes combine physical exercise with advice on lung health and coping with breathlessness.

Charlotte Church, physiotherapist at the hospital, said: “We are extremely grateful to the League of Friends for this bike. Cycling and walking are well advocated in pulmonary rehabilitation and as the bike is static, it means our patients don’t need to worry about their balance or any physical limitations that would normally prevent them from using a bicycle.”

Teal Kornet, 74, started attending the pulmonary rehabilitation sessions at Christchurch Hospital when he began to feel regularly out of breath. He has since given talks on the service to fellow patients during the sessions and praised the purchase of the bike.

“Very fit and well as a result of my sessions with the bike, I would definitely recommend the sessions to other patients,” he said. The League of Friends were more than happy to support the hospital. The bike is another way of helping patients maintain their fitness and wellbeing.

Notes from the League of Friends:

June 2013 ● 37
Jigsaw Building plans for Royal Bournemouth Hospital submitted to council

PLANS for the new Jigsaw Building at the Royal Bournemouth Hospital (RtBH) have been submitted for consideration to Bournemouth Council.

Detailed feedback from hospital staff, patients and the public have been incorporated into the design for the proposed new Women’s Health Unit and Cancer and Blood Disorders Unit.

Richard Renaut, director of service development at the hospital Trust, said: “We’re really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.

“We’re excited about the design and will continue to work with the public to get their views on the interior of the building and the garden area.”

The proposed 2000m2 Jigsaw Building will be based at RtBH between the Eye Unit and the Derwent Suite for Orthopaedics. It will be a centre of excellence for oncology, haematology, gynaecology, breast, and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital.

Subject to planning approval, initial work could start in October with a potential completion date of late 2014.

The plans for the Jigsaw Building can be viewed on the council website: www.bournemouth.gov.uk under planning application number 7-2013-5913-EE. Comments should be submitted to the council in writing by 19 July.
Hospital unit plans submitted for approval

PLANS for a cancer and blood disorders unit at the Royal Bournemouth Hospital have been submitted for council approval after an appeal raised £3m.

Detailed feedback from hospital staff, patients and the public has been incorporated into the designs, which have now been received by Bournemouth Borough Council.

A women's health unit will also be built as part of the project, funded by £3m donations raised through the hospital's Jigsaw Appeal over the last few years as well as NHS funds.

Richard Renaut, director of service development at the hospital trust, said: “We’re really pleased to get to this stage of the process. Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.

“We’re excited about the design and will continue to work with the public to get their views on the interior of the building and the garden area.”

The proposed building will be located between the Eye Unit and the Derwent Suite for Orthopaedics. It will be a centre of excellence for urology, haematology, gynaecology, breast care and early pregnancy.

If given the go-ahead, work could start in October and be completed by late 2014.

The plans will remain on show in the hospital's main atrium or can be viewed at www.bournemouth.gov.uk under planning application number 7-2013-5913-EE.

Comments should be submitted to the council in writing by July 19th.
Land’s End to John O’Groats for Bournemouth Hospital Charity

While some of us hop on a bike for fun or to commute to work, two of the Trust’s consultants are going the extra 980 miles to raise money for their hospital departments.

Dr Neil Hopkinson, Consultant Rheumatologist, and Dr Sean Weaver, Consultant Gastroenterologist, will embark on the epic Land’s End to John O’Groats cycle challenge on 7 July, aiming to cover 980 miles in 14 days.

Their fundraising target is £4,000 with the money they raise to be split between the hospital Trust’s Rheumatology Department and Endowments Department.

Dr Hopkinson said: “It’ll be a tough two weeks and we’ll be averaging 35 miles a day. I’ve done some 100 mile rides before, although none over consecutive days, but it will be good to raise the money for our department.”

Dr Weaver added: "The fact that this day by day we will be progressing up the country, and that half way is still only the Lake District, will give us a real sense of journey. I am keen to cycle in a way and at a speed to enjoy the journey and see our country."

"Looking at the route I think that Devon and Cornwall will be the hardest and I am most looking forward to the remote parts of Scotland."

You can follow the progress of the duo on the Bournemouth Hospital Charity website, www.bournemouthhospitalcharity.co.uk, and on Twitter by following @bzhospitalcharity and @Sh_wea.

If you would like to support Dr Hopkinson and Dr Weaver you can donate online at www.vgmpmoneyraising.com/fundraising/robert_hopkinson.

Alternatively drop by the Bournemouth Hospital Charity office in main stem of the Royal Bournemouth Hospital. Cheques should be made payable to Bournemouth Hospital Charity – John O’Groats"
Charity’s last legacy goes to Royal Bournemouth Hospital

A charity that helped people with respiratory diseases for more than 30 years has generously donated almost £11,000 to the Royal Bournemouth Hospital (RBH) before disbursing for good.

Ann and Rob Maskell set up the Donet Respiratory Group in 1982, gaining more than 500 members in the charity’s early years. However, due to recent dwindling numbers, the pair have disbanded the group and donated their last cheque to the Thoracic Medicine department at RBH and Poole Hospital.

Ann and Rob visited the Thoracic Medicine Department at RBH to hand over the money, which will be spent on a new ultrasound machine.

Dr Diane Lewis, Thoracic Medicine Consultant at RBH, expressed her thanks for the donation and said the machine would improve patient care and the efficiency of the department. She explained: “Patients undergoing investigations for fluid around their lungs often have to undergo a procedure where we remove some of the fluid by putting a needle into it. To improve outcomes and safety, an ultrasound is used to direct the operator. Often the patients needed to be admitted to hospital for the procedure.

“The purchase of an ultrasound machine will enable us to more frequently carry this out as an outpatient procedure, reduce the waiting time for the procedure and improve effectiveness and safety.”
Patients handed a breath of fresh air

Patients who feel short of breath are benefiting from a specialist exercise bike at Christchurch Hospital.

The £1,900 bike, which was bought with funds raised by the hospital trust’s League of Friends, operates at a low-intensity, meaning little pressure needs to be applied to get it moving.

It also monitors speed, distance travelled, heart rate and calories burnt.

It will be used in pulmonary rehabilitation classes at the hospital, which combine physical exercise with advice on lung health and coping with breathlessness, benefiting around 49 patients a week.

Hospital physiotherapist Charlotte Church said: “We are extremely grateful to the League of Friends for this bike.

“Cycling and walking are well advocated in pulmonary rehabilitation and as the bike is static, it means our patients don’t need to worry about their balance or any physical limitations that would normally prevent them from using a bicycle.

“One lady was actually brought to tears when she used the bike as she didn’t think she’d ever be able to use a bicycle again.”

Ted Kennett, 74, started attending the pulmonary rehabilitation sessions when he began to feel regularly out of breath. He has since given talks on the service to fellow patients during the sessions and praised the decision and purchase of the bike.

He said: “My GP recommended the sessions to me and I am so glad I came. The staff have taught me what to do if I get short of breath and how to take things easy.

“I can’t thank them enough. It is great to have a service like this on my doorstep and this bike just makes it even better.”
Donations to hospitals

BOURNEMOUTH: A charity for people with respiratory disease has donated almost £15,000 to RBH and Poole Hospital. Ann and Rob Maskell set up the Dorset Respiratory Group in 1992 and had more than 500 members at its peak. The group has now disbanded due to dwindling numbers.

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26 June 2013
Daily Echo
Donations to hospitals
A charity for people with respiratory disease has donated almost £15,000 to RBH and Poole Hospital.
16
Sixteenth of a page
£635

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27 June 2013
www.seekernews.co.uk
Health talk gets to the heart of matters
Almost 200 people attended a talk on the heart given by Cardiac Consultant Dr Peter O’Kane.

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Additional health talk organised by RBCH governors and focusing on the self-management of asthma, will take place at 2pm in St Mark’s Church Hall, Tidworth Villlage on Tuesday 3 November. It will be led by Dr David Morgan, Consultant in Thoracic Medicine. Call 01202 709421 or email info@rbch.nhs.uk to book your free place.
Piecing together the new Jigsaw Building

Plans for the new Jigsaw Building have been submitted to Bournemouth Council.

This is how the new Jigsaw Building at the Royal Bournemouth Hospital (RBH) could look if Bournemouth council pass the plans.

Detailed feedback from hospital staff, patients and the public have been incorporated into the designs for the proposed new Women’s Health Unit and Cancer and Blood Disorders Unit.

“We’re really pleased to get to this stage of the process,” says Richard Renaut, the hospital Trust’s director of service development.

“Our staff have worked hard to ensure the plans are right and that they reflect the feedback we have received.

“We’re excited about the design and will continue to work with the public to get their views on the interior of the building and the garden area.”

The proposed 2000 sq metre Jigsaw Building will be based at RBH between the Eye Unit and the Devolved Suite for Orthopaedics. It will be a centre of excellence for oncology, haematology, gynaecology, breast care and early pregnancy.

The plans for the new building will remain on show in the main atrium of the Royal Bournemouth Hospital. Subject to approval, initial work could start in October with a potential completion date of late 2014. They can be viewed on the council website: www.bournemouth.gov.uk under planning application number 7-2013-5913-E-E. Comments should be submitted in writing by July 19.
New test will raise hospital standards

WOULD YOU recommend your local hospital to family and friends? That is the question patients are now being asked as part of the new Friends and Family Test.

Launched in April 2013, the aim is to further improve the patient’s hospital experience and raise the standard of care. Patients over the age of 16 who are discharged from A&E or who have had an overnight hospital stay in Bournemouth and Poole are asked to respond to the question either before they leave hospital or within 48 hours of being discharged. This could be through survey cards or hand held devices.

Paula Shobbrook, director of nursing and midwifery at the Royal Bournemouth and Christchurch hospitals, said: “The Friends and Family Test is a very easy but extremely useful indicator on how patients rate their hospital experience so I would encourage every patient to give us their feedback.

Make your voice heard

To have a greater say in your local health services, you can take part in The Big Ask survey, launched earlier this month by NHS organisations in Dorset.

More than 12,000 people will be sent the survey but anyone can take part until it closes on Monday, 9 September.

The survey can now be completed online by going to the website bournemouth.ac.ukthebigask.

Paper copies of the survey can also be requested from Ehren Milner at the Market Research Group by calling 01202 961379 or emailing emilner@bournemouth.ac.uk.

“It provides a really useful tool for us to see how we are performing but is equally as valuable to members of the public who can see how their local health services are performing nationally.”

Answers for the test are completely voluntary and responses are totally anonymous. The first set of tests results will be available on NHS Choices at nhs.uk in July.

CONTACT ME

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Patients rating scheme could raise standards of Bournemouth and Poole Hospitals

By Nicky Fielday

WOULD YOU recommend your local hospital to family and friends? That is the question patients are now being asked as part of the new Friends and Family Test.

Launched in April 2013, the aim is to further improve the patient's hospital experience and raise the standard of care. Patients over the age of 16 who are discharged from A&E or who have had an overnight hospital stay in Bournemouth and Poole are asked to respond to the question either before they leave hospital or within 48 hours of being discharged. This could be through survey cards or hand held devices.

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Timescale created as multi-million transformation gets under way

Work timetable made for hospital renovation

Katie Clark

A TIMESCALE for major renovations of Christchurch Hospital has been drafted as work on the multi-million-pound transformation scheme is set to begin.

Bosses at the Royal Bournemouth and Christchurch Hospitals Trust have released a draft timetable following approval of a key scheme to ensure the future of services at the site.

Planning permission was granted in March for a new GP surgery, assisted living units, a care home and key worker housing on the site.

Other initiatives included in the £42 million scheme include building improvements; a pharmacy and community clinics as well as the retention of services including Macmillan, dermatology, phlebotomy and rheumatology.

And following concerns from local historians about heritage issues – H Block is a former workhouse infirmary – the Trust has assured concerned residents they will get access to the block to create a photographic record of the architecture.

Any items of interest which can be salvaged will be set aside for local re-use in some way.

A permanent history of the site will also be commissioned with the stained glass windows in the main entrance carefully removed and reinstalled near the new chapel.

Next month work will begin to create a new car park at the back of the hospital, as well as the refurbishment of M Block to provide rheumatology offices and staff accommodation.

The demolition of H Block will also take place.

And in January 2014, work is expected to begin on the refurbishment of outpatients, work on the new GP surgery and imaging unit.

During the work, outpatients will relocate to Forest Dene, next to where the dermatology unit is already based. Other arrangements are being finalised.

All the work is hoped to be completed by summer 2015.

Richard Reaunt, director of service development at RBCH, said: “We are very passionate about the development at Christchurch Hospital and would like to take this opportunity to once again thank all those who supported our plans.

“Since gaining planning permission in March, we have been working hard to ensure the many benefits of the scheme are realised as soon as possible.

“We are also keen to implement a schedule of works that will cause minimum disruption to our patients and staff.”

CONTACT ME

t: 01202 411278
e: katie.clark@bournemouthecho.co.uk
twitter: @katiedailyecho
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<td>Karen Flaherty, Trust Secretary</td>
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## Board of Directors Business Programme 2013

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