

Strategic Plan Document for 2013-14

**Doncaster and Bassetlaw Hospitals
NHS Foundation Trust**

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	3 June 2013

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name (Chair)	Chris Scholey
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mike Pinkerton
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	David Pratt
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Signature



Executive Summary

Strategic Context and Direction

Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBH) has over the last 5 years retained its market share in Doncaster and Bassetlaw localities. We are in a strong position to continue to remain competitive. Health forecasts predict a growing, ageing population with increasingly complex healthcare needs. Although there is a threat from competitor organisation's providing care closer to home or in tertiary centers, we believe that through seeking new ways of providing services, developing our market through responding to tenders and AQP programme's and diversification we can protect our market share over the next planning period.

Strategically, local commissioning strategies provide considerable threats and opportunities for us. These include commissioner intentions to re-design services, manage demand, centralise some services and provide care closer to home. During 2012/13 we have been developing, through a process of analysis, involvement and consultation with staff, governors, members, commissioners and other key stakeholders our new *Strategic Direction 2013–2017*. This has taken account of our commissioner and partner strategies and the changing future context of the NHS. It will provide a distinctive, coherent and inspiring vision that will frame and direct our actions over the next five years.

We fully appreciate that our success will depend on working with others in partnership. We have established a number of partnership arrangements and will continue to develop these over the next planning period. Respect for competition rules and patient choice will also guide our actions.

As part of our review, we have considered our demand profile and activity mix and will develop during 2013 a consolidated bed plan to ensure bed stock across the 3 hospital sites matches forecast demand and alternative scenarios of demand. The Board of Directors have agreed plans to increase the Trusts bed stock before winter 2013/14.

Approach taken to Quality

We believe that high quality care is efficient care. We therefore believe that quality (in terms of fitness for purpose) should be our organising principle. We will improve the safety and effectiveness of our services through delivering the objectives in our new *Strategic Direction 2013-2017*.

Our highest priorities for providing the safest, most effective care in 2013/14 are set out in the Strategic Plan which are consistent the Trusts publish *Quality Account*.

The key quality concerns for DBH over the next planning period are;

- 4 hour wait for Accident and Emergency
- 18 weeks referral to treatment target
- C.Difficile rate
- Pressure ulcers – categories 3 and 4
- Bed occupancy rate
- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI).

Action Plans are in place for all of the above which are monitored monthly by the Board of Directors.

We have stated in the *Declaration of Risks against Healthcare Targets and Indicators for 2013-14* that the DBH referral to treatment time, 18 weeks in aggregate, admitted patients target is at risk. We are anticipating being non-compliant in quarter 1 and quarter 2. An action plan has been agreed with Monitor.

The Board derives assurance regarding the quality of its services from a number of sources, both internal and external. These sources are detailed in the Board Assurance Framework (BAF), which is structured around the organisation's strategic objectives. DBH will, as part of its Strategic Direction, review its corporate governance.

Clinical Strategy

The Trusts new *Strategic Direction 2013 – 2017* sets out the Trusts clinical strategy. As part of this strategy the Trust has revised its vision, mission and values. Our strategy for becoming the best healthcare provider in our class is founded on four core themes;

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare

- Develop responsibly, delivering the right services with the right staff
- Focus on innovation for improvement.

The corporate objectives to deliver the first year (2013/14) of the Strategic Direction are included in the Strategic Plan Document.

We are continuing to develop our Service Line Strategy which will support our Clinical Service Units (CSUs) by providing skills and knowledge training and enhanced information.

The Trust is also developing our *People and Organisational Development (P&OD) Strategy* which will be delivered through five strands of work, which mirror the new structure of the P&OD Directorate; Training, Education and Development, Employee Services, Occupational Health and Wellbeing Services, HR Services and Cross Cutting Projects.

The key workforce pressures for DBH in the next planning period are around recruitment; of nurses and healthcare assistants to keep up numbers and medical staff to replace long term locums. Plans to address these issues will be part of our P&OD Strategy.

Productivity and Efficiency

The Trust is planning to achieve £20m of CIPs (including non-NHS income) with a £3m contingency/development reserve. In deriving this plan the Trust has consciously recognised the pressure on, particularly emergency services, and hence the plan:-

1. Focuses 75% of its value on non-clinical or generic areas, whereas 75% is in clinical service units (CSUs);
2. Concentrates on non-pay, mainly, and income, in terms of the profile of the CIPs (c. 78%).

The Trust is already a relatively low cost provider (95 reference cost index) and will be looking to make savings arising from more transformational and process reducing schemes for 2014/15, together with continued downward pressure on waste.

Financial and Investment Strategy

The Trust is making significant investments in 2013/14 with a capital programme that is larger than in recent years, featuring the completion of the state-of-the-art Rehabilitation centre at Mexborough, increased ward and day surgery capacity at Doncaster and the Assessment and Treatment Centre and a new Endoscopy unit at Bassetlaw. There will also be significant investment in ICT, via the new PACS system and progress on our iHospital strategy. Rolling imaging and general medical equipment replacement also feature significantly in the plan.

In terms of revenue investments, funding of activity at 2012/13, c. £4m, has been agreed with commissioners and around £10m will go into inflationary pressures. However, in addition the Trust will be investing £3m in the continuation of 2012/13 developments and up to £4m in additional capacity and other measures to assist operational performance improvement.

This is a significant commitment by the organisation to support the quality and performance agendas at a time when the external financial context is pressurised.

The next year will also see the denouement of planning for the potential future configuration of the Doncaster site.

Financial Risk Rating

Within the context of significant investment on both the capital and revenue fronts, the Trust has to and is committed to maintaining a Financial Risk Rating of 3, or equivalent. The 2013/14 plan is designed to achieve this, delivering a 1% retained surplus and 5% EBITDA.

1. Strategic Context and Direction

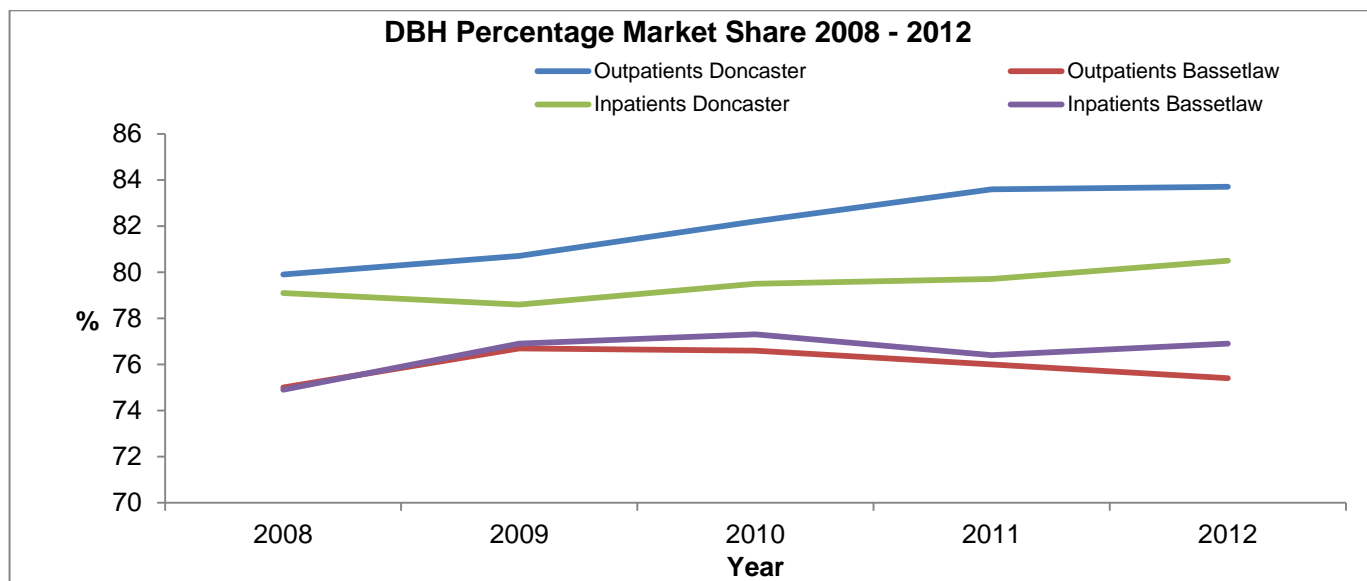
1.1. Our strategic position

Market Assessment

Doncaster and 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, as well as from parts of North Derbyshire, Barnsley, Wakefield, Rotherham, and north-west Lincolnshire.

Over the last 5 years, DBH has retained its share of the acute healthcare market for admitted patients in Doncaster and achieved moderate growth in Bassetlaw. Out-patient market share grew steadily in Doncaster to 2011 and has remained static in 2011/12. Out-patient market share in Bassetlaw has reduced marginally since 2009, with inpatient share increasing, see Figure 1.

Figure 1



Figures 2 and 3 show the provider market share (hospital out-patient attendances) for NHS Doncaster and NHS Bassetlaw in 2012 (Jan-Dec).

Figure 2

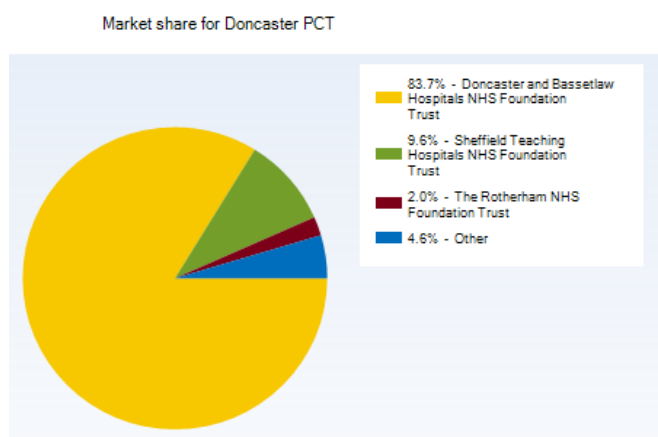
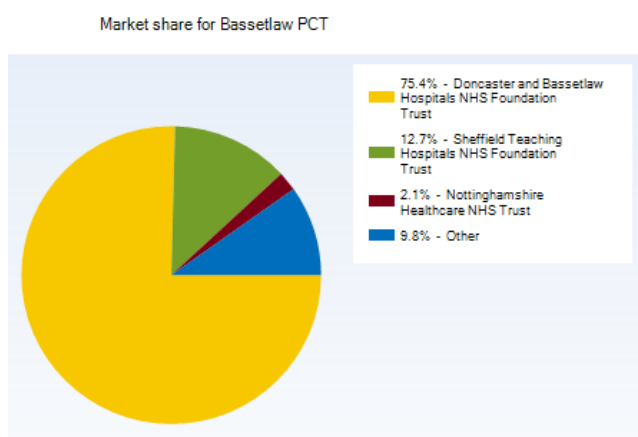


Figure 3



Analysis of this information in comparison to 2011 shows; Sheffield Teaching Hospitals remain our main competitor in both localities with market share of 9.6% in Doncaster and 12.7% in Bassetlaw. The Rotherham Trust has slightly increased market share over the last year (by 0.5%) in Doncaster (2% share in 2012).

Nottinghamshire Healthcare NHS Foundation Trust's market share in Bassetlaw remains static (2.1% in 2012). With commissioner intentions to move care closer to home we would expect community providers in Bassetlaw and Doncaster to increase their market share over the next planning period.

Other NHS acute providers on our borders hold 5.8% market share in Bassetlaw and 2.7% market share in Doncaster. DBH holds a combined 10% share of the healthcare market in neighboring localities. There

are a number neighboring health communities that are actively engaged in major organisational reconfiguration which may provide an opportunity for DBH to increase our market share in these localities.

The market share for private providers of healthcare in Bassetlaw has increased from 1.6% in 2011 to 2.3% in 2012. Doncaster private provider share remains static at 0.4%. DBH will positively respond to AQP and other competitive tenders to advance market share where desirable or to protect or sustain existing services.

Strengths and Weaknesses

Figure 4 provides an assessment of the Trusts key areas of keystrengths/weakness relative to our key competitors (as described above).

Figure 4

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 • New CEO and Board Team - new experience, willingness and energy to change • 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 • Increasingly specialised workforce, potentially producing better outcomes • Excellent relationship with local commissioners • 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 screening provider. New rehab 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. 	<ul style="list-style-type: none"> • Loss of organisational memory • Split site operations can be relatively inefficient – however reduced from 5 to 4 sites in 2012 • 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 • Not met trajectory for reducing C Difficile in 12/13 • Some mortality rate concerns • Relatively low scores in staff survey compared with other acute trusts • Commissioners reviewing some specialist services; vascular, upper GI and renal cancer services potentially at risk • Increasingly specialised workforce, reducing flexibility and capacity • Elective and non-elective capacity challenges • 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.

Health, Demographic and Demand Changes

Forecasts in Doncaster and Bassetlaw predict that the resident population will grow by an estimated 1.6% (approx. 7,000 residents) by 2021. The birth rate is increasing putting a focus on children's and maternity services.

This population in common with the country as a whole will get, on average, older. In Doncaster, people over 64 will have increased from 17.2% to 20.3% by 2020. With an increasing older population our

patients will exhibit a greater range of long term, chronic and overlapping needs with greater numbers of people with dementia and other mental health problems associated with old age.

Over the last 10 years, all cause mortality rates have fallen in both localities. In Doncaster, early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average. In Bassetlaw, the early death rate from heart disease and stroke has fallen and is similar to the England average. There is a higher incidence on average, of cancer in our localities, especially lung cancer incidence in Doncaster. Deaths from respiratory disease remain very high. Improving care for patients suffering from heart disease, stroke, respiratory disease and cancer will therefore remain a priority and will increasingly focus on rehabilitation and survivorship.

Obesity levels in Bassetlaw and Doncaster are high with 18.6% and 19.3% of Year 6 children respectively classed as obese. This will have health consequences on services for diabetes and other long term conditions.

DBH has over the last 5 years retained its market share in Doncaster and Bassetlaw localities. We are in a strong position to continue to remain competitive. Health forecasts predict a growing, ageing population with increasingly complex healthcare needs. Although there is a threat from competitor organisations providing care closer to home or in tertiary centers, we believe that through seeking new ways of providing services, developing our market through responding to tenders and AQP programme's and diversification we can protect our market share over the next planning period, through both development and retraction

1.2. Threats and Opportunities

Figure 5 set's out the key commissioning intentions of our local commissioners over the next three years and their anticipated impact on DBH.

Figure 5

Key commissioning intentions	Anticipated impact on DBH
<ul style="list-style-type: none"> • Promote better health • Develop an unplanned care service that is fit for purpose • Provide efficient and high quality planned care services • Improve mental health services including dementia • Improve children's services • Improve clinical quality • Reduce cancer mortality and increase survival rate • Deliver NHS Constitution and Rights 	<ul style="list-style-type: none"> • Requirement to promote health and provide high quality personalised information and screening expertise • Re-design of urgent care services; ATC at Bassetlaw Hospital, multi-disciplinary assessment, integrated care, reduced length of stay, zero growth in emergency admissions • Reconfiguration – <i>Clinical Services Review</i> implementation • Integrated pathways of care for the elderly and patients with long term conditions • Increased community based services including paediatric community service models • Focus on improving care for patients suffering from dementia • Patient choice extended; potential AQP and competitive tenders, local tariff arrangements • Focus on improving the quality, patient safety and experience of local services • QIPP agenda; service redesign, clinically ineffective procedures, demand management and centralisation • Cancer service priorities; pathway redesign 2ww and GP follow up, focus on survivorship, increase in demand for diagnostic services • Increasing requirement for effective assurance and governance systems • Need to develop fit for purpose IT systems to support all of the above.

DBH will respond to the threats and opportunities provided by local commissioner intentions by;

- Delivering our new *Strategic Direction 2013 – 2017* (see section 3)
- Working in partnership and collaboration with commissioners and other providers (see section 1.3)
- Responding positively to market tenders and the AQP programme
- Diversifying our services for growth and sustainability
- Delivering our iHospital Programme
- Working with commissioners to identify solutions which will allow scalable cost solutions to offset income changes
- Supporting our clinical service units to improve forecasting, develop robust demand and capacity plans and service retraction plans in response to reduced demand
- Reviewing our corporate governance.

Demand profile and activity mix

Figure 6 shows DBH activity profile; non-elective, elective and day-case and figure 7, Accident and Emergency attendances, over the last 5 years. Elective activity (with the exception of a spike in 2010/11) has reduced across the Trust and day case activity has increased steadily. Our intention is to accelerate this trend by providing a dedicated adult day unit facility on the DRI site in 2013 - see service development section 9.

Non-elective activity has increased year on year across the Trust as a whole.

The demand profile for A&E services is mixed. Demand at DRI has increased year on year. Demand at Bassetlaw Hospital is fairly static. Attendances at The Montagu Hospital increased in 2011/12 but have dropped in 2012/13.

Both of our host commissioner's strategic intent is to reduce emergency admissions and re-admissions. Changes in local urgent care systems have already started to impact services in 2012/13 including the implementation of the Major Trauma Network, the Assessment and Treatment Centre at Bassetlaw Hospital and an improved model of care for medicine in Doncaster. Bassetlaw and Doncaster CGG's have identified the transformation of urgent care services as a key service priority for the next planning period – see service development section 10. With the demographic changes described above we do not expect emergency admissions to reduce but if commissioner plans are successful we would forecast zero growth.

During 2013, DBH is developing a consolidated bed plan to ensure bed stock across the 3 hospital sites matches forecast demand and alternative scenarios of demand – see service development section 8. Other key factors which need to be taken into account are the increasing complexity of case-mix and current and future reductions in length of stay.

Figure 6

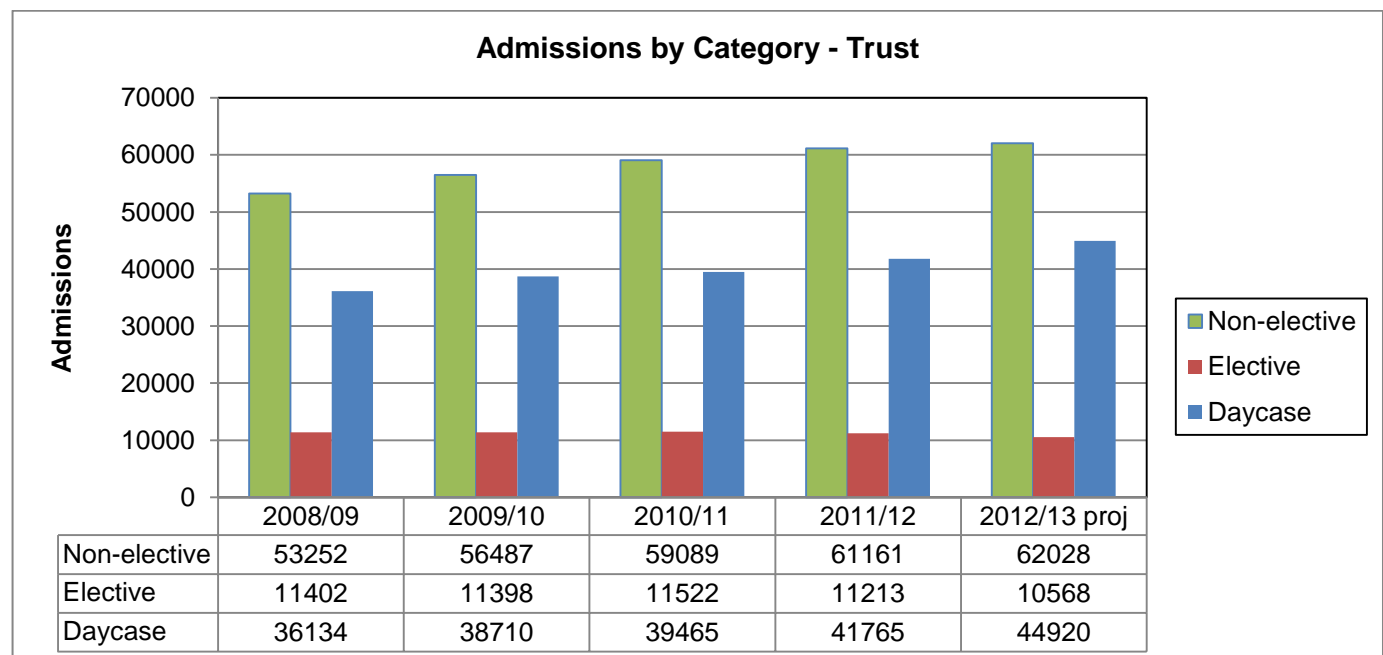
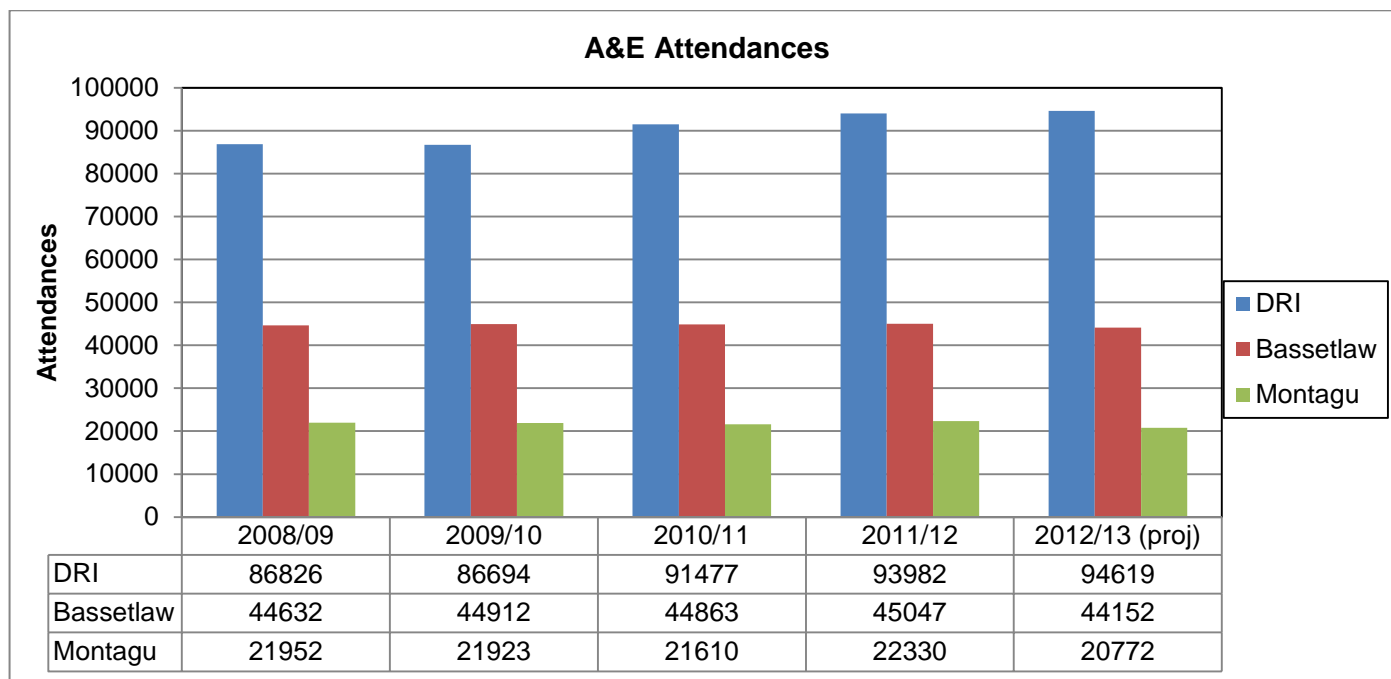


Figure 7



Diversification

It is important that DBH takes the opportunities to diversify its services for growth and sustainability. During the next planning period we will review our current arrangements for the provision of private services and determine the optimum future mix of provision, both internal and external. We will also consider any opportunities that arise to both acquire and/or operate companies which may generate cash or reduce operating expenditure.

The Trust recognises that research output is used to inform service transformation, underpinning future Trust business development. It also supports agendas such as quality, innovation and continues to be a key driver towards clinical excellence. The Trust will develop, during 2013, a Research and Development Strategy to establish DBH as a centre of research excellence, increase research capacity and capability and significantly increase research income. This will be supported by the introduction of an Intellectual Property Policy and Framework.

1.3. Collaboration, Integration and Patient Choice

DBH fully appreciates that providing the safest most effective care possible for our patients whilst controlling and reducing the cost of healthcare depends on working with others in partnership. We have established a number of partnership arrangements and will continue to develop these over the next planning period. These include;

- *Working Together* Partnership – working with 7 acute trusts across South Yorkshire, Mid Yorkshire and North Derbyshire focusing on 5 priority areas; clinical services, workforce, back office services, sharing information, skills and experience and enabling better use of technology
- United Lincolnshire Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust - collaborating across a range of non-clinical services and joint procurement opportunities
- Sheffield Teaching Hospitals NHS Foundation Trust (STH) and Specialised Services Commissioners to develop new service models that are clinically and financially sustainable including cancer, vascular and trauma. An exciting recent innovation is to develop a second radiotherapy site for South Yorkshire and Bassetlaw on the Doncaster Royal Infirmary site (see service development section)
- Community Service Providers, Local Authorities and GPs to coordinate integrated pathways and services across the primary/secondary care interface in Doncaster and Bassetlaw including the transformation of urgent care services and children's services (see service development section)
- Mental Health and Community Service Providers, Local Authorities, Commissioners, Macmillan and service users to improve and develop services for patients living with and surviving cancer

- Other acute provider trusts and local commissioners to explore further developing out-patient services in a range of community locations
- Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), Nottinghamshire Healthcare Trust and local CCGs to collaborate on the iHospital project
- South Yorkshire Acute Trusts and Specialised Services Commissioners to deliver the AAA Screening Service
- Membership of the Doncaster Health and Wellbeing Board in order to improve the commissioning and delivery of NHS and local government services across the locality
- Support the development of the Yorkshire and the Humber Academic Health Science Network (AHSN) as a powerful partnership between patients, health services, industry and academia to improve healthcare across the region
- The development of Local Clinical Research Networks (LCRNs) and the next stage Collaboration for Leadership in Applied Health Research (CLAHRC) to deliver our strategic objective of embedding high quality research in our clinical service delivery in order to improve outcomes and contribute to evidence based knowledge and practice.

The public expects the NHS to provide integrated care, whether we provide a small or larger part of the care package. We will support the development of integrated care pathways in our local communities, using the expertise of our clinicians to provide leadership and advice when required. Examples of where we are working in collaboration with healthcare partners to integrate services over the next planning period include;

- Commissioner supported initiatives in Doncaster and Bassetlaw, working with our healthcare partners to transform and integrate services including urgent care and services for children
- Working with RDaSH to provide an integrated COPD pathway to facilitate earlier discharge
- Working with RDaSH to provide an early supported discharge scheme for stroke patients
- Working with local commissioners, RDaSH and DMBC as part of the *Clinical Services Review* to further integrate acute and primary care rehabilitation pathways
- As part of our comprehensive dementia strategy, work with mental health, community and social service providers in both Bassetlaw and Doncaster to integrate services for patients suffering from dementia – this includes mental health nurses in-reaching into our hospitals
- Working with local and specialised commissioners and Sheffield Teaching Hospitals NHS Foundation Trust to further integrate cancer pathways to improve waiting times, sustain local specialist services and develop innovative models of care e.g. oncology delivery models and follow up pathways and radiotherapy services.

Respect for competition rules and patient choice will guide our actions.

2. Approach taken to quality

We believe that high quality care is efficient care. We therefore believe that quality (in terms of fitness for purpose) should be our organising principle. We will improve the safety and effectiveness of our services through delivering the objectives in our new Strategic Direction 2013-2017 (see section 3 - Clinical Strategy).

We realise that in our efforts to provide the safest, most effective care possible we need to enhance patient experience, dignity, respect and choice. During 2013/14 we will set out a new strategy for enhancing patient experience throughout our many different services and facilities.

The key quality concerns for DBH over the next planning period are;

- 4 hour wait for Accident and Emergency
- 18 weeks referral to treatment target
- C.Difficile rate
- Pressure ulcers – categories 3 and 4
- Bed occupancy rate

- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI).

Action Plans are in place for all of the above which are monitored monthly by the Board of Directors.

We have stated in the *Declaration of Risks against Healthcare Targets and Indicators for 2013-14* that the DBH referral to treatment time, 18 weeks in aggregate, admitted patients target is at risk. We are anticipating being non-compliant in quarter 1 and quarter 2. An action plan has been agreed with Monitor.

The key quality risks inherent in our Plan and mitigating actions to address them are set out in figure 7.

The Board derives assurance regarding the quality of its services from a number of sources, both internal and external. These sources are detailed in the Board Assurance Framework (BAF), which is structured around the organisation's strategic objectives. The Trusts first strategic goal for 2011/12 was *High quality and safe services for all our patients* while for 2013/14, the first strategic goal will be *Provide the safest, most effective care possible*. The quality and safety of services is therefore consistently a key focus of the BAF.

The Clinical Governance Standards sub-committee of the Board has specific responsibility for clinical risk, patient safety, clinical governance and quality governance. It is responsible for reviewing all clinical and quality related aspects of the BAF on a quarterly basis, and reporting back to the Board highlighting gaps in control and assurance. Both the Audit and Non-clinical Risk and the Clinical Governance Standards sub-committees receive quarterly reports regarding the Trust's Quality and Risk Profile alongside details of internal and external assurance in relation to compliance with CQC outcomes.

The Board receives reports regarding all external reviews (e.g. CQC inspections) regarding the quality and safety of services. In addition to this, the Board receives regular performance reports covering the following quality measures, in order to obtain on-going assurance regarding performance against its quality objectives; A&E performance, C Difficile and MRSA, Referral to Treatment times, Pressure Ulcers, Falls, Mortality (HSMR), Stroke performance, VTE, Never events, Cancer waits, Cancelled operations, Diagnostic waits, Patient experience surveys, Serious incidents, Inquests and rule 43 letters and Complaints.

Figure 7 Key quality risks and actions to address them

Category of risk	Description of risk	Potential impact	Mitigating Actions / Contingency Plans	Residual concerns	How the Board will monitor
Failure to achieve Governance Compliance targets; C.Difficile, A&E, 18 weeks	The Trust has failed to achieve its compliance targets for C.Difficile, A&E and RTT during 2012/13. Compliance with these may continue to present difficulties. Risk - High.	Failure to achieve targets will result in harm to patients, breach of the Trust's terms of authorisation, adverse publicity and potential financial penalties.	<ul style="list-style-type: none"> Action plans in place for C.Difficile, A&E and RTT Performance Management and Accountability Framework Escalation policies Daily, weekly and monthly monitoring (patient targeted lists, breaches etc.) Weekly RTT and A&E meetings led by Chief Operating Officer. 	Potential failure of action plans.	Monthly monitoring of performance against compliance targets.
Failure to maintain patient safety by preventing and controlling infection.	The continued requirement to achieve healthcare associated infection targets (MRSA & C.Difficile) presents a challenge. The Trust has breached its C Difficile trajectory for 2012/13. In 2014/15 the C-Difficile national target will reduce to 37 cases representing a significant risk. Monitor agreed target is 48 cases. Risk - High.	Failure to achieve targets will result in harm to patients, breach of the Trust's terms of authorisation, adverse publicity and potential financial penalties.	<ul style="list-style-type: none"> Action Plan in place for C Difficile Universal MRSA screening and pre-emptive decolonisation in high risk units Mandatory training and competency assessment for blood culture technique. Monthly monitoring of contamination rate RCAs with action plans & escalation Proactive deep cleaning and fogging programme Antimicrobial ward rounds Antibiotic policies Multi-agency strategic IPC group to determine health and social care community actions Engagement with District Infection Prevention Control Committee. 	<ul style="list-style-type: none"> Potential failure of action plans Potential failure to ensure compliance with IPC policies and guidance Potential failure of IPC initiatives in health and social care community 	<p>Monthly monitoring of performance through business intelligence report.</p> <p>Monthly monitoring of C.Difficile action plan.</p>
Failure to match capacity with demand, particularly during winter	The Trust has experienced issues with capacity and bed availability during the winter of 2012/13. Ensuring the Trust has an effective bed plan, and appropriate capacity, for 2013/14 underpins a number of key targets and performance measures. Risk – High	Failure to match capacity with demand will jeopardise the achievement of targets, result in poor patient experience, and will have a financial impact due to inefficient use of resources.	<ul style="list-style-type: none"> Business planning processes Winter planning processes Strategic bed planning for 2013/14 and beyond Processes for joint health community working Whole system review for sustainable improvement 	Potential failure to ensure the bed plan is sufficiently robust to deal with peaks in demand.	Monitoring of occupancy levels by the Board. Monitoring of proxy indicators including RTT, A&E and quality measures.
4.Failure to maintain and develop specialist service profile	Failure to maintain and develop specialist services. Risk: High	Significant external risk to the Trust in terms of commissioning intentions/ procurement processes.	<ul style="list-style-type: none"> - Membership of SYCOM - Specialty based project boards (e.g. cardiac, vascular, trauma) - Engagement in procurement exercises - Involvement in AHSN development process - R&D support for specialist service lines - Specialist Cancer Service partnership with Sheffield Teaching Hospitals. 	Potential loss of specialist services which may impact on reputation, recruitment other services provided by the Trust.	<p>Monthly monitoring of external reviews and commissioning processes.</p> <p>Proportion of services reviewed which are retained by the Trust.</p>

3. Clinical Strategy

During 2012/13 we have been developing our new Strategic Direction 2013 – 2017 through a process of analysis, involvement and consultation with staff, governors, members, commissioners and other key stakeholders. We have taken account of our commissioners and partners strategies and the changing future context of the NHS. We have examined our weaknesses and strengths, opportunities and threats and developed a way forward that respects those contributions and integrates them into a distinctive, coherent and inspiring vision that will frame and direct our actions over the next five years.

Vision

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

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.***

Values

To show ***We Care for You;***

- ***We*** always put the patient first
- ***Everyone*** counts – we treat each other with courtesy, honesty, and 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.

Four Strategic Themes

Our strategy for becoming the best healthcare provider in our class is founded on four core themes, each of which is supported by, and to some extent reliant on, the others. A comprehensive list of strategic objectives sets out how we will deliver each theme.

The four strategic themes are;

Provide the safest, most effective care possible

Providing safe, harm-free, high quality and clinically effective healthcare is our highest priority as an organisation. As an industry, healthcare is relatively hazardous and every defect and failure in our care and its organisation has both a human and financial cost which is potentially avoidable. The requirement for improvement is underlined by the Francis Report recommendations for the NHS which challenge all NHS organisations to develop a culture that delivers improved safety, experience and outcomes, by design. Our approach in this area will be characterised by openness, transparency and candour, with ourselves, our patients and our commissioners and regulators.

Our highest priorities for providing the safest, most effective care in 2013/14 as set out in our *Quality Account* include;

a. Patient Safety

- Taking a zero tolerance approach *to never events*
- Reduction in the number of healthcare associated infections; MRSA, C Difficile
- Reduction in the number of patient falls causing serious harm
- Reduction in the number of hospital acquired pressure ulcers above category 2.

b. Clinical Effectiveness

- Venous thrombo-embolism (VTE) risk assessment
- Prescribing of VTE Prophylaxis for high risk patients
- Root cause analysis for all patients admitted for VTE
- Reduction in the number of cardiac arrests as a % of hospital admissions
- Reduction in HSMR
- Reduction in SHMI

c. Patient Experience

- Carrying out the *Friends and Family Test*
- Monitoring and aiming to reduce the number of complaints where patient harm is a feature of the complaint
- Seeking the views of relatives / carers of those patients following end of life care.

Control and reduce the cost of healthcare

The NHS is in a period where resource increases will be limited and, at best, only very marginally above national inflation, for the foreseeable future. The Trust has established a firm base to meet future challenges in terms of both income and expenditure performance and liquidity. Our future requirement is to develop a discipline and mind-set to live within budgets whilst constantly seeking to deliver cost reductions, without affecting care quality.

We will ensure we better understand our key cost and income drivers and make use of comparative analysis, benchmarking, best practice and analytical tools such as patient level costing to understand our relative and absolute positions and progress (see section 3.1).

Our Financial and Investment Strategy is set out in section 5.

Develop responsibly, delivering the right services with the right staff

People's healthcare needs change over time so it is vital that we continue to improve and develop our services. These services are delivered by our people, so it is equally crucial that we communicate and engage with them and facilitate their ongoing education and development.

This will be achieved by working in partnership to ensure we have a sound business model to deliver our finance and quality objectives and clear service visions for all our hospital sites and community services. Our *People and Organisational Development Strategy* will ensure we create a healthy culture within the Trust that reflects our values and supports staff to deliver our ambitions.

Our Clinical Workforce Strategy is set out in section 3.2.

The Trust will also review its corporate governance structure to ensure it is fit for the future.

Focus on innovation for improvement

The programme for innovation and improvement will support and facilitate the other three key strands of the Strategic Direction. This will include;

- Developing our research capability and capacity in order to improve healthcare outcomes and contribute to evidence-based knowledge and practice
- Delivering our I Hospital programme to improve quality/reduce costs using technology and innovation
- Delivering our Innovation Programme to adopt key high impact changes through clinical research and service delivery
- Ensuring we both contribute to and take from the emerging AHSN offer.

Progress on our Strategic Direction will be assessed annually using the corporate objectives and annual plan framework. The document will be subject to a three year formal review.

In line with the Trusts Strategic Direction 2013-2017, the Corporate Objectives for 2013/14 are;

License and Registration

Ensure the Trust maintains its license and registration to operate by ensuring;

- CQC registration without conditions
- A&E performance such that the 95% target is achieved from Q1 and maintained
- RTT issues are resolved by Q3
- That maximum efforts are taken to reduce C. Difficile to no more than 48 by year end
- Maintaining FRR3
- Maintaining compliance with other framework targets.

Provide the safest, most effective care possible

- Develop and start to implement an organisational response to the Francis Report
- Increase day surgery rate from 81% to 85% by year end
- Develop systems to achieve full and timely compliance with NICE guidelines
- Decrease inappropriate prescribing associated with C Diff by 50% over 12/13 level
- Reducing actual to speciality readmissions by 5% on 12/13 outturn level
- Revise complaints management process, reducing outstanding to 80 by year end and ensuring that 90% of complaints are responded to within designated timeframe
- Set a programme to reduce harm to patients, supported by a revised patient safety strategy, aiming to reduce Hospital Acquired Pressure Ulcers (HAPUs) by 14% and falls by 20%
- Aim to achieve a >5% reduction on HSMR 12/13 outturn, to get below 100 by year end, both main sites
- Develop a plan to significantly reduce patients sleeping outside speciality and ward moves/patient
- Improve performance in key patient experience indicators (sleep/dignity/nutrition/hydration/concerns/explanations/pain relief/care and compassion/toilet assistance) >80% as per local CQUIN
- Implement *Friends and Family Test* (FFT) and ensure we are in top 50% nationally, in line with national CQUIN
- Increase nurse recruitment, to improve quality and reduce reliance on bank/agency by 33% < 12/13 level
- Complete the “productive ward” programme and externally assess progress and future sustainability
- Develop and start to implement the Quality Strategy Q3.

Control and reduce the cost of healthcare

- Increased medical recruitment to reduce locum costs by £1.5 M below 12/13 level
- Reduce WTE as set out in CIP Programme (57), primarily by non-recruitment to designated posts
- Set up transformation/change programme (Future Hospital) ready for full implementation 14/15
- Review risks as recognised via NHSLA and develop a plan to improve quality, reduce risk/liability arising
- Deliver procurement savings of £2M+ through Trust and partnership working
- Review capacity to ensure future (14/15) optimal use of subcontracted healthcare providers
- Implement the service line costing programme

Develop services responsibly, delivering the right services with the right staff

- Prepare and implement agreed detailed Trust-wide bed plan. First stage plan finalised May 2013
- Develop a comprehensive site plan for DRI, present options to the Board in October/November
- Develop a plan with STH to deliver Radiotherapy on site and review associated cancer services

- Complete the Montagu Development and deliver planned patient pathway, reducing LOS to 21 days
- Introduce 7 day working for all emergency pathways by September 2013
- Deliver cross site integration for all surgical specialities by year end
- Support the development of CCGs/CB/ Health & Wellbeing through participation and focus on demand
- Review recruitment process and supporting IT to ensure optimum approved vacancy fill rates
- Individual objectives and appraisals for all staff at Band 7 and above, completed by July
- Team objectives for staff below Band 6 completed by September
- Ensure that processes and procedures are in place to control staff sickness to < 3.5%
- Implement revised *Agenda for Change* provisions
- Develop ward based training programmes to enhance patient focus and ward performance
- Implement Values Programme, translating words into actions and behaviour change
- Implement 3 key actions arising from the Staff Survey 12/13
- Develop and start to implement the *People and Organisational Development Strategy* Q1
- Develop and start to implement the *Communications and Engagement Strategy* Q2
- Improve diabetes care as judged by NADIA audit after specialist nurse deployment
- Develop and implement a *Dementia Strategy*.

Focus on Innovation for improvement

- Develop R&D strategy to include CLARHC/AHSN work streams by June, including quarterly reporting.
- Support the *South Yorkshire Working Together Programme* quantifying the Trust benefits
- Deliver an IM&T Strategy, including recommendations for key system development by July 2013
- Develop and start to implement an Innovation Strategy, in line with Innovation, Health and Wealth aims.

3.1. Service Line Strategy

Operational management of the Trust is based around sixteen Clinical Service Units (CSUs) each of which comprise of single or multiple clinical specialties. CSUs are led by a clinician or service head as Clinical Director.

The approach to developing these service lines is to continue to foster the strengths of the CSU structure and clinical engagement in management, whilst underpinning it with enhanced support. The support will take the dual form of skills and knowledge training and enhanced information.

Key elements of the Trust's financial information support to CSUs will come from the implementation of Patient Level Costing (PLICS). This is currently going live and being used to produce reference costs for 2012/13. Also during 2013/14 the Trust business intelligence report will be replicated at CSU level.

The Trust will be working with CSUs to examine the service line performance, quality and profitability, particularly to address variation in each and to benchmark with peers.

A further key strand of the benchmarking approach will be involvement in the local acute Trusts' *Working Together* Partnership, sharing key service line information and using it to obtain efficiencies and effective cross-organisation working, see section 1.3.

3.2. Clinical Workforce Strategy

The overall aim of our *People and Organisational Development (P&OD) Strategy* is to; *ensure that patients trust that staff employed by DBH are well qualified, well trained and well prepared to give the best possible care and that all staff do their best to provide that care because they are well motivated, well engaged and feel well valued and rewarded.*

The strategy will be delivered through five strands of work, which mirror the new structure of the P&OD Directorate; Training, Education and Development, Employee Services, Occupational Health and Wellbeing Services, HR Services and Cross Cutting Projects. The *People Programme Board* will develop

and monitor the milestones for each work stream and provide the necessary assurance to the Board that any workforce changes will not impact on quality.

The key workforce pressures for DBH in the next planning period are around recruitment; of nurses and healthcare assistants to keep up numbers and medical staff to replace long term locums. Plans to address these issues will be part of our P&OD Strategy and include; centralising and reviewing the processes for recruitment, implementing simpler/more streamlined/shorter processes for end-to-end recruitment, re-branding the Trust as an employer of choice specifically focusing on our employee offer and our desire to raise the level of research and development we engage in, ensuring a much closer link between vacancies, budget for staff and recruitment so that decisions can be expedited and action to fill posts taken more quickly.

The Trust will continue to work with the Regional Workforce Planning Team to assess clinical staff requirements for future years. In-year we are using the *Safer Nursing Tool* and other specialist tools to assess whole time equivalent numbers based on acuity and dependency. This will confirm our rolling recruitment requirement.

Other key clinical workforce risks for the Trust include;

- The sustainability of clinical services that are reliable on one individual practitioner. These include; Paediatric Respiratory, Urology Cancer and Tissue Viability Services
- Failure to maintain and develop our specialist service profile due to the lack of critical mass and the commissioner centralisation agenda. Services at risk include; Upper GI Cancer, Vascular and Interventional Radiology Services
- Maintaining services that are supported by a Medical Consultant rota less than 1:6 in line with guidance from the Royal Colleges. Services at risk include; Renal Medicine and Haematology Services.

In order to mitigate these risks the Trust is exploring with other organisations, provider and commissioner, opportunities for partnership and collaboration in the provision of services and any opportunities to increase critical mass to sustain the availability of these services.

The Trust is committed to seeking new and innovative ways of providing services in conjunction with partner organisations that are consistent with commissioner's requirements. The following are examples of collaborative working with commissioners and healthcare partners which deliver integrated care across the primary/secondary care interface and use innovative workforce models;

- Rehabilitation services at the Montagu Hospital (strategic development section 1)
- Urgent care services (strategic development section 12)
- Services for older people including dementia (strategic development section 6).

Dedicated project resource, initially 2 wte, to underpin the workforce strategy developments has been included in the financial plan.

4. Productivity and Efficiency

4.1.Overview

The Trust needs to continue to make significant year on year productivity and efficiency gains in line with tariff deflation and to continue to develop and improve services and maintain a minimum FRR 3 rating.

In formulating the 2013/14 CIP plan we have also endeavoured to take account of the operational performance, particular around A&E/Four Hour Wait and not asked the acute medical CSUs for savings. Indeed the incidence of the savings plan falls 75:25 to non-clinical area or cross-cutting themes, whereas total spend is around 30:70 in CSUs' favour.

We are looking to the surgical specialties for productivity and efficiency improvements however and a new Day Surgery unit coming on-line in July 2013 will be part of the approach to realising higher day case rates and a £250k gain. Similarly we are looking to repatriating work from private providers to earn the bulk of a £1.3m CIP.

Length of stay will be reduced when the Trust opens new, state-of-the-art, rehabilitation facilities at The Montagu Hospital in late summer 2013.

The CIP programme will again focus heavily on bank, locum and agency spend and procurement with targets of £1.5m and £2m respectively.

Whilst it has been possible to produce a firm plan for 2013/14 largely from long-established areas, the Trust will be looking to more transformational items for the bulk of CIPs from 2014/15 onwards.

4.2. CIP governance

Delivery against CIP targets has improved over the last three years as shown by the table below;

Cost Improvement Programmes

2010/11 - 2012/13 Performance

Category	2010/11	2011/12	2012/13
<i>Actual</i>	10,181	16,039	16,783
<i>Monitor Plan</i>	15,500	16,100	16,018
Variance	-5,319	-61	765

The improvement largely coincides with strengthened financial reporting and this will be further developed in 2013/14 with enhanced individual scheme reports and milestone/action prompts.

The CIP performance is reported into all key corporate meetings and corrective action agreed, where necessary.

A transformation based project board is being established early in the 2013/14 year to develop 2014/15 schemes further.

4.3. CIP profile

The CIP profile across 2013/14 is

Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
7.5%	7.5%	7.8%	8.4%	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%	8.7%	8.7%

This shows a fairly uniform profile not overly dependent on significant winter months' increases or unduly back-loaded.

4.4. CIP enablers

The CSU element of CIPs has required the clinical directors to identify schemes and will need them to deliver. To this end progress is routinely presented to the Management Board monthly, at which all CDs are members. This will be under-pinned by regular local scheme reporting.

Clinical leadership and engagement will be crucial in formulating and delivering future year CIPs.

Savings from CIP schemes are targeted net of associated enabling costs, which vary from scheme to scheme in terms of project support, ICT or other inputs.

4.5. Quality impact of CIPs

The Trust assessed the quality impact of CIPs at a dedicated meeting of the Management Board, with representatives of all the CSUs. Each clinical scheme was reviewed and comments taken on board or schemes adjusted or withdrawn accordingly.

Additionally, the Trust's Medical and Nursing Directors have reviewed the schemes as part of the contractual requirement with commissioners.

The in-year change control mechanism for CIPs will also require Medical or Nursing Director, as well as Finance Director sign-off.

Going forward, we see the majority of CIPs needing to be transformational thus linking quality and efficiency in their formulation.

5. Financial and Investment Strategy

The financial approach for the next three years is to continue to underpin the Trust's service development and quality improvement, whilst maintaining a minimum risk rating of 3.

In the immediate 2013/14 financial year, this will largely involve supporting a performance improvement programme in relation to Four Hour Waits, RTT and Clostridium Difficile, and some progress on other developments set out in this plan. We therefore will be maintaining 1% margin and 5% EBITDA as the financial requirements.

The Trust intends to maintain capital expenditure at a level significantly above that supported by depreciation alone.

5.1. Current financial position

The Trust's ended the 2012/13 financial year with a £3.485m surplus, c. 1% margin and 5% EBITDA. Similar results have been achieved over the previous two years and the Trust has a good record of delivery over a number of years.

Ideally, the Trust would have been aiming for a small increase in surplus in 2013/14 but pressures arising from the need to rectify performance in three key areas means that this will not be possible.

Relationships with commissioners are good and where disinvestment is proposed it has largely been accompanied by mutually agreed transition plans. Similarly, some commissioner support has been forthcoming to assist in the priority performance improvement areas.

The Trust has a number of capital schemes that will complete in 2013/14 and ensuring the planned gains arising from these are achieved is important.

Continued delivery of CIPs should enable the Trust to maintain its financial position through the plan period.

5.2. Key financial priorities

There are essentially five financial priorities for the Trust in the next year and going forward:-

- Delivery of 1% surplus, 5% EBITDA and FRR3
- Achievement of CIPs in year and confirmed programme for future years
- Maintained liquidity position
- Continued capital expenditure above internally generated levels of cash
- Fully embedding patient level costing and its use in underpinning service line strategy.

These are not mutually exclusive in themselves and essentially are the main parts of a virtuous circle which the Trust sees as important in order to support safe and sustainable services.

5.3. Key risks

Six key risks to the financial plan have been reported to the Board of Directors, namely;

- Delivering contracted activity
- Avoiding un-remunerated contract over-performance
- CSU/directorate overspending
- Delivery of 2013/14 savings
- Adequately progressing future savings
- Avoiding sub-optimal use of investment money.

The Trust would expect in each case to have robust systems (contract review, budgetary control, CIP reporting and investment appraisal for example) and relationships in place to avoid the above occurring and early warning signs to take action if any did.