



Doncaster and Bassetlaw Hospitals



NHS Foundation Trust

Strategic Plan Document for 2014-19

Doncaster & Bassetlaw Hospitals NHS Foundation Trust

1. Looking Forward to Our Future – Our Strategic Direction

Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBH) serves a population of over 420,000 people in the areas covered by Doncaster Metropolitan Borough Council and Bassetlaw District Council and also parts of North Derbyshire, Barnsley, Wakefield, Rotherham and North-West Lincolnshire. We also provide vascular screening to a population of 1.5M across South Yorkshire and Bassetlaw. In our recently developed *Strategic Direction 2013- 17*, we defined our vision which sets out our ultimate ambition and our mission that sets out the primary purpose of the Organisation.



Our Vision

Our Vision is to become recognised as the best healthcare provider in our class, consistently performing in the top 10% nationally.

Our Mission

We are here to safeguard the health and wellbeing of the population and communities we serve, to add life to years and years to life. We aim to combine the very highest levels of knowledge and skill with the personal care and compassion that we would want for our friends and families at times of need – in short *We Care for You*.

Our Values

Our vision and mission are underpinned by our values that have been developed through wide ranging consultation with staff. To show we care for you:

- We** always put the patient first
- Everyone** counts – we treat each other with courtesy, honesty, respect and dignity
- Committed** to quality and continuously improving patient experience
- Always** caring and compassionate
- Responsible** and accountable for our actions – taking pride in our work
- Encouraging** and valuing our diverse staff and rewarding ability and innovation.

Strategic Themes

To achieve our vision we identified 4 strategic themes (see fig 1 below) and our Strategic Plan for 2014-19 is consistent with those themes and with our Strategic Direction.

Fig 1



2. Market Analysis & Context

DBH works closely with the two local Clinical Commissioning Groups (CCGs) in Doncaster and Bassetlaw and the NHS England Local Area team. In our plans, we have considered the market analysis and needs assessments by the CCGs and Local Area Team in the strategic plans they have submitted. We have actively contributed to the process of strategic planning across the locality including Executive level membership at the Doncaster Health & Wellbeing Board and the Bassetlaw Integrated Care Board.

As part of the process of identifying and evaluating the material challenges facing DBH and the wider Local Health Economy (LHE), we have considered the plans of our LHE partners and the current and anticipated national context. We have analysed the extent of the challenges the LHE faces including affordability, changing healthcare models & demographics and considered the likely impact on DBH in terms of capacity, funding and our position in the local healthcare market. The key material challenges are discussed in more detail below, including an analysis of the evidence base underpinning the assessment.

2.1 Material Challenges

Looking ahead over the next five years the Trust will face a number of challenges. The most significant of these are

- Affordability
- Changes in the Model of Care Provision

2.1.1 Affordability

Rising health care demand, rising costs and flat real funding mean the NHS could face an estimated £30 billion financial shortfall by 2021¹. It is expected that during the next 5 years, there will be a 15% reduction in non-elective activity and a significant improvement in planned care productivity. In terms of implications for the local health economy the major challenge is to ensure that demand is managed to ensure that the non-elective activity is reduced by the effective provision of appropriate alternatives. Many of which are outside the direct control or influence of DBH.

We have considered how the above opportunities can be realised by DBH and have incorporated these into our 5 year strategic plans in order to achieve an affordable position whilst continuing to provide the safest most effective care (see plans in section 1.5). This is consistent with all of our strategic themes. Being clear about the extent of the financial challenge, and how we will address it, will enable us to be in a position to be able to provide appropriate, high quality and cost effective services on a sustainable basis. Addressing the affordability challenge is only possible by working as part of the LHE. In addition to the strong relationships we have with our commissioning, community and local authority colleagues, we have also formed a partnership with seven other trusts in South Yorkshire, Mid Yorkshire and North Derbyshire called “Working Together Programme” (WTP) to share best practice and improve patient care. This is in line with the partnership approach identified in our *Strategic Direction 2013-17*. This partnership work will provide opportunities in many areas including procurement, smaller specialties, locum and agency use and Informatics. We also have an established procurement/shared services partnership with North Lincolnshire & Goole NHS Foundation Trust and United Lincolnshire NHS Trust.

We plan to continue to work toward improving productivity as a result of continued implementation of the Trust’s cross cutting transformation programmes supported by the Quality Improvement & Change Team.

¹ Monitor’s report *Closing the NHS funding gap: how to get better value health care for patients* available at <http://www.monitor.gov.uk/closingthegap>
For Publication June 2014

The organisational accountability and governance for implementation of the transformation programmes will be strengthened further by our revised structure implemented in 2014.

One of our main challenges to affordability is our ability to effectively manage demand for our services. Whilst DBH is an active partner in this process, the sphere of influence is limited by the provision of community services being with other providers. In terms of specialist commissioning there are similar cost pressures in terms of affordability of increasing chemotherapy drug costs and increasing activity.

To help to address this and to provide care in line with best practice, we are committed to the right care being provided in the right place and developing new ways of delivering care. We have existing strong relationships within the local health economy including CCGs, other providers and local authorities in the Doncaster & Bassetlaw area. We have a history of working together to provide integrated services consistent with the national conditions identified in the Better Care Fund guidance. An example of this is our Doncaster Rapid Access Process Team (RAPT) which was cited in the Keogh Report, which works as part of the Integrated Discharge Team providing a joint approach to assessment and care planning over seven days a week.

Our Operational Plan 2014-16 clearly articulated the challenges and benefits associated with the introduction of the Better Care Fund. However, it should be noted that the extent of the impact of this becomes more difficult to accurately predict moving into 2016- 2019. However, given the clear benefits to the LHE that have already been achieved by integration, our continued development in this area and the anticipated changes to models of care (see below) we are committed to developing this further in our strategic plans for the next five years (section 1.5).

We are mindful of the NHS England plans to implement a commissioner led service review of bariatric surgery to ensure minimum numbers are achieved and vascular services to ensure that current providers deliver full arterial networks. We provide good outcomes for these services and will actively engage in this process anticipating impact on DBH in terms of service provision and finance in a number of scenarios (section 1.4).

2.1.2 Changes in the Model of Care Provision

Evidence from Monitor suggests that reconfiguring services and integrating care effectively across providers could yield productivity improvements in the region of £2.4 billion to £4 billion by 2021². We recognise that there is a need for more activity to be delivered in primary care and non-acute settings. This is clearly evidenced in recent reports including Transforming Urgent and Emergency Care Services in England³. In line with this model the health community is required to provide highly responsive, effective and personalised services outside of hospital for people with urgent but non-life threatening needs. This has the dual aims of minimising disruption and inconvenience to patients and their families but also by providing the right care in the right place we are able relieve pressure on our hospital based emergency services.

This requirement for a change in the delivery model toward a community focus is also identified in the plans of our commissioners (see below) and DBH will have an active role in working with commissioners and community health partners in continuing to develop care pathways that avoid unnecessary admissions and out reach into community settings. This is an opportunity in line with our strategic themes of developing responsibly, delivering the right services with the right staff and to controlling and reducing the

² Monitor's report *Closing the NHS funding gap: how to get better value health care for patients* available at <http://www.monitor.gov.uk/closingthegap>

³Department of Health *Transforming Urgent and Emergency Care Services in England – Urgent and Emergency Care Review - End of Phase 1 Report - High quality care for all, now and for future generations*. (2013) Gateway Reference 00691-00694

cost of healthcare. In some situations there will also be an advantage in considering the benefits of vertical integration and responding positively to procurement opportunities for community services where there is a benefit to patients and the organisation.

Whilst moving care closer to home is an opportunity, this will also create a challenge in terms of planning as accurate phasing of implementation of community schemes and reductions in the current DBH bed base will be required. This is necessary to ensure that there is sufficient capacity to cope safely with demand and achieve RTT and 4 hour access times. This risk is likely to be mitigated by the collaborative approach to planning and service development that exists across the LHE and DBH has a history of being able to work with partners to make the required transitions with recent changes to our rehabilitation, reablement and non-reablement pathways.

In Feb/Mar 2013, the East Midlands Procurement & Commissioning Transformation (EMPACT) Utilisation Review of Unscheduled Care at Bassetlaw Hospital suggested that some patients remain in acute care beyond a period of time that is considered clinically necessary. The reasons for this included the availability of alternative care in a community setting and addressing this is a priority for commissioners and DBH.

This local priority to ensure care in the right care setting will create a need to reduce current bed stock. Even if the planned reduction is not realised in its entirety, given the relatively small size of the current bed base (176 adult beds plus critical care, paediatrics and neonates – at April 2014) this will generate a requirement to use the site differently and perhaps consider co-location of other services. This is considered as part of our site plans. This will require community wide planning to address and relevant plans are included in section 4 of our strategic plan.

The Trust has signed a Memorandum of Understanding with Sheffield Teaching Hospital (STH) to bring radiotherapy services to the DRI site during this planning period. This will have a positive impact on local access and outcomes and act as a catalyst and anchor for other cancer and associated services.

2.2 Healthcare Needs Assessment & Commissioning Priorities

2.2.1 Doncaster CCG Strategic Plans

In their 5 year Commissioning Strategy from 2014/15 to 2018/19, Doncaster Clinical Commissioning Group (DCCG) outlined how, after understanding the needs of the population, they engaged with partners and patients and identified 3 strategic ambitions and to implement them have developed 6 outcome based delivery plans. These are outlined below.

The strategic ambitions identified by DCCG echo the need to move to a more community based model of care as discussed above. The ambitions identified in the strategy focus on **community services, care of the elderly and care out of hospital**.

The delivery plans relate to the following areas:

1. Cancer
2. Children's Services
3. Continuing Healthcare
4. Dementia
5. Mental Health
6. Unplanned Care and Long Term Conditions

All of the DCCG ambitions and delivery plans are relevant to the on-going work in DBH and these priorities are reflected within our strategic plans. For DBH the DCCG ambitions create opportunities to

work with partners to deliver care in new ways. In keeping with the strategic theme “develop responsibly, delivering the right services with the right staff”, we will continue to extend our work into community settings if appropriate, where a model of vertical integration would provide clinical and efficiency benefits and improve experience for patients.

This move to delivery of care closer to home also creates the need to reduce bed base which will have some impact on the Doncaster site current bed base (558 adult plus critical care paediatric and neonatology - at April 2014). The Trust will therefore flex capacity as required, however, this will only be possible if demand management and alternative care models outside acute care are successful and whilst this is not all within our direct control, we will work with our partners to support and co-ordinate this change.

2.2.2 Bassetlaw CCG Strategic Plans

The Bassetlaw Strategic plan identifies our vision of the future of Bassetlaw: *Bassetlaw – A Community of Care and Support*. To work together to achieve this, DBH is actively represented, alongside health & social care partners and commissioners, at the Bassetlaw Integrated Care Board.

To support the process of working together, a Memorandum of Agreement is in place. The Integrated Care Board is also the local governance mechanism for the development of the Better Care Fund (BCF) and its deployment on local services.

It is through the establishment of this Board that local organisations have committed to work together and take joint responsibility for the improvement of care and support for local people. Together we have developed our 5 strategic priorities for Bassetlaw for the next 5 years.

Strategic Programmes	Programme Outcomes
Urgent Care	Improved access to same day services for people with urgent care problems, including clear information and alternatives to face to face appointments where appropriate.
Care for the Elderly in the Community	Improved community services built around the primary care team and caring for more people in their own homes
Care Homes	Improved care home quality, more clinical input, co-ordinated care and transparency
Mental Health Services	Improved access to mental health services focusing on urgent problems, vulnerable patients and integration with primary health care teams
Supporting people after acute illness	Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.

The governance arrangements of the Board promote the principle of ‘joint responsibility’ with each individual organisation leading one of the five strategic programs. DBH leads on the strategic programme “Supporting people after acute illness”.

The priorities identified by DCCG are similar to those identified by Bassetlaw. Again it is clear that there is a focus on changing the model of care provision as discussed previously. This creates an opportunity for DBH to develop strategic plans that fulfil the requirements of both of the populations served and provide consistency and reduce duplication in our contribution to the work of our commissioners and partners as far as possible.

2.3 Impact on DBH

To address the above challenges, needs and priorities we have undertaken an analysis of capacity, funding and our position in the local healthcare market.

2.3.1 Funding Analysis

DBH has consistently retained a strong market share in the Doncaster & Bassetlaw localities. We have very strong relationships with commissioners and local GPs who value their local hospitals. Performance is improving and the Trust does not have any significant issues with reputation or the ability to deliver high quality care, therefore we do not anticipate significant changes to market share over the coming 3-5 years due to these reasons. However, there is a reasonable likelihood that non-elective activity overall will reduce given the changes to models of care described above and DBH would expect to maintain market share of the activity, albeit in lower volume. Given these factors, the commissioner assumptions for future growth were used to establish likely future commissioning intention and funding for general and acute specialties. Our activity and income assumptions are based upon commissioners intentions, plus some additional intelligence and can be shown as:

- 0.5% reduction per annum for emergency at DRI and 1.5% reduction at Bassetlaw
- 1.8 % growth for remaining activity

Planned expenses reflect the changes in activity described and anticipated cost pressures. Where emergency activity falls we are only anticipating a marginal reduction in our costs (c20%) as much of our emergency capacity is relatively fixed and challenging to retract (whilst maintaining service quality and compliance).

Our plans for the next five years CIP (cost improvement plans) are shown in the table below and reflect the increasing challenge of finding savings year on year. Whilst the Trust has a good record of CIP delivery in recent years, with £17m CIP delivered in 2013/13, we must also recognise that the Trust is already a relatively efficient and low cost provider with a reference cost of 96.

	Planned Level of CIP (£m)	Planned level of CIP (% of Income)
2014/15	14	4.0%
2015/16	14	4.0%
2016/17	13	3.7%
2017/18	12	3.4%
2018/19	11	3.1%

The Trust recognises that the next five years will provide an increasing challenging financial environment in which to operate. The result of the above assumptions are that the Trust will see EBITDA (a standard measure of net earnings), and I&E surplus margin both steadily deteriorate over the planning period. I&E surplus margin of 1% will be maintained over the next 2 years, falling to 0.6%, 0.5% and 0.2% in subsequent years.

Notwithstanding this, capital investment is planned to continue at c£20m per annum for the next 3 years, falling back to c£15m per annum for years 4 and 5, in part financed externally. The scale of this investment (c£90m over the next 5 years) reflects the need to continue to invest in our equipment and estate to continue to provide the quality of services our patients rightly expect. Within this capital expenditure is significant funding for the continued development of each of our major three sites, with clear linkages between this capital investment programme and other key elements of our 5 years plans such as the repatriation of work from private providers and the transformation of urgent care services.

The Continuity of Services Risk Rating (CoSRR) used to assess the level of financial risk to our ability to continue to provide services remains at a 3 throughout the 5 year planning period, although as margins decrease there is significantly less headroom to a 2 rating than the Trust currently enjoys.

Within the Trust's Operational Plan, which focuses on the next 2 years, we identified 3 key risks to our financial position :

- Overspends in Clinical Services and directorates
- Delivery of planned savings (CIP)
- Commissioner affordability and demand management

We have developed downside scenarios to model the impact of these risks, individually and concurrently, as well as detailed work to describe how the trust can mitigate these risks. These scenarios illustrate the importance to managing these risks, with further reductions in surplus margins, liquidity and CoSRR in years 3 to 5, should the Trust fail to do so.

Based on our activity assumptions described above, the implications for DBH in terms of activity are as follows:

2.3.2 Capacity Analysis

When considering the capacity requirements in general it is necessary to acknowledge and plan for potential changes to the models for provision of both specialised and urgent & emergency care. Our plans are therefore flexible with strategic options that can be responsive to changes in national direction and success of local demand reduction - and our capacity planning has been developed with this in mind.

- **Demand Management & Service Model Changes**

Given the activity projections, and proposed change to care models closer to home, it is clear that there will need to be a continuation of activities to manage demand and to remodel to increase productivity by continuing to develop day surgery and ambulatory care pathways. Our plans for 2014-2016 describe how have begun to address this and we will continue this focus, working with Commissioners and the wider LHE as part of the Unplanned and Urgent Care work streams identified in the commissioning plans and our strategic plans in section 4 of this document.

- **Specialised Commissioning – Commissioner Derogation**

There could be potential changes to the specialist services commissioned by NHS England given the commissioner plans to review the provision of Bariatric Surgery and Vascular Surgery in the region. Implications for bed base and theatre capacity are being considered as part of the site development and bed plan. However, these are services that DBH is aiming to retain, based on good outcomes for patients, and this is reflected in our strategic plans.

• Structure & Staffing

In our Operational Plan we identified where there were medical, nursing and allied health professional gaps. We described how we would be addressing these in 2014-16 and this work will continue with the utilisation of new roles, the effects of looking at the issues with staffing smaller specialties with our local acute trusts as part of the Working Together Programme and the impact of changes in models of care so that fewer inpatient beds are required. The HEE Yorkshire & Humber are also increasing planned commissions to meet demand for nursing staff.

In addition to this we recognise that longer term we need to be an employer of choice and we have recently developed our People & Organisational Development Strategy to support the Trust's Strategic Direction. In production of this strategy we have consulted with colleagues across the Trust, external partners and other organisations and interpreted what each of the four Strategic Themes should mean to the workforce of the Trust. We have listened to the feedback and mirrored the four Strategic Themes within this document, bringing together the projects, outcomes and standards that we need to deliver across the Trust so that all of us who are part of team DBH feel that we:-

- Can be the best we can be and **Develop** our skills qualifications, abilities, attitudes and behaviours for the good of our patients;
- Are engaged and supported and that we are working together for the good of our patients, really feeling we **Belong** in team DBH;
- Trust in the way we do things and people we work with and, if we are choosing a place to work and place to recommend to others it would be **Here**

We have set targets based on national benchmarks to achieve improved vacancy rates, absence rates, turnaround, engagement, flu immunisation, staff survey response rates, appraisal and training. Our clinical management structure during the strategy period will be based on key patient pathways, helping to lead and facilitate transformative change inside and outside the Trust.

• Site Development & Bed Plan

The planned reduction in emergency activity would potentially lead to the reduction of the bed base required. In addition, as part of our site development plan we are increasing the ambulatory care facilities and co-locating them with emergency services and will continue to review this provision.

Current modelling suggests this will be equivalent to approximately 13 beds across emergency Medicine and Surgery. Rather than achieving this by reducing wards at DRI, we will optimise ward size alongside environmental improvements as part of our rolling programme of ward refurbishment. This is planned over 3 to 5 years from 2016- 2019. We will also maintain our decant facility on an on-going basis.

In Bassetlaw this equates to the reduction in acute beds required by approximately 17 beds. We are currently engaged with our commissioning colleagues and community partners to model the requirement for intermediate care and we will work together to phase the implementation of revised pathways to ensure that emergency capacity can be safely reduced whilst maintain access targets and RTT targets. To maintain sufficient critical mass on site we will revise our site plan to ensure that intermediate care provision could be accommodated on site should this option be required.

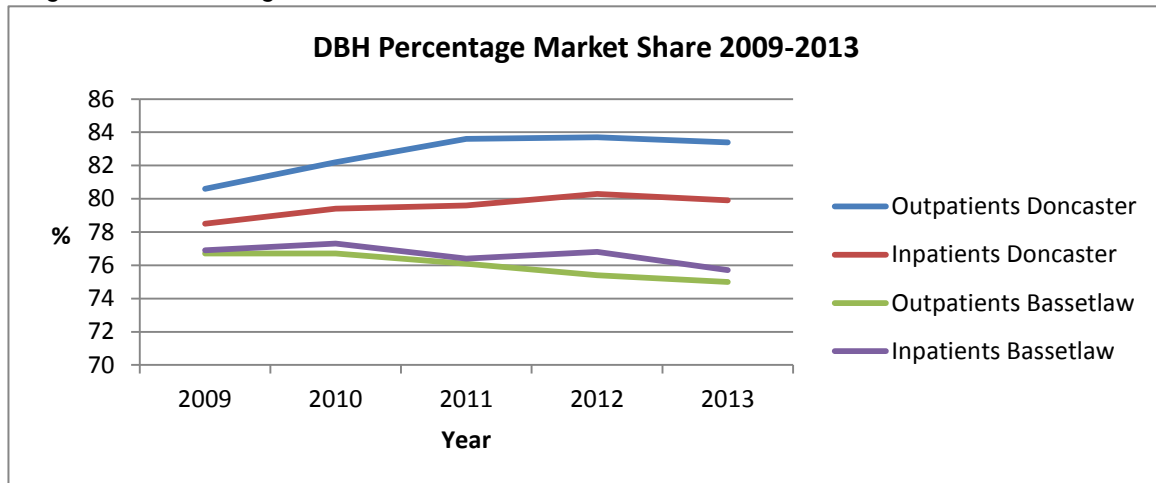
In terms of elective capacity we will be separating elective and emergency environments and increasing facilities for day case at Mexborough. As part of the site development plan we will be increasing theatre and endoscopy capacity in order to repatriate previously outsourced work.

Modelling indicates that an additional 6 beds will be required and this is also factored into the site development plan.

2.3.4 DBH Market Position

We have consistently retained a strong market share in the Doncaster & Bassetlaw localities. Over the last 5 years, DBH has retained its share of the acute healthcare market in Doncaster with a small decrease in both inpatient and outpatient market share in Bassetlaw (See Fig 1 below).

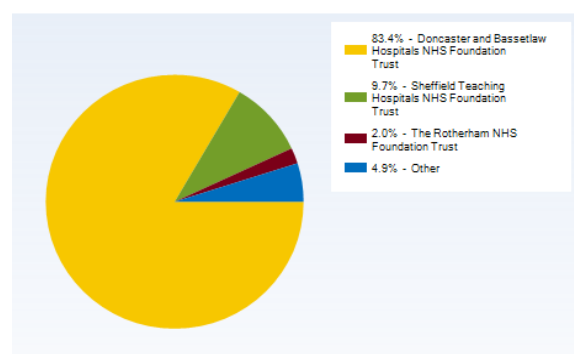
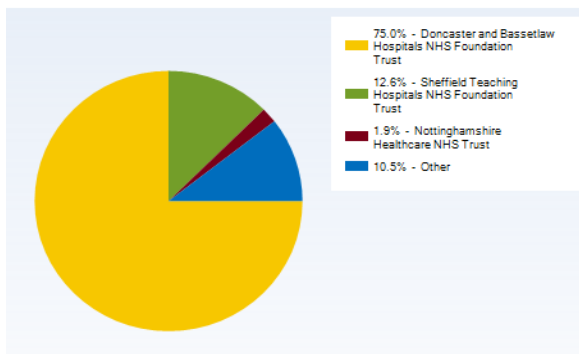
Fig 1 DBH Percentage Market Share



Figures 2 and 3 show the provider market share (hospital outpatient attendances by volume) for Bassetlaw CCG (fig 2) and Doncaster CCG (fig 3) in 2013

Fig 2: DBH Outpatient Market Share -Bassetlaw CCG

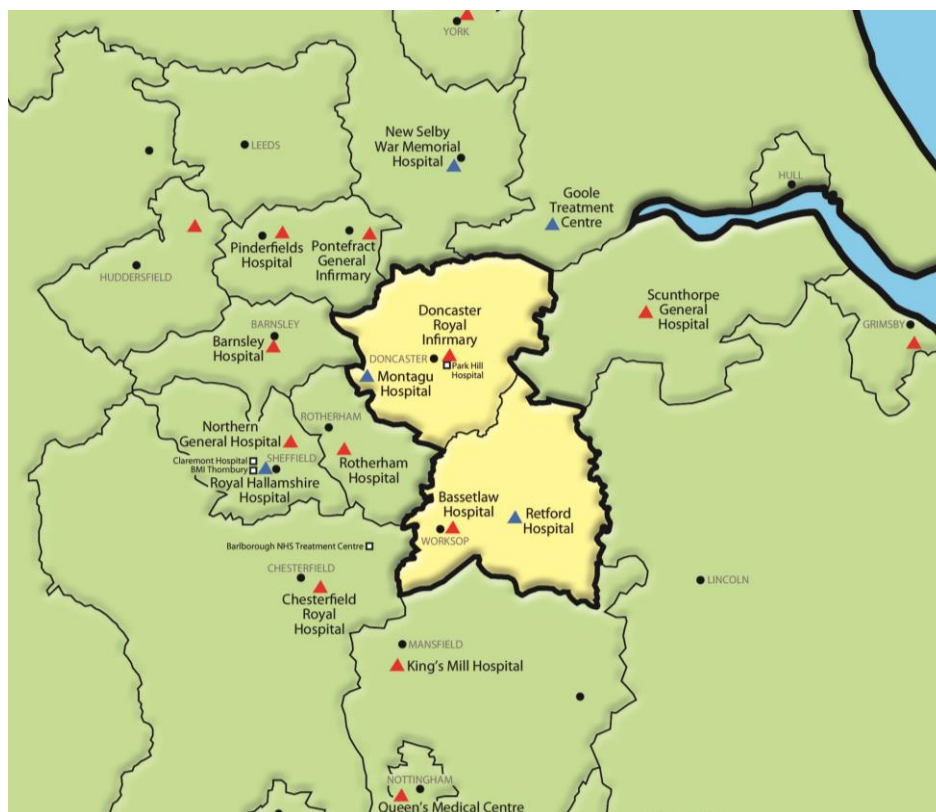
Fig 3: DBH Outpatient Market Share - Doncaster CCG



The second largest provider of hospital outpatient attendances to Doncaster & Bassetlaw residents is STH for both localities with a market share of 9.7% in Doncaster and 12.6% in Bassetlaw and this has remained very similar to the 2012 analysis (where it was 9.6% and 12.7% respectively). This is to be expected with a number of services only being available at STH not DBH. An example is that certain cardiac or Ophthalmology procedures are only available at STH.

In the South Yorkshire & Bassetlaw area there a number of other NHS acute trusts in relatively close proximity, (See diagram on page 11 - Hospitals with A&E departments are in red and those without are in blue). We have undertaken detailed analysis at specialty level to identify specific areas where market share has fallen. An example of this is General Surgery, where recent capacity issues have increased waiting times and we have seen market share in this area reducing at both Bassetlaw and Doncaster.

We plan to address this loss of market share with the on-going work on increasing capacity and improving waiting times.



As identified in the market share analysis, a relatively consistent proportion of Doncaster & Bassetlaw CCG market share is provided by STH and Sheffield Children's Hospital. DBH does not provide a number of the services provided by Sheffield e.g. inpatient Neurology, inpatient Oncology, certain children's surgery. No action needs to be taken to repatriate this work, in line with guidance for this activity to be provided in a specialist centre.

However, in 2013 we have also seen a small increase in market share of surgical and orthopaedic work being provided by STH. Likewise we have seen an increase in private provision of elective work in T&O and General Surgery. In line with our SWOT analysis (strengths, weaknesses, opportunities & threats) below, we recognise that national feedback on Patient Choice identifies that when offered a choice of quicker treatment the majority of patients will take the opportunity. We want our patient population to have the most efficient access possible when they require surgery. To address this issue, we have already improved our Referral to Treatment position with 673 patients less than last year waiting over 18 weeks. We are now compliant with all national targets for RTT. In the longer term we will be increasing capacity to further reduce waits and repatriate private work. Plans to achieve this are detailed in the five year plan in section 4.

We are also aware that, compared with some other local hospitals, DRI is perceived to have issues with parking on site. To address this we have a well-used Park & Ride system operating from Doncaster Race Course but recognise that we also need to improve onsite parking for patients and this is being addressed as part of the site re-development plan.

2.3.5 Our Strengths & Weaknesses

SWOT analysis of DBH current position – see following table

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ✓ First wave foundation trust with established track record ✓ Serves a total population of 420,000+ ✓ Achieved planned surplus retention over previous year and financially stable ✓ Split site operations provides good geographical access ✓ Continue to maintain market share ✓ New CEO and Board Team - new experience, willingness and energy to change ✓ Revised structure – to improve governance whilst maintaining clinical leadership ✓ New Strategic Direction for 2013-2017 developed in consultation with commissioners, staff, governors, members ✓ Good membership and governor influence ✓ Established professional workforce with good reputation ✓ Award winning teams and services (Leadership awards, dementia friendly hospital) and national recognition for discharge initiatives ✓ Increasingly specialised workforce, potentially producing better outcomes ✓ Excellent relationship with local commissioners and Local Authorities ✓ Track record of working with local strategic partners to develop services including a range of specialist services. Interim designation as a trauma unit. 2nd designated site for Radiotherapy. AAA and bowel screening provider. New Rehabilitation Centre at the Montagu Hospital ✓ Developing good systems for customer feedback ✓ Large endowment funds in the top 10 in the NHS to support service developments for competitive advantage ✓ Trust physically incorporates a private healthcare provider and therefore benefits from growth of that provider. ✓ Good relationships with other providers – satellite centre 	<ul style="list-style-type: none"> • Split site operations can be relatively inefficient – however reduced from 5 to 4 sites in 2012 and from 3 to 2 for acute medicine • Bassetlaw Hospital serves a population of less than 115,000 – challenge to sustain some local services but essential to do so to support local population and referral base for specialist services • Some previous mortality rate concerns but improving • Improved in recent staff survey but still have some work to do • Recent loss of Upper GI and Head & Neck Cancer work • Increasingly specialised workforce, reducing flexibility and capacity • Elective and non-elective capacity challenges leading to RTT challenges • Challenges with achieving stroke and fractured neck of femur performance targets • Physical infrastructure at DRI in particular requires significant investment • Relatively poor parking access at DRI – partly addressed by free inter-hospital busses and park and ride facility. • Minimal provision of community services limits extent of vertical integration
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> ✓ Better Care Fund is both an opportunity and a threat ✓ Potential for community services development ✓ Radiotherapy – opportunity to further develop cancer services ✓ Development of screening across local and wider areas ✓ Access to independent sector markets ✓ Elective growth via switching from other providers ✓ Providing a strong service offer through vibrant local hospitals and off site clinics to deliver additional catchment population for specialist services ✓ Develop alternative staffing solutions in key specialties and services ✓ Further improve our Research, Development and Innovation profile 	<ul style="list-style-type: none"> • Better Care Fund • Changes to the shape of NHS Care provision – demand might not reduce as anticipated • Affordability – continue beyond 15/16 • Staffing – continued recruitment & retention issues • Commissioners reviewing some specialist services; vascular, bariatric and some specialist cancer services potentially at risk • Acute trust consolidation in the face of financial and/or service challenges elsewhere • CCG financial restrictions including capitation changes and continuing care provisions • NHS England financial restrictions associated with specialised services • Imposition of new care standards based on minimum populations or patient numbers • Redistribution of training posts to alternative centres

3. Our position in the Future

Given the changing healthcare environment and material challenges identified above, we have reviewed our services in terms of the likely impacts of identified external challenges and internal issues. We are committed to maintaining access and have identified strategic options to mitigate any impact.

We have analysed the likely impact of chosen options on our services and identified the LHE support required and LHE alignment with the proposed options. It is important that we work as a wider health and social care community to ensure that we maintain and develop our position into a strong future in line with our vision to become recognised as the best healthcare provider in our class, consistently performing in the top 10% nationally.

However, it is also important to recognise that there will be some factors that we cannot control, and at best can influence, including the commissioning of specialist services, national guidance on delivery models for urgent care or behaviour of other providers in the support of smaller services. For these, our plans attempt to anticipate and influence the external factors but also have to provide mitigation for a number of potential outcome scenarios.

The services where we identified that there were likely impacts of identified external challenges and internal issues requiring action fall into three main categories:

- 1) *Smaller Services where particular infrastructure and/or specific skilled workforce are required to provide services to a relatively low number of patients*

Wherever possible we will aim to address this by transforming, increasing community provision, the most efficient use of resources across site – for example utilisation of rotation of medical rotas and different on call models. For some of our very specialist services we will need to collaborate to transform. To do this, we will continue to work with the Working Together Programme as part of the Specialty Collaborative Working Group to effectively address the issues as part of a wider network. We will work with our commissioners to implement actions that are identified in this process

- 2) *Specialist services where commissioners might change the commissioning model*

As stated previously, there could be potential changes to the specialist services commissioned by NHS England given the commissioner plans to review the provision of Bariatric Surgery and Vascular Surgery in the region. Implications for bed base of any and theatre capacity are being considered as part of the site development and bed plan. We are also mindful of the potential impact on our general surgical rota. However, these are services that DBH is aiming to retain and grow and this is reflected in our strategic plans (see section 4). We have however, also considered plans for collaboration if this is required to continue to provide local access.

- 3) *Services where there will be an impact from changing models of care.*

In order to address this issue and mitigate the potential effects of increasing community based care models, we will work with our LHE partners to ensure that we are able to transform services by delivering care and utilising our site in different ways, for example co-locating ambulatory or primary care or co-locating intermediate care with our acute services.

As well as undertaking actions to mitigate internal and external factors that might impact on our services, we are also aware that we need to remain competitive and continue to transform to maintain and develop market share in line with our vision in our Strategic Direction 2013-18. Our 5 year plans to enable us to achieve this are outlined in the section below.

4. Our Plans for 2014-19

The following is a summary of our strategic plans for 2014- 19.

1. Specialist commissioning

We plan to ensure that services are provided as locally as possible and in line with national guidance on standards. To do this we will work with our commissioners to participate with the plans to review the provision of Bariatric Surgery and Vascular Surgery in the region. We will continue to be an active participant at commissioning and contract meetings on an on-going basis. It is also possible that this will be an area considered as part of the Working Together Programme as part of the Specialty Collaborative Working Group – provisionally planned for 2015, once the NHS England report is available.

Patients are only eligible for entry into bariatric surgical services through the Tier 3 Weight management Services. We have recently been successful in being awarded a contract to provide tier 3 weight management services in Doncaster and have implemented a number of pathway changes. We intend to continue to develop Tier 3 services and maintain the profile of our services. Timescales for this plan are dependent on NHS England.

2. Sustainability of Smaller Services

We are already working with our colleagues on this area as part of the Specialty Collaborative Working Group. Following the current work there will be a longer term plan covering a variety of specialties and the areas for inclusion in this are currently under discussion.

The initial focus is on shared problem solving around lack of skilled staff, prohibitive locum costs, unjustified and unplanned transportation of patients. This may include further development of medical staff covering rotas beyond individual Trusts, transfer policies at certain times, shared diagnostics. Milestones for the current work on Head & Neck specialties are development of a model by September 2014 for Ophthalmology with a longer timescale for Oral Surgery which is the end of 2014. Implementation will be into 2015 with evaluation and on-going inclusion of new specialties into 2016/17 and beyond.

3. Development of Radiotherapy/Oncology/Haematology

We work collaboratively with our STH colleagues to provide cancer care for patients as close to home as possible. Given local and national demographic changes there will be an increase in demand on these services. We already provide chemotherapy services at Doncaster and we are planning to work with STH to be a satellite radiotherapy service site, which will increase access to many more local patients in Doncaster and the surrounding area.

We have established a Project Board and have commenced development of a business case in partnership. As part of this development we will also be reviewing our chemotherapy suite environment and reviewing clinic capacity.

The milestones are for the Analysis, Development and Approval stage to be completed in 2015 with the build completed in 2016 and on-going Implementation, Service Monitoring & Evaluation of Benefits into 2017.

4. Transforming Urgent Care Doncaster

We plan to improve pathways to the most appropriate urgent care services locally by working collaboratively with our partners on the Unplanned Care Working Group in Doncaster.

Urgent Care services are currently being re-commissioned to ensure they meet the needs of Doncaster patients and are in line with the five key areas of focus highlighted in the Urgent and Emergency Care Review. We will be an active partner in this process, responding in line with internal business processes and competition rules. We will evaluate the impact of the redesign on our current and future services and our urgent care plans for Doncaster will be amended in line with our decision on how to proceed and the outcome of the commissioning process.

5. Transforming Urgent Care Bassetlaw

We plan to improve pathways to the most appropriate urgent care services locally by working collaboratively with our partners on the Integrated Care Board and Urgent Care Board for Bassetlaw. In 2015/16 the BCCG will work with GP practices to explore the feasibility of a GP led urgent care centre co located at Bassetlaw A&E. The new service being considered would stream the minor illness patients using agreed clinical pathways into the urgent care centre where they would be seen by a nurse or a GP or another professional such as social care worker or a pharmacist. This is also being considered as part of our site development plan and construction, implementation and evaluation phases would be in 2016/17 and 2018 (but subject to commissioner timescales).

We have already commenced some community services in Bassetlaw including Cardiac Rehabilitation will also continue our work to develop community based alternatives where appropriate (see plan below).

6. Development of Community Services

We recognise that the move to more community based models of care provides opportunities in circumstances where vertical integration provides benefits to patients and the organisation. We will scope opportunities for community developments and respond where we believe there are opportunities – in line with competition rules. Milestones for this are dependent on commissioners' procurement timescales.

We will continue to develop our current community services for example community paediatrics and cardiac and pulmonary rehabilitation.

7. Site development – Capacity & Commercial Development

As identified in our SWOT analysis above physical infrastructure at DRI in particular requires significant investment. We have reviewed our sites and prioritised programmes of work. In order to ensure sufficient capacity for patient care in the next 5 years and beyond there are changes required to the sites. We intend to right size and develop our theatre, outpatient and endoscopy capacity ensuring that we can grow and develop our surgical specialties including T&O and General Surgery. This will create a better experience for patients and staff and allow the trust to repatriate work from the private sector, saving the associated costs and allowing continued re-investment.

In line with Department of Health policy, we will dispose of surplus land and other assets no longer required for healthcare delivery in order to release resources for investment in modern facilities and equipment.

Alongside this we will look at opportunities to safely develop new and innovative procedures and ways to raise our research and development profile at each opportunity, in line with our aim to be in the top 10% of providers. This should encourage growth in our market share and contribute to recruitment and retention of staff.

As part of the overall site development we will look at the availability of retail and catering facilities in line with patient and staff requirements and the values of the organisation.

DBH has the benefit of an onsite private provider and prior to the end of the lease in 2020, we will progress arrangements for the future, in line with our site plans and capacity requirements.

Supporting Strategies

In addition to the strategic plans described above, in order to describe how we will fulfil our strategic vision, we have been developing seven supporting strategies, these are:

- Quality and Innovation Strategies - 2014
- People & Organisational Development Strategy - 2014
- Information, Communications and Technology Strategy - 2013
- Communications and Engagement Strategy - 2013
- Research and Development Strategy - 2013
- Site Development Strategy - 2014
- Dementia Strategy – 2013