A meeting of the Board of Directors will be held on **Friday 14 November 2014** 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.

JAMES BUFFORD
INTERIM TRUST SECRETARY

### Agenda

<table>
<thead>
<tr>
<th>TIMINGS</th>
<th>1. APOLOGIES FOR ABSENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30-8.35</td>
<td>2. DECLARATIONS OF INTEREST</td>
</tr>
<tr>
<td>8.35-8.45</td>
<td>3. MINUTES OF THE PREVIOUS MEETING</td>
</tr>
<tr>
<td>8.45-8.55</td>
<td>(a) Patient Story Paula Shobbrook Verbal</td>
</tr>
<tr>
<td>8.55-9.05</td>
<td>(b) Draft CQC Report Paula Shobbrook Verbal</td>
</tr>
<tr>
<td>9.05-9.15</td>
<td>(c) Adult Safeguarding and Child Protection Report Paula Shobbrook C</td>
</tr>
<tr>
<td>9.15-9.25</td>
<td>(d) Performance Exception Report Richard Renaut D</td>
</tr>
<tr>
<td>9.25-9.35</td>
<td>(b) Urology Cancer and RTT Richard Renaut E</td>
</tr>
<tr>
<td>9.35-9.45</td>
<td>(c) Quality Report Paula Shobbrook F</td>
</tr>
<tr>
<td>9.45-9.55</td>
<td>(d) Financial Performance Stuart Hunter G</td>
</tr>
<tr>
<td>9.55-10.05</td>
<td>(e) Workforce Report Karen Allman H</td>
</tr>
<tr>
<td>10.05-10.25</td>
<td>7. DECISION</td>
</tr>
<tr>
<td>10.25-10.35</td>
<td>(b) Update on clinical service review and NHS England’s Five Year Forward View Tony Spotswood J</td>
</tr>
<tr>
<td>10.35-10.40</td>
<td>8. STRATEGY AND RISK</td>
</tr>
<tr>
<td>10.45-10.55</td>
<td>(a) Communications Update (including October Core Brief) Karen Allman K</td>
</tr>
<tr>
<td>10.55-11.05</td>
<td>(b) Corporate Events Calendar James Bufford L</td>
</tr>
</tbody>
</table>
10. **NEXT MEETING**  
Friday 12 December 2014 at 8.30am in the Committee Room, Royal Bournemouth Hospital

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

12. **COMMENTS AND QUESTIONS FROM THE GOVERNORS**  
Board Members will be available for 10-15 minutes after the end of the Part 1 meeting to take comments or questions from the Governors on items received or considered by the Board of Directors at the meeting.

13. **RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS**  
To resolve that under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act 1960, representatives of the press, members of the public and others not invited to attend the next part of the meeting be excluded on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted.
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS
NHS FOUNDATION TRUST
(the Trust)

Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Board of Directors (the Board) held on Friday 14 November 2014 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
David Bennett (DB) Non-Executive Director
Derek Dundas (DD) Non-Executive Director
Basil Fozard (BF) Medical Director
Stuart Hunter (SH) Director of Finance
Ian Metcalfe (IM) Non-Executive Director
Steven Peacock (SP) Non-Executive Director
Alex Pike (AP) Non-Executive Director
Richard Renaut (RR) Chief Operating Officer
Paula Shobbrook (PS) Director of Nursing and Midwifery
Bill Yardley (BY) Non-Executive Director

In attendance: Peter Gill (PG) Director of Informatics
James Bufford (JB) Interim Trust Secretary
Anneliese Harrison (AH) Legal Assistant to the Trust Secretary
Tracey Hall (TH) Head of Communications
Dily Ruffer (DR) Governor Co-ordinator
Brian Young (BYo) Public Governor
Graham Swetman (GS) Public Governor
Doreen Holford (DH) Public Governor
David Triplow (DT) Public Governor
Paul Higgs (PH) Public Governor
Colin Pipe (CP) Public Governor
Glenys Brown (GB) Public Governor
Roger Parsons (RP) Public Governor
Carole Deas (CD) Public Governor
Eric Fisher (EF) Public Governor
Ellen Bull (EB) Deputy Director of Nursing
Sue Frost (SF) Nurse Manager, Pathology
Sue Reed (SR) Head of Nursing & Quality
Martin Smith (MS) Head of Nursing & Quality
Kelly Spaven (KS) Directorate Matron, Ambulatory Care
Trudi Ellis (TE) Directorate Matron, Elderly Care
Chloe Cozens New Milton Advertiser

Apologies: None

118/14 DECLARATIONS OF INTEREST
None.

119/14 MINUTES OF THE MEETING HELD ON 10 OCTOBER 2014 (Appendix A)

The minutes of the meeting on 10 October 2014 subject to amendments were approved as an accurate record.

120/14 MATTERS ARISING (ACTIONS LOG UPDATE) (Appendix B)

(a) 100/14 Improvement of stroke services- ‘SSNAP’ data included on the RR agenda.

(b) 111/14 (b) The wording for the role of Governors within the Francis JB report is yet to be completed.

121/14 QUALITY IMPROVEMENT

(a) Patient Story (Verbal)

SF attended from the Cancer Palliative Care Unit at Christchurch and outlined to the Board that many patients are treated on the Haematology and Oncology Wards 10 & 11 for both clinics and day cases. She highlighted that recently the Trust had seen an increase in day cases but that this reflected earlier diagnosis.

Over the last 12 months Wards 10 & 11 had received no complaints which TS commended. Ward 11 Friends and Family Test (FFT) data had provided positive results and was acknowledged as a great achievement. It was noted that the positive feedback did not solely relate to Doctors and Nurses but to Ward Clerks and other support staff.

The Unit had been notified of some informal issues and in particular relating to a patient’s stem cell transplant and the advice given during Neutropenic periods. The patient had been asked to attend a blood clinic although they had previously been advised that whilst in a Neutropenic state patients should avoid crowds and contact with other people. Ward 10 discussed the risks and decided it was not appropriate for the patient to attend and that contradictory advice had been provided. Subsequent to this the time frames for Neutropenic periods were been identified and certain blood tests were arranged to be taken on the ward and the patient confirmed they were happy with the action taken.

The responses to the FFT and national cancer survey had also been positive and 64% of Bournemouth patients contributed to this. The Trust scored 84% within the Chemotherapy national survey although it
was highlighted that further details were required and as such the department had created their own survey to identify any issues.

PS commented that it was a positive story and provided good examples of excellent team work and quick responsiveness. It depicted the Trust’s ambition to be within the top range for cancer care.

KA commented that she had recently awarded the fantastic team on Ward 10 with a pride award and had spoken to staff in the area who expressed that they enjoyed being on the team as they are provided with good training. It was noted that this should be replicated, giving further opportunities by rotating staff to other areas.

PG commented that the story encompassed the Trusts’ values and PS that it should become a showcase story.

**Draft CQC Report (Verbal)**

PS and TS updated the Board on the recent CQC report from August 2014, emphasising that it had provided positive feedback and reflected the significant improvement undertaken by the Trust. It was noted that this was an on-going journey for the Trust to ensure that the hospital is running less busy and provide safe patient care by employing the right number of staff with the right skill mix.

The following key points were highlighted from the report:

- Compliance actions have been addressed and services were found to be responsive, well led and caring;
- Improvements were acknowledged in the delivery of care and support given for the introduction of the Heads of Nursing positions and new matron structure;
- In relation to ensuring privacy and dignity the CQC found that all patients’ needs were being met appropriately;
- Quality assurance was apparent at all levels of the organisation;
- The recruitment of staff was recognised as an on-going challenge but improvements were noted on wards and the Trust’s commitment to secure an appropriate workforce;
- Services were found to be safe and the Trust’s improvement journey was emphasised through the introduction of bay based nursing and that the three escalation beds seen previously were removed;
- There had been an increase in Consultant presence which was deemed to have positively impacted upon elderly care services at weekends and dementia care was commended;
- All services were found to be caring and the attitude of staff praised with privacy and dignity being promoted in all areas;
• The CQC collected comment cards and out of 75 comments only 3 had been negative reinforcing that patients were happy with the care provided and
• The Trust’s vision was shared by all staff and morale had improved with positive comments received from staff as to the connection with the Board;
• Further improvements were highlighted and an action plan was being developed for areas including stroke, mental health services and pathways alongside Dorset Healthcare University Foundation.

DB commented that it was a positive report and was shocked by the initial inspection last year which was unnecessarily negative. He added that the response within the organisation had been good, acknowledging results at the Healthcare Assurance Committee (HAC), and through the leadership at Board level together with wards responses to some challenges.

TS thanked clinical staff, Matrons and work shifting position amongst many services. He noted the driven changes by PS and thanked her for her leadership adding that the CQC reflected this. JS commended staff resolve and determination as to the progress made.

The Board acknowledged that there was no sense of complacency and commended the success of the approach from the Board to the Wards.

(c) Adult Safeguarding and Child Protection Report (Appendix C)

PS updated the Board on the following to provide information and assurance:

• The report and plans over the next year for protection were in line with Government processes;
• A number of referrals had been made and it was positive that the Trust are highlighting risk to ensure investigations are completed;
• Areas of priority are being reviewed and the Trust is consistently learning to promote the safeguarding of adults;
• Discussions are taking place and the sharing of learning with staff and national enquires;
• The Trust is working with other health organisations to change the way in which deprivation of liberty safeguards are reported and how this is managed operationally to focus on those most at risk;
• A designated paediatric trained Nurse is being appointed within ED.

IM commented on the increased levels of reporting and queried when
issues should be escalated. PS advised that the team analyses the numbers and lessons are learnt from those that are upheld and themes are highlighted

(d) Feedback from Staff Governors (Verbal)

JS updated the Board on the recent feedback from Staff Governors:

- Issues had previously been raised around appraisals and a meeting had been arranged to discuss this;
- Staff Governors were updated as to the position regarding the agenda for change and refreshments for housekeeping staff and were content that the process has been followed;
- Briefing dates for staff about the CQC report were raised and had taken place;
- Improvements have been made to the facilities for staff within Pathology following the last meeting;
- Good feedback had been received from the Allied Health Professional forum and will become a positive and rewarding forum;
- Staff Governors want to hold a further event for staff before Christmas
- Pay has been highlighted and staff feel that the NHS is falling behind other organisations.

TS commented that the meeting establishes confidence in the staff community and recognition that need to continue with these actions.

AP queried staff feedback following the CQC report and whether they felt able to continue on this journey noting the inherent pressures. PS responded that it is a challenge but the Trust was committed and would be working with staff to ensure it is achieved.

The Board proposed that mechanisms were devised to feedback to Staff about their concerns to ensure that staff remain motivated.

122/14 PERFORMANCE

(a) Performance Exception Report (Appendix D)

RR updated the Board on the latest information:

- Cancer & Stroke data- in relation to the national set standards for 2 week waits for suspected cancer referrals the Trust is expected to be non-compliant this quarter;
- Accident & Emergency 4 hour - the Trust is at risk of being non-compliant for three consecutive quarters;
- 62 day cancer wait – the Trust is expected to miss the target for
this quarter;

- A risk around outpatient waits was noted and that there were a number of outliers for medicine which has increased but bed reorganisation was taking place and flow improvement in 3 areas would help tackle this issue;
- Delayed transfers of care- working with social services and creating packages of care although the capacity in the community for these patients has impacted upon this;
- Cancer standards- predicting the estimated volumes of activity at 92% for 2 week waits which will be challenging;
- There has been an increase in fast track referrals. The Trust is working with GPs on the awareness of patients through an education program so patients are more aware of how urgent it is for them to attend these referrals;
- The Trust has improved upon breaches for the month of October;
- Referral to treatment for 18 week pathways are running at 86% as the back log is being cleared;
- Admitted long waiters- increased over the summer but the Trust has a focussed team to address this;
- Increase in Urology with 100 extra patients per month from GP referrals putting 3 specialties under pressure;
- SSNAP national scoring- the Trust is performing within band D alongside most other organisations. Scanning has improved although discussions around capital planning are due to take place and will concern the purchasing of scanning equipment to improve access to scanners for stroke patients.

SP queried the audit compliance data and RR commented that this is being investigated and would be identified.

RR advised that the non-compliance for 3 quarters in a row would result in Monitor involvement although they had been assured of the action being taken and achieving weekly compliance will be important to support this.

DD added he was disappointed with the imaging within 1 hour results and queried whether the Trust would have the necessary staff in place to process patients with an additional scanner. BF responded that training was underway to ensure that more radiographers are able to use the CT scanner to provide a 24/7 service.

AP queried the 2 week cancer wait data and whether the Trust now had the systems in place to achieve compliance. RR confirmed that this was the case but that the Trust was struggling with compliance in relation to patient choice and were working with the CCG on this point.

TS requested a report from RR as to the radiographer training and further how the Trust was performing on a comparative basis.
RR emphasised that the 2 week target must be achieved this quarter but raised concern that patients were not honouring their appointments. It was discussed that a process needed to be put in place to ensure patients are placed on an urgent pathway if appointments are not honoured. GPs must be satisfied that patients will be able to complete the 2 week pathway or patients are referred as an urgent care pathway within a month so as not to disadvantage them.

JS emphasised that the Board needed assurance that issues were being escalated especially with regards to capacity issues. She noted the improvements in stroke but that there were issues that needed to be actioned in a timely manner.

It was emphasised by the Board that the Key targets must be achieved this quarter as priority.

(b) **Urology Cancer and RTT (Appendix E)**

RR advised the Board on the actions to be taken:

- The Trust would be taking a predict and avoid approach;
- Increasing the amount of theatre time but were limited by staffing;
- Looking at the booking process and understanding capacity and demand;
- String of engagements from Dorchester hospital and were actively being managed;

BF added that Urologists were committed to being flexible to provide the service and discussions with theatre staff were taking place to ensure theatre flow.

DD commented on the timescale to improve results. RR commented that GPs have confirmed that they do not wish to introduce a further biopsy service and discussions are under way with the CCG.

(c) **Quality Report (Appendix F)**

PS updated the Board as to the Quality report:

Harm free care- Pressure damage is still high and remains higher than the national average as more patients are admitted with existing damage. She noted 16 new pressure ulcers were recorded in October and that category 3/4 ulcers are subject to the Serious Incident process in which a panel focuses on the actions, care and assessments of them.

AIRS- were reported to have been good in terms of falls and it was
highlighted that this incorporates falls with no harm or distress. Risk assessments - compliance decreased within September but increased in October and continues to be an area of focus for teams. Recent discussions as HAC identified areas of focus which will include pressure damage.

Friends and Family Test - strong data notably from Ward 3 and when aligned with the safety thermometer data clear improvements can be seen.

AP commented on the trend for pressure damage ulcers and that she was disappointed that the process was not working. PS commented that categories 3 and 4 had reduced since last year and once picked up on there is a rigorous review to ensure that all is being done.

PS commented on the new process for the FFT data and that NHS England had confirmed that the Trust could no longer use tokens alone and that card comments needed to be obtained. TS added that the Trust should use both methods to obtain a clear view.

AP commented on the Patient Engagement and Communication Committee discussions and that the methodology needed to be consistent in order to make clear comparisons with other organisations. PS assured that the process would be refined.

(d) **Financial Performance (Appendix G)**

SH advised the Board as to the financial position highlighting a £1.9 million variance in comparison to the original plan due to emergency pressures and the vacancies for doctor and nurses posts. In comparison against the recovery plan it was confirmed that the Trust was on target during September and will recover by end of the year. Going forwards the finance committee will be focussing on ensuring that the Trust achieves the plan monthly.

(e) **Workforce Report (Appendix H)**

KA highlighted the following to the Board:

- Data for recruitment remains challenging although some positive progress has been noted through a reduction in vacancy data;
- Appraisal compliance has decreased although the Trust is developing a new appraisal and personal development process with group discussions with Talent Works to help with the changes within the organisation;
- 30 new Consultant appointments have been made over the last
year but remains challenging in some specialties;

- Weekly meetings with matrons are taking place to drive initiatives for recruitment and the Trust is joining up with other organisations to maximise the pull of drawing people to the area;
- Successful open day on 25 October with 25 applications for HCAs;
- A detailed report based upon the results of the friends and family test data for Q2 would be brought back to the Board once received;
- Progress with mandatory training was noted however slight but work is underway to increase compliance;
- New core skills based training system is being developed with a virtual environment which will incorporate competency assessments;
- Mandatory training scores are good when benchmarked against other organisations;
- Challenge for winter pressures recruitment to ensure that the right number of staff are in place;
- KA presented the starters and leavers data to the Board highlighting improvements.

DD commented that more work was being done with retention and recruitment but that the Trust needed to be more welcoming and appealing to the Community and this needed Board support with Volunteers and work experience. KA responded that these proposals had been discussed and would be brought back to the Board.

AP added that there needed to be a retention strategy and commended the move towards IT mechanisms. She further queried whether the training would be enforced as mandatory with prompts. KA responded that the platform needed to be considered and should be reviewed on a monthly basis and if not working new measures will be implemented.

SP commented on the nursing run rate and queried the lessons learnt from the leavers. PS responded that discussions are taking place and within care groups they are developing their own workforce strategy and plans.

BY supported AP view to put rigour behind the importance of mandatory training. He requested visibility of the 10 areas and comparisons as to how the Trust was scoring in terms of appraisals. Further he suggested that more data was provided about behavioural issues before a new system is put in place.

The Board agreed that more rigour was needed and detailed data was required as to mandatory training and compliance along with appraisals and behaviours. JS confirmed that additional support to facilitate this would be provided and DB proposed this was also linked to finance.
DECISION

(a) **Urgent Care Plans and Escalation (Appendix I)**

RR outlined the plan to the Board highlighting the following themes:

- The Board has agreed to increase the deficit to support the escalation plan;
- Staffing will be fundamental to the plan and will include agency staff if the Trust is unable to recruit in certain posts;
- Emergency Department internal recruitments- the volume is a major influence and there will be a culmination of factors in the plan;
- There will be a focus on the Bournemouth and Christchurch population and working with CCG further outside;
- There has been a staff suggestion for a drop in session to advise of what is going on outside of the Trust and how other organisations are coping;
- Action is also being taken to support the work around escalation issues.

TS added that discussions had taken place with the Trust Management Board and that the Board should have confidence to support the plan. DB added that assurance should be taken that a lot of detailed work had been provided.

SP queried whether the Trust would be able to resource the plan with the necessary recruitment required. PS commented that the Trust needed to have a plan and that the Board will have sight of this to be able to review alongside TMB. JS queried whether it had been benchmarked against other organisations. RR responded that it had and notably the Emergency Department.

The Board confirmed their support of the plan.

STRATEGY AND RISK

(a) **Update on Clinical Service Review and NHS England’s Five Year Forward View (Appendix J)**

TS updated the Board as to the Clinical Service Review which was now underway and that there needed to be an overlap with the work of the Board. The aim of the review is to identify a new model of care for services across Dorset. The Trust needs to ensure that it is sustainable in providing these services once identified.

4 Groups have been identified and each organisation has been asked to feed clinicians into these groups with the task of reviewing the
change for best practice and the preferred models going forward. The review is to be completed by the end of March 2015 with a public consultation following the general election.

RR added that the Trust needed to consider networking and franchising of services but also concept of moving towards new locality services. Multi-specialty community providers will also be expecting to directly employ consultants and diagnostics and MCPS making a small hospital even smaller and less viable.

TS added that TMB had discussed the development of a clear vision going forward being a motivating factor behind the push of providing services. The aim will be to put quality at the heart of the organisations. TS requested that the Board supplied their comments about the vision statement which will be discussed with TMB on 5 December. Whilst PS will work with Nursing staff and KA with change leaders and the medical staff committee to obtain a unified vision going forwards.

125/14 INFORMATION

(a) Communications Update (including Core Brief October) (Appendix K)

The report was noted for information.

(b) Corporate Events Calendar (Appendix L)

The report was noted for information.

(c) Board of Directors Forward Programme (Appendix M)

The report was noted for information.

126/14 DATE OF NEXT MEETING

Friday 12 December 2014 at 8.30am, Committee Room, Royal Bournemouth Hospital.

127/14 ANY OTHER BUSINESS

Key Communications points for staff

1. CQC
2. Performance
3. Winter planning
4. CSR
5. The Trusts’ vision

128/14 QUESTIONS FROM GOVERNORS

1. DT commented that 600 children were referred to social care and queried whether the hospital was identifying issues. PS responded that there is a good system of communication in place and lead nurses communicated through meetings with social care links regularly.

2. EF commented on the pressures within ED and queried whether the Trust was engaging the CCG and Dorset healthcare to ensure in terms of the clinical service review that discharge is prioritised. RR added that the clinical service review would concern emerging models of care and services going forward.

3. GB commented on the trajectory and delayed transfers of care which corresponded with outliers and whether there was a sense that with partners the bed complement would improve. RR confirmed that it would.

There being no further business the meeting was declared closed at 10:52
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<tr>
<th>Date of Meeting</th>
<th>Ref</th>
<th>Action</th>
<th>Action Response</th>
<th>Brief Update</th>
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| 11.07.14       | 86/14(a)  | MATTERS ARISING
Update from Pharmacy on Medication on Elderly Care Services Wards (46/14(a)) |                 | PS Complete and reported at board                |
|                |           | PS confirmed that the audit of the provision of drugs to patients on discharge in the Elderly Care Services wards was currently in progress and she would report back on the results of the audit in September. |                 |                                                  |
| 88/14(d)       |           | PERFORMANCE
Workforce Report                                                   |                 | KA Provided in the workforce report              |
|                |           | It was noted that staff attendance at mandatory training was still low but a stronger connection was being drawn with appraisals. SP requested details of the total number of staff recruited compared to the number of vacancies and KA confirmed that this could be provided in a report. |                 |                                                  |
| 12.09.14       | 100/14    | PERFORMANCE
Performance Report and Productivity                                  | RR              |                                                  |
|                |           | Work to be taken forward on improvement of Stroke services             |                 |                                                  |
| 10.10.14       | 111/14(a) | QUALITY IMPROVEMENT
Patient Story                                                             | PS              | Food provision on ward 18 is as follows:
  Breakf... |                                                  |
<p>|                |           | Update the Board on food provision on ward 18                          |                 |                                                  |</p>
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<tr>
<td></td>
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<td>Report to Board on waiting rooms</td>
<td>RR</td>
<td>Incorporated into PLACE Audits</td>
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<td></td>
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<td>AP queried the effectiveness of the Communication training for Consultants and requested further detail as to its contents.</td>
<td>BF</td>
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<td>111/14 (b)</td>
<td>QUALITY IMPROVEMENT Francis Report</td>
<td>Change of reporting structures with amber actions to be reported quarterly at HAC and annual update to be included in the quality report</td>
<td>PS</td>
<td>Reporting systems and quality report plan updated - Complete</td>
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<td>Review of process for management of complaints with reporting structures and systems to be adapted in line with new care group structures</td>
<td>PECC</td>
<td>Added to PECC forward programme</td>
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<td></td>
<td></td>
<td>Amend governors role wording</td>
<td>JB</td>
<td>To be considered at October CoG</td>
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<tr>
<td>111/14 (b)</td>
<td>QUALITY IMPROVEMENT Francis Report</td>
<td>TS added that it would be possible to circulate a note of the meeting to the Board as an example of the process in place.</td>
<td>JS</td>
<td>To be circulated at the November Board Meeting.</td>
</tr>
<tr>
<td>112/14</td>
<td>PERFORMANCE Performance and Productivity</td>
<td>RR confirmed that a plan was to be prepared for November Board setting out options for performance, including cancer 4 hour action plan</td>
<td>RR</td>
<td>On agenda for November Board</td>
</tr>
<tr>
<td>PERFORMANCE Workforce</td>
<td><strong>BY</strong> requested further details about mandatory training and highlighted that it would be useful for the Board to compare results against the Trust’s targets and measure progress together with EXIT interview data.</td>
<td><strong>KA</strong></td>
<td>To be available from December</td>
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<tr>
<td>DECISION System Resilience</td>
<td><strong>Performance Reports to include regular reports on winter plan</strong></td>
<td><strong>RR</strong></td>
<td>Item included on November agenda</td>
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**BOARD OF DIRECTORS**

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>14th November 2014 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Adult Safeguarding and Child Protection Report</td>
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<tr>
<td>Section:</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>Executive Director with overall responsibility</td>
<td>Paula Shobbrook, Director of Nursing and Midwifery</td>
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</tbody>
</table>
| Author(s):             | Kate Rowlinson Adult Safeguarding Lead  
                          | Pippa Knight Child Protection Lead |
| Previous discussion and/or dissemination: | N/A |

**Action required:**
For discussion

**Summary:**

The Adult Safeguarding report details the actions and improvements to comply with the safeguarding agenda and to provide assurance to compliance to the Care Quality Commission (CQC) judgement framework. This report is to inform the Bournemouth and Poole Safeguarding Adults Board, Dorset Safeguarding Adults Board, the RBCH Safeguarding Committee and Board of Directors of the Trusts progress during 2013/14 and aims for 2014/15

The Child Protection report details activity in respect of Safeguarding Children in the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust during the year 2013/14. It is presented to provide assurance of compliance with the Care Quality Commission, Working Together (Dept of Health), Ofsted and the Children and Young Peoples National Service Framework.

**Related Strategic Goals/Objectives:** All

**Relevant CQC Outcome:** All

**Risk Profile:**

- Have any risks been reduced? No
- Have any risks been created? No

**Reason paper is in Part 2** Not applicable
Annual Protection and Safeguarding Summary
Report for Vulnerable Adults and Children
2013/2014

1. Adult Protection and Safeguarding Report for 2013/2014

1.1 Introduction

This report summarises the actions and improvements to comply with the safeguarding agenda progress during 2013/14 and aims for 2014/15. The full report has been approved by the RBCH Safeguarding Committee and Healthcare Assurance Committee and shared with the Bournemouth and Poole Safeguarding Adults Board, Dorset Safeguarding Adults Board.

1.2 Trust Adult Safeguarding structure

- Paula Shobbrook, Director of Nursing is the Trust’s Executive Lead for Adult and Children’s Safeguarding.
- Ellen Bull, Deputy Director of Nursing.
- Kate Rowlinson is the Senior Nurse Adult Safeguarding Lead for the Trust.
- Debbie Hopper, Case Facilitator for Adult Safeguarding and Learning Disability

1.3 Position Statement - Safeguarding Training

1.3.1 The Adult Safeguarding awareness training sessions continue to be delivered to all staff groups clinical, non-clinical and medical staff within the Trust on a regular basis. This includes sharing lessons learnt and outcomes from safeguarding case conferences.

1.3.2 The Senior Nurse for Adult Safeguarding is working with the task and finish group from the Pan Dorset Safeguarding Adults training and workforce development group so training is aligned across Dorset.

Deprivation of Liberty Safeguards (DoLS):

The Supreme Court has recently issued it’s judgement on three cases which have altered the way a deprivation of liberty is interpreted and could mean many more patients in hospitals needing to have their detention authorised, either though the DoLS or by the courts. The test is are patients:

1. lacking the capacity to consent to being in hospital?
2. under continuous supervision and control?
3. not free to leave?
The Trust policy is being rewritten and will be taken for approval to the
Trust Management Board and Healthcare Assurance Committee.

There were 7 DoLS raised within the quarter (Jan – Mar 14) to ensure
patients who lack capacity due to dementia, brain injury or learning
disability, remain safe and receive the treatment they require whilst in
hospital. These have been patients who have actually expressed a wish to
leave and actively tried to.
We are therefore expecting that in accordance with legislation numbers will
be significantly increased in the next quarter.

1.4 Collaboration with Social Services

Monthly meetings continue to take place between the Adults safeguarding
leads, Deputy Director of Nursing and Social Services to give feedback
and discuss any outstanding actions and agree outcomes required. This
continued communication between the teams has greatly enabled clinical
teams to enhance their performance within the Safeguarding agenda.

1.5 Increased levels of reporting

1.5.1 The number of cause for concern alerts reported is very responsive from
all areas within the Trust and viewed as positive and is indicative of the
raised levels of awareness due to the increased training compliance.

Referrals to Social Care from Trust

<table>
<thead>
<tr>
<th>Trust Area</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Dept. and Acute Medicine</td>
<td>153</td>
</tr>
<tr>
<td>Other corporate</td>
<td>108</td>
</tr>
<tr>
<td>Total</td>
<td>261</td>
</tr>
</tbody>
</table>

- In the last 12 months April 2013 – March 2014, 43 alerts were raised
  which were Trust related.
- 30 of these were Pathway 3 full investigations and 13 Pathway 1
  internal investigations.

Trends
- 30 alerts were in relation to quality of care / documentation and
  communication issues
- 4 pressure ulcer related
- 9 of these are in relation to discharge concerns

The main lessons learnt from these have been:-
Quality of Care:
Documentation needs to show levels of risk and appropriate completion of risk assessments, escalating concerns appropriately for specialist advice ie: pressure ulcers.

Discharge Arrangements
Specific care needs to be taken on discharging patients, when giving medications and discharge letters in relation to patient and GP details.

1.5.2 The Trust has not been involved in any Serious Case review so far this year.

1.6 Sharing Lessons Learnt

1.6.1 The internal Safeguarding Board meeting is held quarterly chaired by the Director of Nursing, and attended by all partnership organisations. This reviews and monitors alerts raised and examines themes. This ensures action plans developed following concerns raised are managed by individual directorates and progress is reported by exception.

1.6.2 There is a monthly Adult Safeguarding Leads meeting chaired by the CCG safeguarding lead and attended by the safeguarding leads from RBH, PGH, Dorset County Hospital and Dorset Healthcare University Foundation Trust which allows us to openly discuss safeguarding and best practice in a supportive environment.

1.6.3 Adult safeguarding themes raised in the previous month are shared at the directorate sisters / charge nurses and senior nurse groups monthly. This is chaired by either the Director of Nursing or Deputy Director of Nursing and ensures that corporate actions are delivered.

1.7 Learning Disabilities for the Safeguarding team

The Case Facilitator for Adult Safeguarding and Learning Disability has now been in post for 14 months and in the last quarter we have had no LD safeguarding concerns raised due to continued support to ensure there is good communication with the wards and community services. This provides further evidence of compliance with the Monitor governance requirements related to Learning Disability.

1.8 Action Plan for 2014 / 2015

There are five priority actions to achieve in the coming year

1.8.1 Review the reporting process through the safeguarding board to ensure compliance with CQC outcome 7.

1.8.2 To continue to ensure corporate learning through and across directorates from outcomes following safeguarding case conferences.
1.8.3 To ensure that Directorates are more engaged with the safeguarding process in their attendance at case conferences and proactively responsive for the actions.

1.8.4 To await guidance for pathway 1 training for senior nurses / matrons

1.8.5 Further guidance with regards to the new legislation on DoLS and the Care Bill is due to be given by the DOH this summer for us to action. To have an approved policy for implementing the new guidance.

1.9 Summary

There continues to be considerable achievement over the past year with compliance to the Safeguarding agenda with training having attained a high level to a corporate 87% which is embedded into the induction and update process.

The structure of Safeguarding has been highly visible in the Trust and as a result, alerts have continued to increase. Collaborative working with social services and partnership organisations has also facilitated compliance with the reporting and action planning process.

The adult safeguarding team will continue to support all staff in ensuring that all people under their care are appropriately safeguarded.

1.10 Recommendation

This report is for information.

2 Child Protection and Safeguarding Report for 2013/14

2.1 Introduction

This summary report details activity in respect of Safeguarding Children in the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust during the year 2013/14. It is presented to provide assurance of compliance with the Care Quality Commission, Working Together (Dept of Health), Ofsted and the Children and Young Peoples National Service Framework.

2.2 Local Arrangements

2.2.1 The LSCB Boards (Bournemouth-Poole and Dorset) meet four times per year. The Boards share an Independent Chair and progressively more sub-groups. RBCH predominantly attends the B-P Board, Executive representation is the Director of Nursing and Midwifery. The Named Nurse for Safeguarding Children and the Named Midwife deputise at these meetings and represents the Trust at sub-groups as appropriate.

2.2.2 LSCBs are based on the premise that safeguarding and promoting the welfare of children depends on effective joint working between agencies and professionals. The LSCBs are currently engaged with the formation of a MASH (multi-agency safeguarding hub) which is positive step in sharing relevant family information to
safeguard children. It is likely that a small pilot will be launched in Dorset in the current year. The Named Nurse has represented RBCH at MASH meetings.

2.2.3 The local LSCB PAN Dorset Safeguarding Procedures have been revised and updated reflecting current practice and legislation in year. The LSCBs jointly decided to commission an external agency for the formatting and future updating of the Procedures. The Named Nurse represented RBCH on the working group of the policy meetings and updates. The new procedures were launched on 1st August 2014. Trust staff access these PAN Dorset procedures via the Trust Intranet Safeguarding Children page.

2.2.4 Ofsted inspected Bournemouth Social care and the B-P LSCB during April 2014.

2.2.5 Section 11 of the Children Act 2004 places a duty on all partners to make arrangements to safeguard and promote the welfare of children. An annual Section 11 audit is completed on behalf of the LSCBs. A new e-tool has been used for the annual audit this year which led to a delay in the timing of the assessment and the full report has not yet been published. The audit was completed in June 2014. The audit took a deep dive into areas including Domestic Abuse and Clinical Supervision for staff.

2.3 Trust Arrangements

2.3.1 There is comprehensive contemporary reference material available across the Trust which is accessible via the Safeguarding Children page on the Trust Intranet and the library.

Those holding the statutory positions in respect of safeguarding children during the year have been:

**Executive Trust Lead Nurse**
Paula Shobbrook - Director of Nursing and Midwifery

**Named Nurse for Safeguarding Children:**
Pippa Knight

**Named Doctor:**
Mr Karim Hassan – Consultant, Emergency Department

**Lead Nurse:**
Cheryl Chainey – Nurse, Emergency Department

**Named Midwife:**
Pauline Hawkes – Head of Midwifery

**Lead Midwife:**
Julie Davies – Team Leader Sunshine Team, Maternity

Additionally there is a very dedicated group of staff across most areas of the Trust who take the lead as a child champion for their area. Areas where children frequent as patients have at least one such champion and areas identified as having a gap have nominated staff to take on this role. These staff do not have specific time allocated to this role. They meet together as the Safeguarding Children Group.

2.4 Training

2.4.1 Training at all levels is now deeply embedded within the Trust programme. Overall training compliance is 84% across the staff groups and levels.
2.4.2 The updated inter-collegiate document published in April 2014 will require more staff across the Trust to be trained at level 3. Initially the Trust will therefore note a fall in compliance at this level but this must be seen as the short term fall for the longer term improvement it will be. The Named Nurse is actively involved with supporting the development of a single day level 3 course rather than the current 2-day format.

2.4.3 E-learning has been challenging for staff through the year. This is for a variety of reasons including
* Accessing the on-line training package
* Awareness of how to run the learning programmes
* Access to e-learning facilities
This has been most challenging for medical and dental staff who mostly access safeguarding children training on-line. Moving forward, this is an area for improvement and the Trust now has a dedicated e-learning lead whose work will include easing the user end frustrations of the current system. The local LSCBs and Intercollegiate Document support the use of e-learning for level 1 and 2 training.

2.4.4 Furthermore in-year there have been good opportunities for staff to attend education/practice development events. The Named Nurse, Named Midwife and Lead Nurse for ED have all previously completed level 4 equivalent training. They all attend and contribute to multi-agency/partner meetings and have the opportunity to attend national learning events to maintain their Level 4 training.

2.5 Serious Case Reviews/Audits

2.5.1 The Trust has been formally involved with one Serious Case Review (SCR) this year, Baby J. The Individual Management Review (IMR) was initially submitted in December 2012 with the SCR concluding in March 2013 and the overview Report published in May 2013. The final report noted that RBCH’s review was of a high quality, and the detailed information and analysis about Ms J’s medical history provided a significant contribution to the SCR process.

The Trust has been involved with 2 family chronologies for the LSCB and a further 2 for the Designated/Deputy Designated Nurse. Chronologies are undertaken to assess whether a case meets the threshold for SCR. None of these chronology requests have continued onto SCR.

2.5.2 B-P LSCB and Dorset LSCB have additionally published two additional cases and a national SCR.

2.5.3 Learning from Serious Case reviews and audits are incorporated into mandatory training programmes and are available to staff via the Trust Safeguarding Children page.

2.6 Referrals to Social Care from Trust

<table>
<thead>
<tr>
<th>Trust Area</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12 *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Dept</td>
<td>580</td>
<td>465</td>
<td>255</td>
</tr>
<tr>
<td>Maternity</td>
<td>48</td>
<td>53</td>
<td>14</td>
</tr>
<tr>
<td>Other corporate</td>
<td>17</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

*Data collection commenced and reported for last 2 quarters of the year only.
2.7 Examples of improvements in practice during 2012/13

2.7.1 The Safeguarding Children Group agree that the profile for safeguarding across the Trust is higher and continues to improve. More staff are involved with the group as they stand up to be champions for children in their areas. This is reflected through the increase in the numbers of corporate referrals (i.e. not from ED or Maternity).

2.7.2 Referrals continue to arise from a broad range of areas across the Trust and particularly positive is that in ED the diversity of staff making referrals is much greater than in previous years. The introduction of the e-form has changed this which improves the information shared to social care. An evaluation of the e-forms system with our partner agencies demonstrated that they receive the information in a more timely way, can read the information sent (it is typed rather than hand written) and it is sent via pre-loaded email addresses rather than faxed; reducing the risk of error. Most of our GP partners have now opted to join our email list for this e-form for safeguarding children.

The new system allows all the referrals to be reviewed for quality and trends analysis, a role which initially the Named Nurse held but is now fulfilled by the Named Doctor. Having the ‘line of sight’ to front line practice supports discussions at LSCB for example this year the LSCB have introduced data sets (a dash board type tool) to identify trends and align services with these emerging concerns and we are now able to triangulate data.

2.7.3 There has been greater attention around the Early Help offers in Children’s Services which focuses on sharing information with partners to support families early, as soon as a difficulty or potential difficulty is identified. Throughout the areas where children attend in the Trust there is evidence of much more working with health visitors, school nurses and paediatric services for example at Poole Hospital. Orthodontics Ophthalmology Dermatology and Orthotics are good examples of where staff link with partners for early help.

2.7.4 Safeguarding Supervision has been rolled out to the safeguarding leads in the Trust. An evaluation of the supervision session was completed by the leads after 6 months which supported continuing the service. Safeguarding continues to be a standing agenda item on several Governance and Staff meetings, giving time to share and reflect on cases and experiences, with the intention of service improvement for better patient outcomes.

2.7.5 Signposting and access to information for children and parents continues to improve. Out-patients have a new dedicated area for sharing information with children and families and topics pertain to nationally and locally identified areas of education – FGM for example.

2.8 Reports and Inspections

2.8.1 Designated Nurse Inspection Q2 2013

The Trust hosted an inspection visit from the Designated Nurse in July 2013. During the full day areas including:
- Ophthalmology
- Orthotics
- Out-patients
Formal feedback was positive and informally the Designated Nurse commented on how impressed she was with the staff she met and the Trust as a whole. Specifically staff were described as being:

- Passionate about the jobs
- Very smart and well presented
- Keen to openly share information about their services
- Forward looking about what else can be done, further developments
- Welcoming and full of pride in their work

The overall impression was that Safeguarding practice is embedded within our systems and culture and that the safeguarding leads work with each other and their teams, not in isolation from each other. They take their responsibility to act on concerns and will make a phone call to help a child.

### 2.8.2 Care Quality commission (CQC)

The Trust was inspected in October 2013 some key messages were shared regarding children using the service. The detail is available in the full report, in summary:

- Children’s care maternity, critical care, and end of life care were safe.
- Children’s care maternity, critical care, and end of life were among the positive examples of caring services
- Children’s care, critical care and end of life care were particularly responsive to people’s needs.
- Children’s care, maternity, critical care and end of life care were generally well-led.

The trust confirmed that the Board level executive with lead responsibilities for safeguarding children was the Director of Nursing and Midwifery and that there were named healthcare professionals with safeguarding children responsibilities and a nominated safeguarding children lead. Systems for safeguarding children were monitored by the trust’s Safeguarding Committee, and the trust’s Executive Board received an annual safeguarding report that included training for staff in safeguarding and how to deal with children who missed appointments. They told us that safeguarding processes across the trust were audited annually.

The CQC concluded there were suitable arrangements in place to safeguard children and young people from the risk of abuse.

### 2.9 Areas for development in 20013/14

The Children’s group devise an annual action plan based on risks and gaps to our current service. It has a broad aim to continually improve services across the Trust based on the Section 11 LSCB self-assessment (undertaken annually in September) local and national learning, and feedback about our services.

One action from the 12/13 plan remained incomplete for this year;

It was planned 12/13 to improve data capture electronically when a child attends for an appointment by including who attends with the child and what the
relationship between the person and the child. Funding for this externally
developed IT update was funded in year and launched in August 2014.
The 13/14 workplan was to embed the changes in working practice made in
12/13 rather than introduce further change. The group Safeguarding Children met
in May 2014 and agreed a workplan for this coming year. The workplan largely
focuses on aligning in-house policies and pathways with the new LSCB policies
including

- Teenage Neglect
- Suicide
- Sexual harm
- Pre-birth protective support
- Female Genital Mutilation
- and Domestic Abuse

The Group also aim to further roll out clinical supervision, with them as the
Supervisor. This is a positive reflection of their supervision experience but will
require further training for the group.

2.9 Recommendation

This report is for information.
<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>14th November 2014 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Performance Exception Report including Admitted 18 week RTT Update</td>
</tr>
<tr>
<td>Section:</td>
<td>Performance</td>
</tr>
<tr>
<td>Executive Director with overall responsibility</td>
<td>Richard Renaut, Chief Operating Officer</td>
</tr>
<tr>
<td>Author(s):</td>
<td>Donna Parker / David Mills</td>
</tr>
<tr>
<td>Previous discussion and/or dissemination:</td>
<td>PMG and Trust Management Board November 2014</td>
</tr>
</tbody>
</table>

**Action required:**
The Board of Directors is asked to consider the information provided and support any actions highlighted in relation to non-compliant or ‘at risk’ indicators.

**Summary:**
The attached Performance Indicator Matrix and Exception Report outline the Trust’s performance exceptions against key access and performance targets for the month of September 2014.

It also incorporates an indicative RAG rating for expected performance in the following month based on internal monitoring to date, as well as an indication of Trust level risk in relation to the metrics over the quarter.

Key non compliances in September were:
- Cancer 2 week wait for August performance including for breast symptomatic patients
- 62 day cancer referral to treatment in August
- A&E 4 hour target
- Admitted RTT at aggregate level and in General Surgery, Orthopaedics, Ophthalmology, Dermatology, Rheumatology and Gynaecology
- Non admitted RTT speciality level in ENT and Oral Surgery
- One 52 week wait on incomplete (unadjusted) pathways
- Cancer consultant upgrade in August

Performance risks for the forthcoming month are:
- Cancer 2ww including breast symptomatic patients
- A&E 4 hour target
- RTT admitted, non-admitted and incomplete pathways targets as per national RTT recovery plan
- 52 week waits due to increased RTT pathway pressures and patient choice

For Quarter 2 the key risks to the Trust remain:
- Cancer 2ww including breast symptomatic, predominantly due to patient choice and consultant sick leave
- A&E 4 hour wait - the increase in ambulance conveyances has continued
- RTT admitted pathway targets as per national RTT recovery plan of reducing long waiters
### Related Strategic Goals/Objectives:

| Performance |

### Relevant CQC Outcome:

| Section 2, Outcome 4: Care and welfare of people use services  
| Section 2, Outcome 6: Co-operating with others |

### Risk Profile:

1. Risk assessments for the cancer 62 day wait non-compliance and potential risk to the trust’s authorisation remains on the risk register despite Q1 and Q2 compliance, due to ongoing risks.

2. Risk assessment against the 4 hour target has been reviewed to reflect the increase in ambulance conveyances and attendances and our continued non-compliance.

3. RTT speciality and aggregate performance non-compliance continues on the risk register, though this position is expected as part of the national RTT recovery plans.

4. The urgent care impact risk assessment remains on the Trust Risk Register given the increased activity pressures, 4 hour non-compliance and other indicators such as the increase in outliers.

5. A risk assessment for the cancer two week wait target is being completed.

6. A risk assessment is being completed in relation to the RTT non admitted target compliance.

| Reason paper is in Part 2 | N/A |
Performance Exception Report including Admitted 18 week RTT

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 September 2014, as set out in Everyone counts: Planning for Patients 2014/15, the Monitor Risk Assessment Framework and in our contracts.

2 Cancer

<table>
<thead>
<tr>
<th>Performance against Cancer Targets</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key Performance Indicators</th>
<th>Threshold</th>
<th>Q1 14-15</th>
<th>Aug-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 weeks - Maximum wait from GP</td>
<td>93%</td>
<td>92.9%</td>
<td>70.1%</td>
</tr>
<tr>
<td>2 week wait for symptomatic breast patients</td>
<td>93%</td>
<td>96.7%</td>
<td>20.0%</td>
</tr>
<tr>
<td>31 Day – 1st treatment</td>
<td>96%</td>
<td>98.4%</td>
<td>96.6%</td>
</tr>
<tr>
<td>31 Day – subsequent treatment - Surgery</td>
<td>94%</td>
<td>94.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>31 Day – subsequent treatment - Others</td>
<td>98%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 Day – 1st treatment</td>
<td>85%</td>
<td>87.2%</td>
<td>84.9%</td>
</tr>
<tr>
<td>62 day – Consultant upgrade (local target)</td>
<td>90%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>62 day – screening patients</td>
<td>90%</td>
<td>91.8%</td>
<td>90.5%</td>
</tr>
</tbody>
</table>

As expected we continue to remain below the threshold against the Two Week Wait target predominantly as a result of patient choice. However, demand and capacity pressures in Skin and Breast did contribute a proportion of in month breaches in August. Capacity in the Breast Service has now been resolved. Current medical staff shortages and demand in Dermatology continue to be an issue. Locum cover and additional sessions are currently being sought. We expect to be below threshold against this target for Q2. Positively our 2 week wait performance has improved over October as actions are implemented leading to increased capacity and daily flexibility.

We reported 20% for Augusts’ 2 week wait symptomatic breast patients, this was all due to patient choice on very small numbers.

We were also non-compliant in August against the 62 day target, though a lower number of treatments were carried out in August. This was mainly within Urology pathways. Compliance is currently anticipated for the Quarter.
We reported 0% for August’s consultant upgrade; this was due to a complex diagnostic pathway, between an Upper GI pathway and eventual diagnosis of colorectal cancer.

### 3 A&E Performance

#### 4 hour maximum waiting time – 95%

The 4 hour target has continued to be a challenge throughout the second Quarter with the on-going significant increase in ambulance conveyances (up 10.4%) compared to the same period last year (July to September), with a 13.0% increase in non-elective admissions. The September target was missed with 92.6% of patients waiting less than 4 hours. As expected we did not meet the 95% quarterly target.

Monthly performance for October is currently also at risk, as there has been a 5.6% increase in ED attendances for October (1st - 21st) compared to the same period last year. The Communications Team is currently working on a joint news release with Poole Hospital to highlight alternative avenues of treatment, in order to deter non-emergency patients and thereby relieve front-door pressures.

Task and Finish groups to review implementation of best practice have been established. We are currently in the process of recruiting middle grade doctors and consultants; it is hoped that these may be in post in January. We have trained a number of Majors Assisting Practitioners in ED to support the implementation of rapid assessment, with further practitioners commencing training in November. In addition, an ambulatory area is also being established within the department and this is likely to come on-line in early December. These combined actions should allow a better flow of patients, and enable the 4 hour target performance to improve.

### 4 52 Week Waiter (Incomplete Pathways)

#### Zero tolerance of over 52 week waiters (Incomplete Pathways)

The total number is down from three to one. Unfortunately we need to report one General Surgery patient who had been waiting more than 52 weeks. This was due to a complex set of issues regarding translation and consent, which should be resolved by November.

### 5 Admitted RTT – Aggregate and Specialty Level

#### 90% of patients on an admitted pathway treated within 18 weeks
In line with the national requirement to work towards the reduction of waiting lists and long waiters, we were non-compliant with the Referral to Treatment Admitted aggregate target in September. In line with Monitors’ expectations for implementing the national plan, we will report a non-compliant position against the target for this Quarter.

A more detailed report is attached as an annex.

6 Non-Admitted RTT - Specialty Level

| 95% of patients on a non-admitted pathway treated within 18 weeks |

For September, Oral Surgery increased to 86.6% from 86.4% in August, and ENT increased to 93.0% from 91.9% in August. Whilst both are still below the target, improvements are being made. We have been working jointly with our visiting consultants and provider colleagues so that additional sessions commenced in September and October. The Trust has remained above the target for aggregate Non-admitted RTT waits.

7 Recommendation

The Board are requested to note the performance exceptions to the Trust’s compliance with the 2014/15 Monitor Framework and ‘Everyone Counts’ planning guidance requirements.
### Monitor Governance Targets & Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Measure</th>
<th>Target</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS1</td>
<td>Mixed Sex Accommodation</td>
<td>Number of hospital-acquired C. Difficile cases</td>
<td>(95% 1.0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>KS2</td>
<td>Referral to Treatment</td>
<td>RTT Specialty Compliance with requirements regarding access to healthcare</td>
<td>&gt;95%</td>
<td>95.8%</td>
<td>95.0%</td>
<td>95.1%</td>
<td>95.2%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
</tr>
<tr>
<td>KS3</td>
<td>Cancer</td>
<td>No. of breaches of the 60 minute handover standard</td>
<td>&lt;90%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>KS4</td>
<td>A&amp;E</td>
<td>4 hr maximum waiting time From arrival to admission / transfer / discharge (Type 1 &amp; 2)</td>
<td>&lt;95%</td>
<td>98.8%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KS5</td>
<td>Referral to Treatment</td>
<td>RTT Admitted Incomplete pathway</td>
<td>&lt;90%</td>
<td>96.30%</td>
<td>99.00%</td>
<td>96.50%</td>
<td>99.4%</td>
<td>97.0%</td>
<td>99.30%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

#### Monitors within the Everyone Counts: Planning Guidance/ Key Contractual Priorities

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Measure</th>
<th>Target</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS1</td>
<td>Mixed Sex Accommodation</td>
<td>Number of hospital-acquired C. Difficile cases</td>
<td>(95% 1.0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>KS2</td>
<td>Referral to Treatment</td>
<td>RTT Specialty Compliance with requirements regarding access to healthcare</td>
<td>&gt;95%</td>
<td>95.8%</td>
<td>95.0%</td>
<td>95.1%</td>
<td>95.2%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
</tr>
<tr>
<td>KS3</td>
<td>Cancer</td>
<td>No. of breaches of the 60 minute handover standard</td>
<td>&lt;90%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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</tr>
<tr>
<td>KS4</td>
<td>A&amp;E</td>
<td>4 hr maximum waiting time From arrival to admission / transfer / discharge (Type 1 &amp; 2)</td>
<td>&lt;95%</td>
<td>98.8%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KS5</td>
<td>Referral to Treatment</td>
<td>RTT Admitted Incomplete pathway</td>
<td>&lt;90%</td>
<td>96.30%</td>
<td>99.00%</td>
<td>96.50%</td>
<td>99.4%</td>
<td>97.0%</td>
<td>99.30%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

#### Indicators within the Everyone Counts: Planning Guidance/ Key Contractual Priorities

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Measure</th>
<th>Target</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS1</td>
<td>Mixed Sex Accommodation</td>
<td>Number of hospital-acquired C. Difficile cases</td>
<td>(95% 1.0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>KS2</td>
<td>Referral to Treatment</td>
<td>RTT Specialty Compliance with requirements regarding access to healthcare</td>
<td>&gt;95%</td>
<td>95.8%</td>
<td>95.0%</td>
<td>95.1%</td>
<td>95.2%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
</tr>
<tr>
<td>KS3</td>
<td>Cancer</td>
<td>No. of breaches of the 60 minute handover standard</td>
<td>&lt;90%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>KS4</td>
<td>A&amp;E</td>
<td>4 hr maximum waiting time From arrival to admission / transfer / discharge (Type 1 &amp; 2)</td>
<td>&lt;95%</td>
<td>98.8%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KS5</td>
<td>Referral to Treatment</td>
<td>RTT Admitted Incomplete pathway</td>
<td>&lt;90%</td>
<td>96.30%</td>
<td>99.00%</td>
<td>96.50%</td>
<td>99.4%</td>
<td>97.0%</td>
<td>99.30%</td>
<td>99.8%</td>
<td>99.8%</td>
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#### Monitors within the Everyone Counts: Planning Guidance/ Key Contractual Priorities

<table>
<thead>
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<th>Measure</th>
<th>Target</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS1</td>
<td>Mixed Sex Accommodation</td>
<td>Number of hospital-acquired C. Difficile cases</td>
<td>(95% 1.0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>KS2</td>
<td>Referral to Treatment</td>
<td>RTT Specialty Compliance with requirements regarding access to healthcare</td>
<td>&gt;95%</td>
<td>95.8%</td>
<td>95.0%</td>
<td>95.1%</td>
<td>95.2%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
</tr>
<tr>
<td>KS3</td>
<td>Cancer</td>
<td>No. of breaches of the 60 minute handover standard</td>
<td>&lt;90%</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>KS4</td>
<td>A&amp;E</td>
<td>4 hr maximum waiting time From arrival to admission / transfer / discharge (Type 1 &amp; 2)</td>
<td>&lt;95%</td>
<td>98.8%</td>
<td>95.8%</td>
<td>95.9%</td>
<td>96.0%</td>
<td>96.1%</td>
<td>96.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KS5</td>
<td>Referral to Treatment</td>
<td>RTT Admitted Incomplete pathway</td>
<td>&lt;90%</td>
<td>96.30%</td>
<td>99.00%</td>
<td>96.50%</td>
<td>99.4%</td>
<td>97.0%</td>
<td>99.30%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>
Admitted 18 week Referral to Treatment (RTT) Target Update

This paper details actions to reduce admitted (inpatient and day case) waiting times and numbers.

Position at End June 2014 (prior to extra funding)

Prior to July 2014 the Trust had (just) sustained an aggregate admitted RTT performance for some years. Frequently though we reported below threshold performance (below 90%) in a number of specialities in some months.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks from GP referral to 1st treatment – aggregate</td>
<td>90%</td>
<td>90.2%</td>
<td>90.0%</td>
<td>90.2%</td>
<td>90.1%</td>
</tr>
<tr>
<td>100 - General Surgery</td>
<td>90%</td>
<td>85.8%</td>
<td>89.3%</td>
<td>86.9%</td>
<td>88.5%</td>
</tr>
<tr>
<td>101 - Urology</td>
<td>90%</td>
<td>91.8%</td>
<td>94.8%</td>
<td>92.0%</td>
<td>90.3%</td>
</tr>
<tr>
<td>110 - Orthopaedics</td>
<td>90%</td>
<td>90.3%</td>
<td>89.5%</td>
<td>89.9%</td>
<td>89.1%</td>
</tr>
<tr>
<td>130 - Ophthalmology</td>
<td>90%</td>
<td>83.9%</td>
<td>81.4%</td>
<td>84.2%</td>
<td>86.0%</td>
</tr>
<tr>
<td>300 - General medicine</td>
<td>90%</td>
<td>99.7%</td>
<td>99.7%</td>
<td>98.7%</td>
<td>99.1%</td>
</tr>
<tr>
<td>320 - Cardiology</td>
<td>90%</td>
<td>92.0%</td>
<td>91.0%</td>
<td>92.1%</td>
<td>91.4%</td>
</tr>
<tr>
<td>330 - Dermatology</td>
<td>90%</td>
<td>93.4%</td>
<td>95.9%</td>
<td>91.5%</td>
<td>91.9%</td>
</tr>
<tr>
<td>410 - Rheumatology</td>
<td>90%</td>
<td>100%</td>
<td>97%</td>
<td>95%</td>
<td>97.7%</td>
</tr>
<tr>
<td>502 - Gynaecology</td>
<td>90%</td>
<td>88.4%</td>
<td>80.7%</td>
<td>93%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Other</td>
<td>90%</td>
<td>99.3%</td>
<td>98.1%</td>
<td>98.1%</td>
<td>97.4%</td>
</tr>
</tbody>
</table>

Speciality level issues contributing to non-compliance with the 18 week target previously reported to the Board included:

- Upper GI demand and capacity
- Orthopaedic bed capacity, medical staffing skill mix and training issues, personal specialist cases and an apparent underlying capacity deficit
- Inability to recruit to Ophthalmology medical staff vacancies and approved additional posts to deal with demand
- Gynaecology medical staff shortages and late additions to list for a specialist pathway
- Inability to flex capacity in a timely manner to match peaks in referral/addition to waiting list demand, including not fully backfilling lists
- Urgent care pressures limiting bed capacity and/or resulting in elective cancellations or under booking some lists
- Increasing, or long sub speciality, outpatient waiting times, both at RBH and ‘feeder’ hospitals
As a result of these pressures during and prior to this time over these and a number of specialities, the backlog of longer waiting patients increased. Between April – November 2013 the percentage of patients under 18 weeks on an incomplete pathway was 96-97%, this had reduced to 94.7% in April 2014, though this remained above the national indicator of 92% at aggregate level (i.e. the backlog was not unsustainably large).

**National Resilience Requirement**

In June 2014 the DH required that all health communities, alongside the development of their resilience plans for urgent care, also to develop robust plans for elective care and RTT recovery due to a deteriorated position nationally in both the backlog of long waiters and performance. These plans were supported by national funds with an expectation that below threshold performance would be seen across Trusts from July to September, more recently extended to the end of December.

Following an indication from Dorset CCG that £1m of extra funds would be made available to RBCHFT, the Trust has progressed a number of additional operating lists, outsourcing operations, additional outpatient clinics and additional or outsourced diagnostic capacity. Actual funds were agreed in late August, for extra ‘clock stops’ (completion of a pathway).

The aim is achieving a reduction in long waiters, but also to reduce outpatient and diagnostic pathway times. This is to avoid delays for patients as well as patients being added ‘late’ to inpatient waiting lists. However, it should be noted that increased outpatient and diagnostic pathway activity does result in a temporary increase in longer waiting patients being added to the admitted list and hence, despite providing additional operating capacity, does mean that the ‘backlog’ of longer waiting patients doesn’t reduce as quickly. In addition, increased referral trends, increased fast track referrals and/or specific referral peaks have also impacted on our speed of progress.

**Current Position**

As at mid-October the over 18 week admitted backlog of longer waiters reduced from 770 (early July) to 725, following an initial increase.

*Admitted Backlog:*
As a result of this plan the Trust had a planned non-compliance against the admitted 18 week RTT target at aggregate and speciality level as indicated below, and this is predicted to continue for October - November.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
<th>Nov-14</th>
<th>Dec-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks from GP referral to 1st treatment – aggregate</td>
<td>90%</td>
<td>88.7%</td>
<td>86.8%</td>
<td>86.2%</td>
<td>87.7</td>
<td>87.5</td>
<td>88.4</td>
</tr>
<tr>
<td>100 - General Surgery</td>
<td>90%</td>
<td>80.7%</td>
<td>81.7%</td>
<td>81.8%</td>
<td>83.1</td>
<td>83.1</td>
<td>85.3</td>
</tr>
<tr>
<td>101 - Urology</td>
<td>90%</td>
<td>87.0%</td>
<td>86.0%</td>
<td>91.4%</td>
<td>91.8</td>
<td>89.2</td>
<td>90.7</td>
</tr>
<tr>
<td>110 - Orthopaedics</td>
<td>90%</td>
<td>89.8%</td>
<td>80.0%</td>
<td>76.9%</td>
<td>83.4</td>
<td>83.8</td>
<td>83.3</td>
</tr>
<tr>
<td>130 - Ophthalmology</td>
<td>90%</td>
<td>84.7%</td>
<td>82.9%</td>
<td>84.6%</td>
<td>83.2</td>
<td>82.4</td>
<td>84.6</td>
</tr>
<tr>
<td>300 - General medicine</td>
<td>90%</td>
<td>98.7%</td>
<td>98.3%</td>
<td>99.7%</td>
<td>98.4</td>
<td>98.4</td>
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</tr>
<tr>
<td>320 - Cardiology</td>
<td>90%</td>
<td>93.3%</td>
<td>92.3%</td>
<td>91.0%</td>
<td>88.7</td>
<td>90.0</td>
<td>90.0</td>
</tr>
<tr>
<td>330 - Dermatology</td>
<td>90%</td>
<td>95.6%</td>
<td>94.9%</td>
<td>87.7%</td>
<td>90.9</td>
<td>90.9</td>
<td>90.6</td>
</tr>
<tr>
<td>410 - Rheumatology</td>
<td>90%</td>
<td>97.1%</td>
<td>90.9%</td>
<td>88.9%</td>
<td>96.8</td>
<td>96.0</td>
<td>94.3</td>
</tr>
<tr>
<td>502 - Gynaecology</td>
<td>90%</td>
<td>89.9%</td>
<td>84.9%</td>
<td>79.5%</td>
<td>86.0</td>
<td>90.8</td>
<td>91.0</td>
</tr>
<tr>
<td>Other</td>
<td>90%</td>
<td>100.0%</td>
<td>98.8%</td>
<td>98.7%</td>
<td>98.7</td>
<td>98.7</td>
<td></td>
</tr>
</tbody>
</table>

As indicated in the graph above, predicted performance for October and November continues below threshold. In order to continue to focus on those long waiting patients who are ready, willing and able to be treated, we anticipate that we will be continuing to treat a number of 18+ week patients through December, thereby resulting in a continued below threshold performance in December. As the Trust will already have been non-compliant against the Monitor requirement for Q3 due to failure in October and November, there will be no change on our Monitor score against this target and this patient focussed approach has been supported by Monitor at their recent visit to the Trust.

**Trajectory and On-going Issues**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
</tr>
</thead>
<tbody>
<tr>
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<td>90.0%</td>
</tr>
<tr>
<td>101 - Urology</td>
<td>90%</td>
<td>91.1%</td>
<td>90.9%</td>
<td>89.7%</td>
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<tr>
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<tr>
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<td>91.7%</td>
<td>90.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Other</td>
<td>90%</td>
<td>98.7%</td>
<td>98.7%</td>
<td>98.7%</td>
</tr>
</tbody>
</table>
As shown above, going forward we currently anticipate returning to above threshold aggregate performance with a reduced 18 week backlog, however, issues and risks do remain, particularly in a number of specialities. The below table indicates key risks and mitigation actions.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Potential Impact</th>
<th>Risk Level (LxC)</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper GI operating capacity run rate for routine cases below sustainability requirement</td>
<td>Moderate numbers and potentially on-going issues.</td>
<td>High</td>
<td>Theatre productivity improvement programme. Four Eyes capacity and productivity programme. Routine weekend job planned operating implemented.</td>
</tr>
<tr>
<td>Vascular sub speciality pathway timings and transfers from other providers</td>
<td>Small number of long waits, especially if complex and/or start pathway in Salisbury or Dorchester.</td>
<td>Low</td>
<td>Fourth RBCH vascular consultant started Oct 2014 bringing the vascular network capacity to seven consultants.</td>
</tr>
<tr>
<td>Colorectal personal specialist cases</td>
<td>Small number of long waits, but low capacity across speciality.</td>
<td>Low</td>
<td>Outsourcing some long waiters during Nov 2014.</td>
</tr>
<tr>
<td>Dermatology medical staff vacancies</td>
<td>Mohs operating list far bigger than capacity. General backlogs in clinic waits.</td>
<td>High</td>
<td>Potentially close temporarily to new Mohs listing. Extra sessions maximised.</td>
</tr>
<tr>
<td>Cardiology EP capacity</td>
<td></td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Gastro pressures and patient choice impacting on General Medicine and/or Colorectal and/or Upper GI</td>
<td>Non-admit and diagnostic backlog may add to admitted lists. Main risk is the unknown numbers</td>
<td>Med</td>
<td>Close monitoring and integrate into UGI / Colorectal PTLs.</td>
</tr>
<tr>
<td>Orthopaedic operating activity run rate below sustainability requirement</td>
<td>Operating capacity c. 8% below requirement to sustain natural 18+wk backlog level. Continued below threshold monthly performance.</td>
<td>High</td>
<td>Theatre productivity improvement programme. Four Eyes capacity and productivity programme. Medical staff recruitment.</td>
</tr>
<tr>
<td>Risk</td>
<td>Potential Impact</td>
<td>Risk Level (LxC)</td>
<td>Mitigation</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Orthopaedic surgeon retirement and sick leave</td>
<td>Retirement of experienced consultant, and sick leave for experienced middle grade. Impact on complex cases</td>
<td>Med</td>
<td>Recruitment of consultant for knees now started. Review complex hip cases and deployment of middle grades.</td>
</tr>
<tr>
<td>Orthopaedic outpatient and diagnostic pathway timings (especially sub speciality)</td>
<td>First outpatient waits increasing, potentially storing up issues.</td>
<td>High</td>
<td>Additional orthopaedic outpatient clinics to drive waits back to 6 weeks.</td>
</tr>
<tr>
<td>Winter pressures impact on admitted care – risk of increased cancellations</td>
<td>Unknown number of cancellations, especially Orthopaedics and routine UGI.</td>
<td>Med</td>
<td>Winter pressure plan (see separate paper).</td>
</tr>
<tr>
<td>BOARD OF DIRECTORS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meeting Date and Part:</strong></td>
<td>14th November 2014 – Part 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subject:</strong></td>
<td>Urology Cancer and RTT</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Section:</strong></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Executive Director with overall responsibility</strong></td>
<td>Richard Renaut, Chief Operating Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Mark Titcomb, Director of Operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Previous discussion and/or dissemination:</strong></td>
<td>Trust Management Board November 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action required:**
The Board are requested to note the report and support the action plan.

**Summary:**
The key actions to improve Urology performance for cancer and 18 weeks are set out in the paper. The detailed Urology Action Plan is attached at Annex 2.

**Related Strategic Goals/ Objectives:**
Excellent services.

**Relevant CQC Outcome:**
Safe, effective, responsive.

**Risk Profile:**
Cancer Wait Standards

**Reason paper is in Part 2**
N/A
1. Introduction

Since February 2014 there have been substantial improvements resulting from a detailed Urology action plan, yet demand continues to grow and is outstripping capacity, such that it is affecting the timely delivery of patient outcomes. Additionally, there are several emerging internal and external factors that require addressing. This paper captures the current status of Urology and highlights the key elements within this next phase of the action plan.

2. Demand and performance

Concern remains over the ability to achieve 62/31 day Cancer targets and RTT 18 weeks for Urology which will impact on RBCH ability to achieve compliance.

- **RTT current snapshot and predicted to end of year**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
<th>Nov-14</th>
<th>Dec-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>101 - Urology</td>
<td>90%</td>
<td>87.0%</td>
<td>86.0%</td>
<td>91.4%</td>
<td>91.8%</td>
<td>89.2%</td>
<td>90.7%</td>
</tr>
</tbody>
</table>

- **Cancer 62/31 day targets current snapshot**

  See attached Annex 1

- **Urology referrals**

  Non-routine referrals are steady at c370 per annum during the past 6 years, but fast track referrals have increased by 60% over the same period.


  The 2013 ‘Blood in Pee’ campaign resulted in a 28% increase in referrals and placed significant strain on the system. This year planning has been undertaken since July to prepare and actions include: a review of referral criteria with GPs prior to campaign start, an extended Friday afternoon operating list in DSU, and additional theatre list Urology capacity for three days per week.

3. Key issues

i) **Clinic capacity**

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>Wait to first appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>9 weeks</td>
</tr>
<tr>
<td>Fast Track</td>
<td>9 days</td>
</tr>
</tbody>
</table>
Clinic capacity is being optimised further from end November 2015 through the provision of a weekly nurse-led LUTS (lower urinary tract symptoms) clinic.

ii) Wimborne service provision

Currently there are 2 urology clinics per week but neither runs to capacity so, an option of delivering a single clinic per week to release consultant time while maintaining a service in the locality is being considered.

iii) Theatre capacity/staff

Lack of theatre capacity is identified as the principal reason for RTT delays, with the current schedule apparently containing insufficient for the Urology demand. The Improvement Board ‘Theatre’s work stream’ is investigating and implementing a change programme to address this shortfall. Additional timetabling constraints result from the single theatre (theatre 2) that is configured for the robot, and the requirement for specific robot trained theatre staff. RTT resilience monies are being used until the end of November to outsource Urology lists.

iv) Prostatectomies and DCH

The current status of prostatectomies is shown under the November column within the table below:

<table>
<thead>
<tr>
<th></th>
<th>Nov 14</th>
<th>Dec 14</th>
<th>Jan 15</th>
<th>Feb 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients on</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>the list without TCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients added per</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total on the waiting</td>
<td>26</td>
<td>22</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>list</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removals</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Remainder on the</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>waiting list</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Introducing one robot week each month allows 14 to be undertaken each month (taking into account leave and accommodation of template biopsies) which would mean that by February the backlog would be removed.

A decision was taken in August 2014 to permit the training of a Dorchester consultant using the RBCH robot. Agreement was given to provide 5 all day training sessions (1 per week) from 20 October until 17 November reduces RBCH Urology theatre time while also attracting their breaches. After the Dorchester consultant completes his training it is expected that he will undertake 1 list every 2 weeks at RBCH.

v) Cystoscopies /consent

Follow-up cystoscopies currently require a full consent process rather than a refined consent which would release some nursing time and this forms part of the action plan.
4. The key actions

The detailed action plan is at Annex 2, but the key elements (those are judged to have the most effect) are:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mitigation/Planning (Sep – Dec 14)</th>
</tr>
</thead>
</table>
| Admission process/Validation/facilitation | • Additional validator identified to join urology admissions team from within Care Group from 3 November 2015  
• Achieve ‘front end’ validation of PTL asap to understand scale of non-admitted pathway patients |
| Consultant specific issues (capacity/leave/study leave) | • Finalise business case for additional Urologist  
• Refine study leave/annual leave booking process to smooth urology capacity to match demand |
| ‘Robot week’ to address prostatectomies shortfall. | • Nov 14, Dec 14 ‘robot week’ are now planned, Jan 15, Feb 15 require planning.  
• Develop cadre of robot trained theatre staff  
• Displaced activity plan developed to ensure all capacity is employed (other lists/clinics) |
| Template biopsy service delivered at RBCH (currently sent to DCH) | • Business case written and now being refined  
• Theatre capacity and radiology implications resolved (1 list required per week)  
• CCG discussions (30 Oct and 2 Dec)  
• Unintended consequences re: diagnostic element of pathway required redesign to avoid breaches surging for 62 days |
| Theatre capacity and scheduling for urology | • 4 eyes deep dive in to urology/current theatre improvement work  
• Urology identified as early candidate for theatre 4 hour blocks |

5. Areas requiring further work

Areas already identified include:

• follow on work for capacity/demand analysis for urology outpatients  
• pathway mapping to better streamline template biopsy/brachytherapy/robot pathways  
• consultant/surgeon capacity kept under review

6. Recommendation

Providing the key actions above are achieved and template biopsy is not introduced without the detailed planning required to implement a suitable diagnostic pathway, then Urology should achieve the 62 day and 31 day cancer targets by Q4.

Assuming the key actions above are completed and the urology admissions validation requirement (see above) does not materially change our perception of the size of the task, then RTT Urology compliance is considered achievable for 2014 Q4.
### Cancer 62/31 day targets current snapshot

#### 62 day

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>Actual</th>
<th></th>
<th>Actual</th>
<th></th>
<th>Predicted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>July 14</td>
<td>Aug 14</td>
<td>Sept 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Treated</td>
<td>Breaches</td>
<td>Achieving Target %</td>
<td>Total Treated</td>
<td>Breaches</td>
<td>Achieving Target %</td>
<td>Total Treated</td>
</tr>
<tr>
<td>Urology</td>
<td>85.0%</td>
<td>34</td>
<td>5</td>
<td>85.3%</td>
<td>30</td>
<td>5</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

#### 31 day

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>Actual</th>
<th></th>
<th>Validating</th>
<th></th>
<th>Predicted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>July 14</td>
<td>Aug 14</td>
<td>Sept 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Treated</td>
<td>Breaches</td>
<td>Achieving Target %</td>
<td>Total Treated</td>
<td>Breaches</td>
<td>Achieving Target %</td>
<td>Total Treated</td>
</tr>
<tr>
<td>Urology</td>
<td>96.0%</td>
<td>59</td>
<td>6</td>
<td>89.8%</td>
<td>40</td>
<td>3</td>
<td>92.5%</td>
</tr>
</tbody>
</table>

*most recent information taken from 2014/15 Predictor 24/10/14*
## Plan Title:
Urology Cancer Pathway Improvement Plan

### Core Group / Corporate
Surgery

### Plan Owner
David Bennett

### Date Produced
18/08/2014

### Review Roles and Responsibilities for Appropriateness in Meeting Demands of the Service

**10/10/2014 31/12/2014**
Christine

**First independent operating list to commence**

**14/02/2014 13/10/2014**
Danielle

**Nurse Practitioner to commence training**

**14/02/2014 30/09/2014**
David Bennett

**CNS to commence re-training**

**14/02/2014 06/10/2014**

### PSA Monitoring

**Invest in a system enabling PSA tests taken in the community to be monitored giving confidence that secondary care follow ups are not required**

Arrange a demo electronic monitoring systems

14/02/2014

15/02/2014

16/02/2014

Computer

Sue Davies

Kate Horsefield

Delay raising concern with Davie

14/02/2014

Complete

On Track

Yvonne Webb

David Bennett

### Capacity and Demand

**Watch capacity and demand for urology cancer services**

Pressure current level of urology therapy associated with helping to reduce waiting times for elective referrals to other urology specialties

14/02/2014

20/02/2014

21/02/2014

Computer

Andrew Wedderburn

David Bennett

### PSA Monitoring

**First independent operating list to commence**

Optimise theatre sessions for robotic surgery performed by RBCH Consultants

Review annual leave thresholds and processes to reduce variation in capacity

Review anticipated introduction of NICE guidelines and their impact on capacity

**Review capacity and demand modelling protocol by 4 eyes**

Review capacity and demand modelling protocol by 4 eyes

10/03/2014

12/03/2014

14/03/2014

Computer

Mark Titcomb

David Bennett

### Pathway and Process

**Review current process, bench mark against local and national practice**

14/02/2014

20/02/2014

21/02/2014

Complete

James Manners

David Bennett
<table>
<thead>
<tr>
<th>Ref</th>
<th>Area (What issue are you addressing)</th>
<th>Actions (The ‘How’)</th>
<th>Milestone Due to Start Date</th>
<th>Target End Date</th>
<th>RAG Status</th>
<th>Responsible (Who)</th>
<th>Accountable (Who)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review consent process for cystoscopies</td>
<td>Update consenting process and forms</td>
<td>14/02/2014</td>
<td>15/03/2014</td>
<td>Complete</td>
<td>James Manners</td>
<td>David Bennett</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Review consent process for cystoscopies</td>
<td>Obtain local governance agreement for consent process</td>
<td>14/02/2014</td>
<td>30/04/2014</td>
<td>Significant Concern</td>
<td>David Ecclestone</td>
<td>David Bennett</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Review consent process for cystoscopies</td>
<td>Implement new consent process</td>
<td>14/02/2014</td>
<td>03/03/2014</td>
<td>Significant Concern</td>
<td>James Manners</td>
<td>David Bennett</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Ensure planning for service development</td>
<td>Learn from previous providers to design a patient friendly service</td>
<td>14/02/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Ensure planning for service development</td>
<td>Follow up with local colleagues to discuss service</td>
<td>14/02/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Pathway and process mapping for other tumours e.g. urology with input from urology service</td>
<td>14/02/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Review process for fast track reviews and triaging</td>
<td>14/02/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Improvement of the Histopathology service</td>
<td>Improved biopsies with new pathology</td>
<td>14/02/2014</td>
<td>21/03/2014</td>
<td>On Track</td>
<td>Andrea Grainy</td>
<td>Andrea Grainy</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Improvement of the Histopathology service</td>
<td>Improved local governance, reporting and radiology</td>
<td>14/02/2014</td>
<td>16/03/2014</td>
<td>On Track</td>
<td>Andrea Grainy</td>
<td>Andrea Grainy</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Review and clarification of MDT</td>
<td>Review guidelines for fast track reviews and triaging</td>
<td>14/02/2014</td>
<td>21/03/2014</td>
<td>On Track</td>
<td>Lucy Hart</td>
<td>David Bennett</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Review and clarification of MDT</td>
<td>Achieve significant concerns and improve compliance with local guidelines</td>
<td>14/02/2014</td>
<td>21/03/2014</td>
<td>On Track</td>
<td>Lucy Hart</td>
<td>David Bennett</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Blood in Pro (BiP) Campaign - Capacity Planning (Oct-Nov 2014)</td>
<td>Ensure appropriate capacity in place to meet expected uplift in demand created by the BiP campaign</td>
<td>14/02/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prostate Pathway**

- **Establishment of a two-step diagnostic prostate pathway**
  - Patients will receive a diagnostic biopsy on the same day as they attend the MDT
  - Implementation of 2-step biopsy pathway
  - 14/02/2014 to 31/03/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Implementation of 2-step biopsy pathway
  - 14/02/2014 to 31/03/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Establishment of a two-step diagnostic prostate pathway**
  - Add a biopsy to the biopsy procedure
  - 10/03/2014 to 30/09/2014
  - Complete
  - Lucy Hart, David Bennett

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore

- **Auditorial review of MDT**
  - 14/02/2014 to 28/02/2014
  - Complete
  - Matt Whitlock, Alison Ashmore
## BOARD OF DIRECTORS

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>14th November 2014 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Quality Report – September 14</td>
</tr>
<tr>
<td>Section:</td>
<td>Performance</td>
</tr>
<tr>
<td>Executive Director with overall responsibility</td>
<td>Paula Shobbrook, Director of Nursing and Midwifery</td>
</tr>
<tr>
<td>Author(s):</td>
<td>Ellen Bull, Deputy Director of Nursing and Midwifery Joanne Sims, Associate Director Quality &amp; Risk</td>
</tr>
<tr>
<td>Previous discussion and/or dissemination:</td>
<td>30th October 2014 – HAC 7th November 2014 - TMB</td>
</tr>
</tbody>
</table>

### Action required:

The Board of Directors is asked to note the report.

### Summary:

This report provides a summary of information on patient safety and patient experience indicators for September 2014 including:

**Patient safety incidents**
- 3 Serious incidents were reported on STEIS in September 2014,

**Safety thermometer**
The ST data is 91.7% harm free care. This represents a slight increase from last month.

**Patient experience**
Trustwide FFT is 77, which remains consistent. The compliance rate is 23% which is an increase from the previous month

### Related Strategic Goals/Objectives:

- All

### Relevant CQC Outcome:

- All

### Risk Profile:

- i. Have any risks been reduced?
  - No
- ii. Have any risks been created?
  - No

### Reason paper is in Part 2

- Not applicable
Quality & Patient Safety Performance Exception Report
September 2014

1. Purpose of the Report

This report accompanies the Quality/Patient Performance Dashboard and outlines the Trust’s performance exceptions against key quality indicators for patient safety and patient experience for the month of September 2014.

2. Serious Incidents

Three Serious Incidents were confirmed and reported on STEIS in September 2014.

3. Safety Thermometer

All inpatient wards collect the monthly Safety Thermometer “Harm Free Care” data. The survey, undertaken for all inpatients the first Wednesday of the month, records whether patients have had an inpatient fall within the last 72 hours, a hospital acquired category 2-4 pressure ulcer, a catheter related urinary tract infection and/or, a hospital acquired VTE. If a patient has not had any of these events they are determined to have had “harm free care”.

The results for the August 14 data collection are as follows:

<table>
<thead>
<tr>
<th>NHS SAFETY THERMOMETER</th>
<th>13/14 Average per month</th>
<th>14/15 Target</th>
<th>April 2014</th>
<th>May 2014</th>
<th>June 2014</th>
<th>July 2014</th>
<th>Aug 2014</th>
<th>Sept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Thermometer % Harm Free Care</td>
<td>89.0%</td>
<td>95%</td>
<td>88.8%</td>
<td>90.73%</td>
<td>91.11%</td>
<td>89.82%</td>
<td>89.4%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Safety Thermometer % Harm Free Care (New Harms only)</td>
<td>97.5%</td>
<td>95.5%</td>
<td>97.6%</td>
<td>97.6%</td>
<td>97.4%</td>
<td>96.6%</td>
<td>96.3%</td>
<td></td>
</tr>
<tr>
<td>Monthly survey using Safety Thermometer (Number of patients with Harm Free Care)</td>
<td>480</td>
<td>NA</td>
<td>435</td>
<td>421</td>
<td>451</td>
<td>450</td>
<td>445</td>
<td>444</td>
</tr>
</tbody>
</table>

3.1 Pressure Ulcers: Adverse Incident data

Pressure ulcers were reviewed in detail at the HAC. The RBCH Quality Strategy and CCG Contract Specification for this year has set a 50% reduction in the number of “avoidable” hospital acquired Category 3 and 4 Pressure Ulcers recorded on AIRS (13/14 baseline compared to 14/15 results). Aim: Less than 15 in year

<table>
<thead>
<tr>
<th>Month Number Month</th>
<th>1 Apr-14</th>
<th>2 May-14</th>
<th>3 Jun-14</th>
<th>4 Jul-14</th>
<th>5 Aug-14</th>
<th>6 Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 3 actual in month</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Cat 4 actual in month</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
4. Risk Assessment Compliance

Monthly risk assessment compliance is recorded as part of the Safety Thermometer data collection. Results show a slight reduction in compliance with MUST scores, otherwise stable or improved in compliance.

<table>
<thead>
<tr>
<th></th>
<th>April 2014</th>
<th>May 2014</th>
<th>June 2014</th>
<th>July 2014</th>
<th>Aug 14</th>
<th>Sep 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk assessment compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>83%</td>
<td>92%</td>
<td>91%</td>
<td>91%</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td>Waterlow</td>
<td>87%</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>MUST</td>
<td>77%</td>
<td>88%</td>
<td>88%</td>
<td>89%</td>
<td>90%</td>
<td>87%</td>
</tr>
<tr>
<td>Mobility</td>
<td>83%</td>
<td>91%</td>
<td>91%</td>
<td>93%</td>
<td>87%</td>
<td>93%</td>
</tr>
<tr>
<td>Bedrails</td>
<td>83%</td>
<td>95%</td>
<td>93%</td>
<td>94%</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>
5. Patient Experience

5.1 Friends and Family Test (FFT)


The emergency department (ED) is joint 4th (of 142 trusts) with FFT with a score of 80 (top score 86). The in-patient score is joint 20th (of 170 trusts) with 8 other trusts with a FFT score of 77 (top score 100). Maternity have shown an improvement by seven points from August. Overall Trust compliance has improved from 17% to 23.3% since August.

<table>
<thead>
<tr>
<th></th>
<th>Trust wide</th>
<th>In-patient</th>
<th>ED</th>
<th>Maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT Score September</td>
<td>77 (78)</td>
<td>75 (77)</td>
<td>80 (80)</td>
<td>82 (75)</td>
</tr>
<tr>
<td>Compliance Rate</td>
<td>23% (24%)</td>
<td>47% (48%)</td>
<td>14% (15%)</td>
<td>13% (12%)</td>
</tr>
</tbody>
</table>

Both the Emergency Department (ED) and maternity have not attained the 15% compliance rate; however, Trust wide submission rate at 47% is higher than the national recommendation of 40%.

Extremely Unlikely results from FFT – September data

Within those areas included in submission data there are 19 Extremely Unlikely responses. This is a significant decrease from last month which saw 35 within submission areas.

In August there were 41 “extremely unlikely” responses with a reduction to 30 Trust wide in September distributed as per the table below.

<table>
<thead>
<tr>
<th>Area</th>
<th>FFT Score September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 22</td>
<td>1</td>
</tr>
<tr>
<td>Ward 23</td>
<td>1</td>
</tr>
<tr>
<td>CCU</td>
<td>1</td>
</tr>
<tr>
<td>Ward 16</td>
<td>1</td>
</tr>
<tr>
<td>ED</td>
<td>11</td>
</tr>
<tr>
<td>Eye Unit A&amp;E</td>
<td>3</td>
</tr>
<tr>
<td>Ante Natal</td>
<td>1</td>
</tr>
</tbody>
</table>

Themes from “extremely unlikely’ CCU, wards 22 and Ward 23 all received very positive comments that are incongruent with a response of “extremely unlikely”. ED comments related to waiting times, other areas had no corresponding comments.

Quintiles Report – September data

The table below shows distribution of responses for each area in either the top or bottom quintile. Please note that the new format from NHS England using net promoter scores and percentage to recommend will show a more favourable picture for those in the bottom quintile. This would have a significant impact on Ward 2 and SAU.
Note – Ward 12 currently excluded due to coding changes

6. Care Audit – September 2014 data

Care Audit Trend Data

<table>
<thead>
<tr>
<th>Ward</th>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither likely nor unlikely</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don't know</th>
<th>FFT Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>ITU</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Eye Unit Ward</td>
<td>62</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>95</td>
</tr>
<tr>
<td>Ward 9</td>
<td>34</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>92</td>
</tr>
<tr>
<td>Ward 11</td>
<td>24</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>92</td>
</tr>
<tr>
<td>Ward 2</td>
<td>30</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>SAU</td>
<td>36</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>Ward 26</td>
<td>9</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Ward 4</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>36</td>
</tr>
<tr>
<td>Ward 5</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>19</td>
</tr>
</tbody>
</table>

There is some deterioration in the number of reds/greens in month compared to last month. This is attributed to more reds in September than August in wards 3,4,5 and AMU. The Care Group Matrons and Head of Nursing are supporting actions led by ward sisters/charge nurses. Actions to improve are underway and reported to PECC and HAC. HAC have directed a Campaign approach to improving Call Bells, Pain, Nutrition, and Noise at Night. A Dignity Campaign has already been recommenced.

7. Patients Opinion and NHS Choices

An improved performance on the previous month with 8 comments posted between the two websites (NHS Choices) with 7 positive regarding excellent care, professionalism and information. There has been one posting which is 1 negative regarding speed of waiting times and lack of professionalism.

8. Recommendation

The Board of Directors is requested to review the report which is provided for information and assurance.
<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(s):</strong></td>
</tr>
<tr>
<td><strong>Previous discussion and/or dissemination:</strong></td>
</tr>
<tr>
<td><strong>Action required:</strong></td>
</tr>
</tbody>
</table>

**Summary:**

The activity and demand pressures faced by the trust continued during September, with non elective activity 11% above planned levels and emergency department attendances 7% above planned levels.

This continues the pressures seen in previous years and this year to date, and brings the year to date activity increases to 13% for non elective activity and 8% for emergency department attendances. This level of additional demand continues to have a significant impact on the financial performance of the Trust.

At 30 September, the year to date budget was for a net deficit of £0.6 million, against which the Trust has reported an actual deficit of £2.5 million. This represents an adverse variance of £1.9 million.

Income has overachieved by £812,000 year to date, driven by additional cost and volume drugs, aseptic drug issues recharged to Poole Hospital, and additional CCG income in recognition of the premium agency pressures the Trust is facing due to the national shortage of trained medical and nursing professionals.

Expenditure reported an over spend of £192,000 during September, bringing the year to date over spend to £2.7 million. This has been driven by:

- Activity pressures, particularly in relation to emergency activity for which the Trust only receives 30% of the national tariff price;
- Significant additional pay costs as a result of continued reliance upon locum and agency staff;
- Additional cost and volume drugs, most notably within oncology and which are recharged directly to Commissioners;
Drug issues in relation to the Aseptic unit, which have been recharged to Poole Hospital;

The adverse expenditure position has reduced the Trust Continuity of Services Risk Rating to a rating of 3.

Given the considerable adverse variance reported to date; a financial recovery plan has been developed and approved by the Board. In addition to targeting further Improvement Programme Savings; this focuses on reducing the Trusts expenditure on expensive medical and nursing agency staff.

It is not expected that the Trust will recover the year to date over spend, and as a result the financial recovery plan focuses on minimising additional over spends. The Trust will therefore, exceed its planned deficit for the year of £1.9 million.

<table>
<thead>
<tr>
<th>Related Strategic Goals/ Objectives:</th>
<th>Goal 7 – Financial Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant CQC Outcome:</td>
<td>Outcome 26 – Financial Position</td>
</tr>
<tr>
<td>Risk Profile:</td>
<td>N/A</td>
</tr>
<tr>
<td>Reason paper is in Part 2</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Key Financials

#### Net Surplus/ (Deficit)
- **2013/14 YTD Actual**: £970,000
- **Plan**: £574,000
- **Variance**: £396,000 (71%)

#### EBITDA
- **2013/14 YTD Actual**: £7,162,000
- **Plan**: £6,323,000
- **Variance**: £839,000 (20%)

#### Transformation Programme
- **2013/14 YTD Actual**: £3,842,000
- **Plan**: £3,594,000
- **Variance**: £248,000 (7%)

#### Capital Expenditure
- **2013/14 YTD Actual**: £3,711,000
- **Plan**: £11,692,000
- **Variance**: £7,981,000 (68%)

### Activity

#### Elective
- **2013/14 YTD Actual**: 32,943
- **Plan**: 33,306
- **Variance**: 363 (1%)

#### Outpatients
- **2013/14 YTD Actual**: 140,379
- **Plan**: 168,204
- **Variance**: 27,825 (17%)

#### Non Elective
- **2013/4 YTD Actual**: 14,008
- **Plan**: 14,570
- **Variance**: 5,692 (39%)

#### Emergency Department Attendances
- **2013/14 YTD Actual**: 43,739
- **Plan**: 42,238
- **Variance**: 1,501 (4%)

#### Total PbR Activity
- **2013/14 YTD Actual**: 230,709
- **Plan**: 258,318
- **Variance**: 27,609 (11%)

### Income

#### Elective
- **2013/14 YTD Actual**: £36,023,000
- **Plan**: £34,560,000
- **Variance**: £5,463,000 (17%)

#### Outpatients
- **2013/14 YTD Actual**: £15,623,000
- **Plan**: £15,958,000
- **Variance**: £335,000 (2%)

#### Non Elective
- **2013/14 YTD Actual**: £25,783,000
- **Plan**: £27,218,000
- **Variance**: £1,435,000 (5%)

#### Emergency Department Attendances
- **2013/14 YTD Actual**: £3,936,000
- **Plan**: £4,266,000
- **Variance**: £330,000 (8%)

#### Total Income
- **2013/14 YTD Actual**: £127,531,000
- **Plan**: £129,885,000
- **Variance**: £2,354,000 (2%)

### Expenditure

#### Pay
- **2013/14 YTD Actual**: £75,429,000
- **Plan**: £79,555,000
- **Variance**: £4,126,000 (5%)

#### Clinical Supplies
- **2013/14 YTD Actual**: £16,990,000
- **Plan**: £17,295,000
- **Variance**: £305,000 (2%)

#### Drugs
- **2013/14 YTD Actual**: £12,608,000
- **Plan**: £13,799,000
- **Variance**: £1,191,000 (8%)

#### Other Non Pay Expenditure
- **2013/14 YTD Actual**: £14,118,000
- **Plan**: £11,538,000
- **Variance**: £2,580,000 (22%)

#### Research
- **2013/14 YTD Actual**: £970,000
- **Plan**: £918,000
- **Variance**: £52,000 (6%)

#### Total Expenditure
- **2013/14 YTD Actual**: £126,561,000
- **Plan**: £130,459,000
- **Variance**: £3,898,000 (3%)

### Statement of Financial Position

#### Non Current Assets
- **2013/14 YTD Actual**: £144,980,000
- **Plan**: £166,620,000
- **Variance**: £21,640,000 (13%)

#### Current Liabilities
- **2013/14 YTD Actual**: £28,742,000
- **Plan**: £27,588,000
- **Variance**: £1,154,000 (4%)

#### Total Assets Employed
- **2013/14 YTD Actual**: £184,529,000
- **Plan**: £194,600,000
- **Variance**: £10,071,000 (5%)

#### Income and Expenditure Reserve
- **2013/14 YTD Actual**: £41,370,000
- **Plan**: £42,927,000
- **Variance**: £1,557,000 (4%)

#### Total Taxpayers Equity
- **2013/14 YTD Actual**: £184,529,000
- **Plan**: £194,600,000
- **Variance**: £10,071,000 (5%)

### Continuity of Service Risk Rating

#### Debt Service Cover
- **2013/14 YTD Actual**: 3.37x
- **Plan**: 2.42x
- **Variance**: 1.95x (80%)

#### Liquidity
- **2013/14 YTD Actual**: 56.5
- **Plan**: 49.1
- **Variance**: 7.4 (15%)

#### Total Taxpayers Equity
- **2013/14 YTD Actual**: 184,529
- **Plan**: 194,600
- **Variance**: 10,071 (6%)

### Financial Performance for the Period to 30 September 2014
<table>
<thead>
<tr>
<th>BOARD OF DIRECTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Date and Part:</td>
</tr>
<tr>
<td>Subject:</td>
</tr>
<tr>
<td>Section:</td>
</tr>
<tr>
<td>Executive Director with overall responsibility:</td>
</tr>
<tr>
<td>Author(s):</td>
</tr>
<tr>
<td>Previous discussion and/or dissemination:</td>
</tr>
</tbody>
</table>

**Action required:**
The Board of Directors is asked to: Note the content of the report.

**Summary:**
The report shows the performance of the Trust by care groups across a range of workforce metrics and includes an update on mandatory training.

Recruitment to a wide range of clinical and medical posts remains challenging but progress is being made on appointments to clinical and medical posts.

**Related Strategic Goals/Objectives:**
To listen to, support, motivate and develop our staff

**Relevant CQC Outcome:**
Outcomes 12, 13 & 14 - Staffing

**Risk Profile:**
- Have any risks been reduced? No
- Have any risks been created? No

**Reason paper is in Part 2**
N/A
WORKFORCE REPORT - NOVEMBER 2014

1. Introduction to the Report Content

This report contains information regarding the Trust recruitment and retention activity, progress on completion of the annual national NHS staff survey and a report regarding the mandatory training compliance plans following the October meeting of the Board of Directors when there was a request to understand more around the issues. This paper provides an update on the current situation and progress and aims to provide assurance with the future action plans to continue to improve our Trust position.

2. Workforce data as at 30 September 2014

The monthly workforce data is shown below, both by care group and category of staff. Trust targets of 90% appraisal compliance and 3% sickness absence have been set and performance has been RAG rated against these targets.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Appraisal Compliance</th>
<th>Mandatory Training Compliance</th>
<th>Sickness Absence</th>
<th>Joining Rate</th>
<th>Turnover</th>
<th>Vacancy Rate (from ESR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>66.7%</td>
<td>77.5%</td>
<td>4.19%</td>
<td>11.2%</td>
<td>10.1%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Medical</td>
<td>73.1%</td>
<td>79.2%</td>
<td>3.36%</td>
<td>17.2%</td>
<td>11.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Specialities</td>
<td>73.4%</td>
<td>78.3%</td>
<td>3.72%</td>
<td>10.0%</td>
<td>9.6%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Corporate</td>
<td>75.8%</td>
<td>83.5%</td>
<td>4.20%</td>
<td>13.7%</td>
<td>13.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>72.2%</td>
<td>79.3%</td>
<td>3.82%</td>
<td>13.4%</td>
<td>11.2%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisal Compliance</th>
<th>Mandatory Training Compliance</th>
<th>Sickness Absence</th>
<th>Joining Rate</th>
<th>Turnover</th>
<th>Vacancy Rate (from ESR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technical</td>
<td>68.1%</td>
<td>84.6%</td>
<td>4.43%</td>
<td>10.2%</td>
<td>13.1%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>70.6%</td>
<td>81.1%</td>
<td>5.51%</td>
<td>17.6%</td>
<td>9.8%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>74.5%</td>
<td>81.1%</td>
<td>3.44%</td>
<td>15.0%</td>
<td>12.6%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>70.3%</td>
<td>84.8%</td>
<td>1.74%</td>
<td>15.3%</td>
<td>13.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>81.0%</td>
<td>86.8%</td>
<td>6.26%</td>
<td>10.8%</td>
<td>15.9%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>65.6%</td>
<td>87.8%</td>
<td>3.77%</td>
<td>9.4%</td>
<td>14.1%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>67.0%</td>
<td>48.9%</td>
<td>1.05%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>72.0%</td>
<td>84.2%</td>
<td>3.86%</td>
<td>11.8%</td>
<td>9.5%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>72.2%</td>
<td>79.3%</td>
<td>3.82%</td>
<td>13.4%</td>
<td>11.2%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Trust wide appraisal compliance has dipped slightly this month, whereas sickness absence and mandatory training compliance have both been fairly static. There has been a marked reduction in the vacancy rate from 4.8% in July, 5.5% in August to 4.4% in September and this is also shown by the joining rate exceeding the turnover rate in
all the care groups. This will, in part, be due to the number of newly qualified nurses who commenced at the end of September.

The board will remember that a new appraisal and personal development process is being developed for roll out in the Trust in 2015. This will encompass revised documentation based on the Trust values and behaviours and will require training for all staff who carry out appraisals. It will also reinforce the Trust objectives as these will be translated into individual ones.

In the meantime compliance levels will continue to be monitored through the care group and directorate management structures and action plans to maintain and improve compliance will be required.

3. Medical staff recruitment

Since the last Board report on recruitment was produced, Consultant appointments have been made in Palliative care, Colorectal Surgery and Ophthalmology. Unfortunately interviews arranged for MFE and Stroke appointments had to be cancelled when the candidates withdrew.

Interviews are due to be held on 13 November for a consultant in Acute Medicine and it is anticipated that an appointment should be possible.

In terms of overseas recruitment campaigns for consultants, interviews have been held with two candidates from Australia for posts in Emergency Medicine and it is intended to offer locum posts initially until such time as GMC Specialist registration is obtained. Another overseas candidate is keen to be considered for a Consultant in MFE and a visit is being arranged for when they are due to visit the UK at Christmas time.

Vacancies currently being advertised nationally include a Consultant in Dermatology and one in Histopathology.

In regard to other medical staff posts, a recruitment campaign in Pakistan is planned for late December to recruit 8 Trust SHO/SpR posts. A national advert has been placed recently for an SHO post in Orthopaedics.

4. Nursing staff recruitment

Weekly meetings on nurse recruitment have been arranged to ensure ownership and continued momentum. A number of adverts have been placed for band 5 nurses either for specific wards, departments or more generally within directorates. The majority of these applicants are external to the organisation and it is anticipated that these will translate into permanent appointments.

In addition, 9 candidates are about to start on a Return to Practice course of whom 2 have placements with this Trust and interviews are being held for a subsequent course. To date, 9 students who are due to qualify in January 2015 have applied to work for this Trust and it is hoped that this number will increase following the open day.
Other overseas recruitment campaigns are being planned and a task and finish group has been set up to focus on this specifically, and to establish the market leaders amongst agencies providing an overseas recruitment service and to explore the most appropriate source of candidates.

The Trust was also represented at an open day being held by Bournemouth University on 27 October where the various careers and specialties open to nursing staff were marketed.

The Trust held an open day on Saturday 25 October day for candidates for Health Care Assistant posts and 33 applicants came for interview and we have offered to 26 applicants.

5. Staff Survey update

As at 23 October 2014 the Trust has a response rate of 30% (average response rate for all Trusts 20.5%). A first reminder was sent out from Picker, direct to employees who received questionnaires, on 17 October 2014. An update e-mail was sent to senior managers on 13 October and a reminder was placed in the communications round up of the week ending 24 October.

Further reminders will be sent week commencing 3rd November (Picker) and at regular intervals by Human Resources. We anticipate the report and national results being available in February/March 2015. In the meantime we continue with our Friends and Family Test for staff. Results are about to be cascaded to the directorates and action plans will be required to address areas requiring improvement. These will be reviewed through the care group and directorate structures and also at the next Workforce Committee in December.

6. Mandatory Training - Essential Core Skills

There are 10 national core skills on the Essential Core Skills which is the revised term for Mandatory training across the NHS.

The Trust has a Mandatory Training Committee which meets quarterly and includes subject matter experts and directorate leads. Following the clinical restructure revised membership and terms of reference have been developed although the committee continues to report into the Board Workforce Committee who receive more detailed and specific updates and review compliance.

Current Situation:

Overall Trust compliance rate was 79.3% in September 2014 and 76.6% for 10 National Core Skills Subjects. Most staff groups are 80% plus compliant, apart from medical staff who are 49%. In December 2013 it was 74.9% which demonstrates that there has been a small improvement year on year.
Actions already taken to increase compliance:

- Meetings held with Directorate leads to agree plans to increase compliance and emails to Managers of areas with the lowest compliance requesting improvement plans.
- New reports to Managers giving clearer information regarding compliance accessible on the intranet. New reports on the intranet for staff to access their compliance rates.
- Increased number of Conflict sessions available due to streamlining programme to ½ day.
- Changes to Medical Mandatory training programme to achieve more compliance and working with areas of lowest compliance to have them book on to the new sessions.

Actions planned to increase compliance – March 2015:

- Mandatory Training will be re-launched and rebranded as Essential Core Skills and a new Virtual Learning Environment (VLE) on which all newly designed e-learning topics will reside.
- It will be easily accessible on site and remotely using the URL www.rbch.uk and via tablet devices.
- Staff will access the VLE using their assignment number and password and be presented with their compliance rates for all mandatory training topics using a RAG system.
- There will additional features to assist with compliance such as specific messages that will present themselves for persistent offenders.
- Many topics will change from a two yearly refresher period to a three yearly refresher period.
- Training days to be halved in length, staff able to redeploy to units/wards if necessary and complete assessment of compliance at their workstation, on RBCH tablets or on their own tablet/PC at home.
- Offering RBCH Staff flexibility regarding the method and timescale for completing training is expected to positively impact compliance by reducing the vast number of costly DNA (Did Not Attend).
- Progressive eLearning offers a more stringent assessment of knowledge and subsequent compliance by thoroughly testing the learner against accredited Skills for Health Learning Outcomes.
- If a learner is proficient with a topic they will be able to navigate directly to the Assessment section.
- These changes will help encourage medical staff completion and positively impact on compliance.

Potential Risk:

On 16/09/14 the RBCH IT CAB approved a Request for Change for a Trust wide deployment of Google Chrome to enable staff to access the new VLE. Deployment work must be completed two months prior to the VLE launch date (by 01/01/2015) to allow for eLearning testing and to guarantee a successful launch. Currently this work
has been given a low priority and which might jeopardise new VLE and new Mandatory training launch date but the IT department are reviewing the possibility of bringing this work forward to support the rollout.

**Beyond launch** we will develop Virtual Simulation Clinical Scenarios (VSCS) which are fully interactive, web/iPad accessible virtual scenarios of complex clinical problems. Simulation algorithms are used to create virtual representations that allow online learners to interactively explore a multitude of possible actions and to understand associated consequences. Learners are given the opportunity to experience negative outcomes in a safe virtual environment. RBCH has been invited to submit a Dementia VSCS as part of a national NHS Dementia package rollout in 2015. RBCH has the opportunity to be represented as a progressive Trust supplying best practice technology to enhance Dementia care, nationwide.

7. **Unify Safe Staffing September 2014 Return**

The final Safe Staffing Unify return for September 2014 showed a total Trust fill rate of registered nurses in the day of 91.2% and at night a 100%.

<table>
<thead>
<tr>
<th></th>
<th>RN Actual</th>
<th>HCA Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day</strong></td>
<td>91.2%</td>
<td>96.7%</td>
</tr>
<tr>
<td><strong>Night</strong></td>
<td>100%</td>
<td>110.4%</td>
</tr>
</tbody>
</table>

All areas were appropriately risk mitigated. Staffing is reviewed daily by the Matron workforce with localised assessment and decisions on use of temporary workforce, skill sets required and staff

8. **Staffing for the additional capacity Winter Ward.**

Additional capacity for the seasonal planning is part of the wider plan for managing the anticipated extra interventions our local health economy require through the winter season. A structured procurement process has succeeded in the Trust proceeding with a block booking contract with four of the five interested agency bidders. Collectively the process requested 30 qualified nurses to support the Trust, and the four agencies have proposed a total of 32 individuals.

Some of the individuals have worked in the Trust before. The process for induction and meeting the needs of practice based care is being managed through an identified senior nurse resource and supported by the Education and Training department, to ensure skill sets are utilised appropriately and safely, and by finance to ensure the payment process is integrated appropriately into Trust systems.
The process for placement will be planned with Heads of Nursing and Matrons against skill sets and experience and be approved through the Nursing Structure.

9. Recommendation

The Board of Directors is invited to note the report for information.
<table>
<thead>
<tr>
<th><strong>Meeting Date and Part:</strong></th>
<th>14&lt;sup&gt;th&lt;/sup&gt; November 2014 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subject:</strong></td>
<td>Urgent Care Plans and Escalation</td>
</tr>
<tr>
<td><strong>Section:</strong></td>
<td>Decision</td>
</tr>
<tr>
<td><strong>Executive Director with overall responsibility:</strong></td>
<td>Richard Renaut, Chief Operating Officer</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Richard Renaut, Chief Operating Officer</td>
</tr>
<tr>
<td><strong>Previous discussion and/or dissemination:</strong></td>
<td>Trust Management Board October &amp; November 2014</td>
</tr>
</tbody>
</table>

**Action required:**
The Board of Directors is asked for a decision

**Summary:**
This report gives details of the overall plans to ensure safe care for urgent and emergency patients, especially over the winter months (November – March).

**Related Strategic Goals/ Objectives:**
- to offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care
- to strive towards excellence in the services and care we provide
- to be the provider of choice for local patients and GPs
- to listen to, support, motivate and develop our staff
- to work with partner organisations to improve the health of local people

**Relevant CQC Outcome:**
All

**Risk Profile:**
Urgent and emergency care

**Reason paper is in Part 2**
N/A
Urgent Care Plans and Escalation

1. Executive Summary

There is a significant amount of work occurring to ensure safe care for urgent and emergency patients, especially over the winter months (November – March). These are summarised under:

i. Update on RBCH internal improvement plans and funding already agreed
ii. Emergency Department (ED) internal improvement plans (including 4 hours)
iii. Options appraisal for winter ward opening
iv. Wider health and social system plans (including older people’s services)
v. Escalation plans in the event the above is insufficient (outline, for discussion with full policy to follow next month)

Each needs to be considered in the context of the others, as no one part of the system is capable or competent to resolve the multiple issues, which affect how “hot” the hospital is.

The measures of acute hospital pressures are reviewed daily and include:

- ED waiting times
- Available beds for evenings and weekends (including intensive care)
- Elective cancellations
- Numbers of formal and pending delayed transfers of care and outliers

There are then a large array of other measures, including admits and discharges, Length of Stay (LoS), bed occupancy and ambulatory take up, discharge high impact changes (including estimated date of discharge etc.), which are also reviewed weekly.

Over the next 5-6 months these will be carefully tracked, along with quality metrics, to see if the numerous plans make a difference, and along with staff intelligence, whether the hospital is safe. The escalation plan section details potential options if, even for a short period, the Trust becomes unsafe and unable to admit emergency patients.

The Board is asked to support the overall plans included in this paper. In particular:

- To endorse the ED internal improvement plan and it’s areas of focus, plus Trust wide support needed (e.g. diagnostics, links to critical care etc).
- To debate and decide on the recommended option for the winter ward
- To discuss the updated escalation plan, including when cancelling electives and closing to emergency admissions is required.
- To comment, and endorse, on the overall approach to winter plans.
2. **Update on urgent care plans**

The spreadsheet attached at Annex 1 details the £4m of expenditure on additional urgent care schemes. This plan was shared with Trust Management Board (TMB) and Board of Directors (BoD) in October. Of this £800K is now funded by some recently released national funds, and £400K by RBCH increasing its planned deficit.

2.1 **Update on current schemes**

Improvement work in the hospital has concentrated on developing:

- 7 day services, with more senior decision makers at the evening and weekends for ED and AMU
- More ambulatory care, that has clinic and day care options for emergency patients
- Improving discharge planning, by applying the 10 high impact changes.
- Patient safety which also supports faster and more effective care, such as better management of Sepsis, Heart failure, emergency surgery and respiratory care.

2.2 **Schemes to Support New Care Models in 2014/15**

In addition to the above, our Acute Medicine and Older Person’s services have been developing ambulatory care models and streamlined frail and older persons’ pathways during 2014. These include ambulatory clinics and short stay wards as well as continued development of the discharge and interim care/discharge to assess pathways. Increased consultant presence ‘at the front door’ as well as in-reach to ED and in-reach by other specialities to AMU, together with nurse-led pathways are key features of these models; though this continues to be work in progress and the following further schemes are being implemented.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Current Anticipated Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Ambulatory Emergency Clinic (AEC) operating hours</td>
<td>November 14</td>
</tr>
<tr>
<td>Nurse-led ambulatory pathways</td>
<td></td>
</tr>
<tr>
<td>GP support to AEC</td>
<td></td>
</tr>
<tr>
<td>Additional pharmacy support to Ward 22</td>
<td>In place</td>
</tr>
<tr>
<td>Geriatrician cover to support prospective front door and weekend cover</td>
<td>December 2014</td>
</tr>
<tr>
<td>Elderly Care Nurse Practitioners (x 2)</td>
<td>National advert out, interviews mid- November 2014</td>
</tr>
<tr>
<td>‘Alternative offer’ rollout</td>
<td>Being widened to ‘trusted assessor’ approach using OTs to commence reablement packages of care and reduce delays. Start November 2014</td>
</tr>
<tr>
<td>Alcohol liaison nurse</td>
<td>Recruited. Starts January 2015</td>
</tr>
</tbody>
</table>
Clearly, the biggest risk to these schemes and those outlined below will be our ability to recruit staff together with the continued lack of community and social care capacity to support discharge. This remains under review and has been escalated to the health community-wide System Resilience Group as well as at Chief Executive level.

### 2.3 Additional Internal Schemes to Support Urgent Care and Winter Pressures

Finally, the following further schemes are also being implemented to support the additional pressures this year and anticipated over the winter period with a further investment of £1.027m:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Current Anticipated Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 16 bay (6 beds)</td>
<td>In place, with contracts for permanent staff</td>
</tr>
<tr>
<td>Winter ward incl. additional medical support (<em>see separate Board paper</em>)</td>
<td>End December 2014</td>
</tr>
<tr>
<td>Additional (3rd) bipap bed for respiratory care</td>
<td>Flex up as required</td>
</tr>
<tr>
<td>Flex capacity beds for increased urgent care pressures based in the Eye Unit</td>
<td>Flex up as required</td>
</tr>
<tr>
<td>Additional therapy, housekeeping and portering to support additional beds and outliers</td>
<td>Therapy winter pressure staffing to be in post by January 2015 as forecasted.</td>
</tr>
<tr>
<td>Surgical discharge facilitator</td>
<td>Recruitment underway</td>
</tr>
<tr>
<td>Additional Clinical Site Team cover including medical assistant role</td>
<td>December 2014</td>
</tr>
<tr>
<td>Majors Assisting Practitioner in ED extended hours</td>
<td>Starts November 2014</td>
</tr>
</tbody>
</table>

### 3. ED Improvement

The 4 hour target is for patients benefit, as well as being used as the indicator for an acute Trust’s emergency performance. It is also a measure of public confidence, and a key regulatory requirement. It is expected to be delivered in return for the extra emergency funding released centrally (c£7m for Dorset this year).

This wider paper and all the improvement work of the last year on discharge, 7 day working, ambulatory care, wider system health and social care etc. is intended to reduce “exit blocks” from ED. These are all reasons that stop EDs from enacting a decision to admit or discharge within 4 hours. Work needs to continue in reducing these “exit blocks.”

This section is about improvements ED can make in its internal processes that allow that decision comfortably within 4 hours. These are under four broad headings; each has a small team working on improvements:
1. Majors

- Rapid Assessment on arrival. Quicker decision, allow pull by specialist areas
- Avoiding resus becoming blocked (escalation plans) (A full resus leads to whole department slowing up).

2. Minors

See and Treat:
- Minors should achieve 100% within 4 hours

3. Observation

Protocol led care, Single Sex compliance
- Better use of observation beds

4. Diagnostics

- Blood on arrival, quicker results
- Nurse requested x-rays

5. Ambulatory

Quick diversion to alternative care, such as ambulatory clinics, co-located with ED.

A report back on these actions will occur monthly and will probably inform a Monitor required action plan, should we miss 4 hour performance for a third quarter in row. Our current performance is c91% in October so far. The required performance is 95%+.

The analysis of causes of breaches has been used to inform the priority areas. Beds within the hospital, and rapidity of ambulance conveyances does cause breaches.

However whilst there are complex and multi-factorial issues to consider, the simple conclusion is that it is possible to achieve and sustain the 95% 4 hour target, through addressing the issues within the 5 target areas. Each of these areas are entirely within the control of the Trust.

That said consistently getting these processes right requires focussed effort, full staffing, and being able to cope with fluctuations in demand.

For example a particular area of pressure on ED performance is when resus is full. This requires ED doctors to focus on the sickest patients. As a result, the ability to manage and process all the patients in ED in a timely way suffers. This can mean even when hospital beds are available, ED can still not be functioning, and numerous patients fail the 4 hours.

A further issue is when multiple ambulances arrive at similar times. This can occur when neighbouring Trusts ask for respite to help their ED process current patients in the department. We will pilot with SWAST ways of achieving staggering ambulance arrivals at peak times, and using alternative services, including ambulatory care and access to consultant opinion.

4. Winter pressure ward

As in previous years the winter is expected to bring increased demand, especially for respiratory and frail older patients. We also intend to bed together heart failure patients on ward 21, to improve input from specialists and improve outcomes.
The net effect is 28 extra beds. St Leonards should also open an extra ward. For both funding is available. However securing staffing is the main risk to them opening. Therefore active and creative solutions are being progressed to overcome this.

In summary, a ward for general medicine patients will open January – March 2015. Consultant cover will be provided by Thoracic and BDEC consultants to reflect the patient mix. Junior doctor cover will be via fixed term or extensions to existing posts, or locums.

Older People’s Medicine (OPM) will need to ensure they can manage within the 12 extra beds, plus St Leonards, and avoid outlying. They will need to input into the Heart failure patients on Ward 21, but the majority of care will be from cardiology. This leaves OPM with the capacity to focus on the front door developments such as ambulatory older people’s service, Ward 25 and 26, plus active ward rounds and discharges.

In summary the bed base is aligned to anticipated demand as best as can be planned for at this stage.

5. Wider health and social care plans

5.1 Social Care

Attached at Annex 2 is a paper by Vanessa Mason which summarises agreed actions with social and community care partners.

5.2 SWAST (extra Dorset resources following national funding increase)

- Extend mental health nurse rotas to 7 day working (7 day working currently in 2 clinical hubs only)
- GP presence in the 2 clinical hubs to triage 111 calls to prevent unnecessary referrals to A&E. (GP coverage in hubs currently is Sat/Sun 8hrs and Mon and Fri afternoons 4hrs).
- Additional 5 PSVs to be used for discharging patients from the acute hospitals at a cost of £88,368 per vehicle. Additional 5 MRSVs at a cost of £66,588 per vehicle

5.3 Primary care

GP are focused on over 75 year old care plans, and a process of risk stratifying those most at risk of admission. This includes a follow up within 3 days of discharge (to reduce re-admits). High quality and timely immediate discharge forms are required to support this.

5.4 Bournemouth and Christchurch urgent care cluster: high impact actions.

These are draft but based upon the 6 areas agreed between CEOs in Dorset. A Programme Management Office (PMO) approach is being developed by the CCG. This should combine with our own improvement team. Together they will need to demonstrate both delivery of the schemes, and assess their effectiveness, as most are funded with non-recurrent funds.
| 1. Integrated Health (DHUFT) and Social care locality Teams x4 | All localities within the cluster (Bournemouth East, North and Central, plus Christchurch) to be delivering the following functions:  
- Risk profiling and case finding  
- Monthly MDT meetings  
- Personalised assessment and care planning  
- Case management and Care coordination  
- Working arrangements with the hospitals |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Reduce emergency admission from care homes; links with action area 1.</td>
<td></td>
</tr>
</tbody>
</table>
- Identify those care homes with the highest rate of emergency admissions  
- Agree a model for delivery into the care homes eg through each MDT linked to GP practices or a federated approach across GP practices in locality, initially focusing on those with the highest emergency admission rate.  
- Establish anticipatory care plans and case manage those people most at risk of an unplanned admission to hospital.  
- Roll out above to all care homes within the cluster of localities. |
| 3. Increase the availability, access and capacity of Domiciliary Care |  
- Review current contract T and C’s to identify whether changes are required to incentivise and support workforce sustainability and capacity e.g. guaranteed hours, zoning  
- Establish model, agree funding source (? Resilience funding) and implement model for a crisis/intensive response provision for domiciliary care for step down and step up support.  
NB Strategic commissioning for future model of dom care being taken forward through BTG programme. |
| 4. Crisis social care night support |  
- Obtain evaluation and service spec for DCH/DCC model  
- Establish model, agree funding source (? Resilience funding) and implement model for a Crisis social care night support  
NB Benefits of roaming night service acknowledged through initial pilot in Dorset, service needs further roll-out across Dorset. |
| 5. Reduce the number of people attending ED (minors) and reduce the number of people admitted when they do attend. |  
- Introduce primary care clinical triage at the front door of RBCH  
- Agree funding source and introduce open access for GP out of hours  
- Improve signposting and communications to the public on alternative locations to receive minor injuries and ailments assessment and treatment.  
- Review the GP’s in hours offer’ and 7 day working opportunities. – links to 7 day working action. |
| 6. Reduction in the Ambulance service conveyance rate |  
- Identify high impact changes to increase see and treat and reduce conveyances to inform action plan.  
- Review outcomes of 111 contacts to inform pathway review and potential to direct to SPA and MIU’s.  
- Enhance medical assessors’ engagement within the 111 triage process. |
<table>
<thead>
<tr>
<th>Issue</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Increase use of ambulatory care pathway</strong></td>
<td>Action plan managed through the RBCH Urgent Care Board and updates into Cluster meeting</td>
</tr>
<tr>
<td><strong>8. Hospital at Home</strong></td>
<td>Obtain evaluation and service spec for DCH/DCC model  Establish model, agree funding source (? Resilience funding) and implement model for Hospital at Home</td>
</tr>
<tr>
<td><strong>9. Improve the timeliness of people leaving hospital including a ‘discharge to assess’ model.</strong></td>
<td>Improve the performance of the ward staff in implementation of best practice discharge planning e.g. EDD, engaging with community services on admission for complex patients.  Increase the inreach of community staff to engage in discharge planning of complex patients.  Move CHC checklist completion to out of hospital, and implement a referral process.  Review the current BCHA screening service and support self-funders in discharge planning and securing of on-going care.  Agree funding source and model to implement a ‘trusted assessor’ model for people, requiring on-going rehabilitation and reablement.  Reduce the number of people who are using the CHC fast track process who are not at the end of life.  Secure greater capacity from care homes for people at the end of life.  Increase domiciliary care capacity – see change area 3.  Increase the capacity for specialist dementia placements.</td>
</tr>
<tr>
<td><strong>10. Increase the availability of health and social care 7 day working, 8 to 8</strong></td>
<td>Each organisation to undertake a baseline assessment of 7 day working to identify gaps.  Each organisation to prioritise gaps and share through cluster group meeting to inform cluster prioritisation.  Agree funding to deliver prioritised areas (? Resilience funding).  Implement agreed priorities  Potential areas:  Diagnostics  Pharmacy  Social work assessments  Community hospital medical cover – to enable more step up and step down admissions  Mental Health Liaison  Discharge into care homes at weekends  Review the GP’s in hours offer’ and 7 day working opportunities</td>
</tr>
</tbody>
</table>
6. Escalation plans

The current level 3+ escalation actions for NHS providers are attached as Annex 3. This is one small part of the overall policy which is being updated and will be brought to the next Board meeting for approval. However this section focuses on the actions to consider when the acute hospital is under pressure. Most of these reflect our current set of actions that we deploy.

Several possible additional actions are listed below to see if TMB supports further “working up” of the impact and effectiveness. These include:

- **Planned cancelling of routine inpatient admission work**, mainly for Orthopaedics, and some upper GI (laparoscopic cholecystectomy etc.) on a planned basis i.e. six weeks in advance for known periods of pressure i.e. especially for the first week in January, and for February half term. For example stopping Derwent routine joint replacements, and using the doctors to reduce outpatient waits. Then transferring main Orthopaedic theatre work, especially “personal case” lists to the Derwent. Such an action should be agreed with the CCG so we are not financially penalised.

- **Reducing planned outpatient clinics** for geriatricians in January and February, to maximise number of ward rounds and sessions in interface services.

- **Discharging medically fit patients to care homes**, faster than current policy and practice by (i) enforcing choice policy more actively (ii) the NHS paying top ups for the 1st few weeks whilst choices are made. Moving a medically stable patient out of hospital even if it is not to the first choice of the patient or carers, does still allow them to make a choice from the interim care home. This would be above our current NHS funded interim bed capacity. In particular there is a growing group of “others” and self-funders, who are often having much longer hospital stays than medically required, as ‘choice’ of home and funding sources are explored.

  “Stepping up” the current approach would require a potential mix of: top up funding (to access more care homes), some clinical risk in transferring medically stable patients at short notice, some risk of legal challenge if choice options are not fully explored, assessments completed and updated etc. However in the event of an approaching major incident this would seem a much lesser risk, than not being able to accept ambulance admissions.

- **Closing or phasing to emergency admissions**. “Diverting the take” can be requested, once major incident actions are taken, and all options exhausted (including the above 3 ideas, and all those listed on the action card in Annex 3). Closing quickly has an impact on other, surrounding Trusts, who often have little capacity themselves. It can be enacted for short periods to allow an ED to process patients. There can be other options, such as Ambulance crews leaving or taking patients to alternative services they would not normally use, treating risk assessed patients as “urgent” rather than “emergencies”. Urgent means conveyance within 4 hours. Access to the on call consultants (ED, MFE, surgical, acute physician) can help this decision making. Such an approach could reduce batches of ambulances at the same time, overwhelming an ED.
7. Recommendation

There are extensive plans designed to improve the resilience of health services locally. The measure of success will be how “hot” the hospital is, especially over the peak winter months. Our starting point of being regularly at a state of negative beds, with weekends and Mondays being especially hard pressed. This means the success of these combined plans is essential, and they require the full support of the Board.

Board members are asked to assess the full extent of the plans and comment, in particular on issues high-lighted, namely:

- ED improvement plan priorities
- Opening the winter ward
- Draft ideas for escalation actions
- Draft local cluster high impact actions

Board is then asked to support the overall winter pressures and escalation plans included in this paper.
<table>
<thead>
<tr>
<th>Scheme</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
<th>Month 7</th>
<th>Month 8</th>
<th>Month 9</th>
<th>Month 10</th>
<th>Month 11</th>
<th>Month 12</th>
<th>TOTAL FYE</th>
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</thead>
<tbody>
<tr>
<td><strong>Addtl Portering &amp; Housekeeping</strong></td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
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<td>2,500</td>
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<td><strong>Metro Ancillary Services</strong></td>
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<td>3,000</td>
<td>3,000</td>
<td>36,000</td>
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<tr>
<td><strong>Virtual Ward (Southbourne &amp; Christchurch)</strong></td>
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<td>2,500</td>
<td>2,500</td>
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<td>2,500</td>
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<td>30,000</td>
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<tr>
<td><strong>Additional GP/Primary Care support to ED/frontdoor</strong></td>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
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<td>60,000</td>
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<td><strong>Elderly Care Nurse Practitioners (included above)</strong></td>
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<td>4,500</td>
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<td>4,500</td>
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<td><strong>Intermediate Care Bed (Southbourne)</strong></td>
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<td><strong>Discharge to Assess models</strong></td>
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<tr>
<td><strong>Discharge models - Nurse led ambulatory pathways</strong></td>
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<tr>
<td><strong>Discharge to Assess model</strong></td>
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<td><strong>Primary Care based risk registers and information sharing</strong></td>
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**Note:** ad hoc flex already in use as required as at Sep 14

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The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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

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**Key metrics/benefits**

1. Increased non elective activity fully utilised last year.
2. Reduced LoS and increased short stays evidenced (25%).
3. Increased staff review underway in MFE wards.
4. Reduced LOS and increased parity of care for ED patients per week.
5. Timely discharge, discharges, smooth clerking, discharges awaited.
6. Reduced LoS, reduced LoS requirement for full state, 4hr Flow, outliers, bed dependency on demand over winter.
7. Majors assisting practitioners additional hours 25% increase by 25%.
8. Interim Care Beds only.
9. Virtual Ward (Southbourne & Christchurch) 25%.
10. Interim Care team only.
11. Interim Care Beds* 50%.
12. Emergency Care Practitioners for admission avoidance - SWAST based only.
13. Emergency Care Practitioners for admission avoidance - SWAST based only (note this was moved out of UCB last list).
14. Discharge models - Nurse led ambulatory pathways only (note this was moved out of UCB last list).
Introduction

The Royal Bournemouth Hospital provides secondary care to a population with a high prevalence of older people. Hospital admissions have been rising steadily for over a decade and there have been increasing delays in the discharge of older people from secondary care nationally. This has led to bed crises that have been worsening year on year leading to increasing number of older patients outlying on medical & surgical wards which has an adverse effect on patient care including increased length of stay and increased morbidity and mortality. A length of stay which exceeds well beyond the time that the patient is medically well enough for discharge leads to increased risk of hospital acquired infections, loss of moral and increased dependency, with an increased likelihood of discharge to residential care.

In order to address these ongoing issues further development of the ‘Discharge to Assess’ Model is required to manage the complex needs of older people in a variety of community settings. The model to date has shown beneficial effects in terms of reducing length of stay, inpatient mortality and bed occupancy. The following pilots over the winter period for 14/15 are proposed to drive further efficiencies and to improve the clinical and functional outcomes for patients and thereby reducing demand on the residential and domiciliary care market in Bournemouth and Dorset.

The Philp Principles: Discharge to Assess Model

- **Choose to Admit** – admission avoidance by viable alternatives supported by rapid comprehensive geriatric assessment

- **All older people are under the care of an older person’s specialist** whilst in hospital

- **Discharge to assess** and viable responsive alternatives in the community

- **Prompt post-acute multidisciplinary assessment** and inputs to reduce requirements of long term care

RBCH: Discharge to Assess: Winter Pilots 14/15

RBCH continues to identify a number of medically stable patients across the Older Person’s Medicine wards that would benefit from on-going assessment and intervention within a variety of community settings. The following winter initiatives are proposed to reduce the number of older people that remain in an acute hospital bed whilst on-going assessment and interventions are provided to identify the level of care and support strategies required in the community.
1) Increase the number of Short Stay beds across the Older Person's Medicine wards

There are insufficient eACM (short stay) beds for older people, meaning that eACM patients are often moved onto other outlying wards. This outlying increases length of stay and reduces quality of care and patient safety. Following the success of ward 22, we propose to convert another OPM ward (25) to provide a second short stay ward to reduce the number of eACM outliers across the Trust and to drive further efficiencies with discharges for this cohort of patients.

The aim is convert to ward 25 to become the second short stay ward by the end of October 2014, with further developments of transferring ward 22 to the ward 26 template by December 14 (provision of 50 eACM beds). This will allow ward 25 and 26 to work as a combined short stay unit over the winter to provide the following daily principles to increase discharges for this cohort of short stay patients:

- Patients on the short stay unit have an estimated discharge within 5 days
- OPAL Care hours are used for short term care packages and to assess if increases to care packages are required long term
- Ability to restart a higher number of POCs within 5 days from the short stay unit
- Use of Bournemouth & Dorset Social Workers and Care Managers to embed the culture of “discharge to assess” within the social care workforce
- Rapid access to Intermediate Care Services
- Daily MDT meetings to agree discharge plans and on-going community support from a variety of services

The remaining OPM wards: 4, 5 and 22 will remain as acute medical wards for older people (84 beds in total) and ward 3 will remain as the transitional care ward to cohort medically stable patients requiring complex discharge planning to facilitate discharge into the community.

2) Provide designated discharge planning expertise to the Acute Older Person's Medicine Wards

Due to the ongoing high number nursing vacancies across the OPM wards, it has been difficult to embed the daily discharge planning actions required through the bay-based nursing model. Therefore over the winter period, the Discharge Coordination Team will be based on the OPM wards to drive the daily actions required at ward level to progress discharge planning. The team will also support discharge planning competencies within the MDT and work with the ward clinical leaders to embed a culture of “discharge planning is everyone’s responsibility”.

Cherry McCubbin / Vanessa Mason September 2014
3) Use of Broadwaters for blocked booked interim dementia residential beds

The on-going challenges for the interim care model are the current insufficient number of residential beds for patients with dementia and/or complex manual handling needs i.e. those patients requiring hoisting. It is also difficult to provide the “reablement” model for patients going through the interim care model whilst using a number of interim residential care homes across Bournemouth.

In partnership with Bournemouth Borough Council and Dorset County Council, we propose to block book 13 residential beds at Broadwaters to be used for Bournemouth and Dorset residents who may have a diagnosis of dementia and / or present with complex manual handling needs. This particularly relates to patients who are delayed at RBH awaiting QDS care packages to identify if using a “reablement” approach provided through the interim care team therapists has a positive impact of reducing the number of visits long term. We envisage this will support the drive to increase capacity within the domiciliary care market.

4) Identification of supportive housing to support reablement delays

On-going work is currently underway to identify supportive housing options to be used as an “assessment” model for patients delayed awaiting reablement packages of care. A potential option is “Hibberd Court” in Bournemouth, which would be supported by the opal outreach therapists to assess on-going function in the community.

5) Trusted Assessor Model: Therapy review for patients prescribed domiciliary care packages

Following the concept of the “alternative offer” scheme, the biggest challenge for this model, is the limited capacity within the domiciliary care market. RBCH would therefore like to work in partnership with BBC and DCC to facilitate the “Trusted Assessor” model developed by Heartlands Hospital, Birmingham County Council and Solihull. The model has used therapists to provide reablement assessments and to outreach into the community to review on-going goals which has ultimately reduced overall level of care provided by domiciliary agencies long term. We envisage this will support the drive to increase capacity within the domiciliary care market. Further benefits from Birmingham County Council has demonstrated the reduced demand on hospital social workers to carry out reablement assessments allowing their time to be focused on complex discharges which has improved patient flow.

6) Identification of a designated nursing home to support End of life care

RBCH continues to experience a high number of patients under the fast track CHC pathway who are unable to be transferred to nursing homes in the community for end of life care. There are also a number of patients readmitted from nursing homes who are unable manage end of life care. To address these challenges, RBCH would like to work in partnership with BBC, DCC and Dorset CCG Fast Track Team to utilise a designated care home to support the up skill of the nursing home workforce to manage this group of patients safely in the community. Dorset County Council
have agreed to explore the use of Avon View dual registered care home with a view to utilising beds for both Dorset and Bournemouth residents.

7) Further expansion of community rehabilitation beds

RBCH continues to experience on average between 7-9 patients on a daily basis awaiting transfer to a community hospital for on-going rehabilitation. We propose to work in collaboration with DHUFT to open the winter pressure rehabilitation beds at St Leonard’s hospital. We are keen to work in partnership with DHUFT to expand the discharge to assess model from community hospital beds to reduce the number of blocks these services are also experiencing with on-going access to domiciliary care packages.

8) Admission Avoidance & Early Supported Discharge

A number of developments are currently underway within the Older Person’s Medicine Directorate to increase the number of admissions that can be avoided to RBCH or to increase discharge from the “front door” to avoid admission to our downstream OPM wards. This includes:

- Collaborative working with DHUFT – Intermediate Care Services to adopt an in-reach model of care for the Short Stay Unit to enable a higher number of patients to be discharged with intermediate care services.

- Employment of 2 Nurse Practitioners to support Ambulatory Care for older people (OPAC) and increase nurse led discharges across the OPM wards across 7 days.

- Further expansion of the OPAC clinic to be provided all day Monday – Friday by February 2015 following appointment of nurse practitioners and recruitment of locum Consultant Geriatricians.

- The ability to “pull” older people from ED and further access for GP referrals to OPAC once nurse practitioners and further geriatricians are recruited.

- Joint working with Primary Care to utilise ambulatory services for older people in conjunction with intermediate care services to avoid unnecessary admissions to RBCH.

- Transformation of the OPAL Outreach model to transfer further patients from OPAC and ED into interim beds or supported at home for short term care packages only to create on-going capacity within this service.

- Use of the Day Hospital to provide alternative solutions for managing patients in the community to reduce “social admissions” experienced at RBCH.
Actions taken at Red (level 3)

This action card outlines the minimum expected levels of action at Red (Level 3) status.

Illustration of minimum actions at alert status RED which may be taken to mitigate pressure prior to (and with the intention of avoiding) further escalation:

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</table>
### COMMUNITY CARE PROVIDERS

| 31 | All community care teams to review all patients awaiting assessments in order to expedite discharge or transfer – this to include in reach terms, deliberate self-harm, community hospitals. |
| 32 | Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible. |
| 33 | Community service providers to expand capacity wherever possible through additional staffing and services. |
| 34 | Community providers to consider the use of wider group of agencies to increase staffing capacity. |
| 35 | Patients waiting at home for admission to be referred to Community Teams (by in reach nurses). |

### SOCIAL CARE

| 36 | Social Services on-call Managers to expedite care packages. |
| 37 | Social Services to review all assessments in pipeline to expedite discharge. |
| 38 | Increase domiciliary support to service users at home in order to prevent admission. |
| 39 | Increase staff resource at the front door. |
| 40 | Encourage providers to identify where existing packages could be reduced. |
| 41 | Flex staff to areas of greatest need – utilise mutual aid agreements between Poole, Bournemouth and Dorset Social Services Teams. |

### PRIMARY CARE

| 42 | OOH services to recommend alternative care pathways. |
| 43 | In hours GP services to recommend alternative care pathways. |
| 44 | Review staffing level of GP OOH service. |

### MENTAL HEALTH

| 45 | To review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible. |
| 46 | Increase support to service users at home in order to prevent admission. |

### AMBULANCE TRUST

<p>| 47 | Review and reallocate resources to meet current emergency workload. |
| 48 | Ensure usage of managers/officers, staff and community responders is maximised. |
| 49 | Ensure (in conjunction with other PTS providers if commissioned) current PTS capacity is fully utilised for patient discharge and transfer. |</p>
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<tr>
<td><strong>50</strong></td>
<td>Maintain communication with GP, 111 and OOH services to review potential delays to patient admissions.</td>
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<td><strong>51</strong></td>
<td>Ensure all duty officers and directors are aware of current status levels.</td>
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<td><strong>52</strong></td>
<td>Liaise with acute trust to risk assess and agree clinical plan for any patients delayed in being handed over to the acute trust.</td>
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<td><strong>53</strong></td>
<td>Reinforce with ECPs and other A&amp;E staff the need to use alternate care pathways whenever possible.</td>
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<td><strong>54</strong></td>
<td>Utilise actions from REAP plan to create capacity where possible.</td>
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<tr>
<td><strong>PTS SERVICE</strong></td>
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<td><strong>55</strong></td>
<td>Ensure that capacity is fully utilised for patient discharge and transfer, and that liaison between different PTS providers and the Ambulance Service is functioning well.</td>
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### BOARD OF DIRECTORS

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<tr>
<td>Subject:</td>
<td>Update on Clinical Service Review and NHS England’s Five Year Forward View</td>
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<tr>
<td>Section:</td>
<td>Strategy and Risk</td>
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<tr>
<td>Executive Director with overall responsibility</td>
<td>Tony Spotswood</td>
</tr>
<tr>
<td>Author(s):</td>
<td>Tony Spotswood</td>
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<tr>
<td>Previous discussion and/or dissemination:</td>
<td></td>
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<tr>
<td>Action required:</td>
<td>The Board is asked to note NHS England’s Five Year Forward View</td>
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#### Summary:

Attached is a copy of NHS England’s Five Year Forward View

#### Related Strategic Goals/ Objectives:

Developing our strategy

#### Relevant CQC Outcome:

All

#### Risk Profile:

- i. Have any risks been reduced?
- ii. Have any risks been created?

#### Reason paper is in Part 2

N/A
Clinical Service Review and NHS England’s Five Year Forward View

I will provide for the Board a brief verbal update on the Clinical Service Review. This work has now commenced with the infrastructure being established to ensure the case for change, best practice review and option consideration can be completed as part of the first phase of work. The Trust is presently identifying those clinicians that will contribute to the review.

I wanted to emphasise that this work will need to cover both new models of care and how best they can be delivered. A central part of this work will, however, need to focus on the implementation phase and how the local provision sector is configured in whatever form is necessary to ensure that high quality viable services are provided from viable stable provider organisations.

Of particular relevance is the NHS England Forward View which will provide an important backcloth and reference document to both this work and the development of the Trust’s Clinical Strategy. The document itself also focuses on changing models of care and organisation to ensure a sustainable NHS. I would draw the Board’s attention in particular to the chapter on new models of care which includes the potential to develop integrated health systems that offer a more patient centred approach to care.

This paper is provided for information.

Tony Spotswood
Chief Executive
CONTENTS

Foreword.....page 2

Executive summary.....page 3

Chapter One – Why will the NHS need to change?....page 7

Chapter Two – What will the future look like? A new relationship with patients and communities.....page 10

- Getting serious about prevention.....page 10
- Empowering patients.....page 13
- Engaging communities.....page 14
- The NHS as a social movement.....page 15

Chapter Three – What will the future look like? New models of care.....page 17

- Emerging models.....page 17
- One size fits all?.....page 18
- New care models.....page 20
- How we will support local co-design and implementation.....page 26

Chapter Four – How can we get there?....page 29

- We will back diverse solutions and local leadership.....page 29
- We will create aligned national NHS leadership.....page 29
- We will support a modern workforce.....page 30
- We will exploit the information revolution.....page 32
- We will accelerate useful health innovation.....page 33
- We will drive efficiency and productive investment.....page 36
FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven’t changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS’ national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.
EXECUTIVE SUMMARY

1. The NHS has dramatically improved over the past fifteen years. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients’ needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately there is now quite broad consensus on what a better future should be. This ‘Forward View’ sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, when people do need health services, patients will gain far greater control of their own care – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.
7. **England is too diverse for a ‘one size fits all’** care model to apply everywhere. But nor is the answer simply to let ‘a thousand flowers bloom’. Different local health communities will instead be supported by the NHS’ national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a ‘new deal’ for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients’ experience of interacting with the NHS. We will
improve the NHS’ ability to undertake research and apply innovation – including by developing new ‘test bed’ sites for worldwide innovators, and new ‘green field’ sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS’ long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS’ own past, compared with the wider UK economy, and with other countries’ health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending per person would take account of population growth. Flat NHS spending as a share of GDP would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.
CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils’ social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What’s more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries’ health systems:

- Changes in patients’ health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.
• Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients’ changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That’s because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients
having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

**BOX 1: FIVE YEAR AMBITIONS ON QUALITY**

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.
CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is ‘of the people, by the people and for the people’.

Yet sometimes the health service has been prone to operating a ‘factory’ model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and underdeveloped advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the ‘fully engaged scenario’ that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don’t get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they’re in Year Six, nearly one-in-five are then obese.

And as the ‘stock’ of population health risk gets worse, the ‘flow’ of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation’s waistline keeps piling on...
the pounds, we’re piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England’s new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can’t do everything that’s needed by itself, it can and should now become a more activist agent of health-related social change. That’s why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

*Incentivising and supporting healthier behaviour.* England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

*Local democratic leadership on public health.* Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.
**Targeted prevention.** While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

**NHS support to help people get and stay in employment.** Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving ‘downstream’ costs at the Department for Work and Pensions, if money can be reinvested across programmes.

**Workplace health.** One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees’ health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as “health ambassadors” in their local communities.
BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will:

- Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.
- Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part.
- Support “active travel” schemes for staff and visitors.
- Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC’s Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health.
- Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients’ organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients’ own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often ‘experts by experience’.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS’ longstanding
promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, “year of care” budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

**Engaging communities**

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

**Supporting carers.** Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

**Encouraging community volunteering.** Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 “community first responders” have been recruited by Yorkshire Ambulance in more rural
areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

**Stronger partnerships with charitable and voluntary sector organisations.** When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

**The NHS as a local employer.** The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to ‘experts by experience’ such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

**The NHS as a social movement**

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the ‘nice to haves’ and the ‘discretionary extras’, our conviction is that these sort of partnerships and initiatives are
in fact precisely the sort of ‘slow burn, high impact’ actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

**BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA**

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS’ ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer’s Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.
CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected ‘episodes’ of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in
and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This “social prescribing service” has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients’ experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

**One size fits all?**

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What’s right for Cumbria won’t be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn’t mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let ‘a thousand flowers bloom’. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the
outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That’s why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and ‘out of hospital’ care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

**BOX 3.1: A new deal for primary care**

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.
- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public’s understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.
Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

**New care model – Multispecialty Community Providers (MCPs)**

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of ‘expert generalists’, proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours
inpatient care being supervised by a new cadre of resident ‘hospitalists’ – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the ‘renewable energy’ of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

**New care model – Primary and Acute Care Systems (PACS)**

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these ‘vertically’ integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do
this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

**New care model - urgent and emergency care networks**

The care that people receive in England’s Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.
• Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

• Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

• Proper funding and integration of mental health crisis services, including liaison psychiatry.

• A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

• New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the
forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their ‘back office’ with other similar hospitals not necessarily located in their immediate vicinity. These type of ‘hospital chains’ already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

**New care model - specialised care**

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with
the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

**New care model - modern maternity services**

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women’s Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.
- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.
- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

**New care model – enhanced health in care homes**

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of
models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

**How will we support the co-design and implementation of these new care models?**

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local ‘five year plans’ by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations’ interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several
hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and ‘fast track’ a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

**BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH**

*Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.*

*Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.*

*This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a*
fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children’s services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.
CHAPTER FOUR
How will we get there?

This ‘Forward View’ sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

**We will back diverse solutions and local leadership**

As a nation we’ve just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no ‘right’ answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of ‘special measures’.
We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to support the development of new local care models, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective local assessment, reporting and intervention regimes for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new ‘special measures’ support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to share intelligence, agree action and monitor overall assurance on quality. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and
behaviours to deliver it. That’s why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE’s leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can ‘future proof’ the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage
recruitment and retention in parts of the country and in occupations where vacancies are high.

**We will exploit the information revolution**

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health
professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients’ records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

**We will accelerate useful health innovation**

Britain has a track record of discovery and innovation to be proud of. We’re the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.
We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That’s why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called “commissioning through evaluation” which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE’s assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with
partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won’t come from new standalone diagnostic technologies or treatments - the number of these blockbuster ‘silver bullets’ is inevitably limited.

But we do have an arguably larger unexploited opportunity to combine different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed ‘combinatorial innovation’.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been ‘piloted’ without other needed components. Even where ‘whole system’ innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of ‘test bed’ sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for ‘combinatorial’ innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate
use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care ‘new towns’. England’s population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

**We will drive efficiency and productive investment**

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

**Demand**

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

**Efficiency**

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.
Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS’ own past, compared with the wider UK economy, and with other countries’ health systems. It would require investment in new care models and would be achieved by a combination of “catch up” (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the ‘right care, at the right time, in the right setting, from the right caregiver’. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending per person would take account of population growth. Flat NHS spending as a share of GDP would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

• In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

• In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

• In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to ‘flat real per person’ the £30 billion gap is closed by 2020/21.
Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.

Faster diagnosis. We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will
also work to expand access to screening, for example, by extending breast
cancer screening to additional age groups, and spreading the use of
screening for colorectal cancer. As well as supporting clinicians to spot
cancers earlier, we need to support people to visit their GP at the first sign of
something suspicious. If we are able to deliver the vision set out in this
Forward View at sufficient pace and scale, we believe that over the next five
years, the NHS can deliver a 10% increase in those patients diagnosed early,
equivalent to about 8,000 more patients living longer than five years after
diagnosis.

Better treatment and care for all. It is not enough to improve the rates of
diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure
that existing quality standards and NICE guidance are more uniformly
implemented, across all areas and age groups, encouraging shared learning
through transparency of performance data, not only by institution but also
along routes from diagnosis. And for some specialised cancer services we
will encourage further consolidation into specialist centres that will
increasingly become responsible for developing networks of supporting
services.

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people’s homes; for example,
a greater role for smaller hospitals and expanded primary care will allow
more chemotherapy to be provided in community. We will also work in
partnership with patient organisations to promote the provision of the
Cancer Recovery Package, to ensure care is coordinated between primary
and acute care, so that patients are assessed and care planned
appropriately. Support and aftercare and end of life care – which improves
patient experience and patient reported outcomes – will all increasingly be
provided in community settings.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>AHSCs</td>
<td>Academic Health Science Centres</td>
</tr>
<tr>
<td>AHSNs</td>
<td>Academic Health Science Networks</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>CCGs</td>
<td>Clinical Commissioning Groups</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CT</td>
<td>Computerised Tomography</td>
</tr>
<tr>
<td>EBITDA</td>
<td>Earnings before interest, taxes, depreciation and amortisation</td>
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<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HEE</td>
<td>Health Education England</td>
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<tr>
<td>IPC</td>
<td>Integrated Personal Commissioning</td>
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<tr>
<td>IVF</td>
<td>In Vitro Fertilisation</td>
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<tr>
<td>LTCs</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>NHS IQ</td>
<td>NHS Improving Quality</td>
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<tr>
<td>NHS TDA</td>
<td>NHS Trust Development Authority</td>
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<td>NIB</td>
<td>National Information Board</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>NIHR</td>
<td>National Institute of Health Research</td>
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<td>PHE</td>
<td>Public Health England</td>
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<td>RCTs</td>
<td>Randomised Controlled Trials</td>
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<tr>
<td>TUC</td>
<td>Trades Union Congress</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td><strong>BOARD OF DIRECTORS</strong></td>
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<tr>
<td>------------------------</td>
<td></td>
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<tr>
<td><strong>Meeting Date and Part:</strong></td>
<td>14 November 2014 - Part 1</td>
</tr>
<tr>
<td><strong>Subject:</strong></td>
<td>Communications activities November 2014</td>
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<tr>
<td><strong>Section:</strong></td>
<td>Information</td>
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<tr>
<td><strong>Executive Director with overall responsibility:</strong></td>
<td>Karen Allman, Director of Human Resources</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Tracey Hall, Head of Communications Jane Bruccoleri-Aitchison, Communications Manager</td>
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<tr>
<td><strong>Previous discussion and/or dissemination:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Action required:</strong></td>
<td>The Board of Directors is asked to: To note the report</td>
</tr>
<tr>
<td><strong>Summary:</strong></td>
<td>The Communications Report provides a summary of key communication and fundraising activities for October, a media coverage summary detailing key performance indicators and the October Core Brief.</td>
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<tr>
<td><strong>Related Strategic Goals/ Objectives:</strong></td>
<td>Access to care Provider of choice</td>
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<td><strong>Relevant CQC Outcome:</strong></td>
<td>Section 1, Outcome 1, Section 4, Outcome 13 and 14</td>
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<td><strong>Risk Profile:</strong></td>
<td></td>
</tr>
<tr>
<td>i. Have any risks been reduced?</td>
<td></td>
</tr>
<tr>
<td>ii. Have any risks been created?</td>
<td></td>
</tr>
<tr>
<td><strong>Reason paper is in Part 2</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
Communications and fundraising activities
November 2014

1. Introduction
The following paper includes:
- communication activity for October
- media coverage summary key performance indicators
- October Core Brief

2. Recent activities

Improvement campaign
A range of communication is being planned to tell our improvement story; where we have made improvements over the past year and recognising the journey we still have to provide excellent care for every patient, every day and everywhere. Material will be shared with the Board and governors over the next few weeks.

New look website
We have updated the homepage on our website to make it more visually appealing and easier to find what you are looking for. Take a look at www.rbch.nhs.uk and let us know what you think at communications@rbch.nhs.uk Thank you to the governors who have been part of the web development group that has been working on these improvements.

Patient Information Assessment
The team has put in a tremendous amount of work throughout September and October to develop our patient information process in response to new criteria set by the Information Standard. Following an assessment at the end of October, initial feedback is that the Trust will receive the Information Standard again; a quality mark which assures all patients that they are receiving high quality information to support their care and treatment.

Christchurch Hospital newsletter
The team continues to support the communication around the Christchurch Hospital development and has produced the latest edition of the Christchurch Newsletter. This has been distributed to staff, patients and visitors and details the latest moves and changes in the hospital. The newsletter has proven very popular and hundreds of extra copies have been produced to meet demand. The newsletter has been promoted via social media and was picked up by the local press.

Discharge planning: Joint communication material has been released with Poole Hospital to promote the alternatives places to access treatment

Staff awards: planning for the staff awards ceremony on 20 November is well underway.

3. Recommendation

The Board is asked to note the report.
Media relations - Key Performance Measures 2014

October saw a very high number of positive articles about our Trust and the work of Bournemouth Hospital Charity both online and in the print media. We also received a number of positive letters from patients about the quality of their care as well as praise on Twitter. There was a high number of media enquiries in October, including requests for interviews regarding pressures on ED and alcohol related hospital admissions, which are ongoing.

Our Twitter followers have now exceeded 1,000 and continue to grow each week.

Each month we send our Focus on Quality bulletin to local media, and this continues to generate positive coverage.

For more information, or to access any of the media coverage the Trust has received, contact communications@rbch.nhs.uk or call 01202 726172.

<table>
<thead>
<tr>
<th>2014</th>
<th>Number of proactive news releases distributed</th>
<th>% that received media coverage in that month</th>
<th>Total PRINT coverage (includes adverts)</th>
<th>Total OTHER coverage (online, radio, TV)</th>
<th>Positive media coverage</th>
<th>Neutral media coverage</th>
<th>Negative media coverage</th>
<th>Advertising value (for print coverage) <em>/</em>*</th>
<th>Media enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>11 (including pressures on ED, Light up the Prom and staff member who donated stem cells)</td>
<td>91%</td>
<td>25</td>
<td>13</td>
<td>28</td>
<td>10</td>
<td>0</td>
<td>£52,041 (including ebola, strike action, ED pressures and Christchurch development)</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>8 (including update on XCH works, Pedal Power and a patient turning 105)</td>
<td>75%</td>
<td>27</td>
<td>7</td>
<td>24</td>
<td>10</td>
<td>0</td>
<td>£42,697 (including CQC follow up inspection and catering options for staff)</td>
<td></td>
</tr>
</tbody>
</table>

* Any paid for adverts are not included i.e. advertorials ** Negative articles are not included
Our bid to get as many members of staff vaccinated against the flu virus is well underway.

We have launched our ‘You vs Flu’ initiative which has already seen more than 900 staff at our hospitals given the free immunisation.

Our dedicated team have been primarily targeting patient-facing members of staff in wards and departments during the opening few weeks of the campaign, but the jab is available to anyone working in the Trust that wants it.

We have an official ‘jab-o-meter’ on our intranet page that is being used to give us a running tally of how many people are making the most of the opportunity to fight the flu.

There are many myths and negative preconceptions around having the flu jab, with the majority untrue. Here are a few myths put to bed:

• Does the flu jab make you ill?
  It is impossible to get flu from having the flu jab because the vaccine doesn’t contain live viruses

• What are the side effects of the flu vaccination?
  The seasonal flu vaccine side effects are mild or often non-existent. The most common side effect is soreness around the site of the injection and occasionally aching muscles. These symptoms are a lot less serious than having flu.

• Is the vaccine safe?
  Seasonal flu vaccine is given to millions of people in the UK each year and is one of the safest in the world.

• Can anyone get the flu?
  One of the most common reasons for not getting vaccinated is “I have never had flu before”. There’s no such thing as natural immunity to influenza; with new strains circulating this year, it’s best to get vaccinated.
Consultant for Elderly Care Divya Tiwari: "I get my flu jab regularly every year as I am in constant contact with patients and more prone to getting the virus. It is vital we all get vaccinated."

A Care Plan Review Group has been established to take forward your comments to create the next version of the document. This is running alongside the formation of the electronic nursing assessments (eNA) which will include:

- 1 patient handling
- falls
- bed rails
- VTE
- waterlow
- MUST
- dementia screening

The care plan will be shorter and focused on care assessment, planning, intervention and evaluation, and is due to be launched alongside the eNA.

Your ward sister/charge nurse will be receiving a copy of the current version of the document for you to view. We have already incorporated feedback from some frontline staff and want your help to shape the care plan to be what it needs to be.

You can also give your feedback to members of the Review Group, chaired by Ellen Bull, Deputy Director of Nursing, by visiting a stand situated between the restaurants at RBH from 11.30am-2pm on:
- 17 October
- 31 October
- 14 November

If you have any queries or comments please contact IT specialist nurses Lisa Brinkman or Tracey Cooper on ext. 4980 or email lisa.brinkman@rbch.nhs.uk or tracey.cooper@rbch.nhs.uk

Remember: so many of us come into contact with patients so please help protect them from flu and protect yourself, your colleagues and your family too.

Chief Executive Tony Spotswood: "The vaccination offers protection to staff and patients - it is all of our responsibility to get the jab."

Remember managers (or others) can book a specified time when they would like their teams to be visited, and walk-in sessions are also being organised.

Everyone who has the jab will be entered into a free prize draw, with the top prize of an iPad Mini, and will receive a hot drinks token.

If you would like to arrange a specific time for us to visit, please email occupational.health@rbch.nhs.uk

You can also contact us via mobile on 07920 490427 but please bear in mind that reception is very patchy in the main building.

Your document, your say
The 14 day Patient Care Plan is being reviewed
As an NHS employee, you know that the NHS faces significant challenges. Here in Dorset there are three reasons for this:

1. **changes to Dorset’s population** - an increase in the over 65’s and under 20’s in the next 10 years
2. **clinical challenges** - availability of staff and skills to meet quality standards and targets
3. **financial pressures** - budget deficit could lead to a shortfall of £167m by 2020

This means we now need to start looking at how we provide services in the future.

To prepare Dorset’s NHS for these challenges and evolve services into a robust health care system for the future, NHS Dorset Clinical Commissioning Group (CCG) is going to review local care services to explore what is working well and what can be improved.

This project is called Dorset’s Clinical Services Review and is supported by all local GPs, NHS trusts, local authorities, NHS England, Monitor and Healthwatch Dorset.

The review comprises three stages:

**Stage one:**
Design - a review of current services and the creation of a blueprint for future services that will clearly state what changes are proposed.

**Stage two:**
Consult - a public consultation so people can have their say on any changes proposed.

**Stage three:**
Implement - delivery of any agreed changes.

Stage one will run from October 2014 to spring 2015.

On Wednesday 22 October, NHS Dorset CCG will be holding a free public event at the BIC’s Tregonwell Hall in Bournemouth to explain how and why local services will be reviewed. You may read about this event in your local paper over the next few weeks.

This initial event is primarily for the general public, but a limited number of spaces are available for staff. If you are interested in attending, please visit: www.dorsetccg.nhs.uk or email involve@dorsetccg.nhs.uk to book your place. Please let your family, friends and neighbours know so they can come along too.

Working with our providers, we hope to run staff briefings across Dorset in the next six months to explain the review in more detail. More information will follow in your regular staff communication channels.

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**Gastroenterologists seven day service**

Our team of eight gastroenterologists is now offering a seven day service aimed at providing earlier clinical decision making, resulting in an earlier discharge, reduced length of stay and all round improved patient experience.

At weekends and bank holidays they will review gastroenterology patients on the Acute Admissions Unit and Ward 1, and to support this, the Endoscopy Team will be on call in the morning to provide an inpatient list.

If you have a patient on your ward that requires a non-urgent endoscopy on a Saturday, Sunday or bank holiday, a referral should be taken to Ward 1 and placed on the clipboard by 9.30am.
Changes to staff car parking at RBH

- Public pay-on-foot parking
- Later arrival (after 11.30am) car park and volunteer parking
- Main staff permits
- Jigsaw Building construction site
- Occasional staff permits - pay-on-foot
- Entry/Exit barriers

Staff car parking entrance and exit

Site of Jigsaw Building

Multi storey
Changes to staff car parking at RBH

From 10 November, staff and public parking at RBH will be physically divided by a barrier and staff will only be able to enter the secured staff parking areas via the rear service road.

The changes are to ensure that spaces allocated to permit holders can only be used by staff members, rather than the public. The changes will also ensure we continue to comply with the council’s planning regulations about the number and type of spaces we provide.

When parking, please make sure you only park in the designated car parks or pay the full tariff in the pay-on-foot public car parks. Please do not park at the detriment of patients - for example in disabled parking or drop off areas.

Please ensure you display your permit clearly in your windscreen to avoid being delayed when entering the site. A £40 parking charge notice may be given out to those parking incorrectly or without a permit.

Exiting the site via the front road

To leave the site via the front road, drive into the Occasional Car Park (marked dark blue on the map), collect a free ticket at the barrier, drive through public car park D and C by the Eye Unit and exit through the next barrier by inserting your ticket. You will have 20 minutes to do this. When there is congestion, the barriers will be lifted.

Occasional staff car park

The occasional staff car park is moving to the former gravel car park. This will be a pay-on-foot car park and permit holders can pay for their daily tickets at a pay station which will accept card, coins and notes and will also give change.

Later arrival car park

A car park for staff who arrive after 11.30am will be located at the rear of the multi-storey and be controlled by an electronic barrier which will only open after that time. This will free up more parking on the ground floor of the multi-storey for main permit holders. Staff permit parking holders arriving for late/night shifts should find ample parking in the multi-storey car park.

Volunteer parking

Volunteers can park in the later arrival car park at any time.

What happens if there is congestion when trying to leave the site?

If heavy traffic starts to build, all barriers will be raised.

How do I contact CP Plus?

CP Plus are on site until 9pm. They can be reached by calling 01202 303626 ext 5894 and by pressing the 24-hour ‘help’ button on the parking payment machines and electronic barriers.

How will staff be supported with the changes?

Parking attendants will be on hand to direct staff in the first few days and signs will be installed onsite before the changeover. The Travelwise pages on the intranet will also be updated to keep staff aware of the changes.

Contact us

For more information about the changes, please contact travelwise@rbch.nhs.uk

Flyers are being distributed to staff and the information is also available on the Travelwise pages on the intranet. If you would like extra copies of the flyer, please contact communications@rbch.nhs.uk
Pan-Dorset Pressure Ulcer Strategy launch

Pressure ulcers can cause serious pain and severe harm to patients and cost the NHS billions of pounds each year to treat, yet in the majority of cases they can be prevented if simple measures are followed.

It is important that local health, social care and communities work together to develop a consistent approach to prevention, identification and treatment for the benefit of local people.

In order to make this happen, local partners have been working on a Pan-Dorset Prevention and Management of Pressure Ulcer Strategy for all care providers. This has now been completed and we would like to invite you to the launch event:

**Pan-Dorset Pressure Ulcer Strategy launch**

Bovington Business and Conference Centre, Wareham.
Friday 21 November
Coffee from 9am. Presentations start 9.30am.
Close 12.30pm

The event will be relevant for everyone involved in health and social care throughout Dorset and will include presentations from a range of organisations including the CCG, NHS England and the local ambulance service.

If you have any questions or would like to reserve a place please contact 01305 368064 or email Quality Admin@DorsetCCG.nhs.uk

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Patient information workshop

**Tuesday 18 November**

Information is an important part of the patient journey and central to each patient’s experience. The process for producing and approving patient information aims to raise the standard of information we provide to those who use our services and to ensure consistent quality.

To ensure we continue to provide high quality information for our patients, all patient information, including leaflets, films, and web-based material need to be approved by the Patient Information Group. Last year we received the national Information Standard accreditation for the high standard of our work.

To maintain our accreditation we need to ensure all our information meets governance requirements and best practice in supporting the patient experience.

To find out about the process and how to produce good quality information, you can attend our patient information workshop on **Tuesday 18 November** in the lecture theatre at RBH between 9-10am.

To book a place, please contact Georgie McMahon on ext. 4271 or email Georgina.mcmahon@rbch.nhs.uk

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**The League of Friends Christmas Fayre**

Start your Christmas shopping early by coming along to The League of Friends Christmas Fayre on Saturday 15 November.

The event will take place in the atrium at RBH between 2-4pm.

The League of Friends counter will be open along with a wide range of stalls selling cakes and homemade gifts. There will also be lots to get involved in such as tombolas and various other events.

All the money raised will go towards providing extra equipment and comforts for patients and staff.
Patients empowered to stay well-nourished and hydrated

A new food and drink leaflet has been produced by our Clinical Nutrition and Dietetics Team aimed at informing patients of how important it is to keep hydrated and eat well during their hospital stay.

The leaflet highlights the dangers of malnutrition and dehydration, and features helpful tips on avoiding these conditions. The guide also includes information on how to order meals, the types of food available if there are specific dietary requirements or religious preferences, as well as other helpful details on food. The publication is available on the intranet for all ward sisters and charge nurses to print and hand to patients once they are admitted to a ward.

Clinical Nutrition Specialist Practitioner, Susan Harding, said: “It is vital patients are informed about nutrition and hydration at the earliest stage of their hospital stay. Through this leaflet we can help reduce the risks of patients developing things like kidney injuries and pressure ulcers, and inevitably lead to an earlier discharge.”

Celebrating our stars

Each month we will be announcing five stars, nominated by you, who have been living our values and working towards our vision of delivering excellent care for every patient, every day, everywhere.

Each winner receives a £50 high street gift voucher. Here are the winners for August and September:

August:
- Claudia Tonetto, Endoscopy admin office
- Jane Woodruff, Housekeeping
- Anne-Marie Lacey, Nurse Practitioner, Ophthalmology

September:
- Ward 10 team
- Bridget Benwell, Post Porter
- Julia Knott, Secretary, BDEC
- Marion Hunter, Endoscopy
- Alison Evans, Occupational Health

References

If you do not eat or drink enough your recovery from illness and length of stay in hospital may be impaired. If you do not eat or drink enough and to report any concerns to your nursing and medical team.

Lack of food - malnutrition can cause:
- Increased risk of illness and infection
- Slower wound healing
- Increased risk of falls
- Difficulty keeping warm
- Low mood

How will my food and fluid needs be assessed?

We use an electronic system to order food / meals, through using a bedside TV. You will be shown how to use this and assisted throughout your stay. We use a red crockery system for people who need assistance or feeding. Modified eating/drinking set will be prepared.

We have specials menus available. These include Halal, kosher, vegetarian, gluten free, puree, finger foods and fork mashable.

Our gluten free products include:

Our department is also part of The Royal Bournemouth Hospital Organ Donation Programme. We support the campaign in various ways: we promote organ donation and encourage patients to indicate their donation wishes on their patient record, we promote the topic to patients in the ward environment, we provide literature to patients and staff, we promote events such as the Donor Memorial Service and the World Organ Donation Day.

We can supply this information in other formats, in larger print, on audiotape, or have it translated for you. Please call the Patient Advice and Liaison Service (PALS) on 01202 704886.

Please contact the author if you would like details of the evidence in the production of this leaflet.

Please note there are no facilities on the ward to heat food. Food can be brought in from home, please check with ward staff to ensure its suitability.

You should aim to eat three meals a day and two snacks. Eat well, get better.

How do I keep hydrated?

Water is the most important fluid for your body. When you are dehydrated (lack of fluid/drinks) you may feel:
- Thirst/ Extreme thirst
- Dry, sticky mouth and skin
- Sunken eyes
- Rapid heartbeat
- Headache
- Feeling dizzy/light headedness
- Risk of falls
- Difficulty concentrating

We have drinking cups and modified mugs available on the ward. You may find more comfortable to use a drinking straw, instruction otherwise by your doctor. We have modified drinking cups / mugs which can be helpful if you have difficulty using a straw.

We can provide large print labels. If you need assistance, please let your nursing staff know.

The team from Ward 10 is presented with their golden envelope

Claudia Tonetto from the Endoscopy admin office receives her award

Ophthalmology
New televisions for coronary care patients

Patients cared for in our Coronary Care Unit (CCU) can now recover in more comfort with the recent installation of flat screen televisions.

Unlike many of the ward environments around the hospital, CCU has not had the benefit of Hospedia media screens. In this specialist environment where patients are critically unwell, any additional equipment around the bed space creates a cluttered environment and adds to the infection control risk.

The new televisions have been suspended from the ceiling above each bed space, meaning they are above head height so there is no risk of having to move additional equipment out of the way in an emergency. The television service is also provided free to patients.

Charge Nurse Andy Humphreys says: “The televisions have been funded from patient donations so it feels really good to be able to do something that directly benefits them. We also felt it was really important to be able to provide a free television service for critically unwell patients.

“The feedback so far has been great - with one patient describing the feeling as ‘euphoria’ at having a free television to watch.”

Let’s talk about IT

IT improvement

A performance issue with Open CaMIS (PMS) has been identified by various staff members. The IT Department is investigating and monitoring the causes of the slowdown that Open CaMIS sometimes encounters around 11am-12.30pm.

This process will help IT in collaboration with Ascribe, the developers of Open CaMIS, to identify the underlying causes and then seek a resolution.

As part of this process if you encounter performance issues with CaMIS, please email joel.bryant@rbch.nhs.uk with the following details:

- your name
- your location within the Trust
- which menu item you are using such as PMI or OPS
- length of delay you are encountering and/or any error messages
- if you are also using eCaMIS, whether you are encountering similar performance issues

Health Application Platform (HAP)

IT will start to roll out the Health Application Platform (HAP) this month.

Your login details are your eCaMIS username and your password will be emailed to you. You will be prompted to change this password when you first login and you need to make it the same as your current eCaMIS password.

The layout of the screen is different, but everything else is the same.

An attachment will be sent to you in order to access HAP detailing the changes in the screen layout, but if you have any issues please email Claire.Dolby@rbch.nhs.uk.
Electronic Document Management (eDM) training for doctors

Electronic Document Management (eDM) is growing ever closer and we are running regular training sessions which will enable you to navigate through the Evolve software in the most efficient way.

The roll out will begin later in 2014 and continue into next year, and in order to prepare and support all staff during this transition, IT Training will be offering sessions on how to use Evolve.

We strongly recommend that all staff attend a training session to ensure they are confident in using the system and can efficiently find the information they require from the case notes.

The training will last approximately 90 minutes and include plenty of practice on the following topics:

- finding patients
- locating electronic pages quickly
- keyword searches

Some staff will also need additional functionality which will include:

- using bookmarks and favourites
- using help
- annotations
- creating summary/research notes

Training is scheduled from Monday-Friday between 8.30am-5pm. Dates are published on the ESR Manager Self Service. Places are limited so must be booked. Dates are also available on the intranet at http://nwww.ittraining.poole.nhs.uk/Main.aspx

Bed Management system

This has successfully been piloted on wards 17, 18, 25 and 26.

We have now placed new patient flags for the electronic white boards, and we hope to have the whole Trust live with Bed Management by the end of the year.
**BOARD OF DIRECTORS**

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>14 November 2014  Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Corporate Events Calendar</td>
</tr>
<tr>
<td>Section:</td>
<td>Information</td>
</tr>
<tr>
<td>Executive Director with overall responsibility</td>
<td>Tony Spotswood, Chief Executive</td>
</tr>
<tr>
<td>Author(s):</td>
<td>Georgina McMahon, Communications Officer</td>
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**Previous discussion and/or dissemination:** N/a

**Action required:**
To note for information

**Summary:**
Corporate Events arranged until December 2014

**Related Strategic Goals/ Objectives:** All

**Relevant CQC Outcome:** N/a

**Risk Profile:**
1. Have any risks been reduced? No
2. Have any risks been created? No

**Reason paper is in Part 2** N/A
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<td>Patient Experience Audit – Stroke Out Reach</td>
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<td>On-going</td>
<td>Patient Experience Audit – Orthopaedic Therapy Services</td>
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<td>N/A</td>
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<tr>
<td>Saturday 6 September All Day</td>
<td>Volunteer Annual Reception</td>
<td>Marquee by the hospital lake</td>
<td>01202 704161 By invitation only</td>
</tr>
<tr>
<td>Monday 8 September</td>
<td>Values Afternoon Tea</td>
<td>Royal Bournemouth Hospital</td>
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<td>Meal Time Companion Training</td>
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<td>Understanding Arthritis Health Talk</td>
<td>The Village Hotel, Deansleigh Road, Bournemouth BH7 7DZ</td>
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<td>Wednesday 24 September</td>
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<td>Sunday 28 September</td>
<td>Pedal Power (Charity Bike Ride)</td>
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<td>Council of Governors' Meeting</td>
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<td>Muslim Sisters</td>
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<td>Meal Time Companion Training</td>
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<td>Disability Forum</td>
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<td>Boscombe 10k</td>
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<td>Tree of Lights</td>
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## CORPORATE EVENTS CALENDAR 2015

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<td>Monday 23 February</td>
<td>Understanding Stroke</td>
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<td>Monday 11 May</td>
<td>Understanding Dermatology</td>
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<td>Monday 21 September</td>
<td>Understanding Diabetes</td>
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<td>Friday 4 December (TBC)</td>
<td>Understanding Knee Pain</td>
<td>The Village Hotel</td>
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**Key**

- Surveys and audits
- Meetings
- Volunteer events
- Health and other talks
- Stakeholder groups, events and forums
- Stands at local/community events
- Bournemouth Hospital Charity events
- Staff Events
- Other activities/events
## BOARD OF DIRECTORS

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<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>14 November 2014  Part 1</th>
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<td>Subject:</td>
<td>Directors Forward Programme</td>
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<tr>
<td>Section:</td>
<td>Information</td>
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<tr>
<td>Executive Director with overall responsibility</td>
<td>Tony Spotswood, Chief Executive</td>
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<tr>
<td>Author(s):</td>
<td>James Bufford, Interim Trust Secretary</td>
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<td>Previous discussion and/or dissemination:</td>
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<td>Action required:</td>
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**Summary:**
Update of the Board of Directors Forward Programme

**Related Strategic Goals/Objectives:**
All

**Relevant CQC Outcome:**

**Risk Profile:**
- Have any risks been reduced? No
- Have any risks been created? No

**Reason paper is in Part 2**
N/A
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<th>Mar</th>
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<th>Jun</th>
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**Staff**

| Pride Awards Nominations - Chairman's Prize                          | RR Awards Panel      |              |     |     |     |     |     |     |     |     |     |     |     | Pride Awards |
| Staff Survey - Results                                               | KA Workforce         | Part 1       |     |     |     |     |     |     |     |     |     |     |     | CoG         |
| Local Clinical Excellence Awards                                     | MA Remuneration      |              |     |     |     |     |     |     |     |     |     |     |     | Rem Com     |
| Local Clinical Excellence Awards - Annual Report                     | MA Remuneration      |              |     |     |     |     |     |     |     |     |     |     |     | N/A         |

**Governance**

| Register of interests                                                | KF Trust Secretary   |              | Part 1 |       |       |       |       |       |       |       |       | Trust Secretary |
| Constitutional Documents - Annual Review                             | KF Constitution Ctte |              |       |       |       |       |       |       |       |       |       |       | Monitor     |
| Code of Governance Disclosure Statement                              | KF Trust Secretary   |              |       |       |       |       |       |       |       |       |       | Monitor     |
| Meeting Dates for Next Year                                         | KF Trust Secretary   |              |       |       |       |       |       |       |       |       |       | Part 1 | N/A         |
| NHS Constitution - Bi-annual Self-Assessment                        | KF Trust Secretary   |              |       |       |       |       |       |       |       |       |       | Part 1 | PCT         |
| Annual IG Briefing                                                  | KF HAC               |              |       |       |       |       |       |       |       |       |       | Part 1 | HSCIC       |
| IG Toolkit                                                          | KF HAC               |              |       |       |       |       |       |       |       |       |       | Part 1 | HSCIC       |
| Results of Governor Elections                                       | KF External          |              |       |       |       |       |       |       |       |       |       |       | AMM         |
| Annual Members’ Meeting                                             | CoG N/A              |              |       |       |       |       |       |       |       |       | 24th  |       | N/A         |
| Seasonal Plan                                                       | CoO N/A              |              |       |       |       |       |       |       |       |       |       | Part 1 | PCT/SHA     |
| Board Performance                                                   | JS N/A               |              |       |       |       |       |       |       |       |       |       |       | CoG         |

**Minutes of Board Committees and other groups**

| Audit Committee                                                     | Ctte Audit           |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Charitable Funds Committee                                          | Ctte Charitable Funds |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Council of Governors                                                | K F CoG              |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Finance Committee (including Christchurch Steering Board)           | Ctte Finance         |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Healthcare Assurance Committee                                       | Ctte HAC             |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Infection Prevention and Control Committee                           | Ctte Infection Control |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Patient Experience and Communications Committee                     | Ctte PEC             |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Remuneration Committee                                              | Ctte Remuneration    |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Trust Management Board                                              | Ctte TMB             |              |       |       |       |       |       |       |       |       |       |       | N/A          |
| Workforce Strategy and Development Committee                        | Ctte Workforce       |              |       |       |       |       |       |       |       |       |       |       | N/A          |

**Review Performance & Terms of Reference subordinate Groups**

| Audit Committee                                                     | SP Audit             |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Charitable Funds Committee                                          | KT Charitable Funds  |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Finance Committee                                                   | SH Finance           |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Healthcare Assurance Committee                                      | PS HAC               |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Infection Prevention and Control Committee                           | PS Infection Control |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Patient Experience and Communications Committee                     | RR PEC               |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Remuneration Committee                                              | SC Remuneration      |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Trust Management Board                                              | TS TMB               |              |       |       |       |       |       |       |       |       |       |       | File - KF   |
| Workforce Strategy and Development Committee                        | KA Workforce         |              |       |       |       |       |       |       |       |       |       |       | File - KF   |

**Communications**

| Dr Foster Hospital Guide                                           | RR TMB               | Part 1       |     |     |     |     |     |     |     |     |     |     | N/A          |
| Corporate Events Calendar                                          | KF N/A               |              |     |     |     |     |     |     |     |     |     |     | N/A          |
| Communications Update including Core Brief                         | RR Service Development |              |     |     |     |     |     |     |     |     |     |     | N/A          |