Royal United Hospital Bath NHS
NHS Trust

Building Excellence

RUH
2009 – 2013
Strategic Direction

This document builds upon the Trust Strategic Direction published in November 2004. It presents the next stage of development for the Trust.

During the period 2009 -2013 the RUH will work to become nationally recognised as a centre of excellence for patient care.

To support this it will achieve NHS Foundation Trust status and begin the redevelopment of its site in a way that meets the healthcare needs of the population it serves and that is sustainable within the predicted restrained economic climate from 2011 onwards.

This document has been put together with input from staff, patients, carers, General Practitioners and local health and social care partners. It is a short document and is supported by a number of appendices that give more detail in specific areas.

United in Excellence

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Our Strategic Direction

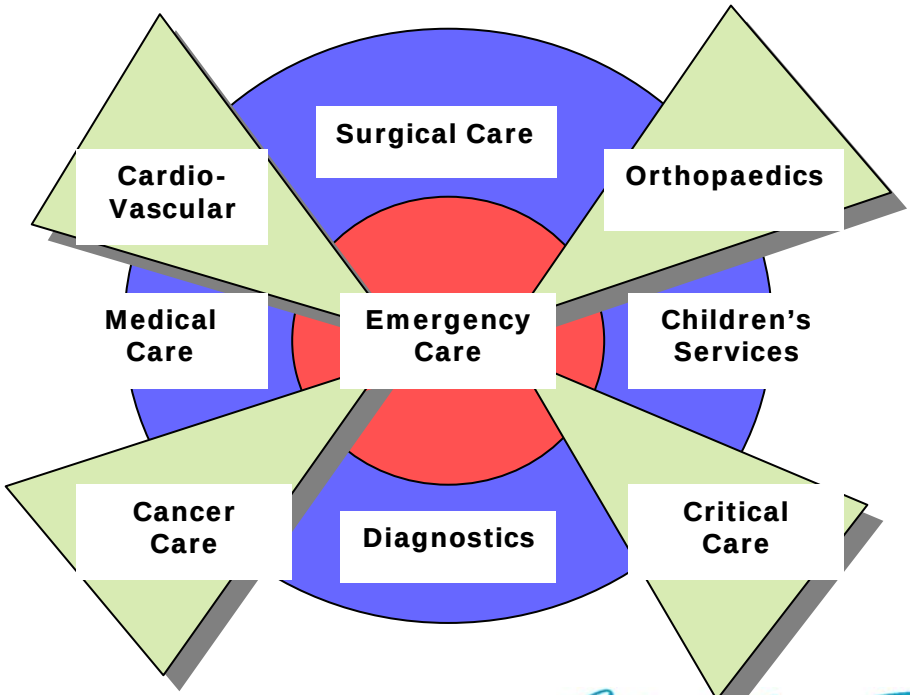
This document seeks to describe the overall development plan of the Royal United Hospital Bath NHS Trust (RUH) during the period 2009 – 2013. It is brief but of sufficient detail to enable staff, patients and our partners to understand our ambitions and how we intend to make improvements to the way we work.

1. Our Purpose:

The RUH is a Major Acute Hospital situated on the North Western side of the City of Bath. We are here for the people of Bath and North East Somerset, Wiltshire and Somerset to provide safe specialist care that cannot be provided at home.

At the core of our business is our service for patients requiring emergency and unplanned specialist care, 24 hours a day, every day of the year. From that core is built a comprehensive planned, surgical, medical and diagnostics service for adults and children. Further specialisation is delivered in a small number of areas – care for those with cancer, cardio-vascular care, higher levels of critical care and specialist orthopaedics. The breadth and depth of services at the RUH supports a 'whole patient' approach to care by allowing immediate and easy involvement of different specialists in any patient's care.

Visually the service profile of the hospital is shown below:



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The RUH, in partnership with local Universities and Colleges, also plays a major role in Education and Research. Doctors, Nurses and many other professions learn with us as students and then as qualified staff. The strength of learning, teaching and Research and Development at the RUH means we attract the best staff to work with us. The focus on learning supports innovation and improvement in providing excellent care for our patients.

2. Our Ambition

To be national exemplar for the NHS through:

dedicated Staff, working together, to give every patient excellent care.

Dedicated staff are:

- Focused on innovation and improvement for patients – willing to go the extra mile
- Supported to fulfil their potential
- Valued for who they are and what they bring to the workplace
- Able to enjoy a good work life balance

Excellent care is:

- Safe
- Effective
- Personal

3. Our Values

In delivering this ambition, we will be guided by the following values:

- We are dedicated to excellent care
- We demonstrate respect and equality for all
- We work together – a united approach to care
- We learn, plan, develop and improve continuously
- We are trustworthy
- We look after our environment

4. Our Strategic Objectives

In order to deliver the ambition of the RUH, we will focus on the following areas for improvement over the next five years:

Delivering what our patients want from us:

We will make being cared for by the RUH a positive experience by:

- Reducing infections
- Improving effective communication with patients – telephone, face to face and written
- Improving patient safety
- Working with patients in managing their care and their expectations from treatment
- Improving the environment for care

Supporting Dedicated Staff

We will make working at the RUH a happy and rewarding experience by:

- Recruiting and retaining the right number and type of staff
- Supporting leaders to lead
- Improving training, personal development and career advancement opportunities
- Valuing education and research and development in teams and individuals
- Rewarding innovation and improvement
- Living the values of the RUH

Ensuring the 'business health' of the RUH

We will make the RUH a successful and financially viable organisation for the long term by:

- Delivering services that meet and exceed national standards of performance
- Sustaining and increasing patient referrals, responding to patient and commissioner needs for new and different service types and securing associated income
- Working effectively with health and social care partners
- Improving value for money in all areas of the RUH

- Delivering a consistent and reliable service by ensuring the necessary physical and staff capacity is available
- Improving performance as assessed by external accreditation bodies (e.g. Care Quality Commission, Audit Commission, NHS Litigation Authority)
- Maintaining and improving cost control and financial management

Progressing Strategic Developments

We will continue to build a solid foundation for the RUH into the future by:

- Achieving NHS Foundation Trust Authorisation to give increased local control and flexibility in our activities
- Working to build effective partnerships with others in the health and social care sectors to improve the provision of care
- Planning and beginning to deliver a phased estate redevelopment programme that substantially improves the environment of care for our patients and our staff
- Delivering Service Level Management as our way of working – giving authority and responsibility to local leaders to deliver and improve their services
- Delivering a new Patient Administration System for the RUH that meets national reporting and patient safety requirements

5. Turning Words into Actions

We will take the above Strategic Objectives to build our annual plans over the next five years. For each objective there will be specific and measureable actions that will be performance managed by the Trust Board. Achievement of these objectives will be reported to the public through the Trust's Annual Report incorporating its Annual Financial Accounts and Annual Quality Accounts.

6. Conclusion

We are well positioned to make the step change from a competent performer to a Nationally recognised centre for excellent patient care. This document has outlined the ways in which this transition can and will be achieved with the support, dedication and input of staff, patients, GPs, PCTs and the general public.

APPENDICES

The National and Local Context

A full description of the context within which the RUH operates and the likely changes in this context, is given below.

National

Political

"High Quality Care for All, NHS Next Stage Review Final Report" otherwise known as the 'Darzi NHS Review' was published in June 2008. This report sets out the direction of travel for the NHS over the next period of the Government. The key themes within this report are:

What the NHS is about

- Improving the health of the population
- Quality at the heart of health services – what we do, how well we do it and how it is experienced by our patients
- Personalised care
- Greater control for patients in their care

How the NHS will provide care

- More care closer to home
- Some shift of specialist care to specialist centres
- More providers – not just NHS Trusts and GPs – providing care for NHS patients

How the system will work

- Fewer National targets, more local priorities
- More involvement of clinical staff
- Reduction in variation and movement to 'best practice' as norm
- Improved value for money
- Payments for quality

Whilst this policy is from the existing Labour Government the main themes within it are consistent with those from the Conservative Party. It is unlikely that there will be any radical change to policy direction within the term of this Strategic Direction document.

The government remains committed to all NHS Acute Trusts becoming NHS Foundation Trusts. Those not assessed as being sufficiently robust in terms of their business strategy, will be subject to take over by another NHS Foundation Trust. The timescale for achievement of Foundation Trust status is not explicitly defined but the vast majority of NHS Acute Trusts have either become NHS Foundation Trusts or are in the process of applying.

Economic

The current global economic position and the local UK position mean that the level of investment in the health service is unlikely to continue at the levels experienced since 1997 at the end of the current public sector funding period – i.e 2010/11. Levels of health funding have been at around 5.5% per annum which, combined with a 3% efficiency reduction in tariff (price per item of service) have resulted in significant increases in funding to be used to finance increased volumes of care as well as paying for new pay deals for clinical staff. There will therefore be increased pressures to reduce costs and improve value for money.

NHS care will remain free at the point of delivery funded from general taxation. However, recent rule changes have introduced the concept of 'private top-ups' where patients may choose to pay for some additional aspects of their care without losing their right to NHS treatment. This is likely to be most prevalent in cancer services where patients may pay privately for high cost drugs that have yet to be approved by National Institute for Clinical Excellence (NICE) and therefore not universally funded by the NHS. The full implications of this change will emerge over time.

Social

Two significant changes will affect the health service:

- The make up of the population
- The expectations of the population from its public services

Population

Generally speaking people are living longer but they are living longer with some degree of ill health or disability. This directly affects the population's requirements of its Health Service – which will be increasingly about supporting large numbers of people with chronic disease or disability across the spectrum of health and social care. In addition, as the traditional 'family unit' continues to

decline, the availability of family carers for older people is also likely to reduce with the potential for increasing demand on health and social care organisations.

Over the next five years there are also likely to be significant healthcare requirements arising from current 'lifestyle' choices; obesity, excessive alcohol use, drug-taking and smoking are all prevalent in our society. Whilst there is a shift to promoting healthy living within government health policy, the results of such a shift in terms of the population's health will take a long time to be realised. In the meantime, health services will need to meet the needs arising from these issues such as cardiovascular disease, cancer and mental health services.

Expectations

The population is becoming increasingly 'consumerist' in its approach to services. The growth of the internet society, used to shopping around to get the best price and the product that most closely meets their personal needs, is exercising the same approach to public services. This means that patients are less likely to accept what is on offer without question and are more likely to demand more from their hospitals. Patients will also be more likely to use the internet to do 'health research' on their condition / symptoms / concern. They will therefore become 'informed amateurs' in their discussion with doctors – this will significantly change the balance of power in clinical care consultations. The government's introduction of new health care providers, will facilitate choices in care and the potential for 'health shopping'. The service base of hospitals will therefore become more vulnerable to individual choice.

Technical

As in the past, the future is likely to see a continuing trend of expansion in what is 'technically possible' in healthcare. The use of less radical care options such as drug therapies and less interventional surgery will develop further. It is likely that hospital stays for surgical and planned care will continue to drop with day surgery being the norm. Diagnostic capabilities are likely to expand. The use of the internet to transfer information between clinicians and locations will result in greater opportunities to access specialist expertise quickly (e.g telemedicine).

The balance to this technological advancement will be an increasing ethical discussion about what *should* be done as opposed to what *can* be done. The overlap between medicine, ethics and law is likely to become more complex.

Environmental

Issues relating to the environment are becoming more visible within healthcare. They are most apparent in issues of planning and building. In planning terms, any development will need to demonstrate the impact that it is having on transport and how any detrimental effects will be mitigated. In building, all public building projects will be expected to be BREEAM good or excellent. (BREEAM is a set of construction targets on materials, energy, waste management etc).

In the future it is possible that attention will turn to the materials used on a day to day basis within a hospital (consumables) and their impact on the environment. For example, healthcare uses a high volume of disposable plastic materials and in the future there may be a financial disincentive introduced to try to lever changes in this area.

Legal

The health service is subject to the law of England and that of the European Union. Within the latter, laws on Working Time limits (European Working Time Directive), the Freedom of Movement for Goods and Services across Europe, and new International Financial Reporting Regimes include health. Over the next five years all of these areas will have a significant impact upon healthcare in UK.

From a national (English) law perspective, case law on Corporate Manslaughter and the Code of Practice for Infection Control (which allows for criminal prosecution) together with the Mental Incapacity Act, will become established.

Summary Issues for RUH from National Context

- The agenda for healthcare in UK will move from one of access and physical capacity to one of Quality. Patients will be encouraged to be active in making choices based on increased information on Quality being made widely available.
- There is likely to be nil-growth for health from 2011 as the Government seeks to control public expenditure.
- Competition for work will increase with continued support of new entrants to the NHS Provider 'market' that will challenge traditional NHS organisations.
- Taken together, the above will force radical improvements in value for money within health.
- All NHS acute Trusts will need to have been authorised as an NHS Foundation Trust by 2010 or face being acquired by such a Trust.
- The population is likely to become increasingly 'consumerist' in terms of the health 'product' they demand and will be more willing to exercise choice about when, how and where they receive care (including accessing services in Europe and deciding to 'co-pay' for enhanced / extended care options).
- Generally speaking there will be more people with underlying 'ill health' needing care – the most significant is likely to be care for an increasingly elderly population together with some specific 'lifestyle' issues such as increasing levels of obesity.
- There will be calls for some more specialist services to be located in 'super centres' rather than in local hospitals.
- Although more will be technically possible, it may not be affordable and choices in making care available may lead to differential services in different places.
- The framework within which NHS works will be subject to both domestic and developing European law (staff, buildings, safety).
- Increasingly the NHS will need to demonstrate that it is taking responsibility for its environmental impact.

LOCAL

Health Services

The Strategic Health Authority within the South West of England has taken the Darzi Review and sharpened it to provide a more specific list of measures for improvement over the period 2009 – 2013. These can be found separately at www.southwest.nhs.uk/strategicframework.html . In summary, the measures are about further reductions in waiting times and offering choices in health care. All local Primary Care Trusts are working within this framework of improvement and in addition have identified local priority areas. These are as follows:

Bath and North East Somerset

- **Mental Health services**
- **Healthcare associated infections**
- **Access to dental care**
- **Stroke care**
- **Cancer reform strategy**
- **Alcohol related harm**
- **Preventing teenage pregnancies**
- **Obesity**
- **Care for vulnerable adults**
- **Childhood immunisation**
- **Smoking cessation**
- **Drug use**
- **Cardiovascular disease mortality rates**
- **End of life care**
- **Supporting carers**
- **Access to hospital services**

Wiltshire

- **Preventing teenage pregnancies**
- **Tender maternity services**
- **Childhood immunisation**
- **Smoking cessation**
- **Delayed transfers of care**
- **Alcohol related harm**
- **Cancer mortality rates**
- **Cardiovascular disease mortality rates**
- **Supporting people to die at home**

Locally the provision of acute health services will be destabilised through the introduction of increased local competition. In addition to the Independent Sector Treatment Centre (IS-TC) operating in Shepton Mallet, two further IS-TCs will open in 2009 in Devizes (day surgery and diagnostics) and Emmerson's Green (simple inpatient surgery, day surgery and diagnostics). Local PCTs have committed to a level of activity being undertaken at these centres, including work moved from existing hospitals over the next five years.

Population

The populations of Bath and North East Somerset and Wiltshire are both more elderly than the national average. The Regional Spatial Strategy projects the local populations to grow (BaNES to have an additional 21,000 households and Wiltshire 11,440 by 2011). This growth in population is envisaged to be across age categories and links with expected local economic growth. Key underlying changes within the older age groups in the existing populations are shown below:

Age	**BaNES (population 184,000)**			**Wiltshire (population 448,990)**		
	2006 (%)	**2012 (%)**	**Change (number)**	**2006 (%)**	**2012 (%)**	**Change (number)**
65 – 69	7.7	9.7	3680	4.8	6.1	5820
70 – 74	6.9	7.2	552	4.1	4.5	2090
75 - 79	6.3	6.2	(184)	3.5	3.7	820
80 – 84	5.1	5.1	0	2.5	2.8	1010
85+	4.5	5.2	1288	2.3	3.0	3280
TOTAL			**5,336**			**13,020**

Note: Wiltshire populations figures from Wiltshire County Council's Economic Research and Intelligence Unit

The ethnic make-up of the population is predominantly White – English, Irish or Other. The ethnic profile of RUH staff has a slightly higher level of non-White staff than is found in the local population. There are no particular health issues arising as a result of the ethnic make up of the population. The greater challenge is around staying alert to the potential for differing needs from the very small numbers of patients from different ethnic backgrounds.

In terms of economic status, the population is generally less deprived, has a higher level of educational attainment and enjoys a higher level of general health than the national average. However, there are some geographical areas in which there are much higher levels of deprivation.

Summary Issues for RUH from the Local Context

- Locally, there will be more elderly people, living longer with ill health
- Patients will be offered more choice from increased numbers of providers of some surgical and diagnostic care (eg new Treatment Centres in Devizes and Emmerson's Green).
- The Regional Spatial Strategy for the South West predicts substantial population growth. The full economic model on which this is based, including details of age, ethnicity and social groups involved, is not yet developed. However, this population will need access to a full health service including hospital services. A profile of current RUH patients by age, sex and ethnicity is given as ***Appendix 1.1***.
- The RUH will be working with its local Primary Care Trusts to ensure equity of access to care for all patients, including those who traditionally do not access healthcare to expected levels.
- Health related issues of aging, obesity, alcohol, smoking, drugs and sexual health are priority areas for prevention and improvement in care by our PCTs and are likely to include a role for RUH.
- NHS South West has ambitions for the region to demonstrate some of the shortest waiting times in the country and Europe and substantial improvements to healthcare and well-being.
- Local PCTs as commissioners are committed to providing as much care as economically possible close to patients' homes. This includes movement from the acute hospital setting to a community setting.
- The 'market' for healthcare services is being opened up by PCTs keen to develop options for patients. Tendering and Any Willing Provider approaches to care purchasing are likely to increase.
- PCTs that currently act as 'Providers' of care will be reconsidering this role within the context of *World Class Commissioning*.

RUH Patient Profile

ELECTIVE Spells Apr08 - Sept08

Female	0-14	15-44	45-74	75+	Grand Total
White	271	1631	3306	1514	6722
Unknown	136	658	770	280	1844
Black	0	18	16	3	37
Chinese	5	3	3	0	11
Asian/Asian British	1	18	9	1	29
Mixed race	3	8	6	0	17
Other	0	4	2	2	8
Female Total	**416**	**2340**	**4112**	**1800**	**8668**
Male	**0-14**	**15-44**	**45-74**	**75+**	**Grand Total**
White	433	988	3112	1623	6156
Unknown	170	461	675	223	1529
Black	0	8	16	3	27
Chinese	1	0	1	0	2
Asian/Asian British	2	2	5	5	14
Mixed race	4	2	1	1	8
Other	3	3	1	0	7
Male Total	**613**	**1464**	**3811**	**1855**	**7743**
Grand Total	**1029**	**3804**	**7923**	**3655**	**16411**

Female	0-14	15-44	45-74	75+	Grand Total
White	4%	24%	49%	23%	100%
Unknown	7%	36%	42%	15%	100%
Black	0%	49%	43%	8%	100%
Chinese	45%	27%	27%	0%	100%
Asian/Asian British	3%	62%	31%	3%	100%
Mixed race	18%	47%	35%	0%	100%
Other	0%	50%	25%	25%	100%
Female Total	**5%**	**27%**	**47%**	**21%**	**100%**
Male	**0-14**	**15-44**	**45-74**	**75+**	**Grand Total**
White	7%	16%	51%	26%	100%
Unknown	11%	30%	44%	15%	100%
Black	0%	30%	59%	11%	100%
Chinese	50%	0%	50%	0%	100%
Asian/Asian British	14%	14%	36%	36%	100%
Mixed race	50%	25%	13%	13%	100%
Other	43%	43%	14%	0%	100%
Male Total	**8%**	**19%**	**49%**	**24%**	**100%**
Grand Total	**6%**	**23%**	**48%**	**22%**	**100%**

NON-ELECTIVE Spells Apr 08 - Sept 08

Female	0-14	15-44	45-74	75+	Grand Total
White	864	1692	2111	2684	7351
Unknown	34	227	175	129	565
Black	6	14	7	3	30
Chinese	1	4	1	3	9
Asian/Asian British	6	7	7	2	22
Mixed race	10	7	4	0	21
Other	1	3	2	1	7
Female Total	**922**	**1954**	**2307**	**2822**	**8005**
Male	**0-14**	**15-44**	**45-74**	**75+**	**Grand Total**
White	1154	1406	2467	1810	6837
Unknown	43	207	176	79	505
Black	10	16	5	5	36
Chinese	4	1	0	0	5
Asian/Asian British	10	11	3	1	25
Mixed race	21	4	2	0	27
Other	5	7	8	1	21
Male Total	**1247**	**1652**	**2661**	**1896**	**7456**
Grand Total	**2169**	**3606**	**4968**	**4718**	**15461**

Female	0-14	15-44	45-74	75+	Grand Total
White	12%	23%	29%	37%	100%
Unknown	6%	40%	31%	23%	100%
Black	20%	47%	23%	10%	100%
Chinese	11%	44%	11%	33%	100%
Asian/Asian British	27%	32%	32%	9%	100%
Mixed race	48%	33%	19%	0%	100%
Other	14%	43%	29%	14%	100%
Female Total	**12%**	**24%**	**29%**	**35%**	**100%**
Male	**0-14**	**15-44**	**45-74**	**75+**	**Grand Total**
White	17%	21%	36%	26%	100%
Unknown	9%	41%	35%	16%	100%
Black	28%	44%	14%	14%	100%
Chinese	80%	20%	0%	0%	100%
Asian/Asian British	40%	44%	12%	4%	100%
Mixed race	78%	15%	7%	0%	100%
Other	24%	33%	38%	5%	100%
Male Total	**17%**	**22%**	**36%**	**25%**	**100%**
Grand Total	**14%**	**23%**	**32%**	**31%**	**100%**

RUH Current Performance

Patient Care

Safety

The RUH performs well in the following areas when compared with other Acute Hospitals in England:

Top Decile
- Adult Intensive Care outcomes
- Neonatal Intensive Care outcomes

Top Quartile
- Surgical Site infections
- Hospital Standardised Mortality Rates

National Average
- Pressure Ulcers acquired during hospital stay

Over the last two years actions focused on reducing numbers of Healthcare Associated Infections have yielded significant improvements as summarised below:

	2007/8	2008/9 (ten months)
MRSA	35	21
C Difficile	301 (patients aged over 65)	258 (all ages)

The RUH now screens all patients for MRSA before admission for planned procedures. No patient admitted for planned surgery since April 2008 has had an MRSA bacteraemia infection.

By 2010 all patients admitted to the hospital as emergencies will be screened within 48 hours and appropriate actions will be taken to manage and / or isolate any patient for whom this is appropriate.

Experience

Patient surveys at the RUH have identified the following areas of strength and opportunity for improvement:

Strengths

- Team working between doctors and nurses
- Good hand hygiene
- Privacy and Dignity needs are respected

Opportunities for Improvement

- Increasing single room provision for isolation and privacy purposes
- Being cared for in a single sex area

Analysis of complaints made to the RUH by patients and contacts made with the Patient Advice and Liaison Service (PALS) shows the following areas for improvement:

- Improving telephone answering
- Improving hospital signs
- Further improving the quality and presentation of patient food

2009 sees the introduction of Patient Experience Trackers to be used in ward and outpatient areas. These are wipe-able hand held computers that ask patients a series of standard questions about the experience they are having at the time. This kind of real time feedback will provide powerful information to staff on issues that need to be tackled as they arise.

Financial Performance

In 2008/09 the RUH will break-even for the third consecutive year. Prior to this, the hospital had not broken even on its basic income since becoming an NHS Trust and as a consequence a significant deficit had been accumulated by the hospital. In 2007 this debt was repaid using a loan from Department of Health which is repayable over a six year period. In the first repayment year (2007/08) the repayment was made in full and in 2008/09 the second year's commitment will be met. On this basis the RUH will be debt free by 2013; however, there is a commitment to accelerate repayments to achieve full repayment at the earliest possible date.

The RUH is a relatively cost efficient Acute Trust as demonstrated by its comparative cost index (reference costs) of 92 against a national average of 100. The hospital is currently working to generate an annual surplus of circa £5.6million towards the debt repayment mentioned above which accounts for much of the gap between income and expenditure.

The RUH does have an opportunity to gain more income for the work it undertakes through the re-negotiation of locally priced agreements for some services, the most substantial of which is care of those with Cancer. The levels of funding in these areas were set some years ago and it is important that they are reviewed to ensure that they meet service costs.

The 2007/08 Auditors Local Evaluation of the RUH (an independent national assessment of the financial position of the hospital) resulted in the following assessment:

Financial Reporting	2
Financial Management	3
Financial Control	3
Financial Standing	2
Value for Money	3
Overall	***FAIR***

Rating scale: 1 (weak), 2 (fair), 3 (good) 4 (excellent).

Operational Performance

Waiting Times

Over the last four years waiting times have reduced drastically. Whilst this reduction has been a national phenomenon, the degree of improvement at the RUH has been greater with the hospital moving from having some of the longest waiting times in the Country to some of the shortest.

In 2007/08 the RUH was assessed by the Healthcare Commission as providing a ***Good*** Quality of Service.

Waiting times are now*:

Waiting time for planned surgery and procedures (from GP referral to	80% of patients are admitted within 13 weeks of referral

admission)	
Waiting time for planned outpatient care (from GP referral to attendance)	95% of patients are treated as outpatients within 13 weeks of referral
Waiting time for patients with cancer (from referral by GP to first treatment)	Over 99% of patients who are found to have cancer receive their first treatment within 62 days of first being referred with suspected cancer (i.e they have been positively diagnosed and a treatment programme determined within this period)
Waiting times for thrombolysis for patients with heart attacks	78% of eligible patients receive thrombolysis within one hour of the call for an ambulance

* end January 2009

The choice of where to go for care is therefore not now predominantly about how long one will have to wait. However, recognising how important it is to local people to get quick access to care, the SHA has committed to reducing waiting times even further – to eight weeks by 2011.

Standards for Better Health

The Healthcare Commission uses twenty four standards covering all aspects of acute care to provide a level of assurance on the systems and processes being followed by the hospital as it delivers its business. In 2007/08, the RUH declared assurance on all but one standard – pursuing the Public Health agenda in its operations. In 2008/09 the hospital will be declaring full compliance against every standard.

Hygiene Code

The Hygiene Code sets out the standards to which a hospital needs to work to ensure the safety of its patients through the management of risks to infection control. The Code is enforceable under law and compliance with it will be assessed by the Care Quality Commission (to be established April 2009). The visit to the RUH to assess compliance with the Hygiene Code (February 2008) found no material breaches of the code and made four recommendations for further improvement all of which have been implemented. The most important issue for RUH was the need to ensure adequate access to isolation facilities. RUH received its second unannounced visit by the Healthcare Commission on 26 /27 January 2009. The report from that visit is awaited.

National Health Service Litigation Authority (NHSLA)

All NHS providers have the financial consequences of their corporate clinical risks (i.e claims for compensation) covered by the NHSLA through the operation of a 'risk sharing pool'. Every hospital pays an NHSLA premium based on an assessment of its level of risk. In 2007/08, RUH was assessed as having an NHSLA risk Level One. Re-assessment is due in 2009/10 at which time the hospital intends to be at Level Two.

Summary

The RUH has made significant improvements in its operational and financial performance over the last four years. Basic systems and processes are robust and the hospital actively assures its activities – both through external assessment processes but also through its corporate governance structure of Trust Board and three Trust Board Assurance Committees – Audit, Clinical Governance and Non-Clinical Risk.

Standards of clinical care at the RUH are high. This means that patients should feel confident that they are getting appropriate and high quality care from the hospital. The hospital provides all the services necessary up to and including critical care (both general and cardiac), to be able to respond to patients' individual needs as they arise.

Strengths, Weaknesses, Opportunities and Threats

Given the information presented in Sections Two and Three, it is possible to produce a high level analysis of the RUH Strengths, Weaknesses, Opportunities and Threats (SWOT). From this, the RUH can determine the priorities for attention over the next five years.

The corporate SWOT is given below:

Strengths	**Weaknesses**
• Clinical standards of care • Large (and growing / aging) population dependent on hospital for acute care • High quality clinical leaders • Clear corporate sense of purpose • Competitive waiting times • Financial control • Loyal patient base • Good relationships between hospital clinicians and GPs • Stable Executive Team	• Delivery of improvement in emergency access times not yet sustained • High bed occupancy levels compromise optimal patient care and efficient operation • Patient perceptions re. infections (often at odds with reality) • Communication – phones, letters and face to face • Vacancy levels in qualified nursing group remain high • Staff feeling pressurised by workload • Some buildings offer a poor environment for care • Loan repayments limit opportunities to reinvest • Patient Administration System in urgent need of replacement

Opportunities	**Threats**
• Increasing elderly population will require support of full Major Acute Hospital facilities • Financial balance now allows recruitment to establishment • Focus on Patient Safety and Patient Experience will improve 'product' offered to our patients • Build on innovation and improvement to attract staff and retain them once here • Site offers opportunities for redevelopment • Possible development of a role for the RUH in the provision of out of hospital local services • Possible links to an Academic Health Sciences Centre partnership approach in the South West	• Competition from IS-TCs • Loss of 'low tech' services to community providers • Loss of 'high tech' services to tertiary centre in Bristol • Economic downturn limits scope and rate of investment in improvement for Primary Care Trusts and the RUH • Lack of development of out of hospital health and social care for increasing numbers of older people results in longer lengths of stay in acute setting

Key messages from the above are, the RUH must:

- deliver key performance standards consistently
- improve the way it communicates with patients
- further develop its clinical strengths
- continue to attract leaders who are focused on innovation and improvement
- recruit and retain the right number and the right type of staff
- plan for appropriate levels of capacity to meet patient needs through peaks of activity
- ensure that it is operating at the highest levels of clinical and non-clinical efficiency to protect itself from the volatility of the market and the likely funding slow down
- be a part of a wider system of health and social care that works effectively and efficiently
- address its buildings issues
- be environmentally responsible

Expectations of Stakeholders

The following description of expectations has been derived from the outputs of Stakeholder events held in October 2008 and January 2009, the outputs of a session on developing a Patient Experience Strategy (September 2008) and various Staff Engagement meetings. An open questionnaire "Have Your Say on the Future of RUH" was also available on the intranet and internet for anyone to complete. Feedback from responses received has been incorporated. A list of those attending one or both of the Stakeholder events is given as ***Appendix 4.1***.

People were asked to describe the ideal 'essence' of RUH in 2013 by adding to 'hanger' questions. A summary of these views is presented below:

Patients and Carers

Being at the RUH it is immediately clear that….

- You know me and are expecting me
- You are serious about care and serious about me
- You have time for me
- Staff are happy and have enough time to do their job
- I really matter to you

I see this in the physical environment by….

- A clean and tidy environment
- Lots of loos (clean loos)
- Modern and uncluttered facilities
- Good sign posting
- Nutritious and appetising food

I experience it from staff in….

- Effective communication from the time I first make contact with you (written, telephone or in person) and then throughout my care
- Friendly and relaxed approach
- Clean and tidy staff
- Being happy to involve me, talk to me and listen to me

It creates a sense of…

- Being well cared for
- Confidence
- Being valued

Staff

Working at the RUH it is immediately clear that….

- We are an Excellent hospital
- We have enough staff and facilities to do the job well
- Everyone enjoys working here
- Everyone is committed to high quality care and working to make things even better
- I am valued for who I am and the experiences and knowledge I bring

I see this in the physical environment by….

- Clean and fit for purpose facilities
- Good staff welfare facilities
- The way it protects me whilst I do my job

I experience it from colleagues in….

- Support and recognition for what I do
- Effective communication with me
- Infectious enthusiasm
- Respect for me and for my health and well-being
- Support for me in my personal development

It creates a sense of…

- Pride in what we do
- Being valued
- Success
- Well-being

Health and Social Care Partners

Working with the RUH it is immediately clear that….

- They provide good acute care for local people
- They treat people as individuals
- They want to work with me and others to improve care for patients and the health of the population we collectively serve
- They value me and my views

I see this in the physical environment by….

- Fit for purpose buildings
- Good and easy access to the site and to the hospital buildings
- Facilities that are free of infection risk

I experience it from staff in….

- Clear and flexible care pathways
- A consistent response to my enquiries
- A good knowledge of the situation
- Good communication with me
- An open approach to thinking differently to deliver improvements

It creates a sense of…

- Responsiveness
- Working together

Summary of Stakeholder 'needs'

Not withstanding the differing perspectives of stakeholders, some very similar themes have emerged from our events. These may be summarised as follows:

- Treat me as an individual
- Get to know me and value me and my views
- Communicate effectively with me – listen to me and talk with me
- I need to have confidence in you – show me that you are competent through your attitude and your behaviours
- Don't take me for granted
- Don't expect me to accept second best
- Be friendly
- Show me that you are focused on Quality

STRATEGIC DIRECTION STAKEHOLDER EVENTS ATTENDANCE SHEET

The following people attended one or both of the stakeholder events held on 8th October 2008 and 14th January 2009.

Staff

1 James Scott
2 Brigid Musselwhite
3 John Waldron
4 Francesca Thompson
5 Peter Hollingshead
6 Tim Craft
7 Peter Wearmouth
8 William Hubbard
9 Chris Gallegos
10 Lindsay Grant
11 Clare O'Farrell
12 Steve Hart
13 John Travers
14 Sharon Preston
15 Jan Lynn
16 Gareth Howells
17 Denise Greenham
18 Julie Stone
19 Elizabeth Vowles
20 Jo Miller
21 Liz Richards
22 Alex Massey

23 Heather Cooper

24 Jenny Evans (Chair Staff side)

25 Lors Allford

26 Chris Meehan

27 Jane Lewis

28 Dorothy Goddard – Breast Unit

29 Lindsey Dow - Older People's Unit

30 Claire Bullard

31 Carol Fievez

32 Regina Brophy

33 Mike Newport

34 Julie Day

35 Jane Derby

36 Nicky Ashton

37 Lee Warner Holt

38 Jeremy Martin

39 Rhiannon Richards

40 Peter Eley

41 Tracy Elvins

42 Amy Shortridge

43 Theresa Hegarty

44 Mark Tooley

45 Steve Boxall

46 Malcolm Ormond

47 Helen Robinson-Gordon

48 Geoff Cross

49 Teresa Hemingway

Patient and Carer Representatives

50 Judith Constantine – Patient Rep

51 Pat West – LINKS

52 Hilary Elms – Patient rep

53 Margaret Greenman – Patient rep

54 Jane Luckham-Down – Patient rep

55 Jim Barker – Patient rep

56 Sonia Hutchison – Off the Record

57 Corinne Shelley – Young Carer

58 Sylvia Humphries – Patient rep

59 Elizabeth Brooks – Patient rep

Health and Social Care Partners

60 Simon Burrell – GP

61 Stephen Locke – GP

62 Nick Whitehead – GP

63 Nicole Howse – GP

64 Tracey Cox BaNES PCT

65 Louise Hurst WILTS PCT

66 Keiran Morgan BaNES PCT

67 Maggie Rae Wiltshire PCT

68 Jean Perry in place of Judith Newman
Somerset PCT

69 Lee Eborall BaNES PCT

70 Nik Attryde in place of David Tappin Bristol
PCT

71 Jenny Barker – Wilts Provider

72 Adrian Inker – Chair, BaNES OSC

Non-Executive Directors of RUH

73 Stephen Wheeler

74 Moira Brennan

75 Michael Earp

76 James Carine – Chairman

Strategic Objectives: 2009 - 2013

In order to deliver the ambition of the RUH, we will focus on the following areas over the next five years:

Delivering what our patients want from us:

We will make being cared for by the RUH a positive experience by:

Reducing infections

Outcome: we give confidence to our patients by demonstrating that we have control of infections.

Key Programmes to support:

Control of Infection Taskforce
Leading Patient Safety Initiative

Assurance: Governance Committee

Improving effective communication with patients – telephone, face to face and written

Outcome: patients feel confident and content during their period of care and feel happy to return / recommend RUH to friends and relatives.

Key Programmes to support:

Productive Ward – Releasing Time to Care
Booking review group (to be established)
Customer care training programme
Patient Experience Strategy including Patient Experience Tracker programme

Assurance: Governance Committee

Improving patient safety

Outcome: our developing 'safety culture' gives better care to our patients and results in being recognised as an excellent provider of care.

Key Programmes to support:

Patient Safety Strategy
Leading Patient Safety Initiative
National Patient Safety Campaign

Assurance: Governance Committee

Working with Patients in Managing their care and their expectations from treatment

Outcome: our patients feel more in control during their time with us and feel more confident to express their preferences / fears. Patients set realistic outcomes from their care and are happy to tell us whether we have met their expectations thereby helping us to learn for the future.

Key Programmes to support:

Patient Safety Strategy
Leading Patient Safety Initiative – Patient Reported Outcome Measures (PROMs)
Co-design in health care initiative (to be established)

Assurance: Governance Committee

Improving the environment for care (including food)

Outcome = care is easier to give, patients have increased confidence in the service and the hospital is better able to deal with challenges and risks associated with the fabric of the building.

Key Programmes to support:

Patient Experience Strategy
Patient Environment Action team
Menu and food feed-back programme
Emerging Hospital Strategy
Way-finding Strategy

Assurance: Non-clinical risk committee

Supporting Dedicated Staff

We will make working at the RUH a happy and rewarding experience by:

Recruiting and retaining the right number and type of staff

Outcome: we have enough staff of the right type to do the job.

Key Programmes to support:

Workforce Strategy
Recruit, Respect and Respond campaign
"Proud to be a Nurse" recruitment and training initiative

Assurance: Non-clinical risk committee

Supporting Leaders to Lead

Outcome: Strong and competent local and organisational leaders set direction and implement improvements for patients and staff quickly making RUH more immediately responsive to issues.

Key Programmes to support:

Leadership strategy – personal skills, leading teams, leading for improvement
Fit to Lead programme for Clinical Leads

Assurance: Non-clinical Risk Committee

Improving training, personal development and career advancement opportunities

Outcome: Motivated staff delivering a good service to patients.

Key Programmes to deliver:

Workforce Strategy
Leadership Strategy (growing new leaders)

Assurance: Non-clinical Risk Committee

Valuing Education and Research and Development in Teams and Individuals

Outcome: Staff seek to learn and in doing so bring knowledge to their day to day work that benefits patients and the hospital and establishes a reputation for academic development that, in turn, attracts staff to RUH.

Key Programmes to deliver:

R&D Strategy

Assurance: Non-clinical Risk Committee

Rewarding innovation and improvement

Outcome: Staff feel motivated to try new things to make improvements for patients and for the hospital

Key Programmes to support:

To be confirmed

Assurance: Non-clinical Risk Committee

Living the values of the RUH

Outcome: RUH is 'trusted' by staff, patients and the public. The RUH 'experience' is good.

Key Programmes to support:

Respect campaign

Assurance: Trust Board

Ensuring the 'business health' of the RUH

We will make the RUH a successful and financially viable organisation for the long term.

Delivering services that meet and exceed national standards of performance

Outcome: The RUH gains the confidence of its commissioners and NHS SW in its ability to manage itself and its services. Focus of attention with commissioners can then switch from performance management to service improvement.

Key Programmes to support

Emergency Care Pathway Improvement Programme
Local Health Economy Urgent Care Network
Elective Care Pathway Improvement Programme
LHE Local Implementation Group – Cancer Services

Assurance: Trust Board

Sustaining and increasing patient referrals, responding to patient and commissioner needs for new and different service types and securing associated income

Outcome: The RUH is the 'first choice' for acute care. Service offering for most patients is 'comprehensive' and as such patients feel no need to 'shop around'. Patients experience services that are designed for them.

Key Programmes to support

Service Development and Improvement Programme
Patient involvement in service planning
Commissioning College
Coding quality and Income recovery programme (including Provider to Provider contracts)

Assurance: Audit Committee, Non-Clinical Risk Committee

Working effectively with Health and Social Care Partners

Outcome: The RUH is experienced as being responsive and open by NHS and Social Care Partners. Relationships are good and trusting.

Key Programmes to support:

GP Liaison Plan
PCT provider Partnership Boards
Commissioning College

Assurance: Non-Clinical Risk Committee

Improving value for money in all areas of the RUH

Outcome: The RUH reduces waste in its activities and thereby releases resource (people, space, money) to be reinvested in value adding activities and strategic priorities. Opportunities for cash releasing efficiency savings are maximised.

Key Programmes to support:

RUH2010 Improvement Programme
Service Level Management

Assurance: Audit Committee

Delivering a consistent and reliable service by ensuring the necessary physical and staff capacity is available

Outcome: The RUH is able to manage peaks and troughs in activity without any effect upon standards of patient care. Good patient experience. Good reputation developed for 'managing' pressures.

Key Programmes to support:

Capacity Planning
Winter Planning
HR Strategy

Assurance: Non-clinical risk committee

Improving performance as assessed by external accreditation bodies (Care Quality Commission, Audit Commission, NHS Litigation Authority)

Outcome: improved reputation for trust through positive media. Reduction in 'risk' premium charged to the RUH.

Key Programmes to support:

SfBH assurance programme
ALE assurance programme
NHSLA assurance programme
CfH Information Governance Toolkit self assessment
H&S self assessments
Single Equality Scheme self assessment

Assurance: Governance Committee, Audit Committee, Non-clinical Risk Committee

Maintaining and improving cost control and financial management

Outcome: The RUH delivers on its statutory breakeven duty.

Key Programmes to support:

Performance management processes
Service Level Management
Auditors Local Evaluation Action Plan

Assurance: Audit Committee

Progressing Strategic Developments

We will continue to build a solid foundation for the RUH into the future.

Achieving Foundation Trust Authorisation

Outcome: The RUH builds a strong and productive relationship with the community it serves and further develops as a thriving Major Acute Hospital with a strong shared sense of purpose.

Key Programmes to support:

Foundation Trust Application Programme
FT Membership Strategy
FT Business / Governance Model

Assurance: Trust Board

Working to build effective partnerships with others in the health and social care sectors to improve the provision of care

Outcome: Patients experience a more 'joined up' service and have greater confidence in the whole health system. Health and Social care system optimises use of resources across organisations.

Key Programmes to support:

PCT Provider and RUH Partnership Boards
Local Health Economy Urgent Care Network
Local Strategic Partnerships

Assurance: Trust Board

Planning and beginning to deliver a phased estate redevelopment programme that substantially improves the environment of care for our patients and our staff

Outcome: Services are provided from appropriate, efficient and high quality accommodation that meets clinical and personal needs of patients. Patients feel happy to choose the 'RUH experience'. Staff enjoy working in facilities that meet their needs. The RUH demonstrates that it is taking responsibility for its effect upon the environment through a reduced 'carbon footprint'.

Key Programmes to support:

Emerging Hospital Strategy Programme

Assurance: Trust Board

Delivering Service Level Management

Outcome: The proposed 'business unit' structure of the hospital results in a more nimble, proactive and innovative organisational culture with the top level of the organisation providing a role of co-ordination, broad scanning and risk management rather than prescriptive direction. Incentives to improve are explicit as there is direct 'pay back' for efficiencies / improvements made through financial reward (increased income, lowered costs)

Key Programmes to support:

SLM Programme
Internal trading accounts

Assurance: Trust Board

Delivering a new Patient Administration System for the Trust that meets national reporting and patient safety requirements

Outcome: improved and easier reporting of activity, streamlining processes and releasing staff time; reduced risk to service continuity, compliance with national requirements; base from which to develop shared electronic patient record.

Key Programmes to support:

Millennium Project Board

Assurance: Trust Board

Performance Management of Delivery

Appendix 5 details the Trust's Strategic Objectives and the programmes that are in place or will be put in place to support their delivery.

These objectives will be consistent over the five year period of this Strategic Direction and on an annual basis, will be translated to specific, measurable, achievable, realistic and time related (SMART) objectives within the annual business plan.

Performance management of delivery will be through the Management Board of the Trust to Divisions and to Corporate Directorates. A performance scorecard will be used to display key targets and performance against them. Distinction will be made between operational delivery targets measured on a monthly basis and strategic improvement projects that may be measured on a quarterly basis.

Each strategic objective will have a lead Executive Director. Performance against these objectives will be included in annual appraisal processes.

Every year the Trust will publish its Annual Report incorporating its Annual Accounts and, from 2010 onwards, its Quality Accounts. These will be made widely available to the public, staff and partners and will be presented in public at the Trust's Annual General Meeting.

Risks

At a corporate level, the RUH will monitor the risks associated with the delivery of the Strategic Direction through its Assurance Framework. For each Strategic Objective a lead Assurance Committee of the Trust Board has been identified. It will be the responsibility of the relevant Committee to seek assurance and if necessary require remedial action to be taken to manage or mitigate risks in delivery of objectives.

The top level risks organisation associated with delivering this Strategic Direction are summarised as follows:

Primary Risks

Operational Performance

The reputation and the future success of the RUH rests on delivery of key basic performance standards, the most challenging of which is the Emergency Four Hour Standard (reducing to two hours by 2011). If standards are not routinely delivered then RUH will not be supported to move to FT status and its standing in the local community will not improve.

Management of this risk will be led by the Director of Operations and will require internal performance improvements and external partnership working with PCTs and Social Services Departments.

NHS Loan

Repayment of the loan is key to the hospital's plans for development as it triggers the following:

- The RUH can proceed to Foundation Trust status
- The Emerging Hospital Strategy becomes affordable as the current loan surplus can be re-routed to support repayments on this capital scheme
- PCTs have funding released back to them that may be used for service investments

Management of this risk will be led by the Director of Finance working with local PCTs and NHS South West.

Secondary Risks

Foundation Trust Authorisation

Failure to deliver operational standards and / or to resolve the loan results in a failure to achieve FT status which in turn, under the new regime of the NHS, means that the RUH may become the subject of acquisition by an existing FT.

Emerging Hospital Strategy

Failure to resolve the loan creates a 'hiatus' in strategic capital expenditure at the RUH which in turn means major environmental concerns will not be addressed and patients will potentially choose to receive care from providers with higher quality estate. This results in a loss of income and a reducing capability to make the necessary investment in the future, to the detriment of local people who will still require the RUH for acute care.

Competition from Other Providers

Guaranteed support to new Independent Sector Treatment Centres over the next five years and within the context of reducing health funding from year two onwards, leads to a loss of income to the RUH. Unless costs can be reduced to offset income loss completely (unlikely) the hospital will see its unit costs increase, raising reference costs and making planned surpluses more challenging to achieve.

Equality Impact Assessment

This Strategic Direction has been discussed with the Patient Experience Group of RUH and with their input and input from the Staff Involvement Group, the following Equality Impact Assessment has been undertaken.