

The Royal Bournemouth and 
Christchurch Hospitals
NHS Foundation Trust

Strategic Plan Document for 2014-19

**The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust**

This document completed by (and Monitor queries to be directed to):

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Date

30th June 2014

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and
- The 'declaration of sustainability' is true to the best of its knowledge

Approved on behalf of the Board of Directors by:

| | |
|-----------------|----------------|
| Name (Chair) | Jane Stichbury |
|-----------------|----------------|

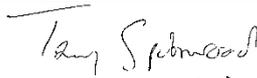
Signature



Approved on behalf of the Board of Directors by:

| | |
|---------------------------|----------------|
| Name (Chief Executive) | Tony Spotswood |
|---------------------------|----------------|

Signature



Approved on behalf of the Board of Directors by:

| | |
|----------------------------|---------------|
| Name (Finance Director) | Stuart Hunter |
|----------------------------|---------------|

Signature



1.1 Declaration of sustainability

| | |
|---|----------------------------------|
| <i>The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.</i> | <i>Confirmed / Not confirmed</i> |
|---|----------------------------------|

The Board of Directors confirm it will be sustainable for the next year, and subject to the caveats below, will be sustainable in three years. The Board does not confirm it can be sustainable in five years, even on the basis of these plans and best endeavours, given the scale and uncertainty of factors outside of the organisation's control. The reasons for this, and strategic options in response, are set out in this document.

The Board's definition of financial, operational and clinical criteria for sustainability uses the following regulatory standards:

Finance - a Continuity of Service Risk Rating (CoSRR) of 3 out of 4.

Governance (operational performance) - NHS Constitution and Monitor Governance measures, especially around waiting times, infection control and safety measures. This also includes compliance with commissioner contracts.

Clinical – includes CQC compliance, as well as the ability to staff services safely. This means all levels of doctors, nurses, Allied Health Professionals and others being recruited and retained in sufficient numbers and skills to meet Royal College and CQC expectations.

The options and strategic intention set out in this document provide the framework for the organisation, working within our local health system, to navigate the next five years. This builds upon our two year operational plan. What is striking is the scale of the gap between success in the three sustainability criteria, and the challenges. These challenges are set out in the "Market Analysis and Context" section. They are summarised here as:

- real terms reductions in funding for hospital services and social care
- growing and ageing local population, all requiring more services
- reducing doctor numbers in training posts and other workforce gaps
- increasing public and political expectations of quality and access.

Sustainability for one year relies upon our robust plans, financial reserves and a strong operational focus on maintaining high quality care. However, the scale of challenges over five years carries a significant risk in maintaining clinically and financially viable services, resulting in the potential to fail these criteria. The speed and scale of the response by RBCH and the local health system, and the significance of the challenges, makes the year three assessment marginal, i.e. can tip either way given the lack of buffers to mitigate risk. Given our current assessment of risks and mitigation, we believe, on balance, we can be sustainable to year three, but wish to highlight how finely balanced this assessment is and could be affected by forces outside our control or beyond our ability to mitigate.

Given this assessment the Trust Board, following consultation with our clinical directors, senior clinicians and Council of Governors, propose the following strategic plan to maximise our opportunity to maintain operational success in delivering sustainable care.

Continuing as we are is not viable. Within the next three years, the organisation will need to look radically different if it is to survive. The challenge is made more complex by the uncertainties of making large scale change happen in the NHS with the different agendas and priorities of partner

organisations, and the political and legal barriers that tend to default to the status quo. Nevertheless the Board is confident it is able to navigate a path of sustainability over years one to three.

It is in this context that the strategic options section sets out the areas of work that we will develop with our staff, partners, public and others. The strategic framework is proposed as:

- our two year improvement programme, which focuses on 8 key streams of activity:
 - Unscheduled Care
 - Integrated Pathology
 - Integrated Pharmacy
 - Surgical Pathway including Productive Theatre
 - Cancer Pathway
 - Productive Series
 - Inpatient Bed Modelling
 - Workforce Development
- community integration, with social care (*Better Together*) and in the NHS (Clinical Services Review) with community and primary care. This is to provide 'joined up' care, especially for the frail elderly and chronic disease management, with greater predictive and preventative care. This represents a key part of our strategy to maintain a sustainable level of provision
- acute hospital reform through the seven day acute care hub (hot/warm service model) and greater networks of care, providing more clinical, financial and performance sustainability via centres of excellence.
- greater ambition and scaled improvement in delivery for supporting strategies (such as IT, workforce, commercial, research and innovation). These will be set in ways that support the core mission of the organisation.

Each clinical service area is developing a clear plan and set of activities to enable implementation of the wider trust framework.

As important is the work to develop the four key organisational capabilities, which are key to underpin this work. These are:

1. Leadership
2. Strategic planning
3. Organisational development
4. Operational improvement

Developing these at both organisational, service area and individual level is a crucial underpinning activity, if we are to be a successful, healthy organisation. A step change has already started in each area and developments are described in the document.

The purpose of this strategic plan is to establish the framework to deliver progress, such that within three years the Board's forecast can be more confident of sustainable success.

Market analysis and context

1. Executive summary

Our aim is to provide excellent care for every patient, every time, every day. To do this our five year strategy focuses on strengthening the provision of high quality district general hospital and integrated community services. We aim to consolidate our specialist services. Our focus is to ensure the care we provide is compassionate and personal care to all our patients.

The key elements of our strategy are:

1.1 Internal improvement

- continuing to improve the quality and effectiveness of our services through staff development, rigorous application of new technology, innovation and rapid adoption of best practice
- strengthening existing centres of excellence
- strengthening the care provided in the evening and at weekends, ensuring timely review and treatment of patients through consultant-delivered services

1.2 Clinical strategies and partnerships

In order to sustain excellent care to the population we serve, our intention is to:

- become an integrated community health provider, and a centre of excellence for older people's care, offering all patients a seamless experience when care extends beyond hospital
- become an urgent care and specialist hub, providing consistently high quality services seven days a week
- work with local trusts and commissioners as part of the Clinical Services Review. This includes improving emergency services and recognising the need across Dorset to concentrate some complex emergency services onto fewer sites. This will ensure patients have access to more comprehensive, timely care provided by senior clinicians and clinical teams
- maintain our portfolio of specialist services
- develop our private patient income to support investment in NHS services

1.3 Organisational capability

- ensure the organisation is well led, and focused on improvement
- has a healthy open, learning culture
- invest in the development of staff, to ensure they are skilled and supported to provide high quality care for all of our patients

We will do this while working to be 'the most improved hospital in England by 2016 through delivering on our ambitious quality, cost and service improvement programme and supporting strategies set out in this document.

The financial model assumptions indicate that there will be extreme difficulty in sustaining the current mix of services and care (business) models in the "base case" and "downside case." The "mitigated downside" though offers three specific changes around the integration of community

and then hospital services, and thirdly alignment with commissioner funding. Even with these it still remains a very tight position recovering from the downside financially. An integrated model is however stronger on the clinical and governance (performance) criteria, because of better deployment of staffing and pathways.

2. Declaration of sustainability

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5. Leadership
6. Strategic planning
7. Organisational development
8. Operational improvement

Developing these at both organisational, service area and individual level is a crucial underpinning activity, if we are to be a successful, healthy organisation. A step change has already started in each area and developments are described in the document.

The purpose of this strategic plan is to establish the framework to deliver progress, such that within three years the Board's forecast can be more confident of sustainable success.

3. Four capabilities to succeed

This document ensures the Trust compliance with the Monitor 2014 requirement to submit a five year strategy for the Foundation Trust. This is in addition to the two year operational plan recently submitted, which covers the near term in more detail.

The strategic planning process will continue actively within the Trust with greater speciality /

service line planning detail, and progress on the organisational capabilities in the four key areas listed. These are:

1. Individual Leadership at all levels across the Trust.
2. Strategic Planning for an uncertain future, including work with partners.
3. Organisational Development is 'how we do things here', our culture and behaviours.
4. Operational Improvement especially for quality, cost and performance measures.



Our development against these draws on the Monitor *Well-led Framework for Governance Reviews*, which encompasses the four above domains into a framework for monitoring Board performance. We had a Board review of corporate governance by Price Waterhouse Coopers in 2013 and more recently Sir Ian Carruthers has also undertake a review of our governance process and our leadership capabilities.

3.1 Developing our approach

We have taken an open approach using the Monitor Strategy Self-Assessment Toolkit as well as surveys and discussions with governors, clinicians, the Board of Directors and other staff groups.

We have also used online (SurveyMonkey) and in-meeting (voting) approaches to test other factors that will affect the Trust strategy, including environmental factors, 'wild cards' and testing alternative strategic options. In developing the scenarios we have drawn on a variety of sources including, Monitor: *A Call to Action: Transformative Ideas for the Future NHS* and; The Kings Fund: *The Productivity Challenge*.

Undertaking this approach has served three purposes:

1. Raising and debating the subjects ensures that there is wider recognition of the difficulties facing the Trust and NHS and the need to find solutions to these.
2. The dialogue that takes place in these discussions has helped us refine the questions we ask, the scenarios we explore and to develop the options we envisage as this process rolls out to wider staff and stakeholder groups.
3. The priorities the various groups have highlighted in these discussions build a consensus as to where to invest energy, time and money.

It is critical that staff inform, shape and give effect to our vision for the future and the plans and strategies that will get us there. Therefore the engagement process that we have embarked upon will continue and develop under the auspices of the Board and its' Strategy group.

3.2 Organisational development: culture and values

Of the four areas Monitor has identified, organisational culture is particularly significant. During January to March 2014, we conducted an Appreciative Inquiry approach with our employees, patients and other stakeholders to identify what made us proud of our Trust and what we want to

provide in our ideal vision of the future. This was developed by a group of employees into a revised set of core values.

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

Communicate – Say it, hear it, do it!

We take time to listen, asking open questions to better understand and keep us all informed.

Improve – Change it!

We always look for ways to improve what we do.

Teamwork- Share it!

We are one team working together to achieve the best outcome for everyone

Pride – Show it!

We are proud of who we are and the care we provide together

These were launched in April 2014:

We intend that these values guide everything we do, how we make our decisions, how we care for patients and engage with colleagues, but we recognise that this requires a long timescale and sustained commitment for successful adoption.

The Trust values need to be recognised by all staff and there is a calendar of events to roll out over the year to introduce the values to the Trust. Over the next few years our values will become embedded into the systems and processes of the organisation, with our leaders being role models and recognising and encouraging the values in others to improve the quality of patient care.

3.3 Leadership

The Trust has a strong and effective board and is investing in strategic leadership capacity within the organisation in conjunction with the Kings Fund and other partners.

Specific actions underway include building on the Appreciative Inquiry work to help focus our culture on our values and our significant investment in leadership at many levels including for Clinical Directors, Matrons and ward sisters. A Board development programme and an exercise to review our Trust Management Board (TMB) role are also underway.

The Trust has purposefully invested in a medical management model to lead clinical directorates. This focus and approach will continue and be developed further through investment in our leadership capability.

The organisation is also restructuring management into three care groups, each with a Director of Operations and Head of Nursing and Quality. This will provide senior level support and leadership with better operational focus.

3.4 Strategic planning

The first main development area is the action plan from the self-assessment exercise. This will be overseen by the Board's strategy group. The second area is the outward facing engagement into system wide initiatives, such as the Clinical Service Review, which will run for approximately a year, and have a significant implementation timescale. The work outlined here provides the Board with specific strategic options outlined below which will be taken forward with the Clinical Services Review.

As well as the work on this strategy and the staff engagement that flows from it, there are well established multi-year planning processes for supporting strategies, incorporating all corporate services.

3.5 Operational improvement

This is an area of traditional strength especially around focused effort to deliver quality, performance and financial improvement. However a refreshed approach, through the newly appointed Director of Improvement and the Improvement Programme Office is designed to accelerate the scale and pace, with the ambition of being the most improved Trust in the NHS by 2016. A particular focus is urgent care improvements, as well as 7 other work programmes that have engagement, quality and value as intrinsic elements. This work is overseen by the Improvement Board, which includes Executive and Clinical Director membership. The new core group model, allied to investment in leadership capability will help mould the necessary capability to manage the delivery of services and our operational performance going forward.

Other improvement activities include for example IT, initially through electronic document management, and after that electronic prescribing, both of which have safety and cost improvement benefits. Our quality improvement work, set out in more detail in our Operational Plan, is another key example.

3.6 Summary of approach for strategic development

Our forward planning has two distinct phases. The first two years (Operational Plan 2014/16), submitted to Monitor in April, focused on quality and operational improvements. Year's three to five will focus on our playing a key role in the development and reconfiguration of the health and social care system across Dorset to ensure we provide clinically and financially sustainable services.

Our Operational Plan includes the transformation of the Royal Bournemouth Hospital's urgent and emergency care pathways (unscheduled care), especially for the frail elderly, ensuring ambulatory diagnosis and treatment is provided, where appropriate. Transforming the way we provide unscheduled care will ensure patients across the hospital receive the right care in the right place, at the right time and with the right person.

In parallel to this improvement work, the Trust will use the next year to further develop its plans for how best to meet patient needs over the next five years and beyond. This will entail specialty level plans to cope with the various scenarios and uncertainties that face the organisation. Where change requires consultation, preparatory work will also be started, mindful of good practice and the secretary of state's four tests: clinical evidence of benefit; support of GPs and commissioners; public engagement; and maintaining choice. Any proposals developed will comply with these tests.

Longer term the case for change across Dorset is compelling. Across the whole health economy, with the acute trusts in Poole and Dorchester, we will need to reconfigure services in order to:

- sustain the quality of health and social care
- move to more seven day services
- meet the needs of an ageing population
- introduce new technologies

- recruit and retain the right staff
- improve outcomes
- meet financial challenges

A key element of successful change will be closer working with partners such as GPs, community health and social services. Likewise, working with other acute specialist hospital services is needed to ensure centres of excellence can survive and thrive in Dorset. Haematology, cardiology, obstetrics, emergency departments, acute surgery and pathology are examples of where integrated networks of care combined in specific instances with site / service rationalisation can provide better outcomes for patients, improve access and allow us to recruit and retain the best staff.

Our intention is to integrate our care with community, primary and social care, learning from models elsewhere, such as Torbay.

For hospital services the right model and location of care needs to be agreed through a collaborative process. RBCH is well placed to adapt to change, with a modern hospital building that can flex to meet new requirements. Our geographic location is well placed to serve Dorset, South Wiltshire and the New Forest for specialist services requiring one million catchment populations, with good road links and a helipad next to the Emergency Department. Our extensive theatres, diagnostics, cardiac and interventional radiology infrastructure are also difficult to replicate elsewhere.

Although this document is submitted at the end of June 2014, in line with Monitor's timetable, we consider our strategic planning as on going. There will be further discussions both internally and, critically, with external organisations such as our commissioners and other providers. This is to optimise the compatibility of this approach with that of others in the Local Health Economy (LHE), and to ensure an iterative and agile approach to the changing circumstances.

4. Strategic analysis

4.1 Background

Two events took place during 2013/14 that had a significant bearing on both the Trust's two year operational plan and the five year strategic plan.

Firstly, the Trust was engaged in a merger process with Poole Hospital NHS Foundation Trust which, following review by the competition authorities, was prohibited. Many of the drivers for change are still valid i.e. reduction in the number of available medical trainees, increased specialist services developments, the need for seven day consultant-led services and capital investment requirements. Some of the responses to these issues were delayed pending the merger and these are now being re-examined to find alternative solutions, or to be progressed via commissioner led reviews.

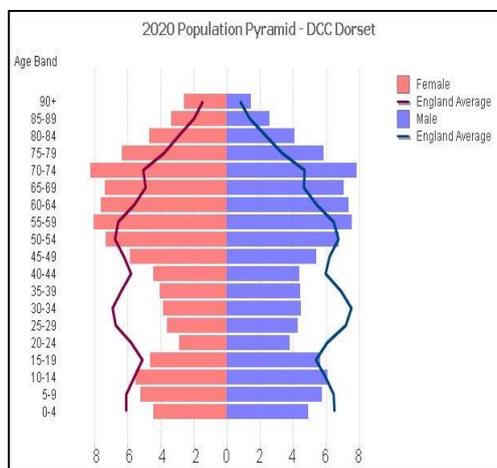
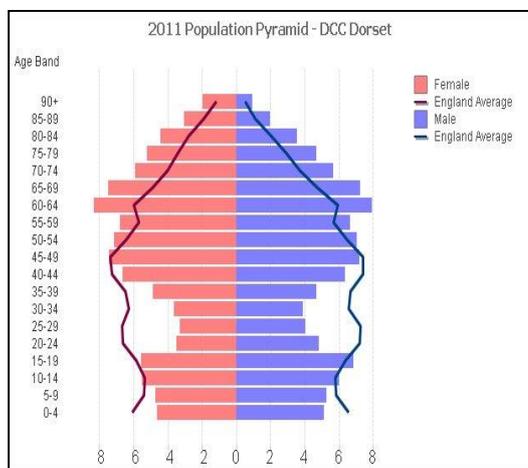
Secondly, in October 2013, the Trust was inspected by the Care Quality Commission (CQC) with particular areas of focus being the urgent care pathway, including the Emergency Department, medical and surgical services and care of the elderly. The report identified inconsistent quality in the services we provide in some of these services. Improved staffing levels, attention to consistency of patient assessments, privacy and dignity and becoming a more open, learning organisation were the four key actions. The organisation has embarked on a number of new

quality improvement initiatives, as well as enhancing many work streams that were already in place.

The ageing population of Dorset will present a number of challenges for the future; in particular potential increases in demand for social care (community and residential based services), supported housing needs and taking account of the increasing burden of chronic disease. The impact of population ageing will vary greatly depending on whether older people are enabled to remain independent and remain in good health for longer. The Trust sees this as a vital part of its future work.

There will also be a growth in the overall population size across Bournemouth, Dorset and Poole of about 150,000 more residents by 2020. This is due to people living longer, internal migration and a rapid growth in the birth rate.

The proportion of people aged over 85 years is 50% higher in Bournemouth than England. There are an estimated 2,300 people now aged 90 or more in Bournemouth.



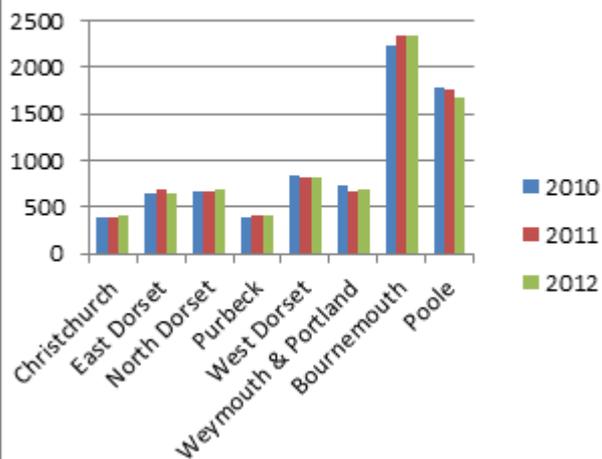
The population

of Bournemouth and Poole is healthier than many parts of England when assessed on measures like life expectancy, all age all-cause mortality rate, and mortality rates due to major causes of death like cancer and circulatory disease. But this relatively healthy picture masks very different health outcomes between smaller areas within the conurbation. All Age All-Cause Mortality (AAACM) rates in the fifth of areas ranked as most deprived are similar to those in some of the most deprived CCGs in England. Analysis suggests that many deaths due to cancer and circulatory disease are due to preventable lifestyle and health behaviours – tackling these risk factors in the most deprived areas as a priority is the only way that further progress can be sustained in reducing national targets such as AAACM rates, under 75 cancer mortality rates and under 75 circulatory disease death rates.

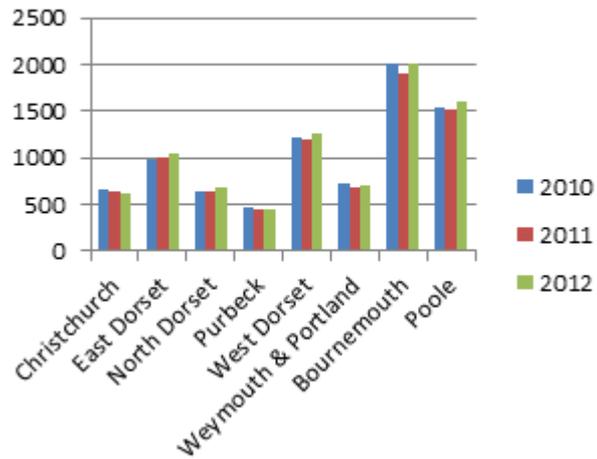
Planning for the increasing birth rate is also important. The total number of births in Bournemouth and Poole has been increasing from 2005 onwards and now stand at more than 4,000 per year – up from about 2,900 a decade ago. Despite this, the births in the midwife led unit have declined as mothers choose obstetric led services.

Since 2007 the overall number of births has exceeded the number of deaths, reversing the previous long term trend.

Births 2010-2012



Deaths: 2010-2012



These population changes are likely to require an increased need for both formal and informal care. The age groups of 20-39 are significantly under-represented across the county, due to a period of low birth rates and the outward migration of this group. Dorset is therefore gaining an ageing population but losing its workforce and those with the ability to deliver informal care. This means the requirement to deliver the required level of care, arising from the expected increase in the ageing population, will be challenging. Creating attractive jobs, giving help with housing, and career progression will be important for our workforce retention.

4.2 Financial context

This plan assumes continuation of the austerity in public services for the next five years as the most likely scenario, given the state of public finances and the national deficit only having been halved, in the current Parliament.

Internal, recurrent Cost Improvements Plans (CIPs) are a critical factor. The Trust predicts only c1.2-2% p.a. as the maximum safe and deliverable savings. This is an average of £4m new CIPs annually. This is because RBCH has over the last five years considerably outperformed the sector average for CIP (4% vs. 2.5%) resulting in actual costs being 10% lower than NHS averages. Going forward we will take a strategic approach to identifying CIP with further analysis of the opportunities that present. Never the less the scope to achieve the reported level of savings is diminished.

This translates into assumptions for RBCH of:

- flat cash income (0% funding growth each year, i.e. below inflation)
- activity levels, service mix and quality targets are all contained within the 'flat cash' funding envelope. Meeting these will require internal productivity improvement, stopping some things to do others, and some wider system re-design, especially to reduce demand below what the demographics predict will occur
- very tight cost control, especially for wages and pension (assumed to rise 1.2-2% p.a.), drugs, consumables, utilities, and NHS Litigation Authority premiums
- there will need to be internal investment each year in staffing, IT and services so as to meet rising quality, staffing levels and access expectations, regardless of the public sector austerity.

The effect of these assumptions results in the current planned deficit considerably worsening. By

2018/19 the annual, recurrent deficit could be -£22m. The downside scenario is significantly worse at -£50m per year. This would fully deplete our cash reserves and require debt for the Trust to remain operational.

4.3 Mitigations

The main aspects of the Trust's mitigation plans for austerity involve whole system reconfiguration. Firstly, this is community integration, especially focusing support around the frail elderly and complex co-morbidity management. Secondly, hospital service reconfiguration towards centres of excellence and seven day working, to improve quality, cost and outcomes. For the vast bulk of services patient access will remain or improve for clinics, daycase and routine procedures. Finally, a redesigned system will allow commissioner confidence to commit to funding that matches their uplift, i.e. at inflation.

If all these plans were achieved in a timely way with excellent benefits realisation, then this would enable a sustainable Trust. However given the high degree of uncertainty and external factors at work in achieving even one of these three aspects, then they are not included in the base case. Our ambition and work programmes and the CCG Clinical Services Review, will work towards community and hospital service integration. This is because we believe this remains the most sensible and effective way to deliver sustainable care for our population.

4.4 Cost Improvement Programme

In all cases CIP at c£4m of new savings per year is challenging. While it is half our average for the last five years, there is less to go at now with strategic change providing opportunities to limit future cost exposure.

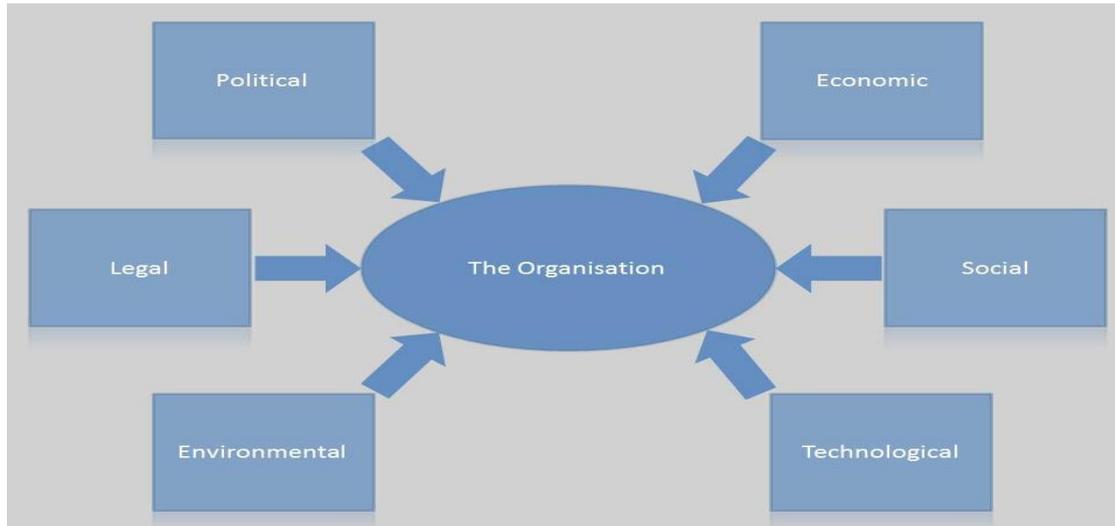
In our forward programme for CIP we have several large (£1m+) savings based on multi-year programmes: e.g. EDM (electronic document management) which will improve quality and reduce health records costs significantly. Securing Christchurch Hospital through a multi-million pound investment also delivers significant savings in reduced building costs and improved commercial income. Procurement savings, emergency care reforms and workforce productivity all continue to be other significant elements of future plans.

The full impact of demographics and rising expectations, and the reconfigurations and demand management to offset some of these, are both difficult to quantify. However it is clear that productivity in our main activities to absorb much of this demand will be an essential, but non-cash releasing, part of our Improvement Programme.

4.5 Strategic analysis

There are a number of tools that we have used to help us understand the context in which our organisation operates. These include PESTEL and SWOT analyses and updated versions of these for our Trust are shown below.

4.5.1 PESTEL analysis (Political Economic, Sociological, Technological, Environmental, Legal)



Clearly an external analysis of the environment in which the Trust finds itself is dependent on national as well as local factors and dynamics. There are often grouped under the PESTEL headings.

PESTEL analysis for RBCH

| Political | Economic |
|--|--|
| <ol style="list-style-type: none"> 1. Election in May 2015, leads to paralysis before and reorganisation after 2. Increasing trend to open up the healthcare market to private sector/ increase competition 3. Increasing emphasis on sector regulation 4. Strengthening in policy of shifting care to community settings with potential for loss of Trust income. 5. Further adjustment of role of NHS England vs. CCGs (primary care, specialist commissioning) 6. Increasing tendency to commission services on a county wide basis 7. New CEO of NHS England 8. Potential for further development of the use of personal health budgets. | <ol style="list-style-type: none"> 1. Flat cash scenario for Trust via real term reductions in tariff. 2. Inflation and pay rises increase cost pressures. 3. Substantial deficit position for many Trusts; potential for failure 4. Significant regulatory pressure to invest in services 5. Reduce spend by local commissioners leading to rationing or decommissioning of some services; development of demand management initiatives. 6. Increasing potential for paid for health services, but NHS remains free at the point of delivery 7. As tax receipts recover, potential for increased resources for the NHS 8. Poole, Bournemouth conurbation still relatively affluent. |
| Sociological | Technological |
| <ol style="list-style-type: none"> 1. Growing and ageing population 2. Increased patient and public expectations of NHS 3. Increasing access to health information and understanding of health issues 4. Significant differences in deprivation and longevity within conurbation. | <ol style="list-style-type: none"> 1. Sharing of health records horizontally and vertically across health economy. 2. Opportunity for increased efficiencies that IT developments offer 3. Increased opportunity for and cost of new technologies (robots, prostheses) and pharmacological treatments |

| | |
|--|--|
| <ol style="list-style-type: none"> 5. Increasing use of IT for social healthcare purposes 6. Potential for more joint provision of healthcare 7. Increasing use of and access to the internet by all demographic groups. | <p>(molecular treatments, genetic profiling)</p> <ol style="list-style-type: none"> 4. Improving opportunities for tele-health and associated technologies 5. Increasing expectation of <u>local</u> health IT developments rather than national 6. Increasing number of mobile phone apps, allowing direct access to health professionals and cloud based storage of personal health records |
| Environmental | Legal |
| <ol style="list-style-type: none"> 1. Pressure to reduce carbon footprint 2. Planning requirements require increased management of traffic / parking / congestion around our sites 3. Recognition of environmental footprint of all organisations and plans and strategies to mitigate this. 4. Recognition that opportunities exist to treat patients outside of hospital leading to smaller estate requirement | <ol style="list-style-type: none"> 1. Competition undertakings placed on the Trust 2. Novel Joint Venture (JV) models developing with different organisations 3. Approach to competition legalities continues to develop and is influenced by European legislation |

4.5.2 SWOT analysis

Many of the issues raised in the PESTEL analysis translate into opportunities and threats for our Trust.

| Strengths | Weaknesses |
|---|--|
| <ul style="list-style-type: none"> • excellent clinical services and clinicians • larger structure enables efficiency and provides clinical and financial stability • trust has record of successful operational performance • high level of internal clinical engagement • strong GP sector locally • strong clinical relationships with referrers • RBCH site has substantial space for further expansion • excellent access by road (including parking) and public transport | <ul style="list-style-type: none"> • poor co-ordination of services with community providers • difficult to recruit to consultant posts e.g. ED, Elderly Care & Acute Medicine • relationship with Local Health Economy (LHE) partners mixed • some services provided inconsistent quality • weak financial metrics in some specialities • insufficient junior doctor posts in acute specialities and limited substitution • absence of alternatives to admission within the community • limited community capacity in east of the conurbation, especially via community hospitals |
| Opportunities | Threats |
| <ul style="list-style-type: none"> • integrated primary and secondary care will fundamentally improve quality and efficiency • develop further strategic alliances and networks • recognition of the need to develop different models of care | <ul style="list-style-type: none"> • competition for skilled workforce • NHS financial position likely to worsen • increasing need for clinical scale as defined by Royal Colleges and other medical bodies • preference to commission and centre services within primary care/ the |

- | | |
|---|---|
| <ul style="list-style-type: none"> • integration encouraged nationally and therefore more local opportunities • share more services with other partners to reduce costs • internet offers an opportunity to improve administrative efficiency and as marketing tool • opportunities to repatriate activity from outside of the county | <ul style="list-style-type: none"> • competition for patient's from other providers • new NHS CEO will encourage further competition • increase use of IT as competitive advantage • inability of CCG's and local health system to effectively manage non elective demand |
|---|---|

Many of the items in the list above can be viewed in either box. The organisation that is able to respond quickly and flexibly to these will not only display the four capabilities expressed by Monitor but will, as a result, be able to turn these issues into opportunities.

There are some key synergies in the above tables – the need for a hot / warm acute configuration would be well served by the excellent access to the RBH site and space available for further expansion. This would also be supported by the primary population centre being in our location. The absence of significant community hospital capacity in the east of the conurbation, lends itself to the increasing emphasis on providing service to patient in their homes wherever possible.

4.5.3 CCG strategies, plans and programmes

The CCG has published its draft five year strategy and has included some demographic analysis including the following highlights:

- overall the population of Dorset enjoys relatively good health with a higher life expectancy than the England average
- major causes of death are cardiovascular disease (CVD) and cancer, death from CVD and cancer accounted for 29% of deaths in 2011
- increasing numbers of people living with long term conditions (LTC). In 2011 in Dorset 19% of people living with LTC or disability which impact on their health
- inequalities in life expectancy across Dorset; although fallen, gaps of 4.4yrs for men and 3.5yrs women still exist
- health related behaviours in the main are good however issues such as smoking, smoking in pregnancy, sexual health, alcohol consumption, and obesity are a cause for concern and focused effort.

The high number of older people across Dorset poses a significant challenge for the health and social care system, using on average triple the health resources of the overall population. This could therefore mean the equivalent of an 18% increase in demand in the next five years.

4.6 Public views

From the Dorset health system-wide engagement exercise in 2013 – ‘The big ask’, over 2,000 members of the public highlighted the following issues:

- focus on prevention and self-management and personal responsibility to shift the focus of local services

- enhance and encourage the use of technology to support self-management and self-care
- integrate health and social care services across NHS and local authorities to improve points of contact for each patient
- consider alternative settings of care which don't always need to be in a hospital or clinic
- improve access to services, including primary care and community services over a seven day period
- support training and development of patients, families and carers to manage their conditions
- ensure that carers are supported and that services are developed which meet their needs
- improve opportunities for local people to engage with our work to develop and design services which meet local need.

Issues arising from this analysis and feedback include;

- key commissioning trends are away from hospitals: Moving from reactive to proactive healthcare in community settings and in particular avoiding emergency hospital admissions is not borne however by current referral patterns which show year on year an 11% rise in emergency admissions
- commissioners (internationally) perceive hospital systems as tending towards being reactive, centralised and high cost, and the default, or barrier, rather than the solution to the future population health needs. This misconception needs challenging
- without challenging these views there is a risk that even if wider NHS funding picks up, the hospital sector sees no benefit. For this reason the Trust needs to fully engage with this agenda, as it is likely to be where the effort and funding growth occurs. International evidence points to these shifts in care being more successful when the hospital sector is involved or leading the new models of care.

4.7 CCG commissioning

Commissioning is an important part of achieving Dorset wide reconfiguration and system transformation. There are three principal local programmes linked to the five year plans of commissioners, these are;

- 'Better Together' health and social care transformation
- Urgent Care Board, emergency services improvement
- Clinical Services Review, including acute hospital service reconfiguration

The commissioning landscape has changed significantly. Dorset and Bournemouth and Poole primary care trusts have been replaced by Dorset CCG and NHS England and the Local Area Team for Wessex, with a specialised commissioning role. Additionally, the commissioning of some services has been taken over by public health, which in turn has been relocated under the responsibility of the local authorities.

4.8 Operational Resilience Board

The Urgent Care Board (now 'Operational Resilience Board') for Dorset has been in operation since 2013 and has been key in developing plans and initiatives across the local health economy. The focus has been two pronged in providing interim support to short term management of winter

2014 and a longer term development of strategy to implement new models of care. A particular focus has been on pathways for the frail elderly. The plan for Bournemouth and its localities has included:

- seven day radiology
- interim “discharge to assess” community beds
- primary care presence extended in the Emergency Department
- improved discharge coordination and integration with social care
- virtual ward, with GP led co-ordination of frail elderly care.

4.9 Better Together

This Dorset-wide programme has been awarded one of the only two large funding grants, to help accelerate the work in this area. This exciting development is actively supported by RBCH and has the potential to reduce unnecessary emergency admissions and support discharge from hospital. These are critical to ensure safe, sustainable services, given the current and growing demand from an ageing population.

The CCG is working with the three local authorities in Dorset, the four major NHS providers in Dorset and voluntary groups to deliver integration, with new models of delivery and commissioning being developed. Improvements will focus on:

- frail elderly and long term conditions (links to urgent care)
- early intervention support and reablement / intermediate care
- urgent and emergency care (links to urgent care)

The UCB and Better Together programmes are also ensuring that the “Better Care Fund” is spent to best effect to enable an integrated, effective response to the challenging local environment.

4.10 Clinical Services Review (CSR)

In parallel with the health and social care agenda, the NHS Dorset CCG is developing a review to determine the service model that will best meet the future needs of our local people in the context of projected demographic and economic change.

The key outcomes for patients;

- delivery of care close to home
- services which are designed around patients
- integrated ‘whole system’ services
- fast, flexible and focussed access to diagnostics, reports, clinical guidance for clinicians for treatment and care planning
- sustainable workforce across health and social care provision
- improved quality and outcomes
- value for money

The expectation is the review will consider some reconfiguration among hospital services and between community and hospital care. This will be developed over the next two years, for implementation in year's three to five. Co-production of the solutions, especially between primary and secondary care clinicians, and with public and patient representatives, is critical for success. RBCH will seek to play a full partnership role in this process.

The CCG has issued a tender for a partner to deliver this work, with an expectation that the first stage review will be concluded by spring 2015, with any public and stakeholder consultation in later 2015.

The cumulative effect of these three programmes for change needs careful coordination, in particular the effect on the acute hospitals' fixed cost base. Given both RBCH and Poole Hospital have very efficient services, and growing demand, this leaves little scope for significant funding shifts out of hospital.

4.11 Specialist commissioning

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients. RBCH provides cardiac, vascular, cancer, bariatric and HIV care as examples of specialist care. Specialised services account for approximately 10% of the total NHS budget, spending circa £11.8 billion per annum. These services tend to be located in specialist hospitals that can recruit staff with the appropriate expertise and that enable them to sustain and develop their skills.

Maintaining and potentially growing a sustainable portfolio of specialised services for our local population is strategically important for RBCH and Dorset residents. The on-going action is to ensure these services meet the service specifications and provide quality care and outcomes. This will often require network solutions with Dorset, Salisbury and Southampton hospitals. All of the RBCH services are candidates for network solutions and this is likely to increase further to meet the criteria of staffing, funding and minimum number of cases. There is of course the possibility that RBCH may lose some services where the level of activity is below that required to deliver an effective service in future. The details will develop over the next two years, and are being actively managed and will form part of the speciality level strategies.

| 26 Specialist Services | Provider Network | Potential Growth |
|---|-------------------------|-------------------------|
| Hepatobiliary & Pancreas (Adult) | ✓ | |
| Cancer: Pancreatic (Adult) | ✓ | |
| Specialised Endocrinology Services (Adult) | | |
| Colorectal: Trans anal Endoscopic Microsurgery (TEMs) (Adult) | ✓ | |
| Specialised Dermatology Services (All ages) | ✓ | ✓ |
| Specialised Rheumatology Services (Adult) | ✓ | ✓ |
| Haemophilia (All ages) | ✓ | |
| Specialised Urology- Cancer: Specialised Kidney, Bladder and Prostate (Adult) | ✓ | ✓ |
| Severe and complex obesity (All ages) | ✓ | ✓ |
| Colorectal: Complex IBD | ✓ | ✓ |
| Colorectal: Faecal Incontinence (Adult) | ✓ | |

| | | |
|--|---|---|
| Cardiology: Cardiac Magnetic Resonance Imaging (Adult) | ✓ | ✓ |
| Complex Gynaecology: Recurrent prolapse and urinary incontinence | ✓ | ✓ |
| Complex Gynaecology: Urinary fistulae | ✓ | |
| Haematopoietic Stem Cell Transplantation (Adult) | ✓ | ✓ |
| Cancer: Oesophageal and Gastric (Adult) | ✓ | ✓ |
| Cancer: Chemotherapy (Adult) | ✓ | ✓ |
| Cancer: Chemotherapy (Children, Teenagers and Young Adults 16-19 yrs. only) | ✓ | |
| Cancer: Teenager and Young Adults (16-19 Yrs. only) | ✓ | |
| Cardiology: Implantable Cardioverter Defibrillator (ICD) & Cardiac Resynchronisation Therapy (CRT) (Adult) | ✓ | ✓ |
| Cardiology: Electrophysiology and Ablation Services (Adult) | ✓ | ✓ |
| Cardiology: Inherited Cardiac Conditions (All ages) | ✓ | ✓ |
| Cardiology: Primary Percutaneous Coronary Intervention (PPCI) (Adult) | ✓ | ✓ |
| Complex Gynaecology: Urogenital & anorectal conditions | ✓ | ✓ |
| Specialised Vascular Services | ✓ | ✓ |
| Specialised Human Immunodeficiency Virus Services (Adult) | ✓ | ✓ |

4.12 Market forecasting

For the purposes of understanding what the local health market will look like in the next five years, we have held a number of debates with governors and staff to explore some changes and scenarios that might be expected to develop over the period of the strategy. We have focused on this initially, to develop our internal understanding amongst our key clinicians of:

1. The difficulties facing the NHS, both nationally and locally, especially the extreme nature of the financial position.
2. The demographic issues as they affect patient demand, but at least as importantly, how they impact on staffing issues, including recruitment, retention and specialisation.
3. Over this five year period there is considerable potential for disruptive innovation(s) that will profoundly affect the way services are made available and funded. These need to be understood at national, local and speciality level.

At this stage in our strategy cycle we believe it is important to explore these and establish the likelihood and impact of these, prior to varying our current activity, costs and revenue plans for the next five years.

To engage with our own stakeholders we have taken a workbook and questionnaire approach to test many of the assumptions pertinent to forecasting, with our clinicians, governors and other staff. Specifically we have asked them to grade the likelihood and impact of a series of issues that will impact on our organisation and its sustainability over the five year strategic period.

Statement / issue

1. Ageing population, baby boomers entering their 70s and 80s (triple costs). Plus overall population growth.
2. Austerity for public sector for whole next Parliament (2015-20) so hospitals get 0% funding growth.
3. Expectations of quality continue to rise
4. Growing consensus frail elderly and complex co-morbidities management (rather than episodic, disease specific care) is **the** critical change for survival of health systems.
5. Commissioners interpret best way to respond to four is integrated localities of health and social care (person-centred, care closer to home etc.)
6. Commissioners interpret best way to respond to four is larger acute sector leading on this.
7. Workforce becomes more stretched with pay and training pegged, meaning less new staff available.

Results

Of the above, ageing population, financial austerity, patient expectations and workforce stretched were rated most significant.

We also tested the following "Wild Cards." In the next 5-10 years could we see:

Statement / issue

1. Breakthrough treatments e.g. dementia, personalised cancer treatments etc.
2. NHS "but not as we know it" e.g. reduced offer, charging, greater private sector role and competition
3. Health and social carefully merge, so an end to the assessment culture
4. Digital NHS, revolutionising care processes, and self-care
5. Disease burden shifts, "we're due a pandemic", obesity, drug resistance etc.
6. Cultural change to accept ceilings of care especially in last year of life
7. Future workforce: Generation Y has different motivations and work ethic, so retention factors will be different

Results

Of these the most highly rated were workforce attitude, digital NHS, disease burden changes and ceilings of care.

4.13 Competitor assessment

The county of Dorset has a population of around 750,000, extending across a large swathe of the south coast, from Lyme Regis in the west to Christchurch in the east, a distance of around 60 miles. However the main population is in the east of the county within the Poole /Bournemouth conurbation. This is served by two district general hospitals (DGHs). Poole Hospital is in the

centre of Poole and the Royal Bournemouth Hospital is on the east side of Bournemouth. Neither hospital trust carries the complete set of typical DGH services and across many specialities can be considered to be complementary. As such the majority of services operate in a collaborative, way between the Trusts. Further to the west in Dorchester is Dorset County Hospital, serving the more rural west of the county. There is limited overlap with other hospital's catchment areas, as the table shows:

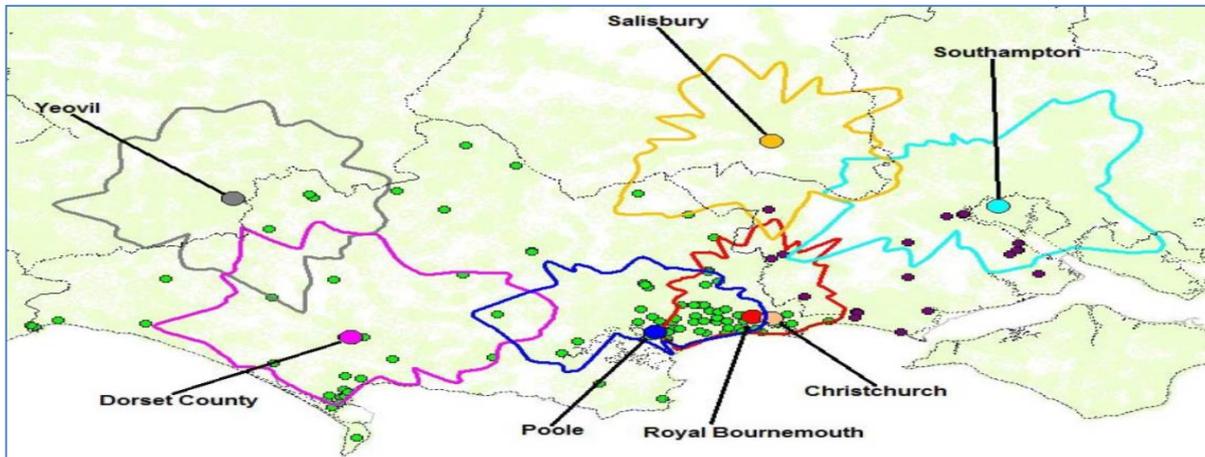


Table: Hospital providers and main catchment areas (source Competition Commission)

All of the hospitals have experienced, or are experiencing, financial difficulties, summarised as follows:

| Trust | Operating Income £Ms (12/13) & 14/15 plan | Summary financial issues |
|-------------------|---|--|
| RBCH | £249m; planned deficit | Non-elective (NEL) income does not cover costs, tariff deflation of elective income reduces cross subsidisation for NEL services |
| Poole | £202m; planned deficit | Predominant income NEL – discounted NEL payments reduce potential for surplus |
| Dorset County | £152m; planned deficit | Smaller scale, rural geography means scale required for sustainability either clinically or financially is more difficult |
| Dorset Healthcare | £226m; planned deficit | Community and mental health services, mainly on a block funding basis. |

4.14 Community NHS services

There are very strong synergies between RBCH and the majority of the community services. This is especially so in intermediate care, elderly care and palliative care. Other strong links include sexual health services and the more general services like dietetics, podiatry and interfaces services for dermatology and orthopaedics.

In addition to the acute hospital sector, there is a significant community hospital sector, mostly situated in the west of the county, as well as community services delivered in and around GP practices and patient homes. The latter operate across the whole county including the Poole / Bournemouth conurbation.

The Dorset county community services were tendered three years ago as part of the Transforming Community Services (TCS) initiative and were acquired by the existing mental health provider Dorset Healthcare NHS Foundation Trust. Integration of these services with those of the acute services has been difficult, partly due to the reconfiguration taking some time to bed in, but also to the conflicting priorities of the community provider versus those of the acute providers.

In the interim there have been some changes in these services, especially an increasing focus on building services around the locality groups within the CCG. At the time of the TCS exercise the services were moved as whole, whereas it is possible that if services are reallocated, this is done on the basis of operational necessity and or geographical appropriateness.

As a Trust we would wish to ensure that given the preponderance of community hospitals in the west of the county, the east of the county was given an allocation of resources commensurate with its demographic.

4.15 Private Sector

There are three principal private hospitals in Dorset; The Bournemouth Nuffield in central Bournemouth, the BMI Harbour hospital, adjacent to Poole Hospital and the BMI Winterbourne on the south side of Dorchester. There has been some potential for an additional private hospital – the Circle Group has explored the possibility of a private location in the Wallisdown area, between Bournemouth and Poole but its future remains uncertain.

Our existing private work is based mainly on significant capital investments in interventional cardiology and in radiology. These labs and scanners have put us ahead of the local market in terms of technology and we have significant income associated with these.

One of our strategic options is to develop our private work further, both in our existing markets and into new markets. A key component of this strategy will be to ensure that our private facilities are 'ring-fenced' so that they are separate from NHS capacity. This may be better achieved by a dedicated private operator and this option is being explored.

4.16 Competition versus collaboration

Increasingly as the hospital moves into a more commercial environment, the tension between competition and collaboration is exacerbated. When looked at across a whole Trust, the temptation is to default to one or the other. The reality is, like the private sector, we need to be able to operate both approaches simultaneously. Each of the Trust's specialities has the possibility of moving toward one or other of these approaches. Some of this is not driven by the Trust itself, but by the approach taken by our commissioners for example, to support competition by tendering services.

The findings of the competition commission (now the Competition and Market Authority, CMA) on the proposed merger with Poole Hospital will also affect our forward plans. While emergency, diagnostic, community and specialist services were generally found to be acceptable to merge, elective, outpatient and maternity services were not. These were balanced judgements and any new proposals would need to be re-evaluated.

The new approach by Monitor and CMA following the merger being blocked, may produce a different result if on a service by service basis the cases were represented. However the main

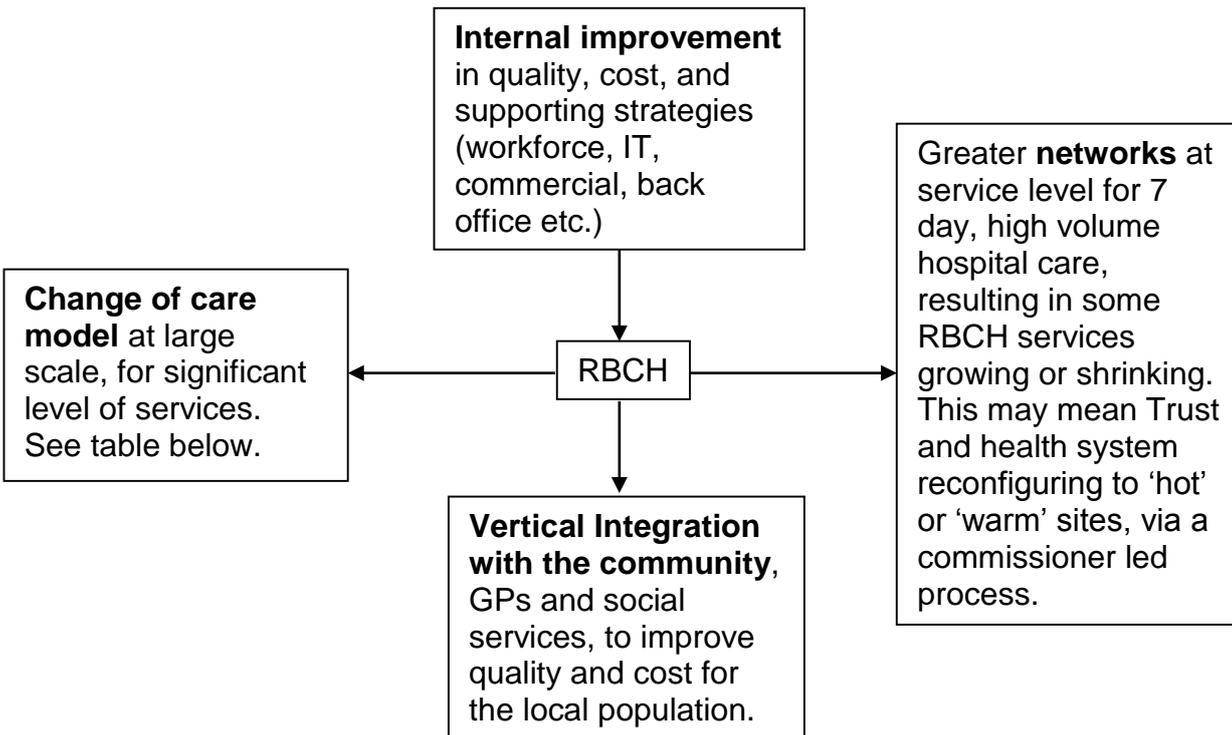
changes in Dorset are expected to be commissioner led in the next five years. Therefore there is a further rationale why service changes are likely to meet competition law requirements.

Risk to sustainability and strategic options

5. Risk to sustainability and strategic options

As the market analysis and context section has made clear, RBCH faces the a significant challenge of rapidly rising demand, declining real terms funding, greater recruitment and retention issues and a political-legal framework that makes significant change difficult to enact.

In crafting a strategic direction that best navigates these issues and maximises the chances of sustainable success, the following are the high level options that the Board are considering:



These options can largely be progressed simultaneously, that is they are not mutually exclusive. However a strategy of “progressing on all fronts” has the risks of not making real progress on any. Therefore the Board, Clinical Directors and Governors are engaged in a process of prioritisation as to which of these high level directions should attract the most attention and resource, and within these what programmes of work should be prioritised.

5.1 Clinical developments and different models of care

The significance of the issues facing the NHS is substantial in scale and scope and we recognise the need to develop different models of care to address this. We have therefore tested these with clinicians, governors within the Trust and our board. The models we have used were principally published in the NHS Futures document by Monitor and NHS England. We added two further items to this: reduction of variation in our care processes and developing a more commercial approach, the latter including enhancement of our private patient income.

| | | | |
|--|--|---|--|
| <p>Capitated budgets</p> <p>Genuine single budget, for all, or cohorts of complex patients with single lead provider.</p> <p>(e.g. personalised care budgets)</p> | <p>Hi-volume Centres of Excellence for planned surgery and specialist centres.</p> <p>(e.g. Derwent hip and knee centre)</p> | <p>7 day hospital hub Consultant care, in reconfigured acute sector, with vertical integration as well.</p> <p>(e.g. stroke and trauma in London)</p> | <p>Reduce variation in services delivery, Toyota model, Quality management, Lean manufacturing</p> |
| <p>“Extensivists” for sickest c2%”</p> <p>Community doctor coordinates <u>all</u> care for sickest patient, regardless of setting.</p> <p>(e.g. palliative care)</p> | <p>Co-production and lose fixed costs. Niche new entrants to disrupt & convert fixed to variable costs, as is retail.</p> <p>(e.g. diabetic self-care)</p> | <p>Current technology & big data used. Manage, at home, chronic diseases and prevention.</p> <p>(e.g. Airedale FT)</p> | <p>Commercial developments e.g. formal partnering with a private patient partner.</p> |

The applicability of these approaches differs by speciality, and so work is being undertaken with staff in each of these groups to understand and consider these approaches. However, taking a trust wide view, centres of excellence; seven day working; reduced variations in care; and increasing commercial income had particular appeal and as such the strategic framework reflects this.

Finally, we also considered a number of scenarios, broadly under the categories of Internal Improvement, and Vertical and Horizontal Integration.

Internal improvement encompasses the high priority given to reducing variation in our services, delivering operational improvement especially in urgent care and for the frail elderly, the development of private patient income and other initiatives that lie largely within our own control.

Community (vertical) integration was given particular emphasis around the need for better integration and coordination with the community services and GPs, to ensure a seamless patient experience and to optimise the use of expensive healthcare resource. Discussions on this highlighted the potential for the CCG to retender Community Services either together or in lots. Our discussions highlighted the need to position ourselves for the successful submission of a tender alongside appropriate partners. We also recognise our appetites for more close working with GPs including the possibility of joint ventures.

Hospital (horizontal) integration focussed on the potential for a reorganisation of clinical services across the acute sector, including the development of ‘hot / warm’ hospital sites within the Poole / Bournemouth conurbation. Also in this category is potential for network or hub and spoke arrangements to deliver higher quality services mitigating manpower and financial constraints. This builds upon the thinking that was developed through the abortive merger process.

The initial feedback from the Operational Board and Governors included:

| Hospital | | Operational / Clinical Board | Governors |
|-------------------------------------|---|------------------------------|---------------------------|
| Horizontal Integration (hot / warm) | Hot sites services, in order of priority: | General Surgery | A&E |
| | | Colorectal | Stroke |
| | | Upper GI. | Trauma |
| | | Vascular | Vascular |
| | | Trauma | General Surgery |
| | | A&E | Interventional Cardiology |
| | | Interventional Cardiology | Interventional Radiology |
| | | Interventional Radiology | Urology |
| | RBCH as small, viable, colder site: | Negative response | Mixed response |

| Hospital | | Operational / Clinical Board | Governors |
|--|---------------|------------------------------|-----------|
| Horizontal Integration Networks / hub and spoke) | Networks | Mixed response | ✓ |
| | Hub and spoke | Mixed response | Mixed |

| Priority | | Operational / Clinical Board | Governors |
|------------|--|------------------------------|-----------|
| Activities | Work more closely with community / integration | ✓ | ✓ |
| | Bidding for tenders | ✓ | Mixed |
| | JVs with GPs / other health providers | ✓ | ✓ |
| | Health Prevention / Promotion | Lower priority | ✓ |

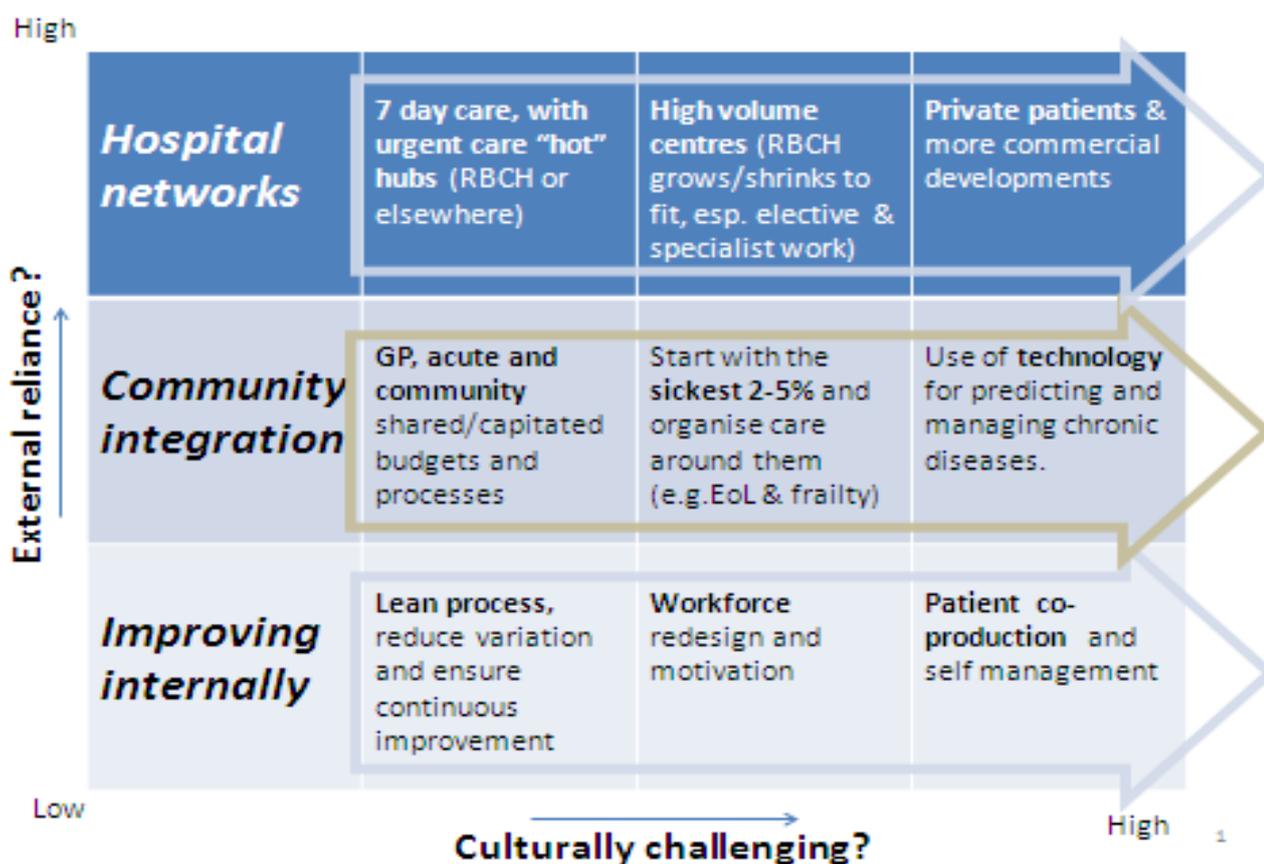
| 1 st priority area of focus? | | Operational / Clinical Board | Governors |
|---|-----------------------------------|------------------------------|-----------|
| | Internal improvement | 28% | 21% |
| | Hospital Integration (Horizontal) | 39% | 21% |
| | Community Integration (Vertical) | 33% | 57% |

These will be integrated with the views of other staff groups and agreed by the Board of Directors

5.2 Conclusions

A key conclusion is that while there is consensus about the issues to address for sustainability, there are mixed views as to the correct speciality level response, and the order of priority and timings. For example integration with community services may be appropriate for medicine for the elderly, whereas our cardiac services might give a higher priority to integration of hospital services. As a result further work is being undertaken on speciality level plans and timing of activities to ensure we maximise the potential to maintain sustainable services.

The table below represents the strategic framework tool we will use to help facilitate speciality level planning. The nine options are set along the two axis. The first is how much control RBCH has over the actions, and secondly the level of cultural acceptance and degree of radicalism inherent in the option. Each speciality can progress on multiple fronts or 'pick and mix' solutions at sub speciality and point of delivery (i.e. outpatients, emergency admissions etc) as well as in timing terms over the next five years. This can be build up to a plan, recognising where external and cultural factors will need to be managed to ensure engagement and success.



All of these options require on-going engagement with partners, to co-produce the right outcomes. For each there are many variables and options, not all are yet fully evaluated. As a result these are strategic options requiring greater assessment and options appraisal, and a dedicated programme management approach, using 'gateways' to make formal decisions, as to what is progressed or abandoned. Much of this work is via engagement with whole system processes, such as the CCG led Clinical Services Review for Dorset. However before RBCH

engages in that process we will ensure we have considered the potential outcomes, and our response in anticipation of these.

We have therefore modelled various scenarios, especially regarding community and hospital integration.

This modelling is both on a clinical as well as a financial and estates basis. To do this the current and projected financial plan and assumptions is set out here, from which variations are tracked.

5.3 Base case key assumptions

- current service mix maintained
- overall c2% activity growth per annum
- overall c2% cost improvement delivered per annum
- “flat cash income” of 0% (i.e. no inflation)
- wages and other costs rise by 1-2% per annum
- non-activity and non-inflation funding of £2.5m per annum (quality and staffing investments for clinical and performance sustainability).

[Non elective activity has risen in 2014/15 by 11% compared with 2013/14. This rate of growth cannot be sustained and demonstrates the need for and integrated acute / community strategy].

This results in a Year 5 recurrent deficit of -£22m, and no financial reserves. This would then not allow any buffer against clinical or performance pressures, resulting in the conclusion RBCH would be non-viable organisation.

A downside scenario to this assessment is that:

- demand rises more quickly (evidenced this year)
- commissioner decisions and system cost pressures rise more quickly, leading to widespread provider failure in Dorset
- the combined effect of failure by year three, and a recurrent deficit of -£50m by year five, triggers a system wide administration process and a rushed reconfiguration of hospital care services to at least maintain clinical and governance sustainability of the system.

Mitigations to the downside are that:

- commissioners support early moves to integrated service models and investment in RBCH as an acute and community hub for the locality
- reconfigured services, in line with commissioner intentions, means income growth can track inflation
- these in turn result in demand being better managed, and headroom to cope with activity and performance fluctuations (e.g. wait times, bed utilisation)
- integration with other acute hospitals (as networks or hot / warm models) resolves most workforce and clinical sustainability concerns in more cost effective way
- overall this still leaves a recurrent deficit by year 5 and a COSRR rating of 2, but with clinical and performance sustainability.

These three main scenarios, and the strategic options contained within, form the long term financial model, upon which the five year plans are based.

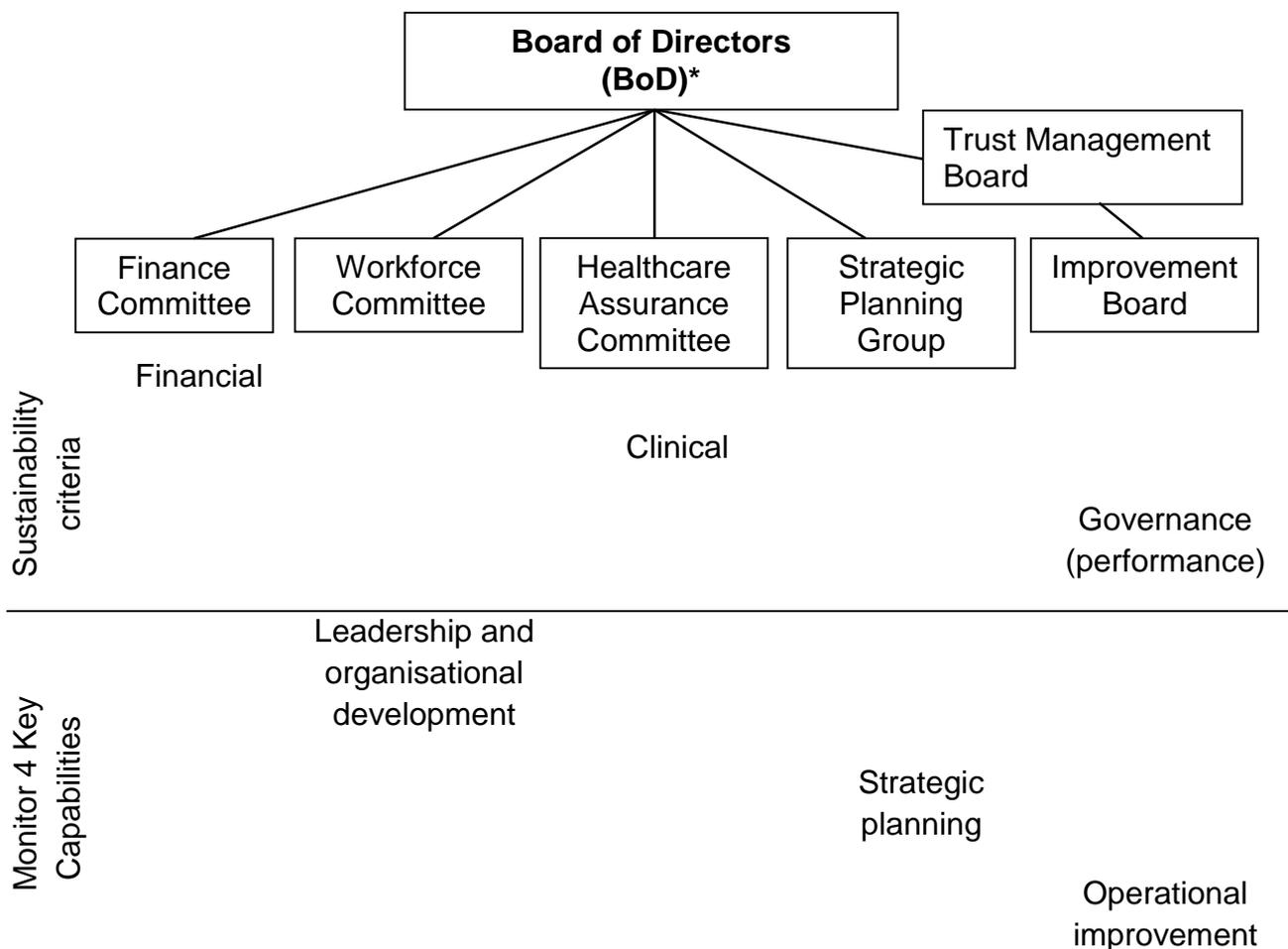
Strategic plans

6. Strategic plans

6.1 Board leadership

The Board and its committees will oversee the development of the right set of actions and mitigations to ensure effective delivery is a whole organisation-wide activity. Included within this is the Trust Management Board, comprising clinical and executive directors, ensuring a strong clinical leadership giving effect to our medical leadership model.

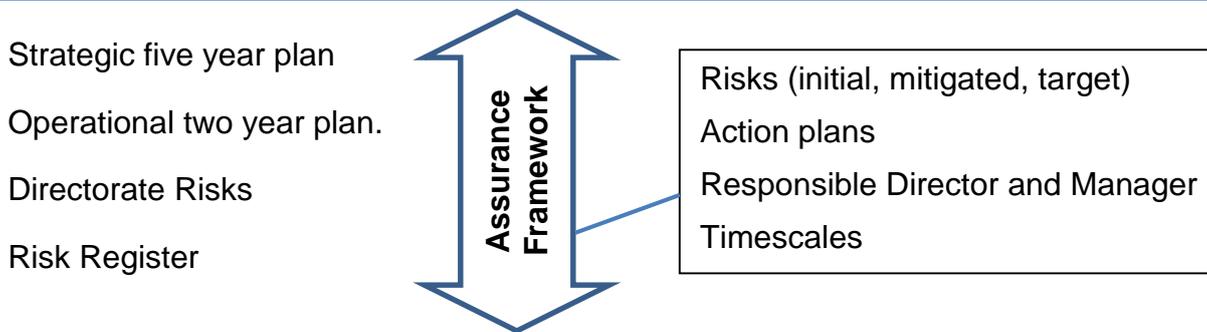
Rather than detail the Terms of Reference and full governance structure here, this section provides a summary of the principles and approach that RBCH has currently, and is adapting, to ensure sustainability and key capabilities are delivered. The issues of sustainability and developing the capabilities for success are inherent in all our work, however the structure diagram represents where, beneath the Board, the practical leadership and oversight occurs.



* Other BoD committees include audit, infection control, patient experience, charities and remuneration.

6.2 Assurance framework

Underpinning this is our extensive Assurance Framework (AF). This is seen by the Board, with more detailed scrutiny at the Healthcare Assurance Committee (HAC).



The AF spans operational risks, which might be generated by adverse incidents, audit findings, performance concerns etc. and are entered on the Trust risk register. It may also include delivery of objectives within the operational and strategic plans, where significant risks requires deliberate mitigations plans, active oversight, and where failure to deliver may generate a critical issue, especially for financial, governance (performance) and clinical sustainability.

As with this entire process, considerable judgement is required to strike the right balance in identifying the key actions and risks, without creating too many or too few items to manage. The AF process provides transparency, with a unified and consistent approach.

6.3 Supporting strategies

Crucial to the success of the overall strategic plan are the specific strategies and processes, in particular for:

- Quality Strategy
- Improvement Programme (including CIP)
- workforce development
- information technology
- estates
- leadership and organisational development
- strategic planning process including engagement with external processes, especially the Clinical Services Review and “Better Together”

These strategies are referred to within the two year operational plan, and have their own processes and structures to ensure delivery and on-going updating. Therefore only very high level summaries are also included below.

Crucially the inter-connections between each of these strategies are important to the success of the overall enterprise. This is achieved through the annual process of updating and setting the operational plan, finances and Board objectives. This is monitored monthly and in some cases, weekly. The Executive team’s weekly meetings also allow a rapid, cross organisation and cross function approach to ensure co-ordinated and successful implementation.

6.4 Quality strategy

The Trust embraces the three key quality components of ‘High Quality Care for All’ and the key quality objectives are therefore to:

- ensure patient safety is a top priority for all staff by:

- reporting and learning from adverse events
- delivering 'Harm Free' care
- implementing high quality falls and pressure ulcer prevention programmes
- reducing and preventing medication errors
- maintaining high standards of infection prevention and control
- maintaining a safe environment for patient care
- ensure patients are offered up to date and effective clinical care by:
 - reporting on clinical outcomes
 - implementing and monitoring delivery of national guidance
- to provide the optimum patient experience by:
 - treating our patients with compassion and respect
 - gaining feedback from our patients and improving in response
 - publishing our findings for the public for each ward
 - managing complaints in an open, transparent and timely way

Key priorities derived from the above include:

Safety

- reduction in inpatient falls
- reduction in hospital acquired pressure ulcers
- increase in 'harm free care' (as measured by the National Safety Thermometer) for all patients
- reduction in medication incidents
- increased reporting and learning from potential and actual adverse events via implementation of a new web based reporting system

Clinical Effectiveness

- deliver the National Clinical Audit programme requirements
- reduce hospital mortality as measured by HSMR and SHMI
- use new IT innovations to support the management of the deteriorating patient

Patient Experience

- improve the Trust Friends and Family results
- reduce the number of formal complaints and improve the timeliness of complaints investigations and responses
- a programme of estates improvements, covered in the capital plan

The other significant focus for quality improvement in the short term will be the continued progress of actions arising from the CQC inspection in October 2013. This is developed further in our Operational Plan.

Specific metrics which articulate the ambitious pace of improvement are contained in the Trusts Quality Strategy.

6.5 Workforce strategy

The NHS is a labour intensive organisation and around 60% of our costs are staff salaries or benefits. It is therefore of paramount importance that we have the right staff available at the right time and that they are prepared, trained and motivated to deliver our service in line with our performance obligations and our cultural aspirations.

We have recently expanded our clinical workforce and have found recruitment in specific areas difficult due to national shortages in supply. We therefore recognise that we need to take a much more strategic approach to planning and implementing our plans in this area.

Some key components of this are already in place, including programmes to develop leadership, organisational development (OD), staff engagement and organisational capability. The redefinition of our vision and values is also a part of this and was described in the introduction to this document.

6.6 Workforce development

The aims of this are:

- to agree future workforce models and developing a plan for the required workforce changes to support seven day working
- to review our approach to succession planning and talent management, including clinical leadership
- to modernise our teaching to improve learning, including development of simulation training and e-learning methods. Supporting / innovating and a 'can do, will do' culture
- to develop existing partnerships with education providers and partner organisations, ensuring that students receive an excellent experience
- to encourage a climate in which staff embrace personal and organisational development and are given real opportunities to improve their own progress.

6.7 Leadership

We have a substantial portfolio of leadership programme underway within the Trust and these are supporting the development of leadership at all levels of the organisation. The aim of this is to have leaders who understand the role of strategic and cultural leadership, and are able to role model both transformational and transactional leadership styles as appropriate.

Specifically these include several strands of leadership development which have been initiated over the last few months. These include a leadership development programme for Clinical Directors and Consultants run by the King's Fund and our in-house Time to Lead Ward Sister Leadership Development Programme.

In addition, we have managers from across the Trust taking part in the third cohort of the Acua programme and alumni events are being arranged with previous cohorts to work on embedding the new values with their teams.

There are also a number of local and national NHS Leadership Academy development programmes that individual members of staff are attending. We are developing a process whereby they feed in their learning from these courses back into the Trust. We have also appointed a Leadership Development Coordinator on a fixed term basis to support these

initiatives.

The reorganisation of the Trust around three care groups will be supported via these leadership programmes and it is likely that in addition to activities already underway there will be further work with the senior nurse group (Matrons).

The range and depth of these programmes is testament to the fact that we believe they will substantially support the development and implementation of this strategy especially give the constraints facing the NHS over this period.

In the medium term we will:

- develop and deliver a Leadership Development suite of programmes by Band, to be identified through development conversations with line managers.
- establish a Coaching for Performance register with regular supervision
- personal leadership development time and reflective learning practices introduced to all senior management roles.

In the long term we will:

- formalise career progression plans for key generic roles
- introduce leadership development alumni activities to reinforce learning and maintain good practice.

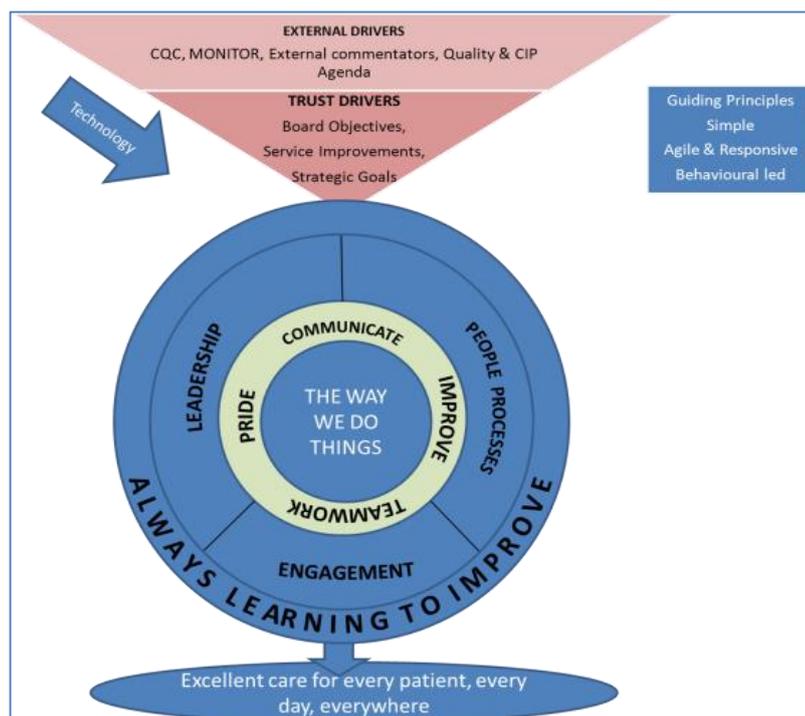
We intend to monitor the impact of these programmes and will use the following metrics for this purpose.

- more staff reporting that they would recommend the Trust as a place to work through the Employee Family & Friends test.
- reduced reports of bullying and harassment, and incidents of formal grievances
- reduced turnover

6.8 Organisational development

Following the decision not to with Poole Hospital in 2013, Trust developed an initial Organisational Development which was focussed on:

- developing a positive (the way we do things)
- continuous learning and improvement
- ensuring clarity of our purpose and direction a cohesive mission and employee driven values.



merge
The
plan
culture
Trust
through
It also

identified the need to develop the necessary capability to meet our Trust's goals in a sustainable way, with mechanisms to effectively measure performance, encourage accountability and improve recognition.

Exciting progress has been made and the foundations are being laid.

6.9 OD Strategy development timeframe and considerations

- a comprehensive three year Organisational Development Strategy is now being developed for review by September 2014
- high level costs to be developed on the basis of this proposal & then detailed implementation plans to be developed for each strand.
- consider implications of strategic plans on skills and workforce required to ensure the OD strategy is fit for purpose.
- work with the new Care Groups to determine development needs across specialty roles and management roles.

6.10 Staff engagement

We will develop the engagement of our workforce such that our staff feel proud to work for our hospital and would recommend the Trust to family and friends, both as patients and as members of staff.

There have been several different employee listening events in 2014, including the Values development work. We have launched the Staff Impressions survey which helps us to capture how our staff are feeling about the Trust, and records the Employee Family and Friends results. Directorate action plans will be developed each quarter based on this feedback.

Charitable funds have been agreed to support an increased programme for employee recognition and to encourage team building activities. #ThankYou! is now live and receiving regular nominations for individuals who have gone out of their way to provide excellent service.

We have thirty change leaders who represent a cross section of the Trust. Their role is to champion change and to act as communication ambassadors, feeding information to and from their spheres of influence.

In the medium term we will undertake:

- regular Employee Listening events
- new Staff Recognition programme will ensure at least 50% of staff are invited to a formal recognition event
- quarterly Staff Impressions Survey and Employee Friends and Family Test and appropriate action plans
- annual Staff Survey
- new Starters and Leavers questionnaires
- values development and increased behavioural focus
- identify opportunities for increased Doctor input and engagement
- Roll out of #ThankYou!

In the long term we will have:

- increased patient involvement in developing trust initiatives
- change leader representation across the Trust and involvement in strategic projects.

We will use the following metrics for this purpose.

- quarterly improvements in staff reporting they would recommend the Trust as a place to work.
- change leader representation is at least 2% of the overall Trust headcount.

6.11 People processes (organisational capability)

We will ensure we have the right skills, processes and people in place to meet our organisation's goals.

Programmes of current work include the development of essential core skills (formerly mandatory training) and commencing delivery of the Health Care Support Worker Certificate. We are also beginning work on a framework for delivering communication skills training across the organisation, in particular, with an emphasis on end of life care

In the medium term we will have:

- values based recruitment
- trust wide training needs analysis
- talent management conversation tool rolled out
- care group development plans
- education and training strategic group
- education and training restructure
- values and behaviours linked to appraisals
- new starter and leavers questionnaires
- HCSW care certificate

In the long term we will have:

- an effective talent management and career development framework to ensure people are developed towards their full potential

We will use the following metrics for this purpose:

- reduced turnover and vacancy rates
- staff report increased personal development opportunities and understanding of career pathways
- more staff report they would recommend the Trust as a place to work through the Employee Family and Friends Test
- increased number of applicants for roles and reduction in number of candidates declining jobs

We intend that the above approaches ensure that RBCH remains an attractive place to work and learn. However, we also recognise that the recruitment difficulties facing the NHS are unprecedented and we need to ensure that through an iteration of this strategy we have made

the best possible plans to mitigate the recruitment risks.

6.12 RBCH informatics strategy

The Informatics service for RBCH is combined with that of Poole Hospital – this gives the advantages of scale and expertise as well as ensuring that the two hospitals, dealing with the same patient population are maximising the opportunity to use the same patient record and the same IT systems.

Key themes of the Informatics Strategy include:

- access to information (instant, 24/7, anywhere)
- automation and process improvement
- system intelligence/memory
- patient in control

The informatics strategy will deliver the following key elements:

An Electronic Patient Record, presenting clinical information to clinicians at the point of care. This includes scanning existing paper health records.

Procuring Best of Breed Clinical Systems including Picture Archive and Communication System (PACS), Electronic Document Management/Scanned Health Records and Electronic Prescribing and Medication Administration.

In addition to this the strategy will provide access in secondary care to primary care / community information.

Another component of the informatics strategy is to support and encourage the digital consumer. This will be a significant challenge to the way the trust currently works so, to begin with, relatively straightforward services will be offered, such as the electronic transmission of patient letters. Subsequently more complex projects such as the development and use of patient held medical devices and patients accessing their own medical records will be pursued.

6.13 Estates

An extensive estates strategy has been updated in the light of not merging, and to reflect the increasing financial constraints. The details for the next two years are set out in the operational plan. Most significant amongst these are the developments at Christchurch Hospital, the new Jigsaw Unit for ambulatory care based Oncology, haematology, breast and gynaecology services and a major programme of ward refurbishments. With completion of the Christchurch project the vast bulk of the Trust's backlog maintenance is resolved.

Looking at the 3-5 year time horizon then the capital programme is flexible to follow the results of any clinical service review and several scenarios have been planned at high level. If there is a major reconfiguration generating a large capital requirement beyond our annual budget sums, then the Trust would need to use ITFF loans, or a commercial partnership. The latter route has been informally market tested recently and we are confident there could be alternative funding sources for the capital and construction phase. The RBH site has great flexibility with outline planning permission for additional buildings. The main constraint is the revenue implication of the capital, which would be a significant impact on the financial position of the Trust from 2019 onwards, and would be an important factor in any reconfiguration decisions.

6.14 Commercial

Commercial developments to diversify the income sources for the Trust, in areas that leverage our knowledge and support our wider aims are being explored. The two most developed are private patient activities, and our commercial joint venture with a nursing home and senior living development on the Christchurch site.

Both of these are being developed and feature as objectives for having longer term strategies in place by the end of 2014/15.

6.15 Research and innovation

The Trust has recently strengthened this function, and is appointing a clinical lead with dedicated time to provide medical leadership. A strategy has been recently adopted, which includes better support and take up of NIHR trials, alongside the continued growth of commercial trials on site.

Our close working links with Bournemouth University in particular, (where the research team offices are based) and active participation in the Wessex Research network will continue.

The Trust is also well represented on the Board of the newly established Wessex Innovation joint venture, and will use this as the primary route to capitalise on any intellectual property developments.

Our improvement work programmes have also a strong element of innovation diffusion and spread of best practice. Learning from others around quality improvement, urgent care and ambulatory emergency clinics, as well as cancer pathways are recent examples. Developing this operational improvement capacity remains one of the four key criteria the organisation will continue to nurture as an enabler for success.

6.16 Strategic planning

The Trust Board has also completed the strategic planning self-assessment tool, and identified areas for development. In our initial assessment using the Monitor Toolkit the areas that we felt required the most development are summarised as follows:

- Regular and frank strategy discussions with a range of LHE stakeholders.
- Quantification of risks to clinical and financial sustainability and developed transformation plans.
- Identifying a vision that establishes why and how the organisation should change or transform.
- Vision is supported by plans for initiatives that can be shown to address any sustainability gap identified.
- Trust staff, patients and other stakeholders able to explain the ambition and initiatives of the provider when asked.

This strategy and the executive summary is the start of addressing these gaps. The Board's creation of the strategy working group will oversee and co-ordinate this work, reporting directly to the Board so that this work has a high profile.

The particular focus of effort will be to generate the internal engagement of staff with the longer term strategic direction of the Trust. The dialogue has started about the need for change and to develop mitigating strategies. As this will need to be speciality based and owned by each service, this will entail using much of year one of this plan in supporting each service developing its own

plans, within the Trust (and health system) framework and priorities.

The second area of important focus is the external engagement, specifically with partner organisations. These relationships exist but can be strengthened, and targeted work is required to co-produce a sustainable health and social care local economy.

The strategic planning working group will, over the next five years, seek to significantly strengthen our strategic planning capability. The self-assessment tool kit approach will be the mechanism to assess gaps and priorities, and agree action to achieve this.

In conclusion our strategic plans are:

1. Early focus on internal improvement
2. Integration of community, then some hospital services
3. Developing our organisational capabilities and supporting strategies

The success of all of these approaches will be key to sustaining excellent care for all patients, every time. This is the set of strategic choices the Trust is passionate about delivering.