Putting patients first

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Draft
Annual Plan for Public Consultation
2011/12
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Foreword

Through this consultation process we want to engage patients, the public, partners and our own staff in discussing some of the key issues facing us. Your comments and opinions will all be carefully considered before any final decisions are made. We very much hope to have ideas, challenges and opinion generated through the next few months.

Overall The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) has had a successful year in 2010/11. This has included:

- All key targets have been achieved or exceeded (“Green” Governance rating).
- Excellent (level 4) rating for use of resources from Monitor.
- Achieved unconditional registration with the Care Quality Commission (CQC).
- Over 12 months without any hospital acquired MRSA infections.
- Delivery of over £10m of efficiency savings, while being awarded a national patient safety award.
- Continuing positive staff survey and improving patient surveys.

Looking forward, there are further major challenges that require us to continue to find innovative solutions. Also, a new government with an ambitious agenda provides further impetus for our need to change and adapt.

These challenges form the structure of most of this draft plan, namely:

- Improving patient outcomes
- Transforming services for quality and value
- Organising for excellence
- Better use of buildings
- New models of care

As a Foundation Trust we have a membership body for which our governors are elected. The governors’ role is to represent the public we serve. We currently have c.12,000 members and are keen to expand this further. This document therefore also covers our plans for membership development of the Foundation Trust.

There is also an important section on our regulators’ requirements, Monitor and the Care Quality Commission (CQC). This section is not for consultation, given they are nationally set requirements, but is provided here for information. Detailed responses to regulatory requirements will form part of the final 2011/12 Annual Plan agreed by the Board of Directors and with the Council of Governors in May 2011.

Please do take the time to read our draft plan, and provide feedback, either at one of the planned public meetings, via our website at www.rbch.nhs.uk/consultations/feedback or in writing using the feedback questionnaire provided.

Tony Spotswood        Jane Stichbury
Chief Executive        Chairman
1. Context

1.1 About the Foundation Trust
RBCH provides a wide range of hospital and community based care to the Dorset, New Forest and South Wiltshire areas. We have an annual turnover of £220m and employ 3,600 staff. The Board of Directors is accountable via our regulators, Monitor and the Care Quality Commission (CQC), for our performance, via contracts to our commissioners (Primary Care Trusts) and to our Council of Governors (CoG).

The CoG is made up of directly elected governors, drawn from 12,000 members, as well as partner governors from local organisations, voluntary sector and staff.

Our Goals
The Trust’s goals set out in the document “A Healthy Future” (Strategic Plan 2008/2012), remain consistent and relevant. They are:

1. To offer patient centred services through the provision of high quality, responsive, accessible, safe, effective and timely care.
2. To promote and improve the quality of life of our patients.
3. To strive towards excellence in the services and care we provide.
4. To be the provider of choice for local patients and GPs.
5. To listen to, support, motivate and develop our staff.
6. To work collaboratively with partner organisations to improve the health of local people.
7. To maintain financial stability enabling the Trust to invest in and develop services for patients.

1.2 Our performance
On the key measures by which healthcare providers are judged, we have traditionally performed very strongly. These include being externally rated as having:

- Excellent waiting times.
- Excellent infection control.
- Excellent management of resources.

In 2009 RBCH was named as HSJ Acute Organisation of the Year, the financial department was named HFMA Acute Provider of the Year and in 2010, CHKS Safest Hospital in the UK.

Despite this, there remain many areas of opportunity for further development. Currently for example:

- RBCH patients’ lengths of stay in our hospitals benchmarks at the national average, showing room for improvement.
- As a multi-site Trust, we spend a higher proportion of our resources on buildings than many other hospitals.
- We need to reduce our unplanned readmission rates as we benchmark as average.
To support this high level performance we have a highly skilled, professional and flexible workforce, with very positive responses to key questions within the national annual staff survey. Therefore we feel confident of rising to the challenges set out in this plan.

1.3 Local commissioner strategies

The strategies of local PCTs who commission our services clearly influence our own planning. National policy and best practice are also carefully considered in the drafting of this plan, alongside local public and partner views.

The government has instigated key changes in the commissioning of services. The intention is that GPs will take the lead role in this via consortia of GP practices. This year will see the start of shadow GP Consortia that will replace PCTs (by 2013). Local GP leaders are increasingly going to have the key say on how health services locally are delivered. While these are early days, the views of GPs have influenced this plan and will influence future iterations.

1.4 Charitable and voluntary support

Patients treated by the Trust are also helped by the very generous amounts of charitable donations which allow us to improve the care we give. Fuller details are available within our Annual Statement of Charitable Accounts.

We also have a large number of loyal and committed volunteers who help our hospitals run smoothly all year round.

1.5 Trust Consultation Policy

The Trust has a Consultation Policy which outlines when we will consult and how the consultation will be undertaken. Further details of this are included within Section 11: How to Have Your Say. As part of the consultation we have a list of key stakeholders who we contact with details of any public consultation we hold.

In addition, we have a further list of contacts that are emailed with information on all public consultations. We are keen to widen the reach of this so that we can let people know about the Trust’s activities, and would welcome your contact details so you can be added to the list.

Information on how to do this is included within Section 11: How to have your say.

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 11: How to have your say
2. Overview

Over the next year, and indeed for the next three years, we expect the key issues and priorities to remain largely the same: how to provide ever improving care to patients; how to respond to rising demand of an ageing population, all within, at best, the current budget. In short, how to do more and better for less.

Over the past two years this is exactly what RBCH has been doing. We have a track record of delivering measurably safer and higher quality care while reducing our annual operating costs by £15m (7%).

By focusing on getting care right first time and using best practice, the Transformation Programme at the Trust has been able to deliver better care and from this better value has followed. Examples are many and a few are listed throughout this strategy. One example is our improved inpatient clinical care leading to patients being well enough to go home more quickly, reducing the time patients need to spend in hospital. This leads to better outcomes and a reduced requirement for beds.

The challenge is how to improve outcomes for patients while planning for a further £30m of recurrent savings over the next three years. This is what this strategy sets out to achieve.

Improving the outcomes of the patients we serve is the main drive for our staff and our organisation. We are motivated by the desire to improve patients’ health. This is why we welcome the national focus on patient outcomes which is very much in line with our vision of ‘putting patients first’. From here the other sections and priorities of this strategy naturally follow.

As part of the White Paper policy development, the Department of Health has produced the National Clinical Outcomes Framework which covers:

1. **Avoidable Mortality**
   Preventing people dying prematurely, especially from the major early killers of cancer, stroke and heart disease.

2. **Long-term Conditions**
   Enhancing quality of life for people with chronic diseases such as asthma, diabetes and arthritis.

3. **Episodes of Acute Care**
   Helping people recover from episodes of ill health or following injury.

4. **Patient Experience**
   Ensuring people have a positive experience of care.

5. **Safety**
   Treating and caring for people in a safe environment and protecting them from avoidable harm.

What RBCH is doing to improve outcomes, and associated future plans, is covered in Section 3. Some actions will contribute to better patient outcomes as well as financial savings. An example is reducing emergency re-admissions to hospital through better management of long term conditions. We will also be looking at how services are organised, such as stroke and cardiac care. Here the clinical evidence clearly shows that rapid access to specialist units saves lives and reduces long term problems, rightly making us look at how we provide our care.

RBCH remains very aware of the external environment in which we operate. Our close relationships with neighbouring NHS and local authority services and the huge support from charities and volunteers are also highlighted. The wider economic difficulties and the
massive savings required of the public sector are also critical in considering future plans. Our transformation plans going forward will help us to identify the £30m savings required. The realities of tighter public finances cannot be ignored and in three years time we would expect to have a smaller more flexible workforce, in a similar way to private sector organisations who survived the recent recession. Making sure this journey is one where staff understand and help create the solutions is critical. Our Transformation Programme has genuinely affected all parts of the organisation and all staff groups. It will continue to focus on improving value and not on cutting treatments or standards of care that are of proven benefit.

Many of the changes need close working with GPs, social workers, community NHS staff and many others. Our programme going forwards will be more balanced between further internal savings alongside external changes with partners. The areas we will focus on over the next three years are covered in Section 4.

As a result of the factors mentioned above, serious thought needs to be given to whether the current range of services across Dorset is set up to achieve best care and value. If we were able to re-map all of our local services, it is unlikely that we would configure them as they are at present. Where there are expensive assets and rare skills, such as equipment or specialist consultants, we should aim to have these rapidly available and ideally available 24 hours a day, 7 days a week. Keeping NHS services there for all patients, at current or higher quality than now, will require us to re-think some of our existing beliefs about how, where and when we provide care. Underpinning this is the core principle of the NHS: there for you, free at the point of delivery.

This is covered in the section ‘Organising for Clinical Excellence’. It sets out the views of RBCH and local health partners about how clinical services in Dorset might change in future years, in ways that will improve patient outcomes. This will also help keep services within Dorset when reductions in medical workforce, higher quality thresholds and other factors might otherwise put local services at risk. This is covered in Section 5.

Part of the planning for our next set of savings comes from benchmarking: comparing our performance with other hospitals and organisations. Generally RBCH scores well, with costs below average. One area we do less well in is our estates and buildings costs. This is partly because we operate from two
sites. Many hospitals are on one site, as are Poole, Dorchester and Salisbury Hospitals.

With the move of many inpatient services from Christchurch to the RBH site, many parts of Christchurch Hospital are empty. It is therefore right to review future options for the Trust with the focus on improving patient outcomes. We will look at whether the money spent on maintaining empty buildings could be better spent on staff, drugs and treatments. We currently estimate that if we ran most services on one site, we would be able to provide the same or better quality care at considerably less cost.

Our wider estates strategy flows from the focus on clinical outcomes, services shaped for clinical excellence, and the transformation agenda to deliver better health and better value. Over recent years the Trust has built up capital reserves and so there is a forward plan of developments allowing us to progress against these three related objectives. Examples include improved stroke facilities, a medical investigations unit, single sex bathroom facilities and a rolling programme of equipment upgrades and replacements. These investments are measured against the clinical and value benefits, many being invest-to-save schemes, made possible by our strong financial performance. Another example is the use of solar panels on our roofs. Further details of our capital and estates plans are covered in Section 6.

As you would expect there are many supporting strategies and plans within the organisation which we continue to improve and develop. These include workforce, information technology, governance and risk and many other important aspects of our work. The Trust has however prioritised Sections 3-7 as the key elements to consult on with partners and the public, as these are where the leading issues and debate need to focus. This way, the quality of care and outcomes for the public we serve will be maximised. Further detail of our supporting plans will be published via Monitor, our external regulator, later in the year.

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 11: How to have your say
3. Patient outcomes

Ensuring positive outcomes for patients is our organising theme for this strategy. The national focus on outcomes sits well with our local work to ensure our care is among the best by national, and indeed international, comparisons. Our low infection rates and our examples of service excellence, such as cardiac, stroke and diabetic services, often feature as exemplars to other parts of the NHS. In 2010 we won the ‘UK Safest Hospital’ award from CHKS in recognition of our excellent performance over a range of patient safety related indicators.

Going forward we expect the National Outcomes Framework (NOF) to become the organising framework for external inspection and regulation, to inform the Commissioning for Quality and Innovation (CQUIN) payments, and to inform GP commissioning. Serious focus is required, not just because the issues are important, but also because the NHS as a whole will be monitored to test improvement against these measures. RBCH will want to remain at the forefront of high quality care. Our performance remains excellent in respect of low waits, low rates of infection and a range of other key measures. The national outcomes framework will sometimes make us look anew
at our performance, or focus on totally new measures, and as such we will need to work through the five domains, as outlined below, in detail.

RBCH has a strong track record of responding well to challenging quality objectives. Our systems, including Governance and Risk Management, our Healthcare Assurance Committee, and other processes will support us to predict, assess and plan for the measures within the framework when further details are confirmed. Many of the indicators are measured by patients’ perceptions and the assessment / observation of other organisations. Therefore, extra care and attention will be needed to deliver improvements so that perceptions are changed as well.

A further challenge will be that success in many cases will be measured by the degree of improvement, year on year, rather than absolute levels. Our generally excellent position across all measures mean that the challenge will be to maintain this excellent record, for example, of no hospital acquired MRSA for over a year, and to improve on our record where further improvement is possible.

3.1 Domain One: Avoidable mortality

Avoiding preventable early deaths is, rightly, the goal of most health systems. Cancer, heart disease and stroke remain the largest killers of the under 75s and can be reduced through lifestyle and healthcare interventions.

RBCH, along with other acute hospitals, are measured using a Hospital Standardised Mortality Ratio (HSMR). This shows whether the death rate in a given hospital is higher or lower than expected when adjusted for age, levels of illness and other factors. RBCH performs well, c5% better than national comparator in 2009/10 (source: Dr Foster).

The measure in future is expected to change and include all deaths within 30 days of discharge. RBCH would expect to do better than peers, given our 30 day surgical mortality rate has been among the best in the country and because we have a low rate of transfer to community hospitals (as there are so few locally). However, this does not stop us from continuing to improve our services and, in particular; deaths in hospital from stroke remain an area of focus.

Stroke care at RBCH performs very well (top 10%) using objective measures of process. Traditionally though, our very long lengths of stay contributed to high hospital mortality rates being reported. That level has come down, and the following actions will improve that further:

- Moving to a combined acute and rehabilitation unit at RBH.
- Direct admissions to the ward, targeted to occur in 90% of occasions.
- A move to seven day therapy input.
- Head scans within one or 24 hours (whichever is clinically appropriate).
- Supported discharge and follow up by specialists.
- Seven day access to TIA (mini-stroke) services and follow up.
- Rapid access to thrombolytic drugs where clinically appropriate.
- Development of high intensity care for the first 24 hours.

These measures are proven to save lives and improve outcomes, including reduced levels of patient disability. This also means reduced ongoing costs to the health, social and charitable care sectors, as well of course to the patients and their carers. As a result RBCH has been investing in developing these services and working with commissioners to
invest further, so as to make long term patient improvements and system savings.

**End of life care** is the second area to focus on. Patients and their carers regularly say they wish for death to be in the place of their choice. Often this is at home and sometimes at a specialist hospice. An unplanned visit to a general Emergency Department followed by a stay on a busy general ward in their final days or weeks is less desirable but sometimes it is the reality for patients. Avoiding unnecessary admission to hospital when a patient has an established palliative care plan, and investing in appropriate community care support instead is better for all. This will be a priority area for review and development in 2011. The excellent services provided by the Macmillan team, based at Christchurch Hospital, will be part of this consideration as well as how best to work with local GPs, care homes and other services available for these patients. Supporting patients, providing dignity and avoiding unwanted admissions to hospitals will be guiding principles. The issues of the physical buildings to best deliver this care are discussed in Section 6: Better use of buildings.

As well as the overall clinical outcomes, the variation by gender, ethnicity, social class and other factors will also be studied as the outcome performance is published over 2011/12. This will further help us target our activities to maximise the benefits to the whole population, and reduce variations and health inequalities.

### 3.2 Domain Two: Long term conditions (LTC)

The framework lists many of the indicators expected to be used, and many focus around:

- Health related quality of care for people with LTCs.
- Patient perceptions of feeling supported to manage their condition(s).
- Clinical measures of good quality care such as, diabetic blood parameters (Hb1Ac).

RBCH has some excellent programmes of care for long term conditions such as, diabetes, rheumatology and eye conditions e.g. glaucoma. We do not know how we will score in some of the patient perception measures like Patient Related Outcome Measures (PROMS) for LTCs, as they have not been developed yet.

We do know that, like many Trusts, we see a high level of emergency admissions and re-admissions within 30 days, for Thoracic (Chest) conditions. These include Chronic Obstructive Pulmonary Disease (COPD) and asthma, both longterm conditions. As a result this is a priority area to develop a better model of care.

Actions planned for 2011 include:

- Piloting a rapid access Acute Respiratory Assessment Unit (ARAU), that is able to provide senior clinical opinion and rapid access test results, and in many cases will lead to a much shorter stay in hospital or will avoid admission to a bed at all.
- To link this to REDS (Respiratory Early Discharge Scheme), to support patients in their own homes.
To work with local GPs, PCTs and community health services to identify high risk patients and put in place robust shared plans and potentially tele-monitoring equipment so patients and clinicians can avoid acute episodes and the need to use hospital in-patient care.

Dementia is an increasingly prevalent condition, affecting many patients locally and having a very large impact on the numbers admitted and re-admitted to hospital. Admission avoidance schemes, including OPAL (Older People’s Assessment and Liaison Service), operate at the hospital ‘front door’ in the Emergency Department. Expanding the service to cover more hours and allow fast direct referral to community services such as re-ablement, memory clinics and the Day Hospital at Christchurch will mean an improved quick response to an emergency situation.

Overall the Trust will progress the actions against the quarterly standards for dementia care within an acute general hospital. The eight standards of dementia care in hospital are:

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<th>Standard</th>
<th>Description</th>
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<tr>
<td>Standard 1</td>
<td>People with dementia are assured respect, dignity and appropriate care</td>
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<tr>
<td>Standard 2</td>
<td>Agreed assessment, admission and discharge processes are in place, with care plans specific to meet the individual needs of people with dementia and their carers</td>
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<tr>
<td>Standard 3</td>
<td>People with dementia or suspected cognitive impairment who are admitted to hospital, and their carers/families have access to a specialist mental health liaison service</td>
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<td>Standard 4</td>
<td>The hospital and ward environment is dementia-friendly, minimising the number of ward and unit moves within the hospital setting and between hospitals</td>
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<td>Standard 5</td>
<td>The nutrition and hydration needs of people with dementia are well met</td>
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<td>Standard 6</td>
<td>The hospital and wards promote the contribution of volunteers to the well-being of people with dementia in hospital</td>
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<tr>
<td>Standard 7</td>
<td>The hospital and wards ensure quality of care at the end of life</td>
</tr>
<tr>
<td>Standard 8</td>
<td>Appropriate training and workforce development are in place to promote and enhance the care of people with dementia in general and community hospitals, and their carers/families</td>
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Making sure discharge is timely, once physical reasons for hospitalisation are resolved, is very important. It is estimated that at any one time all patients who are physically fit for discharge could fill one ward. This diminishes the opportunity for others who do require our services. The complex needs arising from their social care requirements and the complexity of funding responsibilities, result in a longer stay in acute hospitals than clinically necessary. Resolving this remains a key priority and recent government funding commitments for social care (and dementia in particular), will be bid for to progress this initiative.

### 3.3 Domain Three: Episodes of acute care

For many patients their experience of healthcare is short term, perhaps following an acute illness or injury. Nevertheless, it is important to get the experience right and ensure a positive outcome. Key measures include:

- Reducing emergency hospital admissions for conditions that could be managed in the community or on an outpatient basis.
- Reducing readmissions to hospital that are unplanned emergencies.
- Patient Related Outcome Measures (PROMS) for four procedures (hernias, hip and knee replacements, varicose veins) which the Trust currently collects.

Further details on the hospital readmission and hospital admission avoidance work are covered in sections 7.1 and 7.2. This and the long term conditions outcomes measures are critical areas of work.

### 3.4 Domain Four: Patient Experience

For hospitals, the annual national inpatient survey is one of the ways of measuring patient experience. In some years this is added to by outpatient and emergency patient national surveys.

Our most recent outpatient survey was very positive with all areas performing well. We also had an excellent survey result from the recent Maternity service national survey. However, some areas of our annual inpatient survey are below expected levels, in particular:

- Knowing how to complain and posters / leaflets explaining this.
- Being asked to give views on quality of care.
- Explaining waits in the Emergency Department.
- Pain control and explanation.
- Patients being copied into correspondence.

These have been recurrent issues over the years and improvements have not always been maintained. A focus on these in 2011 will be critical to avoid red (bottom 20% of Trusts) scores.

We do receive more good (green) scores (top 20% of Trusts) than bottom 20% scores, especially in areas of doctor and nurse communication with patients, trust in staff, and in recommending the Trust to family and friends. Generating more top scores will require extra effort. In particular, the current work to improve patient information (including leaflets, web videos, LCD screens etc.) is beginning to show improvements.

Another focus going forward are the national five questions that relate to better care and better value. This is because they are linked to improved satisfaction and the reduced need to use or re-use hospital services. These are:
• Were you involved as much as you wanted to be in decisions about your care and treatment?
• Did you find someone on the hospital staff to talk to about your worries and fears?
• Were you given enough privacy when discussing your condition or treatment?
• Did a member of staff tell you about medication side effects to watch for when you went home?
• Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

To improve our services, and make sure we are acting more quickly than via an annual survey, we introduced in 2010 ‘real time’ patient feedback. This allows volunteers using a small handheld device to survey patients. The results are instantly collated and provide immediate results. Pilot wards have started acting on the results, with over 1,000 surveys completed.

Expansion and improvement of the bedside entertainment system is planned for 2011. This will also allow patients to answer surveys in their own time, further improving the mechanisms for feedback.

Some initiatives we have implemented as a result of patient feedback include:

**You Said**

“You didn’t know how to give feedback to the Trust.”

**We Did!**

We have now designed posters giving details which are available throughout the Trust and also in each hospital bedside folder. The posters provide information for patients to either call a bespoke phone number where they are able to leave a voice or text message with their feedback, or how to take part in the hospital survey on-line.

“Too many people still ignoring getting dirty hands.”

“I would like to practice my outdoor walking with a physiotherapist at the Day Hospital.”

“More can be done to brighten up the waiting area. It looks like a factory.”

“Can we use charity funding to make RBH Atrium a make over. Making it attractive and welcoming to our visitors.”
“You required a phone number to contact the hospital following discharge in case you had any problems.”

**We Did!**
We are currently trialling bookmarks, issued to patients on discharge, with details on how to contact the clinical area for advice once you are discharged.

“Noise on the wards kept some patients awake at night”

**We Did!**
We are currently trialling the provision of eye masks and ear plugs to aid a restful nights sleep.

“More can be done to brighten up the waiting area. It looks like a factory.”

**We Did!**
We used charity funding to give the RBH Atrium a make over, making it attractive and welcoming to our visitors.

“I would like to practise my outdoor walking with a physiotherapist at the Day Hospital.”

**We Did!**
A therapeutic garden was built at the Christchurch Day Hospital with charitable funding that contains raised flower beds, special surfaces for practising walking and quiet areas of attractive planting for relaxation and enjoyment.

### 3.5 Domain Five: Safety

Patient safety remains the utmost concern based upon the principle of ‘first, do no harm.’ Across healthcare however, both nationally and internationally, patients are sometimes harmed and hence the Trust Board has led on making patient safety a major part of the agenda for every Board meeting. As well as being the right thing to focus on, it also has the added benefit of often saving money. Every infection, fall, pressure sore, medication error or accident causes harm, requires more resource to put right, takes staff time to deal with complaints and may of course end in litigation. Getting it right first time is clearly better.

Key indicators here include:
- Numbers and types of reported incidents, and the number which are harm events.
- Infection rates.
Over 2010 many initiatives have helped make care safer at RBCH. These include:

- Centralised pre-assessment for surgery enabling standardising of processes.
- Full implementation of MRSA screening for elective and emergency admissions.
- Full rollout of VTE assessment to reduce blood clots with the Trust performing as one of the best large trusts in the country.
- Using patient safety “care bundles”, such as in critical care.
- Participating in the regional “Patient Safety First” project.

Building on these plans for 2011/12 includes:

- Developing and maintaining the above improvements.
- Progressing our assessment against NHS Litigation Authority level 3 (the highest level), to ensure good governance on many safety levels.
- Recruiting a new Director of Infection Prevention and Control, and maintaining our excellent record on low infection rates.

Further details will be set out in our Quality Accounts statement which will be published in May 2011 as part of the Annual Plan supporting strategies:

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 11: How to have your say
4. Transformation Programme

4.1 Transforming care to deliver better health and better value

We have demonstrated our increasing focus on improving outcomes but the second part of our purpose, working within the resources available, also needs planning.

Rising demand for care, an ageing population, rising expectations and new technologies, have increased healthcare costs in all developed countries for many years. These drivers will continue to exist, but, owing to the UK economic situation, the NHS will face a period where funding will, at best, match inflation only. The NHS settlement is better than many other public services but the hospital sector itself is likely to see below-inflation funding, based upon a need to deliver at least 4% efficiency improvements year on year. For RBCH this is likely to mean £30m recurrent savings over the next three years, about 15% reduction in our running costs, in real terms.

Social care, especially for the elderly, will be an area where we continue to work with local councils to make sure they are protected as much as possible. Part of the NHS funding will go to support social care and RBCH will, in particular, look at making sure this funding supports:

- Re-ablement, allowing patients to live independently.
- Post discharge support, particularly for stroke, dementia, orthopaedic rehabilitation and conditions affecting older people.
- Admission and re-admission avoidance services such as the RBCH falls prevention service and Older People’s Assessment and Liaison service (OPAL).

Investments, such as those set out above, based upon business cases and partnership agreements are thought to be the best way to make the reducing social care funds go as far as possible and to avoid further growth in emergency care.

There is a risk that the local hospital, the ‘place of safety 24 hours a day, 7 days a week’, comes under greater pressure as community support reduces. This could then be more difficult if supporting systems for discharging patients with complex needs are not able to respond quickly. Over the first half of 2010/11 nearly 5% of our hospital beds were filled with patients who did not need to be in hospital as their medical treatment had ended. These delayed transfers of care (DTOC) patients result in huge inefficiencies and above all are not right for that patient. After your period of acute care is completed, it is not appropriate to stay in a hospital bed longer than medically needed. Indeed it can affect recovery, which is usually better at home or in one’s usual place of residence, with support from GP and community teams.

Mary’s story

Mary lives at home and has Multiple Sclerosis. In December she contracted pneumonia and had to be admitted to the hospital.

Previously she would have been in hospital for 2-3 weeks, predominantly on rehabilitation wards. This time could have included transfers from ward to ward and potentially from RBH to Christchurch.

However, this time her care was delivered in her own home, by a team of therapists, speeding her recovery and providing a more cost effective service. While she recovered she was able to continue her interests in gardening and painting.
The need to realise £30m of efficiency savings, beyond the £16m already achieved in the last two years will require exceptional effort. RBCH already benchmarks as a highly efficient organisation, delivering services at least 6% more productively than the NHS average. Top quartile performance is achieved in the better care, better value indicators, in all areas except length of stay in hospital. Despite having achieved higher levels of productivity there remains further potential and the requirement for more savings as set out in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Year 1 2009/10</th>
<th>Year 2 2010/11</th>
<th>Year 3 2011/12</th>
<th>Year 4 2012/13</th>
<th>Year 5 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Savings</td>
<td>£6m</td>
<td>£8.5m</td>
<td>£10m</td>
<td>£10m</td>
<td>£10m</td>
</tr>
<tr>
<td>Achieved / Projected</td>
<td>£6m</td>
<td>£10.5m</td>
<td></td>
<td></td>
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</tbody>
</table>

### 4.2 Overview of the Transformation Programme 2011/12 - 2013/14

In 2011/12 directorate-led schemes will still have to deliver 3.8% cost improvements (£8m). These do not rely on new NHS income and will either improve or at least maintain both quality and activity levels. These schemes, as in the previous two years, have been delivered in ways that have forced us to re-think how we deliver care, with the end result being both better care and better value. Examples of this include our central pre-operation assessment and our central admission area for theatres known as the Sandbourne Suite.

#### The Sandbourne Suite

The Day of Surgery Admissions Unit has been designed around the patient journey and combines the admission process for all surgical procedures. Patients are admitted on the day of their surgery, so there is no unnecessary overnight stay before the procedure or operation. Afterwards, patients are cared for on a surgical ward until they are ready for discharge.
As a result of having well developed directorate plans for 2011/12, £8m of the £30m three year total is already identified and agreed. Many of these are continuation or full year effect of schemes started in 2010, and tight budget control.

This leaves £22m savings to be identified (about 10% of the Trust’s running costs) to meet the target for the next three years. This will require some radical thinking and far greater joint work with partners. This is because internal changes alone cannot achieve these savings in a sustainable way. Of equal importance are the new opportunities for joint working, especially with primary and community care services, and with other hospitals. One such example is using spare laboratory capacity at Southampton University Hospital (SUHT) to provide a more cost effective Biochemistry Service, subject to contract discussions.

The summary of schemes that will make up the 2011/12 - 2013/14 Transformation Programme are:

<table>
<thead>
<tr>
<th>Estimated Target Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12 schemes by Directorate</td>
</tr>
<tr>
<td>Back office corporate savings</td>
</tr>
<tr>
<td>Organising for clinical excellence (Acute Service Review)</td>
</tr>
<tr>
<td>Private patient income (benefit to NHS)</td>
</tr>
<tr>
<td>Clinical directorate workforce productivity</td>
</tr>
<tr>
<td>Procurement and prescribing</td>
</tr>
<tr>
<td>Reducing length of stay in hospital</td>
</tr>
<tr>
<td>Better use of estates and buildings</td>
</tr>
<tr>
<td>Theatre productivity</td>
</tr>
<tr>
<td>Resolution of unfunded services</td>
</tr>
<tr>
<td>Directorate own schemes</td>
</tr>
<tr>
<td>Move away from paper (lean processes)</td>
</tr>
<tr>
<td>Diagnostics demand management</td>
</tr>
<tr>
<td><strong>£30m</strong></td>
</tr>
</tbody>
</table>

4.3 Detail of the Transformation Programme workstreams

i Back office, including corporate and management costs

Through rigorous analysis, benchmarking and best practice, a further 10% reduction in non front-line service costs is targeted. This will include looking to reduce waste by making processes lean, for example, by reducing delay, duplication, hand-offs and re work, through simplifying and, where possible, stopping or automating processes. Standardisation of what services offer will then follow.
Finally, where it is practical and there is interest from partners in the wider market, the options of sharing services will also be explored.

**ii Organising for excellence**

This is covered under Section 5. The savings indicated above are merely indicative at this stage.

**iii Private patient income**

Private patient income benefiting NHS services is a target figure from expanding the work on RBCH premises, using spare capacity. Especially appealing are some of our unique, cutting edge technology areas, such as in radiology and cardiology. The “profit” from this work is then used to support higher levels of NHS care than would otherwise be possible. Our core mission remains “NHS care, free at the point of delivery”, and private patient activity helps us to deliver this to a higher standard.

**iv Clinical directorate workforce productivity**

Our clinical workforce of doctors, nurses, allied health professionals and supporting administrative and technical staff are our most valuable asset. Over many years, they have shown how they can work flexibly, innovatively and professionally to deliver better care and better value. Therefore, in percentage terms, this is a much lower target than in previous years. However, there remain areas to explore further. These include:

- Further rollout and benefits realisation of e-rostering.
- Skill mix and rota reviews.
- Continuation of our programme of review of staff groups, (so far management, medical, nursing, medical secretary and porters have been reviewed, and nurse practitioners / specialists are to start shortly).
- Vacancy Review Panel challenge of vacant posts.

**v Procurement and prescribing**

Greater product standardisation, review and re-tendering remains an ongoing programme, delivering significant savings. Expertise in managed equipment services has also meant greater shared savings with suppliers in areas such as pathology. In addition, during 2011 the Trust will explore with partner NHS bodies a “commitment” based procurement approach, which, with strong clinical leadership, could deliver significant savings for the NHS as a whole. Within prescribing we will continue to ensure cost effective use of medicines and work to reduce wastage. There are significant savings also from working together with local GPs and other Trusts, and to share the benefit of this work.

**vi Continue to reduce length of stay in hospital**

Over recent years clinicians at our Trust have proven shorter lengths of stay also mean better care. In surgery, day case procedures, admission on the day of surgery (via the purpose built Sandbourne Suite), enhanced recovery initiatives and other measures have had a profound effect on reducing the length of stay. Within emergency care, ensuring patients get to the right specialist beds, avoid being moved, have regular senior medical attention, rapid diagnostic tests and support and planning for discharge have all come together to reduce the time patients need to spend in hospital.

Continuing this work is important as, so far, it has moved the Trust to have average length of stay, implying there are many other health systems doing better. For example, Torbay, a similar area, has nearly half the beds we have
to meet its hospital care needs. This, combined with the work to reduce re-admissions, and reduce the number of delayed transfers of care (DTOC) will free up beds, and save valuable NHS resources.

vii Better use of buildings
This is covered in Section 6.

viii Theatre productivity
Improving the use of the very expensive operating theatres, in terms of staff and equipment, remains another continuing theme. From our work over the last two years the Anaesthetics directorate have delivered their savings targets, while improving care, such as through centralised pre-operative assessments, improving the consistency, efficiency and environment for patients being prepared for surgery.

Going forward, looking at optimal operating hours to best suit length of operations and use of skilled staff will be one aspect of numerous ways of improving productivity. Moving to a more integrated electronic scheduling system (eTCI) will also help to best deploy the resources available to efficiently meet the need.

ix Resolution of unfunded services
This item covers a range of services provided by RBCH but for which there is no funding
from commissioners. The reasons for this are often historic, or as a result of RBCH deciding to subsidise these due to affordability issues of commissioners. However, this situation is not tenable with the current and future pressures on hospital finances. Commissioners will need to either fund the services, or agree to the services ceasing (as the result of a less generous funding settlement to the Trust). Should the latter occur then there would need to be a period of consultation on service changes, and RBCH would work constructively to find alternatives for the patients affected. However, our intention would be to resolve these issues with commissioners in ways that avoid service reductions.

**x  Directorate own schemes**

This refers to the many other, sometimes smaller schemes within directorates that are not covered by other schemes. There is a minimum 1% efficiency saving requirement for all areas, and therefore the expectation is that every part of the organisation will continue to contribute to the overall savings required. During the year a Bright Ideas scheme was launched to give all staff the opportunity to become involved in generating ideas and some of these ideas are now included within the Directorates own schemes.

**xi  Move away from paper (MAP)**

This is a project to reduce the direct costs of printing, paper and postage, which costs the Trust over £1m each year. By adopting more electronic means of communicating with GPs, patients, staff and the public, considerable cost savings can be made. There are further savings that can be realised through more efficient ways of working such as avoiding duplication, rework and data entry. In addition, there is potential to automate processes and make staff more self sufficient in retrieving and updating information which could lead to considerable savings.

**xii  Diagnostics demand management**

The ordering of tests, by hospital staff and local GPs is a widely accepted area for improvement. Some tests, especially when repeated, can have little clinical value in affecting the decisions for some patient’s treatment plans. Order Communications is an electronic ordering system that is designed to avoid duplicate and unnecessary testing. Once again the savings indicated in the table above are estimates, but across pathology and radiology the opportunities are considerable.

All of these workstreams are areas of potential to be further developed. Savings could be greater than indicated, but where any schemes deliver less, then other new schemes will need to be developed to balance any shortfall.

None of the schemes will be quick or easy to deliver and so supporting projects and infrastructure will continue to be developed. This, along with clinical and managerial leadership, will be essential to maintain the momentum built over the last two years.

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**Have your say:**

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We value your views.

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

Section 11: How to have your say
5. Organising for clinical excellence

Nationally there is strong evidence that by better organising the resources available now we can improve health outcomes. The challenge is how to move from here to there, accepting change is difficult. One starting point is identifying those areas that could potentially gain the most, if organised differently.

To help take things forward it is worth identifying what the drivers or key factors are in optimising quality and cost effectiveness. While the list below is not exhaustive, it summarises recurrent themes from quality improvement work in the NHS and beyond.

Key factors in driving improvements in patient outcomes (as described in Section 3) are:

- Measuring outcomes so as to manage them.
- Focus and prioritise on the things that make the biggest improvement.
- Ensure services have sufficient critical mass / volume of work.
- Develop further multi-disciplinary teams (MDT).
- Ensure services have sufficient resources.

Key factors in driving cost and cost effectiveness:

- Use of inpatient beds and buildings.
- High cost equipment and supplies.
- High cost or scarce specialist staff.
- Service operating hours and rota cover, i.e. 24/7 (168 hours a week).
- High use / volumes then multiply the effectiveness, as cost per treatment rapidly falls.

High volume, outpatient, diagnostic and day treatment services generally need little rationalisation given the key drivers of cost effectiveness are low impact. Low volume inpatient care however, requiring specialist staff, equipment, drugs and supplies, provided with 24 hour a day cover, are the high priority areas to consider. Moving to an MDT approach, avoiding small stand-alone teams or individuals who ensure diagnosis and treatment are for sufficient volumes, will result in a situation where skills are maintained and clinical outcomes are improved.

Moving towards centres of clinical excellence has a compelling evidence base, however; there are also factors which mean simply maintaining the status quo will not be possible. Indeed, quality could reduce as a result of a combination of ‘push’ factors. These include:

- The reducing numbers of junior doctors.
- National quality thresholds are tightening, including minimum volumes of activity.
- The need to update equipment and buildings to new (usually higher) standards.
- Retirements / movements of difficult to replace staff.
- The need for year on year savings.

These factors all combine to make the local health system evaluate what will be the best way to organise local services and to recognise that it is not appropriate, for quality or efficiency reasons, for all hospitals to provide all services. There is compelling evidence that organisations that do less than a certain level of a particular procedure or service do not always deliver a high quality service.
As a result of work with other local NHS organisations, the following list represents the services that may have potential to be organised to achieve better outcomes and better value:

- Inpatient haematology.
- Pathology.
- Cardiac / heart attacks.
- High dependency stroke care.
- Obstetrics and paediatric care.
- Out of hours emergency general surgery.
- Vascular surgery and interventional radiology.
- Specialist palliative care.
- Spinal surgery.

Spinal surgery provision is being tendered in early 2011 and inpatient haematology provision is expected to follow shortly afterwards. The tendering process is being run by local commissioners to decide the best provider for these services.

Pathology, vascular surgery and interventional radiology are part of network discussions among local hospitals.

Commissioners are reviewing specialist palliative care, obstetrics and cardiac care and the methods to take this forward to achieve better outcomes and value. Out of hours surgery and high dependency stroke care are only at early stages of discussion.

Any service changes affecting patients significantly, as identified by the joint local health scrutiny panels, will correctly require separate and detailed public consultation. The rationale for considering these services, and the drivers behind them, are transparently set out here to inform the public and partners why such considerations are necessary now, namely for maintaining and improving outcomes and value.

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Section 11: How to have your say
6. Better use of buildings

6.1 Overview
As a direct result of focusing on patient outcomes and ensuring value for money we need to look at how we use our most expensive asset: our buildings. RBCH benchmarks as high cost for its estate, which is driven by operating on two sites (plus Alderney for our sterile services). Most important of all, is that nearly half the Christchurch site is vacant. The reasons for this, and ways that avoid us heating and maintaining empty buildings at a cost to the taxpayer, are discussed below.

As well as the future of Christchurch Hospital, there are many other important issues to consult on and many of these are driven by important patient safety outcomes, and the expressed satisfaction with our services. We know from both local and national evidence that the environments in which patients are cared for is crucially important. As a result we have a significant programme of estate developments over the next three years. This includes:

- Eliminating mixed sex areas, as per national standards.
- Developing greater privacy and dignity, and a one stop service through our Jigsaw Appeal for a new Women’s Health Unit for patients with breast and gynae cancers, and a range of other conditions.
- Creating a single Stroke Unit combining acute and rehabilitation services, which is evidence based to improve outcomes.
- Pending the outcome of the commissioner decision on inpatient haematology, to progress the long awaited re-build of the Oncology / Haematology Unit.
- A major refurbishment of the Eye Unit day ward thanks to charitable donations.
- A re-build of the Macmillan Unit financed by the support of the local charity Macmillan Caring Locally.
- Upgrade of the Sterile Services Department at Alderney and improve endoscopy sterilisation facilities.
- Development of a medical investigations unit at RBCH, avoiding the need to be admitted to a longer stay ward for specific tests, providing a better patient experience.
- Creation of a winter pressures / summer decant ward at RBH to help the operation of the hospital.
- Piloting solar panels to reduce energy costs and our carbon footprint.

In addition we are also consulting on important plans to re-develop Christchurch Hospital, safeguarding existing services and proposing the development of new services for the local population.

The importance of charitable support for many of these developments cannot be emphasised enough. Local patients and staff benefit greatly from charitable donations and legacies received. This enables greater quality and more regular updating of our estate than would otherwise be possible with NHS funds alone.

The exact order and timing of the above estate developments are interlinked and hence the need for an overall estates strategy. The first crucial decision and one with greatest public interest will be regarding the future of Christchurch Hospital services.
6.2 Christchurch Hospital

Christchurch Hospital provides specific services as set out below:

<table>
<thead>
<tr>
<th>Main services provided by RBCH at Christchurch Hospital *¹</th>
<th>Catchment Served *²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main outpatients</td>
<td>Christchurch +</td>
</tr>
<tr>
<td>Phlebotomy (blood tests for pathology results)</td>
<td>Christchurch +</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Christchurch +</td>
</tr>
<tr>
<td>X-ray and ultrasound</td>
<td>Christchurch +</td>
</tr>
<tr>
<td>Orthopaedic rehabilitation</td>
<td>Christchurch, some Bournemouth</td>
</tr>
<tr>
<td>Rheumatology (bone and joints)</td>
<td>Bournemouth &amp; Christchurch +</td>
</tr>
<tr>
<td>Dermatology (skin)</td>
<td>Bournemouth &amp; Christchurch +</td>
</tr>
<tr>
<td>Day Hospital</td>
<td>Bournemouth &amp; Christchurch +</td>
</tr>
<tr>
<td>Macmillan Unit (specialist palliative care)</td>
<td>Bournemouth &amp; Christchurch +</td>
</tr>
<tr>
<td>Stroke rehabilitation</td>
<td>Bournemouth &amp; Christchurch +</td>
</tr>
</tbody>
</table>

*¹ Support services i.e. pharmacy, facilities etc not listed, and community services based at Christchurch but working in the community (i.e. Falls prevention, Parkinson’s and young disabled / neurological rehabilitation) as these services are delivered mainly off site.

*² Christchurch + catchment covers parts of the New Forest and East Dorset but is a service replicated at RBH, so where patients come from can vary depending upon appointment times and choice.

These services have developed over time and are well thought of by the patients who use them. The majority of Christchurch and neighbouring residents travel to RBH for most of their care, such as Emergency Department and admissions, all surgical, endoscopy and most diagnostics, such as CT and MRI. Over the last few years RBCH has developed Christchurch Hospital services, including a greater range of outpatient specialities, expanding the Day Hospital and phlebotomy (blood taking for pathology results).

The number of inpatient beds has reduced as a direct consequence of improving clinical care and a reduction in the time patients have to spend in hospital. (See our consultation document of 2009 setting these out at www.rbch.nhs.uk/annualplan). Once the Stroke
The existing palliative care service is one of the largest fully NHS services in England. Local GPs and PCTs have commissioned a review of palliative care services and have signalled that more palliative care ought to be provided in the community. The commissioners have also indicted that they wish to review the model of care and this will include the potential for the third sector to play a more significant role in providing these services, as evidenced in many parts of the country.

The Trust therefore needs to agree with commissioners the future model of care for specialist palliative care. Once done, this will enable decisions to be made on the appropriate size of an inpatient palliative care facility. Three options will be considered for the siting of this facility; Christchurch Hospital (the present location), The Royal Bournemouth Hospital, which is a busy acute site and elsewhere within the community. We welcome views at this stage on both the model of care and the location of a newly developed facility. However, any significant changes emerging from future work with commissioners is likely to have a separate consultation. The Board is clear that if Christchurch Hospital is the appropriate site, it will be available to support a new facility.

More generally we have to consider how the whole of Christchurch Hospital is best utilised as we move forward. The two options we are consulting on to gain public and partner feedback are covered next:

Rehabilitation Unit (SRU) has moved to RBH, the sole remaining general ward at Christchurch will be orthopaedic rehabilitation. This service is used by patients transferring from Poole Hospital following trauma surgery, such as for a fractured neck of femur (broken hip). This service is likely to develop into a community based team, supporting patients in their own homes, in line with best practice and the “care closer to home” policy of commissioners. A very small number of rheumatology / dermatology patients currently use J ward and these would transfer with SRU. RBH is much safer for inpatient services with greater medical back up which will not be available after these other moves. As a result the only inpatient beds left will be the Macmillan palliative care beds. The Macmillan Unit is discussed below.

The result of these changes in clinical care has been to leave large sections of Christchurch Hospital empty. Last year, via our Annual Plan, we declared our ambition to find a local public sector partner or other partner to share the overheads of the site. Despite actively pursuing this, the general message was that most organisations, including local authority partners, are looking to reduce their own estates and do not wish to use the facilities at Christchurch Hospital. This has led the Trust to consider what further options are possible. These are captured below and signal an important and exciting opportunity to use the estate for the benefit of local people (see page 29).
6.3 Developing options for Christchurch Hospital

1st Option: Securing current services at Christchurch

- All services currently at Christchurch stay except the current inpatients services for SRU and Orthopaedic rehabilitation.
- The SRU transfers to RBH as per previous consultation to provide a combined Stroke Unit on RBH site which will deliver better care for stroke patients. Orthopaedic rehabilitation becomes a home based service in line with best practice of providing care closer to home.
- The Macmillan Unit is assumed to be rebuilt on the Christchurch site, but the final decision regarding this will be subject to the separate review of specialist palliative care provision.
- All current outpatient services at Christchurch Hospital will remain on site. These include main outpatients, the Day Hospital, phlebotomy, physiotherapy, X-ray and ultrasound, dermatology and rheumatology.
- A space utilisation study will be undertaken for those services remaining at Christchurch in order to determine the most space efficient and cost-effective rationalisation of the buildings to provide those services.
- Land identified as spare from the space utilisation work, will then be developed to provide an older people’s village (see information box for details). We would prioritise this to include at least a nursing home and GP surgery, but this may also be able to provide additional services such as a NHS dentist, pharmacy and assisted living accommodation.

2nd Option: The comparator

- Develop Christchurch as a larger older people’s village, potentially with a GP practice, NHS Dentist, pharmacy and related services, a nursing home and assisted living accommodation, and/or other housing subject to local planning.
- The Macmillan Unit and blood taking service (phlebotomy) potentially remaining on site, subject to future consultation.
- All other clinical services to relocate, mainly to the RBH site. Orthopaedic rehabilitation becomes a home based service.

The initial estimates are that under the 1st Option, all of the current services at Christchurch Hospital would fit into approximately half the current building footprint. The other half of the site would then be available for development into the older people’s village. An outline map below indicates an initial view, but detailed work with staff and users will need to be undertaken to review current uses, how to optimise this and best fit with the existing buildings. For example, could relocating the Day Hospital best utilise the vacated SRU, Howard Centre or a refurbishment of H block (the main building facing the lawn)? Relocation of the sensory garden would also be included.

This space utilisation study will be a critical piece of work. It will include reviewing how services operate, including whether different hours and ways of working could optimise space utilisation.

We are keen to hear local views on the potential to develop Christchurch Hospital to offer a broader range of services while preserving existing services.
This is the potential area required to maintain existing services under the 1st option.
What is an “older people’s village”?

This is a working title for a range of related services which could complement the profile of Christchurch Hospital. This is an area we hope to develop as a result of this consultation, and work with interested parties in testing further. Potential partners could include:

- GP Surgery.
- Pharmacy.
- NHS dentist.
- Nursing home.
- Assisted living accommodation

Other ideas arising as a result of this consultation, that are commercially viable, will also be considered. The potential for key worker or other housing uses would also be considered, but priority for the above list of uses is recommended.

The opportunity of a re-built Macmillan Unit, nursing home and other services provides important flexibility and scope for synergies such as in support services like catering, housekeeping, reception and maintenance work. Engaging with potential partners for the older people’s village, and undertaking this work in line with the current NHS space usage exercise, makes sense to fully realise these opportunities.

Initial work on the 2nd Option to identify how existing Christchurch services could fit onto the RBH site indicates this option is feasible. We may then run evening or weekend clinics and further develop more community based services (such as physiotherapy and blood taking). This would help to reduce peak traffic flows which have grown with the locating of the Village Hotel, law courts and office buildings alongside the main road into the RBH site.

Providing we can secure the support of local commissioners, GPs and PCTs to maintaining and funding services at Christchurch Hospital under the 1st option, we are keen to ensure this occurs.

Under both options exactly the same levels of service are provided to patients, as the savings come from reduced building, maintenance and avoiding duplication of costs between the two sites. However, the 1st Option provides those services from the current Christchurch location and maintains the current geographic access.

The initial costings indicate a much larger annual saving in revenue expenditure under the 2nd Option. Broadly, the estimate is £1m - £1.5m more savings per year for the 2nd Option, over the 1st Option. If the 1st Option is preferred at this stage it would lead to having to find greater savings elsewhere. The support of local PCTs and GP Commissioners will be key in ensuring local access to services is maintained and appropriately funded. The 1st Option is a strong and viable option, and one that the Board could support, subject to comments from the consultation and working through the detailed business case with possible partners. It assumes greater savings will not be required by commissioners above the levels set out in Section 3.

Any capital receipts from the 2nd Option would be used to facilitate the building works necessary to transfer specific services. As a result there is no capital gain from any sale, and this is not a factor in the final decision. As a result of the careful financial management by the Trust over the years the capital required to implement either option is available.

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6.4 Timeline leading to a decision

The timeline for progressing to a decision is:

**Up to April 29th 2011**
Consultation on this Annual Plan.

**Summer 2011**
Space utilisation study for existing services.
Engage potential partners for older people’s village.
Develop detailed business case.

**Autumn 2011**
Trust Board decision as to preferred option, followed by engagement with Local Authority Health Overview and Scrutiny Committees to decide if further consultation required.

**Late 2011**
Potential further consultation period.

**2012 +**
Likely dates to implement changes.

As you can see from the above timeline, there is considerable work before a decision can be made. We are though very keen to hear your comments on the process to reach the right decision.

In summary, the Board will evaluate both options. It is however keen, with the backing of local people, our PCTs and GP Commissioners, to explore the potential to preserve a broad range of existing services and develop an older people’s village, providing this is affordable to our commissioners.

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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 11: How to have your say
7. New Models of Care

Given all the potential changes discussed so far, some of the key processes within the hospital will require review over 2011/12 to make sure quality and value are being delivered. The suggested list is:

- The ‘front door’ for emergency care.
- Better discharge and avoiding unplanned re-admissions.
- High dependency care, both post operatively and other (i.e. stroke).
- GP - Consultant collaborations.

Each of these is discussed in turn, but fit well with the issues discussed in previous chapters and within the Quality, Innovation, Productivity and Prevention (QIPP) agenda nationally.

7.1 The ‘front door’ for emergency care

The Emergency Department (ED) is the front door to the hospital. As well as the walk in area, the Clinical Decision Unit (CDU) and Acute Admissions Unit (AAU) provide the majority of the care for shorter stay emergency patients. Patients needing specialist ward, intensive care or a procedure in theatre or the cardiac laboratories will move onto the appropriate place. We intend to recruit a fifth ED consultant in 2011 to further boost senior medical cover for the service.

There are a range of significant factors driving the need to review our model of care. These include:

- Significant reductions in payment for emergency care including re-admissions, effectively removing millions of pounds of funding.
- Reducing numbers of junior and middle grade doctor posts, reducing medical cover.
- The new emergency care indicators (see the box below).
- The potential for alternatives to admission to hospital for a variety of conditions.
- The opportunity to look at synergies with other urgent care services, such as GP out of hours service, the 8am - 8pm open access (Darzi) health centre in Boscombe and ambulance services.

New Emergency care measures:
1. Reduced DVT and cellulitis admissions.
2. Unplanned re-attendance rate.
3. Total time spent in ED.
4. Patients leaving without being seen.
5. Survey of patient experience.
6. Time to initial assessment.
8. Consultant sign off.

Source: DH Indicators

Over 2011 detailed work will be undertaken to look at the best ways of using the current resources to best achieve the performance required, measured through the Indicators. Trials of different ways of working are already progressing, including:

- Acute Respiratory Assessment Unit (ARAU).
handover to other agencies, and/or to carers, will be part of this work. The availability of community services to support patients in the weeks after leaving hospital is critical. Nationally the expectation is for hospital services to integrate with community provision, and via the payment system for the hospital provider to be responsible. Therefore, closer links with services such as CART, CLICS, re-ablement, local nursing homes, community matrons and others is critical.

In line with good practice RBCH is looking at supported discharge teams as the solution to part of these issues. RBCH will look to develop stroke and elderly care supported discharge, building on the work already in place, for example, in Respiratory Early Discharge Schemes (REDS). Cardiac, thoracic and gastroenterology patients will also be high priorities given the large number of patients seen. Work with GPs and community services will be key to ensuring “joined up” care for patients.

Other ways of supporting discharge will also be targeted at patients following surgery. Here preparation through information, education, pre-operative assessment, pain control and other issues can all make significant differences. Many of these are well established in RBCH, but review work will identify what else can be done to ensure these factors, and others, are consistently applied and so to reduce elective patients requiring emergency re-admission.

7.3 High dependency care

The traditional high dependency unit has sat alongside intensive care within most hospitals for many years. However, as the hospital supports more patients who are sicker so the demand has increased. The need for more high dependency beds, with greater staffing ratios, closer observation and more input, has meant increasingly specific parts of the
hospital have required this kind of facility. The Acute Lung Unit (ALU) has for instance, for the last few years, been a significant factor in reducing respiratory deaths in hospital. The demand for these facilities is increasing, whereas the resources are not. An acute stroke with subsequent thrombolytic treatment is another example of where higher dependency care is likely to be required in the future. Others are post major surgery and cardiac treatments. Over 2011 the most cost effective way of achieving these ambitions to improve outcomes will be reviewed.

7.4 GP - Consultant collaboration

Finally, a very traditional requirement will be looked at anew in 2011. This is about finding more effective ways of providing expert opinion from specialists (usually consultants) to GPs and members of the primary care team. The impact of this should be to reduce inappropriate referrals to hospital and unnecessary tests or avoid emergency admissions. Both of these are important to stop the continuing growth in demand for hospital services and, equally as important, to provide better, faster care for patients.

A variety of means are being explored to achieve this and the views of local GPs are being sought. The right methods will vary as well as the priority for what opinions are sought. At this stage ideas that are being explored are:

- Email advice via Advice and Guidance, with guaranteed turn around times in participating specialities.
- ‘Baton’ mobile phone or bleep to allow a conversation between GP and Consultant, often in an acute situation.
- Increasing education, supervision and links.
- Joint work on easy to access protocols.
- The potential for audit and feedback on referrals and admissions.
- Others, to be developed.

These would be designed to complement the work GPs already undertake via peer review and other feedback mechanisms.

Tracking the results such as quality of referrals, following guidelines appropriately and not simply just counting the number of referrals, is crucial to remain true to our principles of improving health outcomes, while staying within available resources.

Comments on these four areas and best ways to progress them are welcomed.

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 11: How to have your say
8 Environmental responsibilities

8.1 Sustainable Management Plan

The Trust has recently developed its Sustainability Management Plan, which sets out the Trust’s commitment and plans for minimising its impact on the environment. This can be found at www.rbch.nhs.uk/sustainableplan.

There is a senior executive lead for sustainability and the Trust has a dedicated Sustainability Manager who will have a broad remit to promote awareness of sustainability issues throughout the Trust. They will also be responsible for targeting initiatives that reduce consumption of fossil fuels and promote sustainable thinking among all staff. The Trust will appoint “sustainability champions” to explore ways of reducing department’s environmental impact and share best practice across all departments.

The Trust continues to make progress in reducing its CO2 emissions and its impact on the environment generally.

Some recent initiatives include:

- Reducing electricity consumption by installing LED lighting. These fittings not only save money but also provide better light quality. Car park lighting in the main visitor car parks will be replaced by LED fittings before the end of March 2011 so that light levels will be greatly improved and running costs reduced.

- Fitting solar panels to produce electricity from the sun. The first of these installations is due to be complete by the end of March 2011. They will produce approximately 16 kilowatts of power and will have paid for themselves within 10 years. They have a...
life expectancy of up to 25 years so the Trust can enjoy almost free electricity from these for around 15 years.

We are committed to installing further solar panels during 2011. The exact size and location of these will depend upon where the greatest benefit can be achieved but with an electricity bill of around £1m per year anything we can do to save carbon and money will be explored.

The Waste Group continues to look at ways we can recycle more but, more importantly, how we can reduce the amount of waste we produce. Procurement is working with suppliers to reduce packaging, ensure products have as smaller carbon impact as possible and that they are delivered in economic quantities.

Procurement staff have received training in sustainable buying and this knowledge will enable them to ensure the Trust receives products that are best value economically and environmentally.

8.2 Green Transport Policy

The Trust’s Transport Policy, developed with other stakeholders, promotes sustainable travel options. We also work with the Local Authorities to highlight areas for improvements such as cycle ways, and to look at joint promotional events.

Transport Policy initiatives include reduced price bus tickets for both Wilts and Dorset and Yellow buses, car sharing schemes and incentives for staff to use bicycles or walk to work where possible.

Last year, the Trust invested in new shower and changing facilities thanks to a grant from Cycling England. Other initiatives for promoting cycling include:

- Providing loan bikes for staff to try before buying.
- A “Pedal Points” scheme, which has been very successful in encouraging people to cycle. Even in the worst of the winter weather we have an average of 100 cyclists per day, increasing to over 200 in the better weather.
- Tax free cycle purchase scheme, which over 200 staff have taken advantage of to buy new bikes. The scheme will be run again in 2011.
- Cycling for commuting and for leisure will feature in several events throughout 2011.

8.3 Smoke free environment

Our hospitals have been non-smoking since 2005 and the Trust runs a smoke stop service. However, recently the Board of Directors reluctantly agreed the introduction of smoking areas and shelters for health and safety reasons, following incidents of illicit smoking by patients and staff.

The aim of the smoking areas and shelters is to reduce the risks associated with illicit smoking. Although smoking shelters have been implemented, the hospital sites remain non smoking in all other areas. Smoking within the hospital buildings continue to be strictly prohibited.

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 11: How to have your say
9. Monitor Annual Plan and Care Quality Commission

As a Foundation Trust, our regulators are:

- Monitor - independent regulator of NHS Foundation Trusts
- CQC - regulator of health and social care in England

Monitor and the Annual Plan

Monitor authorises and regulates NHS Foundation Trusts and supports their development, ensuring they are well governed and financially robust. As part of this, each year Monitor require an annual plan to be submitted. The 2011/12 Annual Plan is due to be submitted to Monitor at the end of May 2011.

The submission requires a more detailed format than the consultation document and focuses primarily on the identification of the risks associated with our plans and the management of those risks. This is to ensure we can successfully deliver our plans.

The final format required for this year’s submission is not yet available, but is expected to be similar to last year. Last year’s submission focused on nine key areas of strategy, along with supporting financials and information schedules.

The nine areas of strategy are:

- Vision & Key Priorities
- Key External Impacts
- Clinical Quality
- Service Development
- Workforce Strategy
- Capital Programmes & Estates Strategy
- Operational & Financial Effectiveness
- Governance & Leadership
- Regulatory

The full Annual Plan details are published by Monitor mid year, and more information can be found at www.monitor-nhsft.gov.uk

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 11: How to have your say
Care Quality Commission

The Care Quality Commission is the regulator of health and social care in England.

From April 2010, all acute trusts were required to be registered with the CQC in order to provide and deliver health care services. In order to remain registered, trusts must demonstrate compliance with the Essential Standards of Care. These replace Standards for Better Health - the framework used by the previous Healthcare Commission.

The CQC no longer issues an annual performance rating for trusts. Instead, trusts are monitored on an on-going basis, to ensure compliance with the Essential Standards.

This can take the form of performance data scrutiny, inspections (announced or unannounced), surveys and soliciting the views of a range of stakeholders.

RBCH currently holds unconditional registration with the CQC.

More details can be found at: www.cqc.org.uk

We will also publish our Quality Accounts later this year, which will provide more detail on our performance and future plans regarding safety, effectiveness and experience of our care.
10. Membership of the Foundation Trust

10.1 Membership report

Membership Composition - to be completed for final version of the Annual Plan in May 2011

10.2 Membership commentary

The Trust has two membership groups: public and staff.

Public

The constituency boundaries are currently under review. 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

All new staff automatically become a member of the Trust. New staff have the option to opt-out of becoming a member but staff employed before 31 December 2009 still need to opt in.

The staff constituencies are:

- Medical and dental.
- Nursing and midwifery.
- Estates and ancillary.
- Allied health professionals, scientific and technical.
- Administrative, clerical and management.

Developing the Membership

The Trust is keen to use electronic means to enhance the benefits of membership. This will provide news about the Trust and our services by email where possible. This will allow us to improve member engagement and to do this at reduced cost. An early example of this is that people wishing to become members can now do so online.

Membership development is an important part of the role of the Council of Governors and the Membership Development Committee continues to review its strategy in order to meet changing priorities. This year the focus will be on engaging with our membership, ensuring that it is representative of the community and on 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 members.

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

The Trust held an Open Day at the Royal Bournemouth Hospital and the League of Friends organised a summer fete. Governors attended these events and were able to recruit new 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. This 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 maintain 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 Board of Directors.
- 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 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, relating to the appointment or removal of Non-Executive Directors, their remuneration, the appointment or removal of the Trust’s auditors and the development of the membership strategy. During the year, the Council of Governors appointed one new Non-Executive Director and renewed the appointment of one existing Non Executive Director.

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 Trust services. 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 run self-appraisal in 2008/2009 the Council of Governors has reviewed its committee structure. This identified ways in which it worked particularly well and areas where it felt it could do better. Areas 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, such as:

- Visiting wards and departments.
- Governor Scrutiny Group to monitor an element of the Annual Plan.
- Visiting patients as part of the Picker Surveys.

The Council of Governors is now supported by eight sub-committees. Also, Governors are involved in a number of Trust led groups.

2011/12 Governor Elections
During the summer months an election will take place to fill thirteen governor seats. Governors will be appointed at the next Annual Members Meeting that will be held in the autumn. The location of these seats will be dependent on the outcome of the constituency boundary review. Members can obtain information about the role of a governor from the Trust website www.rbch.nhs.uk or from the governor co-ordinator.

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 11: How to have your say
11. 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 2011/12 Annual Plan and informing our considerations.

We have outlined a series of questions, included overleaf, which we would welcome your responses to. Any 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 of 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 approximately 200 stakeholder contacts with whom we consult on the Annual Plan. We have planned a series of public meetings as part of the consultation for those who are interested to learn more about our plans and 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 promote 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 to our existing stakeholder contacts list, we have a further list of contacts who are emailed with information on all future consultations. Anyone wishing to be added to the list is welcome to let us have their contact details (see feedback section below).

The 2011/12 Annual Plan public consultation

The 2011/12 Annual Plan consultation runs from 2nd February to 29th April 2011.

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

- Public meeting at the Lecture Theatre, Education Centre, Royal Bournemouth Hospital on 8th March at 6pm.
- Public meeting at Christchurch Borough Council, Council Chambers at Christchurch Council Offices: 29th March, 6pm.

Meetings in public which the Trust is attending

- Poole Health Overview and Scrutiny Committee, Civic Centre, Poole, 15th March at 7pm.
- Dorset Health Overview and Scrutiny Committee, County Hall, Dorchester, 1st March at 10am.

Understanding Health (public health talks) where you can also find details of the consultation

- Understanding Eye Conditions: 28th March, 11am at the Village Hotel, Bournemouth.

Your feedback on our plans

All responses received during the consultation period, 2nd February to 29th April 2011, 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

The final date for responses to be received is 29th April 2011. We would though, be grateful for responses in March, to maximize the time we have to present these at the Board of Directors and Council of Governors meetings.

Comments after 29th April 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 2011/2012 Annual Plan will be published and available to view on our website in June 2011 or by contacting us direct on 01202 704271.

Alternative formats

If you would like a copy of this document in an alternative format, please contact us on 01202 704271 or by emailing us at comments@rbch.nhs.uk.
1. Given the challenges outlined in this document, do you believe that the proposals we have set out within the 2011/12 Annual Plan adequately address the health needs of the local population?
   - [ ] Yes fully
   - [ ] Yes mostly
   - [ ] Not sure
   - [ ] No only partly
   - [ ] Not at all

2. Are there specific issues we should give greater 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. What could we do to improve against the outcome measures listed? (Section 3)

5. In particular, do you have comments on how we can reduce unplanned re-admission into hospital? (Section 7)
6 Is our Transformation Programme an appropriate response to the need to find savings and improve care? (Section 4)

7 What are your views on the approach set out in “organising for clinical excellence”? (Section 5)

8 In the section “Better use of buildings”, do you have a preference for Option 1 or Option 2 and do you have any comments on the consequences of either option? (Section 6)

9 In developing new models of care (Section 7), do you have any comments to add?

10 Regarding our Membership Strategy (Section 10), do you have any comments to add?

11 Are there any further comments you would like to make? Please continue on a separate sheet if required?
<table>
<thead>
<tr>
<th><strong>Glossary</strong></th>
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<tbody>
<tr>
<td><strong>CHKS</strong> A provider of healthcare intelligence and quality improvement services, who run the annual CHKS Top Hospitals Programme</td>
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<td><strong>Choose and Book</strong> Online booking system offering patients booked appointments from a choice of hospitals</td>
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<td><strong>Darzi review</strong> 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</td>
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<tr>
<td><strong>Dermatology</strong> Diagnosis and treatment of skin disorders</td>
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<td><strong>Diabetes</strong> Results from defects of insulin secretion, insulin action or both</td>
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<td><strong>Domiciliary</strong> At home</td>
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<td><strong>Hb1Ac</strong> Measurement of diabetic blood parameters</td>
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<td><strong>Monitor</strong> Independent Regulator of foundation trusts</td>
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<tr>
<td><strong>Oncology</strong> Concerned with the study and treatment of tumors</td>
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<td><strong>Ophthalmology</strong> Concerned with the eye</td>
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<td><strong>Patient Related Outcome Measures</strong> 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</td>
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<tr>
<td><strong>Phlebotomy</strong> Taking blood samples</td>
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<td><strong>Primary Care</strong> Health care provided by GPs or other health professionals to whom the patient has direct access</td>
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<td><strong>Productive Ward</strong> Initiative focusing on the release of more time dedicated to nursing</td>
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<tr>
<td><strong>Pulmonary</strong> Related to the lungs</td>
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<td><strong>Re-ablement</strong> Supporting greater independence and regaining daily living skills</td>
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<tr>
<td><strong>Respiratory</strong> Relating to or affecting breathing or the organs used to breathe</td>
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<tr>
<td><strong>Rheumatology</strong> Diagnosis and management of disease involving joints, tendons, muscles, ligaments and associated structures</td>
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<tr>
<td><strong>Stroke hyperacute / High dependency Care</strong> Intensified care for stroke patients following Thrombolysis or initial diagnosis</td>
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<tr>
<td><strong>Telemedicine</strong> Use of telecommunication technologies to deliver medical information and services to locations at a distance from the care giver or educator</td>
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<tr>
<td><strong>Third Sector</strong> Charitable and not for profit organisations</td>
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<td><strong>Thrombolysis</strong> Dissolution of blood clots</td>
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</table>
**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**

Related to blood vessels

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Description</th>
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<tbody>
<tr>
<td>CART</td>
<td>Community and Rehabilitation Team</td>
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<tr>
<td>CGRC</td>
<td>Clinical Governance and Risk Committee</td>
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<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
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<tr>
<td>CLICS</td>
<td>Christchurch Locality Intermediate Care Service</td>
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<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<tr>
<td>COG</td>
<td>Council of Governors</td>
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<tr>
<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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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<tr>
<td>CT</td>
<td>Computed Tomography</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DTOC</td>
<td>Delayed Transfer of Care</td>
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<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</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>HCAIs</td>
<td>Healthcare Associated Infections</td>
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<td>HFMA</td>
<td>Healthcare Financial Management Association</td>
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<td>HSJ</td>
<td>Health Service Journal</td>
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<td>HSMR</td>
<td>Hospital Standard Mortality Ratio</td>
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<tr>
<td>I&amp;E</td>
<td>Income and Expenditure</td>
</tr>
</tbody>
</table>
IOG  Improving Outcomes Guidance
IT    Information Technology
LOS   Length of Stay
LTC   Long Term Conditions
MDT   Multi Disciplinary Team
MRI   Magnetic Resonance Imaging
MRSA  Methicillin Resistant Staphylococcus Aureus
NHS   National Health Service
NHSLA NHS Litigation Authority
NICE  National Institute for Health and Clinical Excellence
NOF   National Outcomes Framework
NPSA  National Patient Safety Agency
OCN   Open College Network
OPAL  Older Persons Assessment and Liaison team
PALS  Patient Advice and Liaison Service
PbR   Payment by Results
PCT   Primary Care Trust
PMO   Project Management Office
PPI   Patient and Public Involvement
PROMS Patient Related Outcome Measures
QOF   Quality Outcomes Framework
RBCH  The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
REDS  Respiratory Early Discharge Scheme
REPP  Revised Emergency Patient Process
SHA   Strategic Health Authority
SRU   Stroke Rehabilitation Unit
TIA   Transient Ischaemic Attack
VTE   Venous Thromboembolism
YDU   Young Disabled Unit (neuro-rehab)
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**