Annual Plan for Public Consultation 2010/11
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Foreword

Welcome to the consultation on our Annual Plan. The document lays out the actions and initiatives that form a key part of our plans for the year ahead.

The theme for the 2010/11 Annual Plan is ‘Protecting our future, through better care, better value’. This means finding new ways of improving care, which often results in lower costs.

As you will be aware there has been a significant downturn in the economic climate in the UK. Over recent years the NHS has enjoyed continued growth in funding but the next few years will be very challenging. There will be very limited growth but we will all have to address the continuing issues of an ageing population and new treatments to fund. As a consequence savings will need to be found across the whole NHS, perhaps as much as 15%, to keep pace with demands.

The plans outlined within our Better Care, Better Value programme are about making the best use of our resources, which includes facilities, equipment and staff, in order to protect services for our patients, staff and the principle of high quality NHS care for all.

Some of the most critical initiatives within our plans include:

- Delivering the Better Care, Better Value programme and realising £20m of efficiency gains.
- Participating in the Dorset wide acute services review
- Determining the options for the future of Christchurch Hospital
- Sustaining the 18-week Referral To Treatment times
- The Cancer Reform Strategy and new waiting time targets for cancer patients
- Registration with the Care Quality Commission (CQC)
- Reducing acute hospital stays to better than average
- Developing and implementing action plans arising from patient satisfaction surveys, including reduced perceptions of mixed sex accommodation
- Reducing trust wide dependency on agency staff, bank and overtime
- Developing & implementing a detailed action plan responding to issues raised via the staff survey

We are keen to engage the local population and our stakeholders with our plans, and to hear your views to ensure we develop a plan for 2010/11 and beyond that meets the needs of our local population whilst meeting our clinical and resource constraints.

Tony Spotswood, Chief Executive
Introduction

The theme for this year’s Annual Plan is ‘Protecting our future, through better care, better value’, and is our response to changing clinical and resource constraints. As a Foundation Trust we are wholeheartedly committed to driving efficiencies in the system ensuring value for tax-payers’ money while maintaining and improving the quality of the services offered. In this way we aim to protect services for our local patients, staff and the principle of high quality NHS care for all.

At first glance this would seem to be a tall order. Recently the NHS has delivered dramatic improvements, but these have been based on funding that has increased significantly over the past ten years.

The task now is to maintain the progress on improving services, but within existing resources. Given an aging population and rising health demands this will be challenging. However, we are certain that this is possible and this document illustrates this with local examples of projects where this has been the case.

These local case studies have many similar themes, such as reducing delays, duplications and errors, harnessing technology, and new ways of working. Often they are at the cutting edge of high quality clinical management practices and above all provide a supportive environment that will encourage staff to look at how they work and where to make improvements. Sharing and celebrating these will be an important task, as well as speeding up the adoption of further improvements.

The financial challenge

In 2009 an extensive exercise, using external consultants, helped us develop a three year cost and quality improvement programme. The premise was simple: to take out £20m recurrently, which is about 10% of the operating costs. There could be no new NHS income assumed, the same number of patients needed treatment, and we must maintain, or improve the quality and safety of care.

Great progress has been made against this challenge; indeed winning the national award for Acute Organisation of the Year was based upon this work. Further details are set out in Chapter Two.

Even before these savings are taken out, RBCH has one of the lowest costs in the NHS and is therefore already highly efficient. Despite this, the 2010 budget and the NHS Operating Framework make clear that we will need to go considerably further in reducing our costs. It is likely that a £30m saving, or 15% of our costs, will now be required.

At this point it is difficult to envisage that the current pattern of services, while maintaining quality and volume, can be sustained. Due to this, workstreams looking at the range and types of services provided need to be considered.
Acute Services Review

As well as an extensive programme of internal improvements to services, it is essential to look across the local health and social care sector for further efficiencies. All NHS and local government services will be under similar financial pressures and so options ranging from partnership working through to fully merged services, will need to be considered. An acute service review will start in 2010 looking at the best configuration of services, to be sustainable on both financial and safety grounds.

Areas that will need to be considered include:

- The clinical case for any changes.
- The financial savings that are required to sustain services.
- Whether duplication or triplication of services in Dorset is appropriate.
- The best use of estate (building and land) and high cost equipment.
- Workforce requirements for specialist skills.
- Models of care that meet access and governance requirements including “vertical” and “horizontal integration” (i.e. one specialist service, either across several hospitals (horizontal) or across community and hospital (vertical)).
- Sharing non clinical (back office) support functions.

As these areas are explored and initial views developed, it will be essential that key stakeholders are engaged and contribute. If and when a case for change is developed, it will require the relevant bodies to agree this and then, if the change is substantial, for this to be publicly consulted upon. This is likely to be a lengthy and considered process, however the pressing need to identify savings will become more urgent. Therefore it is important that the public, patients and stakeholders are kept informed. It will also be important to share the reality that no change is likely to lead to less sustainable, and less safe services. These issues are further explored in Section Two.

The future of Christchurch Hospital

Understandably, the public who use and support Christchurch Hospital, as well as staff and volunteers, want certainty over the future of the hospital. With the squeeze on funding, the acute services review, and the trends for shorter lengths of stay in hospital, the role of Christchurch Hospital is likely to continue to change. These issues, and options for the future are considered in Chapter Two. Using 2010 to engage with partners about new uses for the facilities and land that is vacant will be essential before any final decisions are taken.
**Trust Strategy**

Despite turbulent times ahead with the squeeze on public funding, the Trust’s Goals set out in the document “A Healthy Future” (Strategic Plan 2008-2012), remain consistent and relevant. They are as follows:

**Goal 1**
To offer patient centred services through the provision of high quality, responsive, accessible, safe, effective and timely care.

**Goal 2**
To promote and improve the quality of life of our patients.

**Goal 3**
To strive towards excellence in the services and care we provide.

**Goal 4**
To be the provider of choice for local patients and GPs.

**Goal 5**
To listen to, support, motivate and develop our staff.

**Goal 6**
To work collaboratively with partner organisations to improve the health of local people.

**Goal 7**
To maintain financial stability enabling the Trust to invest in and develop services for patients.

This year we have laid out in Chapter 3 the developments we intend to make under each of these goals. These have, as before, been drawn from the strategic intention of national policy, our local PCTs, our own strategies and some developments from the current year that will continue into next year.

This is a consultation document and we are therefore keen to have feedback on these ambitions and plans. In section six there are questions that may help prompt your thoughts on this document together with details of how to provide this feedback.
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) provides high quality general hospital and intermediate care services to a population of over 500,000. We have particular experience and capacity in elective (planned), diagnostic (investigative) and emergency care.

The Trust was granted a licence to operate as a Foundation Trust from 1st April, 2005. As such we are no longer accountable to the Department of Health. Our accountability now rests with:

- Our membership - around 14,000 Members, represented by a Council of Governors.
- Our regulator - Monitor.
- Through legally binding contracts agreed with local NHS Primary Care Trusts (PCTs) who commission the range of services we provide.

The Trust’s performance has been consistently strong across a wide range of measures. Perhaps the most extensive is the Care Quality Commission’s Annual Health Check which uses over 200 indicators, as well as the views of patients, Governors and scrutiny committees. In October 2009 we were judged as follows:

- Quality of Care: Excellent
- Use of Resources: Excellent

The ratings were excellent news for local users of our services and reflect the hard work and commitment from staff to continually improve services for patients.

We are one of only two organisations nationally to have scored full marks for our quality of care and for delivering value for money. More specifically the scores were as follows:

- Safety and cleanliness - 14/14
- Standard of care - 8/8
- Keeping the public healthy - 5/5
- Waiting to be seen - 13/13
- Dignity and respect - 9/9
- Good management - 18/18

There are other measures that also reflect the quality of care delivered. These include:

- Very low infection rates.
- Some of the shortest waiting times nationally.
- High scores in safety governance from the NHS Litigation Authority.
- One of the highest staff satisfaction rates in the NHS.

Trust Consultation Policy

The Trust has a Consultation strategy which outlines when consultation is required and how the consultation should be undertaken. Further details of this are included within Section 6: How to Have Your Say. As part of the consultation we have a list of key stakeholders who we contact with details of any consultation we hold.

We have listened to people who told us they felt the previous consultation was not extensive enough. One of the actions arising out of this feedback is that we have initiated a list of people, in addition to our existing stakeholder contacts list, who will be emailed with information on all future consultations. Anyone wishing to be added to the list is welcome to let us have their contact details. Information on how to do this is included within Section 6: How to Have Your Say.
Our Operating Environment

In assessing our plans for the future we are mindful of significant changes in our operating environment and anticipate further changes. These include:

1. The tightening economic climate and limited public finances.
2. Increasing public accountability for quality of services.
3. The implications for health policy following a general election.
4. Continuation of increasing demand for services from aging population and greater disease burden.
5. Trends in healthcare for greater specialisation and governance requirements for minimum volumes of work for safety and efficiency reasons.

1. The prospect of no additional funding above inflation for the NHS, and yet a steady increase in demand, and the costs of new technology and commitments such as improved stroke care and NICE treatments, will in effect lead to current services needing to be delivered for less. Likely consequences include:
   - Funding for acute hospitals falling in real terms.
   - Restrictions on staff pay that may affect recruitment as the wider economy recovers.
   - Rationalisation of services and estates to ensure maximum value for taxpayers.
   - Restrictions on lower priority treatments or new treatments that do not have very firm evidence of effectiveness.

2. The public expectation of safe and clean NHS services offering privacy, dignity and respect as well as effective treatment will continue to rise. As a result there will need to be a continued focus on quality reporting and improvement, as well as explaining to patients, staff and partners how we are doing. Infection control, mortality rates and single sex wards are all areas where RBCH performs well, but will need to continue to improve. Our award winning Communications Team will need to continue to work with clinicians across the Trust to achieve public understanding and assurance.

3. Following the General Election in 2010 there may be a change in policy direction which may in turn result in a need to review our plans. Particular areas most subject to change are currently seen to include:
   - A change in GP led commissioning and role of PCTs.
• Greater reductions in tariff income for hospitals.
• Choice of consultant and wait times policies.
• Abolition of SHAs and some QUANGOs.
• A move from targets to longer term health outcomes.

4. The year-on-year rise in both elective and emergency workload is expected to continue. However, given the limited funding, greater productivity and prevention will be required. The “transforming community services” initiative (TCS) is a national drive to improve the quality, productivity and effectiveness of community services (particularly for long term conditions) and shifting care into the community away from acute and specialist services. The evidence of both whether this programme will deliver and whether it is in fact more expensive needs to be considered.

Alongside TCS are moves to consider vertical integration (all services provided by one organisation). This is usually community and hospital services, either as an “in-reach” into hospital or outreach from a specialist service. A move away from Payment by Results (cost per case) to an annual capitation (ie payment based on population size) for managing both monitoring, prevention and hospital care is also a possible scenario.

Personalised budgets for some long term conditions (LTC) and greater market testing of services are also expected, to drive competition and hopefully cost and quality improvement. Avoiding very significant transaction costs and fragmentation of services will be crucial as both of these can remove the cost and quality gains. The Department of Health is particularly keen to promote integration of services and will look at how to enable and incentivise Foundation Trusts to develop in this agenda.

5. Trends in healthcare provision remain predominately towards higher quality and better value from finding the right “critical mass” level (the point at which services are delivered most efficiently and with best quality outcomes). For example, a surgeon undertaking a particular operation once a week, rather than once every few months, has better clinical outcomes, is usually more productive, and can purchase supplies at volume discounts. Given the trend to concentrate expertise,
there are likely to be moves to having only one specialist centre in Dorset, rather than two or three that currently exist, or alternative models of care, such as Dorset wide services. In some circumstances, it may mean services moving out of the county, while still being accessible to the local community.

In some instances the critical mass can mean moving the other way, where technology, training, volumes of work and other factors mean it is more efficient and effective to disaggregate work. Some procedures and diagnostic tests may fall into this category and some work undertaken in hospitals in the past may now occur at a GP or community setting. The key is to understand at what level critical mass occurs, rather than to assume automatically that bigger is better, and whether care closer to home is or is not effective.

In establishing this Annual Plan, the planning undertaken by the Trust’s Board of Directors and the Trust Management Board of clinical directors has included consideration of the factors outlined above and the wider operating environment, considering the risks, and ensuring a robust leadership to deliver the plan.

Local PCT Strategies

Our host commissioner, NHS Bournemouth and Poole, is currently in the process of updating its own strategy. They have identified six key programme areas to form the basis of their strategy, these are:

- Improving health and wellbeing and reducing health inequalities
- Improving services for children and families
- Redesigning acute care closer to home
- Redesigning long term conditions services
- Expanding planned care services outside hospital
- Improving end of life care services

Some of these themes, for example redesigning long term conditions services, have some fit with the initiatives already taking place within the Trust, for example, the work on providing education for patients with long term conditions. Others, such as redesigning acute care closer to home, may have more significant impacts on some of the services currently offered by the Trust and will need to be carefully considered once more details of the PCT strategy are available.

Other local PCT’s, including Dorset PCT, are also currently updating their strategies. Implications of those strategies for the Trust will be considered once the updated strategies are published.
Social Responsibilities

Environmental responsibilities

As well as the economic situation, the requirement for action to reduce global warming is also being taken seriously by the Trust.

The NHS has a carbon footprint of 18 million tonnes CO2 per year. This is composed of energy (22%), travel (18%), and procurement (60%). In recognition of the urgency of climate change, the Government has committed to take action now and has introduced the Climate Change Act with carbon reduction targets for public bodies to reduce their 2007 footprints by 10% by 2015, 20% by 2020, and a massive 80% by 2050.

The Carbon Reduction Commitment (CRC) is a new mandatory emissions trading scheme starting April 2010. It targets large public and private sector organisations and is intended to have a significant impact on reducing UK carbon dioxide emissions. The Trust will be guided by NHS targets. The Trust has developed an action plan to ensure the requirements are met.

The Trust closely monitors its production of greenhouse gases, and there has been a 1% reduction of CO2 from 2007/2008 to 2008/09 despite the fact that our activity and building sizes have increased. There is an ongoing programme of activity to reduce the hospitals’ carbon footprint.

The evaluation of all major building projects includes consideration of the implications of our carbon footprint and we comply with the BREEAM (environmental building) regulations, and in addition there is an ongoing programme of initiatives to save energy.

As well as environmental considerations, energy savings are an important aspect of the Trust Cost Improvement Programme. The initiatives have achieved real reductions in energy consumption year on year. Energy comparisons for 2007/08 to 2008/09 show a reduction of 1.7% for electricity and 18% for gas.

We have been working towards 100% electricity generated backup, which can then be used to control consumption and high costs during peak periods from the grid and this will be completed by April 2010.

Waste and recycling

The Trust has a Waste Management Group, with the objective to provide awareness of the cost of energy and waste management both in financial and environmental terms. A key remit of the Group is the level of recycling throughout the hospital and how to improve this.

Over the past months and over the next year there will be a number of changes taking place throughout the hospital to make waste management more effective. Examples include.

- expanding recycling facilities to include glass, plastics and aluminium that would otherwise go to landfill sites:
- providing recycling collections from all departments in order to facilitate recycling of newspapers, magazines, plastic bottles, bags, cups and cans:
- alternative containers provided for disposal of batteries, aerosols and broken glass to allow them to be disposed of correctly.
10% of our waste volume is currently recycled. An increase in recycling of at least 5% is expected for 2009/2010.

The Trust now separates all hazardous waste. This has reduced the volume of clinical waste, allowing a significant proportion to be classified instead as ‘household’ waste and resulting in high cost savings to the Trust.

The Catering Department has increased recycling facilities and has also introduced bio-degradable cups and other environmentally friendly products. As a result, catering has reduced their landfill refuse by half.

**Green Transport Policy**

The Trust’s Transport Policy, developed in partnership with the local council, is regularly updated and encourages staff, patients and visitors to consider alternatives to using their car to come into hospital. This includes subsidised bus fares and car sharing schemes and incentives for staff to use bicycles or walk to work where possible including the increased provision of cycle and changing facilities.

**Smoke Free Environment**

The Smoke Free Policy has been in place since 1st January 2007, under which smoking is not permitted anywhere on Trust premises. In addition the Trust runs a Smoke Stop service.
2. Programmes to deliver Better Care, Better Value

2.1 Introduction

During 2009 an extensive effort was made to develop three-year plans that would deliver recurrent savings of £20m (almost 10% of our current costs) in a way that would not reduce either the number of patients treated or the quality of their care. In many instances however, the Cost Improvement Programme (CIP) has actually meant improved quality and safety as some of the workstreams and case studies will demonstrate. These programmes are summarised here and form a large part of where RBCH's efforts will be directed over the coming years.

Clearly, reducing our operating costs by this scale will have an impact on the organisation in terms of staffing levels, spare or flexible capacity to respond to a changing situation and in the way services are delivered. With an annual turnover of staff of around 10% and the large number of employment opportunities in a workforce of several thousand, redundancies will be reduced where possible as they will often be of low value to the taxpayer and individual involved. Reduced spare capacity will need to be managed through tighter planning and prioritisation and moving to more flexible ways of working for all types and grades of staff. How services are delivered will also need careful review but once again this could bring benefits, such as the use of telemedicine phone clinics, or less inpatient stays in hospital meaning that fewer beds are required.

Taken together these change programmes will, if delivered, transform the quality of care while ensuring services are financially sustainable. The encouraging news is that most of these change programmes are already well established and beginning to deliver early results. To deliver them fully will require extensive effort as well as understanding and support from partners, patients and the public. A detailed monitoring mechanism is in place run by the Trust's Programme Management Office (PMO).

2.2 The Workstreams

The Cost Improvement Programme has the following workstreams with which individual directorates and departments will engage to
deliver the savings within their areas of budget responsibilities.

The workstreams can be summarised as:

- Reducing length of stay in hospital beds.
- Theatre safety and efficiency.
- Electronic rostering of shift based staff (e.g. ward nurses).
- Procurement (purchasing) of goods and supplies.
- Medicines management.
- Corporate and management savings.
- Clinical coding and service line reporting.
- Admin and clerical work.
- Medical staffing.
- Diagnostics.
- Estates and Capital.

2.2.1 Reducing length of stay in hospital beds

There is a common misperception that a long length of stay is somehow a sign of quality when in fact, the reverse is true. Caring for patients until they reach the right level of recovery and planning their discharge remain the real measures of quality. In many instances this can be achieved in far shorter times than we have previously achieved by a combination of the following measures:

Case Study: Improvements to hip and knee replacements

To help meet the 18 week referral to treatment target in orthopaedics the Trust purchased a self-contained former private hospital on the main Royal Bournemouth Hospital site which opened in July 2007. The vision was an entirely patient-centred pathway for patients coming into hospital for a hip and knee replacement. It meant reviewing every aspect of the care given and identifying many specific changes to improve quality and reduce variation.

Changes to the way orthopaedic patients receive care for hip and knee replacements included being admitted on the day of surgery, walking to theatre and beginning physiotherapy within 18 hours of surgery. Other benefits are:

Better care

- All patients have a private en-suite room
- Pre-operative classes to reduce anxiety and manage expectations
- Exceptionally high patient and staff satisfaction
- Complication and re-admission rates have decreased
- Physiotherapy and anaesthetic techniques have lowered post-operative pain scores
- Exceptionally low infection rates
- Complications such as dislocation and DVT are well below the national averages
- Every patient has a follow-up six week after their operation

Better value

- Reduction in average length of stay from eight days to four days, saving around £600 per patient meaning less beds are needed
- The overall cost to taxpayers is less for a higher quality operation
Case Study:
REDs

A new Respiratory Early Discharge Scheme was launched in February 2009 at the Royal Bournemouth Hospital allowing patients from the Bournemouth area who are admitted to hospital with COPD (Chronic Obstructive Pulmonary Disorder) to recover in the comfort of their own home.

Patients with chronic respiratory illnesses who come into hospital are assessed for suitability for early supported discharge by a respiratory nurse who can then arrange for the patient to go home. Most will be able to go home in less than two days and some sooner. Patients then receive a daily visit from the specialist respiratory nurse for up to seven days – instead of spending those seven days in hospital.

If the patient is not progressing well he or she can be taken back to hospital but most will be discharged back to their GP.

Better care
• Patients spend less time spent in hospital
• Patients receive the same care by a specialist nursing team but in their own home
• High levels of patient satisfaction

Day case surgery.
Day of surgery admissions.
Planned date of discharge.
Improved use of the Discharge Lounge.
Reducing the number of bed moves between wards.
Increased senior medical ward rounds and decision making.
Supportive discharge through community services such as REDS, CART and mental health liaison team.
Avoiding infections, pressure sores and malnourishment wherever possible.
Access to rapid diagnostics and specialist opinions.
Close working with Social Services and the voluntary sector for patients requiring ongoing support after their acute care.
Enhanced recovery project to recover patients more quickly after surgery.

This workstream is also mutually supportive of others, such as:
• Medicines management: in avoiding drug errors, ensuring compliance with drug taking and in having drugs ready for discharge.
• Electronic rostering to ensure the right staff are in the right place.
• Diagnostics so there are no delays in getting test results.

Overall, RBCH has more hospital beds than would be expected for the population we serve. We know from both audit and everyday experience there are many patients, up to 50 beds at some points, who do not need to be in hospital but are waiting for transfer home or to ongoing, continuing healthcare. This represents a poor use of resources as well as a poor service for the patient. As a result, this workstream is one of the most critical for better care and better value.
The role of in-patient beds at Christchurch Hospital will be discussed later, but it is worth noting a transfer to Christchurch can often add a week to a patient's length of stay, as rehabilitation can often be delayed in preparing for, making and then adjusting to the move. Where patients are rehabilitated in dedicated areas at Bournemouth, then this delay does not occur, or to a much lesser extent. Stroke rehabilitation and elderly emergency care rehabilitation on the RBH site would therefore have significant patient benefits in terms of quicker recovery as well as more rapid access to medical and diagnostic resources.

A further benefit from reducing length of stay will be the opportunity to better align the right specialist beds to the current and expected workloads. Currently we have times when emergency patients are placed on other wards that do not have the specialist nurses and staff that would be available on the appropriate specialist ward. This results in less optimal care and often longer stays. Huge progress has been made for instance in getting stroke patients admitted directly to the stroke ward. This saves lives, improves recovery and means better care is actually provided with fewer beds.

2.2.2 Theatre safety and efficiency

The leadership of clinical staff in identifying issues and resolving them has led to improvements in theatres already. Over the next year the plan is to continue work through the key sub groups:

- Scheduling and pre-op assessment.
- Theatre turn around times.
- Information for improvement.
- Day of surgery admissions.

Two very visible changes have been planned for 2010. First was the opening of our Day of Surgery Admission Unit (The Sandbourne Suite). This provides a high

Case Study: Predicted dates for leaving hospital

The Rehabilitation Team developed an extensive programme to reduce the length of time that rehabilitation patients stay in hospital. One of the key parts of the programme was to ensure that all Medicine for the Elderly (MFE) patients had a predicted date for leaving hospital (known as Predicted Date of Discharge or PDD).

What we did:

- All patients now have a predicted date for leaving hospital within 48 hours of admission to the acute MFE wards
- This date is made in conjunction with the patient and their carer
- All patients being transferred to Christchurch Hospital must have a predicted date for leaving hospital before being accepted by the ward
- All patients have the date they are leaving hospital clearly displayed above their beds
- Predicted dates are reviewed daily during ward handovers

How we did it:

- Reviewed and strengthened admission criteria for all wards
- Each ward was given a target for reducing length of stays for all rehabilitation patients
- All patients were given clear plans for leaving hospital
- All referring wards outside of the rehabilitation directorate ensure that their patients have a predicted leaving date including a transfer to Christchurch or a Medicine for the Elderly ward

Better care

- Patients and their carers now have more control over their discharge process
- Better communication to patients and carers about their discharge process
- Patients will spend less time in hospital

Better value

- Free up beds that are not in use
- Release latent capacity
- Reduce pressure on clinical staff
Case Study:
New Clinical Processes for Genito-Urinary Medicine (GUM)

What we did:
A patient audit was undertaken to evaluate what patients thought of the current service. All staff were consulted about how we could build a service that better met their abilities and needs.

How we did it:
The clinics were redesigned with staff input so that there are now more specialised doctor-led clinics, nurse-led clinics, health advisor clinics, early morning treatment clinics and 4 evening clinics a week. The walk-in clinics are now every afternoon.

Better care
• 501 patients are now being seen a week - a rise of 69 patients (15%)
• More clinics and clinic times designed around patient needs
• Refurbished waiting area where patients can wait together
• Audit of patient satisfaction shows they are much happier with the service
• Texting service for patient results
• The clinic meets the 48 hour target
• More specialist clinics means patients get seen sooner and have faster access to more appropriate treatment
• The nurses with extended roles are now responsible for seeing 109 patients a week

Better value
• More patients seen
• Better use of existing resources: staff and buildings
• Faster treatment means avoidance of having to admit patients if condition worsens

quality environment to prepare for going to main theatres and the Day Treatment Centre. This purpose built area avoids the need for most patients to come in the night before their procedure, which is often a time of great anxiety, where being at home is more preferable.

A well designed processes and layout, including dedicated specialist rooms means a more efficient process, saving staff time and resources. The ‘regional blocks’ also mean a quicker recovery time after theatre, contributing to shorter lengths of stays.

The second major change is the development of a central pre-operative assessment centre. Located next to main outpatients at RBH this will provide a high quality environment to ensure all the checks and preparation for theatres are undertaken. Currently this happens in a large number of locations and can result in delays and duplications, and some generic tasks being undertaken by highly qualified staff, which could be delegated. The environment is often less than ideal on wards, cramped offices or consultation rooms.
The new processes, often on the same day as patients are listed for surgery, will be a far better patient experience. By making the process more efficient as well as saving staff time and resources, we will also reduce delays or cancellations for theatres which are very costly. This is another example of better care leading to better value.

2.2.3 Electronic Rostering

Ensuring the right staff are in the right place at the right time will improve patient care. It will also provide, for the first time, a greater transparency as to how often we achieve best deployment of our staff against the “template” or planned level of staffing and grade.

Currently, planning the month’s rota of staffing is a paper based, time consuming exercise. Using a proven software package will, after implementation and training, speed this process up, freeing time of some of the most senior nurses to lead their teams.

The visibility and structure of the software will, from evidence in other Trusts, reduce the need for bank and agency shifts and ensure the right skill mix of qualified and health care assistants. As a result, there are likely to be significant savings on overtime, bank and agency. Reducing this spend will contribute to the £7m saving target for 2010/11. This, combined with the regular reporting showing what skills and experience are required and how well they are matched, will be a very useful tool in ensuring safe staffing levels. Currently is a labour intensive process to audit.

2.2.4 Admin and Clerical staffing

RBCH currently spends over £10m a year on administrative and clerical (A&C) staff who provide essential services to a high standard. Roles include receptionists, booking, ward and health records clerks and medical secretaries. There are two main areas that have been explored: the use of technology and the right levels of skills and experience for the roles.

Case Study: Providing Choice for End of Life Care

In line with the national agenda, the colorectal care team actively sought to give patients a greater choice over their end of life care in partnership with the Primary Care Palliative Service.

What we did:

- We reviewed deaths of bowel cancer patients and identified significant improvement opportunities. In May 2007, the acute and primary care teams started to jointly assess the efficiency of a community palliative care register (cPCR)
- Patients are placed onto the cPCR during the transition from active treatment to focussed palliative care. Thereby ‘red-flagging’ an early assessment by the Community Palliative Care Team.
- The register also allows health professionals both in and out of hours access to patient information regarding: diagnosis, treatment-to-date, patient expectation of care, and their “ceiling of care” such as pre-agreed limits on interventions. It also addresses important issues such as whether re-admission would be appropriate.

Better care

- Significant increase in palliative colorectal patients dying in place of their choice
- 412 patients registered who have died - 358 were in their place of residence, and just 54 in hospital, 77 died in the specialist palliative unit
- Avoidance of unnecessary admissions and painful treatments
- Deaths in hospital were 2.5 times less likely
- No significant increase in workload for the Specialist Palliative Care Team
- Faster access to information around appropriate prescribing and treatment
- Better communication between primary and secondary care clinicians

Better value

- Reduction in unnecessary admissions has delivered a net saving of at least £70,000 for commissioners
Faster Diagnosis and Access to Treatment for Bowel Cancer Patients
The team sought to deliver faster access to treatment for patients with suspected bowel cancers and to improve the speed and accuracy of bowel cancer diagnosis.

What we did:
- Create a ‘fast-track’ system for referring patients with bowel cancer symptoms, using digital technology and an Electronic Referral Protocol (e-RP). Created a multi-disciplinary team involving the Bournemouth colorectal unit, gastroenterology and GP input.
- The team developed the protocol to analyse symptoms and signs of bowel disease as well as offering referral and investigation routes.
- The GPs felt it significantly benefited patient care and was simple to use. The education strategy and access to the protocol was expanded to the whole PCT with impressive adoption and uptake.

Better care
- Faster treatment of patients
- 98.7% of fast-tracked patients treated within 62 days
- Faster diagnosis of colorectal cancers, with a 50% increase in TWW ‘fast-track’ clinics
- A 50% increase in cancers being sent via ‘fast track’ and 46% drop in cancer patients seen as routine
- Higher detection rates of cancers, with the same number of tumours being diagnosed from less patients
- Cancers discovered in the fast track clinic increased 2.07% to 12.82%
- Beneficial trade in specificity and sensitivity of the clinic. For a 50% increase the sensitivity there was 4% fall in specificity

Better value
- 650 less attendances at the hospital through more efficient use of clinic time, with a saving of up to £41,600
- Earlier detection means fewer patients treated for advanced stage illness

Technology comes in many forms. This workstream has been considering opportunities for using technology, such as common IT systems and the use of digital dictation software, so that system duplications can be eliminated and clinicians are both using systems as part of their real time clinical duties and avoiding the need for other staff to then undertake data entry which can often be delayed and is at risk of transcription errors.

Overall the quality of data is known to improve the more clinicians and front line staff use IT in managing patients’ care. This way of working needs to become embedded within the way that front line staff work. Self-checks by patients already exist and exploring the use of email and other forms of communication to reduce postage and printing costs will also be undertaken. The first step will be a major project to reduce the amount of high cost desk top printers in the organisation, and move to less printing and more pooled printers, which have much lower running costs.

The second part of the A&C work is to ensure an appropriate career ladder and skills development which also matches the type and level of work needed by the organisation. For example, medical secretaries are only at one grade, whereas in many other NHS organisations there are entry-level and support grades as well as more senior supervisor
grades. Whilst the often 1:1 relationship is very valuable between consultant and medical secretary, moving to a situation of perhaps two consultants working with a medical secretary and support secretary will provide consistent cover for leave, allow greater flexible working and a grading to reflect the work and responsibilities. Such an approach has been developed by the A&C staff themselves and is subject to specific consultation. Progress is also likely using natural turnover of staff.

Finally the use of scanning and document management software should, over time, reduce the amount of paper we need to send around the organisation. The move of invoices from paper to electronic records, trialling of electronic notes in clinics and the use of electronic discharge summaries will also have the potential for being faster, more accurate and have less risk of being lost. Over time, as these projects come to fruition, and through the natural turnover of staff, it will allow the freed up time of admin and clerical staff to result either in a budget saving or redeployment to other tasks.

2.2.5 Corporate Services

Significant savings exceeding the 3.5% year on year target for clinical directorates are planned for the services supporting front line clinical care.

The largest of these is Estates and Facilities, which manages budgets such as security and portering, cleaning, catering, transport and sterile services. With the reduction in beds at Christchurch this allows savings in many of the support services without affecting quality of care. Closer management of security and transport has already seen savings which are expected to continue. Exploration of the most cost effective ways of upgrading sterile services (including the option of relocation to the RBH site as a possibility) will also bring benefits in more efficient working.

Stroke Thrombolysis

Why we did it:
A Telemedicine project was initiated to provide 24 hour access to specialist stroke expertise to provide early diagnosis and ensure that only appropriate patients are given the thrombolysis.

What we did:
The system consists of a 2-way video conference link between the patient and physician including CT/MRI-image transfer. The video camera captures real-time clinical signs from the patient, and the computer screen enables the patient to view and communicate with the remote “stroke expert”. Each member of our on-call stroke team has a small, high-grade laptop that they use via the mobile phone network to receive and send patient data and integrated scanning images. This enables the consultant to “virtually” assess the patient’s suitability for thrombolysis treatment.

Better care
• Interaction with a consultant takes place via video link
• Patient gets diagnosis (including scan) and treatment within 3 hours
• Telemedicine enables stroke specialists to be able to rapidly and accurately make the critical decisions to determine if a patient is eligible for thrombolysis
• Decisions can be made by a clinician in another hospital, from home, or from a mobile location, thereby removing delays in treatment due to travel time.
• By speeding up treatment, damage to the patient from a stroke is minimised

Better value
• Reducing the patient’s length of stay by minimising the impact of a stroke
• Reducing the cost of having a stroke specialist permanently on site
• The Emergency Department staff are reassured that the appropriate action has been decided by a stroke specialist
• The stroke specialist is provided with the required information to make an accurate clinical decision.
The Capital budget is very significant for the Trust and the excellent work in reducing our waste and energy bills will also reduce our costs. This combined with some restructuring of the team will deliver the savings required.

Overall management costs within the organisation have often benchmarked as low and yet delivered top level performance as judged by external assessors. Nevertheless, the need for significant savings will mean a reduction in management costs.

A consultation is under way with staff affected and this includes an initial restructure of clinical directorates. The largest change (in staff numbers) is the move of Medicine for the Elderly, Stoke and Day Hospital / intermediate care services in to the Medical Directorate. This makes clinical sense as the pathways of care will then be within one Directorate. GUM (Sexual Health Services), Orthodontics, Outpatients and Health Records and Pharmacy also change clinical directorate within the proposed restructure.

Longer term discussions towards having four clinical divisions instead of the current clinical directorates will also be explored, but with the strong preference to retain the number of clinical directors as a key part of the strong clinical engagement that has been a success factor of the Trust. The net result of these changes will be savings in management and support costs but, just as important, the

The Bournemouth Diabetes and Endocrine Centre (BDEC)

The BDEC team sought to provide newly diagnosed diabetes patients with the tools to self-manage their condition and fully engage in the behavioural changes associated with controlling their condition.

What we did:
The team created a three month rolling group education programme for all newly diagnosed patients, which involved:
• Peer support
• Problem solving
• Carbohydrate counting
• Insulin dose adjustment

How we did it:
Reorganised patient therapy around the education programme and replaced the standard clinic list. Created a multi-disciplinary team consisting of doctors, nurses, dieticians and psychologists, who are each available to see patients on an individual basis. This replaces traditional clinic visits for the first year.

Better care
• Significant improvements in overall diabetic control and anxiety control
• Patients felt considerably more in control of their condition
• Programmes promoted greater self control over their condition

Better value
• Clinic time better utilised on issues which were truly clinical and could not be dealt with by the self-management programme
• Lower demand for clinical time led to better use of expertise from medical staff
• Better self management led to reduction in future complications in emergency admissions

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management team will be aligned to future requirements to support the service going forward.

A review of training and education across the Trust has resulted in a set of recommendations which will be worked through. Pulling together some of the functions, and thus providing less duplication, will allow greater effectiveness and value for money in our training and education spend.

The NHS Litigation Authority is effectively the insurance scheme for hospital trusts and they charge a significant premium based upon their assessment as to how safely and effectively the organisation is managed. They rate organisations as levels 0 to 3, with 3 being best and with a 30% premium discount. Our overall score and that for maternity is level 2 (with our scores being high for both within that banding). By improving our safety further and demonstrating this we aim to make a significant saving as well.

There are many other smaller schemes and new ways of working that add up to a significant reduction in costs without affecting the quality of support provided by corporate services. Indeed in many cases the level of support will be enhanced and focused on the new priorities. The costs of the support services cannot be significantly reduced without risk, and in particular the flexibility to respond to rapid and unforeseen events is diminished. As a result, we will need to continue to monitor closely both the required savings and the quality of services offered.

Included below is the current matrix of workstreams and directorates which has been developed as part of our three year planning to identify £20m of recurrent savings. However, some elements of this plan are dynamic and so it should be noted this matrix is subject to change.

### 2.3 Acute Services Review

Much of the Trust effort in responding to the financial pressures in the NHS has been focused internally, and the resulting Transformation Programme under the Better Care Better Value banner is described earlier in this chapter. This links with the national and regional workstreams designed to promote quality, innovation, productivity and prevention (QIPP).

<table>
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<tr>
<th>Workstream</th>
<th>Rehab</th>
<th>Orthopaedics</th>
<th>Ophtalmology</th>
<th>Surgery</th>
<th>Medicine</th>
<th>Anaesthetics</th>
<th>Radiology</th>
<th>Pathology/Oncology</th>
<th>Maternity</th>
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<td>1,811</td>
<td>214</td>
<td>4,323</td>
<td>19,736</td>
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Improving care for patients with dementia
The National Dementia Strategy was launched in 2009 which aims to improve dementia services in three areas: awareness, earlier diagnosis and intervention and a higher quality of care.

To achieve this strategy, the Foundation Trust has developed a specific care pathway for the management and care of people with dementia in hospital.

While there is still much work to be done, so far there have been significant benefits to patients:

What we did:
Implementation of the plan is ongoing but the achievements to date include:

- A training programme on mental health and dementia has started for nursing staff working with older people.
- Early assessment by a Medicine for Elderly consultant to speed up diagnosis and implement a care plan.
- As far as possible, ensure patients with dementia are cared for on specialist older people’s wards where there is greater expertise.

Better care
- Specialist care provided by specially trained nursing staff
- A safer ward environment for patients to walk and wander
- An improved environment to reduce anxiety and confusion
- Increased independence

Better value
- A plan for when the patient leaves hospital is started as soon as they arrive on the ward to avoid delays in discharge.
- Better use of staff resources

An additional approach is to consider the opportunities that lie outside the Trust or across the organisational boundaries between our services and other related healthcare organisations. Generally speaking we are considering this across the County of Dorset, but this may include other areas if opportunities occur, for example with Salisbury, Southampton or further afield. Partner organisations could include the GPs and their practices, other Trusts, local government organisations and PCTs.

Potential areas for consideration are where there are opportunities for:

- Elimination of duplication and delay through better integration of services.
- Better use of estate and expensive equipment.
- Combining consultant teams and best use of limited availability skilled staff.

An independent expert will work with RBCH, Poole Hospital and Dorset County Hospital clinicians and managers to develop a set of proposals that can provide increased value for money, and clinically sustainable services, meeting safety and governance requirements, both now and for the future. Given there is likely to be little funding available for capital building works, any service changes will need to be feasible within the same estate as currently exists. The speed of the savings...
required will also mean any changes need to be made within one to three years.

The last significant service review was undertaken and completed during the early 1990’s. It has stood the test of time and allowed both Poole and RBCH Trusts to flourish, and provide independently assessed excellent care. It has also allowed both organisations to maintain very low cost bases, providing taxpayer value.

Significant decisions at the time were to concentrate paediatrics and obstetrics at Poole, along with trauma surgery, radiotherapy, ENT and oral maxillofacial. RBCH had the district wide services such as urology, vascular, interventional cardiology, elective orthopaedics and ophthalmology. Other services that were high volume and relatively lower infrastructure costs were kept at both sites, such as general medicine, general surgery, gastroenterology and medicine for the elderly. By concentrating the more specialist services at one site it has allowed greater specialisation, which leads to higher quality and more productive services. Many years on, it is now appropriate to revisit that concept to see whether it applies to other services.

Areas of particular interest are where high cost services are duplicated or triplicated, and are intensive users of theatres, beds, equipment or highly specialist staff. Where the numbers of patients are low this will tend to mean such services are less efficient.

As part of the review various models of service provision will need to be considered, such as:

- Centralising aspects of services onto one site.
- Networks or Dorset wide services.
- Combining consultant teams.
- Shared ‘on call’ rotas.
- The use of tele-medicine to allow offsite expertise to be accessed.
- Specialist or complex cases being treated at the appropriate centre of expertise.

In addition, not just considering services as they are now, but how they are likely to develop in five to ten years will be needed to ensure expected changes are reflected in final recommendations.

Services that are mainly outpatient based are likely to realise less savings through rationalisation. They are also seeing more patients for short appointments. In these circumstances centralisation would entail longer patient journeys for short visits, as well as smaller savings as they are less resource intensive. However the potential for closer working with primary care in these services will need to be considered.

**Vertical integration** is the term for one organisation to provide both community and hospital care. Currently, this is split between the GP and their team, the hospital and intermediate or community services such as district nurses and specialist teams (e.g. CART, the Community Assessment and Rehabilitation Team). Increasingly, the national view is that one provider reduces duplication and delay, and has greater incentive to avoid admission to hospital and increase care delivered at home, supporting independence and recovery of patients. Exploring the potential for this with PCTs, provider arms of PCTs, the third sector (voluntary and not for
profit organisations) and GPs will be an area of importance going forward.

**Back office functions** is a broad term covering all non-clinical services required to support hospital care, and also clinical support services such as pathology, therapies, sterile services etc. Corporate services such as finance, procurement, information management and technology, human resources, housekeeping, catering, estates services, porters and supplies are just some examples. Reviewing whether these could be more efficient and effectively provided through sharing back office functions will be part of a SHA sponsored review, chaired by the RBCH Chief Executive on behalf of the South West NHS. Again, the savings here will be essential to maintain the current frontline services.

Given the size of the financial savings required, and the likelihood of the squeeze on public funding lasting for at least the next five years, it is inconceivable that the current mix and location of services can remain unchanged. The question is how to protect the quality, safety and viability of those services, so as to avoid services failing, or the need for cutting back on the availability of clinically effective services. A further balance will need to be struck between the geographic ease of access to services, especially where they are high volume services, and the other factors listed above. Finally, but importantly, the view of staff working in these services will also need to be considered carefully.

The Acute Service Review therefore represents a significant opportunity to allow services to consider the best balance between the many competing factors such as scale, governance and safety, productivity and efficiency, location and access and, being “future proofed” to ensure high quality services are maintained.

**2.4 The future of Christchurch Hospital - Current position**

Christchurch Hospital provides a range of outpatient, diagnostic and therapy services, the MacMillan Palliative Care Unit, orthopaedic rehabilitation beds, the Day Hospital and other intermediate care services. Rheumatology, Dermatology and neuro-rehab (YDU) are also based at Christchurch.

**Developing Christchurch**

Over the last two years Christchurch Hospital has seen both significant investment in and expansion of services, in order to make better use of the facility, including:

- Over £1m investment in building upgrades including Day hospital and replacement roofs.
- Expanding clinics, including: Gastro, breast, oncology, medicine for elderly and ophthalmology.
move. In addition, PCT commitments to fund community stroke rehabilitation services will be important for patients after leaving hospital to ensure continued care.

The trend to improve patients’ length of stay (LOS) in hospital is set out above (section 2.2). These changes mean less time in hospital, but often with better health outcomes and quicker recovery. As a result, less hospital beds are needed. In reviewing what the right number of beds is, and the right allocation of those beds to different specialities and services, the following changes are apparent:

- Increasing the number of acute medical beds, especially for older emergency patients.
- Less surgical beds, following improved day case and admission facilities.
- Less rehabilitation beds, following increased rehabilitation from the start of the admission, and more community based services.
- Less dermatology and rheumatology beds as a result of new drugs and treatments.

**Inpatient Services**

The Stroke Rehabilitation Unit will move in 2010 to combine with the acute service at Bournemouth. This is part of the evidence based improvements that combined stroke acute and rehab units save lives and improve outcomes. Plans to ensure an appropriate rehabilitation environment, such as a dining area and gym access will be designed into the move. Improved phlebotomy (blood taking) service.
• Less palliative care beds as a result of improved community services, especially to support the wishes of patients choosing to die at home.

• Less orthopaedic rehabilitation beds as a result of more intensive therapy and better integrated care with other NHS services.

As a result of these improvements to inpatient (bed based) care, spare wards are available at Bournemouth Hospital. The combining of rehabilitation with treatment, and the rehabilitation starting earlier, is improving the care for patients. By shifting two wards originally based at Christchurch Hospital to Bournemouth, it allows for more acute medical beds where they are needed, backed up by more intensive medical, nursing, diagnostic and other clinical support services. These are not available at Christchurch to the same extent.

A further change planned is for the small number of rheumatology and dermatology beds to be combined with the orthopaedic rehabilitation beds in the vacated space at Christchurch. Currently there is a need for 18 orthopaedic beds, although this may continue to reduce as LOS continues to improve. The rheumatology and dermatology beds are currently on Forest Dene Ward, however the majority of beds there are often used by general medical patients or those awaiting transfer to another location such as a nursing home. As a result of the wider improvements in medical LOS, and the two additional wards at Bournemouth, the number of outliers is expected to reduce. It is therefore planned the ten beds on J Ward that are spare can be used for rheumatology and dermatology inpatients. In consequence, we are consulting via this document on the closure of Forest Dene Ward with the associated inpatient services relocated to other wards.

The neuro-rehab (YDU) inpatient service currently on Forest Dene will combine with the stroke rehabilitation beds at Christchurch, given the similarities in the need for therapy input. When the move of stroke beds occurs, a decision will be made in the light of the acute services review, whether Christchurch, Bournemouth or a community setting is best suited as the long-term base for this service.

A further advantage to the rationalisation of beds and wards is that five wards at RBH are now single sex, allowing greater privacy and dignity. In addition, there are now more single rooms at Bournemouth.

In addition to the currently planned moves, we need to also consider that, over time, some of the remaining inpatient services (palliative and orthopaedic rehabilitation) may become either more community based, potentially moving to support people in their own homes, and/or transfer to RBH or another location.
2.5 The future of Christchurch Hospital - Potential Options

Christchurch Hospital still represents a significant and important hub of activity as well as having strong community support. There are four potential issues to be considered when examining the opportunities for Christchurch, these are:

- The planned review of acute service reconfiguration.
- The potential to develop Christchurch Hospital, for instance as a re-ablement facility reducing the need for expensive continuing care packages.
- The future of surrounding community hospitals, including St Leonards.
- The potential options for the provision of a new palliative care facility.

In addition there could be significant opportunities that arise from partner organisations which can be explored. These include more intensive use of Christchurch, for provision of other health, social care and voluntary services.

One potential option would be around making more intensive use of Christchurch with the introduction and development of more outpatient type services. This could include accelerating the move of more ambulatory outpatient based services from RBH across to Christchurch, as well as working with health and social care partners to co-locate other facilities and in turn to share in the overhead costs of the site. This ‘campus’ approach would also have the potential for greater integration of services, especially for older people.

A further option has the potential to develop significant new services at Christchurch Hospital whereby bed based services for other providers of health and social care could be introduced. This would have the advantage of maximising the efficiency of the infrastructure required for supporting bed based services at Christchurch (for example catering, portering, laundry). Thus whilst there is a declining need for acute hospital beds on the site there may be other bed based services required by partner organisations.

NHS spend in Dorset for continuing healthcare is approaching £50m. The vast majority is in private and residential care and there is potential need for more capacity, potentially for long stay and/or respite care. A further opportunity is re-ablement, namely supporting greater independence and regaining daily living skills. The emphasis is on ensuring patients can maintain their own independence in the community. This is better for the individual, as well as reducing the need for costly long term care that Councils and PCTs are currently spending. Other bed based services could include nursing and residential care, mental health and slow stream neuro-rehabilitation. Other ideas and suggestions are also being generated.

The feasibility of developing bed based services for other health and social care providers at Christchurch will only be determined when we have had a chance to consider with local PCTs whether or not Christchurch Hospital should be developed as a re-ablement unit. We also need to consider the role of the community hospital services we have at present.
More intensive use of Christchurch would need to be at commercial rental rates, so as to lower the overall operating costs for the Trust and contribute to the savings required. At this stage it is not known what partner services would be best located at Christchurch and any building or other enabling works required. By clearly signalling these potential options now, we hope that partners will come forward with suggestions, schemes and funding which can then be tested. If there is sufficient uptake then these options have the potential to maintain and improve services and provide a financially sustainable future.

Each of the options for both ambulatory and bed based service expansion require significant work to fully assess their viability. Before this can occur other organisations that may potentially contribute to the solution need to consider if there are opportunities for them. As a result of this process, other options may emerge but the end result will be a costed business case with assessment of the options and a recommendation. This will then be subject to consultation (if it represents significant change in service).

Timescales will be developed and a full project plan drawn up. At this stage, we would be seeking expressions of interest by May 2010 at the latest, and would seek to develop these into firm proposals by the end of the summer. The fully costed business case would aim to be completed by the end of 2010/11. The implementation of any decision would of course then take some time, depending on the option. Decisions by service funders (such as Councils and PCTs) and any potential planning permission would also add further stages to the process.

The MacMillan Palliative Care Unit based at Christchurch Hospital provides an excellent service, across both hospital and the community. Working with the local MacMillan Trust charity on plans for the future, including options for upgrading the physical infrastructure, will be part of our work in the year ahead. Clearly this will both influence and be influenced by the discussions about best use of the overall Christchurch site.

Christchurch represents an excellent opportunity to provide better care, not just to Christchurch residents but all of the community across Bournemouth, East Dorset and parts of the New Forest. However, a solution needs to be identified which compliments both meeting anticipated needs and the financial viability of any proposal. Working in partnership with other organisations will be essential to achieve the best outcome.

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Have your say:

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3. Future Business Plans

3.1 Strategic overview
In the development of the 2010/11 Annual Plan, the Trust has considered several sources to inform our plans, including:

- The Trust’s own five year strategy “A Healthy Future” and the more recent “Better Care, Better Value” transformation project initiatives.
- The strategies of our local primary care trusts (PCTs), including our host Commissioner, NHS Bournemouth and Poole.
- The strategy of the South West Strategic Health Authority (SHA).
- National policy from the Department of Health, including the NHS Constitution and the National Operating Framework.

Some of these organisations have published new strategies and guidance within the last year, the key themes of which have been identified and used to update and influence our strategy.

3.2 Strategic goals

Vision
The vision for the Trust is to continuously put patients first while striving to deliver the best quality healthcare.

This means realising opportunities to ensure local people have access to outstanding clinical services which offer a high quality patient experience and excellent outcomes. This vision is derived from the values that we as an organisation hold dear and continue to strive to achieve.

Our vision will be realised through the attainment of the Trust’s strategic goals that were developed as part of the Trust’s Strategy “A Healthy Future”, Strategic Plan 2008 - 2012. In the Strategic Plan we developed seven goals that, as we make progress on these, move us towards our vision. These remain very relevant and underpin our strategic planning, they are:
• Goal 1: To offer patient-centred services through the provision of high quality, responsive, accessible, safe, effective and timely care
• Goal 2: To promote and improve the quality of life of our patients
• Goal 3: To strive towards excellence in the services and care we provide
• Goal 4: To be the provider of choice for local patients and GPs
• Goal 5: To listen to, support, motivate and develop our staff
• Goal 6: To work collaboratively with partner organisations to improve the health of local people
• Goal 7: To maintain financial stability enabling the Trust to invest in and develop services for patients

Progress against these goals is measured firstly through specific and measurable objectives being identified, such as new services or improved performance. Secondly, progress is regularly measured by setting and reviewing indicators under each goal. These indicators often involve setting ourselves stretching targets, to ensure we are amongst the best in the NHS.

Public reporting of progress is made to the Board of Directors on a quarterly basis through a Strategy Tracker. The Council of Governors undertakes a detailed examination of selective actions as further assurance that progress against the strategy is being made. In addition, performance on safety, effectiveness, access and experience as well as on finances are regularly made to the public Board of Directors meeting.

Many of the actions set out in this chapter are in line with PCT, regional and national strategies. Progress against these actions will be highly dependent upon the NHS funding that is agreed with our local commissioners - NHS Bournemouth and Poole, NHS Dorset and NHS Hampshire. These three organisations provide the vast majority of the Trust’s funding and therefore their agreement as to the speed and scale of progress for most of these developments is vital.

Infection Control Strategy
The Director of Infection Prevention and Control produces an annual report including plans for the forthcoming year. This will be produced as a separate document in early 2010/11.

Strategic Actions
For the purposes of the Annual Plan, and to ensure a robust connection between vision and actions, we have included a brief explanation of each action under the relevant goal.

There are around 60 actions in this first draft. This is the long list of actions included to ensure widest possible consultation. However as our plans for next year are more finely developed, for example as a result of commissioning decisions from the local PCTs and consultation feedback, the finalised list is expected to be a shorter list.

More detailed and measurable outcomes will be developed for the quarterly strategy
Goal 1: To offer patient-centred services through the provision of high quality, responsive, accessible, safe, effective and timely care

This goal primarily describes the need to improve quality of our services for all, through shorter waits, more convenient times and locations and that the services respond to individual patient needs. The areas of key focus during 2010/11 for this goal include:

Critical

1.1 Sustaining the 18-week Referral To Treatment times at 90%/95% levels, subject to funding. *(updated from 2009/10)*

1.2 Sustaining the Cancer Reform Strategy new wait time targets for cancer patients. *(updated from 2009/10)*

Other

1.3 Improving theatre safety and efficiency work stream, such as better use of theatre staff through improved scheduling and turnaround times, move to long day working and improved pre-op assessment.

1.4 Launching the new Jigsaw For Women Appeal, which over the next three years will raise funds for the refurbishment of the Women Health Unit, and developing architects plans for that refurbishment.

1.5 Implementing Community Stroke Rehabilitation service for the Bournemouth area. *(updated from 2009/10)*

1.6 Developing further community rehabilitation services, in collaboration with PCTs.*PCT

1.7 Moving services into the community where appropriate and reducing unnecessary follow-ups.

1.8 Supporting PCT strategy for end of life care including increasing percentage of patients dying at home, reduction in hospital admissions at end of life and increased domiciliary support. *(updated from 2009/10)*

1.9 Further developing phone consultation services. *(updated from 2009/10)*

1.10 Improving facilitation of prompt supported discharge via implementation of the Discharge Arrangements project recommendations.

1.11 Relocating pre-assessment services centrally within Outpatients to improve access and consistency of the service. *(updated from 2009/10)*

1.12 Community optometry patients service to be reviewed *PCT

1.13 Reduction in emergency admissions, (part of the PCT Care closer to home strategy).

*PCT Denotes services which we hope to develop but which will be subject to commissioning from the local primary care trusts.

*updated Denotes an action similar to one identified in the 2009/10 Annual Plan.
Goal 2: To promote and improve the quality of life of our patients

There is increasing intention on behalf of the commissioning organisations within the NHS towards education of patients and the public and, arising from this, the prevention of ill health. We have included within this heading the increasing number of initiatives associated with the management of long-term conditions (LTC), patient education and preventative healthcare. All of these will help improve patient quality of life.

2.1 Developing a “Tier 3” (hospital based) obesity service to assess and advise patients that may require weight loss surgery. *(PCT (updated from 2009/10))

2.2 Extending the existing sleep apnoea service to include treatment, as well as the current diagnostic service. *(PCT (updated from 2009/10))

2.3 Investigate opportunity for Emergency Village (with view to reducing emergency attendees between primary and secondary care). *(PCT)

2.4 With PCTs and partner organisations, ensure every patient with a long-term condition has a care plan, access to a multi-disciplinary team and working with other services to have a single point of access including: rheumatology, diabetes, vascular, respiratory, dermatology. *(updated from 2009/10)

2.5 Offering more education for LTC patients to support self-management, e.g. diabetes, rheumatology, dermatology. *(updated from 2009/10)

2.6 Development of Acute Respiratory Assessment unit. *(PCT)

Education for long term conditions: Enhanced longevity has increased the number of patients with long-term conditions such as diabetes, arthritis and eczema. There is good evidence that these patients can be supported to improve their understanding of their condition and to enhance their self-care. This reduces their use of the healthcare services and thus improves their quality of life and reduces health expenditure. A pilot of this is underway in rheumatology for arthritis patients, which allows them to ask questions of health professionals in front of other patients; the support and knowledge of other patients has also been shown to be beneficial.

Goal 3: To strive towards excellence in the services and care we provide

Developing centres of clinical excellence is at the heart of this goal, alongside receiving externally recognised and benchmarked scores in the excellent category. This will often mean being in the top 20-25% of performance in the NHS or better, and earlier delivery of national and regional ambitions. Often, development of new services will be subject to commissioning from our local primary care trusts, and in the challenging financial climate healthcare commissioners may have to...
prioritise funding for new service developments. The areas of key focus during 2010/11 for this goal include developing stroke and cardiac services as well as meeting quality performance measures for all services.

Critical

3.1 Registration with the Care Quality Commission (CQC).

3.2 Reducing acute hospital stays to better than average

Other

3.3 Achieving “Excellent” rating from CQC annual health check.

3.4 Developing the stroke strategy in collaboration with PCTs, including increased TIA mini stroke clinics with one stop diagnostics, thrombolysis available 24/7, provision of dedicated hyper acute care and achievement of the stroke quality markers.*PCT (updated from 2009/10)

In 2009/10 the National Sentinel Stroke Audit rated the Trust’s stroke services in the top 10% of services in England, in addition the stroke team won the South West Innovation award. In collaboration with NHS Bournemouth and Poole Stroke services within RBCH are being further invested in as part of a programme to achieve early implementation of the National Stroke Strategy. The plans include significant developments in the services provided for stroke patients both during the initial treatment period and rehabilitation in order to enable faster patient recovery. This strategy requires significant investment, but will ensure the Trust has one of the leading services in the country.

3.5 Relocating the stroke rehabilitation ward from Christchurch to the Bournemouth site so that integrated stroke care can be provided on one site in line with best clinical practice and safer care.

3.6 Achieving the target of 90% of stroke patients spending 90% of time on acute specialist multi-disciplinary stroke unit by March 2011.

3.7 Implement the bed review programme for length of stay initiatives including the Ward 21 / 23 new patient pathway, transfer of shared care beds from surgery and five-day beds in gastro.

3.8 Develop and implement initial stage of an agreed Dorset plan for a cardiac emergency 24/7 Primary Percutaneous Coronary Intervention (PPCI) (heart attack) service.*PCT (updated from 2009/10)

3.9 Develop initial proposals for development of a Dorset wide Heart Attack Centre to provide faster, safer and more cost effective care.
3.10 Delivery of the Maternity Matters agenda incorporating greater choice for maternity services, including: place of birth, with home births in up to 30% of cases by 2011; 85% breastfeeding initiation rate; higher % pregnant women seen by relevant health professional by week 12 and 6 days; sustaining of the United National Baby Friendly Initiative status and supporting community midwifery in all localities; accredited multi agency breastfeeding programme and smoking cessation in pregnancy. *(updated from 2009/10)*

3.11 Achieving NHS Litigation Authority level three accreditation (the highest possible) as a result of our strong patient safety strategy and track record.

3.12 Publish our quality accounts including Patient Safety First initiatives and five interventions to save lives and reduce harm.

3.13 Improving clinical coding to deliver more accurate quality measures e.g. mortality rates.

3.14 Develop proposals for MRSA screening of more emergency patients, ahead of the current target to screen all emergency admissions by April 2011. *(updated from 2009/10)*

3.15 Maintaining our excellent low rates of healthcare acquired infections, especially for MRSA and Clostridium difficile, and delivering our stretching local ambition for further reductions as part of our extensive Infection Control Strategy. *(updated from 2009/10)*

The Trust already has one of the lowest rates of MRSA in the country (Source: Healthcare Commission). During 2009/10 significant investment was made in both staff and technology in order to ensure the Trust would be able to test all elective patients and the required volume of tests could be performed efficiently and promptly. During 2009/10 the Trust is expected to have screened over 90,000 patients for MRSA prior to their admission to hospital. The Trust is now considering the most effective way to screen emergency admissions.

3.16 Delivering the National Strategy for Dementia.

3.17 Delivering of IT strategy.
(list of key elements - will be added pre public consultation)
Goal 4: To be the provider of choice for local patients and GPs

We interpret this goal as incorporating our Putting Patients First strategy and this includes all efforts to make our services more patient centred. This is further supported by our plans to improve significantly the quality of buildings and services.

Critical

4.1 Developing and implementing action plans arising from national patient satisfaction surveys and responding to the CQUIN requirements for improvements.

4.2 Increasing availability of single rooms on wards and reduced perceptions of mixed sex accommodation.

*(updated from 2009/10)

Other

4.3 Review and update the Putting Patients First (PP1st) strategy* (updated from 2009/10)

4.4 Focusing support on improving patient experience in high profile areas (Emergency Department, Outpatients and Rehabilitation wards).

*(updated from 2009/10)

4.5 Complete the stroke and oncology unit business case and move to implementation phase,* (updated from 2009/10)

4.6 Achieving Patient Related Outcome Measures (PROMS).

4.7 Deliver GP engagement plan reflecting the change in external financial environment and the need for greater integration of care and management of demand.

4.8 Rolling out the Productive Ward programme “Releasing Time to Care” to all wards and more departments.

*(updated from 2009/10)

The Productive Ward initiative is now in its second year. Throughout the last year the initiative has been rolled out in cohorts, with the fourth and final cohort starting January 2010. Productive ward is now being implemented across the majority of wards in the Trust. This initiative has seen unprecedented engagement across the Trust of staff of all disciplines. Teams have come together to work on innovations which are making a significant difference to patient experience. In addition support services are engaging with ward based teams, offering ideas, suggestions and support to work more effectively and collaboratively together.

4.9 Develop new systems for providing rapid patient feedback, including real-time electronic surveys and results of patient surveys.
Goal 5: To listen to, support, motivate and develop our staff

Fundamental to achieving our vision is to maintain and enhance our excellent workforce, ensuring that we optimise the use of our staff to take account of changing requirements to ensure our workforce is equipped to meet these in the future. Without support and development, careful listening and positive actions in order to achieve this we will not be able to achieve the other strategic goals. The areas of key focus during 2010/11 for this goal include:

Critical

5.1 Reducing Trust wide dependency on agency staff, bank and overtime.

5.2 Developing and implementing a detailed action plan responding to issues raised via the staff survey, including improving rates of staff receiving appraisals and development planning. *(updated from 2009/10)*

Other

5.3 Developing medical staff through investment in training, reviewing job plans to take account of changing work patterns and reviewing on call rota arrangements where appropriate.

5.4 Introduction of e-rostering to optimise deployment of nursing staff.

5.5 Reviewing of theatres skill mix and shift patterns as part of the theatres efficiency work stream.

5.6 Developing non clinical staff action plans to optimise use of our non clinical workforce including completion of the admin and clerical staff review and planning for implementation of recommendations.
5.7 Undertaking review of sickness and absence management policy and practice to achieve our 4% or less target.

5.8 Implementation of the training and development strategy, including grouping more of these services together to better co-ordinate this work.

5.9 Developing the business case for a dedicated training facility able to accommodate larger groups.

*(updated from 2009/10)*

**Goal 6: To work collaboratively with partner organisations to improve the health of local people**

The health of a local population is dependent as much on the collaborative performance of local agencies as the individual performance of those agencies in their own right. Many of the difficulties with accessing services occur at the boundaries between provider organisations. Effective collaboration can contribute substantially to reducing these barriers, improving quality and releasing resources. Proactive collaboration also represents an opportunity for us to contribute to the developing agenda on preventative healthcare as indicated in Goal 2. The areas of key focus during 2010/11 for this goal include:

**Critical**

6.1 To actively participate in a review of acute services across Dorset and to move to a more clinically and financially sustainable provision of services.

6.2 Development of options appraisal for the use of Christchurch hospital with appropriate stakeholder consultation.

**Other**

6.3 Discuss with PCTs the opportunity for community provision of some services.

6.4 Develop an ophthalmology triage service to reduce demand for services.*PCT

6.5 Review the angioplasty pathway and compliance with UK and European guidelines via a prospective audit, to demonstrate appropriate levels of intervention.
6.6 Continuing to develop the Community Assessment and Rehabilitation Team (CART), Older Peoples Assessment and Liaison (OPAL), services and mental health liaison service in the community, to reduce emergency admissions and time in hospital. *(updated from 2009/10)*

6.7 Develop the business case, with PCT support, for further expansion of the falls prevention services. *PCT (updated from 2009/10)*

6.8 Full roll out of electronic immediate discharge summaries to GPs and audit for quality of these. *PCT (updated from 2009/10)*

6.9 Seek volunteers and facilitate a steering group to explore a twinning arrangement with a healthcare organisation in the developing world via THET (Tropical Health and Education Trust). *(updated from 2009/10)*

6.10 Implement the plan for reducing the carbon footprint of the Trust by reviewing opportunities in the capital plan and across the Trust’s activities. *(updated from 2009/10)*

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**Goal 7: To maintain financial stability enabling the Trust to invest in and develop services for patients**

The delivery of financial stability is not an end in itself, rather it allows the services and the people working within them to plan ahead and ensure best quality of care is delivered. However, within cash limited systems, ensuring that a position of financial stability is maintained requires a high level of diligence, and is ever more critical in this challenging financial climate. The Trust has consistently achieved an Excellent rating for its management of resources and in planning ahead needs to find new ways of achieving efficiency, for example via the introduction of the “better care, better value” transformation programme. The areas of key focus during 2010/11 for this goal include:

**Critical**

7.1 Delivering the Transformation Programme in 2010/11 which will deliver £7m of new savings on a recurrent basis.

7.2 Further development of 2011/12 service transformation plans and initial identification of 2012/13 plans, focusing on how improved quality can reduce costs and identifying a further £14m recurrent savings Trust-wide.
7.6 Delivery of the capital investment plan for equipment, IT and estates to add improved quality and cost effectiveness of our services.

7.7 Rolling out of full Service Line Reporting (identification of costs and revenues at dept / specialty level) to Trust directorates to better understand and influence costs, department efficiency opportunities and future investment decisions.

Other

7.3 Implementing the strategy for developing private patient income opportunity, for example using spare capacity in our state of the art CT scanner for cardiac CT.

7.4 Delivering ongoing procurement strategy of reduced purchase costs, specifically: prosthetic costs in orthopaedics, pathology cost per test, consideration of managed services and development of business case for theatre caskets.

7.5 Improving and developing income streams, e.g. developing 1st trimester screening tests including potential supply to neighbouring trusts’ maternity units.
4. Risk Analysis

4.1 Presentation of risk

Assurance Framework

The Trust has developed a comprehensive Assurance Framework to provide assurance to the Board that sufficiently robust processes are in place to achieve the strategic objectives and to mitigate identified risks. The Trust's Assurance Framework reflects the seven domains of the Standards for Better Health and also cross-references the Trust's seven key strategic goals and the Trust Risk Register.

The Assurance Framework will be regularly reviewed by the Healthcare Assurance Committee. Each risk area has a Board level lead (normally an executive director) and each lead presents an update on their key risk areas to the Healthcare Assurance Committee on a rolling programme basis. Gaps in assurance / control are formally monitored and will be followed up via the Trust Risk Register process. In addition the Trust’s programme of internal audit will assist in providing assurance in specific areas.

The Trust's Assurance Framework for 2010/2011 has been received and noted by the Healthcare Assurance Committee, recommended for approval by the Audit Committee and formally approved by the Board of Directors.

NHS Litigation Authority (NHSLA) Compliance

The Trust holds Level 2 compliance with the general NHSLA Risk Management Standards, obtained in June 2008. Our aim is to achieve Level 3 compliance in the 2010/2011 and work is in progress towards this.

In respect of maternity services, the Trust achieved Level 2 compliance with the NHSLA new Maternity Risk Management Standards in November 2009. Having consolidated this level of compliance the Trust will work towards achieving Level 3 compliance.

National Institute for Health and Clinical Excellence Guidance (NICE)

The Trust has a routine process for the dissemination and co-ordination of new NICE guidance, MRHA Alerts, drug alerts, National Confidential Enquiry and other associated reports. A database, managed by the Associate Director - Clinical Governance, is used to record receipt, dissemination and implementation of all NICE guidance and alerts. Issues of non- or partial compliance are reported formally to the Clinical Governance and Risk Committee and placed on the Trust Risk Register until compliance has been achieved. Details are also included within the quarterly Clinical Governance Report to the Board of Directors.

Alerts from external agencies

The Trust is developing a formal system for responding to external alerts e.g. from the Care Quality Commission and Dr Foster. This involves prospective review of data collected by external agencies, formal review of cases and detailed discussion by a monthly monitoring group. This process will be further developed and led by the Medical Director.
4.2 Governance risk

Legality of Constitution

The Trust’s Constitution is compliant with all relevant legislative requirements and the Trust remains fully compliant with it. The current and all previous versions have been approved as such by Monitor. A full review of the Constitution was undertaken in 2009 by the Constitution Review Group and the recommended changes were approved by the Board of Directors, the Council of Governors, the Annual Members’ Meeting and Monitor.

Growing a Representative Membership

Section 5 of the Annual Plan provides a detailed commentary on the current and planned membership position. The Membership Development Committee has undertaken a thorough review of the Membership Strategy and, through this line of work, the Trust will continue to ensure it has a representative membership of all the constituencies it has established.

Appropriate Board Roles and Structures

The role of the Board, committees and management structures has been reviewed on a regular basis and in 2009 there has been a full review and re-structuring of the Board Committees. In addition to the Audit, Charitable Funds and Remuneration Committees, the Board operates with the support of six formal Board Sub-Committees - the terms of reference for which have all been revised during the year and approved by the Board.

- Trust Management Board.
- Healthcare Assurance.
- Finance.
- Infection Control.
- Marketing.
- Workforce.

Between them, these committees cover the Assurance Framework and provide a range of assurance to the Board that the strategic objectives of the organisation are being met or that mitigation and / or action plans are in place to correct any areas of concern. The committees are supported, where appropriate, by a range of sub-committees where detailed work is undertaken relating to specific areas. The Board Sub-Committees are robustly delivering the work streams required of them and the integrated governance structure will be reviewed and further developed as appropriate on an ongoing basis in the future.

The Board maintains its register of interests and can confirm that there are no material conflicts of interest in the Board.

A policy for the composition of the Non-Executive Directors on the Board was put in place at the beginning of the year and this work was used to inform the refreshment of the Non-Executive element of the Board. Particular regard was paid to the changes to the operating environment within which the Trust operates, including the challenge presented by the contraction of the economy.

The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Board receives regular updates on areas such as risk management and other important areas.

The management team has the capability and experience necessary to deliver the Annual Plan.
The Board greatly values and continues to strengthen its relationship with the Council of Governors. As well as the attendance of Directors at general meetings, Non-Executive Directors sit on Governors committees. A number of Directors and Non-Executive Directors have also attended the Governors’ less formal strategic sub-groups and have welcomed increasing Governor involvement in working groups across the Trust for issues such as marketing, governance and the patient experience. The Board of Directors and Council of Governors have met jointly twice during the year. This forum has proved very useful and will continue in the coming year.

**Effective Risk and Performance Management - Risk Register**

The Trust has an active Risk Register that is regularly reviewed by the Healthcare Assurance Committee and the Board of Directors. The Board of Directors gives a high priority to risk management and all risks on the register are assigned a Board level lead. A standard risk scoring system is used and all significant risks, based on this scoring system, are presented to the Board on a monthly basis as part of the Trust’s performance management framework. The on-going management of clinical governance and risk is undertaken by the Clinical Governance and Risk Committee (CGRC) which meets on a monthly basis and reports directly to the Healthcare Assurance Committee. The CGRC consists of clinical governance and risk leads from all directorates within the organisation. The Committee is chaired by the Associate Medical Director.

The active Risk Register is divided into those risks that are soluble with resource allocation, those risks that are directly linked to the Trust’s Assurance Framework and those risks that are accepted as currently managed to the lowest level practical but still present in the system. The Register addresses general and clinical risk, financial risk and mandatory service risk. Detailed reports can be produced for individual risks and this is done on a regular basis for all significant risks.

The process of managing risk and providing assurance is overseen by the Trust’s Audit Committee. This meets quarterly and is authorised by the Board to:

- Investigate any activity within its Terms of Reference.
- Seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.
- Obtain independent legal advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Operational performance management is a further area where robust systems are in place, evidenced by achievement of the key targets over previous years in virtually all areas.
Care Quality Commission core standards

All directorates produced a detailed Development Plan for 2009/10 to improve further the arrangements in place and supporting evidence for compliance with the Care Quality Commission requirements. Directorate plans included action for progress on implementation of the patient safety and clinical governance standards. This work will be continued in 2010/11.

A robust Annual Audit Programme (clinical and non-clinical) that includes both internal and external reviews further supports implementation of the Plan.

The Annual Health Check administered by the Care Quality Commission is currently in an interim year while arrangements for the new registration process are finalised. As such the Trust has been required to make an interim declaration against the Core Standards as at 31 October 2009, covering the period 1 April – 31 October 2009. At this stage the Trust considers itself compliant with all 24 core standards. The Trust will be required to update this declaration at 31 March 2010, and at this point it is envisaged that full compliance will be declared.

In the meantime, the Trust is preparing to submit an application for registration with the Care Quality Commission in accordance with the new legislation. It is anticipated that the organisation will be able to meet the requirements for registration.

4.3 Mandatory service risk

Significant risks

The Trust has a small number of significant mandatory service risks relating to either clinical, service delivery or service developments on the Trust Risk Register.

Risks against the national targets, and actions to resolve these, in 2009/10 included:

- **Sustainability of 18 weeks Referral to Treatment target** - this target was achieved.
- **Reducing MRSA and C. difficile rates** - There is an ongoing detailed infection control strategy in place to support risk reduction.
- **Managing winter pressures** - Work has taken place to create additional capacity and flexibility to meet seasonal demands and increased pressures.
- **Emergency Department four-hour waits** - the Emergency Department has installed new computer software to improve tracking and management of patients. In addition, the Trust continues to review establishment and skill mix within the department. Robust, real time reporting of potential breaches is now well established. The Department has managed to achieve waiting targets despite a significant increase in emergency activity and admissions.
- **Cancer Access Targets**. The Trust has appointed a Trust lead for cancer services to oversee development of service, compliance with IOG and coordination of peer review visits as well as ensuring delivery of all cancer targets.
- **Business Continuity**: The Trust Business Continuity Manager has ensured that all departments have Business Impact Assessments and Business Continuity plans that are BS25999 compliant. The Trust is aiming to be one of the few Trusts in the country with BS25999 continuity plans.
• Pandemic Flu: The Trust now has a comprehensive Pandemic Flu Plan that links with the Major Incident Plan. Relevant parts of the plan have also been agreed with NHS Bournemouth & Poole, the ambulance service and the Local Resilience Forum (LRF) to ensure a county-wide response. In addition, the Trust has a mutual aid agreement with Poole Hospital NHS Foundation Trust to ensure ongoing provision of paediatric intensive care service.

• Lone workers: The Trust has implemented a hospital wide lone working system in 2010 to ensure the safety of staff working in lone working situations in hospital and in the community.

Other risks for services listed under the Terms of Authorisation include:

• Managing capacity for oncology services and ensuring compliance with Cancer Peer Review recommendations for improvements to accommodation as well as staff and patient safety.

For 2010/11, risk assessments for the national core standards and mandatory services are to be completed for the final version of the Annual Plan.

For the majority of these risks, the level of risk relates to the potential severity of an adverse event if it did occur rather than the actual likelihood of occurrence. In each case mitigating strategies have been identified to either reduce the likelihood or mitigate the severity. For all identified risks the Board has been provided with assurances on the controls in place and regular monitoring is undertaken to ensure that any gaps in controls are immediately identified and resolved.

4.4 Financial risks
[This section will be completed for the final version of the annual plan May 2010]

4.5 Risk of any other non-compliance with terms of authorisation

There are no known significant risks of non-compliance that are expected in 2010/11 and as such we would currently expect to be issued with a green rating for governance and mandatory services.

Have your say:

What do you think about our proposals?
We value your views.
To give us your feedback, please refer to the final section of this document:
Section 6: How to have your say
5. Membership

5.1 Membership Report

Membership Composition
to be completed for final version of plan May 2010.

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<th>Number of members in constituency</th>
<th>Number of seats contested</th>
<th>Number of contestants</th>
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<td>1</td>
<td>7</td>
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**Election Turnout**

An election took place in the Bournemouth constituency during the year. Efforts to maximise turnout included extensive publicity and meetings both pre and post nomination.

The Board confirms that the election to the Council of Governors was held in accordance with the election rules as stated in the Constitution.

5.2 Membership commentary

The Trust has two membership groups; public and staff.

**Public**

The Constitution of the Trust was changed during the year to add a fifth constituency, Salisbury and South Wiltshire, the Isle of Wight and the rest of Dorset and Hampshire. Eligibility for membership of the public constituency is open to those who live within five geographical areas: Bournemouth; Christchurch, East Dorset and Purbeck; Poole; New Forest and the new constituency referred to above.

The areas served by the Trust are diverse in nature with areas of social deprivation and affluence and a mixture of urban and rural environments. The socio-economic profiling demonstrates that the mix of members broadly reflects the wider population.

**Staff**

The Constitution of the Trust was changed during the year to move from an opt in to an opt out system for new staff joining the Trust. The staff constituencies are medical and dental; nursing and midwifery; hotel services and estates; allied health professionals; administrative and clerical management.

**Developing the Membership**

Membership development is a crucial part of the role of the Council of Governors and the Membership Development Committee is revising its strategy in order to reflect changing priorities. This year the focus will be on growing the membership, ensuring that membership is representative of the community and increasing the amount of contact the Governors have with the members and the public.
Various events have been held during the year to raise the profile of the Trust and engage with our constituents.

Governors have held a number of public information sessions that have brought members and prospective members together to listen to presentations on various aspects of the services delivered within the Trust. In addition, Governors talks were given at several community meetings.

The Trust ran two Open Days at the Royal Bournemouth Hospital and the League of Friends organised a fete. Governors attended these events and were successful in recruiting additional members to the Trust.

The Board of Directors and the Council of Governors continue to share the aim of developing an engaged and representative membership. To further this aim, membership issues are led by the Membership Development Committee which is chaired by a public Governor with Governor representation from each constituency, a staff Governor, Non-Executive Director and members of the Trust staff. The Committee meets to develop and progress the Membership Development Strategy.

Over the next 12 months planned developments include:

- Continuing to build a membership representative of the local community and grow membership numbers.
- Continuing to develop and improve the co-ordination of recruitment activities.
- Raising the profile of Governors within the community to establish better local links and to encourage members to stand for election as public and staff governors.
- Continuing to increase joint working between the Council of Governors and the
- Developing an interactive members' area on the website with the support of the Trust.

**Board of Directors**

The Trust is run by its Board of Directors, which is made up of Executive and Non-Executive Directors. Together they are responsible for the day-to-day running of the Trust and the delivery of our objectives and wider strategy. The operational work of the Trust is led by the Executive Directors who work closely with consultants, clinical leaders and managers throughout the Foundation Trust with the Non-Executive Directors providing an independent oversight of that work and fulfilling the role of critical friend.

**Council of Governors**

The role of the Council of Governors is twofold: they help to set the overall strategic direction of the organisation by advising the Board of Directors of the views of the constituencies they represent. The Council also has specific responsibilities set out in statute in relation to the appointment or removal of Non-Executive Directors and their remuneration, the appointment or removal of the Trust’s auditors and development of the membership strategy. During the year, the Council of Governors appointed two new Non-Executive Directors, will have appointed a new Chairman and renewed the appointment of two existing Non Executive Directors.

Oversight of the Trust’s activities and input into the strategy are combined with a responsibility to communicate with the local community over a range of issues regarding the services of the hospital. Consultation is an ongoing process and Governors hold regular public talks around the constituencies making themselves available to the membership and the wider population.
There are 30 members of the Council of Governors.

Following an externally facilitated self-appraisal in 2008/2009 the Council of Governors has reviewed its committee structure and the work of the Council of Governors is now supported by eight committees. In addition, Governors are involved in a number of Trust led groups. This identified ways in which it worked particularly well and areas where it felt it could do better. Areas appropriate for review were identified. Various sub-groups have been responsible for considering and reporting on these areas to the Council of Governors. As a result of this Governors have introduced a number of new initiatives to assist them with their role within the Trust. These include a Consultation Committee which is responsible for reviewing the Annual Plan and a group to develop joint Board of Director/Council of Governor working.

**Governor Elections**

A contested election for a public governor for the Bournemouth constituency took place in July 2009.

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**Have your say:**

What do you think about our proposals?

We value your views.

To give us your feedback, please refer to the final section of this document:

Section 6: How to have your say
6. How to have your say

It is important that there is consultation on the proposals contained in this Annual Plan so that we can carefully consider the feedback provided by the general public, our staff and local stakeholders. This feedback will help in finalising the 2010/11 Annual Plan and informing our considerations.

We have outlined a series of questions, included overleaf, to which we would welcome responses. Your further comments would also be welcome.

Trust Consultation Policy

The Trust has a Consultation Policy which outlines when consultation is required and how the consultation should be undertaken. All public consultations carried out by the Trust follow the principles of The Consultation Charter, which are:

- **Integrity**
  Honest intention, willing to listen and be prepared to be influenced

- **Visibility**
  Stakeholders should be aware of the consultation exercise

- **Accessibility**
  Methods that meet the needs of the intended audience

- **Confidentiality**
  Ensure all stakeholders are aware as to the level of information that will be made public

- **Disclosure**
  Disclosure on behalf of the Foundation Trust of information that can influence the exercise and disclosure on behalf of consultees, for example, if the consultee represents an organisation

- **Fair Interpretation**
  Objective collation and assessment of information and viewpoints

- **Publication**
  Publication of both the output and the outcomes of the exercise

As part of the consultation we have a list of c.200 stakeholder contacts with whom we consult on the Annual Plan. We have a series of planned public meetings as part of the consultation, in order for those who are interested to learn more about our plans, there will also be the opportunity to ask questions. There are other events including meetings in public which the Trust is attending where you can also find out more. A schedule of the public events is included below. We publicise the consultation through publications such as the local Echo column, our members’ newsletter (FT Focus) and through Governor constituency events.

We also have a comprehensive schedule of internal events and publications for our staff.

In addition, we have listened to people who told us they felt the previous consultation was not extensive enough. One of the actions arising out of this feedback is that we have initiated a list of contacts, in addition to our existing stakeholder contacts list, who will be emailed with information on all future consultations. Anyone wishing to be added to the list is welcome to let us have their contact details.

The 2010/11 Annual Plan public consultation

The 2010/11 Annual Plan consultation runs from 1st February to 23rd April 2010.

As part of our consultation there are a number of public meetings and other events scheduled, as follows:
### Public Meetings

Public meetings hosted by the Foundation Trust at:
- **Howard Centre at Christchurch Hospital**
  - 3rd March, 2010: 2pm and 4pm
- **and Causserie Suite, Carlton Menzies Hotel, East Overcliff, Bournemouth on 17th March, 2010 at 2.30pm**

Spaces are limited so please telephone in advance to book your space on 01202 704271

### Meetings in public which the Trust is attending

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th March, 2010, 6.30pm</td>
<td>Public meeting hosted by Christchurch Borough Council. Poole Health Overview and Scrutiny Committee, 9th March, 2010 at 7pm. Bournemouth Health Overview and Scrutiny Committee, 7th April, 2010 at 6pm Dorset Health Overview and Scrutiny Committee, 12th April, 2010 at 10am.</td>
</tr>
</tbody>
</table>

### Understanding Health (public health talks)

Understanding Cataract 29th March, 2010 11am at the Village Hotel. Copies of the consultation document will be available on the day.

### Open Day - Focusing on Better Care, Better Value

14th April, 2010 10am - 4pm in the Atrium at the Royal Bournemouth Hospital. Copies of the consultation document will be available on the day.

### Your feedback on our plans

All responses received during the consultation period, 1st February to 23rd April, from questionnaires, letters and other feedback will be included in our analysis.

Responses to the consultation should be either submitted via the Annual Plan consultation section on our website:

www.rbch.nhs.uk/consultations

or sent to:

**Tony Spotswood, Chief Executive, The Royal Bournemouth Hospital, Castle Lane East, Bournemouth, Dorset. BH7 7DW**

or by email to: comments@rbch.nhs.uk

Where possible we would ask that responses are submitted to us by 26th March 2010, in order to allow us to fully incorporate these for our April Board of Directors and Council of Governors meetings. The final date for responses to be received is 23rd April 2010. Comments after this time will be noted, but cannot be guaranteed to be included in the final version of the Annual Plan. Comments and responses made by individuals may be reflected in the final Annual Plan report and may be quoted verbatim. Individuals will not be named in this report, however comments and responses made by organisations may be publicly attributed to those organisations.

The final 2010/2011 Annual Plan will be published and available to view on our website after the 1st June or by contacting us direct on 01202 704271.
1 Do you believe that the proposals we have set out within the 2010/11 Annual Plan adequately address the health needs of the local population?
Please put tick box for
☐ Yes fully    ☐ Yes mostly    ☐ Not Sure    ☐ No only partly    ☐ Not at all

2 Are there specific issues we should afford more priority to or which have not been highlighted within this Annual Plan document?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3 Are there proposals within the Annual Plan that you do not think we should be addressing?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

4 Are there any further comments you would like to make?
Please continue on a separate sheet if required

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Glossary

Emergency Village
DoH initiative to have all emergency department services as a one stop service

Angioplasty
Intervention to improve functioning of the heart via dilation of a narrowed or completely obstructed blood vessel

Bariatric Surgery
Surgical treatment for obesity

“Call to needle” / “call to door” / “door to needle” targets
National core standards target for people suffering heart attack to receive thrombolysis within 60 minutes of call (call to needle) split into two targets by arrival at hospital door

Catheterisation
Insertion of flexible tube into bodily cavity for collection of fluid

Choose and Book
Online booking system offering patients booked appointments from a choice of hospitals

Clostridium difficile
Bacterium which can be fatal to humans unless treated promptly

Darzi review
Lord Darzi’s report on the future of the NHS commissioned by the Department of Health: High Quality Care for All - NHS Next Stage Review

Dermatology
Diagnosis and treatment of skin disorders

Diabetes
Results from defects of insulin secretion, insulin action or both

Domiciliary
At home

Electrophysiology
Measurements/investigations of the electrical conduction in the heart

Gastroenterology
Study of gastrointestinal disease

Genito-Urinary Medicine
Study and treatment of sexually transmitted diseases

Hyperacute Care
Intensified care for stroke patients following Thrombolysis or initial diagnosis

Interventional cardiology
Procedures/treatment of cardiac disorders

MoH’s technique
Removal of skin lesions

Monitor
Independent Regulator of Foundation Trusts

Myocardial Infarction
Heart attack

Norovirus
A group of viruses that are the most common cause of gastroenteritis, (stomach and gut upset) in the UK. Also known as “winter vomiting viruses”
**Oncology**
Concerned with the study and treatment of tumors

**Ophthalmology**
Concerned with the eye

**Orthopedics**
Concerned with disorders or deformities of the spine and joints

**Pandemic flu**
A severe strain of flu that can spread worldwide

**Patient Engagement Framework**
The strategy being developed by the Trust to ensure we meet our vision of “Putting Patients First”

**Patient Related Outcome Measures**
New guidance that will support the NHS to collect patient feedback on the success of their operations was published recently by the Department of Health

**Phlebotomy**
Taking blood samples

**Primary Care**
Health care provided by GP’s or other health professionals to whom the patient has direct access

**Productive Ward**
Initiative focusing on the release of more time dedicated to nursing

**Pulmonary**
Related to the lungs

**Re-ablement**
Supporting greater independence and regaining daily living skills

**Respiratory**
Relating to or affecting breathing or the organs used to breathe

**Rheumatology**
Diagnosis and management of disease involving joints, tendons, muscles, ligaments and associated structures

**Sleep apnoea**
Stopping breathing during sleep

**Telemedicine**
Use of telecommunication technologies to deliver medical information and services to locations at a distance from the care giver or educator

**Thrombolysis**
Dissolution of blood clots

**Transient Ischaemic Attack (TIA)**
‘Mini stroke’ - in which symptoms of a stroke subside within 24 hours

**Type I Diabetes**
Insulin dependent diabetes

**Type II Diabetes**
Non insulin dependent diabetes

**Urology**
Concerned with the diagnosis and treatment of disorders of the urinary tract or urogenital system

**Vascular**
Pertaining to blood vessels

**Vertical integration**
Where one organisation provides both community and hospital care
<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BREEAM</td>
<td>Building Research Establishment Environmental Assessment Method</td>
</tr>
<tr>
<td>c. difficile</td>
<td>Clostridium difficile</td>
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<tr>
<td>CART</td>
<td>Community and Rehabilitation Team</td>
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<td>CIP</td>
<td>Cost Improvement Programme</td>
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<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<td>CT</td>
<td>Computed Tomography</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DoSA</td>
<td>Day of Surgery Admission Unit</td>
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<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<td>GRMC</td>
<td>Governance Risk and Management Committee</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GUM</td>
<td>Genitourinary Medicine</td>
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<td>HCAIs</td>
<td>Healthcare Associated Infections</td>
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<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>I&amp;E</td>
<td>Income and Expenditure</td>
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<td>IIP</td>
<td>Investors in People</td>
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<td>IOG</td>
<td>Improving Outcomes Guidance</td>
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<td>IT</td>
<td>Information Technology</td>
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<tr>
<td>KSF</td>
<td>Knowledge and Skills Framework</td>
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<td>LOS</td>
<td>Length of Stay</td>
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<td>LTC</td>
<td>Long Term Conditions</td>
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<td>MHRA</td>
<td>Medicines and Healthcare Products Regulatory Agency</td>
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<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
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<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSLA</td>
<td>NHS Litigation Authority</td>
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<td>NICE</td>
<td>National Institute for health and Clinical Excellence</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<tr>
<td>OCN</td>
<td>Open College Network</td>
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<tr>
<td>OPAL</td>
<td>Older Persons Assessment and Liaison team</td>
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<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
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<td>PbR</td>
<td>Payment by Results</td>
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<tr>
<td>PCI</td>
<td>Percutaneous Coronary Intervention</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>PET</td>
<td>Positron Emission Tomography</td>
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<tr>
<td>PPCI</td>
<td>Primary Percutaneous Coronary Intervention</td>
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<tr>
<td>PPI</td>
<td>Patient and Public Involvement</td>
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<tr>
<td>PROMS</td>
<td>Patient Related Outcome Measures</td>
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<tr>
<td>PwC</td>
<td>Pricewaterhouse Coopers, Consultants</td>
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<tr>
<td>QUANGO</td>
<td>Quasi-autonomous non-governmental organisation</td>
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<td>RBCHFT</td>
<td>Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust</td>
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<tr>
<td>REDS</td>
<td>Respiratory Early Discharge Scheme</td>
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<td>RTT</td>
<td>Referral To Treatment</td>
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<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>SLR</td>
<td>Service Line Reporting</td>
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<tr>
<td>SLM</td>
<td>Service Line Management</td>
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<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack</td>
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<tr>
<td>YDU</td>
<td>Young Disabled Unit (neuro-rehab)</td>
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</tbody>
</table>
If you would like a copy of this document in an alternative format, please contact us on 01202 704271 or email: comments@rbch.nhs.uk