

A meeting of the Board of Directors will be held on **Friday 24 April 2015** at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**.

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

SARAH ANDERSON  
TRUST SECRETARY

## A G E N D A

TIMINGS				APPENDIX
	<b>1. APOLOGIES FOR ABSENCE</b>			
	<b>2. DECLARATIONS OF INTEREST</b>			
<b>8.30-8.35</b>	<b>3. MINUTES OF THE PREVIOUS MEETING</b>			
	(a) To approve the minutes of the meeting held on Friday 27 March 2015			A
	<b>4. MATTERS ARISING</b>			
<b>8.35-8.40</b>	(a) Update to Actions Log		All	B
<b>8.40-9.00</b>	<b>5. QUALITY IMPROVEMENT</b>			
	(a) Patient Story	Paula Shobbrook Claire Mills		Verbal
	(b) Feedback from Staff Governors	Jane Stichbury		Verbal
<b>9.00-9.55</b>	<b>6. PERFORMANCE</b>			
	(a) Performance Exception Report	Richard Renaut		C
	(b) Quality Report	Paula Shobbrook		D
	(c) Financial Performance	Stuart Hunter		E
	(d) Workforce Report	Karen Allman		F
<b>9.55-10.15</b>	<b>7. STRATEGY AND RISK</b>			
	(a) Clinical Services Review	Tony Spotswood		Verbal
	<b>8. DECISION</b>			
	(a) No items			
<b>10.15-10.25</b>	<b>9. INFORMATION</b>			
	(b) CQC Guidance for providers on meeting the regulations	Paula Shobbrook		G
	<ul style="list-style-type: none"> <li>• requirement to display CQC ratings</li> <li>• Duty of candour</li> <li>• Fit and proper persons requirement for directors</li> </ul>			
	(c) Policy for Visitors in Clinical Areas	Paula Shobbrook		Verbal
	(d) Communications Update (including April Core	Karen Allman		H

Brief)

- |  |                       |   |
|--|-----------------------|---|
| (e) Corporate Events Calendar            | <i>Sarah Anderson</i> | I |
| (f) Board of Directors Forward Programme | <i>Sarah Anderson</i> | J |

**10. NEXT MEETING**

Friday 29 May 2015 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

10.25-10.30

**11. ANY OTHER BUSINESS**

Key Points for Communication to Staff

10.30-10.45

**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 27 March 2015** in the Committee Room, Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairman (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Stuart Hunter	(SH)	<i>Director of Finance</i>
	Ian Metcalfe	(IM)	<i>Non-Executive Director</i>
	Steven Peacock	(SP)	<i>Non-Executive Director</i>
	Alex Pike	(AP)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Sarah Anderson	(SA)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Jane Bruccoleri-Aitchison	(JB-A)	<i>Communications Officer</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Lisa Lee	(LL)	<i>Matron, Orthopaedics</i>
	Derek Chaffey	(DC)	<i>Public Governor</i>
	Eric Fisher	(EF)	<i>Public Governor</i>
	Bob Gee	(BG)	<i>Public Governor</i>
	Paul Higgs	(PH)	<i>Public Governor</i>
	Paul McMillan	(PM)	<i>Public Governor</i>
	Roger Parsons	(RP)	<i>Public Governor</i>
	Colin Pipe	(CP)	<i>Public Governor</i>
	David Triplow	(DT)	<i>Public Governor</i>
	Brian Young	(BYo)	<i>Public Governor</i>
	Keith Mitchell	(KM)	<i>Public Governor</i>
	David Bellamy	(DB)	<i>Public Governor</i>
	Graham Swetman	(GS)	<i>Public Governor</i>
	Margaret Neville		<i>Chairman of the Friends of the Eye Unit</i>
	David Sidwick		<i>Member of Public</i>
	Sharon Carr Brown		<i>Member of Public</i>
Apologies:	David Bennett, Non-Executive Director		
	Derek Dundas, Non-Executive Directors		
	Basil Fozard, Medical Director		
	Bill Yardley, Non-Executive Director		

21/15      **DECLARATIONS OF INTEREST**

None.

22/15 **MINUTES OF THE MEETING HELD ON 27 FEBRUARY 2015 (Appendix A)**

The minutes of the meeting on 27 February 2015 were approved as an accurate record.

23/15 **MATTERS ARISING (ACTIONS LOG UPDATE) (Appendix B)**

The action log was discussed and updated.

24/15 **QUALITY IMPROVEMENT**

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

LL presented the patient story regarding patient feedback from the Derwent ward. 90% of patient experience cards and thank you letters are very positive. Negative feedback concerned cold food served to patients. This was due to the logistics of the ward and a change in the delivery process which had caused problems with maintaining food temperatures.

In response to the feedback dieticians, risk management and catering were involved to ensure there was an overview of the inherent challenges and regular meetings were held to resolve the issue. Infection control concerns arose when considering bringing plated hot food through Pathology however, following assessments this has now been trialled for three months from December 2014 and positive comments have increased. This will continue to be monitored to ensure it is consistent.

IM queried how the Trust monitors the nutrition of the meals provided. LL commented that food intake is monitored on an individual basis and dieticians are involved if necessary. PS added that pre assessments identify whether additional support is required.

The Board noted that the catering department were keen to ensure a variety of food is available and that it was important to feedback RR comments to support improvements.

SP raised concern about food nutrition levels and suggested looking to best practice options and identifying a successful option to PS implement. The Board proposed that this should be explored.

**(b) Feedback from Staff Governors (Verbal)**

JS outlined the key themes which included;

- A question time event is being run by staff governors who are seeking ideas and themes;

- Staff are encouraged by the new appraisal process and the Trust values. Some aspects have been considered as lengthy but overall staff are enthusiastic;
- The use of 'corporate speak' needed to be addressed to ensure all staff understand the language used;
- Staff governors could not understand the issue of staff violence arising from the staff survey and requested more information;
- Staff governors are relishing their important role and involvement with staff and communication links overall.

The issue with language was discussed and concerned the use of corporate terminology being difficult to understand for some staff particularly where English was not their first language. PS noted that classes and support are being provided.

**(c) "Freedom to Speak Up Review" (Appendix C)**

PS outlined that the Trust is currently developing an action plan with executive leads which will be brought to the Healthcare Assurance Committee (HAC) and Board. The appointment of a 'freedom to speak up' guardian is being considered who will be trained to deal with safety issues. JS proposed that both non- executives and executives should be identified to lead on this area. PS/ Board

It was discussed that staff were reflecting the type of culture described and that issues were being voiced more frequently without blame. The increase in reporting of incidents was reflective of the cultural change within the Trust.

KA noted that the FFT data from staff had been encouraging and more are able to voice concerns. KA is due to attend the audit committee to discuss the whistleblowing policy.

It was noted that it was important to ensure there was a system in place for staff to raise concerns. The Board were asked to accept the cultural principles formally and confirmed **endorsement** of the principles.

25/15

**PERFORMANCE**

**(a) Performance Exception Report (Appendix D)**

RR outlined the performance exception target data noting the following key information:

- 4 hour performance for March was 96.9% and is the Trust's best performance for some time with similar levels of activity;
- 2 week cancer targets were on track for an improved position

but there are a small number of patients missing the target. The key concerns relate to staffing and the overall tracking of patients;

- Admitted RTT performance is back on track;
- Non admitted RTT is predicted to be breached until the backlog has been addressed;
- Over the Easter and May bank holiday periods there are expected to be spikes in demand and the Trust has a range of actions prepared to address activity levels;
- Norovirus is in the community and presents enhanced risks for the Trust and is currently being managed.

It was queried how teams had improved performance. RR advised that teams had focused on activity levels and were being proactive with best practice. A 'PDSA' approach was being used with regular feedback and sight of the impact that changes were making. This has also increased staff morale.

The Board discussed cancer performance targets and that it will be important to consider resilience and being able to cope with a rise in demands. The tracking of patients at this stage is an area of focus. RR assured that overall cancer pathways are performing well however there are particular areas that require focus due to capacity issues and diagnostics in GI pathways. Endoscopy processes are currently being reviewed. The Board noted the impact of campaigns and that patient choice was also a factor. RR added that some patients were taking longer to consider treatment later into their pathways.

The Board recognised progress in the 4 hour ED performance and emphasised that activity levels could not be assumed. It was suggested that the learning from ED performance should be used in other areas and regular feedback should be provided on the progress made. RR

**(b) Stroke Performance Update (SSNAP) (Appendix E)**

- SSNAP – there is confidence the Trust will achieve 60% this quarter;
- There is a level of detail and focus on what is needed to achieve the next level of performance with sustained progress overall. This will be done on a weekly basis by the team;
- The stroke outreach service is being developed which will help to achieve the targeted performance levels and progress is being seen on the indicators.

RR noted that there had been an improvement in the 1 hour scanning process and that the data did not incorporate the impact of the

outreach team yet.

The Board queried the impact that an additional scanner would have upon performance. RR added that this was under consideration due to resources and the need to sign off the Trust's budget. The Board noted the importance of considering the business case and that this was an issue to return to. TS commented on moving the cancer service and standards forward and important to achieve both.

The Board discussed that there should be further monitoring of scanning for stroke with clearer milestones in terms of improvements. RR The Board **agreed** to adopt the action plan.

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

PS outlined the following key information from the report:

- Increase in serious incidents over the last 4 months;
- Relatives have been invited to panel meetings which caused delays when identifying dates to attend, but overall had been positive;
- Increase in falls, pressure damage this month which are being investigated;
- Performing above 97% for risk assessment compliance;
- Patient experience data remains strong with 3,000 cards being returned;
- There is a continued focus on pressure damage and falls and this is being monitored through HAC.

The non-compliance in two ward areas was queried. PS confirmed that additional focus and support had been provided and it was expected to improve within the next month.

The 80% score for MUST was queried. PS commented that scores were dropping where patients are moved and reassessed. The Trust is developing an electronic assessment tool to improve the process. Documentation is also being made clearer to ensure it is completed. It is hoped by quarter 2 it will be compliant.

Pressure ulcer damage and how the Trust is going to improve avoidable pressure ulcers was raised. PS responded that the demographics of patients admitted to the Trust with pressure ulcer damage is higher than other Trusts when compared nationally. The Trust has also received assurance that the right processes are in place and numbers have decreased from last year but there is a continued focus on improvement. TS suggested approaching the CCG to improve care in care homes to help reduce the number of patients admitted with existing issues.

The Board agreed that it was not acceptable and the Trust needed to develop better practices and collaborate with other organisations to look to improve care in the community. They recognised the challenges but that there had been good patient feedback and thanked staff for the positive FFT results.

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

SH advised that pressures continued and that February had been a particularly expensive month. The Trust is £4.8 million off the revised plan with little flexibility to achieve it. It was acknowledged that national funding had been cut by half a million pounds and that assurance from NHSE had been provided that the CCG would address this.

It is expected that in relation to the Trust's budget next year there will be a significant deficit. SH emphasised that there must be a clear message from the Board about stabilising the deficit as it is increasing and this will be important going into the CSR.

The Finance Committee had noted that the Trust needed to consider how to manage its resources now. It was emphasised by the Board that the focus on quality was not being overlooked in light of financial resources.

**(e) (i) Nurse Staffing Report 'Hard Truths NHS England Compliance' (Appendix H)**

PS outlined the monthly return for the Trust highlighting:

- Staffing reviews- surgery skill mix has been changed;
- AMU – increase in Band 6 nurses to provide a greater number of higher skilled staff;
- Ward 3- areas of challenge over the last month but further band 6/7 nurses have been added;
- It is the Matrons responsibility for swapping staff and to provide safe staffing levels;
- Internal reviews- staff are able to describe staffing levels and what is being done to mitigate issues on wards;
- NHS is providing guidance for Trusts to audit care contact time with patients. The Trust is working through the methodology and this will be brought back to Board to consider before it is implemented.

SP recognised improvements from last year and questioned whether there was the right skill mix of staff in place in light of the difficulties in managing pressure ulcer damage. He further queried whether staff were being provided with enough opportunities. PS advised that



nurses are being moved around different areas to provide variety and rotational posts are being introduced to ensure moves are more planned. Exit interview data is being reviewed and the Trust is working to bring back people to work in the organisation.

**(ii) Workforce Report (Appendix H)**

The Board acknowledged it was a difficult time for the Trust with national shortages however it is working to support staff in their roles and with recruitment.

The new appraisal process was receiving positive feedback from the training along with BEAT and the virtual learning environment. KA confirmed that the trajectories requested were provided in the information pack and will be monitored by the workforce committee. The trajectories for mandatory training are for each care group to achieve 95 % by the September period. The Board requested targets were set at 100% compliance for mandatory training and appraisals for eligible staff.

The recruitment event at Bournemouth University had been positive. A newly qualified open day will occur on 16 May and following overseas recruitment there are 12 prospective candidates.

**(f) Staff Survey Results (Presentation)**

KA advised that the survey was national across the NHS and was sent to a random selection of staff. It is to be considered whether the Trust will send it to every member of staff in the future. There had been a lower response rate this year but was still significant. The following points were highlighted:

- CQC report raised some concerns amongst staff but more staff reporting errors and near misses reflecting a better reporting culture;
- Fewer staff feel pressured at work and are working less additional hours;
- Staff are more secure about raising concerns for clinical practice;
- Weaker areas concerned physical violence from colleagues and the Trust is looking to work with Trade Unions on this issue;
- More staff are attending work feeling unwell;
- Health and safety training attendance was low and this may be linked to mandatory training;
- Reduction in experiences of harassment and bullying;
- Caring for patients and service users is a high priority amongst

- staff;
- Percentage of staff reporting good communication with senior managers has decreased.

The key priorities following the survey include: action to be taken with regard to the reported staff experiencing violence and for care groups to receive the data relevant to individual areas. It was also noted that the improvement training programme is due to be launched and this will increase the opportunities for staff to be more involved.

SP requested that areas of concern were brought back and measured by Board. AP emphasised that the Board needs to demonstrate that there is a zero tolerance approach to violence within the organisation.

PG commented upon the staff sampling and encouraging staff engagement. He suggested this should form part of staff appraisals.

The Board proposed that a clear action plan was produced. KA noted this will be monitored by the workforce committee and would be brought back in May. There was a strong agreement that the issue of staff violence should be addressed with more detailed information KA provided to Board. KA confirmed the slides would be circulated.

26/15

## **STRATEGY AND RISK**

### **(a) Clinical Service Review (Verbal)**

TS updated the Board on the recent developments with the CSR which included:

- The Trust Management Board have identified the outcomes relevant to the Trust and for the services for patients across the whole of Dorset;
- Hospital services are to be maintained at the DGH in the west and will be reshaped across whole of Dorset with a Green Emergency hospital and Purple elective hospital;
- There have been discussions which have included a view that RBCH should be the green site due to concentration of population, accessibility of site in terms of development and patient access and the cost effectiveness of any investments in expansion. This is subject to further work by McKinseys;
- The first option elective services are assumed to remain at the current location,
- The second option elective services and in patient services are to be split by the yellow and purple hospital with no elective service at the green site which will be discussed with McKinseys;
- Purple hospital will not have a critical care service which will impact upon services and the man power of the three units;

- CCG anticipate being able to draw options together at the end of May, consult in the Summer with decisions being made in Autumn/Winter;
- Clinical workshops have not reached a conclusion as yet and the Board will need to be engaged in the ramifications of the options proposed.

**(b) Easter Resilience Planning (Appendix I)**

Work continues around resilience with learning being utilised from the winter pressures period. Patient flow is being addressed by 5 key stages with clear language and good practice. The focus of the work will be on implementing the 5 stages everyday with strong clinical leadership. The Trust will remain much safer as a result with discharges taking place earlier in the day.

Discharge planning was raised and RR emphasised that work was focused on streamlining the processes and making them more efficient for staff. RR advised that the Trust's partners including social services had provided verbal assurance of better staffing over the holiday period. He noted that the CCG could not provide this assurance.

The Board noted the risks going into the Easter period and requested a post implementation review was brought back to the May Board. The Board **endorsed** the proposal.

RR

27/15

**DECISION**

**(a) Directors Register of Interests (Appendix J)**

The Board **agreed** the Register.

**(b) Trust Vision (Appendix K)**

It was confirmed that Option F had been identified by a broad tranche of staff and the Board was requested to endorse the proposal of the vision. The Board **endorsed** the proposal.

**(c) Trust Objectives (Appendix L)**

It was noted that six key objectives will underpin objectives for individuals within the organisation through the appraisal process. The Board **confirmed** they were content with the proposal.

28/15

**INFORMATION**

**(a) Communications Update (including Core Brief February) (Appendix M)**

The item was noted for information.

**(b) Corporate Events Calendar (Appendix N)**

The report was noted for information.

**(c) Board of Directors Forward Programme (Appendix O)**

The report was noted for information.

29/15

**DATE OF NEXT MEETING**

Friday 24 April 2015 at 8.30am, **Conference Room, Education Centre, Royal Bournemouth Hospital.**

30/15

**ANY OTHER BUSINESS**

**Key Communications points for staff**

1. Staff survey and values- zero tolerance to any bullying and violence
2. Freedom to speak up
3. Performance
4. Finance
5. Trust vision & objectives

31/15

**QUESTIONS FROM GOVERNORS**

1. GS commended the stroke report and requested a comparison with other Trusts. RR advised the SSNAP data provided this level of information and noted that there were few areas performing within the A/B categories.
2. PH queried the definition of physical violence. It was confirmed that this was based upon individual perception when responding to the staff survey. The Board was assured that an investigation had taken place and evidence of violence had not been identified.
3. BYo suggested that nutrient density should be considered. PS responded that 'MUST' was an assessment tool used together with dietitians, the nutrition team and catering to obtain detail and provide support for patients.
4. EF queried the number of cancelled operations resulting from winter pressures. TS added that the Trust had compensated for disruptions caused and thanked the public for their consideration in light of the pressures.
5. DC queried whether more community hospitals such as Kings Park

would increase discharges and capacity. TS responded that there were no proposals but there would be a reduction in community hospital beds and it will be important to consider care in the community with the CSR as a driver for consideration of investment.

6. BG questioned if the safety thermometer could be more up to date. PS confirmed that the survey is undertaken on the first Wednesday of every month and this date works best for the Trust. PS assured that the metrics are closely monitored.

**There being no further business the meeting was declared closed at 10:49**

RBCH Board of Directors Part 1 Actions March & previous

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
27.03.15	24/15	<b><u>QUALITY IMPROVEMENT</u></b>			
	(a)	Patient Story			
		Ensure that feedback and comments are fed back to the catering department.	RR		
		To explore best practice for food nutrition levels and identify a successful option for use in the Trust.	PS		
	(b)	<b><u>Feedback from Staff Governors (Verbal)</u></b>			
		Provide support to those staff who do not understand 'corporate speak.'	KA		
	(c)	Freedom to speak up review			
		Identify non- executives and executives to lead on the freedom to speak up review.	PS		
	25/15	<b><u>PERFORMANCE</u></b>			
	(a)	Performance Exception Report (Appendix D)			
		To trial the learning from ED performance in other areas and provide regular feedback on progress made.	RR		Plan, do study, act (PDSA) approach being used for Quality Improvement projects across the Trust (in line with objectives).
	(b)	Stroke Performance Update (SSNAP) (Appendix E)			
		Further monitoring of scanning with clearer milestones for improvements.	RR		Milestones in the action plan have been provided. Key decisions being brought to April Board for ED scanner.
	(f)	Staff Survey Results			
		Provide an update from the Workforce Committee on the monitoring of the staff survey results.	KA	May	

RBCH Board of Directors Part 1 Actions March & previous

	26/15	<b><u>STRATEGY AND RISK</u></b>			
	(b)	Easter Resilience Planning			
		Provide a post implementation review for the May Board.	RR	May	
27.02.15	13/15	<b><u>MATTERS ARISING</u></b>			
		(05/15) Workforce Report (Appendix F)			
		Clear targets are to be developed in relation to how care groups will achieve 95% compliance	KA		Care group trajectories are being prepared and will be discussed at March/April Board.
	14/15	<b><u>QUALITY IMPROVEMENT</u></b>			
	(a)	Patient Story (Verbal)			
		To circulate the Trust's revised policy for external visitors to clinical areas to staff	PS		Email sent to wards, departments and managers regarding external visitors to clinical areas. Policy being finalised.
	15/15	<b><u>PERFORMANCE</u></b>			
	(b)	Quality Report (Appendix D)			
		Trust activity to be overlaid on the pressure ulcer data to identify the pure rate of cases	PS		This is in progress and will be placed on the forward planner to be reviewed at HAC.
31.01.15	05/15	<b><u>PERFORMANCE</u></b>			
	(b)	Quality Report (Appendix C)			
		To analyse the impact of the demographic of patients from the safety thermometer data between the periods of December 2013 – April 2014 to identify whether is a constant pressure.	PS		The information will be included in the Quality performance presentation for HAC and Board. (March)
	(g)	Talentwork Feedback (Presentation)			

RBCH Board of Directors Part 1 Actions March & previous

		The Talentwork's information to be circulated to the Board.	KA		Talentwork's information is still to be agreed, it is hoped it will be available next week. (March)
	06/15	<b><u>STRATEGY AND RISK</u></b>			
	(a)	Clinical Service Review (Appendix H)			
		How the Trust will embark on and be involved in the plans for the CSR Consultation phase.	TS		The consultation (external) will be lead by the CCG. Internally TS will lead a briefing programme to include Governors. Up to date briefings are currently being provided. Purdah operates from 30 <sup>th</sup> March 2015.
	(b)	Development of the Trust's Strategy (Appendix I)			
		The information from Monitor is to be provided to Governors.	RR		The draft annual plan will be shared with the governors.



BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 <sup>th</sup> April 2015 - Part 1
<b>Subject:</b>	Performance Report
<b>Section:</b>	Performance
<b>Executive Director with overall responsibility</b>	Richard Renaut
<b>Author(s):</b>	Donna Parker/David Mills
<b>Previous discussion and/or dissemination:</b>	PMG
<b>Action required:</b> <p>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.</p>	
<b>Summary:</b> <p>The attached Performance Indicator Matrix and Exception Report outline the Trust's performance exceptions against key access and performance targets for the month of March 2014.</p> <p>The Matrix 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 in the next reporting quarter for each metric.</p> <p>As an overview of the key risks for Q4, these are non-admitted waits (especially Dermatology, Orthopaedics and Poole based specialties), Cancer 2 week, 62 day and 31 day waits, and 4 hour ED compliance. The report also includes some key updates on progress against our detailed recovery action plans.</p>	
<b>Related Strategic Goals/ Objectives:</b>	Performance
<b>Relevant CQC Outcome:</b>	Section 2 – Outcome 4: Care and welfare of people who use services. Outcome - 6 Co-operating with others.
<b>Risk Profile:</b> <p>The following risk assessments remain on the risk register:</p> <ul style="list-style-type: none"> <li>i. Cancer 31 &amp; 62 day wait non-compliance and potential risk to the trust's authorisation, due to ongoing risks.</li> <li>ii. 4 hour target due to the continued high level of ambulance conveyances, attendances and admissions and our continued non-compliance, though noting strong March performance above 95%.</li> <li>iii. RTT admitted and non-admitted speciality and aggregate performance due to speciality pressures.</li> </ul> <p>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.</p>	
<b>Reason paper is in Part 2</b>	N/A

## Performance Exception Report 2014/15 - April

### 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 March 2015, as set out in *Everyone counts: Planning for Patients 2014/15*, the *Monitor Risk Assessment Framework* and in our contracts.

As an overview of the key risks for Q4, these are non-admitted waits (especially Dermatology, Orthopaedics and Poole based specialties), Cancer 2 week, 62 day and 31 day waits, and 4 hour ED compliance. The report also includes some key updates on progress against our detailed recovery action plans.

### 2 Infection Control

Number of Hospital acquired C. Difficile and MRSA cases

For March 2015, five cases of C. Difficile were reported on the Wards, bringing the financial year total to 21. Whilst this is over the monthly Monitor target of one, we are still within both the Monitor cumulative target and the local cumulative target (25). Of the 5 cases, 3 have been determined unavoidable and were linked to complex antibiotic treatments, the investigations for the other 2 cases are underway. There have been no reported cases of MRSA.

A challenging national target for 15/16 has now been confirmed at a maximum of 14. Actions are being developed in conjunction with the Nursing Directorate and Infection Prevention and Control Committee.

### 3 Cancer

Performance against Cancer Targets

Key Performance Indicators	Threshold	Qtr 3	Feb-15	Q4 predicted
2 weeks - Maximum wait from GP	93%	86.1%	90.1%	
2 week wait for symptomatic breast patients	93%	91.5%	100.0%	
31 Day – 1st treatment	96%	93.0%	96.4%	

31 Day – subsequent treatment - Surgery	94%	94.2%	76.0%	
31 Day – subsequent treatment - Others	98%	100.0%	100.0%	
62 Day – 1st treatment	85%	82.3%	79.8%	
62 day – Consultant upgrade ( <i>local target</i> )	90%	87%	100%	
62 day – screening patients	90%	90.7%	85.7%	

### Two Week Wait

The Two Week Wait target was additionally challenged through February and March due to Endoscopy capacity for Upper GI when on 'straight to test' pathways. Whilst outsourcing of Endoscopy procedures was undertaken during this time, unfortunately the provider was unable to fully meet the original requirement, putting additional pressure on the service. Secondly Urology surgeon capacity (consultant and middle grade) for Haematuria clinics was down significantly due to unplanned absence, though this is now resolving.

The improvements following the changes in the operational management of 2 week waits including more robust management of patient choice, have continued to see improved compliance in other areas and almost 100% compliance is currently being achieved for outpatient based fast track appointments. We currently expect to be close to, though below, threshold for Q4 but trajectories currently indicate moving to a compliant position for Q1. Recovery has also now been achieved against the Breast symptomatic target.

### 62 Day

Increased theatre capacity, continuation of the 'robot weeks', as well as the provision of locum cover is continuing to improve our capacity in Urology however, we remain non-compliant for Q4. The pressure on this target has been exacerbated by the Dorchester patients for robotic surgery and template biopsy waiting lists. Additional Dorchester capacity which is expected to come on line in Q1 as well as joint working with Dorchester in relation to waiting patients, will support improvement in this position. A local template biopsy service will also be commencing in Q1.

### 31 Day First Treatment, Subsequent Surgery and 62 Day Screening

The particular challenge we have faced in Q4 in relation to the 31 day first treatment, subsequent surgery and 62 day screening standards, is medical staffing, with sudden and unplanned leave affecting both Skin and Breast services. Locum cover is being secured along with a permanent advertisement and re-profiling of work across the county, as well as training and additional capacity from existing staff is now reducing the impact. Further risk to the trust in relation to the 31 day targets is in our Urology team, again due to a sudden unplanned shortage of medical staff. However, a locum is now in place, and flexible working across the team is assisting with recovering the position. We are continuing to manage performance against these targets, but these will remain non-compliant for Q4, during the recovery period.

## 4 Diagnostics

99% of patients to wait less than 6 weeks for a diagnostic test

An improved position against the 6 week wait diagnostic target was seen in March as a result of significant additional work and outsourcing in Endoscopy. Unfortunately, the outsourcing capacity was under plan which resulted in some continued breaches and a compliance level of 98.38% against the 99% threshold. Additional sessions, together with increased capacity through Nurse Endoscopist roles are continuing and the availability of further outsourcing capacity is also being explored for Q1. The trajectory for Q1 will be reviewed in light of the outcome of this.

## 5 Admitted RTT – Aggregate and Specialty Level

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

Due to the national validated upload date of 21/4/15 the final position is not currently available for this report and will be updated next month. The performance will however, be confirmed by presentation at the Board meeting on 24/4/15.

Current data shows expected compliance against the admitted target on aggregate, with speciality level non compliance expected in General Surgery, Orthopaedics, Dermatology and Gynaecology. This is in line with trajectory, with most specialities and the aggregate position being marginally better than expected.

In line with our detailed action plans, we are progressing various medical appointments in Orthopaedics to backfill current gaps and increase capacity. Interviews have been/are between March and May and our capacity and performance trajectory will be reviewed when start dates are confirmed. The directorate are also undertaking some improvement work in relation to scheduling to maximise capacity as well to move patients forward where possible. Work to improve outpatient waits have also seen a reduction in the outpatient waiting list since last Autumn. Late transfers from other providers remain a challenge and we will be working jointly to secure a plan to resolve this.

Dermatology is seeing an improved position on non admitted pathways, however, specialist surgical capacity remains a challenge due to current medical gaps. Additional sessions are being secured to provide capacity and we are also reviewing the external demand/capacity modelling that is being undertaken, as well as reviewing current pathways and approaching referring providers in relation to joint work on late transfers

Weekend capacity together with a locum post continues to support the management of long waiters in Upper GI. Pathway reviews as well as seeking additional clinic capacity to reduce pathway delays in Gynaecology are being progressed.

The above challenges will continue to present a risk to our aggregate position though this is being closely managed through our detailed action plans. Our current trajectory indicates a compliant aggregate position going forward.

## 6 Non-Admitted RTT - Specialty Level

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

As above, the March RTT non admit and incomplete pathways performance will be reported through presentation to the April Board and included in next month's Performance Report.

We currently anticipate meeting our trajectory which indicates non compliance against the non admitted target in March. Pressures and actions in Orthopaedics, Dermatology and Gynaecology are indicated above which are closely interlinked with the non admit and incomplete pathways performance. Our detailed action plans with the aim of ensuring that long waiting patients are treated in Q1 across all specialities, are focussed on securing recovery overall in Q2 15/16. Joint work with Poole Hospital is resulting in additional capacity from April/May for ENT, Oral Surgery and Neurology. Our performance trajectories are being reviewed in light of the additional capacity that is available but it is anticipated that there will be a significant reduction in longer waiters and pathway delays through Q1. Ongoing discussion will be progressed in terms of the longer term improvements and capacity to meet increased referral growth in these specialities.

Work to move fully to the new recording system (PPW) continues to progress well and is now beginning to support a more robust patient tracking system. Tracker Leads are now in post to support the further development of our systems and processes.

## 7 Recommendation

**The Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2014/15 Monitor Framework and 'Everyone Counts' planning guidance requirements.**

**RICHARD RENAUT**  
**CHIEF OPERATING OFFICER**

2014/15 PERFORMANCE INDICATOR MATRIX FOR BOARD OF DIRECTORS

Area	Indicator	Measure	Target	Monitor	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Forecast - Next Month	Forecast - Quarter	RAG Thresholds			
Monitor Governance Targets & Indicators																									
Infection Control	Clostridium difficile	Number of hospital acquired C. Difficile cases	(25.2.1 pcm)	2.1	0	1	2	1				6		3	1	1	2	2	5			> trajectory		<= trajectory	
Referral to Treatment	RTT Admitted	18 weeks from GP referral to 1 <sup>st</sup> treatment – aggregate	90%	1.0	90.1%	90.1%	90.2%	90.1%				87.2%	89.3%	87.4%	87.7%	90.0%	90.1%					<90%		≥90%	
	RTT Non Admitted	18 weeks from GP referral to 1st treatment – aggregate	95%	1.0	98.1%	98.0%	98.7%	98.5%				97.6%	96.4%	95.3%	95.0%	92.7%	91.0%					<95%		≥95%	
	RTT Incomplete pathway	Patients on an 18 week pathway awaiting treatment – aggregate	92%	1.0	95.1%	95.1%	94.9%	95.0%				94.6%	95.1%	94.5%	94.0%	92.4%	92.7%					<92%		≥92%	
Cancer	2 week wait	From referral to to date first seen - all urgent referrals	93%	1.0	93.6%	95.7%	95.9%	90.4%				78.2%	80.7%	88.1%	90.2%	94.2%	90.1%					<93%		≥93%	
	2 week wait	From referral to to date first seen - for symptomatic breast patients	93%	1.0	100.0%	100.0%	100.0%	100.0%				68.8%	86.7%	88.5%	96.7%	100.0%	100.0%					<93%		≥93%	
	31 day wait	From diagnosis to first treatment	96%	1.0	95.4%	94.5%	91.6%	97.6%				96.1%	96.4%	89.8%	91.4%	91.4%	96.4%					<96%		≥96%	
	31 day wait	For second or subsequent treatment - Surgery	94%	1.0	94.4%	100.0%	93.8%	96.3%				95.5%	96.6%	96.4%	89.7%	83.3%	76.0%					<94%		≥94%	
	31 day wait	For second or subsequent treatment - anti cancer drug treatments	98%	1.0	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					<98%		≥98%	
	62 day wait	For first treatment from urgent GP referral for suspected cancer	85%	1.0	80.7%	76.6%	81.7%	82.4%				87.1%	83.3%	83.8%	81.4%	78.4%	79.8%					<85%		≥85%	
62 day wait	For first treatment from NHS cancer screening service referral	90%	1.0	86.4%	100.0%	94.4%	90.5%				96.4%	93.8%	92.3%	85.7%	87.5%	85.7%					<90%		≥90%		
A&E	4 hr maximum waiting time	From arrival to admission / transfer / discharge (Type 1 & 2)	95%	1.0	94.4%	95.8%	95.8%	94.5%				93.9%	92.9%	94.1%	89.94%	89.84%	91.59%	95.87%				<95%		≥95%	
LD	Patients with a learning disability	Compliance with requirements regarding access to healthcare	n/a	1.0																		No		Yes	
Indicators within the Everyone Counts: Planning Guidance/ Key Contractual Priorities																									
MSA	Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	n/a		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			> 0		0	
Infection Control	MRSA Bacteraemias	Number of hospital acquired MRSA cases	0		0	0	0	0	0	0	1	0	0	0	0	0	0	0	0			≥1		0	
Cancer	62 day – Consultant upgrade	Following a consultant's decision to upgrade the patient priority *	90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	0.0%	100.0%	100.0%	60.0%	100.0%	100.0%					< 90%		≥90%	
VTE	Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95%		93.5%	95.3%	95.0%	95.3%	95.3%	95.0%	95.8%	95.0%	95.1%	94.2%	94.7%	95.0%	95.5%	95.8%					<95%		≥95%
Diagnostics	Six week diagnostic tests	More than 99% of patients to wait less than 6 wks for a diagnostic test	>99%		96.04%	99.87%	99.62%	99.4%	97.0%	99.30%	99.8%	99.8%	99.8%	99.8%	98.9%	97.0%	94.2%	94.8%	98.4%			<99%		≥99%	
A&E	Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0		0	0	0	0	0	0	0	0	0	0	1	2	5	0				≥1		0	
	Ambulance Handovers	No. of breaches of the 30 minute handover standard	tbc		19	17	24	15	46	25	52	37	33	75	74	72	66	55	49			tbc			
	Ambulance Handovers	No. of breaches of the 60 minute handover standard	tbc		13	4	11	13	14	9	4	9	9	13	13	27	31	31	6			tbc			
Cancelled Operations	28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0		2	0	1	0	0	0	1	0	0	1	0	1	0	2	0			≥1		0	
	Urgent ops Cancelled for 2nd time	No. of urgent operations cancelled for a second time	0		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0			≥1		0	
Referral to Treatment	52 week waiters	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0		3	1	1	0	0	0	1	3	3	1	0	1	0	0				≥1		0	
RTT Specialty	RTT Admitted	100 - General Surgery	90%		85.1%	84.9%	85.8%	89.3%	86.9%	88.5%	80.7%	81.7%	81.8%	84.7%	85.1%	84.1%	86.9%	88.7%				<90%		≥90%	
	RTT Admitted	101 - Urology	90%		91.8%	90.0%	91.8%	94.8%	92.0%	90.3%	87.0%	86.0%	91.4%	92.5%	90.1%	92.7%	88.4%	93.3%				<90%		≥90%	
	RTT Admitted	110 - Orthopaedics	90%		89.6%	89.0%	90.3%	89.5%	89.9%	89.1%	89.8%	80.0%	76.9%	84.0%	80.3%	80.1%	82.3%	86.2%				<90%		≥90%	
	RTT Admitted	130 - Ophthalmology	90%		85.4%	86.3%	83.9%	81.4%	84.2%	86.0%	84.7%	82.9%	84.6%	83.2%	85.0%	85.6%	91.9%	88.6%				<90%		≥90%	
	RTT Admitted	300 - General medicine	90%		99.7%	99.7%	99.7%	99.7%	98.7%	99.1%	98.7%	98.3%	99.7%	99.4%	98.3%	98.0%	99.4%	98.3%				<90%		≥90%	
	RTT Admitted	320 - Cardiology	90%		93.8%	91.3%	92.0%	91.0%	92.1%	91.4%	93.3%	92.3%	91.0%	89.3%	92.8%	92.7%	94.5%	93.5%				<90%		≥90%	
	RTT Admitted	330 - Dermatology	90%		90.2%	91.2%	93.4%	95.9%	91.5%	91.9%	95.6%	94.9%	87.7%	91.7%	87.6%	82.0%	84.3%	84.8%				<90%		≥90%	
	RTT Admitted	410 - Rheumatology	90%		96.9%	100.0%	100.0%	97.4%	95.1%	97.7%	97.1%	90.9%	88.9%	98.1%	94.5%	97.1%	98.2%	100.0%				<90%		≥90%	
	RTT Admitted	502 - Gynaecology	90%		91.3%	88.7%	88.4%	80.7%	93.0%	86.7%	89.9%	84.9%	79.5%	85.7%	75.7%	87.6%	84.4%	78.9%				<90%		≥90%	
	RTT Admitted	Other	90%		97.3%	98.6%	99.3%	98.1%	98.1%	97.4%	100.0%	98.8%	98.7%	99.4%	97.7%	98.9%	97.8%	100.0%				<90%		≥90%	
	RTT Non admitted	100 - General Surgery	95%		95.3%	95.0%	99.3%	96.5%	98.5%	96.6%	96.4%	95.2%	95.7%	90.9%	96.4%	95.5%	95.1%	92.5%				<95%		≥95%	
	RTT Non admitted	101 - Urology	95%		99.2%	99.1%	99.6%	98.1%	99.1%	98.7%	99.1%	99.5%	97.4%	99.5%	96.5%	99.4%	96.2%	92.8%				<95%		≥95%	
	RTT Non admitted	110 - Orthopaedics	95%		98.8%	97.6%	98.7%	99.4%	99.2%	97.8%	100.0%	97.8%	97.8%	96.7%	91.4%	91.8%	87.9%	82.9%				<95%		≥95%	
	RTT Non admitted	120 - ENT	95%		95.2%	95.4%	95.1%	95.2%	95.8%	95.0%	95.2%	91.9%	93.0%	92.6%	89.9%	87.6%	83.6%	85.4%				<95%		≥95%	
	RTT Non admitted	130 - Ophthalmology	95%		100.0%	99.4%	99.6%	99.5%	100.0%	100.0%	99.7%	99.7%	99.7%	100.0%	96.4%	96.3%	95.5%	89.3%				<95%		≥95%	
	RTT Non admitted	140 - Oral surgery	95%		96.2%	97.4%	97.3%	97.4%	95.6%	96.8%	92.1%	86.4%	86.6%	91.0%	90.6%	78.7%	76.0%	68.2%				<95%		≥95%	
	RTT Non admitted	300 - General medicine	95%		95.3%	95.2%	97.6%	97.6%	98.6%	95.9%	96.9%	96.3%	95.1%	93.3%	96.5%	99.1%	95.7%	96.8%				<95%		≥95%	
	RTT Non admitted	320 - Cardiology	95%		98.2%	97.8%	97.0%	98.3%	97.8%	100.0%	99.5%	97.3%	97.8%	95.8%	93.4%	93.4%	95.5%	96.5%				<95%		≥95%	
	RTT Non admitted	330 - Dermatology	95%		100.0%	99.6%	99.7%	100.0%	100.0%	97.9%	99.4%	100.0%	100.0%	100.0%	94.5%	85.0%	80.4%	81.3%				<95%		≥95%	
	RTT Non admitted	340 - Thoracic medicine	95%		100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%	98.7%	97.5%	98.5%	98.9%	96.9%	100.0%				<95%		≥95%	
	RTT Non admitted	400 - Neurology	95%		100.0%	100.0%	100.0%	98.5%	100.0%	96.5%	100.0%	97.9%	98.5%	97.4%	96.4%	95.3%	87.5%	81.0%				<95%		≥95%	
	RTT Non admitted	410 - Rheumatology	95%		99.0%	98.4%	97.2%	97.7%	98.3%	99.0%	97.7%	96.6%	97.5%	95.9%	95.3%	97.5%	97.9%	97.3%				<95%		≥95%	
	RTT Non admitted	502 - Gynaecology	95%		99.0%	98.9%	98.5%	99.4%	99.4%	98.6%	99.1%	100.0%	97.7%	98.3%	96.2%	98.2%	93.0%	94.4%				<95%		≥95%	
	RTT Non admitted	Other	95%		98.0%	97.1%	100.0%	99.6%	99.3%	98.0%	97.8%	98.5%	98.8%	99.3%	98.8%	99.5%	99.3%					<95%		≥95%	
SUS Submissions	NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99%		N/A	N/A	N/A	100%	100%	100%	100%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%					<99%		≥99%	
	NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	95%		N/A	N/A	N/A	98%	98%	97%	97%	96.8%	97.0%	97.3%	97.4%	97.5%	97.5%					<95%		≥95%	

\* Local standard of 90% with a de minimis of 2 breaches per month or 6 per quarter

BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 April 2015 Part 1
<b>Subject:</b>	Quality Report
<b>Section:</b>	Performance
<b>Executive Director with overall responsibility</b>	Paula Shobbrook, Director of Nursing and Midwifery
<b>Author(s):</b>	Joanne Sims, Associate Director Clinical Governance Simon Dursley, Complaints and PALs Manager Sue Mellor, Head of Patient Engagement
<b>Previous discussed at:</b>	
<b>Action required:</b> For Information. The full report will be discussed at HAC on the 30 April 2015	
<b>Summary:</b> This report provides a summary of information and analysis on new key performance and quality (P&Q) indicators agreed by the Board for 13/14. The Trust level dashboard provides information on patient safety and patient experience indicators including: <ul style="list-style-type: none"> <li>• Patient safety incidents</li> <li>• Never events</li> <li>• Patient falls</li> <li>• Pressure ulcers</li> <li>• Safety Thermometer – Harm Free Care (CQUIN standard)</li> <li>• Patient experience performance</li> </ul> The dashboard and end of year performance against all agreed quality indicators for 14/15 will be discussed at HAC on the 30 April 2015.	
<b>Related Strategic Goals/ Objectives:</b>	All
<b>Relevant CQC Outcome:</b>	All
<b>Risk Profile:</b> <ul style="list-style-type: none"> <li>i. Have any risks been reduced? No</li> <li>ii. Have any risks been created? No</li> </ul>	
<b>Reason paper is in part 2</b>	N/A

# Quality & Patient Safety Performance Exception Report

## March 2015

### 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 March 2015

### 2. Serious Incidents

4 Serious Incidents (SI's) were confirmed and reported on STEIS in March 2015.

### 3. Safety Thermometer

All inpatient wards collect the monthly Safety Thermometer (ST) "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".

3.1. The results for the 2014/15 ST data collection are as follows:

NHS SAFETY THERMOMETER	13/14 Av per month	14/15 Target	Apr	May	Jun	Jul	Aug	Sep
Safety Thermometer %Harm Free Care	89.0%	95%	90%	91.59%	91.72%	90.82%	90.16%	92.36%
Safety Thermometer % Harm Free Care (New Harms only)		97.5%	96.73%	97.84%	97.58%	97.8%	97.19%	96.9%

NHS SAFETY THERMOMETER	13/14 Av per month	14/15 Target	Oct	Nov	Dec	Jan	Feb	Mar
Safety Thermometer %Harm Free Care	89.0%	95%	89.47%	86.55%	91.45%	91.82%	90.73%	91.47%
Safety Thermometer % Harm Free Care (New Harms only)		97.5%	96%	96.43%	97.76%	97.41%	97.3%	97.22%

3.2 Results are as follows:

	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of patients surveyed	498	484	475	476	491	501	518	504



	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
New Pressure Ulcers	9	11	11	14	10	11	13	13
New falls (Harm)	0	3	2	2	1	0	0	0
New VTE	1	0	2	0	0	0	0	0
New Catheter UTI	4	1	4	1	0	3	2	1

#### 4. Risk Assessment Compliance

	June 2014	July 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 15	Mar 15
Risk assessment compliance										
· Falls	91%	91%	88%	91%	91%	88%	93%	86%	88%	88%
· Waterlow	96%	96%	94%	96%	96%	93%	97%	91%	91%	91%
· MUST	88%	89%	100%	91%	87%	80%	87%	74%	76%	81%
· Mobility	91%	93%	89%	90%	93%	91%	95%	87%	88%	89%
· Bedrails	93%	94%	90%	93%	95%	92%	95%	88%	90%	89%

#### 5. Patient Experience

National Comparison using the NHS England data base

##### 5.1 In-Patients Family and Friends Test (FFT) ranking

	January 2015	February 2015
<b>FFT Ranking</b>	5 <sup>th</sup> (with 33 other Trusts)	4 <sup>th</sup> (with 22 other Trusts)
<b>Our score. Number of patients who would recommend service</b>	96%	97%
<b>Trust sample size</b>	168	167
<b>Top score</b>	100%	100%
<b>Lowest score</b>	51%	82%

##### 5.2 Emergency Department – (ED)

	January 2015	February 2015
<b>FFT Ranking</b>	5 <sup>th</sup> (with 10 other Trusts)	7 <sup>th</sup> (with 10 other Trusts)
<b>Our score Number of patients who would recommend service</b>	94%	92%
<b>Trust sample size</b>	139	139
<b>Top score</b>	98%	98%
<b>Lowest score</b>	55%	53%

Inpatient and ED performance is consistent with previous months.

### 5.3 FFT scores

	FFT Score Mar 2015 (Feb 2015)	Compliance Rate Mar 2015 (Feb 2015)
ED	70 (70)	8% (10%)
In-Patient	80 (77)	44% (42%)
Maternity	71 (79)	19% (20%)

In total, 3027 patient experience cards have been completed Trust wide including all areas (OPD included but not yet for submission) in February, of which 1449 are from areas for NHS submission. Outpatient FFT has commenced across an additional 40 clinical areas, with submission starting in April 2015. This is being supported through staff meetings and one to one support.

Aggregation of all FFT submission areas in the Trust identify 96.3% of patients would recommend the Trust, 2.4% would not recommend the Trust, this is influenced by 3 respondents who “did not know”.

### 5.4 Extremely Unlikely results from FFT – March data

There have been 26 “extremely unlikely” to recommend from a total of 1359 FFT responses for submission areas (excluding “don’t know” respondents)

### 5.5 Trust wide 6 month trend analysis of unlikely’s and extremely unlikely’s

The table below shows the proportion of ‘Unlikely and Extremely Unlikely to Recommend’ FFT responses from across the Whole Trust - For internal Monitoring only

Unlikely & Extremely Unlikely Responses	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
<b>FFT Trust wide</b>						
No of FFT responses for all areas Trust wide Unlikely or Extremely Unlikely to recommend	43	53	37	48	59	49
No of FFT responses for all areas Trust wide	3153	3134	2347	2916	2818	2802
% Unlikely or Extremely Unlikely to recommend	1.4%	1.7%	1.5%	1.6%	2.1%	1.8%

## **5.6 Patients Opinion and NHS Choices: March data**

Patients Opinion and NHS Choices are monitored daily from Monday – Friday and responses are provided with a 24-hour working day timescale, using the criteria set and monitored by Patients Opinion.

We received 16 comments during March, 12 comments which were a positive reinforcement of high quality care, professionalism, communication and pain management. The 4 negative comments received highlighted poor staff attitude and communication.

## **7.0 Recommendation**

The Board of Directors are asked to note the report.

BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 April 2015 – Part I
<b>Subject:</b>	Financial Performance
<b>Section:</b>	Performance
<b>Executive Director with overall responsibility</b>	Stuart Hunter, Director of Finance
<b>Author(s):</b>	Pete Papworth, Deputy Director of Finance
<b>Previous discussion and/or dissemination:</b>	Finance Committee and Trust Management Board
<b>Action required:</b>  <p>The Board of Directors is asked to note the financial performance for the year ending 31 March 2015.</p>	
<b>Summary:</b>  <p>For the first time since achieving 'Foundation' status; the Trust moved into a deficit financial position during 2014/15, with a planned deficit of £1.9 million.</p> <p>However, the Trust has experienced considerable activity and demand pressures which has placed significant operational pressure on the Trust. These pressures have included activity increases above the initial plan in the following areas</p> <ul style="list-style-type: none"> <li>• Non Elective activity 12%</li> <li>• Elective activity 4%</li> <li>• Emergency Department attendances 4%</li> </ul> <p>In addition; national shortages of medical and nursing professionals has resulted in a substantial number of clinical workforce vacancies which have been covered by locum and agency staff.</p> <p>These two items together led to a significant over spend against the approved expenditure budget; and resulted in a revised mid-year forecast deficit of £5.2 million after taking into account a range of mitigating actions.</p> <p>The Trust has now ended the year with an overall net deficit of £5.232 million. This position includes an income over achievement of £4 million, relating to additional 'winter resilience' funding together with additional income in relation to pass through drug costs; off-set by an expenditure over spend of £7.3 million which mainly relates to premium staff costs, additional drug and clinical supply costs, and costs associated with outsourcing activity to the independent sector.</p> <p>The Trust has delivered cash releasing efficiency savings of £7.5 million, with further productivity and cost avoidance savings recorded above this level.</p> <p>The Trust set an ambitious capital programme for 2014/15, and has delivered well against</p>	

this. However, delays in the Christchurch Development due to environmental issues have led to a significant underspend against both the initial plan and mid-year reforecast.

Despite the most challenging year in its history, including reporting a significant deficit; the Trust ends the year in a comparably strong financial position, and reports a Continuity of Services Risk Rating of 3.

The focus for the Trust moving into the new financial year is one of further improvement and efficiency; and as such, there is a clear focus on quality and safety, supported by enhanced cost control procedures.

**Related Strategic Goals/  
Objectives:**

Goal 7 – Financial Stability

**Relevant CQC Outcome:**

Outcome 26 – Financial Position

**Risk Profile:**

No new risks have been added to the Trust risk register, and none have been removed or reduced.

**Reason paper is in Part 2**

N/A

## THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

## FINANCIAL PERFORMANCE FOR THE PERIOD TO 31 MARCH 2015

KEY FINANCIALS	2013/14 YTD ACTUAL £'000	CURRENT YEAR TO DATE				IN MONTH			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %	PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
NET SURPLUS/ (DEFICIT)	558	(1,900)	(5,232)	(3,332)	175%	(1,109)	(467)	642	(58%)
EBITDA	11,875	12,097	7,080	(5,017)	(41%)	58	(1,092)	(1,150)	(1,983%)
TRANSFORMATION PROGRAMME	8,798	7,408	7,521	113	2%	486	946	460	95%
CAPITAL EXPENDITURE	9,736	20,226	17,240	(2,986)	(15%)	2,451	2,500	50	2%

ACTIVITY	2013/14 YTD ACTUAL NUMBER	CURRENT YEAR TO DATE				IN MONTH			
		PLAN NUMBER	ACTUAL NUMBER	VARIANCE NUMBER	VARIANCE %	PLAN NUMBER	ACTUAL NUMBER	VARIANCE NUMBER	VARIANCE %
Elective	67,086	66,883	69,288	2,405	4%	5,817	6,617	800	14%
Outpatients	282,533	337,738	332,993	(4,745)	(1%)	29,371	29,218	(153)	(1%)
Non Elective	28,493	29,019	32,441	3,422	12%	2,465	2,718	253	10%
Emergency Department Attendances	83,187	83,240	86,727	3,487	4%	6,974	7,126	152	2%
<b>TOTAL PbR ACTIVITY</b>	<b>461,299</b>	<b>516,880</b>	<b>521,449</b>	<b>4,569</b>	<b>1%</b>	<b>44,627</b>	<b>45,679</b>	<b>1,052</b>	<b>2%</b>

INCOME	2013/14 YTD ACTUAL £'000	CURRENT YEAR TO DATE				IN MONTH			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %	PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Elective	72,606	69,394	70,144	749	1%	6,034	5,776	(259)	(4%)
Outpatients	31,273	32,043	32,047	4	0%	2,786	2,830	43	2%
Non Elective	51,264	54,288	54,668	380	1%	4,611	4,622	11	0%
Emergency Department Attendances	7,707	8,411	8,490	79	1%	705	684	(21)	(3%)
Non PbR	68,673	69,883	69,626	(257)	(0%)	6,211	7,095	884	14%
Non Contracted	26,538	26,416	29,305	2,889	11%	2,910	3,483	572	20%
Research	2,026	1,834	1,952	118	6%	153	162	9	6%
Interest	149	150	149	(1)	(1%)	13	12	(1)	(6%)
<b>TOTAL INCOME</b>	<b>260,236</b>	<b>262,419</b>	<b>266,381</b>	<b>3,961</b>	<b>2%</b>	<b>23,424</b>	<b>24,663</b>	<b>1,239</b>	<b>5%</b>

EXPENDITURE	2013/14 YTD ACTUAL £'000	CURRENT YEAR TO DATE				IN MONTH			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %	PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Pay	154,875	160,383	164,217	(3,834)	(2%)	14,726	14,713	13	0%
Clinical Supplies	36,533	34,629	36,014	(1,384)	(4%)	3,213	3,370	(157)	(5%)
Drugs	26,049	27,750	29,122	(1,373)	(5%)	2,402	2,836	(435)	(18%)
Other Non Pay Expenditure	27,953	25,043	27,355	(2,312)	(9%)	2,778	4,709	(1,931)	(70%)
Research	2,027	1,838	1,973	(135)	(7%)	154	180	(26)	(17%)
Depreciation	7,860	9,450	8,188	1,262	13%	788	(565)	1,352	172%
PDC Dividends Payable	4,382	5,226	4,744	482	9%	473	(113)	586	124%
<b>TOTAL EXPENDITURE</b>	<b>259,678</b>	<b>264,319</b>	<b>271,613</b>	<b>(7,294)</b>	<b>(3%)</b>	<b>24,533</b>	<b>25,130</b>	<b>(597)</b>	<b>(2%)</b>

STATEMENT OF FINANCIAL POSITION	2013/14 YTD ACTUAL £'000	CURRENT YEAR TO DATE			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Non Current Assets	159,375	170,877	170,783	(94)	(0%)
Current Assets	69,727	65,857	65,218	(639)	(1%)
Current Liabilities	(30,925)	(25,755)	(27,809)	(2,054)	8%
Non Current Liabilities	(3,000)	(17,705)	(15,482)	2,223	(13%)
<b>TOTAL ASSETS EMPLOYED</b>	<b>195,177</b>	<b>193,274</b>	<b>192,710</b>	<b>(564)</b>	<b>(0%)</b>
Public Dividend Capital	78,674	78,674	79,665	991	1%
Revaluation Reserve	73,002	72,999	72,364	(635)	(1%)
Income and Expenditure Reserve	43,501	41,601	40,681	(920)	(2%)
<b>TOTAL TAXPAYERS EQUITY</b>	<b>195,177</b>	<b>193,274</b>	<b>192,710</b>	<b>(564)</b>	<b>(0%)</b>

CONTINUITY OF SERVICE RISK RATING	2013/14 YTD ACTUAL METRIC	CURRENT YEAR TO DATE			
		PLAN METRIC	ACTUAL METRIC	RISK RATING	WEIGHTED RATING
Debt Service Cover	2.86x	2.28x	1.64x	2	1
Liquidity	48.9	50.8	42.9	4	2
<b>CONTINUITY OF SERVICE RISK RATING</b>	<b>4</b>				<b>3</b>

BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 <sup>th</sup> April 2015 - Part 1
<b>Subject:</b>	Workforce report
<b>Section:</b>	Information
<b>Executive Director with overall responsibility</b>	Karen Allman
<b>Author(s):</b>	Karen Allman
<b>Previous discussion and/or dissemination:</b>	Workforce Committee – 16 <sup>th</sup> April 2015
<b>Action required:</b> The Board of Directors is asked to: Note the content of the report.	
<b>Summary:</b> The report shows the performance of the Trust by care groups across a range of workforce metrics: Appraisal, Mandatory Training, Turnover and Joiner rates, Sickness and Vacancies. This month's report includes an update on the Employee Assistance Programme (EAP) following receipt of the Annual Report for March 14-February 15 from the provider, Care first; and an update on complex employee relations cases for the last quarter.	
<b>Related Strategic Goals/ Objectives:</b>	To listen to, support, motivate and develop our staff
<b>Relevant CQC Outcome:</b>	Outcomes 12, 13 & 14 - Staffing
<b>Risk Profile:</b> <ul style="list-style-type: none"> <li>i. Have any risks been reduced? No</li> <li>ii. Have any risks been created? No</li> </ul>	
<b>Reason paper is in Part 2</b>	N/A

## WORKFORCE REPORT – APRIL 2015

The monthly workforce data is shown below, both by care group and category of staff. A revised Trust target of 100% appraisal compliance (as per the board discussion in March) and 3% sickness absence have been set and performance has been RAG rated against these targets. We will develop some new criteria around both the 100% appraisal and Essential Core skills compliance to support these enhanced levels and agree these at relevant board subcommittees.

Care Group	Appraisal Compliance	Mandatory Training Compliance	Sickness Absence	Joining Rate	Turnover	Vacancy Rate (from ESR)
	At 31 Mar		Rolling 12 months to 31 Mar			At 31 Mar
Surgical	66.5%	75.9%	4.55%	11.8%	10.0%	2.3%
Medical	75.9%	76.4%	3.71%	18.0%	12.6%	5.0%
Specialities	69.0%	73.0%	4.55%	9.7%	10.4%	3.5%
Corporate	71.8%	75.7%	3.60%	14.0%	16.0%	4.5%
Trustwide	71.3%	75.5%	3.93%	13.8%	12.2%	3.9%

Staff Group	Appraisal Compliance	Mandatory Training Compliance	Sickness Absence	Joining Rate	Turnover	Vacancy Rate (from ESR)
	At 31 Mar		Rolling 12 months to 31 Mar			At 31 Mar
Add Prof Scientific & Technical	73.1%	73.2%	3.77%	10.5%	15.0%	6.7%
Additional Clinical Services	69.3%	76.3%	6.18%	18.0%	12.9%	1.7%
Administrative and Clerical	69.0%	75.4%	3.46%	15.2%	13.2%	4.6%
Allied Health Professionals	64.6%	79.4%	1.66%	12.2%	13.6%	3.6%
Estates and Ancillary	73.3%	74.6%	5.70%	12.2%	18.8%	3.0%
Healthcare Scientists	81.0%	78.3%	3.94%	16.4%	18.0%	2.9%
Medical and Dental	78.6%	56.5%	1.09%	9.8%	5.8%	0.5%
Nursing & Midwifery Registered	71.9%	80.5%	4.05%	12.0%	9.4%	6.2%
Trustwide	71.3%	75.5%	3.93%	13.8%	12.2%	3.9%

A target of 100% compliance has been set for Mandatory Training. Compliance levels below this level are red.

Please note the Medical and Dental vacancy figure may be slightly distorted due to difficulties allocating funding from Finance into ESR, which should be resolved by Finance in April.

As noted previously, turnover in Corporate Directorate and Estates & Ancillary and Administrative & Clerical staff groups includes the transfer of 29 Commercial Services staff to Poole ESR.



## **1. Appraisal Compliance**

Appraisal compliance dropped slightly from 72.5% last month to 71.3%. The new Trust appraisal behavioural framework has now been launched with 17 training sessions delivered for appraisees and around 300 staff having attended so far.

Feedback regarding the training sessions has been very positive from attendees.

## **2. Essential Core Skills Compliance**

The new Virtual Learning Environment launched in March and at the time of writing over 3,990 modules have been completed so far, which is encouraging. As previously advised, April data will be brought back in detail to the Trust board in May for review.

## **3. Sickness Absence**

Sickness absence has deteriorated slightly on the previous months rolling 12 months sickness. We are implementing a pilot for sickness absence support that should support the management of short term sickness as part of the workforce transformation workstream.

## **4. Turnover and Joiner Rate**

The turnover rate for March at 12.2% was the same as February and joiner rate showed a slight decrease to 13.8% as against 14.2% in February but again continues the positive trend being higher than turnover.

## **5. Vacancy Rate**

The vacancy rate is reported as the difference between the total full time equivalent (FTE) staff in post (including locums and staff on maternity leave) and the funded FTE reported by Finance, as a percentage of the funded FTE. Trust-wide our vacancies remain at 3.9% of funded posts as per last month.

## **6. Recruitment Initiatives**

The Trust has launched its refreshed recruitment portal on the Trust website which contains easily accessible information about vacancies, staff benefits and living and working locally. We have developed some new marketing material including videos and have been advertising opportunities on local buses and embracing social media.

We continue to attend regional and national job fairs and were exhibiting at an RCN event in Glasgow over the weekend of 9/10 April. Six confirmed offers have been made to qualified nurses for areas including OPM (Older Peoples Medicine), Endoscopy and Surgery, with a further cohort of interviews being arranged from contacts made at the event.

We are delighted that 14 overseas nurses will be joining the Trust from European Union countries on 18th May and 16 Filipino nurses have confirmed offers – 14 for theatres and 2 for endoscopy. A programme of support and adaptation to the NHS is being developed and further overseas interviews are scheduled for the end of April and into May.

An open day with interviews for newly qualified nurses is planned for Saturday 16th May. We have 60 interviews already booked and have a full programme of visits and tours in hand for this event.

## 7. Safe Staffing

A table of planned versus actual nursing hours for March 2015 is shown below:

Roster	Day		Night	
	RN/RM Fill Rate %	HCA Fill Rate %	RN/RM Fill Rate %	HCA Fill Rate %
AMU	89.8%	108.7%	94.3%	103.1%
BEU Ward	102.8%	150.4%	109.6%	300.0%
CCU	97.0%	79.5%	95.0%	n/a
Day Surgery Services	87.7%	72.0%	104.5%	100.0%
Derwent Ward	94.7%	103.3%	100.9%	106.3%
ICU/HDU	91.5%	n/a	100.0%	n/a
Mac Unit	101.2%	94.5%	100.2%	109.7%
Maternity Unit - Birthing	94.7%	56.2%	102.7%	96.2%
Stroke Unit (28)	84.6%	94.1%	96.5%	100.0%
Surgical Admissions Unit (SAU)	86.5%	92.5%	95.0%	100.0%
Ward 1	88.2%	99.7%	97.8%	112.9%
Ward 11	84.9%	97.5%	101.1%	100.0%
Ward 14	94.2%	93.7%	104.2%	102.9%
Ward 15	92.8%	106.9%	116.0%	160.8%
Ward 16	86.5%	90.8%	98.4%	123.9%
Ward 17	97.5%	106.3%	100.0%	108.9%
Ward 2	93.0%	93.4%	96.9%	148.8%
Ward 21	88.1%	104.8%	100.0%	109.4%
Ward 22 (26)	88.0%	96.1%	98.2%	109.3%
Ward 23	109.4%	139.3%	99.8%	104.5%
Ward 24	83.0%	88.1%	100.1%	100.1%
Ward 25	100.8%	134.6%	98.8%	115.7%
Ward 26 (22)	90.7%	91.1%	98.3%	102.7%
Ward 3 (WP)	81.9%	97.6%	99.8%	106.3%
Ward 4	80.7%	122.9%	100.3%	140.4%
Ward 5	89.2%	107.8%	103.7%	134.5%
Ward 7	66.4%	74.2%	104.6%	74.6%
Ward 9 (3)	86.5%	102.3%	98.7%	134.0%
<b>Grand Total</b>	<b>89.5%</b>	<b>99.8%</b>	<b>99.5%</b>	<b>113.0%</b>

By Exception:

- § The Eye Unit, extra capacity is open requiring extra staff.
- § Day Surgery have vacancies and some sickness which has affected their fill rate in month.
- § The wards have mitigated using substantive HCA over recruitment, careful review of skill mix and local review of current status managing and moving as appropriate.

Overall:

On aggregate, the planned versus actual registered nursing/midwifery hours were at 89.5% during the day in March 2015 (90% in February), 10.5% below the agreed collective template.

## **8. Care first – Employee Assistance Programme (EAP)**

### **Annual Report : March 2014 - February 2015**

The Board is aware of the support that is provided and each year the Trust's EAP provider produces a summary of how often their service has been used by staff and the main issues presented. We have now received the report for the period March 2014-February 2015 and the salient points are highlighted below.

	2012/13	2013/14	2014/15
Total number of new callers to help line	154	150	170
Total number of repeat callers to help line	<u>29</u>	<u>216</u>	<u>371</u>
	<b><u>183</u></b>	<b><u>366</u></b>	<b><u>541</u></b>

### **Gender**

Female	78%	80%	85%
Male	22%	20%	15%

This does not reflect the gender split in the Trust. A greater number of female staff are accessing the service.

## Types of Contact

The chart below shows a breakdown of the type of contacts made to the EAP.

All Contacts by Type	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	YTD	
Telephone Information	16	12	13	17	58	11%
Telephone Counselling	46	60	76	63	245	45%
Face to Face Counselling	69	36	64	64	233	43%
Online Counselling	2	1	-	2	5	1%
TOTAL	133	109	153	146	541	

It is encouraging to see that approximately half of all counselling is completed face to face and staff feel confident to return to Care first to use their services.

## Work/Career/Information issues in order of frequency - 2014/15

- Personal Health Concerns: 237 (calls) e.g. emotional health, family issues, relationship issues and coping with family bereavement.
- Work: 108 (calls) - emotional and physical health and changes at work.
- Information Specialist: 51 (calls) - Legal issues 18%, employment issues 18%.

Personal Issues	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total	
Alcohol	1	1	1	-	3	1%
Bereavement	4	6	8	1	19	8%
Debt	-	-	-	-	-	-%
Domestic Abuse/Violence	-	1	-	-	1	-%
Drugs	-	-	-	-	-	-%
Family	11	15	14	7	47	20%
Gambling	-	-	-	-	-	-%
General Finance	1	2	-	-	3	1%
Health - Emotional	25	32	30	18	105	44%
Health - Physical	4	6	7	5	22	9%
Housing	-	-	-	-	-	-%
Relationship	8	9	12	6	35	15%
Retirement	-	-	-	-	-	-%
Traumatic Incident	-	1	1	-	2	1%
TOTAL	54	73	73	37	237	

The high numbers above reflect cases being seen through the EAP service, citing emotional wellbeing ( 40%) and family issues (20%) as the highest themes.

Information Specialist	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total	
Benefits	4	-	1	-	5	10%
Childcare Information	1	-	-	-	1	2%
Children	1	-	-	-	1	2%
Consumer	-	-	-	-	-	-%
Debt	-	-	1	-	1	2%
Divorce/separation	3	-	2	-	5	10%
Education	-	-	-	-	-	-%
Eldercare Information	-	-	1	-	1	2%
Employment	3	2	1	3	9	18%
Finance	2	-	3	-	5	10%
Health/medical	1	-	-	-	1	2%
Housing	1	-	2	1	4	8%
Immigration	-	-	-	-	-	-%
Law	1	-	1	-	2	4%
Legal Information	3	1	1	4	9	18%
Pay & Benefits Review	-	-	-	-	-	-%
Retirement	-	-	-	-	-	-%
Substance abuse (incl. alcohol)	-	-	-	-	-	-%
Tax queries	-	-	-	-	-	-%
Other Information	2	1	3	1	7	14%
TOTAL	22	4	16	9	51	

Employment and legal issues are the most frequently accessed, however they remain small in number.

The EAP service remains well received with an increasing number of staff accessing the services. Regular review meetings are held with the provider and they attend the Valuing Staff group and any Health and Wellbeing events such as the one held on 15 April.

A further development of the service has been the addition of themed support sessions including “Managing Pressure” - these are sessions of an hour’s duration which have been attended by 80 staff so far and on 23rd April Care first will be providing four Mental Health awareness sessions for managers to help them recognise symptoms and provide support for staff.

Overall feedback from staff has been extremely positive; some of the comments include:

- § *“This is a really useful service and has really helped me deal with difficult situations.”*
- § *“I have been very grateful to have the opportunity to talk to someone totally outside of the situation I was in”*
- § *“Useful to talk to someone who was neutral Even though she wasn't in my profession, she quickly pin-pointed the problems/causes of stress. Would recommend to colleagues”*

- § *"I found the service I received from Care First very good and, my face to face counsellor, a lovely person and she helped me through my daughter's illness. I would recommend using this service. Thank you."*
- § *"Felt safe and comfortable with counsellor who was gentle and empathetic but helped motivate me."*
- § *"Very good service"*
- § *"The counsellor had a quiet and calm manner. He helped me to explore areas of difficulty including suppressed anger and emotional upset, following the separation from my husband after 34 years of marriage".*

## Client Work Status

	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Grand Total
<b>At Work</b>	<b>24</b>	<b>24</b>	<b>28</b>	<b>22</b>	<b>98</b>
<b>Not Applicable</b>	<b>9</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>21</b>
<b>Off Sick</b>	<b>6</b>	<b>15</b>	<b>17</b>	<b>6</b>	<b>44</b>
Less than 1 week	2	4	5	2	13
1 week to 1 month	3	5	6	3	17
1 month to 3 months	1	3	5	-	9
3 months to 6 months	-	3	1	1	5
More than 6 months	-	-	-	-	-
<b>Off work - not sick</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>7</b>
Less than 1 week	1	-	-	-	1
1 week to 1 month	1	1	-	1	3
1 month to 3 months	-	-	1	1	2
3 months to 6 months	-	-	-	-	-
More than 6 months	-	-	1	-	1
<b>Grand Total</b>	<b>41</b>	<b>44</b>	<b>51</b>	<b>34</b>	<b>170</b>

## Client Evaluation Results for the report period:

Q. Did the counselling / information from Care first enable you to:

Remain at work: 82%

Return to work: 75%

## **9. Complex Cases**

The chart below is a summary of employee relations cases being managed within the first quarter of 2015 (this does not include 'low level' incidents, i.e. those managed without HR input).

Type of hearing	Care Group				Total
	Surgical	Medical	Specialities	Corporate areas	
Conduct	5	12	2	6	25
Capability (performance)	1	1	2	1	5
Sickness	15 (4 returned)	26 (3 returned)	13 (1 returned)	16 (5 returned)	70 (13 returned)
Grievance and B&H	1	6	0	3	10
Employment Tribunals	1	0	0	0	1
Appeals	0	0	0	2	2
Dismissals	3	3	1	7	14
TOTAL	26	48	18	35	127

At the present time there is a significant drive on the management of sickness absence, with many cases working towards a phased return to work or redeployment. 10 of the 14 dismissals were as a result of sickness absence.

Conduct hearings have been for a variety of issues, although frequent unacceptable behavioural issues occurred on several occasions, sometimes linked with complaints about Bullying and Harassment. This may be due to raised awareness of Trust values and encouragement to report unacceptable behaviours.

Overall there has been an increase in the number of complex cases being brought to the Human Resources and Occupational Health teams.

BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 April 2015 Part 1
<b>Subject:</b>	Complying with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
<b>Section:</b>	Information
<b>Executive Director with overall responsibility</b>	Paula Shobbrook, Director of Nursing and Midwifery
<b>Author(s):</b>	NHS Providers
<b>Previous discussed at:</b>	Board of Directors
<b>Action required:</b> The Board is asked to note the report which is provided for information	
<b>Summary:</b>  The enclosed briefing report from NHS Providers provides a briefing on the new CQC standards from April 2015. This incorporates the Fit and Proper Persons Test, The role of the CQC, The role of councils of governors, Fundamental Standards and Displaying of CQC ratings.  The standards are being reviewed internally and will be discussed at QARC, HAC and TMB.	
<b>Related Strategic Goals/ Objectives:</b>	All
<b>Relevant CQC Outcome:</b>	Safe, Caring, Effective, Responsive & Well Led



# BRIEFING: COMPLYING WITH THE HEALTH AND SOCIAL CARE ACT 2008 (REGULATED ACTIVITIES) REGULATIONS 2014

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 deal with the fit and proper persons test and the duty of candour which came into force in November 2014 and with fundamental standards which come into force on 1 April 2015. This briefing includes an updated version of our earlier advice on the fit and proper persons test and the duty of candour and provides guidance on meeting the fundamental standards.

## FIT AND PROPER PERSONS TEST

### The regulations

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) places a duty on NHS providers not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director (NED) under given circumstances.

### The requirement for fit and proper persons

Providers must not appoint a person to an executive director level post (including associate directors) or to a non-executive director post unless they are:

- Of good character;
- Have the necessary qualifications, skills and experience;
- Are able to perform the work that they are employed for after reasonable adjustments are made;
- Can supply information as set out in Schedule 3 of the Regulations (see the Role of the CQC below).

Paragraph 5 (4) of regulations states that in assessing whether a person is of good character, the matters considered must include those listed in Part 2 of Schedule 4.' Part 2 of Schedule 4 refers to:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The CQC's definition of good character is not the objective test of having no criminal convictions but instead resets upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for boards and councils in reaching a decision and allows for the fact that people can and do change over time.

The regulations list categories of persons who are prevented from holding the office and for whom there is no discretion:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;

- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment;
- The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

In implementing the provision providers must have regard to the guidance issued by the CQC beginning on page 16 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>. It will be the responsibility of the chair of the provider to discharge the requirement placed on the provider, to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

The CQC expects senior leaders to set a tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. It is important therefore that in making appointments boards and councils take account of the values of the organisation and the extent to which candidates provide a good fit with those values.

## The role of the CQC

The regulations give the CQC powers to assess whether both executive and non-executive directors (but not foundation trust governors) are fit to carry out their role and whether providers have put in place adequate and appropriate measures to ensure that directors are fit and proper persons.

The CQC has the right to require the provision of information set out in Schedule 3 of the Regulations and such other information as is kept by the organisation that is relevant to the individual as follows:

1. Proof of identity including a recent photograph.
2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(38), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(39).
3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:
  - (a) health or social care, or,
  - (b) children or vulnerable adults.
5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.
6. In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.
7. A full employment history, together with a satisfactory written explanation of any gaps in employment.
8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.
9. For the purposes of this Schedule:
  - (a) 'the appointed day' means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;
  - (b) 'satisfactory' means satisfactory in the opinion of the Commission;
  - (c) 'suitability information relating to children or vulnerable adults' means the information specified in sections 113BA and 113BB respectively of the Police Act 1997

Where the CQC receives information from a third party regarding an alleged lack of fitness of a director the CQC will convene a panel to determine whether the information is significant and should be considered by the provider. The consent of the director concerned will be sought to pass information to the provider. Where the CQC does not obtain such consent it will consider whether to share the information with the provider. It will then be for the provider to consider whether the director in question remains or is a fit and proper person under the regulations.

The role of the CQC in determining whether information is satisfactory should be confined to forming a view on the quality of the evidence and whether it has been taken account of rather than attempting to second guess the decision of a board. Similarly the CQC should be examining the robustness and effectiveness of procedures rather than on the individual directors that are in post as a result of the procedures.

The CQC will expect providers to take account of some core public information sources about providers in making appointments; for example information from public inquiry reports, serious case reviews and Ombudsmen reports. The CQC will make further information available on its website.

During inspections the CQC will assess compliance with the test as part of the well-led domain. Where a provider cannot demonstrate that it has undertaken the appropriate checks in the appointment of its board members the CQC will decide whether or not to take regulatory action, and what action to take on a case by case basis. Where the CQC decides to take regulatory action providers may appeal to the First-tier Tribunal and or seek leave for judicial review.

## The role of Monitor

Standard condition G4 of the provider license requires that a foundation trust must not appoint or allow an unfit person to remain in post without Monitor's permission. At present Monitor's definition is the narrower definition set out in the Schedule 7 of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Monitor is able to use its enforcement powers to deal with a breach of a license condition by requiring the foundation trust to remove the unfit person from office or by taking such action itself.

## The role of councils of governors

The role of the nominations committee (with a majority of governor members) or the nominations committee for non-executive director appointments (if there are two nominations committees) is to interview and otherwise assess the candidates and to recommend suitable candidates for appointment to meetings of the full council. The committee also recommends to the council whether or not to approve the appointment of the chief executive. Councils of governors may also remove the chair or non-executive directors from post.

The degree to which nominations committees involve themselves in chair and NED appointments prior to interview varies greatly from trust to trust and it is not intended to cover all eventualities here. As a minimum however nominations committees and through them councils of governors will need to satisfy themselves that the relevant checks set out in the table above have been carried out and they will want to satisfy themselves that the board has adequate assurances on the robustness of procedures.

Where a candidate has made a declaration in respect of their character that does not comply with the regulations or in respect of past mismanagement and has offered an explanation of the circumstances, the nominations committee will need to investigate and form a view as to whether the explanation is sufficient to allow the candidate to continue in the appointments process.

Where the nominations committee decides to recommend such a candidate for appointment, the meeting of the council will need to satisfy itself that the investigation carried out by the nominations committee was robust.

Where a chair or NED declares a change in the status of their character or where such a change becomes known, the council of governors will need to decide on a procedure to investigate and determine the case if such a procedure is not already in place.

Where Monitor or the CQC consider that serious mismanagement has occurred within the trust or where there has been a serious breach of a licence condition councils of governors will need to decide on a procedure to investigate and deal with any cases if such a procedure is not already in place.

We do not believe that there is a general issue within the NHS of unfit individuals being recruited to provider boards and our organisations have all argued for a nuanced approach to implementing the regulations.

The definition of how NHS providers are expected to be 'privity to' particular evidence about whether an individual is 'fit and proper' to undertake a given role, is of particular concern because at face value, the absence of evidence of action could be taken as evidence against the individual. For instance, taken to its extreme, a failure to whistle-blow

could become a career limiting decision unless the individual concerned can demonstrate that they had good reason for not doing so.

## Complying with the fit and proper persons test

	Standard	Assurance process	Evidence
	<b>At appointment</b>		
1.	<p>Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations.</p> <p>(Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.</p> <p>Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.)</p>	<p>Employment checks in accordance with NHS Employment Check Standards issued by NHS Employers including:</p> <ul style="list-style-type: none"> <li>two references, one of which must be most recent employer;</li> <li>qualification and professional registration checks;</li> <li>right to work checks;</li> <li>proof of identity checks;</li> <li>occupational health clearance;</li> <li>DBS checks (where appropriate);</li> <li>search of insolvency and bankruptcy register;</li> <li>search of disqualified directors register.</li> </ul>	<p>References;</p> <p>Outcome of other pre-employment checks;</p> <p>DBS checks where appropriate;</p> <p>Register search results;</p> <p>List of referees and sources of assurance for FOIA purposes.</p>

	Standard	Assurance process	Evidence
2.	Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	<p>Report and debate at the nominations committee(s).</p> <p>Report and recommendation at the council of governors (for NEDs) or the board of directors (for EDs) for foundation trusts, reports to the board for NHS trusts.</p> <p>Decisions and reasons for decisions recorded in minutes.</p> <p>External advice sought as necessary.</p>	Record that due process was followed for FOIA purposes.
3.	Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.	<p>Requirements included within the job description for all relevant posts.</p> <p>Checked as part of the pre-employment checks and references on qualifications.</p>	<p>Person specification</p> <p>Recruitment policy and procedure</p>
4.	<p>The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept.</p> <p><i>N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to NED appointments.</i></p>	<p>Employment checks include a candidate's qualifications and employment references.</p> <p>Recruitment processes include qualitative assessment and values-based questions.</p> <p>Decisions and reasons for decisions recorded in minutes.</p>	<p>Recruitment policy and procedure</p> <p>Values-based questions</p> <p>Minutes of council of governors.</p> <p>Minutes of board of directors.</p>

	Standard	Assurance process	Evidence
5.	In addition to 4. above, a provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	Discussions and recommendations by the nominations committee(s). Discussion and decision at board of directors or council of governors meeting. Reports, discussion and recommendations recorded in minutes of meetings. Follow-up as part of continuing review and appraisal.	Minutes of committee, board and or council meetings. NED appraisal framework NED competence framework Notes of ED appraisals
6.	When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process.	Self-declaration subject to clearance by occupational health as part of the pre-employment process.	Occupational health clearance
7.	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	Self declaration of adjustments required. NHS Employment Check Standards Board/council of governors decision	Minutes of board meeting/council of governors meeting



	Standard	Assurance process	Evidence
8.	<p>The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.</p> <p>('Regulated activity' means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Schedule 1 covers the provision of:</p> <ul style="list-style-type: none"> <li>personal care; accommodation for persons who require nursing or personal care; accommodation for persons who require treatment for substance misuse; treatment of disease, disorder or injury; assessment or medical treatment for persons detained under the 1983 Act; surgical procedures; diagnostic and screening procedures; management of supply of blood and blood derived products etc.; transport services, triage and medical advice provided remotely; maternity and midwifery services; termination of pregnancies; services in slimming clinics; nursing care; family planning services.</li> </ul> <p>'Responsible for, contributed to or facilitated' means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.</p> <p>'Privy to' means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.</p> <p>'Serious misconduct or mismanagement' means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.")</p> <p><i>N.B. This provision applies equally to executives and NEDs.</i></p>	<p>Consequences of false or inaccurate or incomplete information included in recruitment packs.</p> <p>Checks set out in 1. Above i.e.</p> <p>Employment checks in accordance with NHS Employers pre-employment check standards including:</p> <ul style="list-style-type: none"> <li>self-declarations of fitness including explanation of past conduct/character issues where appropriate by candidates;</li> <li>two references, one of which must be most recent employer;</li> <li>qualification and professional registration checks;</li> <li>right to work checks;</li> <li>proof of identity checks;</li> <li>occupational health clearance;</li> <li>DBS checks (where appropriate);</li> <li>search of insolvency and bankruptcy register;</li> <li>search of disqualified directors register.</li> </ul> <p>Included in reference requests.</p>	<p>NED Recruitment Information pack</p> <p>Reference Request for ED/NED</p>

	Standard	Assurance process	Evidence
9.	<p>The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.</p> <p>N.B. The CQC accepts that providers will use reasonable endeavours in this instance.</p> <p>The existence of a compromise agreement does not indemnify the new employer and providers will need to ensure that their Core HR policies address their approach to compromise agreements.</p>	<p>Consequences of false, inaccurate or incomplete information included in recruitment packs.</p> <p>Core HR policies for appointments and remuneration</p> <p>Checks set out in Section 1 above.</p> <p>Included in reference requests.</p>	<p>NED and ED Recruitment Information packs</p> <p>Core HR policies</p> <p>Reference Request for ED/NED</p>
10.	<p>Only individuals who will be acting in a role that falls within the definition of a 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS).</p> <p><i>N.B. The CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.</i></p>	<p>DBS checks are undertaken only for those posts which fall within the definition of a "regulated activity" or which are otherwise eligible for such a check to be undertaken.</p>	<p>DBS policy</p> <p>DBS checks for eligible post-holders</p>

	Standard	Assurance process	Evidence
11.	As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant DBS list.	Eligibility for DBS checks will be assessed for each vacancy arising.	DBS policy
	<b>Continuing provisions</b>		
12.	The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	<p>Assessment of continued fitness to be undertaken each year as part of appraisal process.</p> <p>Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process.</p> <p>Board/Council of Governors reviews checks and agrees the outcome.</p>	<p>Continual to be assessed as part of appraisal process</p> <p>Register checks if necessary</p> <p>Board/council minutes record that process has been followed.</p>

	Standard	Assurance process	Evidence
13.	<p>If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter.</p> <p>The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.</p>	<p>Core HR policies provides for such investigations.</p> <p>Revised contracts allow for termination in the event of non-compliance with regulations and other requirements.</p> <p>Contracts (for EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement.</p>	<p>Core HR policies</p> <p>Contracts of employment (for EDs and director-equivalents)</p> <p>Service agreements or equivalent (for NEDs)</p>
14.	<p>The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions.</p>	<p>Core HR policies include the necessary provisions.</p> <p>Action taken and recorded as required</p>	<p>Core HR policies</p>
15.	<p>Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.</p>	<p>Core HR policies</p>	<p>Managerial action taken to backfill posts as necessary.</p>
16.	<p>The provider informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others.</p>	<p>Core HR policies</p>	<p>Referrals made to other agencies if necessary.</p>

*In the table above, unless the contrary is stated or the context otherwise requires, "ED" means executive directors and director equivalents.*

## FUNDAMENTAL STANDARDS

### Person-centred care

Regulation 9 specifies that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. To meet this standard provider organisations must

- Carry out an assessment of the care and treatment needs of then service user in the context of their preferences, involving the service user or their representative as appropriate;
- Aim to meet the service users' preferences while ensuring that their needs are met;
- Ensure that the service user understands their options for care and treatment and has the opportunity to discuss the risks and benefits of those options with a healthcare professional;
- Ensure that the service user or their representative is involved in decisions relating to their care and/or treatment to the maximum extent;
- Provide appropriate opportunities for people or their representatives to manage their care or treatment;
- Involve people using services in decisions relating about the way in which the service is delivered in so far as it relates to their care or treatment;
- Provide relevant persons with the information they would reasonably need to participate in decisions on their care and treatment;
- Make reasonable adjustments to enable the service user to receive their care or treatment;
- Where meeting a service user's nutritional and hydration needs, have regard to the service user's well-being.

The CQC cannot prosecute providers for breach of the regulation or any of its parts, but the CQC may decide to take regulatory action.

The CQC's guidance, <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>, gives more detail on what providers might do to meet the standard. The underlying principles for providers are that they must do what is practicable and reasonable in each instance to comply with the standard. Clearly a culture that promotes involving people in their treatment will be as important as having the right systems and processes in place. However boards will want to assure themselves that what is reasonable and practicable in delivering patient-centred treatment is being achieved.

### Dignity and respect

Regulation 10 stipulates that patients and service users must be treated with dignity and respect.

To comply with the regulation provider organisations must:

- Ensuring the privacy of the patient or service user;
- Support the autonomy, independence and involvement in the community of the patient or service user;
- Give due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the patient or service user. The protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 34 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>. The CQC cannot prosecute providers for breach of the regulation or any of its parts, but the CQC may decide to take regulatory action.

The dignity and respect regulation applies to both facilities and to the way in which individuals are treated. The requirement for separate sleeping and bathroom facilities for each sex is not subject to a reasonableness test, although other aspects of the privacy dimension of the regulation are subject to the provider organisation making all reasonable efforts: to hold discussions in private spaces and to respect the privacy preferences of the patient/service user, for example.

The CQC's guidance appears to acknowledge that autonomy brings with it different and sometimes additional risks. In recognising the need to support independence as safely as possible the guidance ostensibly recognises that while risks associated with supporting independence can be identified and controlled they cannot be completely eliminated. The logic of the acknowledgment is that in enforcing the regulation the CQC will accept that from time to time controls will not deliver the desired outcome and adverse incidents will occur.

To comply with the provisions on protected characteristics provider organisations will need to ensure that they do not discriminate unlawfully either directly or indirectly. It is likely that NHS provider boards will already have sources of assurance available to them in this respect.

## Need for consent

To comply with regulation 11 provider organisations must ensure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment for which they are seeking consent. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 37 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>.

The CQC can bring a criminal prosecution for a breach of this regulation or a breach of part of the regulation. To bring prosecution it is not necessary for the CQC to first take other regulatory action or issue a warning notice. It is a defence to this offence that the provider organisation took all reasonable steps to comply and acted with all due diligence.

Provider organisations already have well functioning systems in place to ensure that consent is obtained, but given the consequences of any system failure boards will probably wish to check the health of their systems and assurances on them.

## Safe care and treatment

Regulation 12 sets out what provider organisations must do to deliver safe treatment. This includes:

- Assessment and control of the risks to the health and safety of patients or service users;
- Ensuring staff have the qualifications, competence, skills and experience to provide safe care and treatment;
- Ensuring premises are fit for purpose and safe for use;
- Ensuring equipment is safe for such use and is used safely;
- Ensuring equipment or medicines are available in sufficient quantities to ensure safe treatment;
- Ensuring medicines are managed properly and safely;
- Ensuring effective infection control including health care associated infections;

- Ensuring that shared responsibility for care or treatment and transfer to other providers is dealt with safely and effectively.

A component of the regulation is that provider organisations must have regard to nationally recognised guidance and the section of the CQC's guidance beginning on page 41 of the following:

<http://www.cqc.org.uk/content/regulations-service-providers-and-managers>. In effect the requirement is that provider organisations should follow such guidance. The CQC guidance contains further detail on how to comply with the regulation. Effective systems of risk management operated with diligence and rigour go to the heart of complying with the regulation.

The CQC can bring a criminal prosecution for a breach of this regulation or a breach of part of the regulation if the breach results in avoidable harm to the patient or service user or if a person using the service is exposed to significant risk of harm. The regulations themselves make no mention of 'exposed to significant risk of harm' and the guidance does not define it further, however the implication is that the CQC will consider prosecutions for 'near miss' situations if the fact that significant harm did not occur was fortuitous rather than because of the operation of a last line of defence.

Oversight of robust, effective risk management and assurance systems to ensure patient safety goes to the heart of a boards work. Nevertheless boards may wish to review the operation and effectiveness of their risk management systems in the light of the new criminal offence.

## Safeguarding service users from abuse and improper treatment

The expectation set out in regulation 13 is that provider organisations have a 'zero tolerance approach' to abuse, unlawful discrimination and unlawful restraint. Abuse is defined in the regulation as: any behaviour towards a service user that is an offence under the Sexual Offences Act 2003; ill-treatment whether of a physical or psychological nature, including degrading treatment; theft, misuse or misappropriation of money or property and neglect.

Restraint is defined in the guidance as when someone: 'uses, or threatens to use, force to secure the doing of an act which the service user resists, or restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means. An offence is committed where such restraint is unnecessary or disproportionate restraint, or where a person is unlawfully deprived of liberty.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 48 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>.

The CQC can go straight to prosecution if a failure to meet the sections of the regulation dealing with abuse, discrimination or unlawful restraint results in avoidable harm or significant risk of harm. Once again it is a defence that the provider organisation took all reasonable steps to comply and acted with all due diligence, so boards will wish to be assured that this is the case.

## Meeting nutritional and hydration needs

To comply with regulation 14 provider organisations must make sure that people using their services have enough to eat to meet their nutrition needs and enough to drink to meet their hydration needs. Provider organisations

must ensure that people using their services have their nutritional needs assessed and that food is provided to meet those needs. This will include prescribed nutritional supplements and/or parenteral nutrition. Provider organisations must take account of preferences and religious and cultural backgrounds when providing food and drink and must provide the support necessary to enable people to eat and drink.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 54 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>. The CQC can go straight to prosecution if a failure to meet the regulation results in avoidable harm or significant risk of harm. It is a defence that the provider organisation took all reasonable steps to comply and acted with all due diligence, so once again, boards will wish to be assured that this is the case.

## Premises and equipment

To comply with regulation 15 provider organisations must ensure that premises are clean, fit purpose, well maintained and accessible. They must also ensure that equipment is clean, suitable, properly maintained, stored securely and used properly. It should be noted that legal responsibility remains with the registered provider organisation even where they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. Where the service user or patient owns the equipment needed to deliver their care and treatment, or the provider does not provide it, the provider must still make every effort to make sure that it is clean, safe and suitable for use.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 59 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>. The CQC cannot prosecute under this regulation but it can take regulatory action. However where a breach of this regulation results in unsafe care or treatment regulation 12 in respect of safe care and treatment, against which criminal charges can be brought, will apply. Boards will therefore wish to confirm assurances in respect of premises and equipment.

## Receiving and acting on complaints

To comply with regulation 16 providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints made by anyone. All complaints must be investigated thoroughly and, where failures have been identified, any necessary action must be taken. The regulation does not define what a complaint is, so it is important that provider organisations have their own robust and justifiable definition so that they can demonstrate compliance. However the guidance states that complaints may be made either orally or in writing, suggesting a broad definition of complaints along the lines of: any expression of dissatisfaction.

The CQC cannot prosecute in regard to this element of the regulation, but it can take regulatory action. However regulation 20 on the duty of candour also applies to the complaints procedure and prosecutions can be brought under regulation 20. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 64 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>.



When requested to do so, providers must provide CQC with a summary of complaints, responses and other related correspondence or information within 28 days of the request being made. Failure to comply with this element of the regulation is an offence and the CQC can move straight to prosecution without a warning notice being issued.

Provider organisations already have complaints procedures in place, however complaints systems in the NHS have been under increasing scrutiny of late and it is important that NHS providers check that their complaints processes are up to date and functioning well.

It is also important that providers can demonstrate that they are learning from complaints at all levels of the organisation, from trends in feedback and complaints, and can cite examples of where complaints have led to service change and improvement.

## Good governance

To meet regulation 17 provider organisations must ensure that the systems and processes that underpin good governance are in place and operate well. This will include systems of risk management, assurance and checks on assurance. One of the key outcomes should be an enhanced ability to assess, monitor and drive improvement in the quality, safety and experience of the services provided. The regulation places a duty on provider organisations continually to evaluate and seek to improve their governance and auditing practice.

Provider organisations are required under the regulation to maintain accurate, complete and detailed records for each person to whom they provide a service and records relating the employment of staff and the overall management of the regulated activity. Provider organisations are required under the regulation to seek and act on feedback from patients/service users, those acting on their behalf, staff and other stakeholders to enable them to evaluate their services and drive improvement. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 68 of the following:

<http://www.cqc.org.uk/content/regulations-service-providers-and-managers>. Failure to comply with this element of the regulation is not an offence, but the CQC may take regulatory action.

When requested, provider organisations must give to the CQC a written report setting out how they assess, monitor, and where necessary improve the quality and safety of their services within 28 days of the request being made. Failure to comply with this element of the legislation is an offence and the CQC can move straight to prosecution without first issuing a warning notice.

Sound corporate governance underpinned by robust systems and processes is part and parcel of the work of provider organisations' boards and is subject to periodic review in accordance with the provisions of the foundation trust Code of Governance. Those boards that have not yet commissioned an external review of their governance arrangements may wish to consider whether it would be timely to do so in the light of the regulations.

## Staffing

To meet regulation 18 provider organisations must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are available to meet the needs of patients/service users at all times as well as to meet the other regulatory requirements. Provider organisations must ensure that their staff receive the support, training,

professional development, supervision and appraisals necessary for them to carry out their duties effectively and so that they continue to meet the professional standards necessary to practise.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 75 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>.

The CQC cannot prosecute for a breach of this regulation but it may take regulatory action. Provider organisations will need to be cognisant and take account of any recommended guidelines on staffing levels including NICE guidelines where available and need to take account of the views of their staff in determining staffing. There is currently no legal requirement to follow guidelines such as those produced by NICE, but organisations that choose not to follow the guidelines should have followed a rigorous process in deciding otherwise and should have a body of evidence available to them to assure themselves on the decision.

## Fit and proper persons employed

To comply with regulation 19 provider organisations must ensure that persons employed to carry on a regulated activity must:

- (a) be of good character;
- (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and
- (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.

**'Regulated activity'** means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It is a matter for the provider organisation to decide whether a person is of good character but they must take account of all available information to confirm that the person is of good character, and have regard to the matters outlined in Schedule 4, Part 2 of the regulations:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The CQC will expect that processes followed to assess good character take account of honesty, trust, reliability and respect. In common with directors, employees must be able to provide information in accordance with Schedule 3 of the regulations: <http://www.legislation.gov.uk/ukdsi/2014/9780111117613/schedule/3>. If a provider organisation considers that an applicant is suitable, despite them having information about anything set out in Schedule 3, their reasons for reaching that decision should be recorded for future reference.

There is a requirement that provider organisations review the fitness of their staff on a regular basis and take appropriate action where necessary including ensuring that staff found to be unfit no longer carry out the regulated activity. Appraisals are likely to be a suitable vehicle for such reviews. Provider organisations will need to ensure that they have effective and fair procedures in place to deal with concerns about a person's fitness, but where there is the possibility of imminent risk organisations should be able to respond immediately.

Where a qualification is not required by law it is for provider organisations to decide what qualifications are necessary for a role. In either case provider organisations must take steps to ensure that appointed staff hold the necessary qualifications and remain fit and qualified to practise.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 79 of the following: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>.

The CQC cannot bring a prosecution for a breach of any element of this regulation unless it also constitutes a breach of one of the other prosecutable regulations. It can however take regulatory action.

## Duty of candour

Regulation 20 makes it a statutory requirement that health service bodies to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

**'Regulated activity'** means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In this context a 'relevant person' is the patient or service user. In the event of the patient or service user's death, or if they under 16, or over 16, but lack capacity in relation to the matter the relevant person can be someone lawfully acting on their behalf

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must:

- (a) notify the relevant person that the incident has occurred in accordance with the paragraph below and;
- (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

The notification must:

- (a) be given in person by one or more representatives of the health service body;
- (b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification;
- (c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate;
- (d) include an apology; and
- (e) be recorded in a written record which is kept securely by the health service body.

This must be followed by a written notification to the relevant person containing:

- (a) the information provided orally as described above;
- (b) details of any enquiries to be undertaken;
- (c) the results of any further enquiries into the incident; and
- (d) an apology.

All correspondence between the parties must be kept by the health service body. If the patient or service user or the person acting on their behalf cannot be contacted in person or declines to speak to the representative of the

health service body the above paragraphs do not apply, but the health service body must keep a written record of attempts to contact or to speak to service user, patient or their lawful representative.

### Further definitions

The regulations provide definitions as follows:

**Notifiable safety incident** means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or severe harm, moderate harm or prolonged psychological harm to the service user.

**Severe harm** means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

**Moderate harm** means harm that requires a moderate increase in treatment, and significant, but not permanent, harm.

**Moderate increase in treatment** means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

**Prolonged psychological harm** means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

**Apology** means an expression of sorrow or regret in respect of a notifiable safety incident.

Most of the requirements under the duty of candour are clear cut. NHS provider organisations will already have in place arrangements to comply with the contractual duty and these are likely to be adaptable to deal with the statutory duty. Nevertheless boards are likely to wish to be assured that the processes they have put in place are compliant with the statutory duty and are delivering the required outcome.

### The CQC's approach

The CQC has included consideration of the duty in its key lines of enquiry (KLOEs) for inspections and intends to use the regulations to promote and encourage good practice and to acknowledge good practice where it is found. The CQC has committed to working with provider organisations to develop processes by which compliance with the duty can be assessed and to reserve use of prosecution for those cases where there is evidence of deliberate withholding or manipulation of information.

The duty on providers to ensure an open and honest culture across and at all levels within its organisation is not in itself controversial, and indeed parallels the existing contractual duty of candour. However NHS provider boards will need to assure themselves that they comply fully with the spirit of openness implied by the duty. While processes and procedures can be put in place quite quickly alongside measures to deliver compliance, culture change

generally takes place over a much longer timescale and it is often the case that behaviours will change before attitudes.

Please find our consultation response here: <http://www.foundationtrustnetwork.org/resource-library/fit-and-proper-persons-and-duty-of-candour/?preview=true>.

## Display of CQC ratings on NHS provider organisation premises and websites

Regulation 20A of the Fundamental Standards sets out the requirement to display ratings ('performance assessments') at their physical premises and on their website(s). This will be a legal requirement from 01 April 2015. This Annex summarises CQC's guidance but we strongly recommend you read the full guidance (13 pages) and approach CQC for clarification about how you can meet the display requirements with respect to any logistical or practical challenges for your own trusts' premises and services. CQC's guidance for the display of ratings can be found [here](#).

### Specific requirements placed on healthcare providers

To comply with this duty CQC offers the following guidance for NHS Trusts and Foundation Trusts:

- **You must display your ratings at each and every premises where you provide a regulated activity**, even if the premises is not registered with the CQC, and in your main place of business. Vehicles and patient's homes are exempt.
- Your ratings must be displayed at all premises **no later than 21 calendar days after your inspection report has been published on CQC's website**. This applies even if you have submitted a request for a review of ratings.
- **There are up to three different types of posters outlined by CQC:**
  - The provider poster (with information on the trust rating overall),
  - Premises poster (for information relating to services provided at a specific site)
  - Activity poster (for information relating to specific core services).
- **Posters need to include specific information:** CQC has made posters for displaying ratings available to download from [their website](#). You may also design your own poster but it must be as readable as the CQC template.
- **Which posters need to be displayed?** There is a table in the guidance that sets out CQC's expectations for different sectors on how posters should be displayed and at which locations. In brief:
  - the premises poster should be displayed at each site, with the provider poster used if there is no premises level poster (for example, for community or mental health providers) or if a premises level poster is not relevant (for example, an NHS trust head office not in a CQC rated location).
  - You may wish to also display activity posters at the entrances to wards/clinics where core services are delivered.
  - Activity posters should always be displayed alongside either the premises poster or the provider poster.
  - Posters should be printed in colour and at a minimum size of A4 (or larger to ensure visibility).
- **Where posters should be displayed:** CQC expects **hospitals** to display ratings posters at the main entrance(s) to each hospital so as many people as possible can see them. **Community-based services** will need to ensure that the poster(s) are visible to patients when they use services. **Mental Health trusts** will

need to display poster(s) at the main entrance(s) so as many people as possible are able to see them. If some patients do not use the entrance (for example, they are on a locked ward) you must display the poster so those patients can see it. In premises where several registered providers operate, it is up to each provider to ensure the ratings for the services they provide are displayed.

- **Additional information:** Providers are encouraged to display additional information (alongside, not instead of, the CQC poster) for patients if considered that it will aid their fuller understanding of the CQC ratings.
- **Websites:** CQC have developed a 'widget' to help you display your rating online (available [here](#)). Wherever possible, it is advised that ratings be placed on a 'context-specific' page. For example, a hospital rating should be included on the main page for that hospital. If your trust does not have premises specific pages, you are still required to display your premises ratings. You must put your ratings on every website that you operate that describes the services you offer and the ratings should be on a page that can be reached via the main navigation.

### NHS Providers' view

From your feedback to date, we recognise that members may find the requirements set out above onerous, or more difficult to implement in some care settings than others. We welcome your on going feedback on the implementation of all of the regulations emanating from the Care Act, and we are in an open dialogue with CQC and others about their implementation. Our consultation responses to date can be found [here](#).

## Conclusions

The regulations are intended to comprise a comprehensive suite of requirements that will help the CQC to regulate provider organisation's compliance with fundamental standards. Breach of regulations 11, 12, 13, 14, 16, 17 and 20 can lead to directly to the prosecution of organisations with the possibility of substantial fines being imposed in addition to possible damage to the reputation of the organisation involved. It is not known whether prosecution will be the preferred route for breaches given that other regulatory action will be available to the CQC however all provider boards will wish to assure themselves that they have the necessary processes and procedures in place to comply for patient benefit and to support staff appropriately, as well as given the likely national focus on monitoring compliance with the new standards.

NHS Providers  
March 2015

BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 April 2015 - Part 1
<b>Subject:</b>	Communications Report (including media KPIs and Core Brief)
<b>Section:</b>	Information
<b>Executive Director with overall responsibility</b>	Karen Allman, Director of Human Resources
<b>Author(s):</b>	James Donald, Head of Communications, and Jane Bruccoleri-Aitchison, Communications Manager
<b>Previous discussion and/or dissemination:</b>	
<b>Action required:</b>  The Board of Directors is asked to: To note the report	
<b>Summary:</b>  The Communications Report provides a summary of key communication activities over the past month as well as upcoming activities and media KPIs	
<b>Related Strategic Goals/ Objectives:</b>	Access to care Provider of choice
<b>Relevant CQC Outcome:</b>	Section 1, Outcome 1, Section 4, Outcome 13 and 14
<b>Risk Profile:</b> <ul style="list-style-type: none"> <li>i. Have any risks been reduced?</li> <li>ii. Have any risks been created?</li> </ul>	
<b>Reason paper is in Part 2</b>	N/A

## **Communications activities April 2015**

### **1. Introduction**

The following paper includes:

- recent and future communication activities
- media coverage summary key performance indicators
- April Core Brief

### **2. Recent activities**

- Focus on our objectives for Core Brief
- Clinical Services Review – update in Core Brief
- Website updates
- Annual Report
- War on Sepsis – improvement working group led by Deb Matthews
- Kiss Goodbye to Sepsis social media campaign – linked to national campaign
- Working with fundraising on developing local networks
- Launch of recruitment website and twitter account
- Promotion of staff question time
- Promotion of RBH staff who have been given Wessex Quality improvement fellowships
- Promotion of public campaign explaining what to do if feeling unwell over Easter bank holidays to try and ease pressures on ED

### **3. Upcoming activities**

- Annual Report
- Development of social media policy, with Information Governance
- Development of VIP visitor policy
- Planning the 2015 Pride Awards
- Raising sponsorship for 2015 Pride Awards
- Supporting materials for Sexual Health Dorset bid
- FT Focus magazine for members
- Updating all ward webpages
- Outsourcing outpatient pharmacy communications
- eNursing Assessment communications
- Staff governor comms
- Workforce transformation comms
- Comms for planned works on A338 from September
- Quality improvement projects – patient flow and surgical checklist

### **4. Recommendation**

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

March saw a high level of positive articles both online and in the print media. Articles included a pan Dorset appeal for people to seek appropriate medical support over the Easter weekend and stories about what to do to prevent the spread of norovirus. The Communications Team also facilitated two pieces of filming in March, one in our Emergency Department for the BBC Three show *Don't Tell The Bride* and the second a focus on our Sterile Services Department at Alderney Hospital for the *One Show*.

March also saw a series of articles about the work of our Bournemouth Hospital Charity, including online video coverage of its event March for Men.

Both our Twitter and Facebook followers continue to grow, with our support for the national social media campaign #hellomynameis and a visit from Lee Ryan from Blue to one of our patients helping boost followers. A separate Trust Twitter page dedicated to recruitment has also been set up.

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

2015	Number of proactive news releases distributed	% that received media coverage in <u>that month</u>	Total <b>PRINT</b> coverage (includes adverts)	Total <b>OTHER</b> coverage (online, radio, TV)	Positive media coverage	Neutral media coverage	Negative media coverage	Media enquiries
<b>March</b>	13 (including planning for Easter pressures, charity activities and NHS Change Day)	100%	33	25	48	10	0	8 (including norovirus, non-smoking day, emergency admissions and filming requests)
<b>February</b>	8 (including information standard, staff survey and new NASA treadmill)	88%	25	12	34	1	2	10 (including delayed discharges, winter pressures, the NASA treadmill and filming requests)

*excellent care for every patient,  
every day, everywhere*

The Royal Bournemouth and  
Christchurch Hospitals  
NHS Foundation Trust



# Core Brief

From: Tony Spotswood, Chief Executive

April 2015

# Our objectives

Our Board of Directors has agreed our objectives for 2015/16. These objectives focus on quality of care for our patients, improvement, performance and value for money and will become the basis for individual objective setting across the whole organisation.

The objectives, which tie in with our vision to provide 'excellent care for our patients reflecting the care we expect for our families', are:

- **Quality:** providing safe, effective and compassionate care
- **Improvement:** using the Quality Improvement methodology to support achievement of the Trust priorities of sepsis, procedure checklist, simple discharge, emergency laparotomy, and cancer referral pathways, or locally agreed improvement priorities
- **Strategy and partnerships:** to have a clear strategy that responds to the Clinical Services Review and provides a basis for maintaining viable high quality services through until its implementation
- **Staff:** focusing on good organisational health with a positive development and learning culture, strong leadership and team work

- **Performance:** delivering the performance required to maintain access to elective diagnostic and emergency services

- **Value for money:** staying within budget using resources wisely and cutting waste to allow the maximum funding to go to front line patient care

You can read more about our objectives by following the 'Trust Objectives 2015/16' link on the homepage of our intranet site.

## The new objectives and you

The new Trust objectives will be used to shape and develop your own care group and departmental 'goals'. Your manager will then use these to set your own individual objectives during your appraisal.

We have changed the appraisal process to better enable you to understand how your own objectives fit with those of your team as well as the Trust.

The appraisal process also includes a new behavioural framework which is closely linked to our values. You can find out more on page 9.



# Improvement

## - let's all play our part



One of our key objectives for this year is to drive continued improvements in patient experience, outcomes and care across the whole Trust. As you know, 'Improve' is one of our four key values and doing things differently and changing to improve is not just down to one person, team or project. Everyone can play a part and we want you to get involved.

Our aim is for continuous quality improvement as part of your everyday work and our key priorities are:

- Improving the management of sepsis to ensure our patients' symptoms are spotted early, diagnosed quickly and treated rapidly
- Improving patient flow through the hospital and timely discharge, ensuring the right patient is in the right environment at the right time
- Using a standard operating procedure for all patients undergoing emergency laparotomy
- Ensuring a uniform use of safety checklists for all operations and procedures to increase patient safety
- Implementing the NICE guidelines for patients referred with suspected GI cancer ensuring a minimum of 93% of them receive an appointment within two weeks

### Why improve?

- Better patient experience and feedback
- Better working environment for staff
- Delivering a cost effective and value for money service

## Focus on Sepsis

You may have noticed the logo below on posters, social media and screensavers across our hospitals. That's because we're waging war on sepsis. Sepsis is a serious infection which can kill, but together we can beat it.

Our teams in the Emergency Department, Acute Medical Unit and Surgical Admissions Unit have already started on stage one of the improvement cycle and are working hard to reduce the time from identification of severe sepsis and / or septic shock to the administration of antibiotics.

Training packs have been developed for the clinical teams which convey the importance of administering antibiotics within one hour and working closely as a team for the benefit of our patients. The training is being delivered by staff in the three areas and the pack is also available for all staff to view on the homepage of the intranet.

We'll keep you updated on progress.

## We are one team working together



**SE:PS:IS**  
Think Sepsis Save Lives



# Improvement

- let's all play our part



## Staff use '5 daily actions' to improve flow for patients

On Wednesday 1, Tuesday 7 and Wednesday 8 April, staff across the Trust trialled using '5 daily actions' to get the right patients in the right environment at the right time. Feedback is now being collected about how effective the '5 daily actions' were. They can be seen on the intranet home page and your feedback about whether they worked is crucial.

Please give your feedback via email to BJ or Claire, to your heads of nursing or



matrons, or at the stand in the RBH Atrium on Thursday 9 and Friday 10 April, 12-2pm.

BJ Waltho,  
Associate Director of Operations,  
ext. 4743, [BJ.Waltho@rbch.nhs.uk](mailto:BJ.Waltho@rbch.nhs.uk)

Claire Mills,  
Improvement Manager,  
ext. 4982, [Claire.Mills@rbch.nhs.uk](mailto:Claire.Mills@rbch.nhs.uk)

## Transformation programme

The NHS is facing a time of unprecedented challenge, both in terms of finances and the way in which healthcare is provided. Demand for services is outstripping funding and across counties and regions the NHS - including hospitals, GPs and community care providers as well as social services - is looking at how we can all work differently and more efficiently while meeting the needs and expectations of our patients.

We are no exception to this local and national picture. To help us to meet these challenges, a transformation programme has been established, led by Mark Friedman, but also working closely with Deb Matthews and the Quality Improvement (QI) team.

The programme entails three main areas of work:

- Savings - also known as cost improvement plans (CIPs)

- Reorganising services, either alone or with partners, where efficiencies are possible
- Generating income, for example through more private patient work.

Maintaining the high quality services our patients receive is vital, and there are robust measures in place to ensure that no savings idea or service change can be implemented without this being carefully addressed.

Many staff will be involved with steering groups working across the Trust to help push this work forward, but all of us have a role to play both individually and collectively in securing our future by thinking how we can work in a different way to support the Trust's goals. Any staff can contribute by putting forward thoughts on how we can be more efficient or reduce waste.

If you have an idea, the programme management office (PMO), in the management offices, is keen to hear from you. It could be developed into a practical project that could benefit you, your colleagues and our patients and help ensure our viable future.

Drop in to the office, or please email [geraldine.sweeney@rbch.nhs.uk](mailto:geraldine.sweeney@rbch.nhs.uk).

# Electronic Nurse Assessment (eNA) on the way

Nurses will soon be able to complete core risk assessments for patients electronically at the bedside thanks to a new mobile application.

Electronic Nurse Assessment (eNA) will enhance the use of iPods and iPads to collect patient and clinical data. A 'Clinical Compass' will also be developed to demonstrate the real time ward, directorate, care group and Trust compliance of all assessments.

Staff will be able to drill down to an individual patient episode, look at trends of risk assessment data for it and analyse further problems going back six months.

Other benefits include:

- reducing the risk of human error and improving data accuracy
- immediate access to patient information 24/7
- reducing the number of falls, pressure ulcers etc
- reducing the time it takes for nurses and other staff to complete the risk assessments
- reducing duplication and the double entry of patient data

It is hoped that the new application will go live at the beginning of July 2015.

Tracey Cooper, IT Specialist Nurse, said:

*"eNA is the next step in this exciting journey for nurses and ward staff who are using electronic solutions on hand-held devices to assist and ease the documentation of assessment, planning, implementation and evaluation of patient care. This has been developed to go hand in hand with the revised 14 day care plan document."*

# Clinical Services Review - The next steps!

Work is now taking place by the Dorset Clinical Commissioning Group (CCG) to evaluate and analyse potential options for the future pattern and delivery of health care across Dorset following the publication of its Clinical Services Review.

No changes will be made until proposals have been put to public consultation. The CCG will decide on the potential options for consultation at its meeting on Thursday 21 May. It is the CCG's intention that the consultation will start late summer and run for 12 weeks into November 2015.

Find out more by joining the Health Involvement Network ([www.dorsetsvision.nhs.uk/get-involved](http://www.dorsetsvision.nhs.uk/get-involved)) to keep up-to-date on the consultation and we will also be sharing further updates with you in the future.

**Clinical Services Review:** [www.dorsetsvision.nhs.uk/the-review](http://www.dorsetsvision.nhs.uk/the-review)



# Staff Question Time - get involved

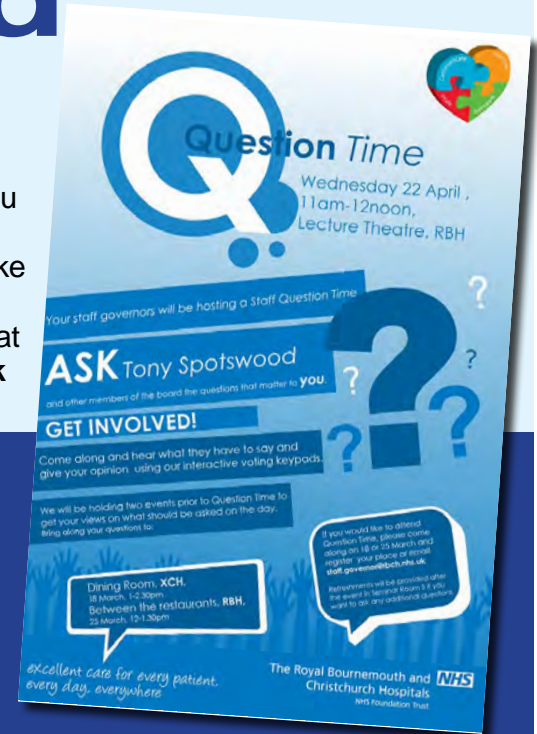
Your staff governors will be hosting Staff Question Time on Wednesday 22 April from 11am-12noon - asking Tony Spotswood and other members of the board the questions that matter to you. Come along and hear what they have to say and give your opinion along the way using our interactive voting keypads.

The main event will take place in the Lecture Theatre at RBH. Refreshments will be provided after the event in Seminar Room 5 if you want to ask any additional questions.

You don't need to ask the questions yourself on the day as your staff governors will

do it for you. We have already hosted stands at RBH and at Christchurch where you have given us ideas for questions you want answering but it's not too late to have your say. If you'd like to submit a question or want to attend the event, just email us at [staff.governors@rbch.nhs.uk](mailto:staff.governors@rbch.nhs.uk)

**Note to managers!**  
**This is an important opportunity for staff to hear directly from the Board so where possible, please ensure your staff are freed to attend.**



## Leadership Improvement and Change Programme for bands 2-8

A four day practical programme aimed at equipping existing and emerging managers with the tools and techniques they need to lead their teams more effectively has been introduced.

The course has a specific focus on leading change and improvement initiatives, and is framed around the Trust's Change Model and looks at how to manage, engage and involve others in facilitating successful change and improvement.

The programme covers a range of areas to enable leaders to:

- understand what drives change and how to engage staff in improvement initiatives
- utilise a range of improvement tools to drive change in their area
- raise self-awareness of you and others to improve communication skills, reduce conflict, increase resilience and adapt leadership approach to better engage and motivate staff
- improve delegation, time management, problem solving and prioritisation skills
- utilise a range of tools and techniques to confidently challenge poor behaviours and performance and have difficult conversations



The programme is aimed at individuals who have some line management or supervisory responsibility or at those who might assume responsibility for others in a deputising capacity.

Places are limited and a selection process will be used to allocate places according to individual readiness to benefit from training.

For more information and how to apply, please complete the form on the training intranet pages and email it to [leadershipdevelopment@rbch.nhs.uk](mailto:leadershipdevelopment@rbch.nhs.uk) by Friday 17 April.

# Wessex Quality Improvement Fellowships

Health Education Wessex and the Thames Valley Wessex Leadership Academy have begun recruiting individuals to participate in a 12-month Quality Improvement Fellowship programme.

They have announced the appointment of seven fellowships, three of which are from our Trust.

Name	Improvement Area
<b>Tom Bartlett</b>	Flow: Geriatrician support to surgical teams
<b>Ed Hewertson</b>	Flow: Best practice board / ward rounds
<b>Claire Gregory</b>	Fast track cancer referrals

The trio will be released from their current roles for two days each week to participate in the scheme.



## Ed Hewertson said:

*"I have been actively involved in Quality Improvement for the last two years. This fellowship is a fantastic opportunity for me to improve my QI skills and methodology. I hope it will allow me to make a significant contribution to RBCHT during my time here. One of my aims is to disseminate my learning to staff within the organisation and throughout Wessex."*

There have also been seven successful applicants from our Trust for the SAS Doctors Programme, which is the largest cohort across Wessex.

Name	Improvement Area
<b>Clare Baggett</b> <b>Sathyabama Loganathan</b>	Discharge planning in MFE and Stroke
<b>Anwar al Huda</b>	Effect of volume versus pressure controlled ventilation on intraocular pressure of patients in Trendelenburg position for laparoscopic robotic prostatectomy
<b>Rajeev Ghat</b>	Text and email patient reminders for outpatient and theatre appointments to decrease non attendance
<b>Kauser Kazem</b>	One stop breast clinics for new referrals within one week of receipt of referral
<b>Monika Prabhakar</b>	Introduction of contraception (limited) based on the quick start method (FSRH guidance) within the department with a view to providing an integrated sexual health service to the patient
<b>Sally Hamblin</b>	Introduction of a young person's clinic for screening for CSE (child sexual exploitation) within Sexual Health

**Well done everyone.**



# Let's talk about IT

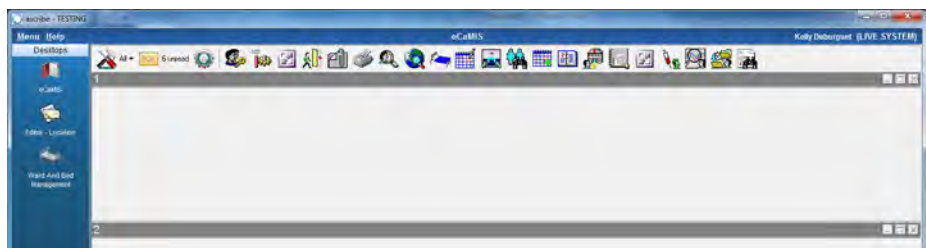
## eCaMIS update

The HAP rollout is nearly complete and you should now be using eCaMIS through the HAP instead of clicking on the eCaMIS icon itself on your desktop, as this will soon be removed. You will soon be informed by email with a new password to access the HAP.

The HAP is designed to ensure you are focusing on a single patient at any one time so that when other integrated

applications are added to it and you select a different patient the context changes for all panes. This means you will only be able to view one patient at a time in a single pane.

Other benefits of the HAP are the ability to view the Poole EPR data/results in Clinical Viewer as part of the Interim EPR Solution.



## eBed Management

The new eBed Management system is now on all iPads and desktop computers across the Trust.

Please make sure you book your full training and refresher sessions on how to use it.

It is all ward staff's responsibility to keep the new resource

updated and accurate at all times. This is a real time system and needs to show a clear picture of a ward so that your colleagues know what beds are available and those that aren't.

To book your training, contact either Kelly or Lisa on ext. 4980 or bleep 2818.

<b>RB01</b> Capacity: 18 Patients in beds: 18 Patients waiting: 0 Closed beds: 0 Available Beds: 0	<b>RB01G1</b> Capacity: 4 Patients in beds: 4 Patients waiting: 0 Closed beds: 0 Available Beds: 0	<b>RB02</b> Capacity: 22 Patients in beds: 22 Patients waiting: 0 Closed beds: 0 Available Beds: 0	<b>RB02ALU</b> Capacity: 4 Patients in beds: 3 Patients waiting: 0 Closed beds: 0 Available Beds: 1	<b>RB03</b> Capacity: 28 Patients in beds: 23 Patients waiting: 0 Closed beds: 0 Available Beds: 5	<b>RB04</b> Capacity: 28 Patients in beds: 21 Patients waiting: 7 Closed beds: 0 Available Beds: 5	<b>RB05</b> Capacity: 28 Patients in beds: 26 Patients waiting: 1 Closed beds: 0 Available Beds: 2
<b>RB07</b> Capacity: 21 Patients in beds: 18 Patients waiting: 0 Closed beds: 0 Available Beds: 3	<b>RB09</b> Capacity: 27 Patients in beds: 29 Patients waiting: 0 Closed beds: 0 Available Beds: 2	<b>RB11</b> Capacity: 17 Patients in beds: 16 Patients waiting: 0 Closed beds: 1 Available Beds: 0	<b>RB1255</b> Capacity: 16 Patients in beds: 9 Patients waiting: 0 Closed beds: 6 Available Beds: 1	<b>RB14</b> Capacity: 28 Patients in beds: 28 Patients waiting: 1 Closed beds: 0 Available Beds: 3	<b>RB15</b> Capacity: 26 Patients in beds: 23 Patients waiting: 0 Closed beds: 0 Available Beds: 3	<b>RB16</b> Capacity: 28 Patients in beds: 19 Patients waiting: 0 Closed beds: 6 Available Beds: 3
<b>RB17</b> Capacity: 21 Patients in beds: 16 Patients waiting: 0 Closed beds: 5 Available Beds: 5	<b>RB18SA</b> Capacity: 15 Patients in beds: 9 Patients waiting: 0 Closed beds: 0 Available Beds: 6	<b>RB21</b> Capacity: 22 Patients in beds: 20 Patients waiting: 0 Closed beds: 1 Available Beds: 1	<b>RB22</b> Capacity: 28 Patients in beds: 26 Patients waiting: 1 Closed beds: 0 Available Beds: 2	<b>RB23</b> Capacity: 21 Patients in beds: 6 Patients waiting: 10 Closed beds: 0 Available Beds: 15	<b>RB24</b> Capacity: 25 Patients in beds: 18 Patients waiting: 0 Closed beds: 0 Available Beds: 7	<b>RB25</b> Capacity: 25 Patients in beds: 25 Patients waiting: 0 Closed beds: 0 Available Beds: 0
<b>RB26</b> Capacity: 25 Patients in beds: 25 Patients waiting: 0 Closed beds: 0 Available Beds: 0	<b>RBAAU</b> Capacity: 49 Patients in beds: 0 Patients waiting: 50 Closed beds: 0 Available Beds: 49	<b>RBCCU</b> Capacity: 10 Patients in beds: 7 Patients waiting: 1 Closed beds: 0 Available Beds: 3	<b>RBH - CARDIAC INT</b> Capacity: 0 Patients in beds: 0 Patients waiting: 11 Closed beds: 0 Available Beds: 1	<b>RBH - ENDOSCOPY</b> Capacity: 0 Patients in beds: 0 Patients waiting: 0 Closed beds: 0 Available Beds: 0	<b>RBH - MAIN RECOV</b> Capacity: 0 Patients in beds: 0 Patients waiting: 5 Closed beds: 0 Available Beds: 0	<b>RBH - STROKE UNIT</b> Capacity: 36 Patients in beds: 35 Patients waiting: 1 Closed beds: 0 Available Beds: 1
<b>RBITU</b> Capacity: 13 Patients in beds: 8 Patients waiting: 0 Closed beds: 0 Available Beds: 5	<b>RBO</b> Capacity: 10 Patients in beds: 9 Patients waiting: 1 Closed beds: 0 Available Beds: 7	<b>RBSDJL</b> Capacity: 0 Patients in beds: 0 Patients waiting: 2 Closed beds: 0 Available Beds: 0	<b>RBITU</b> Capacity: 0 Patients in beds: 0 Patients waiting: 31 Closed beds: 0 Available Beds: 0	<b>RDER</b> Capacity: 30 Patients in beds: 24 Patients waiting: 0 Closed beds: 2 Available Beds: 4	<b>XCH - MACMILLAN</b> Capacity: 0 Patients in beds: 0 Patients waiting: 15 Closed beds: 0 Available Beds: 0	

## IT best practice

Our IT Department has now been trained in ITIL foundation, with a large number of senior staff recently gaining qualifications in the Intermediate Service Design course.

The Information Technology Infrastructure Library (ITIL) is a set of practices for IT Service Management (ITSM) that focuses on aligning IT services with the needs of business.

In its current form, known as ITIL 2011 edition, it is published as a series of five core volumes, each of which covers a different ITSM lifecycle stage.

ITIL describes processes, procedures, tasks, and checklists which are not organisation-specific, but can be applied by an organisation for establishing integration with their strategy, delivering value and maintaining a minimum level of competency.

It allows the organisation to establish a baseline from which it can plan, implement, and measure, and can be used to demonstrate compliance.

The Service Design (SD) volume provides good-practice guidance on the design of IT services, processes, and other aspects of the service management effort.

Significantly, design within ITIL is understood to encompass all elements relevant to technology service delivery, rather than focusing solely on the design of the technology itself.



# eDM rollout update

A number of specialities have now gone live and are actively using Electronic Document Management (eDM).

Over the coming weeks and months, further specialities will be going live. These include:

**April 2015:**

**Trauma and Orthopaedics, Dietetics, Rheumatology, Diabetics and Endocrine**

**May 2015:**

**Ophthalmology, Max/Oral, Occupational Therapy, Occupational Medicine**

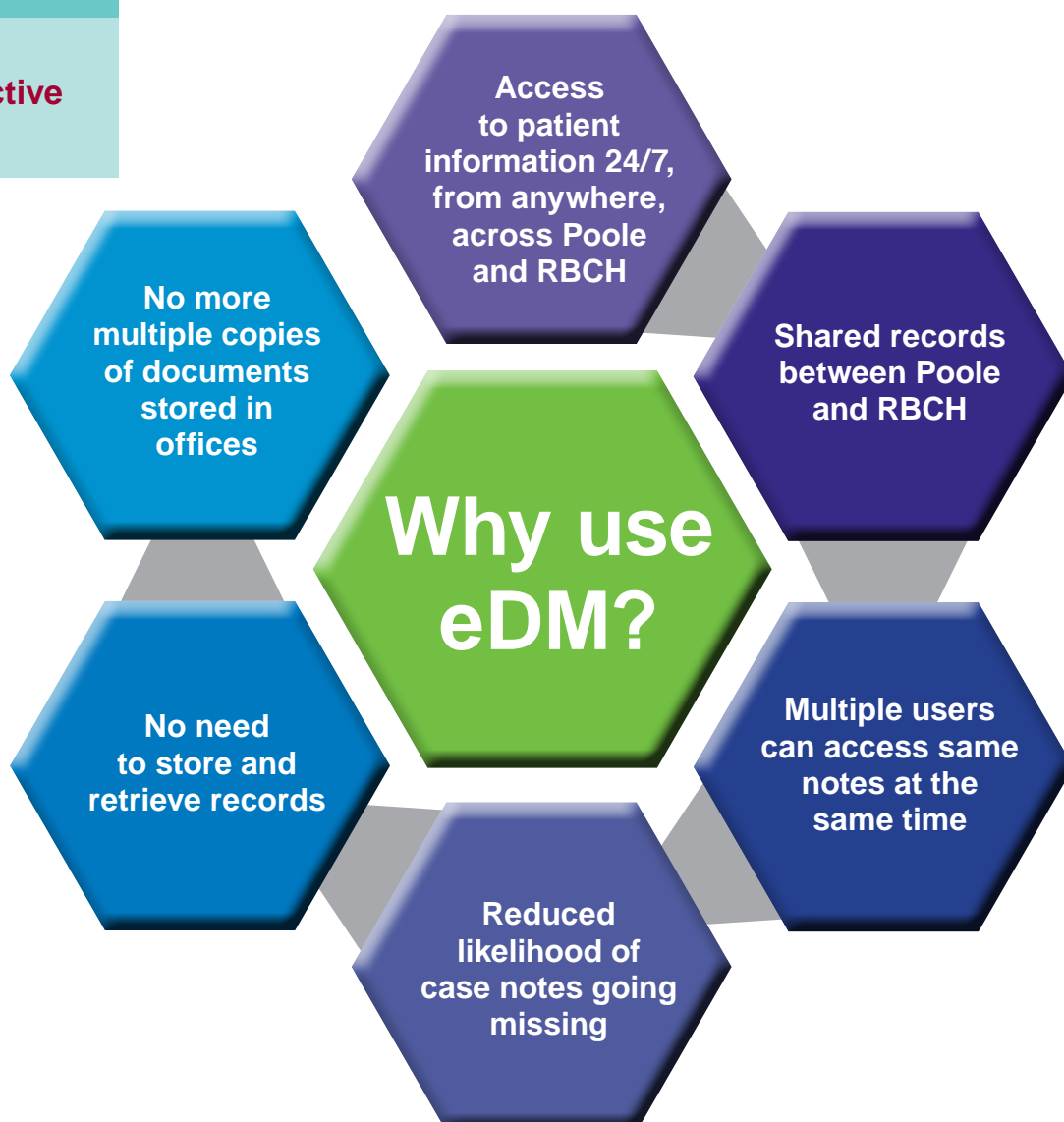
**June 2015:**

**Paediatrics and Elective Admissions**

Specialties already live	Date of Go Live
Radiotherapy - Clinical Oncology	10 November 2014
Breast and Gynecology	19 November 2014
Medical Oncology, Hematology, Palliative Care, Neurology, Colorectal	1 December 2014
Stroke and General Medicine	19 January 2015
MFE/DME	26 January 2015
Cardiology, Thoracic	2 February 2015
Gastro, Hematology	16 February 2015
Dermatology	2 March 2015
ENT, General Surgery, Upper GI	16 March 2015
Urology and Vascular	30 March 2015

Classroom based training is key. Please encourage all of your staff to attend eDM training at the earliest opportunity. The floor walking team will be on site to provide refresher training and advice.

**To book a training session, contact the Training Department on ext. 4285.**



# Values based appraisal



We have launched our new appraisal process for all non-medical staff and it's all about you. It means you will be asked to reflect on the past year, and what you have done well. It will also be an opportunity for you to receive feedback on your performance and behaviour over the last 12 months. The new process ensures that your personal objectives are clearly linked to your teams, and helps you to understand how your role supports the Trust in achieving our overarching vision and objectives.

The new appraisal period runs from the beginning of April to Monday 30 November. This means you will need to have a new values based appraisal during this time. You won't have your appraisal until your line manager has had theirs. This is to ensure the objectives are clearly linked to the Trust's.

You will need to prepare for your appraisal before the meeting. The new forms and our new Trust behaviour sets can be found on the intranet, under Training/Appraisals.

When your appraisal has been completed it will be stored on the Virtual Learning Environment so that you can see it when you like. As an appraiser, you will need to enter the completed appraisal date into ESR using the new competency **(153|LOCAL|Appraisal-Values Based Competency|Core)**.

If you are an appraiser, you must also attend one of the new training sessions before conducting any appraisals. To find out more take a look at the resources on the intranet. We will be adding more shortly.

Please use this form to cascade key messages from Core Brief to your staff – please return to the Communications Department, ppB43, RBH

## Core Brief

Date of Core Brief cascade briefing: 8 April 2015

Name:  
Department/Ward:

Date delivered:

Who to:  
How many:

Please use the *Core Brief* that has been circulated to all staff via global email to support you in cascading the following messages:

**Our objectives:** Our Board of Directors has agreed our objectives for 2015/16. The objectives, which tie in with our vision to ‘provide excellent care for our patients reflecting the care we expect for our families’ focus on quality, improvement, strategy and partnerships, performance and value for money. The new objectives will be used to shape and develop your own care group and departmental ‘goals’. Your manager will then use these to set your own individual objectives during your appraisal. The appraisal process has been changed to better enable you to understand how your own objectives fit with those of your team as well as the Trust.

**Action:** Managers should use these objectives to set departmental objectives which then feed into individual objectives. Please can all managers make sure they advise staff that they can read more about our objectives by following the ‘Trust Objectives 2015/16’ link on the homepage of our intranet site.

**Improvement and transformation – we can all play our part:** One of our key objectives for this year is to drive continued improvements in patient experience, outcomes and care across the whole Trust. Our aim is for continuous quality improvement as part of your everyday work and our key priorities include enhancing the management of sepsis to ensure our patients’ symptoms are spotted early, diagnosed quickly and treated rapidly. They also look at improving patient flow through the hospital and timely discharge, making sure the right patient is in the right environment at the right time.

**Action:** The Communications Team will continue to provide updates on each improvement area and the transformation project. Please can all managers ensure their staff are given these updates as and when they are disseminated and encourage staff to contribute their ideas.

**Staff Question Time event:** Your staff governors will be hosting a Staff Question Time event on Wednesday 22 April where they will be asking Tony Spotswood and other members of the board the questions that matter to you. You are all welcome to attend and hear what they have to say. The main event will take place in the Lecture Theatre at RBH. You don’t need to ask the questions yourself on the day as the governors will do it for you. We have already hosted stands at RBH and at Christchurch where you have given us ideas for questions.

**Action:** This is an important opportunity for staff to hear directly from the Board so where possible, please can all managers ensure your staff are freed to attend, as well as advising them on how to submit a question and confirm their attendance for the event.

**Leadership Improvement and Change Programme for bands 2-8:** A four day practical course aimed at equipping existing and emerging managers with the tools and skills they need to lead their teams more effectively has been introduced. The programme has a specific focus on leading change and improvement initiatives, and is designed around the Trust’s Change Model. The course is aimed at individuals who have some line management or supervisory responsibility or those who may deputise

**Action:** Places are limited and a selection process will be used to allocate places according to individual readiness to benefit from training. For more information and how to apply, please complete the form on the training intranet pages and email it to [leadershipdevelopment@rbch.nhs.uk](mailto:leadershipdevelopment@rbch.nhs.uk) by Friday 17 April.

**Staff questions: (please list any questions your staff have following the briefing)**

**Signed:**

**Date:**

BOARD OF DIRECTORS	
<b>Meeting Date and Part:</b>	24 April 2015 Part 1
<b>Subject:</b>	Corporate Events Calendar
<b>Section:</b>	Information
<b>Executive Director with overall responsibility</b>	Tony Spotswood, Chief Executive
<b>Author(s):</b>	Anneliese Harrison
<b>Previous discussion and/or dissemination:</b>	N/a
<b>Action required:</b> To note for information	
<b>Summary:</b> Corporate Events arranged until December 2015	
<b>Related Strategic Goals/ Objectives:</b>	All
<b>Relevant CQC Outcome:</b>	N/a
<b>Risk Profile:</b> <ul style="list-style-type: none"> <li>i. Have any risks been reduced? No</li> <li>ii. Have any risks been created? No</li> </ul>	
<b>Reason paper is in Part 2</b>	N/A

## CORPORATE EVENTS CALENDAR 2015

Date and Time	Event Description	Venue	Contact Details
Thursday 23 April	Staff benefits	Between Restaurants	
Thursday 23 April	Parkinson's awareness week	Main Atrium, Royal Bournemouth Hospital	01202 704160
Friday 24 April	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Friday 24 April	Cake sale, Orthodontics department	Between restaurants	01202 704705
Tuesday 28 April	Council of Governors' Meeting	Conference Room, Education Centre, Royal Bournemouth Hospital	01202 704246
Wednesday 29 April	Rheumatology Focus Group	Howard Centre	01202 704253
Friday 8 May	Heart Failure Awareness	Atrium	01202 704394
Monday 11 May	Understanding Dermatology	The Village Hotel	01202 704271
Wednesday 20 May	Clinical Trials Day	Atrium	01202 704394
Wednesday 27 May	Stakeholder Event for Carers	TBA	01202 704253
Friday 29 May	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Sunday 31 May	Wing Walk	Bournemouth Hospital Charity	01202 704060
Monday 1 June – Friday 5 June	Volunteer Week	Atrium and between restaurants	
Friday 5 June	Twilight walk for Women- Women's Health Unit	8pm Bournemouth Pier	01202 704060
Friday 26 June	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Wednesday 15 July	Council of Governors' Meeting	Conference Room, Education Centre, Royal	01202 704246

		Bournemouth Hospital	
Saturday 18 July	Sky Dive	Bournemouth Hospital Charity	01202 704060
Friday 31 July	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Saturday 12 September	Volunteer's Tea Party	Invitation Only- Volunteer's Office	01202 704253
Monday 21 September	Understanding Diabetes	The Village Hotel	01202 704271
Friday 25 September	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Sunday 27 September	Pedal Power	10am New Forest	01202 704060
Saturday 3 & Sunday 4 October	Bournemouth Marathon	Bournemouth Hospital Charity	01202 704060
Friday 30 October	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Friday 16 October	Light up the Prom- for Oncology & Haematology	8pm Bournemouth Pier	01202 704060
Throughout November	Movember		
Thursday 5 November	Council of Governors' Meeting	Conference Room, Education Centre, Royal Bournemouth Hospital	01202 704246
Friday 27 November	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Friday 4 December (TBC)	Understanding Knee Pain	The Village Hotel	01202 704271
Friday 18 December	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777

## 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	
<b>Meeting Date and Part:</b>	24 April 2015 Part 1
<b>Subject:</b>	Directors Forward Programme
<b>Section:</b>	Information
<b>Executive Director with overall responsibility</b>	Tony Spotswood, Chief Executive
<b>Author(s):</b>	Sarah Anderson, Trust Secretary
<b>Previous discussion and/or dissemination:</b>	N/a
<b>Action required:</b> To note for information	
<b>Summary:</b> Update of the Board of Directors Forward Programme	
<b>Related Strategic Goals/ Objectives:</b>	All
<b>Relevant CQC Outcome:</b>	
<b>Risk Profile:</b> <ul style="list-style-type: none"> <li>i. Have any risks been reduced? No</li> <li>ii. Have any risks been created? No</li> </ul>	
<b>Reason paper is in Part 2</b>	N/A

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Monitor Quarter 1 Submission	SH/RR/SA	Finance, HAC & Audit Cttees								Part 2					Monitor
Monitor Quarter 1 Report	SH/RR	Monitor/COO										Part 1			N/A
Monitor Quarter 2 Submission	SH/RR/SA	Finance, HAC & Audit Cttees										Part 2			Monitor
Monitor Quarter 2 Report	SH/RR	Monitor/COO										Part 1			N/A
Monitor Quarter 3 Submission	SH/RR/SA	Finance, HAC & Audit Cttees										Part 2			Monitor

