The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Strategic Plan Document for 2013-16

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Executive Summary

As an integral provider of healthcare within the local Dorset healthcare economy, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) is committed to working with other key stakeholders (patients, commissioners, GPs, other health and social care providers and third sector organisations) to successfully address the challenges facing it and to improve the health outcomes for the local population. These challenges recognise the impact of a predominantly elderly population including increased demand upon healthcare services, a high prevalence of patients with long term conditions, significant levels of avoidable admissions, variations in service delivery between rural and urban areas and significant levels of socio-economic and health inequalities. The Trust has utilised guidance on local priorities and commissioning intentions and national government policy such as the NHS Mandate and NHS Health Outcomes Framework to inform our strategic plans for the next 3 years, as outlined in this document.

The plan sets out the Trust's specific strategy and objectives for clinical services and quality (clinical outcomes, experience of care and safety), meeting its regulatory requirements, leadership and governance and development of its workforce, alongside financial and capital priorities.

The 5 key strategic issues are:

1. Managing the rising emergency workload to ensure safe, appropriate and seamless care
2. Improving the quality of care (safety, experience and outcomes)
3. Maintaining a strong financial position
4. Delivering the contracted services, in both activity and performance terms
5. Developing the business case for merger with Poole Hospital NHS Foundation Trust

Strategically, in relation to addressing these issues and its future direction, the Trust has identified the importance of a process of two-way vertical integration to maintain and grow the quality and clinical sustainability of services, as well as ensure its financial stability over the next 3 years. The two key future strategies that arise from this will be the development of both existing and new community-based services and the long-term consolidation of the tertiary type services within the specialised commissioning agenda.

Financially, the Trust faces a very challenging period given the current economic context. Against a backdrop of recurrent efficiency savings over the past three years of over £24m, about 10% of our total costs, the Trust is required to deliver a further £9.8m (4%) recurrent savings in 2013/14 to fully meet our internal cost pressures and the estimated 1.8% reduction in what we get paid for the work we do.

It is recognised that delivering such efficiencies is becoming more and more difficult, especially given the Trust's reference cost index of 91, indicating that we continue to deliver a mix of services at significantly below the national average cost. Despite this, however, the Trust has detailed plans in place to achieve the required savings without adversely impacting on patient care.

As a result, the Trust continues to plan a modest surplus in 2013/14 to re-invest through our capital programme. The two future years will be even more challenging with the standalone savings identified less than the 4% CIP target. These savings are also RAG rated and at this stage present the trust with a degree of risk. The 2015/16 financial year is broadly balanced through the release of non-recurrent contingency.

1. Strategic Context and Direction

The Trust's vision and goals remain consistent with those that were agreed following consultation on our strategy upon becoming a Foundation Trust in 2005. These are:

Vision

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

Goals

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

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

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

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

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

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

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

However, how to best achieve this vision, and the goals that underpin it, are reviewed each year and adjusted to reflect our honest assessment of how we are performing. These plans are informed via:

- Feedback from patients and the public, through the many mechanisms we have developed.
- Our staff and their views.
- Our Council of Governors.
- Our commissioners (clinical commissioning groups, NHS England commissioners and local authorities).
- Department of Health, via the Operating Plan and guidance, NHS Mandate and the NHS Outcomes Framework.
- Monitor and Care Quality Commission, our regulators.
- Our partners including local councils and other NHS and charitable bodies.

There are then detailed plans and monitoring mechanisms to ensure good governance and assurance of delivery. These are overseen by the Board of Directors. Key metrics for quality and financial management are publicly reported by Monitor and assigned governance or finance risk ratings (GRR and FRR). RBCH has performed well on both these measures over the seven years since becoming a Foundation Trust through regular proactive management of issues, including recently, cancer wait times and results of CQC inspections, both of which required action plans and have now resulted in improved compliance.

The 5 key strategic issues for 2013/14 are summarised as:

1. Managing the rising emergency workload to ensure safe, appropriate and seamless care.
2. Improving the quality of care (safety, experience and outcomes).
3. Maintaining a strong financial position.
4. Delivering the contracted services, in both activity and performance terms.
5. Developing the business case for merger with Poole Hospital NHS Foundation Trust.

This plan focuses on 2013/14 but rightly also considers the longer term issues and solutions.

Therefore, much of the work is multi-year in nature, including issues such as improving clinical services

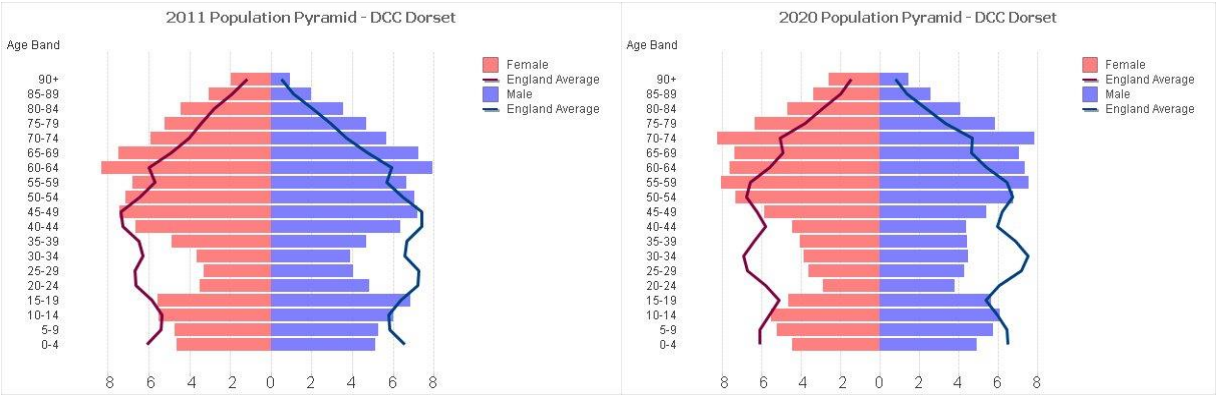
across the district.

2. Local Health Economy

Dorset, Bournemouth and Poole have a combined population of just less than 800,000. The shire county is relatively sparsely populated, along with the other catchment areas served by the Trust, namely the New Forest and South Wiltshire. However the conurbation of Bournemouth, Poole and Christchurch with a population of about 350,000 is urban, with greater density and socio-economic and health inequalities.

The catchment of our services varies by speciality. Numerous factors influence this including historic patterns of service delivery, population density and where the other providers are located. Technology and capacity also affect this, as well as how services are delivered (i.e. if they require complex theatre or laboratory back up, or could be delivered in outpatients only).

The most significant population issues facing the Trust is the existing elderly population and the extent to which this is set to grow over the next few years. This is shown as follows:



The pyramid charts show that Dorset already has a demography that is orientated toward the elderly age groups, with more over 55s than the national average. This position is destined to become more accentuated over the next few years, as the 60-69 “bulge” continue to live locally and into the “4th age” of extreme old age: 80, 90 and 100 year olds. The increasing preponderance of the elderly locally will lead to an increased significance of long-term conditions with key examples including: cancers, rheumatology, diabetes and especially dementia. There are also a rising number of single occupancy homes, which risks greater isolation and reliance on statutory services rather than family support. This can affect rates of emergency admissions, and the difficulty of discharging patients back home.

3. SWOT Analysis

A self-assessment of the strengths, weaknesses, opportunities and threats to the Foundation Trust are summarised below.

The process to undertake this has been influenced by:

- The market assessment
- Strategic alignment assessment with NHS England Mandate
- Gap analysis with the NHS Health Outcomes Framework
- Assessment of commissioner intentions
- Discussions with partner organisations

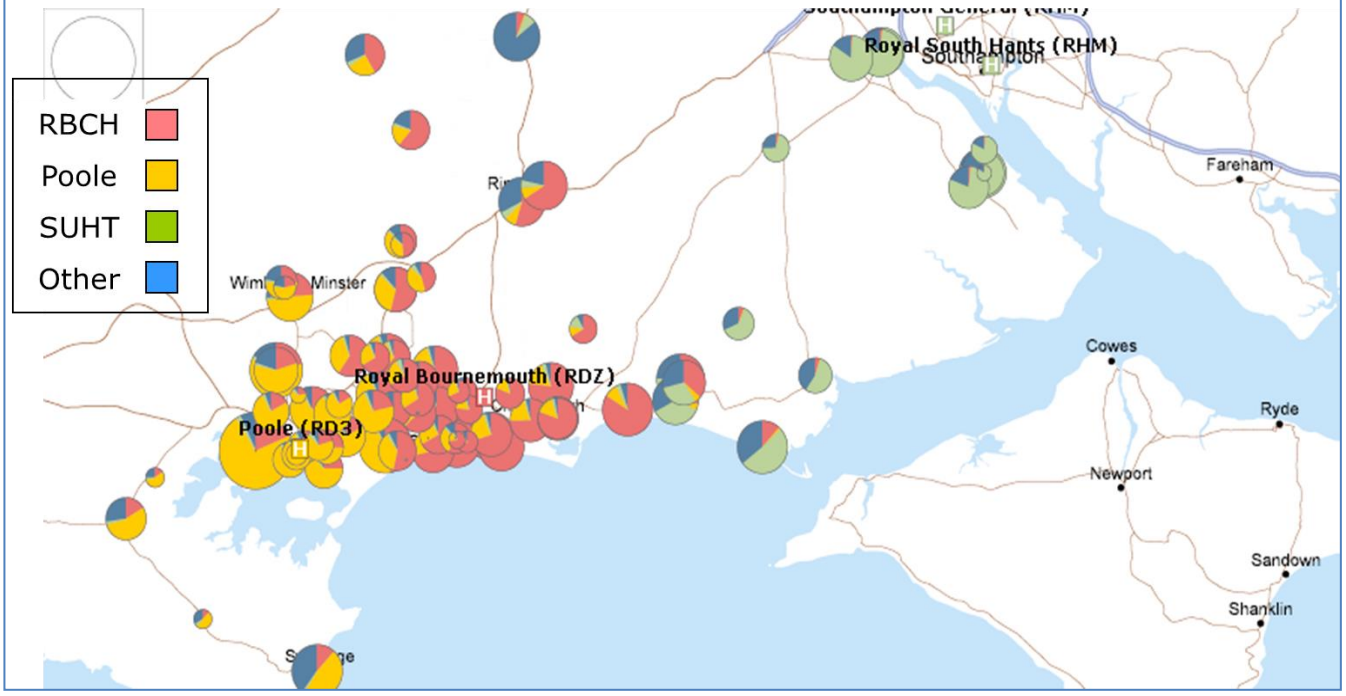
Strengths	How we will exploit our strengths
• Excellent clinical services and clinicians, benchmarking well on most metrics • Trust has record of successful performance - access times, infection control, safety etc. • High level of internal clinical engagement • Strong workforce and leadership • Good clinical relationships with referrers and strong GP sector locally • Corporate consultation processes are robust and effective • Cash reserves allowing capital investment, and financial stability allowing access to borrowing capital	• Developing a stable base to continue to improve on quality of care • Develop partnerships with GPs and others to deliver better health outcomes for patients and the population • We will continue to recruit the best candidates for our jobs ensuring the further success of our services • Opportunity to use our financial strength to make investments that deliver quality and efficiency improvements, such as in IT and estates
Weaknesses	**How we will mitigate the potential weaknesses**
• Poor co-ordination of Trust services with community providers may impact demand control and discharges • Income growth limited while cost pressures (inflation, standards, demand) all increasing	• Change in commissioning arrangements will allow different ways of contracting for services and provide partnership opportunities • The Trust will explicitly develop services into primary care, recognising the impact of this on the overall health economy
Opportunities	**Benefit of Opportunity**
• Shared back office functions to deliver same/better service and release related savings • Develop further strategic alliances and networks i.e. Dorchester and Salisbury • Technology opportunities to improve efficiency, safety, communications and empowerment • Further opportunities to repatriate activity from outside of the County through developing greater specialisation	• Networks will offer the capability to ensure high quality specialist services are available at suitable scale • Trust will be able to recast itself as a provider of services across primary, secondary and tertiary care • With further repatriation of services from outside of the County, patients will be able to access services more locally
Threats	**Actions to Mitigate the Threats**
• Competition for skilled workforce and declining medical training numbers • Increasing need for clinical scale as defined by Specialist Commissioners and Royal Colleges • Competition for patients from other providers, especially in “cherry- picking” certain services • Preference of commissioners to centre services within primary care/the community that may destabilise acute care services • Increasing costs, challenging cost improvement and income losses risk financial instability	• Local area popular for relocation so we can use this to ensure that we recruit the best candidates for jobs • We have many services that previously would only have been in tertiary centres and we can build on these to ensure their continuity • Specialist services agenda provides clarity in determining the requirements for specialist services and we will be able to use this to ensure that our services meet these

4. Market Share and Competition

The map below shows East Dorset, with each circle being a GP practice. This shows the divide in services between ourselves and Poole Hospital, down the middle of the conurbation. The size of circle indicates the scale of secondary care activity (of both planned and emergency admitted care, including day case work). There is evidence of a clear linkage between provider and distance with the majority of patients choosing their local hospital. However the main reason the Bournemouth and Poole practices do not have near universal coverage in their immediate vicinity is less due to choice, but the portfolio of services. For example Bournemouth practices need to use Poole for admitted care in Paediatric, ENT, Trauma and Oncology.

The main areas showing greater mix in providers is across the New Forest. Southern Health (at Lymington Hospital), University Hospital Southampton, Salisbury NHS Foundation Trust and RBCH again all reflect geographic proximity and service portfolios. Maintaining or growing share in these practices remains a constant watching brief, and one that a strengthened IT support will most successfully support, as a major barrier has been linkages with GP practice systems.

Market Analysis: Map GPs (Elective and Non-elective, admitted care spells)



Significant changes in other providers in the vicinity possibly occurring in the next 1-5 years include the following:

- Potential for establishing a part private/part NHS elective hospital in the middle of the Bournemouth/Poole conurbation. With 24 beds and 4 theatres it would be expected to have a high surgical component especially in Orthopaedics, given the large private market.
- The Nuffield Health private hospital in Bournemouth and BMI Harbour Hospital in Poole continue to develop niche NHS services, especially in day case elective surgery where both have capacity. However these, along with other AQP providers for Dermatology and Endoscopy, are in areas where demand is increasing significantly and therefore some of this risk is mitigated by volumes increasing. The Trust intends to qualify as a provider to maintain these existing services and income.
- Dorset Healthcare University Foundation Trust (DHUFT) is also developing elective capacity in its community hospitals.

Commissioners may seek to tender services over the next few years, but specific plans are not known at this stage. It is a working assumption these will be focused on services that are more outpatient and community based, as the greatest numbers of competitive tenders are likely to come from here, and GPs are most interested in these as both providers and commissioners.

We have actively participated in a variety of tenders for clinical services, including Any Qualified Provider. However, the precise evolution of policy on competition and choice continues to be negotiated nationally and therefore the extent of local manifestation of this remains uncertain.

There is not considered to be any competition for emergency care, as this is both growing rapidly and not something any other providers wish to take on. It is a major objective of the local health economy to reduce the levels of inappropriate or avoidable admissions as this is better for patients, carers and taxpayers.

5. Commissioning Intentions

The NHS Mandate

On 13th November 2012 the Secretary of State for Health published the NHS Mandate. This set the key objectives for improvement that NHS England need to deliver on up to 2015. The NHS Mandate includes the updated NHS Health Outcomes Framework, with which the government will hold NHS England to account. In turn we would expect the rest of the health system, such as regulators and clinical commissioning groups, to align around the NHS Mandate and the Outcomes measures. As such the Mandate has a vital role in setting out the strategic direction for the organisation.

The objectives of the Mandate focus on the role of the NHS in preventing ill health, managing ongoing physical and mental health conditions, helping people recover from episodes of ill health, experience better care, as well as improving safety. Those areas correspond to the five parts of the NHS Outcomes Framework, which align with the Trust's key strategic direction and will be used by the Trust as the instrument to measure progress.

Income Contracting and External Environment

The significant changes to the NHS commissioning structures with GP- led clinical commissioning groups (CCGs) are well established locally, with strong engagement from the Trust and a shared vision of population health gain and high quality, sustainable services. This plan is developed with reference to the NHS Dorset CCG Strategy 2013-18 and the Bournemouth and Poole Health and Wellbeing Strategy 2012- 2016. Features of both strategies include the delivery of 'Care Closer to Home', integrated care pathways and the management and optimisation of outcomes for patients with long term conditions.

The wider picture remains unchanged with at least five years of austerity, whilst an ageing population, rising expectations and technology provide a stimulus to constantly reappraise how we can provide more, with less.

The overall Annual Plan update provides practical examples of how the Trust will deliver its strategic objectives, updated in the light of these observations.

Working with partners such as Dorset Healthcare University Foundation Trust, local councils and the third sector will help RBCH to broaden its positive impact on health outcomes. These will be measured through the Health Outcomes Framework and early examples are included in the plan. Emergency care with greater GP input and support for discharge home, as well as more help for patients with long-term conditions to self-manage all create greater independence and quality of life.

Taken together, these responses to our environment, along with the plans included below, represent our best approach to the future.

Contracts for 2013/14

Over February to May 2013 the Trust and commissioners agree activity and tariff based costs, so as to inform the budgeting for 2013/14.

Overall the assumption is to slow the historic growth in demand, by reducing variation and closer working with GPs. However, significant activity pressures remain, especially in:

- Emergency admissions, especially out of hours, putting pressure upon achievement of the 4 hour maximum wait target.
- Cancer 2 week wait referrals and overall cancer wait times.
- 18 week waits, especially Orthopaedics, Upper GI and Urology, with increasing GP referral numbers.
- Diagnostic waits, especially Endoscopy and Radiology (MRI / CT)

These are all being proactively managed, with redesign and capacity flexibility being applied, along with strong partnership working, especially with local GPs. However the Trust Board statement, and communication with commissioners, have both highlighted that the first three standards are at risk of not being achieved in 2013/14. This is the first time the Board has formally indicated this, and the main underlying cause is the rise in emergency admissions. This is an issue that many acute hospitals have seen, especially over the last year. Joint working through the local Urgent Care Board will seek to mitigate this national trend and a dedicated emergency care fund has been established by commissioners.

Specialist Commissioning

Specialised services are those services provided in relatively few hospitals, accessed by comparatively small numbers of patients, often with a catchment population of more than one million. The Dorset, South Wiltshire and eastern New Forest area, plus the higher age profiles and greater morbidity, often mean the Trust meets the threshold that determines a specialist service. However in some circumstances this is on the borderline. Networks of care, often with Dorset County and Salisbury Hospitals, help to ensure services can remain local, such as clinics, but inpatient care is concentrated to ensure safety and viability can be maintained. Examples include vascular and interventional radiology, and various forms of cancer surgery.

The work currently underway with the national Clinical Reference Groups (CRGs) for specialist services has now produced a large range of service specifications and clinical commissioning policies. These are important in clearly defining what NHS England expects to be in place for providers to offer evidence-based, safe and effective services. They have been developed by specialist clinicians, expert patients and public health representatives to describe core and developmental service standards. Core standards are those that any reasonable provider of safe and effective services should be able to demonstrate, with developmental standards being those that really stretch services over time to provide excellence in the field.

Many specifications are still being reviewed and amended but the direction of travel is clear. This is towards greater transparency and equity in applying both clinical and cost-effectiveness to these services. In many cases this will require services to change and either to network or centralise. Much has already occurred across Dorset but the next two to five years may see further change and this will be a regular area of review, with the NHS England local area team for Wessex.

Within the Trust work is underway to assess the gap between the national aspirations and our local services. This will be followed by the commencement of work to close the gaps to fully meet all specifications for existing services.

6. Clinical Services and Quality

This section describes how we intend to improve the quality of our clinical services and focuses upon:

1) Clinical outcomes (including mortality and effectiveness measures).
2) Experience of care (as measured through patient surveys).
3) Safety (avoiding harm).

There are extensive programmes in place to ensure safe, effective care, delivered in a way that puts patients first. We therefore measure well on many aspects of quality, including very low infection rates.

We have been recently listed as the second highest scoring trust in England (out of around 150 other trusts) for patient specified measures of quality.

There is always room for improvement however and our focus over the next 3 years, in line with our Quality Report, will be in the following areas:

- To continue with our "Harm Free Care" programme to reduce falls, pressure ulcers, urinary tract infections from catheters (CA-UTI) and hospital acquired Venous Thromboembolism (VTE) using the "Safety Thermometer" approach. This is the main priority set out in our Quality Report.
- To implement a new "Releasing Time To Lead" programme for ward clinical leaders.
- CQC Essential Standards assurance.
- Reducing mortality as measured by HSMR and SHMI metrics.
- Complying with CQUIN standards including:
  i. Implementing dementia strategy and early diagnosis and referral.
  ii. Knee replacement patient related outcomes measures (PROMs).
  iii. The delivery of respiratory discharge care bundles.
- Embedding 'Ward to Board' reporting to allow more rapid and transparent identification of variations in quality metrics so as to support continuous improvement on each ward.
- To focus upon the improvement of the patient experience in areas such as response to call bells, reduction in noise at night, privacy and dignity, same sex bathrooms/accommodation and information upon discharge.
- Continuing to develop our patient engagement strategy and implementation of the "Friends and Family Test", to track the level of recommendations for treatment at the Hospital.
- Developing ways to reduce emergency re-admissions through audit and review of best practice, and expanding actions taken in 2012/13 such as:
  - closer GP working
  - patient information
  - supported discharge
  - telephone follow ups.
- Supporting the improvement in End of Life Care, both within the Trust and in the community settings.

Further information about the quality measurement and improvement work will be published as part of the Trust's Quality Report in May 2013. Monthly quality reporting in the public Board of Directors meetings will continue to ensure transparent assurance as to safety, effectiveness and experience of the care provided.

In addition, the NHS Outcomes Framework will also be developed, measuring 60 indicators under these three broad headings above. Many of these are local health system measures, requiring long-term multi-agency, multi-faceted approaches (e.g. cancer mortality rates). Here clinical quality

improvement work will need to work on issues beyond our immediate sphere of influence, as well as those we are directly responsible for, such as hospital safety. This will require us working ever more closely with primary, community and social services as well as supporting patients and carers to manage their own care more confidently. Specific focus will be on the quality premium priorities, which include emergency admissions, infection control, friends and family test, avoidable mortality, knee PROMs, respiratory care discharge bundle and dementia screening.

The Trust will also work with partners on developing the "Health Promoting Hospital" approach supported by the World Health Organisation (WHO). This is focused on ensuring the effectiveness of the NHS "brief interventions" and signposting to "make every contact count", so that patients gain the widest possible health benefits. These include diet, exercise, smoking, alcohol and positive mental attitude.

There will also be a partnering with local charity Help and Care and other organisations. This is to develop a self-care support service for patients with long-term conditions, in line with commissioner specifications. This combined with the "Health Promoting Hospitals" approach will help increase RBCH's contribution to wider health outcome improvements.

Regulatory Requirements

This section of the plan deals specifically with the risks of non-compliance with CQC and contractual requirements including meeting the NHS Constitution requirements. Further requirements in self-regulation include good governance in financial, quality, information governance and other processes and procedures. Most of these have external audit. The Trust has an extensive system of Board and sub-committee reporting, which includes anticipating and mitigating risks, identifying accountability and delivering robust action. This is embedded in the Assurance Framework which, via the Clinical Directorates and the corporate risk register, identifies, quantifies and manages risk across the diverse and complex nature of an acute hospital workload. This process for clinical care in particular is overseen by the Healthcare Assurance Committee, which reports directly to the Board.

In assessing the most significant risks facing compliance with regulation in 2013/14, they include:

- Delivering safe care, especially for emergency admitted patients, in the light of significant rises in demand. This creates a risk for sustained delivery of the 4 hour maximum wait policy in ED. This is being managed through integrated working with New Wave (GP collaborative), additional medical, nursing and management focus and improved flow through the hospital and safe discharge from hospital beds.
- Maintaining cancer waiting times (in particular achieving the 62 day target) in the face of significant increases in fast track (two week wait) referrals and very large rises in screening and surveillance work, especially in gastroenterology and urology. Detailed action plans exist to manage this but CCG joint work is essential to ensure external demand is appropriate and predictable. Investment in additional staffing and treatment capacity and IT support systems is underway.
- 18 week NHS Constitutional requirement for treatment and national rule changes for 92% RTT on incomplete pathways, and speciality level compliance. This will require greater headroom against performance targets, especially in Orthopaedics, Urology, Upper GI Surgery and Gastroenterology, which means greater and more flexible capacity, as well as continued work to manage demand and variation.
- Infection control and maintaining our very low rates for MRSA and Clostridium difficile (C.diff) through detailed work overseen by the Trust's Infection Prevention and Control Committee.
- Control of exposure to Legionella risk through regular monitoring and large range of preventative measures, in line with the Trust policies.

The other major piece of work is developing the business case for merger with Poole Hospital NHS Foundation Trust and this will entail a continuation of the significant time and resources required and potential disruption to those staff that may be affected by change. Significant governance, additional resource and expertise are part of the plans to avoid this work diverting attention from delivery of the

annual plan requirements for 2013/14.

Leadership and Governance

The leadership skills and supporting governance processes are critical to delivery of the plan. To achieve this several key work streams will continue to be developed over 2013/14 and beyond based around:

a) Merger governance to manage the application processes including Competition Commission assessment. From September onwards Monitor will also assess the Integrated Business Plan (IBP) and the governance arrangements of the new organisation. This will be a significant area of work in 2013/14. After this the Implementation Plan will then track delivery of the merger benefits. In brief, this will be led by the proposed Board of Directors, the membership of which is drawn from each organisation and will also include external appointees.

b) Governors ongoing training and support (for new and established governors). This will continue, along with the development of governor input into both Council of Governors led, and Board led committees. In addition, activities related to merger such as joint working with the Council of Governors at Poole Hospital NHS Foundation Trust, will accelerate including the recruitment of members for the proposed merged organisation, from which the elected members of the new Council of Governors will come.

c) Membership Development Strategy. The Council of Governors have approved a specific work plan for 2013/14. This includes both recruitment of new members and engagement of existing members. The broader work programme sets out the Council of Governors' objectives including scrutinising the Board of Directors' work. Also there will be specific work in relation to the merger proposals, including appointment of non-executive directors for the proposed Board of Directors.

d) Recruitment to the non-executive Board vacancy on an interim basis has occurred following the decision on merger now not being until the end of the financial year. Ian Metcalfe was appointed and is an experienced non-executive director, having previously served on the Board.

e) An organisational development strategy will continue to be developed using the excellent work of the change leaders, facilitated by The King's Fund, as part of the appreciative inquiry approach to establishing what is important to staff.

f) Following successful completion of the Jigsaw funding appeal, the change in government legislation and accountancy rules for NHS charities, and a year long review, the Board have supported the direction of travel toward an independent charity to safeguard and take forward the excellent support we have to go above and beyond what we can offer local patients. A process will occur over 2013 to develop this proposal.

7.Clinical Strategy

The potential merger of the Trust with Poole Hospital NHS Foundation Trust has entailed a significant level of work including determining the overall strategy of the merged organisation and shadow directorate plans. Clearly the decision on whether merger goes ahead or not will have a significant impact on the future plans of both organisations. However, much of the work done can be utilised even if the Trust does not merge since many of the issues considered remain the same.

At a corporate level the Trust has considerable variety of strategic choices in terms of its future direction and two fundamental strategies have resulted from this.

1. The Trust has concluded that given the overall direction of current government policy (specifically at the Department of Health), the Trust will seek to develop its services in community settings and will endeavour to develop new services in the community, especially through partnerships.
2. The development of the specialised commissioning agenda has significant implications for us, mainly because we have been so successful at developing tertiary type services on a local basis. This gives us an opportunity to consolidate these services on a long term basis and we are currently active in determining the degree to which we are meeting the draft specifications.

Service Developments

The key service developments for 2013-15 include:-

- The review and reconfiguration of the inpatient Haematology unit and service
- Review of acute surgical services
- Full implementation of the new model of care for the Emergency Department, covering 24/7 with additional consultant and middle grade cover.
- Further strengthen the emergency "front door" by:
  - more senior medical time, including from Medicine for the Elderly Consultants (MFE) and senior GP presence
  - enhanced Older People's Assessment & Liaison Service (OPAL)
  - alcohol and dementia specialist nursing
  - new cardiac and respiratory pathways.
- Develop an integrated emergency response with South Western Ambulance Service NHS Foundation Trust ambulance and out of hours service, GPs, care homes, DHUFT and Social Services, based upon shared principles, including assessments occurring in non-acute settings which can dramatically improve long-term outcomes for patients and local services.
- To build upon recent developments such as the delivery of Ophthalmology services from Blandford Community Hospital and a 7 day a week TIA clinic in conjunction with Poole and Salisbury Hospitals and develop more "Care Closer to Home" in a wide variety of services, including exploring :
  - Support GPs and nursing homes to manage patients in community settings
  - Phlebotomy (blood testing) in more community settings
  - Physiotherapy in more community and sports venues
  - Provision of community chemotherapy
  - Further develop community based diabetic services
- Develop local anaesthetic, "awake" surgery to allow more rapid patient recovery after a procedure
- Transforming the operating hours and booking process for elective surgery, to improve patient flow and efficiency and rationalise theatre timetables.
- Develop a formal vascular network with Dorset County and Salisbury Hospitals, including interventional radiology.

The Trust is in the process or reviewing and redeveloping its private patients' strategy. In essence our intention is to continue to build incrementally on our existing significant private income, currently predominantly in radiology and cardiology. This work is largely based on our continued investment in "best of breed" capital investments and by using our high quality bedded and ambulatory services more creatively. The NHS benefit is income to offset funding reductions, better equipment and estates (than would otherwise be affordable) and security of jobs and staff income.

Allied to this we are developing a more proactive approach to research and innovation. We have long had an active research base across many specialities, but these have been developed separately at departmental / specialist level. We are keen to develop a Trust-wide approach to ensure that this culture is prominent across all Departments. The Trust has been in discussions with Bournemouth University regarding being granted University Hospital status, predicated on being a merged organisation.

Workforce Plans

Priorities for developing the Trust's workforce over the next 3 years include:

- Undertaking the Trust and Directorate level actions arising from the staff survey
- Working to implement the latest changes to Agenda for Change, especially around increments and appraisals.
- Continuing to support the management of sickness absence and the monitoring of appraisal and training compliance to reach internal targets of 3.5% and 90% respectively.
- Developing the staff welfare package of measures, including health & fitness, easier travel to work and improved take home pay.

In addition to the core Human Resource functions the potential merger with Poole Hospital NHS Foundation Trust gives rise to a number of work streams both corporately but also for the Human Resources Directorate itself. The plans include:-

- Planning for an Human Resources Directorate which meets the needs of the combined trusts through aligning processes, reducing duplication and standardising activities
- Preparing for the potential TUPE transfer of staff into the new merged organisation
- Consulting with Trades Unions on planned workforce changes and new policies and procedures

8. Productivity & Efficiency

The Trust has an extensive and successful track record of delivering Cost Improvement Programmes (CIPs). Our approach for our 2013/14 transformational savings plan has been to focus on higher percentage savings outside of clinical services. As a high level summary, these plans include:

- Length of Stay- using a range of measures around admissions, patient pathway and discharge management. This will include ensuring that the right patient is seen in the right place at the right time to improve clinical outcomes and therefore safely reduce length of stay.
- Procurement- through the purchase of goods and services, retendering and managed services
- Pharmacy –a variety of measures such as retendering, homecare services, prescription management and migration to off patent drugs
- Year Two of Corporate Services Transformation (10% reduction in costs) through efficiencies in corporate functions
- Theatre Utilisation- the development of a new theatre timetable, including speciality based theatres running extended days
- Private work (see section 7)
- Radiology Systems- joint procurement of new IT systems

All of the above projects are supported by coherent governance arrangements, including tracker and summary reporting by directorate to the Trust's Finance Committee. The Trust has fostered strong clinical engagement within the CIP programmes and the clinical directors for each directorate report their directorate's CIP performance to the Board. The governance arrangements are managed by the Project Management Office (PMO). The PMO reports to the Executive team and ultimately ro the Board.

All major projects have a steering group with clinical membership and use a PRINCE based project management methodology. All of the CIP plans have a Quality Impact Assessments for which the

metrics will have been chosen by the project team and are therefore specific to each project. Several of the Trust standard documents (CIP finance reports, business cases) now have a mandated section on Quality Impact Assessments and for CIPs these are signed off by the Medical Director and Director of Nursing and Midwifery as further assurance.

Given the four previous years' experience of cost improvement over delivery, the Trust is cautiously confident of delivery of the financial values, in ways that maintain or enhance patient care.

9. Financial and Investment Strategy

Capital Plans

As a result of the strong financial position achieved over many years, the Trust is able to re-invest the surplus into capital programmes for equipment and estates. We shall continue our programme of new and replacement equipment, with a particular focus on theatre equipment and minimally invasive (laparoscopic or keyhole) surgery, which improves patient outcomes and safety.

There will be several major schemes in 2013/14, including:

- The new Jigsaw building for cancer and blood disorders and Women's Health (Breast and gynaecology), with building starting in Autumn 2013
- Additional endoscopy facilities to meet increasing demand in the only JAG quality assured facilities in the locality
- Developing a major bus hub and covered walkway to the hospital to encourage more visits by bus, and improve traffic flow at the hospital entrance
- Refurbishment of residences to improve staff accommodation
- Major investment in Information Technology (IT), such as network upgrades, and systems including electronic National Early Warning System (eNEWS) to promote patient safety through rapid escalation of deteriorating patients
- Initial work in major energy saving projects, to reduce costs and carbon footprint

In addition the Trust Board will decide in summer 2013 about the multi-million pound investment in Christchurch Hospital. The plans now have local authority planning approval, and include a new GP surgery, x-ray department and major upgrades to all the clinical service buildings. There are also enabling schemes of community benefit for assisted living units, an 80 bed nursing home and key worker housing coming on site.

The funding is intended to come via the Trust's borrowing capacity with the Foundation Trust Financing Facility. Therefore the strategic plan financial template *does not* include this major invest to save scheme, as the Board have not yet agreed the full business case. The Trusts capital plan will be updated following Board and loan approval, and whilst not large enough to be a major transaction Monitor, and other partners, will be kept informed of this exciting scheme to secure services locally.

Subject to those agreements, and the subsequent legal agreements with partners in the development of the site, work is expected to start in late 2013 and continue till early 2015.

Summary financial commentary

The Trust has achieved a remarkable level of efficiency savings over the past three years through the Better Care, Better Value transformation programme. This totals over £24m recurrent savings, about 10% of our total costs. This is whilst the Trust has continued to measurably improve the quality of care and deal with higher levels of activity, especially in emergency care and cancer referrals. This makes us one of the most cost and quality efficient providers in the UK. Our reference cost index (a measure of efficiency) is one of the best in England. We still however need a further £9.8m (4%) recurrent savings in 2013/14 to fully meet our internal cost pressures (especially pay), and the estimated 1.8% reduction in what we get paid for the work we do. This is a significant challenge, but one the Trust is

well placed to respond to.

Given the wider economic context, we do not expect nationally for NHS funding growth to return to pre-recession levels, however CCGs received 2.3% growth for 2013/14, on top of inflationary rises in previous years. NHS provider income growth has been substantially below this, leaving commissioners considerable headroom to invest elsewhere. This includes community services to reduce demand, especially in emergency and chronic conditions.

The cost pressures facing the Trust include:

- Investment in emergency care services, i.e. Emergency Department and Treatment & Investigation Unit
- Pay
- Nursing Costs to support greater numbers on wards
- NHS Litigation Authority premiums
- Utilities with rising energy costs
- Tariff Deflator

In setting our budgets we will seek to secure full payment for the goods and services we provide to commissioners and make a modest surplus to allow re-investment in equipment and buildings. In the face of yearly cost pressures and tariff / income reductions a surplus also allows us to stay ahead of the financial pressures, which if not addressed, can rapidly affect the amount and quality of care we deliver.

A significant amount of work in the first half of 2013/14 will be the development of the following five years Integrated Business Plan with Poole Hospital NHS Foundation Trust and the long-term financial projections that underpin this. This will need to meet the stringent financial modelling requirements equivalent to an application for Foundation Trust approval. As such, the business case for merger will need to demonstrate the financial and clinical sustainability of the new organisation. This will require a “base case” of approximately £60m savings (5% pa over three years). A “downside” scenario of a further £20m of savings will also be needed to demonstrate how, if income and activity fall significantly, the new organisation can respond. Such a change would be unprecedented but the work started in 2012 is good preparation for these future scenarios that may occur in the five year period from 2013, with greater detail in the first three years.

These savings are required of all trusts (regardless of merger). What the proposed merger allows is access to greater savings that protect or improve frontline clinical care. Approximately £15m of these savings can only be released through merger. A further £10m are enabled to happen more quickly and easily. In addition various cost pressures are also avoided by combining teams and support services working across the district. Capital spending, especially on IT and estate is far more efficiently developed, reducing the costs that the two trusts (and taxpayers) would have to incur.

Overall as a stand-alone organisation, not accessing the clinical benefits of merger, and facing even greater financial pressures (if blocked from accessing the economic benefits above), the future is considerably more difficult. Therefore the Board continues to work through the due process for merger, including being the first NHS applicant to the Office of Fair Trading and Competition Commission. The overall process, including Monitor assessment, is likely to take the full financial year until the end of 2013/14 to complete.

The financial templates submitted as part of this plan are based on a standalone basis and includes those savings currently identified in 2014/15 and 2015/16 that are non-merger dependent. The value of these schemes does not add up to the required 4% CIP. To achieve a balanced financial position in 2015/16, required the release of £1.3m of recurrent contingency. This plan is based on the latest information available and the Trust will continue to work up new schemes to avoid the use of the contingency. The CIP schemes in 2014/15 and 2015/16 are currently RAG rated and work is in hand to move the red rated schemes to amber and green.

Key priorities which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's strategy, with milestones of delivery of each over the period of the plan:

Key Priorities	How this Priority underpins the strategy	Key milestones (2013-14)	Key milestones (2014-15)	Key milestones (2015- 16)
Goal 1: To offer patient-centred services through the provision of high quality, responsive, accessible, safe, effective and timely care.	Deliver the Trust's quality and safety programmes such as "Harm Free Care"	Embed safety express safety thermometer tool and ward to board reporting Achieve at least 95% harm free care across all 4 harms (falls, UTI, VTE, pressure ulcers) Introduction of an electronic National Early Warning System (eNEWS) Implement "Time To Lead" programme for ward clinical leaders	Embed action plans and service improvements from safety thermometer reports. Implementation of electronic prescribing	The introduction of an Electronic Patient Record
	Improve the whole system approach to urgent and emergency care	Reduction in emergency re-admissions through audit, adoption of best practice and post discharge support The implementation of a new improved model of Emergency Department cover with increased medical cover and specialist nursing and Allied Health Professional input The development of an integrated emergency response with local partners. Agreed action plan and funding with partners and KPIs		
	To deliver care 'Closer to Home' in a variety of community settings	The establishment of close working models with GPs and nursing homes to support the management of patients in community settings	The transfer of some outpatient Physiotherapy services into community and sports/ leisure venues	

	Improved inpatient flow and throughput along the whole pathway	The delivery a proportion of Phlebotomy services in community settings	The implementation of a community chemotherapy service The growth of admission avoidance and supported discharge models to reduce LOS	
Goal 2: To promote and improve the quality of life of our patients	Further develop our services especially around long-term condition (LTC) self-management and the health promoting hospital. Deliver agreed CQUIN targets including respiratory discharge care bundle, knee replacement PROMs, VTE and improvements in dementia diagnosis	Qualification as a 'Health Promoting Hospital' Development of bid for long-term conditions self-care support services Quarterly progress reporting against CQUIN action plans	Embed the 'Health Promoting Hospital' approach and culture across the Trust Quarterly progress reporting against CQUIN action plans	Quarterly progress reporting against CQUIN action plans
Goal 3: To strive towards excellence in the services and care we provide.	Deliver and exceed regulatory requirements Develop models of care and reconfiguration where necessary, to achieve centres of excellence	Achieve all governance targets, in all quarters CQC Essential Standards compliance Specific Plans for Centres of Excellence & Clinical Strategy as part of Merger Integrated Business Plan (IBP) by Q1 The development of plans for the review and reconfiguration of the inpatient Haematology service To undertake a review of the Acute Surgical service Assessment and action plan to close	Achieve all governance targets, in all quarters. Extension to Cardiac Department To implement Haematology inpatient reconfiguration plans To deliver action plan from Acute Surgical service review	Achieve all governance targets, in all quarters. The establishment of combined centres of excellence (dependent upon merger outcome)

	Assess current services against the Specialist Commissioner Specifications	gaps by Q1 Secure specialist commissioning goals and successful service delivery	Secure specialist commissioning goals and successful service delivery	
Goal 4: To be the provider of choice for local patients and GPs.	Undertake a "listening" exercise with the local public and GPs to understand what they most value, and what they wish to protect and what to change Improve patient experience through enhanced engagement To significantly develop the Christchurch Hospital site To actively participate in AQP tenders as appropriate to both maintain and grow services	Structured approach using independent facilitation Q1-Q2, to report and inform Trust plans Implement Friends and Family Test in all clinical areas by Q3 Regular reporting and achievement of targets for Friends and Family test The finalisation of plans and commencement of work on the redevelopment of Christchurch Hospital To qualify as a provider for AQP Endoscopy and Dermatology services	Formal public consultation around significant service reconfiguration post-merger (if appropriate) Regular reporting and achievement of targets for Friends and Family test Christchurch Site redevelopment	Regular reporting and achievement of targets for Friends and Family test The completion of Christchurch Hospital development
Goal 5: To listen to, support, motivate and develop our staff.	To build upon the initial work undertaken via a process of appreciative inquiry to inform organisational direction Further roll out of staff welfare schemes Achieve high levels of staff satisfaction (as measured by staff survey)	The completion of an organisational development strategy In place by Q2, with take up improving over the year. Includes Staff Welfare Advisor positions to support implementation Annual survey, with subsequent action plans from 2012/13 in Q2 and survey in Q3	To achieve significant increase in uptake of the Staff Benefit Schemes by Q2.	

	Continue to improve sickness and appraisal rates To further develop and support the role of the Trust Governors	Ongoing actions with 3.5% sickness and 90% appraisal targets. Implementation of Membership Development strategy and wider work plan		
Goal 6: To work collaboratively with partner organisations to improve the health of local people.	Develop the business case for merger with Poole Hospital NHS Foundation Trust Develop partnerships with GPs and others to deliver integrated care Continue to exceed our carbon reduction targets	Submit evidence to the Competition Commission and complete by June 2013 Complete IBP case and submit to Monitor September 2013 Submission of joint partnership bid to provide self-care support services for patients with long term conditions. The development of a formal vascular network with Dorset County and Salisbury Hospitals, including interventional radiology To implement the following carbon reduction plans: - Sustainable Procurement Policy - Climate Change Risk Mitigation Plan - Waste Management Strategy	Consolidation of the merged organisation (if appropriate) Development of formal joint ventures with partners such as GPs Establishment of GP Order Comms system	To achieve the Trust's target of an overall carbon reduction of 10%
Goal 7: To maintain financial stability enabling the Trust to invest in and develop services for patients.	Delivery of the transformation plan savings of £9.8m Deliver the capital plan investments to improve services Develop a private patient strategy To revise the Trust's charity	Quarterly delivery against plan Ongoing monitoring each quarter against plan Agree plan and actions of implementation strategy	Delivering the Transformation, Capital and Private Patient Programmes in 2014/15 Implementation in key services e.g. Chemotherapy, Gastroenterology	

	support structure towards an independent charity	The development of an independent charity		