

A meeting of the Board of Directors will be held on **Friday 30 January 2015** at 8.30am in the **Committee Room, Trust Management Suite, Royal Bournemouth Hospital**.

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

SARAH ANDERSON
TRUST SECRETARY

A G E N D A

TIMINGS	1. APOLOGIES FOR ABSENCE	APPENDIX
	2. DECLARATIONS OF INTEREST	
8.30-8.35	3. MINUTES OF THE PREVIOUS MEETING	
	(a) To approve the minutes of the meeting held on Friday 12 December 2014	A
8.35-8.40	4. MATTERS ARISING	
	(a) To provide updates to the Actions Log - Winter escalation	Richard Renaut Verbal
8.40-8.55	5. QUALITY IMPROVEMENT	
8.40-8.50	(a) Patient Story	Andrew Wedderburn Verbal
8.50-8.55	(b) Feedback from Staff Governors	Jane Stichbury Verbal
8.55-10.25	6. PERFORMANCE	
8.55-9.10	(a) Performance Exception Report	Richard Renaut B
9.10-9.20	(b) Quality Report	Paula Shobbrook C
9.20-9.30	(c) Stroke Update	Richard Renaut D
9.30-9.35	(d) Same sex accommodation	Paula Shobbrook Verbal
9.35-9.45	(e) Financial Performance	Stuart Hunter E
9.45-9.55	(f) Workforce Report	Karen Allman F
9.55-10.20	(g) Talentworks feedback	Karen Allman Presentation
10.20-10.25	(h) Monitor Quarter 2 Report	Richard Renaut G
10.30-10.40	7. STRATEGY AND RISK	
	(a) Clinical Services Review	Tony Spotswood H
	(b) Development of the Trust's Strategy	Tony Spotswood I
10.40-10.50	8. INFORMATION	
	(a) Communications Update (including December and January Core Brief)	Karen Allman J
	(b) Briefing on travel and site access	Richard Renaut K

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|--|-----------------------|---|
| (c) Corporate Events Calendar | <i>Sarah Anderson</i> | L |
| (d) Board of Directors Forward Programme | <i>Sarah Anderson</i> | M |

9. NEXT MEETING

Friday 27 February 2015 at 8.30am in the Committee Room, Royal Bournemouth Hospital

10.50-10.55

10. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.55-11.10

11. 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.

12. 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 12 December 2014** 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>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>
	Basil Fozard	(BF)	<i>Medical Director</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>
	Bill Yardley	(BY)	<i>Non-Executive Director</i>
In attendance:	Peter Gill	(PG)	<i>Director of Informatics</i>
	Sarah Anderson	(SA)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Legal Assistant to the Trust Secretary</i>
	David Wrixton	(DW)	<i>Communications Officer</i>
	Ellie Cowley	(EC)	<i>Communications Officer</i>
	Dily Ruffer	(DR)	<i>Governor Co-ordinator</i>
	James Knowles	(JK)	<i>X-Ray Superintendent Radiographer</i>
	Kate Horsefield	(KH)	<i>Head of Nursing and Quality</i>
	Sarah Oliver	(SO)	<i>Directorate Manager Radiology</i>
	Sue Reed	(SR)	<i>Head of Nursing and Quality</i>
	Eric Fisher	(EF)	<i>Public Governor</i>
	David Bellamy	(DBe)	<i>Public Governor</i>
	Derek Chaffey	(DC)	<i>Public Governor</i>
	David Triplow	(DT)	<i>Public Governor</i>
	Doreen Holford	(DH)	<i>Public Governor</i>
	Glenys Brown	(GB)	<i>Public Governor</i>
	Keith Mitchell	(KM)	<i>Public Governor</i>
	Mike Allen	(MA)	<i>Public Governor</i>
	Roger Parsons	(RP)	<i>Public Governor</i>
	Carole Deas	(CD)	<i>Public Governor</i>
	Brian Young	(BY)	<i>Public Governor</i>
	Colin Pipe	(CP)	<i>Public Governor</i>
	Paul Higgs	(PH)	<i>Public Governor</i>
	Paul McMillan	(PM)	<i>Public Governor</i>
	Margaret Neville		<i>Chairman of the Friends of the Eye Unit</i>
	Chloe Cozens		<i>New Milton Advertiser</i>

Apologies: Dave Bennett (Non- Executive Director)

129/14 **DECLARATIONS OF INTEREST**

AP declared that she had been appointed as Non- Executive Director for Simply Health commencing November 2014 for a period of 3 years.

130/14 **MINUTES OF THE MEETING HELD ON 14 NOVEMBER 2014 (Appendix A)**

The minutes of the meeting on 14 November 2014 were approved subject to amendments.

131/14 **MATTERS ARISING (ACTIONS LOG UPDATE) (Appendix B)**

- (a) 111/14 b - Wording to be provided to Governors as to role and Governors consulted.
- (b) 112/14 a - Communications to publicise the patient's story.
- (c) 121/14 d - A buzzword article has been featured. Leaders are to ensure feedback is provided to staff. KA has also set up monthly meeting with staff governors to voice concerns
- (d) 124/14 - TS confirmed work was underway on Trust vision and an update would be provided in the meeting.

132/14 **QUALITY IMPROVEMENT**

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

JK presented the patient story which focused on the improvement of patient experience within Radiology. The Radiology Department conducted an audit that produced positive feedback in areas such as infection control and privacy and dignity. Within the audit it was also highlighted that used bags for gowns were often left on the floor and the gowns themselves were transparent. There was also a problem with storage of the gowns which were stored in changing rooms for ease of distribution. The Radiology team also noted that patients were sometimes unable to follow verbal instructions about how to put on the gowns and this affected some patients' privacy and dignity.

Following this the team implemented a number of changes including:

- Changing to material gowns to aid privacy and dignity which also realised a saving;
- A poster was designed to display in each cubical how gowns are to be put on;
- Gowns are to be stored in units with space for patients'

property which also aids with infection control.

The Board commended the initiative taken in completing an audit and emphasised that this was an excellent example of teamwork and patient care. Further JS celebrated the link the department had made with the Trust's values in improving patient experience.

(b) CQC Action Plan (Appendix C)

PS outlined that the action plan formed in response to the October 2013 CQC recommendations was due to be submitted on 28 November 2014. The action plan is to be monitored through the Healthcare Assurance Committee (HAC) and Care groups are to each have a copy to ensure this is embedded throughout the organisation.

TS commented that there were issues remaining that were outside of the Trust's control noting that the CCG would not be allocating funding to develop a crisis team for Dorset healthcare due to lack of national funding. He welcomed thoughts as to how to address this emphasising that the team provided support for patients with mental health issues which needed to be developed.

PS noted that the recommended 'should do's 6 & 7' fall outside of the Trust's control and would discuss this with the CQC link.

JS proposed working with other organisations on this issue and BF supported that other Medical Directors would support this.

(c) CQC Intelligent Monitoring Report (Appendix D)

PS advised the Board that the report was published on 3 November 2014 and reflected an example of positive progress. The Trust's risk rating as an organisation was band 5 with 6 being the best. It was highlighted that the Never events were acknowledged and would be reviewed together with Proms at the next HAC committee.

BF noted that a full report on Mortality would be brought to the Board in January.

SP queried the Trust's reporting of Never events. BF responded that the high reporting may reflect that the Trust is better at reporting compared to other organisations. This was a positive process in that key points of learning are recognised.

JS added that there had been personal presentations by directorates concerned and emphasised that the Trust was not complacent and progress in learning from these lessons should be recognised. TS emphasised that the Board should have regard to the fact that no

catastrophic harm to patients was incurred.

(d) CQC Fundamental Standards of Care (Appendix E)

PS advised that the CQC would be issuing a set of new regulations for fundamental standards of care from April 2015. On November 24 2014 two of these requirements came into force for NHS bodies: the fit and proper person's requirement for Directors and the Duty of Candour. These are to be enforced and regulated by the CQC forming part of the new inspection methodology.

PS requested that the Board took assurance that the fit and proper persons' requirement had been completed and confirmed that Directors declarations would be kept on personnel files as evidence for the CQC. The Trust will be measuring how the new requirement is implemented through a new Human Resources (HR) process.

KA added that advice had been sought nationally for examples of a good process but little guidance had been obtained however, HR will be liaising with other Trusts to develop this further.

Further PS advised that steps had been taken to embed the Duty of Candour further through the Trust's policies although culturally the Trust is already striving to be open and transparent with patients and relatives. PS highlighted that the serious incident form will require confirmation that a team has complied with the duty of candour which is scrutinised at the panel. BF confirmed that this was taking place in practice.

TS queried the training on the Duty of Candour and how compliance was to be monitored. PS responded that the quality and risk committee would monitor compliance with this regulation.

IM commented that staff should be given practical examples and training to ensure what is required is clear. BF commented that this principle should be part of common practice within the Trust.

The Board requested assurance about the model to be adopted for the fit and proper person's requirement and an update on what other **PS/KA** organisations were doing to implement the Duty of Candour.

(e) Feedback from Staff Governors (Verbal)

JS updated the Board on the following discussion points raised by Staff Governors:

- The current position of the Trust's workforce together with the national issues with recruitment;

- Training was felt to be too remote and more training needed to be brought back within a clinical environment;
- The Allied Health Professional forum requested that the Workforce Committee review staffing templates;
- The time spent in the role as a Staff Governor and fitting this in with work commitments.

DD outlined that discussions at the workforce committee featured training on wards and blending this with the training programme being developed. It was recognised that employing more practitioners was favourable amongst staff and that incentives were needed especially for staff on MFE wards to provide assurance. There had been a positive workforce strategy session and more focus had been acknowledged in this area.

SH noted that funding was available to Staff Governors to back fill the time spent in the role. TS added that it was also important that the organisation should not be disadvantaged through the role and ensure that patients and staff come first.

JS summarised that use/ allocation of available funding should be identified as Staff Governors have a vital role within the Trust and feedback to staff should be provided on the issues raised. **SH/JS**

133/14

PERFORMANCE

(a) Performance Exception Report (Appendix F)

RR updated the Board highlighting that the dashboard data indicated that there had been a spike in outliers due to delayed transfers of care and that the hospital remained 'HOT'.

The Trust was non-compliant in September on the following targets:

- 2 week Cancer wait;
- 62 and 31 day cancer targets although the Trust will be compliant for October;
- A&E 4 hour target performance was not compliant however this was planned in accordance with the agreed trajectory with the CCG;
- Admitted RTT at aggregate level for a number of departments, although this was in line with the planned breach to remove those patients waiting longer;
- Non Admitted RTT within specialist directorates, although aggregate was maintained;
- 52 week waits- 1 incomplete (unadjusted) pathway as the patient was treated in November;

RR advised that in relation to cancer standards the Trust was working

to clear historical patients in the system by increasing theatre time for robotic surgery and another Surgeon from Dorchester would be working at the Trust although their backlog would also be included. It was emphasised that patients were benefitting from the use of the robotic surgery but operating time and theatre nursing caused restrictions. The Trust is coping with the amount of work and is increasing theatre capacity for January, February and March to address this. The Board was assured that surgeons and the Urology team were dedicated and that the plan had been approved by the Trust's Management Board. It is expected that the Trust will be compliant for Quarter 4 although caution was noted in managing the risk of variation.

It was highlighted by the Board that the Trust must work to achieve the target expected by the Commissioner and the Board requested further assessment at the next meeting. **RR**

TS added that patient choice was one aspect and if the Trust aspires to be the robotic centre patients must be treated within the 62 period. SP commented that having visibility of the next few quarters with the plans against this will allow for the Board to monitor this easily and identify progress.

The Board was advised that an action plan was in place for the cancer 2 week wait target together with a new system for patient choice to ensure appointments within 2 weeks are accepted. There is also a faster escalation process with a clinical template review and more slots to compensate and it is predicted the Trust will be compliant for Q4.

18 week RTT the Orthopaedic department remains under pressure in terms of GP referrals along with Urology and Outpatients. In order to address this a significant amount of outpatient activity will be required over the next year. It was emphasised that the admitted waiting list for 18 weeks was improving. TS noted that within the final quarter the Trust must ensure that planning is in place for capacity to prevent any breaches.

BY queried outpatient figures as they were significant and noted that more capacity was required. RR responded that the Trust needed to target longer wait pathways with a new system managing them to the clock and changing the culture.

Stroke performance within 12 hours had improved although the unit was under pressure with beds and outliers noting a decline in November. Teams have been put in place within Radiology and a stroke proposal has been put forward.

Compliance with the ED 4 hour wait was difficult due to the continued increase in ambulance conveyances. The Board were advised that

four changes were to be implemented to aid with pressures and support the patient flow. ED work streams are focused on high impact areas and ensuring that the 4 hour target and decision making process is regarded by all staff. Higher acuity beds are being introduced within AMU to ensure that the sickest patients are not within ED for too long. It is hoped that the minors department should be able to run without breaches although it is a high volume area and it is when doctors are called to majors that breaches are incurred.

It was requested that an update was provided on the performance of robotic surgery from the changes implemented. The Board also requested that the predictions for Q4 were made green; RR confirmed this could be provided in a table format. **RR**

JS summarised that the Trust was expected to be compliant for the four hour target although it may be tight and commended the quick changes implemented for the cancer 2 week wait appointment process.

(b) Quality Report (Appendix G)

PS highlighted to the Board the following key areas of the report and Harm free care:

- Falls- Results highlighted that for the month of October there had been a fall with patient harm.
- Pressure damage- It was reiterated that this is an area of focus at the HAC. The Trust is performing above the set CQUIN target. The Trust has commissioned an external peer review by Jackie Fletcher who developed the NICE standards to review the process for Pressure Ulcers in practice on elderly care wards and surgical wards. A report will be brought back to the Board following completion of this work.
- AIRS- There is a robust process in place for avoidable pressure damage and damage that is avoidable and the Trust is progressing towards the set target.
- Friends and Family Test- the Trust is producing consistently strong data and experience cards have contained positive feedback about the care the Trust provides. There has also been an improvement in the numbers of patients who are likely to recommend the Trust to friends and family.

JS summarised that it will be positive to have an external view of the Trust's processes with regards to pressure ulcers and acknowledged the detailed and focused work of the HAC. DD attended a panel and supported there was a lot of variability and a lot of detail is reviewed to

support the work in this area.

(c) Financial Performance (Appendix H)

SH advised that activity and demand pressures continued during October impacting upon financial performance resulting in an overspend of £727,000.

He advised that Monitor had contacted the Trust to request a reforecast for the year which will be provided on 17 December 2014. The Trust has set a predicted target of £5.2 million deficit which exceeds the planned deficit of £1.9 million for the year. Improvements had been noted and the Trust's position is broadly in line with the revised plan. The adverse expenditure position has reduced the continuity of services risk rating to 3.

IM added that the heat of the hospital and staff retention was impacting financially but that there was a focus on reducing expenditure and in particular the use of agency staff.

(d) Workforce Report (Appendix I)

KA outlined the report to the Board noting the workforce metrics by care group. She emphasised that a number of clinical and medical positions remained difficult to recruit for but appointments were being made.

The Friends and Family test survey and staff impressions highlighted the following themes:

- Following the results there may be an element of survey fatigue and the Trust may need to consider how this is balanced;
- The results for Quarter 2 had been positive and more staff were feeling happy and valued;
- Details of the survey are shared with care groups and plans will be developed to ensure any themes are identified and responded to.

The Board considered that staff needed to be engaged more in the process in order to improve results and ensure staff are listened to.

SP commented that there was an element of disconnection if staff were feeling that they were not being listened too. PS added that it will be important to identify areas in particular but emphasised that the August CQC report reflected that staff felt that they **were** being listened to. KA added that care groups would receive this detail and support would be given in these areas.

RR added that the Trust needed to get the balance right and noted the

response to progress. BF commented that, in contrast to the data, on a recent walk around having spoken to staff at all levels he had received assurance that morale was high and communication was being recognised. He further emphasised that the quality improvement programme would be key.

KA continued to highlight to the Board that in terms of workforce metrics that the retention of Allied Health Professionals was being explored and the reasons behind those leaving the Trust. It was emphasised that the turnover for Nursing staff and retention had improved. Appraisal compliance had increased although it was noted that this needed to be improved upon and continues to be an area of focus.

134/14 **DECISION**

(a) **Sign Up to Safety Pledge (Appendix J)**

PS updated the Board about a national patient safety campaign launched in July 2014 that aims to strengthen patient safety. The pledge was not currently mandatory but is advocated by regulatory bodies. PS requested the Board's approval to sign the pledge and join the campaign. JS noted caution for the strict targets contained within the pledge.

The Board confirmed **approval** of the pledge.

135/14 **STRATEGY AND RISK**

(a) **Clinical Service Review (Presentation)**

TS updated to the Board on the developments of the Trust's vision emphasising the importance of patient care and the right support for staff. The options that had been developed that would be provided to the organisation for further consultation were presented:

- Option A - Striving to provide a healthier future;
- Option B - Quality safe and compassionate care;
- Option C - Our vision working together to be the best for our patients;
- Option D - The best quality care for all of our patients- delivered with PRIDE;
- Option E - Compassionate high quality care.

TS further updated the Board as to the recent Clinical Services Review developments:

- There had been a series of public events focusing on what the review will lead to in terms of change;
- There will be an emphasis on the funding cap and those funds available to the NHS;
- The CCG's message focuses on sustaining safe and affordable services for the future;
- Looking for public engagement as to what services are viewed as important;
- Implementation of the chosen model will take place towards 2016/17;
- There is an emerging case for change with data gathered across Dorset and a focus on all aspects of the health sector;
- Clinicians across primary and secondary care will be involved and proposals will start to be developed soon.

JS added there was a commitment from the CCG and McKinseys to keep the Trust and public up to date as to the emerging proposals. She noted caution that the Board must engage with the review but maintain performance and quality in the run up to the proposals, and not be diverted in anyway.

TS advised that clinical groups would meet on 17 December 2014 to consider the models of care going forward. There will be a discussion with Monitor on 26 January 2015 as to the strategy for the Trust and the model identified.

BF commented that the Board, Governors and Health sector must support the medical board in the development of the new model of care as significant changes were essential.

136/14

INFORMATION

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

The report was noted for information.

(b) Corporate Events Calendar (Appendix L)

The report was noted for information.

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

The report was noted for information.

137/14

DATE OF NEXT MEETING

Friday 30 January 2015 at 8.30am, Committee Room, Royal Bournemouth Hospital.

138/14

ANY OTHER BUSINESS

Key Communications points for staff

1. CQC issues on quality
2. Performance- noting the challenging areas and improvements
3. The Trust's efforts in improving workforce
4. The Trust's vision
5. Patient story

139/14

QUESTIONS FROM GOVERNORS

1. DC queried stroke and whether there was an opportunity to mobilise funds for stroke care CT scanning until the Trust had a better workforce. RR responded that the Trust was training more radiographers and increasing capacity to allow for this.
2. EF requested the figures for the flu jab target. KA responded that there had been a good response this year with a 10% increase and commended the work of the Occupational Health team.
3. RP commented on his attendance at a recent CCG event about the clinical services review and suggested that an average comparison with England overall should be used as part of the Trust's communications about Monitor targets.
4. BYo commented on the proportion of appointments that had been cancelled and whether patients could be seen quicker by taking earlier cancellations. RR responded that where a patient provides notice there was a system in place but it is an area that is very labour intensive and encouraged use of the online system to book appointments and slots.

There being no further business the meeting was declared closed at 10:57am.

AH

Date of Meeting	Ref	Action	Action Response	Brief Update
12.12.14	131/14	MATTERS ARISING (ACTIONS LOG UPDATE) (Appendix B)		
	(a)	(111/14b) Quality Report- Francis Report		
		Wording to be provided to Governors as to the enhanced role so that the Governors are consulted.	EB/JS	
12.12.14	132/14	<u>QUALITY IMPROVEMENT</u>		
	(d)	CQC Fundamental Standards of Care (Appendix E)		
		Assurance about the model to be adopted for the fit and proper person's requirement and an update on what other organisations were doing to implement the Duty of Candour.	PS/KA	
	(e)	Feedback from Staff Governors (Verbal)		
		To identify whether the available funding for back fill is being utilised by Departments for Staff Governors.	SH/ JS	
12.12.14	133/14	<u>PERFORMANCE</u>		
	(a)	Performance Exception Report (Appendix F)		
		Further assessment of how the Trust will achieve the Cancer target expected by the Commissioner.	RR	
		Predictions for Q4 to be made green and provided in a table format.	RR	

BOARD OF DIRECTORS	
Meeting Date and Part:	30 th January 2015 - Part 1
Subject:	Performance Report
Section:	Performance
Executive Director with overall responsibility	Richard Renaut
Author(s):	Donna Parker/David Mills
Previous discussion and/or dissemination:	PMG/TMB
Action required: <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>	
Summary: <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 December 2014.</p> <p>It also incorporates an indicative RAG rating for expected performance in the following month based on internal monitoring to date, as well as an indication of Trust level risk in relation to the metrics in the next quarter (Q4 Jan – March 2015).</p> <p>Key non compliances for December were:</p> <ul style="list-style-type: none"> • Cancer 2 week wait (for November) performance including for breast symptomatic patients, though compliance has been recovered since December • 62 and 31 day cancer targets in November • A&E 4 hour target and 12 hour breach (x 1 December and x 2 January), though we achieved the 92% Q3 trajectory agreed with the CCG and NHSE • Admitted RTT at aggregate level and in General Surgery, Orthopaedics, Ophthalmology, Dermatology and Gynaecology – in line with nationally approved breach to remove longer waiters • Non admitted RTT speciality level in Orthopaedics, ENT, Oral Surgery and Dermatology, though aggregate was maintained. • 52 week waits (x1) on incomplete (unadjusted) pathways – patient treated in January. • VTE slightly under threshold at 94.7% (vs. 95%) • Diagnostics 6 week wait, due to Endoscopy pressures (not a Monitor rating) • One cancelled operation (due to HDU bed availability) not rebooked within 28 days due to consultant leave (non-Monitor) <p>For Quarter 4 the key risks to the Trust are:</p> <ol style="list-style-type: none"> 1. A&E 4 hour wait – the higher level of ambulance conveyances and full beds has continued into January 	

<p>2. Significant risk to RTT admitted targets due to speciality pressures, cancellations and capacity though compliance is currently expected</p> <p>3. RTT non-admitted, especially in Dermatology, Gastro and Poole specialities (ENT, Oral, Neuro)</p> <p>4. Cancer 62 and potentially 31 day predominantly due to Urology treatments being carried out</p> <p>5. <i>Diagnostics 6 week wait due to pressures in endoscopy (non-Monitor)</i></p> <p>6. <i>Single Sex Accommodation due to changes in front door processes (non-Monitor)</i></p> <p>These remain under close review and management.</p> <p>The overarching Trust Balanced Dashboard for December is also included.</p>	
Related Strategic Goals/ Objectives:	Performance
Relevant CQC Outcome:	<p>Section 2 – Outcome 4: Care and welfare of people who use services.</p> <p>Outcome - 6 Co-operating with others.</p>
<p>Risk Profile:</p> <p>The following risk assessments remain on the risk register:</p> <ul style="list-style-type: none"> i. Cancer 62 day wait non-compliance and potential risk to the trust's authorisation, due to ongoing risks. ii. 4 hour target due to the increase in ambulance conveyances and attendances and our continued non-compliance. iii. RTT admitted and non-admitted speciality and aggregate performance due to speciality pressures. <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>	
Reason paper is in Part 2	N/A

Performance Exception Report 2014/15 - January

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

2. Cancer

Performance against Cancer Targets

Key Performance Indicators	Threshold	Nov-14	Predicted Dec-14	Predicted Q3
2 weeks - Maximum wait from GP	93%	88.1%	95.0%	86.8%
2 week wait for symptomatic breast patients	93%	88.5%	95.8%	90.8%
31 Day – 1st treatment	96%	89.8%	78.9%	90.6%
31 Day – subsequent treatment - Surgery	94%	96.4%	95.0%	96.1%
31 Day – subsequent treatment - Others	98%	100%	100%	100%
62 Day – 1st treatment	85%	83.8%	75.0%	80.0%
62 day – Consultant upgrade (<i>local target</i>)	90%	60%	100%	77.8%
62 day – screening patients	90%	92.3%	80.0%	91.2%

The changes in the operational management of 2 week waits have made a significant improvement to compliance especially by more focused management of patient choice, and quicker flexing of capacity. It is anticipated this target will be compliant for Q4.

As previously predicted the risk to both the 31 day and 62 day standard has been mainly due to demand in Urology; strategies to improve this position are now beginning to improve the predicted position for Q4, with the backlog having been largely removed as a result of “robot weeks”, with increased operating.

Taking the Dorchester Urology robot work has created further pressures, (we ‘own’ 50% of the breaches) but allows a local, better service for these patients.

Early indications for Q4 show an improvement in compliance with the 31 day target, however, the Trust remains challenged in achieving the 62 day standard for all tumour sites, affecting aggregated performance.

3. A&E Performance

4 hour maximum waiting time – 95%

December saw an increase in ED attendances resulting in longer waiting times and a monthly performance of 89.94% (below the 95% threshold). Quarter 3 target was not met (92.32%) though was in line with the trajectory agreed with the CCG, which accepted the wider system pressures. The on-going significant increase in ambulance conveyances continued: up 14.6% in December '14 compared to December '13. This was up 7.6% overall in Quarter 3 compared to the same period last year. There was also an 11.8% increase in non-elective admissions for Quarter 3 compared to Q3 2013-14, and a 13.5% increase in December 2014 compared to December 2013. There was unfortunately one patient who waited over 12 hours to be admitted where it was deemed more appropriate to leave this palliative patient together with their family in the side room in ED.

Task and Finish groups to review implementation of best practice have been established. Specific focus is on initial assessment which started in January and has been working well, 'see and treat' for minors (started in December), improved Resus capacity and flow, and faster diagnostics. Unfortunately we have not been successful in securing a further consultant post and are now re-advertising. Whilst Middle Grade cover has improved, we do anticipate that we may have some gaps when the next doctor rotation takes place. We have trained a number of Majors Assisting Practitioners in ED to support the implementation of rapid assessment and further practitioners have commenced training. In addition, an ambulatory area has also been established within the department to improve patient flow.

Performance in January has been affected as the rest of the country, but with further activity rises, and crucially, slowed discharges, especially for the elderly performance January to date is c89%

The most recent comparable week to English A&Es puts RBCH 21st out of 131 Trusts. Only the top 4 Trusts achieved 95%+

4. VTE

Risk assessment of hospital-related venous thromboembolism

For November, the VTE return was 94.66%, narrowly missing the target of 95%. An improvement in compliance is anticipated for December.

5. Diagnostics

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

For December, the 99% diagnostic target was missed with a return of 96.95% due to demand and capacity issues in Endoscopy. This is anticipated to continue in January and a recovery plan is being developed which includes commencement of a Consultant post in January and exploring options for outsourcing. Radiology demand, strike actions and some equipment failures have been mitigated through significant extra sessions.

6. Cancelled Operations

Patients offered a date within 28 days of cancellation (on the day of operation)

Unfortunately, one patient was cancelled on the day of operation due to there being no HDU bed available post op for a complex Vascular procedure. Due to consultant annual leave, this was unable to be rebooked until January. The patient has now been treated.

7. 52 Week Wait (Incomplete Pathways)

No patients waiting over 52 weeks on an incomplete RTT pathway

In December, one patient who had been transferred from another provider late in their pathway declined a procedure date resulting in their waiting time being over 52 weeks. The patient was treated in January.

8. Admitted RTT – Aggregate and Specialty Level

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

In line with our plan agreed with the CCG and Monitor, we remained non-compliant against the aggregate RTT target whilst continuing to treat long waiting patients. The particular specialities which were below threshold in November were: General Surgery, Orthopaedics, Ophthalmology, Dermatology and Gynaecology. It is planned to return to aggregate compliance for Jan-Mar 2015 though some speciality pressures do remain, particularly in Orthopaedics, General Surgery and Dermatology. This target therefore remains at risk.

9. Non-Admitted RTT – Specialty Level

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

For December, whilst aggregate performance was compliant, a number of specialities were non-compliant: Orthopaedics, ENT, Oral Surgery and Dermatology. Particular pressures are being seen in 'visiting' specialities and we are working with our partner provider on plans going forward due to a shortage of capacity. A shortage of medical cover together with growing demand continues to affect Orthopaedics and Dermatology and recruitment as well as additional sessions and outsourcing are currently underway to improve this position.

Work to move to the new recording system (PPW) continues to progress well and is now beginning to support a more robust patient tracking system.

The roll out of Electronic Document Management (EDM) is also being achieved during this same period, reflecting excellent programme management and huge staff flexibility to adapt to these significant changes.

10. 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.

2014/15 PERFORMANCE INDICATOR MATRIX FOR TRUST MANAGEMENT BOARD

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							> trajectory		<= trajectory
Referral to Treatment	RTT Admitted	18 weeks from GP referral to 1 st treatment – aggregate	90%	1.0	90.1%	90.1%	90.2%	90.1%				87.2%		89.3%	87.4%	87.7%							<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%							<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%		≥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%								<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%								<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%								<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%								<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%								<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%								<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%								<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%	89.9%							<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
Infection Control	MRSA Bacteraemias	Number of hospital acquired MRSA cases	0		0	0	0	0	0	0	1	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%								< 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%		≥95%
Diagnostics	Six week diagnostic tests	More than 99% of patients to wait less than 6 wks for a diagnostic test	>99%		96.30%	99.00%	96.50%	99.4%	97.0%	99.30%	99.8%	99.8%	99.8%	99.8%	99.8%	97.0%							≤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	0	1							≥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							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							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							≥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							≥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							≥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%							<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%							<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%							<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%							<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%							<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%							<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%							<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%							<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%							<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%							<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%		≥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%							<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%							<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%							<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%		≥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%							<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%		≥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%	98.9%							<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%							<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%							<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%							<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%							<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%							<95%		≥95%
	RTT Non admitted	Other	95%		98.0%	97.1%	100.0%	99.6%	99.3%	98.0%	98.9%	97.8%	98.5%	98.8%	99.3%	98.8%							<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%	tbc							<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%	tbc							<95%		≥95%

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

Trust Balanced Dashboard

Quality, Performance, Clinical Outcomes, Productivity and Efficiency

Reporting Month: Dec 2014

Trust Performance Dashboard: Dec 2014

Report produced: 22/01/2015 13:53:08

Quality							Clinical Indicators							Productivity & Workforce						
KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend
HSMR - RBH - August 2014	Ratio	99.2	100.0	77.5			Medication administration incidents	No.	32		15	35		Average number of Outliers	No.	49.4		25.8	23.1	
HSMR - MAC - August 2014	Ratio	150.4	100.0	163.0			IP cardiac arrest calls / 1,000 bed days	Ratio	TBC	TBC	TBC			Average length of Stay	Days	5.1		4.4	5.2	
% Harm Free Care (Patient Safety Thermometer)	%	90.4%	95.0%	85.5%	89.9%		Acute Kidney Injuries / 1,000 bed days	Ratio	9.7		9.2	8.6		Theatre session utilisation	%	83.7%	85.0%	83.5%	82.8%	
Serious incidents	No.	6	3	2	7		Returns to theatre / 1,000 bed days	Ratio	1.7		1.4	3.5		Average follow-ups per new attendance	Ratio	0.70		0.68	0.69	
Emergency Department Friends & Family Test	Score	79		73	75		Unplanned IP admissions to ITU or HDU / 1,000 bed days	Ratio	TBC	TBC	TBC			Sickness absence	%	4.1%	3.0%	3.7%	4.2%	
Inpatient Friends & Family Test	Score	80		76	71		Dementia CQUIN (step 1 compliance)	%		90%	80%	74%		Vacancy	%	6.9%		5.9%	6.2%	
Delayed Transfers of Care	No.	21	10	24	8		% of CHC fasttrack patients that die on a ward	%	28%		22%	6%		Appraisals	%	72%	90%	73%	78%	
30 day readmissions	No.	547		492	434		Time to antibiotics for patients with severe sepsis	hh:mm	TBC	TBC	TBC	TBC		Mandatory training compliance	%	79%		79%	75%	
Performance							Activity & Finance													
KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend
MRSA Bacteraemias	No.	0	0	0	0		Hospital at Night Average Response Time - Amber Calls	hh:mm	NA	NA	NA	NA		ED Attendances	No.	6,975	6,985	6,798	6,303	
Clostridium difficile	No.	1	2	1	1		Hospital at Night Average Response Time - Red Calls	hh:mm	00:52	00:15	00:41	00:49		Elective admissions	No.	5,400	5,543	5,671	5,217	
RTT metrics (below plan)	No.	1	0	1	0								Non-elective admissions	No.	2,749	2,465	2,530	2,341		
Cancer metrics (below plan) (1)	No.	4	0	3	3		Stroke mortality rate (SSNAP)	%	21%		20%	15%		GP OP Referrals	No.	4,985	4,347	5,352	4,676	
A&E 4 hr maximum waiting time	%	89.9%	95%	94%	94%								Risk ratings	Rating	3	4	3			
Patients with a learning disability (Monitor compliance)	Y / N	100.0%	100.0%	100.0%	100.0%								Surplus	£000s	-£ 578	£ 169	-£ 852			
													Transformational plans	£000s	Not yet available	-£ 4,779	£ 461	£ 837		

BOARD OF DIRECTORS	
Meeting Date and Part:	30 th January 2015 Part 1
Subject:	Quality Report
Section:	Performance
Executive Director with overall responsibility	Paula Shobbrook, Director of Nursing and Midwifery
Author(s):	Ellen Bull, Deputy Director of Nursing and Midwifery Joanne Sims, Associate Director Quality & Risk
Action required: The Board of Directors is asked to note the report.	
Summary: This report provides a summary of information on Patient Safety and Patient Experience indicators.	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	All
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	Not applicable

Quality & Patient Safety Performance Exception Report

December 2014

1. Purpose of the Report

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

2. Serious Incidents

Six Serious Incidents (SI's) were confirmed and reported on STEIS in December 2014.

3. Safety Thermometer

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

3.1 The results for the December 14 data collection are as follows:

NHS SAFETY THERMOMETER	13/14 Average per month	14/15 Target	Aug 2014	Sept 14	Oct 14	Nov 14	Dec 14
Safety Thermometer %Harm Free Care	89.0%	95%	89.8%	92.2%	89.0%	85.5%	90.6%
Safety Thermometer % Harm Free Care (New Harms only)		97.5%	97.2%	96.9%	95.8%	96.4%	97.6%
Monthly survey using Safety Thermometer (Number of patients with Harm Free Care)	480	NA	484	469	455	459	479

3.2 Results are as follows:

	13/14 Total	July 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	14/15 YTD
Number of patients surveyed	6475	501	498	484	475	476	491	NA
New Pressure Ulcers	144	5	9	11	11	14	10	83
New falls (Total)	105	6	5	11	12	8	5	61
New VTE	14	0	1	0	2	0	0	7
New Catheter UTI	35	2	4	1	4	1	0	18

4. Risk Assessment Compliance

	May 2014	June 2014	July 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Risk assessment compliance								
· Falls	92%	91%	91%	88%	91%	91%	88%	93%
· Waterlow	96%	95%	96%	94%	96%	96%	93%	97%
· MUST	88%	88%	89%	90%	87%	87%	80%	87%
· Mobility	91%	91%	93%	87%	93%	93%	91%	95%
· Bedrails	95%	93%	94%	90%	95%	95%	92%	95%

5. Patient Experience

National Comparison using the NHS England data base

5.1 In-Patients Friends and Family Test (FFT) percentages

RBCH	October 2014	November 2014
FFT Ranking	4 th (with 17 others)	5 th (with 31 others)
Our score <small>Number of patients who would recommend service</small>	97%	96%
Top score	100%	100%

5.2 Emergency Department (ED)

	October 2014	November 2014
FFT Ranking	9 th (with 12 others)	5 th (with 9 others)
Our score <small>Number of patients who would recommend service</small>	91%	95%
Top score	99%	99%

Please note the above data is always published on the NHS England website one month in arrears and using only the percentage of patients who would either be 'extremely likely' or 'likely' to recommend. NHS England no longer publishes the FFT score on the website, this is shown below for consistency.

6. FFT scores

	FFT Score Dec (Nov)	Compliance Rate Dec (Nov)
Inpatient	80 (76)	39% (46%)
ED	79 (73)	*10% (15%)
Maternity	70 (81)	*9% (11%)

Please note compliance rates are rounded to the nearest whole number.

There is a significant decrease in the data compliance rate; this may be a reflection of the increased activity and the impact of excessive surge in admissions. Wards sisters, charge nurses and managers are actively addressing this with front line staff. Both in-patients and ED have evidenced an improvement in the FFT score.

6.1 Extremely Unlikely results from FFT – December data

The CQIN target on aggregate is the percentage of “extremely unlikely to recommend” to remain below 1.5% throughout January, February and March 2015.

6.2 There have been 10 “extremely unlikely” to recommend from a total of 1253 cards completed (excluding “don’t know” respondents) within submission areas.

The comment attributed to ward 24 was not congruent and read “all staff were excellent, thanks to all, Merry Christmas”.

6.3 The overall trend of “extremely unlikely” is improvement. This is shown below.

The table below offers a Trust wide 6 month trend analysis

Extremely Unlikely	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total Extremely Unlikely to recommend (*From Dec results show Unlikely or Extremely Unlikely to recommend)	40	44	32	25	31	*38
No of returns	2527	3278	3188	3277	3276	2568
% Unlikely or Extremely Unlikely to recommend	2.73%	2.68%	2.10%	1.40%	1.62%	1.48%

*Please note that the calculation has been changed in the table above to reflect both “extremely unlikely” and “unlikely” to recommend.

7. Recommendation

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

BOARD OF DIRECTORS	
Meeting Date and Part:	30 th January 2015 - Part 1
Subject:	Stroke Services Update
Section:	Performance
Executive Director with overall responsibility	Richard Renaut, Chief Operating Officer
Author(s):	Vanessa Mason, Associate Director for Integrated Care
Previous discussion and/or dissemination:	December 2014 Board – SSNAP Regional Report
Action required: The Board of Directors is asked to note the action plan, and the additional funding for the stroke outreach team, in line with CQC recommendations.	
Summary: This paper covers the current stroke performance against the latest SSNAP publication and details the actions the service is taking to improve and sustain performance over the next twelve months.	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	All
Risk Profile: Stroke performance risk	
Reason paper is in Part 2	N/A

Stroke Services Update

1. Introduction

This paper covers the current stroke performance against the latest SSNAP publication and details the actions the service is taking to improve performance into the upper quartile of Trusts, with no area below C, and the majority moving to B or better. Ensuring sustainability of improvements over the next twelve months relies upon recruitment to the Stroke outreach team, expansion of the radiology service out of hours and management of risks (set out in Section 4).

The recent internal audit identified a number of data quality issues that are under review by the management team. The actions being taken to mitigate the risks are also included.

2. Summary

The quality of stroke services is measured via the quarterly SSNAP results. This paper focuses on the stroke performance from July to September 2014, in which RBCH achieved SSNAP level D (in line with 50% of all reporting Trusts) and most within Wessex. The SSNAP performance is based on 10 domains covering 44 key indicators and the results benchmarked against national performance. A summary of our most recent performance is provided below.

Quarter	<i>Oct-Dec 2013</i>	<i>Jan-Mar 2014</i>	<i>Apr-June 2014</i>	<i>July-Sep 2014</i>	<i>National Average</i>
SSNAP level	D	D	D	D	
SSNAP score	54.4	43.4	55.3	55.3	
<i>Case ascertainment band</i>	A	A	A	A	
<i>Audit compliance band</i>	D	D	D	D	
1) Scanning	E	E	D	D	C
2) Stroke unit	C	C	D	D	C
3) Thrombolysis	D	D	C	C	C
4) Specialist Assessments	E	D	D	D	C
5) Occupational therapy	A	C	A	C	D
6) Physiotherapy	B	D	B	B	B
7) Speech and Language therapy	B	D	C	C	B
8) MDT working	B	B	B	B	C
9) Standards by discharge	C	D	B	B	C
10) Discharge processes	B	B	B	A	C

December 2014 Performance of key access targets (which inform 1) Scanning (and 2) Stroke unit performance (see above)

Performance criteria	Target	Achieved
Direct admission within 4 Hours	90%	54.2%
Imaging within 1 hour	50%	35.6%
Imaging within 12 hours	100%	93.2%
Imaging within 24 hours	100%	100%
90% stay on stroke unit	80%	61.4%

3. Key Action Points

In response to the need to improve performance, the Stroke team has developed a robust improvement plan. The priority areas for improvement have been identified and actions for improvements outlined below.

Audit Compliance: Score D

Issues Arising	Actions	Target date	Lead
Inconsistently carrying out NIHSS Screening on all stroke admissions due to lack of competencies within the service	Training in place for all trained stroke unit nurses/stroke outreach practitioners to perform NIHSS screening on all stroke admissions. Online training also made available.	March 2015	CG
Inability to record NIHSS on vitalPAC	New acute stroke observation chart to include NIHSS developed and awaiting printing	March 2015	CG

Scanning: Score D

Issues Arising	Actions	Target date	Lead
Ongoing delays with urgent and non-urgent CT requests, by non-stroke clinicians.	1. IRMER training in progress to enable band 6 nurses/stroke outreach practitioners to request CT scans. 2. Protocol developed to support nurse-led CT brain requests 3. Implementation of stroke outreach to capture the majority of stroke admissions, initiating pathway and avoiding referral delays.	April 2015	SH

Lack of clarity on referral process, targets and indications for urgent imaging	1. Streamlining referral process for all urgent CT's and in hour's requests. Direct contact made with CT co-coordinator and next slot prioritised. 2. Communication to all junior doctors and AMU staff to provide update on targets and referral process.	Complete	TD
To reduce response times out of hours for urgent imaging and to improve access rates	To provide on site out of hours service using existing scanners Phase 1 existing staff on site cover as additional sessions and commence training of all relevant staff. Phase 2 move to fully staffed OoH on site rota through additional recruitment. To proceed with the business case for additional scanner	Phase 1 – Feb 2015 Phase 2 – Oct 2015	AD

Stroke Unit: Score D

Issues Arising	Actions	Target date	Lead
Delays in transfers to the stroke unit, primarily due to delayed diagnosis, beds and lack of outreach service.	Two Phase approach to the implementation of the stroke outreach service. Phase 1 - Existing experienced staff will provide cover in hours primarily Monday –Friday 8-1. Additional cover will be provided by experienced staff on the bank with the aim to capture the peak of admissions. Phase 2 – To recruit 3.5wte permanent outreach practitioners to cover 7 days per week 7am-midnight.	Phase 1- To commence January 2015 Phase 2 – To provide full coverage end of April 2015	CS
Increase in the number of stroke green dot patients moved off the unit, patient flow and medical outliers due to Trust pressures. Increase in the number of patients with extended LoS and lack of information on formal social delays. Increase in complex patients and under 60's	1. Audit in progress to identify key discharge waits to improve discharge planning and communication with community services. 2. Implementation of stroke outreach to improve bed flow and assist in deferring inappropriate admissions to the unit.	Feb 2015 April 2015	KC CS

Specialist Assessments: Score D

Issues Arising	Actions	Target date	Lead
Delays in transfers to the stroke unit and subsequent assessment by a specialist nurse	Implementation of stroke outreach as above, providing full specialist stroke assessment prior to accessing the unit.	To provide full coverage end of April 2015	CS
Delay in access to the unit and subsequent water swallow screen performed	SALT team to provide water swallow screen training in ED/AMU as part of education programme. This will support full coverage to perform WSS on arrival, particularly when no outreach cover available.	April 2015	CI

Occupational Therapy: Score C

Issues Arising	Actions	Target date	Lead
Inconsistencies in data collection and entry onto SSNAP. (Also to support SALT and PT metrics)	1.To capture an end date for therapy to ensure performance is only reported for when active therapy is required and not distributed across total LoS 2. Aspects of data collection have been moved to a volunteer to release direct therapy time. 3. Data captured in real time by therapists and entered by SSNAP administrator to remove inconsistencies and release therapy time.	Complete	KC
To increase opportunities for therapeutic sessions with patients	To provide ongoing OT input to lunch group Monday to Friday to support patients therapeutically.	Complete	KC
Staff Vacancies Therapy assistants Unfilled maternity cover	1. Therapy assistance back to full complement as of December. New assistants have required training in order to have the skills to provide 1:1 OT and PT sessions. Training in place and ongoing. 2. Post will be filled from Feb – 15	Feb 2015	KC

Internal audit recommendations

Issues Arising	Actions	Target date	Lead
Delays in capturing SSNAP data for stroke patients on outlying wards	1 Implementation of stroke outreach service will ensure data requirements for SSNAP are updated at time of assessment if there is an unforeseen delay in transfer to the stroke unit. 2. Stroke outreach referral process will facilitate early notification of stroke patients and record of patient details added to SSNAP patient list database. 3. Implementation of electronic patient records will facilitate timely completion of SSNAP records if notes unavailable.	April 2015	TD
Data validation checks currently limited to KPI breaches.	Random sample checks of patient records to be implemented on a regular basis. Any issues identified will be considered across the full population of patients.	March 2015	TD
A number of data sources including electronic patient systems and documentation forms are used to populate SSNAP data fields. This could lead to inconsistencies and inaccuracies in the data reported.	To review current stroke pathway documentation to assess whether this could be adapted to reflect the SSNAP proforma. This would require completion by the clinical team and therefore reduce the risk of interpretation of notes by non-clinical data administrator.	April 2015	TD
Out of date and formalised procedure documentation to reflect data collection process in place.	To update procedure documentation and ensure appropriate training and knowledge of this document to ensure consistent cover can be provided if data administrator unable to carry out the role, ensuring timely and accurate entry of the data.	March 2015	TD

4. Risk mitigation

The actions above, especially Stroke outreach team and extended radiology will enable the stroke service to achieve significant improvements in performance and data quality, which should be reflected from April onwards.

Risks remain in achieving the targets; these include access to stroke beds due to timely discharges and the surge in admissions leading to non-stroke patients outlying. This will be mitigated through the wider urgent care work and the specific actions on discharge.

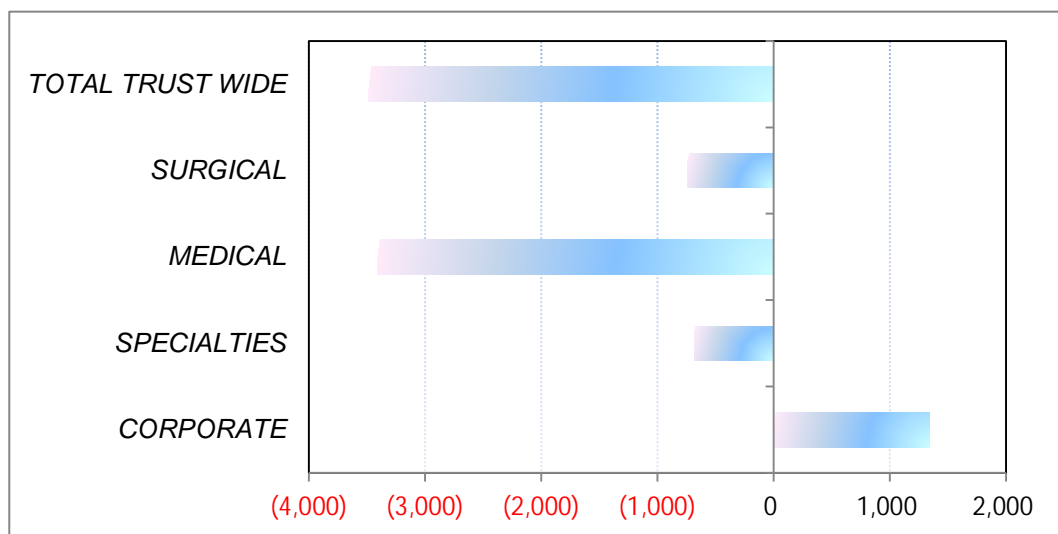
The service is also going through a period of vacancies and failure to recruit into the following; consultant post, nurse consultant and ward nursing staff. The latter at Band 5 level is mainly due to staff career developments, as the Stroke unit remains a popular place to work. The outreach service will have an impact on the timely achievement of the above actions as it requires 3.5 staff. These could be therapists or nursing staff, to increase recruitment success and can also rotate.

5. Recommendations

- (i) To support the funding for Stroke outreach and radiology extended hours service, and implementation of these actions.**
- (ii) To report quarterly the SSNAP results to Board**

BOARD OF DIRECTORS	
Meeting Date and Part:	30 January 2015 – Part I
Subject:	Financial Performance
Section:	Performance
Executive Director with overall responsibility	Stuart Hunter, Director of Finance
Author(s):	Pete Papworth, Deputy Director of Finance
Previous discussion and/or dissemination:	Finance Committee and Trust Management Board
Action required: The Board of Directors is asked to note the actions taking place as part of the Recovery Plan & continue to support delivery.	
Summary: The activity and demand pressures faced by the Trust continued during December, with non-elective activity 11% above planned levels which has placed considerable pressures across the Trust this month. This continues the pressures seen in previous years and this year to date, and brings the year to date activity increases to 12% for non elective activity and 6% for emergency department attendances. This level of additional demand continues to have a significant impact on the financial performance of the Trust. At 31 December, the year to date budget was for a net surplus of £0.1 million, against which the Trust has reported an actual deficit of £3.4 million. This represents an adverse variance of £3.5 million. Income has overachieved by £2.2 million year to date, driven by additional cost and volume drugs, aseptic drug issues recharged to Poole Hospital, and additional CCG income in recognition of the premium agency pressures the Trust is facing due to the national shortage of trained medical and nursing professionals. Expenditure reported an over spend of £928,000 during December, bringing the year to date over spend to £5.7 million. This has been driven by: <ul style="list-style-type: none"> • Activity pressures, particularly in relation to emergency activity for which the Trust only receives 30% of the national tariff price; • Significant additional pay costs as a result of continued reliance upon locum and agency staff; • Additional cost and volume drugs, most notably within oncology and which are recharged directly to Commissioners; • Drug issues in relation to the Aseptic unit, which have been recharged to Poole Hospital. 	

The Trusts' variance to budget is illustrated at Care Group level below, which highlights the impact of the demand and recruitment pressures within the Medical Care Group particularly.



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

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

A re-forecast position has been provided to Monitor, demonstrating a predicted £5.2 million deficit, which exceeds the planned deficit for the year originally of £1.9 million.

The Trust has a number of Urgent Care Schemes still to be undertaken and the introduction of the Winter Ward should help to improve performance.

The Trust is currently working towards securing 2015-16 Improvement Programme savings and identifying further sustainable delivery plans.

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 DECEMBER 2014

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)	833	119	(3,364)	(3,483)	(2,922%)	169	(578)	(747)	(441%)
EBITDA	10,022	10,616	7,123	(3,493)	(33%)	1,336	615	(721)	(54%)
TRANSFORMATION PROGRAMME	6,396	5,529	4,852	(677)	(12%)	729	728	(1)	(0%)
CAPITAL EXPENDITURE	6,435	12,871	12,458	(413)	(3%)	2,203	1,774	(429)	(19%)

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	50,107	50,227	51,141	914	2%	5,550	5,415	(135)	(2%)
Outpatients	211,122	253,637	249,712	(3,925)	(2%)	28,031	26,540	(1,491)	(5%)
Non Elective	21,041	21,861	24,516	2,655	12%	2,465	2,748	283	11%
Emergency Department Attendances	63,187	63,034	66,705	3,671	6%	6,985	6,975	(10)	(0%)
TOTAL PbR ACTIVITY	345,457	388,759	392,074	3,315	1%	43,031	41,678	(1,353)	(3%)

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	54,423	52,114	52,816	701	1%	5,760	5,790	30	1%
Outpatients	23,490	24,064	24,014	(51)	(0%)	2,660	2,629	(31)	(1%)
Non Elective	38,729	40,902	41,263	361	1%	4,611	4,679	68	1%
Emergency Department Attendances	5,863	6,368	6,464	96	2%	706	712	6	1%
Non PbR	50,492	52,285	51,524	(761)	(1%)	5,995	6,041	47	1%
Non Contracted	18,100	18,783	20,596	1,813	10%	2,246	2,291	45	2%
Research	1,463	1,376	1,450	74	5%	153	170	17	11%
Interest	112	113	111	(2)	(2%)	12	12	(1)	(6%)
TOTAL INCOME	192,672	196,004	198,237	2,232	1%	22,142	22,323	181	1%

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	114,125	119,050	122,051	(3,001)	(3%)	13,158	13,738	(580)	(4%)
Clinical Supplies	26,106	25,936	26,673	(737)	(3%)	2,874	3,029	(155)	(5%)
Drugs	19,064	20,792	21,723	(931)	(4%)	2,364	2,631	(268)	(11%)
Other Non Pay Expenditure	21,503	17,753	18,664	(911)	(5%)	2,204	2,080	124	6%
Research	1,463	1,379	1,453	(74)	(5%)	153	170	(17)	(11%)
Depreciation	6,233	7,088	7,088	(0)	(0%)	788	805	(18)	(2%)
PDC Dividends Payable	3,343	3,888	3,949	(62)	(2%)	433	448	(15)	(3%)
TOTAL EXPENDITURE	191,838	195,885	201,601	(5,716)	(3%)	21,973	22,901	(928)	(4%)

STATEMENT OF FINANCIAL POSITION	2013/14 YTD ACTUAL £'000	CURRENT YEAR TO DATE			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Non Current Assets	145,530	165,613	165,200	(413)	(0%)
Current Assets	70,774	69,948	70,063	115	0%
Current Liabilities	(29,424)	(28,799)	(31,250)	(2,451)	9%
Non Current Liabilities	(2,489)	(11,470)	(11,814)	(344)	3%
TOTAL ASSETS EMPLOYED	184,391	195,292	192,199	(3,093)	(2%)
Public Dividend Capital	78,674	78,674	79,063	389	0%
Revaluation Reserve	64,485	72,999	72,999	0	0%
Income and Expenditure Reserve	41,232	43,619	40,137	(3,482)	(8%)
TOTAL TAXPAYERS EQUITY	184,391	195,292	192,199	(3,093)	(2%)

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	2.78x	2.69x	1.72x	2	1
Liquidity	55.0	52.6	47.9	4	2
CONTINUITY OF SERVICE RISK RATING	4				3

BOARD OF DIRECTORS	
Meeting Date and Part:	30 th January 2015 - Part I
Subject:	Workforce report
Section:	Performance
Executive Director with overall responsibility	Karen Allman
Author(s):	Karen Allman
Previous discussion and/or dissemination:	Workforce Committee takes place on 11 th February when many of the issues will be reviewed in more detail.
Action required: The Board of Directors is asked to: Note the content of the report.	
Summary: The report shows the performance of the Trust by care groups across a range of workforce metrics and includes an update on Education & Training and the Flu Campaign. Recruitment to a wide range of clinical and medical posts remains challenging but progress is being made on appointments to clinical and medical posts.	
Related Strategic Goals/ Objectives:	To listen to, support, motivate and develop our staff
Relevant CQC Outcome:	Outcomes 12, 13 & 14 - Staffing
Risk Profile: i. Have any risks been reduced? No ii. Have any risks been created? No	
Reason paper is in Part 2	N/A

WORKFORCE REPORT – JANUARY 2015

1. Workforce data as at 31 December 2015

The monthly workforce data is shown below, by Care Group and category of staff and has been RAG rated against the Trust's targets of 90% appraisal compliance and 3% stretch sickness absence.

Care Group	Appraisal Compliance	Mandatory Training Compliance	Sickness Absence	Joining Rate	Turnover	Vacancy Rate (from ESR)
	At 31 Dec		Rolling 12 months to 31 Dec			At 31 Dec
Surgical	65.6%	78.0%	4.41%	12.8%	9.9%	3.8%
Medical	73.7%	79.3%	3.46%	19.9%	12.5%	3.8%
Specialities	71.6%	76.3%	3.85%	10.2%	10.3%	2.7%
Corporate	79.2%	83.0%	3.77%	13.2%	17.6%	5.1%
Trustwide	72.4%	78.9%	3.83%	14.6%	12.5%	3.8%

Staff Group	Appraisal Compliance	Mandatory Training Compliance	Sickness Absence	Joining Rate	Turnover	Vacancy Rate (from ESR)
	At 31 Dec		Rolling 12 months to 31 Dec			At 31 Dec
Add Prof Scientific and Technical	75.2%	81.8%	3.97%	10.6%	15.1%	6.0%
Additional Clinical Services	69.1%	81.0%	5.90%	22.3%	11.5%	3.0%
Administrative and Clerical	76.5%	80.6%	3.51%	16.1%	14.7%	4.7%
Allied Health Professionals	72.5%	83.3%	1.58%	13.5%	12.4%	0.9%
Estates and Ancillary	87.2%	84.6%	6.00%	8.7%	19.1%	5.9%
Healthcare Scientists	75.4%	80.3%	3.65%	12.6%	17.3%	2.4%
Medical and Dental	62.7%	52.3%	1.05%	8.1%	7.2%	0.9%
Nursing and Midwifery Registered	70.2%	83.7%	3.80%	12.7%	9.9%	4.7%
Trustwide	72.4%	78.9%	3.83%	14.6%	12.5%	3.8%

The appraisal compliance rate Trust-wide is very similar to last month and has been fairly consistent since April; mandatory training /essential core skills compliance is also quite static. The Board will be aware that the new Virtual Learning Environment (VLE) platform for mandatory training will launch in March 2015 and that a new Appraisal process is also under development and due for launch shortly.

Turnover has increased in the corporate group but this is partly attributable to the transfer of 29 staff in Commercial Services to Poole Hospital. As per last month the overall joining rate exceeds the turnover rate, with the highest percentage joining in the additional clinical services category which includes health care assistants.

Sickness absence is relatively unchanged with absence highest amongst additional clinical services and estates and ancillary categories of staff.

2. Medical staff recruitment

Since the last Board report an appointment for a Consultant in acute medicine has been made.

Interviews are planned for 5 February for two further consultant posts in acute medicine and one shared between acute and stroke medicine.

We continue to try and attract consultants from overseas using recruitment campaigns including two separate visits over the Christmas period from an Australian consultant in medicine for the elderly, and an American consultant in emergency medicine (currently working in New Zealand); both visits were over two days giving them the opportunity not only to get good knowledge of the hospital and the role of a UK consultant, and to view the surrounding area for housing, schools etc. Unfortunately both of the doctors have decided not to move to the UK at this moment in time for family and personal reasons.

Vacancies currently being advertised nationally include a Consultant in Orthopaedics.

In regard to other medical staff posts, a recruitment campaign in Pakistan took place in December and proved successful with 85 applications. Dr Raza interviewed 25 applicants in Pakistan while on his leave over the Christmas period and further video interviews will take place on 5 February. The aim is to appoint at least 8 medical staff to join the Trust in June, go through a 6–8 week NHS adaptation then either slot into the August rotation Trust posts, work supernumerary normal hours and additional locum cover shifts based on previous experience, and the doctors will then be placed in fixed term rotational post at the end of September.

3. Recruitment and retention

3.1 Nurse recruitment

The recruitment of band 5 nurses, especially within Elderly Care, remains challenging. A national advert for Elderly Care was run with an emphasis on “selling” the Trust as a centre of excellence for Elderly Care explaining the work being undertaken around Dementia. This campaign resulted in 3 successful recruits. Other methods of local and national advertising are also being trialled to attract applicants.

The Older Peoples Medicine (OPM) incentive payment of 2% of basic salary is being paid to all nursing staff on OPM wards from January 2015. This has also been included on all OPM adverts to attract internal and external applicants to apply. This is 6 month pilot which will be evaluated.

The recruitment of specialist areas such as Cardiac, ITU and Ophthalmology continues to be successful. There are a number of internal recruits for these posts and although this is very positive for the development of employees, it does have a negative effect on “difficult to recruit” wards.

The Trust will be represented at a number of recruitment events including a recruitment event on the 6/7 February at the Westfield shopping centre in London, national RCN events and University open days.

There are also plans for Nursing open days and a schedule of dates for Health Care Assistant recruitment days.

We have developed a “Return to Acute Nursing” (RAN) programme to encourage people who are qualified nurses working in nursing homes or other roles to return at the Trust. A pilot programme starts in March 2015 and the programme is being advertised currently.

The Trust is continuing to pursue overseas recruitment and has interviews through agencies planned for January onwards.

Recruitment videos and supporting marketing material has also been developed for use at all our recruitment events by the communications and HR team.

3.2 Recruitment - hard to fill posts

We have looked back at posts which have not elicited a good response and been advertised more than once since April. In addition to band 5 nurses, there are two broad categories: specialist clinical roles, such as lead interventional radiographer, specialist physiotherapist, specialist diabetic nurse, experienced theatre practitioners; and estates and craftsmen posts, such as estates maintenance, painters & carpenters. Representatives of the Trust will have knowledge of all vacancies when attending recruitment events and care groups and directorates are also working through their plans for workforce development and planning following the successful workforce strategy event held on the 4 December.

3.3 Retention

Staff welfare clinics have been set up so staff can discuss any problems with matrons and other relevant contacts in order to try and resolve problems and identify solutions before staff decide to leave the Trust.

Managers are being encouraged to give time to any employee that has resigned to complete the leaver's questionnaire to ascertain any emerging patterns.

A further exit/retention project is planned for February to understand why people are leaving and this will have an emphasis on high turnover areas.

A successful “Afternoon tea” with new HCAs took place on 15th January. Overall themes and issues are being fed back to managers and care groups as appropriate so that we learn from any mistakes and improve retention and staff satisfaction.

3.4 Safe Staffing

The final Safe Staffing Unify return for December 2014 showed a total Trust aggregate fill rate of registered nurses in the day of 92.3% and at night a 98.4%.

The aggregate fill rate of healthcare assistants is 97.9% in the day and 110.9% at night.

	RN Actual	HCA Actual
Day	92.3%	97.9%
Night	98.4%	110.9%

NB: throughout December wards were relocating so template anomalies are being realigned.

- Areas which were below 90% for registered nurse fill rate on day duty were; AMU, day surgery, Derwent, surgical admissions unit, ward 1, ward 21, ward 3, ward 7. These areas were all mitigated at a local level.
- Ward 9 (orthopaedics); the template has been reviewed. The position is much more favourable than reported from e-roster as the actual number of patients is lower than the number of patients the staffing template is set for.
- Day surgery and the maternity unit were below 90% for the registered nurse/midwife fill rate on night duty.
- There were 2 wards across care groups where the HCA fill rate was lower than 90% in the day.
- There are 14 ward areas across surgery and the older people's wards where over 100% usage of HCAs existed during the night shifts. This is due to clinical acuity, falls prevention and specials. This is being reviewed within the Care Group. This has elevated the overall aggregate.
- All areas were appropriately risk mitigated. Staffing is reviewed daily by the Matron workforce with localised assessment and decisions on use of temporary workforce, skill sets required and staff movement.
- Overall, the fill rate has been maintained comparable to previous months supported by movement of staff, extra ad hoc staff and staff 'goodwill' supporting areas where short term sickness adversely affected areas locally.

Staffing for the additional bed capacity on ward 3

Ward 3 opened a day earlier than planned on Sunday 28th December with a template for nursing 16 inpatients as agreed at Trust Management Board (TMB). Substantive staff on this template have been supported by 4 competent block booked agency staff.

Due to the surge in inpatient admissions in early January 2015, much more than usual even for this time of year, the ward was opened to full capacity - 28 beds within the week. Ad hoc staff were requested. Following a further review of the nursing template on 14/15th January 2015, patient acuity and dependency, and fill rates were scrutinised. Subsequently a capacity reduction programme balancing safety and patient flow has been planned. This is currently being implemented.

4. Education and Training

The new structure, as detailed in the October Board, is now fully in operation. Key work streams include:

- a) Review of Clinical Skills Training in collaboration with key stakeholders.

- b) The development of a “Return to Acute Nursing” programme in collaboration and endorsement by Bournemouth University. This will enable clinical staff new to acute nursing to gain the relevant competencies for them to be safe working in a fast paced acute Trust such as RBCH. (referenced earlier in section 3.1)
- c) Increasing number of Apprenticeships particularly amongst the younger age group. We have also changed the education contract to a different partner as this will achieve greater value for money.
- d) Implementation of the Care Certificate for Health Care Support Workers in line with the national launch in March 2015.
- e) Developing a career pathway for Associated Practitioners.
- f) Developing a student strategy to ensure that all students (from all professional groups) feel part of the trust in an aim to retain the students as newly qualified practitioners.
- g) The implementation of the new Training needs analysis which ensures that all education and training needs are captured in a streamlined way.

Mandatory Training

The Trust has shown only a small improvement in the figures for mandatory training compliance again in December. Mandatory training will be re-launched in March as Essential Core Skills together with a redesign of the Core Induction programme. The Virtual Learning Environment will also be launched with the inclusion of 13 new e-learning modules that staff will be able to access on site or remotely via their laptop, tablet or mobile device. Once logged in, staff will be presented with a graphical dashboard of their compliance by subject they are required to complete.

The Trust will be aligned to all ten of the National Core Skills Training Framework subjects that will allow us to benefit from staff coming to the Trust with their in-date training compliance from other Trusts. There will be various changes to refresher periods and splitting certain subjects from one to two levels for clinical and non-clinical staff. As such, there may be a slight drop in compliance with some subjects in March which will reflect the reduction to refresh periods for some subjects; however, this should be quickly overcome with the new provision of eLearning via the VLE.

Leadership

A proposal for a four day Leading Quality, Improvement and Change programme for bands 2-7 has been agreed at the Education and Training Strategic Group and funding identified to run the programme in-house. Leading Improvement and Change is a 4 day management development programme that educates delegates on a variety of tools and techniques to effectively lead and manage change and improvement within teams. The programme 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 roll-out of the programme is anticipated from May.

5. Flu Campaign Update

Vaccination uptake

The 2014 flu campaign within the Trust resulted in 2696 members of staff having the flu vaccination, representing 55% of staff employed.

Where uptake is lower consideration will be given to initiatives which might increase this in 2015 with colleagues. However, overall the Trust performance improved upon the 44% of staff vaccinated last year, and we were the best performers within the local area at close of data for November 2014.

Nationally there has been a smaller increase in uptake with rates increasing from 35% to 36.8%; our Trust increase is considerably higher than this at 11%.

Initiatives undertaken in 2014

To encourage staff to have the flu vaccination a number of initiatives and incentives were introduced in 2014.

- Opportunity to win an ipad
- Jabometer on the intranet showing uptake rates etc.
- Pop-up clinics very successful.
- Free car parking spaces for 1 month.
- Gym Pass

Excellent support was given by the communications team to publicise the campaign and ensure that the message was consistently given of the benefits to patient care and individuals of receiving the vaccine.

BOARD OF DIRECTORS	
Meeting Date and Part:	30 January 2015
Subject:	Monitor Quarter 2 Report
Section:	Performance
Executive Director with overall responsibility	Tony Spotswood, Chief Executive
Author(s):	Sarah Anderson, Trust Secretary
Previous discussion and/or dissemination:	None
Action required: To note Monitor's Quarter 2 report.	
Summary: Monitor have responded to the Trust's Quarter 2 submission and continues to rate the Trust as level 3 for the Continuity of services risk rating and green for the Governance risk rating although some targets have not been achieved.	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	All
Risk Profile: <ul style="list-style-type: none"> i. No changes to risks 	

5 December 2014

Mr Tony Spotswood
Chief Executive
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
Dorset
BH7 7DW



Making the health sector
work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.monitor.gov.uk

Dear Tony

Q2 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q2 submissions is now complete. Based on this work, the Trust's current ratings are:

- | | | |
|--------------------------------------|---|-------|
| • Continuity of services risk rating | - | 3 |
| • Governance risk rating | - | Green |

These ratings will be published on Monitor's website later in December.

The Trust has been assigned a Green governance risk rating but has failed to meet the following targets:

- Referral to treatment time, 18 weeks in aggregate, admitted patients;
- A&E Clinical Quality – Total time in A&E under 4 hours (the Trust also failed this target in Q1);
- Cancer 2 weeks (all cancers) (the Trust also failed this target in Q1); and
- Cancer 2 weeks (breast symptoms).

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the Trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance¹ and the Risk Assessment Framework².

We expect the Trust to address the issues leading to the target failures and achieve sustainable compliance with the targets promptly. Monitor does not intend to take any further action at this stage, however should these issues not be addressed promptly and

¹ www.monitor-nhsft.gov.uk/node/2622

² www.monitor.gov.uk/raf

effectively, or should any other relevant circumstances arise, it will consider what if any further regulatory action may be appropriate.

As communicated to you via email on 14 November 2014, our analysis of your reporting at Q2 indicated that there may be material change to the Trust's financial projections. As a result, we have asked you to complete a reforecast for the remainder of the 2014/15 financial year. This reforecast should be submitted by 4pm on Wednesday 17 December 2014.

A report on the FT sector aggregate performance from Q2 2014/15 is now available on our website³ which I hope you will find of interest.

We have also issued a press release⁴ setting out a summary of the key findings across the FT sector from the Q2 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0192 or by email (Justin.Collings@Monitor.gov.uk).

Yours sincerely



Justin Collings
Senior Regional Manager

cc: Ms Jane Stichbury, Chair
Mr Stuart Hunter, Director of Finance and IT

³ <https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-2-201415>

⁴ <https://www.gov.uk/government/news/foundation-trusts-urged-to-tackle-financial-challenge>

BOARD OF DIRECTORS	
Meeting Date and Part:	30 January 2015 - Part 1
Subject:	Clinical Service Review
Section:	Strategy and Risk
Executive Director with overall responsibility	Tony Spotswood
Author(s):	Tony Spotswood
Previous discussion and/or dissemination:	Clinical Review Workshops
Action required: The Board is asked to note the Case for Change underpinning the CSR	
Summary: Details of the Case for Change developed in conjunction with partners to support the CSR	
Related Strategic Goals/Objectives:	Developing our strategy
Relevant CQC Outcome:	All
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? Yes ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

Clinical Service Review

The Board is asked to note the attached “Case for Change” developed in support of the work now underway to complete a comprehensive review of the pattern and provision of health care and service across Dorset.

Work is now underway to identify the future models of care which supports the provision of high quality services, compliant with national recommendations concerning configuration, outcomes and best practice. From this will emerge consideration of important issues including:

- The need to ensure Dorset retains sustainable high-quality services including emergency and complex services
- We work towards more integration between primary, community and hospital based services
- We work together to ensure those services are affordable to the local health economy

This paper is provided for information. The intention of the Clinical Commissioning Group is to formally consult on proposals post the General Election. I will ensure that as part of this process, there is an opportunity for full consultation within the Trust.

Tony Spotswood
Chief Executive

Dorset's Health Services

The need to change



Modernising your health service

Dorset Clinical Commissioning Group is the name of a group of local doctors and other health professionals whose job it is to plan and secure the healthcare for Dorset's people. Our members come from 100 GP practices across the county.

We are working with hospitals, GP practices and other health and care providers and specialists to improve and modernise Dorset's health services. Together, we believe we need to make significant changes to Dorset's health services to ensure you have high quality and affordable care not just now but into the future.

Although most patients currently receive good care in Dorset, achieving the best standards of care for everyone is becoming increasingly difficult.

We need you to join us on our mission to achieve the right healthcare for the people of Dorset now and in the future.

Your help

This document explains the current picture of healthcare in Dorset based on the evidence we have gathered. It also describes some of the challenges we face to meet the health needs of local people.

To be able to look after everyone's health as well as possible we are developing some options for how we could change the way health care is delivered. We want to know what you think about the possible changes. So in the summer of 2015 we will run a formal consultation and ask for your views. To receive the consultation document please sign up to our Health Involvement Network and we will stay in touch and share information with you. The details of how to do this are on page eight.

As part of gathering the evidence we have reviewed recent feedback from local people to understand what you need from your health services and what changes you would like. Your views have been gathered from health surveys, such as the 6,000 responses we received in 2013 to *The Big Ask*, and from other research. We have used this information to help to demonstrate why the current system must change and we will continue to use it to inform our ideas for the way our services might be best provided in the future.



Why change?

The needs of patients in Dorset today are very different from back in the 1940s when the NHS healthcare system was set up.

Then, the average life expectancy was lower, and the most common conditions facing people were injuries, heart attacks and strokes. Now many more people live into old age. We have among the longest life expectancy in the country and the number of Dorset pensioners is predicted to rise by 30 per cent over the next decade.

Although this is great news, increased longevity brings new challenges. The most significant is that more people are living with chronic conditions such as diabetes and dementia. The way we currently organise our health resources doesn't reflect people's changing needs as well as it could.

Meanwhile due to advances in surgical techniques and anaesthetics, people no longer need to spend weeks in hospital. Today many patients need just a few days or sometimes only a few hours hospital recovery time after surgery.

However despite this and many other exciting new developments in medicine and technology we are not making the best use of the advantages they bring.

Some specialist staff don't get to see sufficient cases to maintain and build their skills and expertise and the way services are currently organised means that patients don't always get access to the specialists that do exist. In addition, specialist staff may not be available seven days a week. As a result, patients with similar conditions can have better or worse treatment depending on the staff they are treated by or the hospital they are treated in. Similarly patients get different treatment and services depending on which GP practice they use.

We don't currently organise health services as efficiently as we might, for example health and social care services could be more joined up, which means we don't help people as well as we'd like and we don't always get the best value for money.

A key problem is the way we organise staff. We have highly skilled staff carrying out tasks other more appropriately trained doctors and nurses could do. We still have too many staff vacancies. This means we are often forced to employ more expensive agency staff. Our health system today needs a wider variety of skills to meet current health problems.

Underlying these difficulties is the need to control the amount of money that is being spent. This is a huge and growing problem for the NHS. By 2020/21 we forecast Dorset will have to spend £167m to over £200m more each year than it receives if nothing changes (the amount depends on changes in demand and inflation costs).

So there is an urgent need to change the way we do things. We need to reorganise our health service to ensure we have the right skilled people, efficient buildings, wise use of technology and money allocated in the right places to help to look after everyone's health properly. Doing nothing is not an option.

The problems we are currently facing are not unique to Dorset. The NHS in England has recognised these are national challenges and that the health system everywhere has to adjust. In Dorset we are facing up to the issues and preparing to take action because we are committed to ensuring everyone has access to safe, high-quality, up-to-date and affordable healthcare into the future.



Dr Forbes Watson

GP and Chairperson, Dorset Clinical Commissioning Group

The evidence

As clinical leaders we have been gathering together a large quantity of information about how we need to adapt to the new challenges facing our health system. We have studied this research and our findings indicate we need to start to plan to change the system now to help patients receive the right care in the right place in the future.

Our ageing and diverse population

By 2023, the population of Dorset is expected to grow by 6 per cent from 754,000 to over 800,000 with much of the growth happening amongst the oldest.

We need our health service to care for our ageing population and the conditions associated with it, such as heart disease, stroke and diabetes.

We also need to reduce the gap between the health of the poorest and richest. Within Weymouth and Portland the life expectancy varies by over 11 years between men living in the most deprived and more prosperous areas.

Population growth 2013-2023



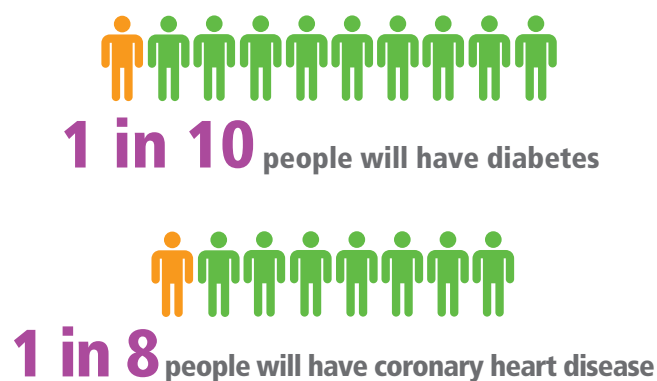
Source: ONS 2012-based Sub National Population Projection

Our changing health needs

The people of Dorset generally have better health compared to the England average, with low smoking rates and fewer obese children.

But due to our older population we have higher numbers of people with heart problems and diabetes and we expect this to grow faster than the national average. By 2020 around one in ten of the people in our county are predicted to have diabetes and 1 in 8 will experience heart disease.

Increasing numbers of people living with long term conditions. By 2020:



Source: Association of Public Health Observatories

Your expectations

We know from our research amongst local people that you want easier and better access to care.

Surveys show the public wants:

-  Out of hours GP services, and longer GP opening hours.
-  More services such as blood tests and physiotherapy provided locally with longer opening hours.
-  Consultant led teams in hospitals available seven days a week.
-  Specialist centres of excellence to ensure patients get the best treatments even if they need to travel further to reach them.
-  Better communication between hospitals, specialist consultants and GPs and the patient.

Source: The Big Ask, Market Research Group, 2013

The evidence

GP practices and out of hours care

The quality of general practice in Dorset is recognised as being generally high but there is significant variation that needs to be addressed.

Whilst practices are open from 8am - 6.30pm Monday to Friday (with some closures over lunchtime) and all offer some appointments outside of this time, the amount of extended hours offered in evenings and at weekends varies considerably.



24% of patients don't find it easy to contact out-of-hours GP services by phone

Source: GP Patient Survey CCG Report (July 2014)

Outside the standard opening hours, general practice care is available through the 111 service.

However, access to out of hours services and the ease of accessing them depends on where you live. This may contribute to the large differences in the variation of the number of people who attend A&E according to which GP practice they use.

As well as variations in people's ability to access general practice services more could also be done to tackle variations in the quality of care provided. For example patients with diabetes in Dorset do less well than those in some other areas of the country.

In addition, the GP workforce is under strain. Many practices are unable to recruit GPs, training posts are not being filled and many GPs are approaching retirement. GPs also spend considerable time on tasks that could be better provided by team members with a range of skills and expertise, being led by a doctor.

Variation in A&E attendances across GP practices



Lowest 173
per 1,000 population
(adjusted for age and health status)



Highest 459
per 1,000 population
(adjusted for age and health status)

Source: HES 2013/14



“Patients in Dorset deserve the best possible care. To deliver this we need high quality general practice, supported by services that are designed to meet the needs of patients in the 21st century. The Clinical Services Review is designed to achieve this.”

Dr Nigel Watson, GP and Chief Executive, Wessex Local Medical Committees

Community and mental health services

In Dorset 12 community hospitals and a number of home based teams provide a range of care to people in their homes and in their local area.

More than half of the patients currently admitted to community hospitals could instead be supported at home and a further third nursed in their own home, meaning they can be treated and cared for, but also safely maintain their independence.

Other community services such as those provided by district nurses, health visitors, chiropodists and occupational therapists add an important element to home care, but often they do not have access to patients' health records and time may be wasted

if they don't know the full details of each patient's needs.

Evidence shows patients with physical long term conditions are more likely to experience depression or anxiety and we need to ensure they receive a more comprehensive range of services.

Although Dorset generally enjoys good access to mental health services, in some areas there is not enough support provided to patients outside working hours and in other places there are not enough services for children with mental health conditions. *The Big Ask* also told us that you would like to see an improvement in the quality of mental health services offered.

The evidence

Hospital care

In Dorset hospital-based emergency care, planned and specialist care, maternity and child care is provided by Dorset County Hospital, Poole Hospital and The Royal Bournemouth Hospital.

Emergency care

A&E attendances have increased significantly over the past few years. Over half of these patients have minor conditions that do not require hospital treatment.

Other people who are ill and need to go into hospital are forced to wait longer in emergency departments because there are not enough free beds to admit patients. This is partly because elderly people, who cannot be discharged because they do not have proper support available in their homes, take up beds whilst waiting for support to be put in place. Many patients also cannot be discharged on time because they have conditions that mean they have ongoing needs for treatment close to home which our current health system is not set up to provide.

10 year projected increase:

A&E
+22%
A&E attendance


+30%
Hospital admissions

Source: HES 2013/14; Office of National Statistics 2012 based sub-national population projections over 10 years

In addition, emergency surgery in our three hospitals does not always meet national quality standards, partly because in smaller units surgeons are not treating enough patients with the same conditions to sufficiently maintain a specialist skill.

Some life threatening emergencies are not dealt with quickly enough. For example the percentage of stroke patients receiving a potentially life-saving diagnostic brain scan within an hour is 10 per cent lower in Dorset than the national average. This means these patients are at higher risk of suffering from complications.

As emergencies can happen at any time of the day or night it is important there is round the clock consultant cover for each hospital. However at the moment there is not 7 day a week consultant cover on site in all three hospitals.

Planned and specialist care

Access to planned hospital care is good across Dorset, with most patients treated from GP referrals within the national target of 18 weeks. But there is variation in the quality of this care depending on the health condition, particularly in cancer treatment. For example there is a 2.8% variation in patients with bowel cancer who die within 90 days of treatment.

We need to ensure that professionals with the appropriate specialist expertise are available to treat patients, and that they have access to the latest available equipment.

Maternity and obstetric care

If mums need to give birth in hospital, babies are more likely to be born safely if there is a consultant who can be called upon during their labour if the need arises. Most consultants operate during working hours, which means babies delivered in the evenings or at weekends may not have immediate access to a consultant on site and this can be especially problematic if things go wrong.

At the moment there are two obstetric units in Dorset and these have consultant obstetrician cover on site for 40 hours a week and 60 hours a week (from a total of 168 hours).

Percentage of time in the week when there is a consultant obstetrician on the labour ward


24%


36%

The Royal Bournemouth Hospital has a midwife led maternity unit for low risk pregnancies, but these midwives still need to be able to access additional specialist services if required. We need to make sure specialist services are available to women in labour at all times of the day and night.

Children's care

Dorset County Hospital and Poole Hospital both have children's wards with over 16,000 unplanned admissions. Nearly half of these children are admitted for less than 24 hours, which shows their cases are usually not serious and often just need observation. This indicates their care could be delivered in a different way, rather than being admitted to hospital.

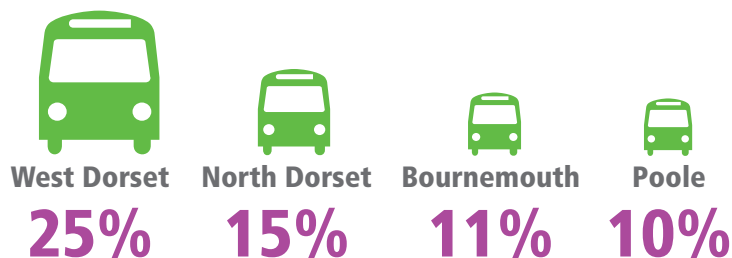
The evidence

Getting to health services

Car ownership in Dorset is around 60 per cent, which is higher than the England average.

However due to the rural nature of some areas in Dorset, many people have little access to public transport. For example ten per cent of the population do not have an easy connection to an acute hospital. In the design of our future health system we need to take transport issues into account and ensure people can receive healthcare in different ways and as close to home as possible.

Percentage of people estimated to have no/limited public transport connection to an acute hospital



Source: Peak Public Transport Data, SDG

Working together with social care

Many people across Dorset point out a lack of close working between different parts of the health system and social care services.

Local doctors, along with patients and their families, believe if there were better community support services patients could leave hospital more quickly, which would reduce their risk of hospital acquired infections and free up the beds for others in need. At the moment there are too many delays in discharging patients from hospital.

We also want to continue current work to get health and social care teams working better together to help people stay independent for longer and prevent the problems that can lead people to need hospital care, as well as giving the right support to those leaving hospital.



“A key aspect of any future plan should be to ensure a more seamless service and the ability to provide quality care at home. This will reduce people’s need for hospital admissions and speed up their discharge if admitted.”

Dr Chris McCall, GP

Staffing challenges

The organisation of Dorset’s health services means that doctors, midwives and nurses are not always available in the places and at the times that patients need to see them. In addition, nationally, and locally there is a shortage of some clinicians with key specialist skills and it is difficult to recruit to some posts. These factors mean there is a reliance on expensive short term clinical staff. We need to organise our health professionals better in the future.

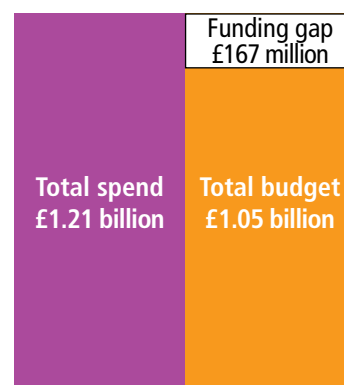
Royal College of Emergency Medicine recommended number of consultants per emergency department



Growing shortage of money

The NHS in England is expected to have a £30 billion shortfall by 2020/21. For Dorset experts have forecast that in five years we will have a shortage of between £167 million and £200 million each year, between our income and our costs, depending on the demands on the service and inflation costs.

As NHS funding cannot keep pace with the growth in demands and costs, and to get the most from the money we do have, regardless of any potential increase in our future budget we have to ensure we organise the resources we have to best provide the health services that meet changing needs. This means we have to be more efficient, organise and deliver our services in different ways, and invest more money in disease prevention.



Dorset Clinical Commissioning Group forecast financial position 2020/21

Our review

We want to ensure all patients have access to care in the right place at the right time, whether it is at a hospital, at their GP surgery or at home.

We need to recognise our population is growing and changing. We are expecting a 6 per cent rise in Dorset's population between 2012 and 2020, many of whom will be pensioners.

To meet your changing needs and improve the quality of care we need to re-design our services so everyone can get the best quality, specialist and up-to-date care in the right place and in an affordable way.

We also need to ensure we can provide this health care alongside support for people at home and in their communities so they can easily get the help they need from their surgery, a hospital or at home.

NHS Dorset Clinical Commissioning Group is working out how we need to change by carrying out a Clinical Services Review. We are taking advice from a wide range of doctors, nurses and health and social care specialists, along with patients, carers, voluntary groups and the general public to improve care, reduce the variation in treatment and ensure we spend our money to get the maximum health benefit for all.

Our review is focused on understanding:

- What are your needs?
- What services can meet your needs?



“I think it is clear why we need to restructure our healthcare system - the data shows services are not sustainable. This is an opportunity for change and improvement – particularly around better integration of services.”

Local Dorset resident

Patient and Public Engagement Group member



“Some people and services appear saturated with resources, others are not. We need more focus on equity and equality and plain economics - getting the right services to the right people.”

Local Dorset resident

Patient and Public Engagement Group member

If you would like further information about the review of Dorset's health services then visit www.dorsetsvision.nhs.uk e-mail involve@dorsetccg.nhs.uk or ring **01202 541946**. Please also contact us to sign-up to the Health Involvement Network to receive regular updates on the Review's progress and the consultation document in the summer of 2015.



[facebook.com/NHSDorsetCCG](https://www.facebook.com/NHSDorsetCCG)



[twitter.com/@DorsetCCG](https://twitter.com/DorsetCCG)

Easyread, audio and translated copies of this document are available on request.

BOARD OF DIRECTORS	
Meeting Date and Part:	30 January 2015 - Part 1
Subject:	Development of the Trust's Strategy
Section:	Strategy and Risk
Executive Director with overall responsibility	Tony Spotswood
Author(s):	Tony Spotswood
Previous discussion and/or dissemination:	Trust Management Board, Board of Directors
Action required: The Board is asked to note the work underway to refresh the Trust's Strategy	
Summary: Details of the proposed discussion on the Trust Strategy with Monitor	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	All
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? ii. Have any risks been created? 	
Reason paper is in Part 2	N/A

Development of the Trust's Strategy

Introduction

The Trust is developing a refreshed strategy which responds to the emergent themes and outcomes from the Clinical Service Review. This strategy will set out a plan to ensure the sustainability of services going forward. The backdrop for the development of the strategy is the wider strategic context and specifically the external drivers for change, including national guidance for provision of high quality, safe, and effective care, national priorities for service delivery, new models of care (outlined in the Five Year Forward Look), the financial framework for the NHS, anticipated changes in devices and technology, and key manpower constraints.

Discussion regarding the development and implementation of the emergent strategy will take place with Monitor in February (following their cancellation of our proposed meeting in January). These discussions will include a focus on:

- The sustainability and resilience of services in 2015/16 and 2016/17
- The Trust's quality priorities and work to secure ongoing improvements in care and outcome
- The development of the Trust's refreshed clinical strategy and its evolution as part of the CSR process
- The Trust's performance
- Our approach to organisational change and leadership, and organisational form

A report on this meeting will be given to the Board once discussions have taken place. Board members will receive under separate cover details of the briefing material being shared with Monitor.

This report is provided for information and consideration.

Tony Spotswood
Chief Executive

BOARD OF DIRECTORS	
Meeting Date and Part:	30 January 2014 - Part 1
Subject:	Communications Report (including media KPIs, Core Brief, way Staff can give feedback)
Section:	Information
Executive Director with overall responsibility	Karen Allman, Director of Human Resources
Author(s):	Jane Bruccoleri-Aitchison, Communications Manager
Previous discussion and/or dissemination:	
Action required: The Board of Directors is asked to: To note the report	
Summary: The Communications Report provides a summary of key communication activities over the past month as well as upcoming activities and media KPIs	
Related Strategic Goals/ Objectives:	Access to care Provider of choice
Relevant CQC Outcome:	Section 1, Outcome 1, Section 4, Outcome 13 and 14
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? ii. Have any risks been created? 	
Reason paper is in Part 2	N/A

Communications activities January 2015

1. Introduction

The following paper includes:

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

2. Recent activities

- Work on the A-Z of services on the Trust website – current focus is the patient and visitor section and cancer services
- Christmas recognition activities – including the 12 days of Christmas Draw
- Diarising and planning all events for the year – health talks, open day etc
- Supporting recruitment communications – including nurse recruitment film and recruitment folder
- Clinical Services Review – staff communications, public events, governor engagement
- Winter pressures communications – internal and external, including media, social media, screensavers, joint working with health partners in Dorset
- Supporting Organisational Development in promoting the options for the Trust's vision

3. Upcoming activities

- Next Christchurch Hospital newsletter and promotional messages on hoardings around the site: 'Celebrating our past, looking forward to our future'
- Focus on updating the recruitment section of the external website
- Annual Report
- Next issue of member magazine *FT Focus* and staff magazine *Buzzword*
- Car park communications
- Development of social media policy
- Focus on Sepsis – with Sean Weaver

4. Department update

Joanne Faithful, PA and Communications Admin Assistant, has been welcomed into the team and joins us from Education and Training.

Jane Bruccoleri-Aitchison is currently Interim Head of Communications. James Donald has been appointed the permanent HoC and will be joining us from Bournemouth University where he is currently Press and PR Manager. We look forward to welcoming him.

5. Ways for staff to give feedback

Below is a list of ways that our staff can give their feedback. Communications will be developed to ensure staff know about these avenues and any feedback will be presented in a 'You said, we did' format in *Buzzword* and on screensavers.

- HR
- Tony on Tour
- Core Brief feedback
- Email to communications@rbch.nhs.uk
- Speak to line manager
- Speak to matrons
- Staff governors
- Staff survey
- Staff side reps
- Events – meet your matrons, improvement events
- Workshops – values, appraisals
- Board walkarounds
- Whistleblowing
- Occupational Health
- Appraisals
- #Thank You!
- Staff Impressions Surveys and Employee Friends and Family Test
- Breakfast Briefings
- Change Leaders
- Improvement Ideas suggestion scheme

6. Recommendation

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

December saw a very high number of articles about our Trust in the print media as well as online. The majority of the articles were very positive and included several large pieces about the opening of our new Bournemouth Birth Centre, a story which also performed well online.

December also saw a series of articles about how winter pressures and norovirus were affecting our hospitals. We chose to be proactive with these stories to ensure the public were kept informed and in certain circumstances were advised to stay away from the hospital.

Our Twitter followers have grown by 150 in a month and now exceed 1,150. The news section of our website is also attracting an increased number of viewers since the homepage was relaunched in October.

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

2014	Number of proactive news releases distributed	% that received media coverage in <u>that month</u>	Total PRINT coverage (includes adverts)	Total OTHER coverage (online, radio, TV)	Positive media coverage	Neutral media coverage	Negative media coverage	Advertising value (for print coverage) */**	Media enquiries
December	10 (including new Birth Centre, extended gastro service, winter messages)	80%	32	29	45	14	2	£59,070	11 (including ED pressures, traffic issues and norovirus)
November	13 (including the CQC reinspection, 2015 events, staff success stories)	100%	26	32	40	12	6	£44,405	21 (including CQC reinspection, delayed transfers of care and data breaches)

* Any paid for adverts are not included i.e. advertorials ** Negative articles are not included

excellent care for every patient,
every day, everywhere

Core Brief



From: Tony Spotswood, Chief Executive

December 2014

Clinical Service Review

The Clinical Services Review is a programme of work being led by the Dorset Clinical Commissioning Group (CCG) that will analyse the health and social care needs of people living in Dorset for the next 10 -15 years.

It will make recommendations as to how best to meet those needs, consult the public about the findings and then, subject to consultation, implement any changes to our health services that are necessary to support people in Dorset.

There are three reasons why we need to carry out a Clinical Services Review:

Population:

The population in Dorset is getting older and younger. This brings different health needs and demands.

Patients' needs:

Services vary in quality and don't always meet new quality standards. We want to ensure everyone receives safe, high quality care.

Money:

We are very finely balanced financially and if we carry on as we are there will be a £167m gap between costs and income by 2020.

What is our vision of the future:

- more accessible and convenient

- streamlined and integrated
- delivering better care
- embracing advances in technology and innovation
- re-balancing of care across the community and hospitals
- affordable into the long-term

What is the current state of

healthcare in Dorset: Local doctors, nurses and other health leaders are currently looking at a detailed range of data and information which shows the current picture of healthcare in the county. This highlights where the county's NHS is performing well and where improvements are needed.

What does good look like and

how can it be delivered: We need to think differently about how we can deliver health services to meet quality and financial challenges, as well as changing needs of our population.

How can we deliver this in

Dorset: A total of 11 clinicians from RBCH, including Director of Nursing Paula Shobbrook and Medical Director Basil Fozard, are looking into ways to improve health care in the county so that everyone has access to safe, effective,

high-quality affordable services now and in the future.

What is the timeline for this?

The CCG is currently in the 'review, engage and design' stages which will be completed by spring 2015.

The CCG will then formally consult on the options in the summer of 2015, making its decision in the autumn.

Implementation is expected to start in 2016, and depending on the changes proposed, including the relocation of services and the development of new facilities, will take two to three years.

Keep up to date:

You can find out more about the Clinical Services Review, including how to share your thoughts and frequently asked questions, by logging onto **www.dorsetvision.nhs.uk**

The Communications Team will provide you with regular updates on the progress of the review through our publications and correspondence.

It is still early days, but if you have any questions please direct these to Communications and we will do our best to answer them.



Dorset's Clinical Services Review
shaping your local NHS



Highway congestion

If you drive to and from work, you will most likely have experienced significant congestion when leaving the Royal Bournemouth Hospital.

Being delayed getting off site after a day's work is hugely frustrating for all staff and patients. Unfortunately there is no simple answer to the problem.

Most staff have been patient and recognised this problem is caused by the volume of traffic on the main roads and is beyond our control.

We are working with the council to explore ways to reduce congestion without reducing the number of parking spaces at RBH.

These include:

- creating a simple exit/entry route on to Cooper Dean slip road - this is being actively pursued with a design being developed
- creating a new junction on to the Wessex Way - estimated to cost £15m and take two to three years to deliver
- widening Deansleigh Road and or Riverside Avenue. Neither are owned by the council or the Trust and are therefore unlikely to go ahead
- provide bus passes and personalised travel plans
- improve shower and change facilities for cyclists and walkers
- encourage car sharing
- offer more flexible working hours

- installing traffic monitoring cameras to allow staff to gauge congestion
- provide access to public car parks for staff working overnight who have permits

The above are all being actively promoted by Travelwise and the Trust and may offer an alternative to car use for some.

When we are made aware of any potential highway issues that may affect us, our Communications Team will send out an email alert. However the recent problems do not seem to be a result of planned works.

All staff are asked to consider if there is an alternative to single occupancy car travel to and from work, to help ease congestion and avoid the frustration of being unable to leave the hospital without delay.

CQC ratings indicate low risk for RBCH services

Our hospitals have been given an overall risk score of five, out of a maximum possible risk score of 188, in the Care Quality Commission's (CQC) latest Intelligent Monitoring Report.

The report, which gives a score based on performance in respect of 94 indicators, puts us in band 5 (band 1 is the highest priority trust for inspection and band 6 the lowest). It identified three areas of risk and one area of elevated risk, out of 94.

Director of Nursing, **Paula Shobbrook**, said: "Following our recent follow-up

inspection, this is further confirmation of the improvement that we are continuing to make, which is reassuring for both our patients and staff.

"We are already aware of the areas that have been indicated as a risk. We are already working with our teams and the CQC to review the data and continue to make the improvements that are needed."



The CQC has developed the intelligence monitoring tool to assess a hospital's performance in respect of a range of indicators. It is used to group NHS trusts in to six priority bands for inspection. The data used to calculate the risk rating includes information from:

- staff
- patient surveys
- mortality rates
- hospital performance information such as waiting times and infection rates

NHS Pensions Choice 2

What is Choice 2?

Choice 2 is a second opportunity to move all of your '1995' NHS Pension scheme benefits to the '2008' NHS Pension scheme. Individual letters are being sent out detailing how you are affected and what you need to do if you would like to move.

Will everyone have a Choice 2 letter and a second Choice?

Only those members of the 1995 scheme who are in active membership and don't have full protection will be moved to the 2015 scheme on **Wednesday 1 April 2015** or at a later date. They will receive a letter.

For more details about protection log on to www.nhsbsa.nhs.uk

Why are we being given Choice 2?

From **Wednesday 1 April 2015** the new '2015' NHS Pension scheme will be brought in which links your normal retirement age within the NHS Pension with your state retirement age.

Most members will move to the 2015 scheme in April or at a later

date, and therefore, had they been aware of the need to work longer before accessing their pension benefits, may have chosen to move to the 2008 scheme in the first choice exercise.

In the interests of fairness, those who chose to stay in the 1995 scheme and are due to move to the 2015 scheme will be given another opportunity to move their 1995 benefits to the 2008 version up to **Tuesday 31 March 2015**.

What is my state pension age?

Go to the state pension age calculator at www.gov.uk/calculate-state-pension

Will I be better off moving to the 2008 scheme?

Some members will and some won't. It is different for each individual so base your decision solely on your own situation and not others. Whether you will be better off will depend on different factors, but mainly on what age you are planning to retire and whether you will leave the NHS Pension scheme before retirement.

Getting the most out of your pre-2015 benefits

You are strongly advised to read your letters and all the information available to you on the Choice 2 website before making a decision.

For further guidance on Choice 2 go to the 'Choice 2' tab on the Pensions intranet page. You can also contact the Pensions Department on ext. 4342 or by email.

Seminars will also be held in the Lecture Theatre at RBH on three dates in January 2015 to discuss Choice 2 and the 2015 pension scheme changes where all staff are welcome to attend and ask questions.



Patient information and blood transfusion consent forms

It is vital that our patients who are receiving blood transfusions are informed about the risks and benefits of the procedure, and any alternatives so they can make informed choices.

The following should be clearly documented in a patient's notes:

- the reason for transfusion
- information received consent form

- whether verbal consent has been obtained
- whether the risks and benefits have been explained

If the patient cannot be given information or a consent form prior to having a transfusion, then they should be given it at the earliest opportunity afterwards.

You can find out more by logging onto the blood transfusion pages of our internet site.



Patient safety film

A film has been produced by Guy's and St Thomas' which supports patients to play an active role in their care.

Based on the concept of safety advice given on aeroplanes, the film includes advice about preventing falls, blood clots, pressure ulcers and other avoidable complications.

You can view the film via our video tutorials tab at the bottom of the homepage on our intranet site.

It will also be available on our external website shortly.



Let's talk about IT

Electronic patient notes - eDM roll-out continues

Congratulations to all the staff that have gone live with eDM. Your preparation and commitment to using the Evolve system has made this a very successful rollout so far.

Preparation for 'Go Live'

There are still some areas that are yet to implement the new system. In preparation for the 'Go Live', we strongly recommend referring to the following:

Classroom based training:

If you are a manager, please encourage all your staff to attend eDM training as soon as you can. We have a 'floor walking' team on site to provide refresher courses if needed, but initial training is essential. You can organise a session by contacting the Training Department on ext. **4285**.

eDM website:

The eDM pages on our intranet site contain lots of useful information. This is regularly updated by the project team.

Contact the eDM team:

You can contact the eDM team if you want to discuss any concerns you may have. Simply bleep us on ext **2268**.

Check your log on details:

Encourage your team to log on to eDM to make sure there aren't any concerns with accessing the system. We have had a number of you who no longer remember their eCAMIS log on credentials.

The roll-out process

Only patients attending outpatient clinic appointments will have their case notes scanned. Therefore patients for breast and gynaecology admitted to theatre, wards and treatment areas will carry on using the blue case note until they are given a clinic appointment.

Once the case notes are scanned it is then a permanent digital record, so if a patient attends clinic and is then subsequently admitted to a ward their record will be digital. Initially we do not expect a lot of inpatients to have digital records.

This is a rolling process until all active blue case notes are scanned.

New eDM Scanning Bureau goes live

The new Scanning Bureau has officially gone live, and has two main roles.

It ensures case notes for specialities going live are carefully selected, labelled, boxed and sent to Kainos, our scanning partners, to prepare, scan and upload the patient record onto the eDM/Evolve system. This process will continue as each new speciality comes on board.

The Scanning Bureau has started copying all eNote folders returned to the department from clinical areas, loading the new digital records to the eDM/Evolve system and quality checking the documents to ensure the highest standards are met.

Sharon Murawski, Health Records/Scanning Bureau Manager, said:

"The project has started really well. All systems are going and we are excited about what this means for patient care in the future."

You can find out more information about eDM on the front page of our intranet site.



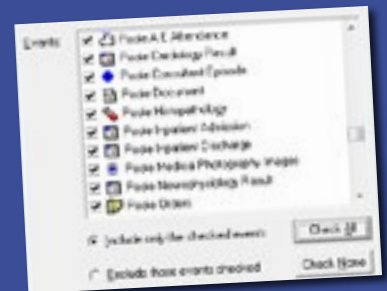
Interim EPR

Our Interim EPR solution has been delivered so that Poole Hospital events are now integrated with the Bournemouth events in Clinical Viewer.

We have started to roll this out to each group within eCAMIS and this will be completed by the new year.

Every user will be informed by email and via a message in eCAMIS.

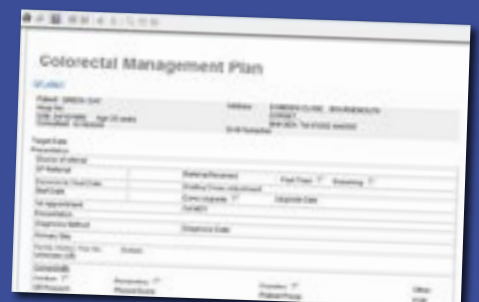
The Poole events are displayed on the Filter Criteria screen. They will all be ticked and you can de-select them so they do not display if you do not wish to view them.



When the Clinical Viewer opens all events are still displayed in chronological date order so will show a combination of Bournemouth and Poole events.

Poole events are clearly identified by the name in the 'event type' column and a description of the event in Qualifier text.

Double click on a Poole event to display in the 'viewer event browser' window.



KNOWLEDGE BANK

Need a quick solution to an IT challenge?

Want some "just in time" IT training?

Want a video demonstration of how to carry out an IT task?

Knowledge Bank is brought to you as part of the IT Skills Pathway and is a free search tool that helps you find the things you need to know quickly.

It gives you instant access to the full range of resources available via the IT Skills Pathway. Rather than doing a search via the Internet, or working through full courses, it gives you access to

quality controlled, standardised answers to your questions in simple terms while delivering "just in time" training by way of e-learning and videos.

To access the IT Skills Pathway Knowledge Bank, with videos and interactive tutorials covering Microsoft Office applications, visit www.itskills.nhs.uk

If you are an existing user of the IT Skills Pathway, you can log in using your current Delegate ID - there is no need for a new account to be created.

If you are a new user, just click the 'register' button and complete the form. Make a note of your Delegate ID to access the next time.

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: 10 December 2014

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:

Clinical Service Review: The Clinical Services Review is a programme of work being led by the Dorset Clinical Commissioning Group (CCG) that will analyse the health and social care needs of people living in Dorset for the next 10-15 years. The CCG is currently in the 'review, engage and design' stages which will be completed by spring 2015. They will then formally consult on the options in the summer of 2015, making its decision in the autumn. Implementation is expected to start in 2016, and depending on the changes proposed, will take two to three years.

Action: You can find out more about the Clinical Services Review, share your thoughts and read frequently asked questions by logging onto www.dorsetvision.nhs.uk. Our Communications Team will provide you with regular updates in the progress of the review through their publications and correspondence. Please can you make sure your teams are aware of where they can find this information and who to contact.

Highway congestion: If you drive to and from work, you will most likely have experienced the significant traffic congestion when leaving the Royal Bournemouth Hospital. Unfortunately the problem is caused by the sheer volume of traffic on the main roads and is beyond our control. However, we are working with the council to explore ways to minimise the congestion without reducing the number of parking spaces at RBH. We have included a list of possible solutions in this month's Core Brief.

Action: Please make sure your team's highlight any potential highway issues that may affect us and let our Communications Team know. They can then send out a global email alert to make staff aware. Could you also encourage staff, where possible, to think about an alternative to single occupancy car travel to and from work where appropriate.

CQC ratings indicate low risk for RBCH services: Our hospitals have been given an overall risk score of five, out of a maximum possible risk score of 188, in the Care Quality Commission's (CQC) latest Intelligent Monitoring Report. The Report gives a score based on performance in respect of 94 indicators and puts us in band 5 (band 6 is the lowest priority). This just goes to show how far we have come since our last report and how hard staff have worked during this time.

Action: Our Communications Team will continue to keep us up to date with CQC developments over the coming months, and highlight the good work that is being done by you across the Trust. Please make sure all of this material is shared with your teams and let the Communications Team know of any key improvements in your area.

Career progression for bands 2-5: We currently have opportunities for 10 employees to undertake professional registration qualifications starting in September 2015 in various different areas including nursing, midwifery and dual qualification nursing. These posts are a great way for staff to extend their skills base and progress their careers.

Action: Staff can apply via the intranet or contact Martin Hyland or Lesley Morritt in the Education and Training Department.

eDM roll-out continues across the Trust: Most departments and wards across the Trust have now gone live with Electronic Document Management (eDM) – thank you for your preparation and commitment to using the Evolve system which has made this a very successful roll-out. There are still some areas that are yet to 'go live' and this month's Core Brief outlines what you can do to prepare for eDM once it arrives in your department.
Action: Please ensure all of your staff are aware of the support/training available to them with regards to eDM and provide them with the relevant contact details of the Training Department and the eDM team.

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

Signed:

Date:

excellent care for every patient,
every day, everywhere

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



Core Brief

From: Tony Spotswood, Chief Executive

January 2015

Message to all staff

A big thank you to all staff who have, and continue to support the huge effort in keeping the hospital safe and functioning over what has been an exceptionally busy Christmas and new year period.

The Emergency Department, AMU and Clinical Site Team have coped with unprecedented levels of demand, and all wards and supporting departments have stepped up.

We have seen a 24% increase in emergency admissions, and a very large number of frail elderly patients who will require our care for some time.

You have responded exceptionally well to the increased demands so thank you. It is this level of teamwork which makes us proud to work here.

Over the coming weeks, please consider what extra you can do to do. For example:

- **extra shifts, or even a few extra hours** for work on wards and in ED, from nurses, HCAs, AHPs, ward clerks and

hostesses and others willing to help. Please contact the Staff Resource Pool, or the matron for your area

- **supporting discharges**, by highlighting any delays or solutions that could make a difference
- **deferring non-urgent work**, such as training or non-essential meetings, to support clinical activities

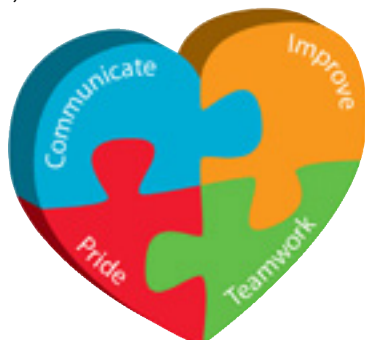
We would also encourage you to nominate your colleagues for a #ThankYou in recognition of them going that extra mile. Many of you have worked beyond your required hours over the Christmas period, often filling in for others or undertaking roles that aren't necessarily in your job description.

This is a good way of highlighting individual cases of exceptional work and examples of those going above and beyond the call of duty.

If you wish to nominate someone, please log on to the homepage of the intranet or send a brief email to **organisational.development@rbch.nhs.uk** outlining who you are nominating and why.

We will then make sure your comments are published on our website and Twitter feed.

If you see someone really demonstrating our values, you may also want to nominate them for a 5 Star monthly award (via Organisational Development).



Setting out the case for change for healthcare in Dorset

Most patients currently receive good care in Dorset, but there is too much variation, both against national standards and within the county itself, according to the Dorset Clinical Commissioning Group's Case for Change published on Thursday 8 January.

This sets out why the NHS in Dorset needs to change if it is to deliver high quality, affordable services effectively for local people into the future.

The Case for Change presents a compelling case for why services need to adapt to changing needs and cannot continue to be delivered in the same way as now. Our population is changing and getting older, bringing new health demands we need to meet.

To address these challenges, Dorset CCG launched a clinical services review in October looking at the whole system, focusing on what

is working well and areas for improvement.

The CCG has been talking to doctors, nurses and health leaders and looking at evidence of how services are currently performing.

The review is being led by clinicians and the next stage is for them to look at the evidence and feedback they have received and ask 'what does good look like? They will then start to develop proposals for public consultation next summer.

The Case for Change evidence is available in PDF format. If you require a printed version for your department please contact the Communications Team at communications@rbch.nhs.uk, or call us on ext. **4905** or **6172**.

You can also view the document at www.dorsetsvision.nhs.uk.

There are several public events taking place in January where you can hear more about the Clinical Services Review and to let us hear your views and feedback as our work develops.

Tuesday 13 January:

2-4pm at Digby Hall, Hound Street in Sherborne

Wednesday 14 January:

10am-12 at Weymouth Pavilion

Thursday 15 January:

6-8pm at The Thistle Hotel in Poole

To register to attend one of these events log on to www.dorsetsvision.nhs.uk/get-involved

Have you been to one of the Clinical Service Review events recently and are wondering why you should come again?

- new information will be presented, called the Case for Change
- you said - we did - hear how we have been listening to your feedback
- update on the work of the Clinical Working Group



Dorset's Clinical Services Review
shaping your local NHS

Highway and congestion update

You will all be well aware of the recent congestion and problems encountered leaving RBH. Being delayed leaving the site is extremely frustrating for you our staff, our patients and visitors.

We know the problems are mainly down to the sheer volume of traffic on the main roads around the hospital, although there have been times where road traffic accidents have caused long delays. However, a solution to this needs to be found as quickly as possible.

The Trust has been developing a proposal for a second hospital exit and entrance from/to the slip road to Cooper Dean from the southbound A338 Spur Road on to the RBH site.

A first draft supporting this idea has been produced and we will be seeking pre-application discussions with Bournemouth Borough Council during January with a view to submitting a full application shortly after.

The council will consider this idea, taking into account highway safety, environmental impacts and how the services that already run along the road can be preserved safely. A series of

traffic surveys and an impact assessment will also need to be carried out. The entire process is likely to take around three to four months.

An example of how the road may look if the proposals are given the go ahead is featured below.

Unfortunately the situation is likely to get worse before it gets better, with significant construction work scheduled to take place along a stretch of the Wessex Way from September 2015 which could last up to four months.

Ideally the Trust would like the construction of the new access road to take place during this time, but there is still likely to be disruption.

To try and lighten the impact on you, the Trust will support the use of public transport by issuing discounted bus tickets and refunding bus travel costs to those of you who leave vehicles on site overnight.

In the long term we are hoping to use our CCTV cameras to monitor roads within the hospital boundary and stream this footage on the intranet so staff can view live traffic conditions.

In the meantime, there will be opportunities for staff and patients to support our application and contact details for correspondence will be provided once the bid for the new junction has been submitted.

The Communications Team will continue to pre-warn you of any congestion on site where possible so you can make alternative arrangements.

If you live in Bournemouth, and want to raise the issue with the council, you can write to your local councillor to let them know your views. You can find out who your local representative is by entering your postcode on **www.writetothem.com**

If you live outside Bournemouth you can still write to the chairman of the Environment and Transport Overview and Scrutiny Panel, Cllr Mark Anderson, **mark.anderson@bournemouth.gov.uk**, and the leader of the council, Cllr John Beesley: **john.beesley@bournemouth.gov.uk**

You can also write to the MP representing Bournemouth East, Tobias Ellwood MP: **tobias.ellwood.mp@parliament.uk**



Recruitment and Retention Initiative within Older People's Medicine

We have high levels of vacancies within Older Peoples' Medicine (OPM) and are implementing a number of initiatives to improve both the recruitment and the retention of staff into the ward teams in this directorate.

Having permanent members of staff on our OPM wards will improve the consistency of care we can offer our patients and will allow ward sisters and charge nurses the opportunity to build and develop strong, permanent teams.

To help tackle the OPM recruitment issue, the Board of Directors has agreed to trial an incentive payment to OPM ward-based nursing staff of 2% of basic pay. This will be paid for six months from January to June 2015 and will be reviewed as part of the ongoing recruitment and retention plan.



This trial has been discussed and agreed with staff side representatives and the first payments will be made in the January 2015 payroll.

This is one of a number of

recruitment ideas and we want to know your thoughts. A list of questions and answers has been prepared to explain more. If you have any further questions please contact your line manager, matron or HR.

FAQs

How much is the payment?

2% of basic pay

Who will receive this payment?

Nursing staff and healthcare assistants in bands one to seven from wards 4, 5, 9, 22, 25, 26 and the Stroke Unit will receive the payment, including new starters.

This incentive payment is for ward nursing staff only and at this stage does not include AHPs, administrative staff and staff working in day hospitals.

How long will it last?

The duration of the incentive trial is for six months initially from January to June 2015.

I am not a nurse, why am I not getting the payment?

Nursing is where the most significant recruitment and retention issues are and as such this group of staff will receive the payment as part of the trial. If the trial is successful in terms of

recruitment and retention this may be spread to other professional staff groups.

I am a ward based nurse in a different specialty, why am I not getting the payment?

Older People's Medicine wards have the most significant issues with nurse staffing. If the trial is successful then this may be spread to other specialities.

Is it paid as pensionable pay?

Yes.

Is it included in future maternity calculations?

If maternity pay is calculated on average pay then this payment will be included.

If a member of staff has had their annual increment in December, will they still receive this 2% increase?

Yes as it is a percentage of basic pay.

Is it included in future AFC absence calculations for

annual leave and sickness pay?

Yes

How will this payment be shown on my payslip?

This will be shown as "OP incentive payment".

How much will this cost the Trust?

The cost to the Trust is approximately £163,000. Our current spend on agency nurses is far more than this.

Is this the only recruitment idea?

No, this is one of a number of actions we are implementing to improve recruitment and retention of staff. If you have any further ideas, please do share them with us.

How can I give my feedback about this trial?

Please email Martin Smith, Head of Nursing for the Medical Care Group, at martin.smith@rbch.nhs.uk Please entitle your email 'Incentive trial feedback'.

The Public Health Responsibility Deal

The Public Health Responsibility Deal is about empowering people to make informed, balanced choices that will help them lead healthier lives.

Our Valuing Staff and Wellbeing group has been actively working on various health and wellbeing initiatives for several years, which has allowed us up to sign up and support the following pledges:



Pledge	Action
Chronic health guide	To support staff with chronic health conditions and ensure reasonable workplace adjustments are considered
Health and wellbeing	To ensure health and wellbeing initiatives are reported in the Annual Report and information is available for staff to access on the intranet
Healthier staff restaurants	To encourage healthier menus, vending outlets and buffets
Staff health checks	To promote a healthier lifestyle for staff and provide advice for those wishing to make wellbeing changes. Also, provide access to corporate leisure centre discounts and the Employee Assistance Programme (EAP)/Vitality links
Mental health and wellbeing	Support staff with mental health conditions to continue working, promote emotional resilience and mental health awareness
Active travel	To promote active ways of travelling to work, cycle schemes and walk to work weeks
Physical activity in the workplace	Provide access to 'fit for work' exercise classes, pilates, on-site tennis court and the EAP vitality portal

We have developed a delivery plan for each pledge, which is updated regularly with the scheme administrator. This means that the Trust has received a certificate, signed by the Secretary of State for Health, and can use the following statement on all corporate materials - "Improving health through the Public Health Responsibility Deal"

Further information about Health and Wellbeing can be found at <http://rbhintranet/redev/wellbeing/>

Let's talk about IT

EDM update

An enhancement to EPR has now been introduced to allow the viewing of scanned patient records via integration with the Evolve Document Management System.

Evolve holds the paper records for Poole Hospital NHS Foundation Trust (PHT) and RBCH in electronic format. This is known locally as the EDM.

This integration allows a user in the PHT's EPR system to view the documents stored in the EDM without the need to log into a separate system.

This data is accessible in EPR via a folder marked 'Scanned Record' in the Patient Tree.

Bed Management update

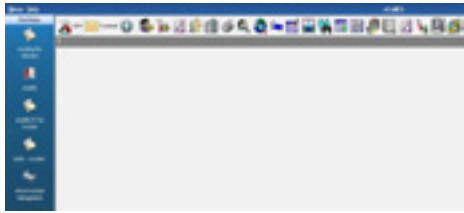
We are currently live on the majority of wards across the Trust with the new Bed Management system.

To increase nursing staff engagement of electronic bed management, the iPad version will be rolled out soon.

Once the iPad version has been fully deployed all nursing staff will have easy access to the system to keep it updated in a timely manner.

Let's talk about IT

eCaMIS to move to the Health Application Platform (HAP)



The new year will see all eCaMIS users moved over to the new Health Application Platform (HAP). This means you will be able to view the Poole EPR data/results in Clinical Viewer as part of the Interim EPR Solution.

You will be informed by an email when you have been moved across and you will be able to



login using the Ascribe Live HAP icon.

Your username will be the same as the one you use for eCaMIS and you will be informed of a new password, which you will be prompted to change when you first login.

Please make sure your new password is the same as your current eCaMIS password.

The layout of the screen will look different. Your icons are now across the top of the screen and "desktops" are displayed down the left side.

Interim EPR

An enhancement to EPR has now been introduced to allow the sharing of electronic patient documents between Poole, Bournemouth and Christchurch hospitals. This is known locally as the Interim EPR.

This facility allows a user in the PHT's EPR system to view documents stored on RBH's Clinical Viewer system and vice versa.

Examples of the types of RBH document you can view in EPR include endoscopy, PAS inpatient and outpatient attendances, as well as rheumatology clinic reports.

This data is accessible in EPR via a folder marked 'Bournemouth' in the Patient Tree.

What else is new?

Self check-in

You will start to see new self check-in kiosks in outpatient areas across the Trust. These are being installed during January. This will enable patients to check-in via terminals with the barcodes on their appointment letters.



SCAS EPR in ED

The South Central Ambulance Service is deploying a new Electronic Patient Record System and they are arranging access for ED staff. This should be in operation before the end of March but details are still being arranged.

Google Chrome

A new eLearning platform has been developed in Training. As part of this, IT is deploying the Google Chrome browser. Remember most applications in the Trust will only work on Internet Explorer so be aware of which browser you are using.

Important reminders

Please remember to log out of EPR using the 'log out' button on the toolbar rather than clicking the 'x' on the Internet Explorer window.

It is also important that you only use one session of the Internet Browser to access EPR at any one time. Opening two sessions in the same browser, even in different windows, could lead to a corruption in the EPR data.

For more information on any of the above, please contact the IT Service Desk on ext. 2347.

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: 7 January 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:

Message to all staff: A big thank you to all staff who have, and continue to support the huge effort in keeping the hospital safe and functioning over what has been an exceptionally busy Christmas and New Year period. Our ED department, AMU and Clinical Site Team have, and are still coping with unprecedented levels of demand, and all wards and supporting departments have stepped up. We have seen a great response to the demands placed upon us all. Thank you for all you and your teams are doing. In order to recognise the good work you are doing, we are encouraging staff to nominate each other for a #ThankYou.

Action: Please speak to staff about how they can help during the pressures and also highlight how staff can nominate a colleague for a #ThankYou (available from the homepage of the intranet)

Recruitment and Retention initiative within Older People's Medicine: We have high levels of vacancies within Older Peoples' Medicine (OPM) and are implementing a number of initiatives to improve both the recruitment and the retention of staff into the ward teams in this directorate. To help tackle the recruitment issue, the Board of Directors has agreed to trial an incentive payment to OPM ward-based nursing staff of 2% of basic pay from Jan-June. This is one of a number of recruitment ideas and we want to know your thoughts. A list of questions and answers has been prepared to explain more and will be circulated.

Action: Please ensure your staff are aware of the initiative, and you circulate the frequently asked questions. If anyone has further queries they can also contact HR, or email Martin Smith, Head of Nursing for the Medical Care Group at martin.smith@rbch.nhs.uk. Please entitle your email 'incentive trial feedback.'

Highway congestion: You will be well aware of the recent congestion and problems encountered leaving RBH. The Trust has been developing a proposal for a second hospital exit and entrance from/to the slip road to Cooper Dean from the southbound A338 Spur Road on to the RBH site. We have a number of meetings scheduled with the council and will continue to update you on progress. Unfortunately further delays are expected with significant construction work scheduled on the Wessex Way from September 2015 lasting for up to four months. More information to follow as we receive it.

Action: Please make sure your teams highlight any potential highway issues that may affect us and let our Communications Team know so that they can circulate the information. Please encourage staff, where possible, to think about an alternative to single occupancy car travel to and from work where appropriate. Please disseminate to your staff any updates regarding proposals for the second hospital exit as and when information becomes available.

Dorset's Clinical Services Review: Dorset Clinical Commissioning Group, the organisation responsible for commissioning most NHS services in Dorset, is undertaking a review of health care in Dorset to ensure that everybody in the county has access to safe, high-quality, effective and affordable health services now and into the long-term. Information will be passed on to staff as the review continues and staff can also attend the public information events. Three are taking place in January at three locations in the county. Dates will be published in Core Brief and the Staff Bulletin.

Action: Please ensure all of your staff are aware of the dates, times and locations of the public events. The Communications Team will continue to provide you with regular updates with regards to every stage of the Clinical Services Review.

BOARD OF DIRECTORS	
Meeting Date and Part:	30 th January 2015 – Part 1
Subject:	Briefing on Travel and Site Access
Section:	Information
Executive Director with overall responsibility	Richard Renaut, Chief Operating Officer
Author(s):	Richard Renaut, Chief Operating Officer
Previous discussion and/or dissemination:	None
Action required: The Board of Directors is asked to support the further working up of travel infrastructure plans, and joint work with the Council and other local employers.	
Summary: Attached is the joint press release following a meeting between the Chair and CEO of RBCH and the Leader and CEO of Bournemouth Council. It sets out some practical steps to reducing the significant congestion issues for patients, visitors and staff. The second attachment provides further information as to the work RBCH has undertaken to reduce car journeys to RBH. This has seen considerable success, with single occupier car use down from 75% to 50% in 3 years.	
Related Strategic Goals/ Objectives:	To offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care To be the provider of choice for local patients and GPs To listen to, support, motivate and develop our staff To work with partner organisations to improve the health of local people
Relevant CQC Outcome:	By responsive, we mean that services are organised so that they meet people's needs.
Risk Profile:	
Reason paper is in Part 2	N/A

BRIEFING PAPER ON RBCH TRAFFIC CONGESTION ISSUES

BACKGROUND

- Royal Bournemouth & Christchurch Hospitals (RBCH), key facts:
 - 4,000 staff
 - 40,000 inpatient stays per year
 - 250,000 outpatient appointments per year
 - 80,000 emergency department attendances per year.
- We are constantly reviewing, improving and developing services and facilities to keep up with current healthcare needs. Current developments include Jigsaw Building (Cancer & Women's Health) and a new Maternity Birthing Unit.
- There are increasing pressures of demand on the hospital arising from:
 - Local economic development strategies giving rise to increases in:
 - Resident population and students
 - Tourists, Conferencing, Visitors to showpiece events (air-show, Rugby & 7s etc)
 - Increasing resident population of European workers, who see hospital as primary access to healthcare
 - Ageing population (50% of patients are aged over 70; 20% are over 80)
 - Staffing shortages, for both qualified staff (struggling with house prices and travel costs), and local, less qualified workers (HCAs, receptionists etc)
 - Public health issues due to lifestyle choices (smoking, alcohol, drugs, obesity)
 - Increased quality & staffing levels, inspection and patient expectations.
- This means we have to employ more staff, run more clinics and accommodate more patients.
- Working as part of a successful local economic development strategy including transport links, will help secure services and jobs.

IMPACT OF TRAFFIC ISSUES ON THE HOSPITAL

- Traffic congestion and parking are amongst our greatest operating challenges, this leads to:
 - Peak time delays for patients, volunteers and visitors getting on and off the hospital site
 - staff recruitment and retention risks – not being able to offer a parking permit, and delays of over an hour to exit the site on a frequent basis
 - Risk of obstruction to blue-lighting ambulances
 - Risk of delays in movement of blood and tissue samples for analysis.
- We are subject to Council restrictions on permitted numbers of parking spaces at the hospital. Accordingly, we have 1,905 designated staff and patient/visitor spaces, of which at least 705 must be made available for patient/visitor use.
- Issues arising from limited parking capacity on site include:
 - Lengthy waiting list for staff parking permits
 - Staff recruitment and retention problems

- Difficult decisions on the balance between staff and patient parking allocations
- Some friction with neighbouring communities regarding overspill parking in residential areas.

MITIGATING MEASURES TAKEN TO DATE

- The 2014 Staff Travel Survey demonstrates a successful reduction in single-occupancy car use, as a proportion of all staff journeys, from 75% to 48% over the past 3 years. This is a direct result of combined measures that have been unpopular with staff, but avoided the congestion getting worse.
- Measures taken by RBCH to reduce single-occupancy car travel, mitigate the impact of traffic congestion, and manage our limited parking capacity, have included:
 - Travel Planning:
 - Active Travel Plan (approved by the Council; currently being updated in collaboration with Council officers)
 - Membership of the local Business Travel Network
 - Parking Restrictions:
 - Permit parking system for staff with monthly charges (currently waiting list of c.300)
 - 52 dedicated car sharers' parking spaces, supported by a Lift-share website.
 - Pool Cars:
 - 5 pool vehicles on site (including 3 electric vehicles).
 - Encouraging Use of Public Transport:
 - New bus hub (built on land donated by the Trust)
 - Subsidised bus travel offers for staff (e.g. 102 staff buy monthly Yellow Bus Glo cards - up from 57 in 2011)
 - Real-time travel information provided at the main hospital entrance.
 - Incentives for Cyclists & Pedestrians:
 - We have up to 300 cyclists per day in summer, and up to 200 per day in winter
 - Active on-site Bicycle Users Group (BUG) with 25 core members
 - Cycle to Work Scheme (bicycle hire scheme for staff, tax-deductable)
 - Pool Bike Scheme (20 bikes available for short term loans and try-before-you-buy)
 - Extensive on-site cycle storage facilities (currently 210 secure covered spaces; 125 bike shelter keys issued per year)
 - On site shower & change facilities for cyclists
 - 450 staff lockers
 - Bicycle toolkits, repair facilities, monthly cycle MOTs, security tagging.
 - On-Site Accommodation:
 - We have 205 residential units on site for staff and their families, plus recently we have acquired a further 34 units within walking distance at Abbotsbury House.
- In summary, we could be said to be helping to keep in the region of 600-700 cars per day OFF the road at peak times through the range of mitigating measures taken by the Trust to reduce single-occupancy car travel by our staff between home and work, including:

- Car sharing: 52
- Subsidised bus travel: 102
- Cycling: 200-300
- Residential accommodation: 239.
- We are currently developing a new staff parking policy with revised eligibility criteria, to ensure the staff with the greatest need and best meeting the criteria get permits. This will lead to withdrawal of permits for non-eligible staff in BH7, BH6, BH8 and BH23(west) postcodes (first tranche) and BH5, BH1, BH9, BH2, BH3, BH23(middle) and BH4 postcodes (second tranche). This is of necessity in the face of insufficient parking capacity and will be subject to good communication and careful management to explain why change is overall required to ensure the fairest distribution of a finite number of permits.
- We are also exploring a range of other operational measures designed to manage peaks of activity on the hospital site, including:
 - Where clinically & economically possible moving some clinics (e.g. some blood tests) off site, where GPs and others are able to (re)establish such services.
 - Further extending visiting hours
 - More weekend working.
- Notwithstanding the above measures (and any other mitigating actions which may be agreed), the core infrastructure issues remain in terms of capacity of the local road infrastructure and adequacy of on-site parking provision.

INDICATIVE TIMESCALES

- The local Councils are planning for major works to the A338, incorporating widening, junction improvement and re-surfacing schemes, starting from September 2015 and running for several months. It would make sense to plan and programme any approved entry/exit slip road scheme into this wider scheme with a view to cost effective implementation, co-ordination of infrastructure works and the management of disruption.
- The following is an approximate timetable, showing milestones for the key proposals of:
 - changes to bus lanes to allow better flow
 - extra traffic light at Cooper Dean roundabout and Deansleigh junction
 - Deansleigh road widening
 - Planning approval decision on Wessex Way slip road junction

SKETCHES

Proposed New Hospital Entry/Exit Route Sketch



Estimated Cost: £2.7million

Riverside Grade-Separated Junction Example (as per the previous approved Troika plan)



Estimated Cost: £10 million

STAFF POSTCODE PLOT



16 January 2015

Partnership approach to ease traffic congestion at the Royal Bournemouth Hospital

Bournemouth Borough Council and the Royal Bournemouth Hospital (RBH) will continue to work together on easing congestion along Castle Lane East and outside the Royal Bournemouth Hospital.

Yesterday (15 January) both parties agreed a series of actions to reduce the immediate pressures on traffic flow in and around the hospital area.

As an interim solution and subject to planning permission, the local authority will work with the Trust to support the establishment of a new entry/exit route onto the south bound slip road coming off the Wessex Way.

More immediately a number of solutions are proposed to ease congestion, and ensure ambulances can continue to exit and enter the hospital. These include:

- modification of the west bound bus lane
- implementing traffic lights within the hospital site to manage traffic exiting onto Castle Lane
- encouraging employees and visitors to travel to the hospital sustainably

Trust Chief Executive, Tony Spotswood, said: "We're really pleased at the support given to help address these issues and look forward to instating them as quickly as possible for the benefit of our patients, staff and visitors."

As a longer term solution the Trust and Bournemouth Borough Council will work together to create a split grade junction linking the hospital directly with the Wessex

Way. This will require support from the government, Dorset Local Enterprise Partnership and other local partners.

Subject to agreement with partners in the locality preliminary investigation will also be undertaken into creating an additional lane for Deansleigh Road.

Councillor John Beesley, Leader of Bournemouth Borough Council, said: "Keeping the town moving is a top priority and we will continue to work in close partnership with RBH and other local businesses to improve the flow of traffic around the hospital."

Ends

Contacts:

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Communications Department

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communications@rbch.nhs.uk

Bournemouth Borough Council

Carly Earnshaw

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Carly.earnshaw@bournemouth.gov.uk

BOARD OF DIRECTORS	
Meeting Date and Part:	30 January 2015 Part 1
Subject:	Corporate Events Calendar
Section:	Information
Executive Director with overall responsibility	Tony Spotswood, Chief Executive
Author(s):	Anneliese Harrison
Previous discussion and/or dissemination:	N/a
Action required: To note for information	
Summary: Corporate Events arranged until December 2015	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	N/a
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

CORPORATE EVENTS CALENDAR 2015

Date and Time	Event Description	Venue	Contact Details
Throughout 2015	Abseiling	Bournemouth Hospital Charity	01202 704060
Friday 30 January	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Monday 2 February	My Health My Way	Main Atrium, Royal Bournemouth Hospital	01202 704956
Monday 23 February	Understanding Stroke	The Village Hotel	01202 704271
Friday 27 March	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Sunday 22 March	March For Men	9:30am Bournemouth Pier	01202 704060
Throughout April	Brew up for Dementia & Older people's care	Hold a coffee morning/tea	
Friday 24 April	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Tuesday 28 April	Council of Governors' Meeting	Conference Room, Education Centre, Royal Bournemouth Hospital	01202 704246
Monday 11 May	Understanding Dermatology	The Village Hotel	01202 704271
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
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 Bournemouth Hospital	01202 704246
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
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	
Meeting Date and Part:	30 January 2015 Part 1
Subject:	Directors Forward Programme
Section:	Information
Executive Director with overall responsibility	Tony Spotswood, Chief Executive
Author(s):	Sarah Anderson, Trust Secretary
Previous discussion and/or dissemination:	N/a
Action required: To note for information	
Summary: Update of the Board of Directors Forward Programme	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

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