



Strategic Plan Document for 2014-19
The Rotherham NHS Foundation Trust

1.1 Strategic Plan for y/e 31 March 2015 to 2019

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

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Job Title

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Date

30th June 2014

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name **Martin Havenhand**
(Chair)



Signature

Approved on behalf of the Board of Directors by:

Name **Louise Barnett**
(Chief Executive)



Signature

Approved on behalf of the Board of Directors by:

Name **Anna Anderson**
(Interim Finance Director)



Signature

1.2 Declaration of sustainability

<i>The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.</i>	<i>Confirmed</i>
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In April 2013, Monitor decided to accept from the Trust an Enforcement Undertaking which required the Trust to develop and implement a financial recovery plan and develop and submit to Monitor by 31 December 2013 a three year strategic plan. Accordingly, and following the work undertaken by Bolt Partners LLP, the Trust submitted to Monitor in December 2013 a Five Year Plan and Strategic Options. This Strategic Plan document reflects the contents of the 31 December 2013 submission to Monitor, progress that has been made since its original submission and the further steps which need to be taken to ensure that the Trust has a plan which provides financially and clinically sustainable services over the strategic period. In summary, the Plan concludes:

1. Strategic Options - As part of the options appraisal work, three options were considered: Option 1 – the Trust remaining as a standalone entity; Option 2 – vertical integration with a social care provider; and Option 3 – merger with another acute provider. Following consideration, the Trust Board decided to pursue option 1 - for the Trust to remain as a 'standalone' organisation whilst also exploring potential opportunities for collaboration with other acute providers in the Local Health Economy, and in particular exploiting the opportunities provided by the "Working in Partnership Programme" (see below). The potential impact of future changes, such as 7 day working and clinical and regulatory requirements was not factored in to this assessment.

2. Financial Sustainability - The financial position for the Trust is set within the context of challenging economic conditions in the UK economy over recent years and the limited growth assumptions for the NHS over the next 5 years. Against this background, the Trust entered the 2014/15 financial year with an improving financial position. The Trust reported a deficit of £6.5m in 2012/13 and achieved a deficit of £3.2m in 2013/14, £1.6m above its planned deficit of £4.8M. The challenging position facing the NHS as a whole will require significant efficiencies to continue to be identified and delivered within this strategic period in order to maintain service delivery and to achieve financial sustainability.

The 2 year operational plan stated that year 1 of the plan (2014/15) would generate a surplus of £0.7m and a surplus of £2.2m in year 2 (2015/16), Following work undertaken initially by Bolt Partners LLP, and subsequently by the Trust, the Trust's recurrent underlying deficit was assessed at £5.9m in the 2013/14 outturn position and at £3.5m underlying deficit at the end of year 1 (2014/15). This was predicated on the Trust achieving its planned CIP programme.

The 2 year planning assumptions included an element of recurring non-recurrent income which in effect enabled achievement of surpluses in years 1 (14/15) and 2 (15/16) and £5.4m the majority of which is expected to continue throughout the 5 year period in line with CCG plans.

With the benefit of further review, and in the light of Monitor's recent feedback to the sector which highlighted significant concerns about the quality of the sector's planning, particularly that year two of the plans may, on aggregate, be overly optimistic, assumptions have been amended. A more prudent approach has been adopted eg with the use of national assumptions about tariff deflation and cost increases rather than the more optimistic local assumptions used previously. In addition most of the uncertain year end income has been removed. Lastly the Trust has now included an additional £3.5m of income expected to be provided by the CCG to enable 7 day working. The net effect of these changes is that the planned surplus for 2015/16 is now

£0.5m, not £2.2m as in the plan submitted in May.

As a result, higher levels of CIPs will need to be delivered particularly in 2015/16 and 2016/17. The Cost Improvement Programme for 2014/15 is £10.9m. In 2015/16, the consequence of the trust's revised position is that £12.9m of CIPs are required (5.9%), with a further £10.5m, 5%, in 2016/17 and c£8.3m in the two following years. Whilst the CIP target is particularly challenging in year 2, in the outer years it remains, broadly comparable to that facing similar sized trusts (The NHS productivity challenge; Experience from the front line, Kings Fund May 2014).

Achieving this magnitude of savings will require the Trust to apply a level of rigour in execution that it has not previously demonstrated, and hence a Transformation Programme supported by a Project Management Office and approach has been set up. Potential risks to delivery of the plan and mitigation have been identified in this submission. The Trust is making good progress in achieving efficiency savings and a total of £9m of fully worked up and confirmed cost improvement programme schemes, towards the total requirement of £10.9m, were in place as at early June 2014. This provides a good base from which to develop future savings which will need to be achieved from transformational change within the Trust and across the Local Health Economy. Independent benchmarking undertaken in 2011 and 2012, indicated a £4m - £9m CIP opportunity which would take the Trust to upper quartile performance. The plan assumes that peer Trusts in the upper quartile continue to improve consistent with the efficiency expectations facing the acute sector year on year, and therefore that there is the opportunity to deliver the CIPs identified in the plan period by moving towards or matching upper quartile performance.

Further independent benchmarking is due to be undertaken to re-assess potential CIP opportunities and achievability through the plan period. Deloitte have been appointed and work will commence in July. In addition, the implementation of Service Line Reporting will improve the Trust's ability to target specific specialty areas for efficiency savings. Lastly, it is important to note, that the achievement of the CIP levels required is dependent upon fundamental service redesign. This will be determined from the clinical specialty reviews and Working Together Programme workstreams identified in the plan, and will include redesign of service provision in conjunction with external stakeholders across the local health economy.

Clinical and financial sustainability is dependent upon eroding the underlying deficit. The two year plan indicated that this could be reduced to £3.5m at the end of 2014/15 and that there would be an underlying surplus of £2.2m at the end of 2015/16. Further work is being undertaken to confirm the pace at which the current underlying deficit can be reduced and eliminated over the planning period.

The early evidence points to the potential benefits of having an integrated approach to the provision of emergency care. Therefore, following public consultation undertaken by Rotherham CCG in July 2013, a joint business case to create an Emergency Centre on the Rotherham Hospital site is currently under development with the support and input of the Department of Health's Emergency Care Intensive Support Team. This would provide a single point of access for patients, co-locating the existing walk-in centre, GP out of hours service and A&E department, whilst redesigning pathways to create an integrated model of care to streamline the assessment and treatment of presenting patients. A decision is due to be taken in late summer 2014. Pending this decision, the Trust Board has decided not to include the financial impact of the development in its financial planning assumptions at this point. If the decision about the Emergency Centre is favourable, it would impact positively on the financial position in 2015/16 and 2016/17 as CCG funding towards the capital cost would be included in the Trust's income. At that point the Trust will need to consider the impact of this development and assess the implications for its financial assumptions. The commissioner has assumed no savings arising from this development in their 5 year plan and at this point the impact on income and expenditure in relation to activity and resources is assumed to be neutral.

A contingency of 1% has been allowed for each year of the plan and the income assumptions within our plan are consistent with the commissioner's 5 year activity planning assumptions.

The table below summarises the key points of the Trust financial plan underpinning this strategy:

Summary of financial plans 2014/15 to 2018/19					
	2014/15	2015/16	2016/17	2017/18	2018/19
	£m	£m	£m	£m	£m
Income	231.8	226.2	226.7	226.3	225.8
Expenditure	-221.2	-216.3	-215.3	-214.6	-213.5
Interest, tax depreciation etc	-10.0	-9.4	-9.3	-9.0	-8.9
Surplus	0.7	0.5	2.0	2.7	3.4
CIPs £m	10.9	12.9	10.5	8.3	8.3
CIPs %	5.2	5.9	5.0	4.0	4.0
Cash balance at year end	10.6	10.8	10.7	11.2	12.4
Capital expenditure	7.6	6.1	5.7	5.8	5.4
CoSRR	3	3	3	3	3
Tariff inflation/-deflation%	-1.4	-1.6	0.4	-0.6	-0.7
Cost inflation %	1.8	2.9	4.4	3.3	3.3

3. Clinical Sustainability -The strategic options appraisal work undertaken in 2013, concluded that the Trust was clinically sustainable at that time, and in particular assumed on-going provision of a 24 Hour A&E service, on-going provision of a comprehensive and safe maternity service, retention of acute and community services whilst improving their integration. Whilst the Trust is considered to be clinically sustainable at this time, like other similarly sized trusts, there will be increasing future pressures on services in terms of demand, clinical quality, including patient expectations, professional and regulatory

requirements which will need to be considered and addressed. Further work is, therefore, needed to assess sustainability in more depth at specialty level in order to identify strategies to increase resilience in service delivery in the longer term. Clinically led, systematic speciality based reviews will commence in July 2014, supported by information on service size, reference costs and clinical outcomes. This is essential to inform financial and clinical sustainability and has been recognised in our regular on-going performance review meetings with Monitor. In essence, the future configuration of services needs to be determined. In parallel, the Trust is an active participant in the “Working Together Partnership” Programme involving all commissioners and providers in the South Yorkshire, Mid Yorkshire and North Derbyshire local health economy and which is seeking to exploit the opportunities for further collaborative working across the region, and building on existing models and arrangements where collaboration has already been shown to work. It is worth noting that the Trust has a history of developing approaches with other providers where different models of service provision offer a better solution, e.g. the provision of joint ophthalmology services on behalf of Barnsley NHS Foundation Trust and of oral maxillofacial services with Doncaster and Bassetlaw NHS Foundation Trust.

4. Operational Sustainability - The Trust is at an early stage in terms of its organisational restructure and strengthening capacity and capability at Board and executive team levels to focus on the key strategic and operational priorities. The substantive chairman was appointed in 2014 followed by the appointment of a substantive chief executive in April 2014. Arrangements are currently being progressed to make substantive appointment offers have been made for the other key executive posts of including Director of Finance, Chief Operating Officer and Executive Director of Workforce and Transformation. In addition significant progress has been made in restructuring at clinical management level from 11 divisions and community services, to 4 clinical directorates. This restructuring incorporates community within the Medicine Directorate to facilitate and drive the integration agenda. Further work is required to ensure the full development of effective and embedded governance arrangements from ward to Board. In support of the management structure an integrated performance reporting approach has been agreed and implemented at board level. This is being refined and adopted at directorate level with steps taken to increase the transparency and effectiveness of accountability and performance management throughout the trust at directorate and individual levels.

In accordance with the Trust enforcement undertakings, an independent review of governance arrangements which reported in July 2013 concluded that there were a number of material concerns in relation to the effective operation of governance of the Trust including the effectiveness of the Board. A subsequent independent follow-up review which reported in March 2014 concluded that the Trust has focussed on enhancing its performance and governance arrangements and confirmed that the Board has made good progress in implementing the recommendations of the earlier report whilst acknowledging that further improvements are still necessary. These included the requirement for a Board Development Programme and the development of a Board Assurance Framework, both of which are now in place.

A further enforcement undertaking required the Trust to put in place a sustainable plan for the implementation of the Electronic Patient Record System (EPR). The Trust has made very significant progress in this regard and has recently submitted to Monitor an application, supported by detailed evidence, to demonstrate compliance with this enforcement undertaking. Currently the Trust is succeeding in meeting the majority of its operational performance standards/targets. However, we face challenges in a number of areas including 2 week wait for breast symptomatic referrals, some Stroke performance indicators and C.difficile. With regards to the A&E 4 hour target, the Trust achieved this in Quarter 4, and for the year 13/14 and, is on track to achieve in Quarter 1 14/15. We are taking steps to achieve sustainability whilst faced with increased and sustained pressures on A&E attendances and emergency admissions.

The Trust is clearly sighted on the need to reduce sickness absence levels, to increase appraisal and significantly improve staff satisfaction. In addition The Trust must continue to take steps to meet the workforce resourcing requirements over the plan period and faces occupational shortages consistent with national workforce pressures. The Trust has adopted the Listening into Action programme as a vehicle to drive improved engagement and to empower staff

in delivering high quality care to patients.

5 Meeting the Strategic Challenge in Rotherham: Our Current Strategic Plans

“Facing the future: smaller acute providers” (Monitor, June 2014) acknowledges the scale of the financial and clinical sustainability challenge faced by smaller acute providers such as Rotherham. It highlights the range of initiatives which such hospitals will need to consider in order to ensure financial and clinical sustainability for the future, including:

- developing new models of care for patients, for example by re-designing services to improve the integration of care;
- finding creative ways to address “the scale challenges”, such as sharing staff with nearby Trusts, using new technology, or building networks between smaller hospitals and major centres;
- ensuring the right balance is struck between redesigning services and making sure patients are treated near to where they live.

Our commitment regarding financial and clinical sustainability is predicated on the same assumption that these initiatives will be required to achieve this sustainable position. The Trust is committed and recognises the necessity to deliver against this range of initiatives.

Our current approach and Strategic Initiatives consist of a range of similar initiatives and which currently include:

- **Unscheduled Care** – a review and development of alternative service delivery models
- **Community Transformation Programme: Managing Long Term Conditions in non-acute settings** – a detailed programme of transformation change for community services
- **Clinical Referrals Management** – a programme of change to deliver outpatient efficiencies
- **Service Transformation and Cost Improvement Programme** – a major efficiency savings programme underpinning the Trust’s financial sustainability
- **Delivering 7 day working** – a transformation programme to assess the impact of and implement 7 day working arrangements across the Trust

Collaboration and Integration: “Working Together Programme” – a major transformation programme comprising commissioners and providers across the Local Health Economy with dedicated workstreams focussing on specialty review and collaboration, and “back office” functions and systems which could be provided at scale. In the later sections of our plan, we therefore outline the steps which we are seeking to take to do this , given their importance and their significance in ensuring sustainability.

6 Next Steps

Whilst the Trust already has in place some significant transformation programmes it recognises the need for even greater clarity to its strategic direction in order to meet the “Strategic Challenge” of ensuring financial and clinical sustainability. Building on the work already undertaken in the production of the Five Year Plan and Strategic Options , the Trust has already agreed the following steps, with timescales agreed with Monitor, to provide greater clarity to its strategic direction:

- **Benchmarking** - the Trust is undertaking a detailed exercise to inform its future savings plans and clinical services strategy involving an overall review

of costs within the Trust when compared with peer organisations;

- Clinical Specialty Reviews – detailed reviews of each clinical specialty will be undertaken in order to assess in more detail clinical sustainability and future service configuration;
- Service Line Reporting is being developed in order to provide greater detail on the performance of individual specialties.

Taken together, these actions will enable the Trust to more clearly describe the future shape and configuration of its services, which will determine its future clinical and financial sustainability.

1.3 Market analysis and context

1 Market Analysis

Population Statistics

The population of Rotherham continues to grow and is projected to reach 269,000 by 2021. The age profile will be increasingly dominated by the elderly with the number of people over 65 expected to grow by 13% over the next eight years; however nearly all that growth will be in people aged over 70. By 2030, the number of people aged 50 plus is anticipated to increase by a further 50%. This is likely to be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. Currently, there are more than 11,000 people in Rotherham with diabetes, and 5,500 on GP stroke registers. By 2025 there will be over 4,500 people living in Rotherham with dementia.

Health Demographics for Rotherham

The Joint Strategic Needs Assessment and Rotherham Public Health Annual Report confirm that the health of people in Rotherham is generally worse than the average for England. From 50 socio-economic and health indicators benchmarked, Rotherham is rated significantly worse than the national England average in 40 areas. There is a socio-economic gradient in that people living in more deprived areas of the borough are more likely to have unhealthy behaviours; deprived areas are also more likely to have people with multiple unhealthy factors leading to increased long term illness.

The Health Profile for Rotherham (Source: Public Health England Health Profile 2013)

In summary:

- The health of people in Rotherham is generally worse than the England average. Deprivation is higher than average and about 11,500 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 10.2 years lower for men and 6.4 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is worse than the England average.
- In Year 6, 20.5% of children are classified as obese. Levels of teenage pregnancy and breast feeding are worse than the England average.
- Estimated levels of adult 'healthy eating', smoking and obesity are worse than the England average. The rate of road injuries and deaths is better than the England average. The rates of statutory homelessness and violent crime are better than average.

This picture confirms the significant challenges faced by the Local Health Economy in addressing and improving the health of the local population, and in the impact it has on the provision of hospital and community based services. Those of particular concern are described further below.

Infant and Childhood Health

Maternal infant and childhood health is a particular cause for concern with high levels of smoking in pregnancy, low birth weight, breast feeding initiation and teenage pregnancy being much worse than the national average.

Obesity

Whilst the percentage of children in Reception classed as obese or overweight at 8.3% is positive and significantly lower than the national average, at Year 6 this rises to 21.6% (significantly worse than the England average). Additionally adult obesity in the locality remains significantly worse than the national average. Rotherham Public Health Annual Report indicates an 'obesity crisis' in Rotherham, which is similar to the rest of England. Obesity is also a significant contributor to the high levels of disability found in the area.

Smoking Prevalence Substance Misuse

Smoking prevalence is significantly worse than the national average. Smoking is the single most important factor in causing avoidable cancer deaths. Over 90% of lung cancer is caused by smoking and it is also a significant contributory factor for head and neck, stomach, bladder and kidney cancers. Stopping smoking should be the key priority for the Borough in tackling excess cancer deaths.

Alcohol

It is predicted that within the adult population of Rotherham 7,086 individuals are dependent on alcohol, with a further 10,432 drinking at harmful levels and 51,569 drinking above low risk. Using national Alcohol Concern¹¹ calculations based on hospital activity statistics (2009/10) for Rotherham there were 53,689 alcohol related hospital attendances at Rotherham Hospital. Of these, 28,827 were in A&E, 18,275 in outpatients and 6,587 inpatient stays were related to alcohol. The majority of inpatients (2,658) were aged 55-74.

Mortality

In Rotherham the age-standardised rate of mortality from causes considered preventable is 159.8 per 100,000 population, substantially above the England average. This indicator is broken down into its component indicators with under 75 years mortality from:

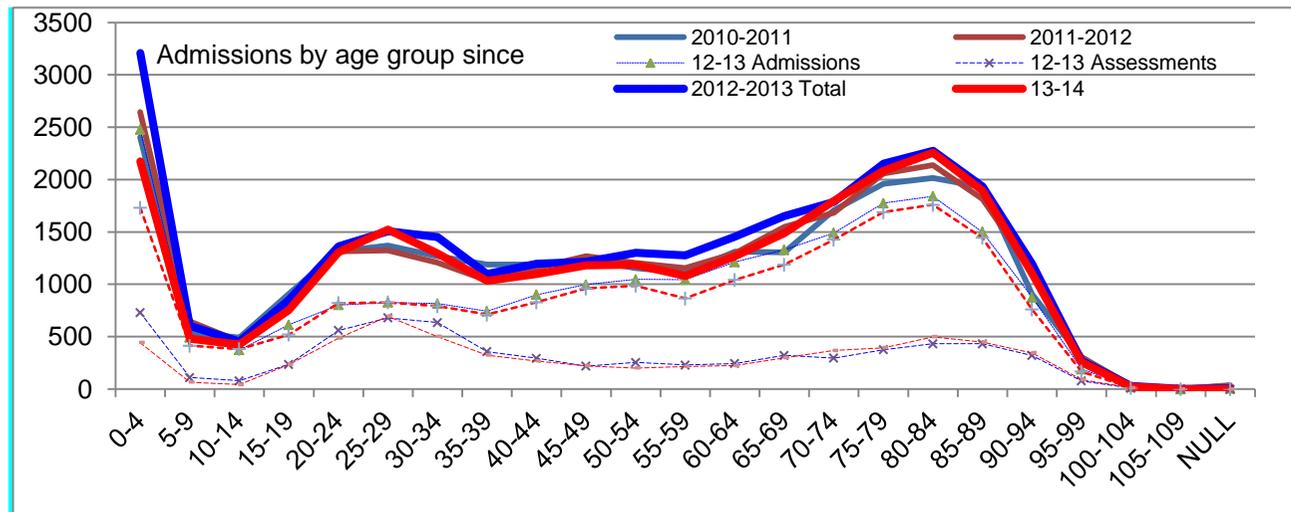
- *cardiovascular disease* (30% of the gap is caused by circulatory disease, heart attacks and stroke)
- *Cancer* (26% by cancer with over half of this explained by lung cancer deaths)
- *Respiratory disease* (33% of this gap is caused by excess respiratory deaths)
- *Liver disease* (Although the contribution of liver and gastro-intestinal disease to inequalities is relatively small at the moment, the increasing trend in numbers of deaths is of concern)

This demographic make-up of the Rotherham population places particular demands on services within Rotherham (as described below) and it is therefore important that the future design of services continuously meets the needs of the population.

Health Indicator	Impact to TRFT	Supporting Evidence
Increase in ageing population	High levels of avoidable admissions in the elderly	A recent audit demonstrated that 34% of admissions in over 80's could have been avoided providing opportunities for efficiency (further increased when applying to the over 75's) Avoidable emergency admission were found to have a greater length of stay leading to further opportunity if this group can be alternatively managed

Deprivation, Mortality & Increasing Ageing population	<p>Increasing non-elective admissions</p> <p>Increase in referral rates</p> <p>Over-reliance on acute hospital services</p>	<p>Analysis of Rotherham resident only activity reveals an overall increase of 4% from 11/12 to 13/14 with 5.3% and 10.9% increases in ages 75-79 and 80+ respectively</p> <p>Analysis of local data comparing referral rates in 13/14 to the same period in 11/12 demonstrate the following specialties to have increased: Cardiology, Gastroenterology, Colo-rectal, Thoracic, Urology, Breast, Oral Surgery, Gynaecology and ENT. Some of these higher levels of referral experienced can be linked to the local demographics (i.e. Cardiology, Thoracic)</p> <p>24/7 availability and historic trend of patients presenting at A&E. Quarter 1 of 14/15 has presented a concerning trend of sustained increases in attendances at A&E</p>
Maternal Health	Increase in complex pregnancies	Linked to smoking prevalence and increasing levels of substance misuse and obesity
Alcohol Use	Increase in alcohol related admissions	April-October 13/14 saw a rise of 7.2% in alcohol related admissions on the same period the previous year
Obesity	Requirement to increase bariatric equipment to manage these patients	Since April 2011 to date £82k has been spent on purchasing bariatric equipment

The graph below shows the age-range of admissions over a 3 year period and clearly demonstrates the curve in 75+ admissions.



The projected increase in the ageing population and the associated increase in demand for services, to be provided within a resource constrained environment will compound the financial challenge for acute and community providers. This demand supports the need to review and re-model healthcare services across organisational boundaries within the local health and social care economy to meet future needs and deliver financial and clinical sustainability. In developing our Strategic Plans, TRFT have considered the implications of the future needs of its local population, however through our programme of transformation, the Trust will need to determine how it will redesign service provision to meet this growing demand.

The healthcare needs assessment described above sets out the current status of the health of people in Rotherham. In light of this and taking into account the likely national, regional and local changes, it is recognised that the services the Trust delivers in the future will need to be delivered differently than they are today. This radical shift will be essential to assure clinical and financial sustainability for the future. Accordingly, our ability to adapt the Trust's capacity in a range of dimensions will be crucial.

2 Capacity Analysis

Capacity Analysis – Estate

Over the next five years the plan will focus on developing the estate and its buildings to meet the organisation's current and future needs. It is essential that our estate is fit-for-purpose, designed to achieve the best quality outcomes and provides those accessing our services with a positive experience. The Trust has already identified a level of capital expenditure to assist in this. Important features of our estates strategy will include:

- A full review of the Trust's estate including current community locations to ensure efficient and effective service delivery to the local population. Significantly, the Trust's estate is sufficiently diverse in type and location that it may offer scope for realising the benefits of rationalisation
- Our aim to consistently reduce the average length of in-patient stay will ultimately lead to a reduction in bed numbers but provide opportunities, wherever possible, to create an enhanced environment (i.e. increase the number of single rooms, provide en-suite accommodation within multi bed bays)
- Develop a Dementia friendly environment and facilities in appropriate areas
- Review the number of side rooms available to further support achievement of the challenging infection prevention targets
- Outcomes of clinical and non-clinical reviews and the potential impact on the estate requirements
- Positive progress in integration of acute/community services across adults and paediatrics
- As care pathways are reviewed and implemented our estate will need to be responsive in its ability to meet the changes required
- Work with partner agencies to utilise alternative available buildings wherever possible and appropriate to do so

Capacity Analysis – Workforce

The services the Trust delivers are often complex and require specific expertise. In reviewing our workforce aligned to the changing requirements of healthcare needs, we will ensure we have the right people, with the right skills, in the right place, at the right time, delivering high quality services that meet the needs of our patients. In line with our clinical and non-clinical review of services, there will undoubtedly be an impact on the current and future workforce of the Trust as we develop an operating model that is first and foremost safe, fit for purpose but able to deliver the necessary efficiencies required to ensure the financial and clinical sustainability of the Trust. The Trust's workforce strategy importantly needs to take account of national and local skills shortages and plan accordingly. Ensure we have a workforce of the right size, having the right people, with the right skills, in the right place at the right time.

- Provide a systematic approach to building an efficient and cost effective workforce
- An integrated approach linked to financial and business planning
- An efficient, productive and skilled workforce to meet future Commissioning Plans
- Embrace partnership working with other neighbouring Trusts to identify any mutually agreed ways of working which will deliver safe, sustainable, high quality clinical services within the region
- Seek out and identify best practice or collaborative working around clinical pathways
- Identify potential efficiencies in relation to corporate or support functions (i.e. procurement costs and locum expenditure)
- Ensure nursing levels on the wards are being reviewed in line with the recommendations of the Francis report
- Ensure clinical capacity meets the needs of the future service requirements
- Develop new roles (i.e. Advanced Nurse Practitioners)
- Recognise there is likely to be a reduction in junior doctor numbers over the period and review and develop roles in an attempt to address the shortfall
- Engage the current workforce in developing new skills and taking up new roles to meet the demands of the service.
- Take account of the need to be more flexible around working days and hours in the lead up to a 7 day, round the clock service (particularly in medical specialties)
- Recognise those 'hard to recruit' areas and seek innovative models to attract the right people with the right skills
- Improve lines of accountability and communication

Throughout the implementation of our strategic plans (i.e. benchmarking, clinical specialty reviews, non-clinical specialty reviews, service line reporting etc.) workforce requirements will be continually re—assessed to ensure delivery against the proposed new models. In the meantime, we continue to work on delivering the supporting strands of the workforce strategy to ensure robust systems, processes and procedures are embedded within and throughout the organisation to deliver a seamless and successful outcome.

Capacity Analysis – Beds

The strategy adopted by our key commissioners over the next five years is to tackle the following:

- Reducing avoidable emergency admissions
- Reducing the average length of stay for admitted patients
- Improved case management of people with long term conditions
- Reviewing and improving care pathways (across all parts of intervention)
- Referrals managements and efficient use of resources
- Maximise partnerships and partnership working
- Increase use of alternative levels of care
- Integrating acute/community services to deliver care out of hospital

The emphasis is clearly to shift the balance from acute admission to admission avoidance by keeping people healthy within their home environment

wherever possible to do so. In addition, provision of acute healthcare at home will be considered, where appropriate and safe to do so, to support effective use of capacity aimed at decreasing the need for acute hospital admission. As these pathways of care are developed and introduced and the appropriate resources become embedded in the alternative care setting(s), the requirement for acute beds should (all things being equal) diminish. For example an integrated respiratory pathway now more effectively utilises bed capacity at Breathing Space, an out of hospital state-of-the-art respiratory centre thus releasing capacity in the acute setting, similarly step-down facilities are available and utilised in the on-site community hospital.. Once this has been established, it is expected that the numbers of beds will be decreased on a gradual basis over the period of the strategy as aligned to achieving the lower levels of admissions and reductions in length of stay. This will provide significant efficiency savings and free up estate allowing enhancements to ward environments or, in the case of whole ward closures, assessment for alternative use.

Whilst the strategy described above is well known and understood as the direction of travel the Local Health Economy wishes to pursue this must also be considered in the context of the predicted increase in the ageing population (described above) which is already having a noticeable impact on acute services both in terms of attendances at Accident & Emergency and subsequent admissions. As a health economy we need to work cohesively to get the balance right and recognise that the necessary levels of support out in the community must be in place to make this work. We can, and will, take responsibility for ensuring those actions within our direct control are taken, however, it is also recognised there are other factors outside of our control, which were we can we will seek to influence through building effective relationships with stakeholders.

In partnership with stakeholders across the health community we will commence a review of care pathways to ensure services across the whole sector are used to optimum effect to provide those needing them with the required level of expertise and care at the time they need it. All work to review pathways of care and transformation schemes will be clinically driven to ensure safe and sound clinical practice is sustained and that any alternatives proposed are clinically sound. All changes will be risk and quality impact assessed at various stages throughout the process.

A multi-agency, multi-disciplinary approach will be fostered to deliver a holistic approach to all aspects of healthcare provision in order to fully understand the range of third sector services available to support our revised models of care which will be based on best practice.

To effectively drive these changes at pace will require excellent management and leadership skills to anticipate and plan for the changing workforce requirements. Along with the revised care pathway models comes the need to review staffing inputs. A potential outcome of this may require a reduction in medical staff for some areas and an increase in fully qualified Enhanced Nurse Practitioners and/or Enhanced Allied Healthcare Professionals to deliver specific elements of service.

The overarching principle behind all of the transformation and pathway re-design is to ensure the right services are delivered in the right place at the right time by the right people. Our ability to sustain/reduce non-elective admissions and/or care for people in alternative care settings in the community will facilitate an opportunity to reduce our inpatient bed base. We are committed to delivering solutions via a multi-disciplinary approach, ensuring we provide the best quality of service and outcome for the patient.

Capacity Analysis – National, Regional and Local Agenda

It is important that we utilise all sources of information available to keep abreast of developments which are likely to impact upon us in the future. Adopting this approach allows us to incorporate these potential changes as part of our strategy and business planning processes and, wherever possible, to prepare for the changes. To this end we will dedicate sufficient time to actively seek information and understand any implications with regard to the following areas

(the list is not exhaustive):

- NICE Guidance
- Technology Appraisals
- Cooperation and Competition
- Best Practice Recommendations
- NHS England Specialised Service Reviews
- NHSE England Service Specification reviews
- Medical staff Training/future workforce and capacity impact
- Nursing staff training/future workforce impact
- OHP staff training/future workforce impact
- National changes to pay structures

Whilst it is important we are aware of and understand the implications of these we also recognise that over the period of this 5 year strategy some things are subject to change. A cohesive approach to managing development changes will be handled through the executive and senior management team incorporating regular up-dates on current status on all known future impacts. Whilst our overall strategic direction may not be affected, the approach may need to be adapted in light of changes which may arise, particularly those relating to national policy. We will regularly review the contents of our 5 year strategic plan and adapt this accordingly.

Capacity Analysis - Activity

In considering our forward plans we have based our assumptions on the commissioning plans as set out by our lead commissioner (Rotherham CCG only) which are outlined as follows over the 5 year period (A&E attendances are reaching levels of 75,000 per annum in overall terms):

	Sum of Total 2014/15 Contract Activity	Sum of 2015/16 Contract Activity	Sum of 2016/17 Contract Activity	Sum of 2017/18 Contract Activity	Sum of 2018/19 Contract Activity
A&E Attendances	61,499	61,499	61,499	61,499	61,499
Day Case	23,820	24,177	24,540	24,908	25,281
Elective	5,236	5,315	5,394	5,475	5,557
Emergency	21,516	21,522	21,527	21,532	21,537
OP First Attendances	55,453	56,562	57,693	58,847	60,024
OP Follow-up	127,809	123,432	123,432	123,432	123,432
OP Procedure	27,288	27,488	27,692	27,899	28,111

The table below shows actual income over the last 3 years and projected income over the 5 year strategic plan period:

Income trends over the last 3 years and over the five year strategic plan period								
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£K							
Elective	38,622	35,222	35,982	35,922	35,755	36,309	36,508	36,674
Non elective	49,596	50,934	50,311	47,966	47,228	47,446	47,191	46,888
Outpatient	37,638	33,622	35,987	35,460	34,646	34,967	34,942	34,886
A&E	7,051	7,342	7,509	7,569	7,448	7,478	7,433	7,381
Community, direct access and other	77,079	84,735	86,902	87,727	86,032	85,191	84,818	84,368
Total patient care income	209,986	211,855	216,691	214,644	211,109	211,391	210,892	210,197
Other income	22,741	22,354	18,421	17,201	15,139	15,291	15,442	15,594
Total income	232,727	234,209	235,112	231,845	226,248	226,682	226,334	225,791

Rotherham CCG accounts for c80% of the Trust's income for patient care and the CCG's activity forecasts have been used as the basis of the values of future income. The CCG forecasts assume flat emergency activity, with growth being offset by initiatives to redirect patients who could be treated outside a hospital environment. Modest growth is built in for new outpatient attendances and elective activity. Activity funded by other CCGs or NHS England is assumed to be flat overall, growth in some areas e.g. ophthalmology for Barnsley CCG is likely to be offset by reductions elsewhere.

The Trust's income forecasts reflect Rotherham CCG activity levels deflated by national tariff assumptions and reflect the 2 year contract agreed for 14/15 and 15/16. They also take account of Better Care Fund funding transfers to the local authority.

3 Competitor Analysis

In order to develop this strategy, it is essential that TRFT identify and understand the current status and any known future developments of its direct competitors as this may ultimately influence/affect future business decisions.

The residents across South Yorkshire (and the wider adjacent boundaries) benefit from four Acute Foundation Trusts all within a 20 mile radius. Sheffield Teaching Hospitals lies to the North West of TRFT with Barnsley and Doncaster & Bassetlaw Hospital to the North. In addition there are three well established Independent Sector providers within the area (two in Sheffield and one in Doncaster). Despite the close proximity, in the main residents remain highly loyal to their local hospital and are often resistant to travel or use alternative locations unless it is clinically necessary to do so.

TRFT has identified its key competitors to be:

- Sheffield Teaching Hospitals Foundation Trust
- Barnsley Hospitals NHS Foundation Trust
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust
- Sheffield Children’s Hospital Foundation Trust
- Chesterfield Hospital Foundation Trust
- Independent Sector Providers
- General Practitioners

Below is an assessment of the potential threats posed to TRFT by each of the organisations identified above:

Competitor	Competitor Strengths	Opportunities for TRFT
Sheffield Teaching Hospitals NHS Foundation Trust	<ul style="list-style-type: none"> ▪ High profile tertiary teaching centre ▪ Established clinical body with regional and national expertise ▪ Ability to recruit to ‘hard to recruit to’ posts (particularly consultant) due to teaching status ▪ Financially stable compared to most teaching centres ▪ Serves a population of 500,000 for secondary care and 1.7m for tertiary services ▪ STH staff tend to hold key roles on clinical networks ▪ Developing national policies are pushing more work to the centres 	<ul style="list-style-type: none"> • Review potential to increase specialised service provision at DGH’s in line with capability to deliver against service specifications leaving STH to develop ‘true’ tertiary services • Sheffield CCG introducing new models of commissioning with STH at prime provider offer opportunities to increase income to TRFT (subject to further discussions & capacity) • Further development of local chemotherapy services • Potential to benefit from introduction of hub and spoke models being explored by NHSE
Barnsley Hospital NHS Foundation Trust	<ul style="list-style-type: none"> • Have moved to use STH staff in certain key specialities (e.g. urology) leading to good service 	<ul style="list-style-type: none"> • Joint Ophthalmology services with TRFT • TRFT have been providing support to the

	<p>resilience</p> <ul style="list-style-type: none"> • Geographically well located to access Huddersfield and other northern markets • Generally good access times • Single site operation with relatively modern accommodation 	<ul style="list-style-type: none"> • Dermatology service • Pathology partnership
Doncaster & Bassetlaw NHS Foundation Trust	<ul style="list-style-type: none"> • Serves a total population of c450,000 • Upside of split site operations provides good geographic access • DBH has an established track record • Financially stable organisation and relatively new Board • Trust physically incorporates an ISTC provider and therefore benefits from growth of that provider and extended service capacity • Massive endowment funds (£12M+) in the top ten in the NHS, seeds and supports service developments for competitive advantage • State of the art Rehabilitation Centre on the Montagu site • Taking an active lead in developing sub-hub services • Working with STH to deliver local Radiotherapy services • Combination of strengths provides overall strong competition 	<ul style="list-style-type: none"> • Joint ENT/OMFS services with TRFT • Bassetlaw Hospital portfolio of services potentially at risk due to catchment population of <125,000 • Recent issues with access time • TRFT providing support to deliver Ophthalmology services • Opportunity to expand joint working
Sheffield Children's Hospital	<ul style="list-style-type: none"> • Strong reputation for provision of general and specialised children's services • Attracts significant levels of charitable donations due to nature of the services provided • Increased centralisation of children's services aligned to service specification requirements • Potential to grow services 	<ul style="list-style-type: none"> • Potential to collaborate on hub and spoke models of care • Review joint opportunities for delivering care closer to home
Chesterfield Hospital Foundation Trust	<ul style="list-style-type: none"> • Serves a population of 350,000 • Financial and clinically very sound with a stable management team 	<ul style="list-style-type: none"> • Potential to investigate joint working arrangements
Independent Sector Providers	<ul style="list-style-type: none"> • Access time are effectively on demand • Usually high quality patient environment and hotel like services • Opportunity to streamline offer to profitable 	<ul style="list-style-type: none"> • Potential to recover some work from IS providers as part of revised commissioning arrangements • Excellent access times and facilities pose IS as strong competition

	<p>services only – i.e. no core requirements to deliver a range of mandatory services unlike NHS providers</p> <ul style="list-style-type: none"> • No centrally mandated pay terms and conditions • Increased transfer of profitable elective work would leave acute hospitals dealing with an increasingly unsustainable workload in both elective and non-elective work (although this does not appear to be affecting the market share at present) 	
General Practitioners (primarily Rotherham)	<ul style="list-style-type: none"> • Potential to pursue provider status for applicable services, particularly community services as they are put out to tender 	<ul style="list-style-type: none"> • Further enhance strong clinical links • Provide support and training

4 SWOT Analysis

It is known that over the coming 5 year period the NHS will undergo radical changes some of which will be centrally mandated, some which will be necessary as a consequence of national commissioning reviews and pathway redesign and some of which will be determined locally to deliver financially stable provider organisations whilst sustaining the level of quality rightly demanded of NHS services in today's market. Against this background TRFT has identified the Strengths, Weaknesses, Opportunities and Threats for the organisation over the forthcoming period. These are outlined in the table below attached as Appendix 1

5 'Do Nothing' Scenario'

A 'do nothing' scenario would arise if the Trust and Rotherham CCG were not able to achieve any of the savings built into plans. The Trust's savings plans for the five year period total £50.7m Clearly the non achievement of this target is untenable as it would mean an unacceptable level of deficits and the Trust would have to borrow on a large scale to continue delivering services for patients. The Trust would not be financially viable. Furthermore if the CCG did not achieve its QIPP targets (£15.8m for this Trust alone over this period) this would exacerbate the situation.

The Trust is focusing on what it has to do to avoid a 'do nothing' scenario. Strong management of its CIP programme, joint work with partners in the LHE on savings in general and on the most appropriate and affordable configuration of services in each specialty, are key to achieving this.

1.4 Risk to sustainability and strategic options

As a consequence of Monitor intervention (described at 1.2 above), TRFT developed three strategic options, as follows:

Option 1 – The Trust as a standalone entity

- Option 1 dependent on achieving significant levels of CIP particularly in the first year and second year of the plan
- The opportunity to properly integrate community and acute services is significant and must be progressed
- There is overwhelming support from the lead commissioner and other local stakeholders to retain locally-run services for the population of Rotherham, led and managed by TRFT
- There are a significant number of potential opportunities that would be realised through closer working and collaboration with other providers without recourse to merger.

Option 2 - Vertical Integration with a social care provider

- There was no interest from potential social care partners to formally integrate with the Trust.
- The Trust has a historically poor track record in vertical integration, with a current objective to effectively integrate adult acute and community services.
- Nevertheless it is still important to integrate further with social care through closer working with Rotherham Metropolitan Borough Council and other social care providers.

Option 3 – Merger with another acute provider

- Neighbouring acute providers
- Clinical and patient benefits but would need to be confirmed through clinically-led discussions
- Significant potential challenges, not commissioner preferred option
- Could provide efficiencies through back office and support function rationalisation
- Timescale for merger is a number of years – so option 1 still needed in addition to option 3
- Investment for investigating the options before any deal

With a focused programme of transformation and efficiency the Trust is financially viable. However, it is recognised there are significant risks associated with this option and increasingly national pressures such as 7 day working will create additional challenges for the Trust. As a result, the Trust Board decided to pursue this option of retaining the Trust in its present form whilst also exploring potential opportunities for collaboration with other providers in the local health economy. This is important to achieve further efficiencies and improve the quality of services provided to patients.

Option 2 was rejected on the basis that there was no interest from potential social care partners and option 3 was rejected on the basis that the outcome of option 1 (to remain a stand-alone organisation) was that the Trust could achieve this subject to delivering some key actions and remain clinically and financially viable.

Impact of the Chosen Option

The chosen options was considered to be of benefit for Rotherham residents and was the preferred option of Rotherham Clinical Commissioning Group and other local stakeholders to ensure service delivery remained locally led wherever possible to do so. This provides us with the opportunity to ensure that joint decision making regarding pathway changes and future service delivery models is led locally, with a clear focus on the interest of the local Rotherham population. We will benefit from remaining a single entity in continuing to provide services across both acute and community within Rotherham giving us the ability to manage all aspects of the care pathway across both levels of service, giving us greater opportunity for more holistic re-design. In addition our chosen option allows us to continue to have direct links with other healthcare services within the locality and further enhance and foster our existing working relationships to ensure a joined up approach to delivery of healthcare across all disciplines.

As we work through our plans to review current models of care we will be reliant on support from other stakeholders e.g. Health and Social Care, Continuing Healthcare, Social Services and Mental Health to help us shape the changes required to deliver better care to our patients which will subsequently make them more effective and efficient. In addition we need to explore in more detail how the voluntary sector can provide invaluable support to our patients at various points during and after a period of care. We have already commenced some of this following the recently held event of the Perfect Week which aimed at identifying bottlenecks within the hospital for managing patients during their hospital stay.

Whilst our chosen option is to remain a stand-alone entity, we will, through the local provider Working Together Programme, continue to explore potential opportunities for more collaborative working where it is identified as beneficial to do so within the wider health economy. This is important to achieve further efficiencies and improve the quality of services provided to patients.

The risks and mitigation associated with the delivery of option 1 are dealt with as part of the overall risks and mitigation for delivery of the plan.(refer to section 1.5.

1.5 Strategic Plans

1. Context: the Strategic Challenge

The strategic challenge for the Trust in terms of Financial, clinical and operational sustainability and the consequent approaches which need to be taken are as described in section 1.2. Below we set out in more detail those strategic initiatives which are in progress and those which we are planning to take over the period of this 5 year plan.

2. Meeting the Challenge in Rotherham: Our Current Strategic Plans

2.1 “Facing the future: smaller acute providers” (Monitor, June 2014) acknowledges the scale of the financial and clinical sustainability challenge faced by smaller acute providers such as Rotherham. It highlights the range of initiatives which such hospitals will need to consider in order to ensure financial and clinical sustainability, including:

- developing new models of care for patients, for example by re-designing services to improve the integration of care;
- finding creative ways to address “the scale challenges”, such as sharing staff with nearby Trusts, using new technology, or building networks between smaller hospitals and major centres;
- ensuring the right balance is struck between redesigning services and making sure patients are treated near to where they live.

2.2 Our current approach and Strategic Initiatives include a range of similar initiatives and which currently include:

Strategic Initiative	What we are doing
1. Unscheduled Care – in particular meeting the demand from the ageing population and increase in frail elderly resulting in <ul style="list-style-type: none"> • Increased attendances at A&E • Increased admissions • Increased length of stay 	<ul style="list-style-type: none"> • Review of service delivery models • Review of alternative levels of care • Joint partnership working across all sectors to review alternative care options and capacity requirements • Need to develop discharge to assess processes as opposed to patient in hospital awaiting assessment • Workforce requirements • Active implementation of Emergency Care Intensive Support Team (ECIST) Review (January 2014)
2. Managing Long Term Conditions in non-acute settings: Community Transformation Programme	<ul style="list-style-type: none"> • Joint review of service delivery models • PMO project for transforming community services • Exploration and piloting of tele-health solutions • Workforce and skill mix review • Managing patient expectation
3. Clinical Referrals Management – delivering outpatient efficiencies	<ul style="list-style-type: none"> • Clinical Referrals Management Committee is a joint Commissioner/Provider forum which manages pathway re-design • Efficiency targets are agreed based upon realistic timeframes for delivery

	<ul style="list-style-type: none"> • Performance against contractual targets are monitored closely to determine deviances from plan to facilitate a review and development of a remedial action plan • PMO work stream to undertake outpatient review
4. Service Transformation and Cost Improvement Programme	<ul style="list-style-type: none"> • £10.9M of Cost Improvement Programmes in 2014/15, with in-month performance at month 2 14/15 of £566,164 (97.7%) against plan • Development of plans to underpin future CIP and transformation programme requirements • Programme Management Office approach in operation • Each scheme led by a responsible Executive Officer • Each scheme allocated a dedicated project lead to maintain focus and drive
5. Delivering 7 Day Working	<ul style="list-style-type: none"> • Workforce capability and capacity requirements: Recruitment to additional clinical posts required across several professions in some where there are known shortages • Commissioner/Provider joint working groups established to review 7 day working requirements • Project Management Officer work stream to ensure sustained focus • Delivery milestones to be agreed • Commissioners performance management regime to monitor delivery of agreed milestones
6. Collaboration and Integration: "Working Together Programme."	<ul style="list-style-type: none"> • TRFT participates in and contributes to the Working Together programme • CCG led workstreams focussed on cardiology and stroke, paediatrics and neonates, smaller specialties and out of hospital care • A provider led programme focussed on specialty collaborative working, consistency in care, specialised services, sharing and adopting good practice, procurement, locums and informatics. • 7 day working is a cross cutting theme to deliver PMO work streams • identifying reduction in non pay spend through joint procurement initiatives and standardisation of products utilised

3. Strategic Plan: Next Stages

Against this background the Trust is taking the following further steps in support of its view about the financial and clinical sustainability of its services and in order to bring greater clarity to its strategic direction:

3.1 Benchmarking Exercise

In order to confirm the size of the Trust's opportunity for efficiencies in the outer years of the Plan and relative to our peers, it will undertake a benchmarking exercise. This work will commence in July 14 and will:

- Review overall costs at TRFT in comparison with peer organisations
- To assess the CIP opportunity compared to peer organisations
- Compare performance indicators such as length of stay, new to follow-up ratios, etc.
- Identify types of savings opportunities delivered successfully in other organisations

This work and the outcomes of it are imperative to us identifying the areas where we need to focus our efforts. This will also provide additional information in support of our Strategic Plan.

3.2 Clinical Specialty Reviews

As described above, there needs to be thorough review of clinical specialties across a range of dimensions including quality, volume, performance, staffing, in order to determine future service configuration for the Trust and the contribution this will make to financial and clinical sustainability. As acknowledged the determination of future service configuration in some specialties may also be determined by the outcome of the “Working Together” Programme. However, the Trust completing its own work in this area will only serve to better inform the Trust’s position in the Local Health Economy debate.

The approach to the Clinical Specialty Reviews will be as follows:

- The development of health community strategies in respect of Ophthalmology, ENT Services and Maxillofacial surgical services covering a number of Trusts, through the “Working Together Programme” of South Yorkshire.
- The development of clinical speciality reviews for all other services at TRFT which will be led by the Directors of Clinical Services with corporate support. A draft template has been structured which will support this delivery and ensure common purpose and format. These reviews will include potential challenges, an assessment of current state, a review of commissioners’ strategies and anticipated activity over the next five years.
- As part of the outcome of the specialty reviews, those services identified as potentially vulnerable will be subject to a Medical Director led deep dive. Equally the review may identify those services where there is opportunity to grow activity and commensurate income

Whilst, recognising that the Trust needs to undertake a specialty by specialty review of all services, particularly focussing on those services that are sub-optimal in terms of volume, it is worth noting that volumes for A&E attendances and admissions, maternity births and paediatric inpatient spells are within guidelines but significantly lower than national averages. Consequently, the Trust’s Strategic Plan needs to address the full scale of that challenge, as described below:

1. A&E	2. Maternity & Paediatrics	3. Right care, right time, right place	4. Scale of Services
<ul style="list-style-type: none"> • Shortage of A&E mid grades & consultants, leading to 4 hour breaches • National problem locally manifesting in ongoing difficulty in safely staffing A&E, high locum usage • Smaller department & EWTD increases proportion of anti-social shifts • Particular competition for resource with 6 other local A&E sites 	<ul style="list-style-type: none"> • TRFT below paediatric consultant headcount (Latest Royal College guidance = 10 WTEs for each tier of the medical rota) • Volume of births and Royal College guidelines • Hours consultant present on labour ward • Interdependency for other services • Legislative requirements 	<ul style="list-style-type: none"> • Ageing population increases need to provide care for frail elderly patients in the right setting • Approaches include care closer to home, avoiding hospital admissions, assisting discharge from acute • Will require joined-up healthcare with other care providers 	<ul style="list-style-type: none"> • Need to fit appropriate service provision for our local population & provide services at scale that is safe • Population size means TRFT may be sub-scale for certain procedures / specialties • Balance between local provision of key services and access to more specialised care • Challenges in attracting sufficient talent and scale for seven day care

Source: Working Together, Finnermore

3.3 Service Line Reporting

In order to develop a robust clinical strategy the Trust needs to understand performance at specialty level much better and in more detail than is possible currently. We are therefore working on the development of SLR following the purchase of software earlier this year to support this. While the initial focus has been on improving the calculation of reference costs we are now moving on to SLR with the aim of having the first draft SLR reports late in 2014. One of the key requirements for SLR to be successful is clinical leadership and clinical engagement. We plan to establish a clinically led SLR Steering Group in summer 2014 to lead the development and to firm up detailed project plan to focus the work required.

Service Line Reporting (SLR) has been used for a number of years by a number of Foundation Trusts and we plan to learn from the experience of others. Initially we expect to provide reports on a quarterly basis before moving to integrate SLR into the Trust's regular monthly performance management processes. SLR information is expected to be particularly helpful in the short term to understand surgical performance as it is easier to identify patients and direct/indirect costs attributable to surgical specialties than to medical ones. It is crucial that information is shared with clinicians quickly as that will achieve improvements in data quality and decision making and ensure clinical engagement and leadership.

During the transitional phase, when specialty strategic reviews are being undertaken in advance of well developed SLR information being available, we will utilise reference cost information on the allocation of costs to specialties to inform decisions about their future..

The new clinical directorate structures are embedding and once they are more established the Trust will consider how and when to move to SLM so that

lead clinicians for service lines can develop their services as businesses and, over time, be given earned autonomy to manage their services. This will give them the ability to look at all aspects of their services – quality, patient experience, performance, market position, activity levels and trends as well as financial performance, in order to maximise the performance of their services in the round.

3.4 Local Health Economy and the “Working Together” Programme

As the market and competitor analysis above shows, the Trust operates within the South Yorkshire Local Health Economy (LHE) with five other acute service providers. Relative to other Local Health Economies, South Yorkshire provides a larger share of care in more expensive settings, e.g. South Yorkshire has the highest number of acute beds per weighted population, compared to the peer group and low community provision relative to acute spend. In recognition of the geography, clear interdependencies, opportunities, and an acknowledgement that the strategic solutions necessary are more likely to result from collaborative working, consequently a “Working Together” Programme is underway involving all commissioners and providers in the local health economy. A CCG led workstream is focussing on cardiology and stroke, paediatrics and neonates, smaller specialties and out of hospital care. There is also a provider led programme focussed on specialty collaborative working, consistency in care, specialised services, sharing and adopting good practice, procurement, locums and informatics. In due course the outcome from some of the main specialty programmes will influence and determine our Strategic Plan.

4. Critical Enabling Strategies

Whilst ensuring that future financial and clinical sustainability of the Trust remains the object of our Strategic Plan, there are other important key contributors to that goal:

4.1 Quality Strategy

At the heart of all our strategic plans is delivering the highest quality and safest of care to our patients. Throughout the period of this strategic plan our aim is to be considered as one of the safest Trusts in the country. Key measures of a successful outcome will include:

- Achieving 97% harm free care as measured by the NHS safety Thermometer consistently for a 2 year period
- Reduced avoidable pressure ulcers to zero consistently for a 2 year period
- Delivered C-diff targets consistently for a 3 year period
- Achieved improvement in staff satisfaction
- Achieved optimal staffing levels

Considering the healthcare needs assessment and the subsequent strategic commissioning plans, achieving the quality indicators above are aimed at reducing avoidable admissions, reducing length of stay, strengthening the effectiveness and efficiency of the workforce and ensuring our staffing levels are appropriate to deliver the highest quality of care to those who require a hospital stay.

In addition we will ensure all aspects of quality and safe care are embedded throughout clinical and non-clinical areas of work. All Cost Improvements identified throughout the period of this strategy will undergo a thorough Quality Impact Assessment (by the Chief Nurse and Medical Director) and those

deemed to have a negative impact on quality will be rejected.

4.2 Workforce Strategy

The Trust's staff is its greatest asset and it relies on their continued support and engagement to deliver to the highest standards of care and service. Over the period of the strategy our workforce will be shaped in line with the changing needs and increasing demands of healthcare provision, reflecting the scale of efficiencies and transformation that will need to be achieved. Such a level of service change will need to ensure that staff are appropriately supported at all times, effectively and regularly communicated with and engaged. In addition the Trust's systems and processes for managing organisational development will need to be clear, robust and successfully implemented and monitored. The Trust Board's Strategic Workforce Committee will be instrumental in providing the assurance that these objectives are achieved. Key measures of the Trust's success will include:

- Staff survey engagement score will be in the top quartile of comparable Trusts nationally
- Friends and Family net promoter score will be top quartile of Trusts nationally
- Sickness absence will be at or below NHS average
- PDR and medical appraisal rate will be at or above 95%
- MAST compliance will be at or above 95%
- Staff turnover will be at an optimal level

4.3 Informatics Strategy

The Trusts' Health Informatics Strategy 2014-2017 underpins the ethos of ensuring the provision of a first class Health Informatics service to support excellent clinical outcomes and patient experience. As part of the review of business and clinical strategies the strategy laid out in this document draws from the key recovery principles and is also focussed on external 'known' local/national Informatics initiatives but is flexible and dynamic enough to withstand and support new business and clinical models as they emerge over the next 12 to 18 months. To this end a common theme is that the Health Informatics strategy is a significant enabler and driver of improved information flows so that we can effectively measure what we do now and most importantly, how to improve it, particularly in relation to patient safety, outcomes and patient experience.

The strategy is designed to focus on the opportunities and innovation that Information Technology and information/data management can offer to the Trust and sets out how the Trust can deal with rapid changes both in respect of the internal and external environment. We must ensure that the use of information and information technology to improve patient care, access to care, the patient experience, delivery of clinical outcomes, health record keeping and value for money should be, and will be, a fundamental part of the Trust. Our strategy is about using IT for the benefit of our patients and staff. .

To harness, exploit and therefore realise the full value of the data/information resources at the Trust's disposal to proactively contribute to better clinical practice and administrative management of the organisation and its relationship within the local and national environment. Maximise data resources by fully embracing key business management processes or techniques (such as Knowledge Management (KM), data mining, Business Intelligence (BI) or Business Analytics (BA)) to capitalise on realising the full value of this data/information resource to reengineer processes.

The Highlights of this Strategy are therefore:

- The vertical and horizontal expansion and improvement to MEDITECH & SystemOne EPR's
- To wrap all services in an integration skin which allows other 'non-Acute' access, provides a smooth clean and intuitive human interface to multiple systems.
- The interfacing and integration of other key clinical to ensure key clinical information is not locked in systems and to streamline reporting.
- Prioritise the clinical big wins, E-prescribing & A&E being the obvious critical gains, but also to consider imaging and diagnostics systems currently at end of life.
- To address the legacy reliance on paper case notes by a combination of digitisation, integration and the promotion of clinical assessments on MEDITECH.
- New Digital Technologies, Digital Dictation and voice recognition revised and improved to fully integrate to host systems and/or the Clinical skin.
- Better and quicker access Clinical Information and focus on outcome measurement.

4.4 Procurement Strategy:

To implement the new NHS Procurement Strategy in order to reduce the Trust's £85M non pay spend by:

- Adopting the new NHS standardised clinical product range
- Benefit from the saving commitment provided by NHS Supply Chain
- Improve the automation of the purchase to pay process including the required adoption of GS1 and PEPPOL standards with all suppliers
- Engage with DH on spend data sharing to benefit from the price comparison service to be provided centrally
- Work across South Yorkshire to implement joint procurement and product standardisation to reduce purchase costs.
- Implement best practice contract management

5 Vision, Mission, Values & Strategic Objectives

Delivery of our strategic plan is underpinned by the Trust's vision, mission, values and strategic objectives which are as follows:

Our Vision: To ensure patients are at the heart of what we do, providing excellent clinical outcomes and a safe and first class experience

Our Mission: To improve the Health and Wellbeing of the population we serve ,building a healthier future together

Our six values; *safe, compassion, together, right first time, responsible and respect* will underpin the way we work and define the culture we wish to build within the organisation. Our commitments are outlined below:

Value	Statement/Commitment
Safe	We earn trust by putting safety first. We believe 'first do no harm' and are committed to designing out potential harm by managing risk, reducing errors and learning from mistakes, both ours and others. Healthcare is not risk free but we make people feel secure and safe, knowing we always intend to do our best.

Compassion	We treat everybody as individuals, showing dignity and compassion. We will respond with humanity and kindness to each person's distress, anxiety or need and will do our best to alleviate suffering. We do not wait to be asked; we will find the time because we care.
Together	We know that we achieve our best when we work together, with our colleagues and our patients in partnership. We believe that each member of our team makes a valuable contribution towards delivering excellent patient care. We value professionalism. We talk and listen and we rely on each other.
Right First Time	We know it is better to do things right first time than to put things right. When we waste resources, cause harm or duplicate effort, we waste opportunities, both ours and those of our patients, to do better and achieve more. We are accountable for the use of public money; we take this responsibility seriously and will use our resources wisely to improve the health and wellbeing of those we serve.
Responsible	We take pride in the quality of care we provide. We accept praise and criticism in equal measures and when we make a mistake we learn from it. We are proud to be part of our vibrant and diverse community. We are conscious of our impact on the environment, on the economy and on society as a whole.
Respect	We respect people's aspirations and commitments in life and seek to understand their needs whilst maintaining privacy and dignity. We treat everybody with courtesy and respect and provide them with a healthy and nurturing environment where they feel supported.

Strategic Objectives	
1	Develop high quality and safe services that effectively meet the changing healthcare needs of the population we serve
2	Achieve clinical and financial sustainability
3	Work with partners across the local health economy to ensure sustainability of wider healthcare provision
4	Ensure that we have the leadership capability and capacity to deliver our strategy and services
5	Ensure that our governance arrangements are fit for purpose and help shape the behaviours that will achieve our strategy
6	Meet our regulatory requirements
7	Develop and maintain an appropriately skilled and engaged workforce to meet service needs now and in the future
8	Develop a culture based on our values and behaviours

6 Summary Plans

Strategic Objectives		Strategic Plan - Key Deliverables			Milestones				
					Y1	Y2	Y3	Y4	Y5
1	Develop high quality and safe services that effectively meet the changing healthcare needs of the population we serve	1.1	Deliver a 4 point reduction in HSMR over the first 2 years	✓	✓				
			Plan to deliver further and sustained reductions in HSMR	✓	✓	✓	✓	✓	
		1.2	Achieve a minimum of 96% Harm Free Care	✓	✓	✓			
			Plan to achieve 97% Harm Free Care consistently for a 2 year period	✓	✓	✓	✓	✓	
		1.3	Achieve zero avoidable grade 3 and 4 pressure ulcers	✓	✓	✓	✓	✓	
			Plan to reduce avoidable pressure ulcers to zero consistently for a 2 year period	✓	✓	✓	✓	✓	
		1.4	Achieve a zero avoidable falls with harm	✓	✓				
	1.5	Achieve C.difficile targets	✓	✓	✓	✓	✓		

		Plan to deliver C.difficile target consistently for a 3 year period	✓	✓	✓	✓	✓
	1.6	Achieve zero MRSA	✓	✓	✓	✓	✓
		Sustain delivery of zero MRSA consistently over a 3 year period	✓	✓	✓	✓	✓
	1.7	Achieve 3 point increase in A&E NPS	✓	✓	✓	✓	✓
		Achieve 3 point increase in inpatient NPS	✓	✓	✓	✓	✓
		Plan to deliver improvements and sustain performance	✓	✓	✓	✓	✓
	1.8	Achieve a zero avoidable falls with harm	✓	✓			
	1.9	Achieve 40% response rate for A&E, inpatients and maternity combined	✓	✓	✓	✓	✓
	1.10	Sustain/reduce emergency admissions	✓	✓	✓	✓	✓
	1.11	Reduce ambulatory care sensitive conditions not normally requiring admission to hospital	✓	✓	✓	✓	✓
	1.12	Reduce alcohol related admissions	✓	✓	✓	✓	✓
	1.13	Deliver against Dementia targets	✓	✓	✓	✓	✓
	1.14	Plan to achieve optimum staffing levels	✓	✓	✓	✓	✓
	1.15	Adhere to and rigorously apply agreed protocols for reviewing quality impact assessment of all proposed changes to clinical services	✓	✓	✓	✓	✓
2	Achieve clinical and financial sustainability	2.1	Deliver agreed CIPs (year-on-year)	✓	✓	✓	✓
			Plan to deliver a recurrent financial surplus	✓	✓	✓	✓
		2.2	Complete benchmarking exercise	✓			
			Utilise benchmarking exercise outputs to inform clinical reviews	✓			
			Embed regular use of benchmarking data for performance management purposes	✓	✓	✓	✓
		2.3	Undertake clinical service reviews. Once complete refresh on a rolling basis	✓			
			Review outcomes of clinical service reviews, agree next steps and develop action plan	✓	✓	✓	✓
			Commence implementation of agreed action plan	✓	✓	✓	✓

		2.4	Service Line Reporting implementation with work progressing to Service Line Manager implementation	✓	✓	✓		
			Embed service line reporting as part of a suite of standardised performance monitoring tools throughout the organisation	✓	✓	✓	✓	✓
		2.5	Community Transformation Programme - work with lead commissioner to agree new service models to deliver integrated pathways of care	✓	✓	✓	✓	✓
			Community Transformation Programme - agree service model for an Enhanced Care Co-ordination Centre	✓	✓	✓	✓	✓
			Community Transformation Programme - review and revise community service specifications and KPIs and agree governance framework for community services	✓	✓	✓	✓	✓
		2.6	Review resource impact of implementing 7/7 working and agree funding to support implementation.	✓				
			Agree funding levels to support implementation	✓				
			Develop and agree implementation plan (to include recruitment and training needs requirement with realistic timescales)	✓	✓	✓		
			Commence implementation of actions required to deliver 7/7 working in line with the resources agreed	✓	✓	✓	✓	✓
		2.7	Consider development of an Emergency Centre to deliver an alternative model of Emergency Care	✓	✓	✓	✓	✓
		2.8	Implement revised (and continue to review) Risk Management arrangements and sound accountability and performance framework for the new directorates	✓	✓	✓	✓	✓
		2.9	Develop and implement an Estates Strategy in support of financial, clinical and operational sustainability	✓	✓	✓	✓	✓
		2.10	Implement the Informatics Strategy In support of financial, clinical and operational sustainability	✓	✓	✓	✓	✓
		2.11	Complete clinical and Senior Manager re-structuring	✓	✓	✓	✓	✓
3	Work with partners across the local health economy to ensure sustainability of wider healthcare provision	3.1	Actively participate in the Working Together Programme to review areas (clinical and non-clinical) which provide opportunities for collaborative working to deliver efficiency and productivity	✓	✓	✓	✓	✓
		3.2	Work collaboratively with Local Health Providers/Commissioners and stakeholders to identify further opportunities for service re-design and enhanced collaboration	✓	✓	✓	✓	✓
		3.3	Specifically engage with the Voluntary Sector to identify opportunities for supporting out of hospital care initiatives	✓	✓	✓	✓	✓
		3.4	Maintain open and transparent relationships with our commissioners	✓	✓	✓	✓	✓

		3.5	Develop and implement a Stakeholder Engagement Plan	✓	✓	✓	✓	✓
		3.6	Ensure full and proper Governor engagement	✓	✓	✓	✓	✓
4	Ensure that we have the leadership capability and capacity to deliver our strategy and services	4.1	Engage with and promote National Leadership Academy programmes	✓	✓	✓	✓	✓
		4.2	Further develop the coaching and mentoring strategy	✓	✓	✓	✓	✓
		4.3	Develop the Talent Management Strategy, ensuring alignment with Leadership Strategy and PDR process to further support staff retention	✓	✓	✓	✓	✓
		4.4	Appoint to revised Executive Team structure	✓				
		4.5	Implement clinical management re-structuring	✓				
5	Ensure that our governance arrangements are fit for purpose and help shape the behaviours that will achieve our strategy	5.1	Review of Board and operational committee meetings effectiveness	✓				
		5.2	Review and revise (where appropriate) key supporting strategies to ensure full synergy with strategic objectives and strategic direction of travel	✓	✓	✓	✓	✓
		5.3	Continue to strengthen quality governance arrangements at corporate and divisional levels.	✓	✓	✓	✓	✓
		5.4	Implement revised (and continue to review) Risk Management arrangements and sound accountability and performance framework for the new directorates	✓	✓	✓	✓	✓
		5.5	Review performance against delivery of Strategic Objectives in the 5 Year Plan	✓	✓	✓	✓	✓
		5.6	Produce and implement an annual Board development programme	✓	✓	✓	✓	✓
6	Meet our regulatory requirements	6.1	Produce and regularly review Board Assurance Framework	✓	✓	✓	✓	✓
		6.2	Implement Performance Management Framework (Ward to Board)	✓	✓	✓	✓	✓
		6.3	Achieve waiting time targets in Cancer, A&E, 18 week pathways and 6 week diagnostic waits	✓	✓	✓	✓	✓
		6.4	Zero patients waiting longer than 52 weeks	✓	✓	✓	✓	✓
		6.5	Achieve zero MRSA and sustain position	✓	✓	✓	✓	✓
		6.6	Achieve target for C.difficile and sustain position	✓	✓	✓	✓	✓
		6.7	Deliver against contractual obligations	✓	✓	✓	✓	✓
		6.8	Achieve Stroke targets	✓	✓	✓	✓	✓
		6.9	Plan to deliver stroke targets consistently for a 3 year period	✓	✓	✓	✓	✓
		6.10	Achieve and sustain Financial Risk Rating in line with the plan	✓	✓	✓	✓	✓
		6.11	Achieve and sustain Governance Risk Rating in line with the plan	✓	✓	✓	✓	✓
7	Develop and maintain	7.1	Review the workforce plan in line with the structural and transformation programmes	✓	✓	✓	✓	✓

	an appropriately skilled and engaged workforce to meet service needs now and in the future	7.2	Refresh the recruitment and retention strategy to enable to Trust to attract staff who possess the right skills and behaviours to fit with the organisation's Mission, Vision and Values (i.e. move to values based recruitment to support Nursing & Midwifery care strategy) - also links to priority 8	✓	✓	✓	✓	✓
		7.3	Re-design job roles to fit with future service needs linked to partnership working with the Health Education Yorkshire & Humber and Universities e.g. Advanced Practice	✓	✓	✓	✓	✓
		7.4	To develop a comprehensive L&D Strategy and delivery plan including the introduction of comprehensive organisational Learning Needs Analysis	✓	✓			
		7.5	Develop access to existing workforce knowledge to support manager self-service in ESR	✓	✓			
		7.6	Employee recognition/engagement schemes (i.e. Listening into Action) and staff champions networks embedded throughout the organisation (links to priority 8)	✓	✓	✓	✓	✓
		7.7	Develop and implement staff communication and engagement plan (including Listening into Action)	✓	✓	✓	✓	✓
8	Develop a culture based on our values and behaviours	8.1	Year on year improvement in Staff survey engagement score to achieve top quartile performance	3.6	3.7	3.8	4	4.2
		8.2	Year on year Improvement in Friends & Family net promoter score to achieve top quartile performance	✓	✓	✓	✓	✓
		8.3	Year on year improvement in PDR & Medical Appraisal rates to achieve top quartile performance	95%	95%	96%	97%	98%
		8.4	Year on year improvement to reach at or below NHS average sickness absence rates	4.5%	3.7%	3%	3%	3%
		8.5	Undertake a root and branch review of MAST delivery, reporting and compliance	✓	✓			
		8.6	MAST compliance	85%	87%	90%	92%	95%

7 Risks and Mitigation

Risk Type	Nature of Risk	Mitigation
Quality of Care	Failure to deliver high quality patient care, leading to poor patient outcome, reputational damage, increased regulator involvement, financial penalties and reduced staff satisfaction. Impact of national requirements, royal college guidelines and other initiatives e.g. 7 day working	Continue to strengthen quality governance arrangements at corporate and divisional levels. Implement revised risk management arrangements and sound accountability and performance framework for new directorates. Implement transformational pathway changes.
Commissioning and competition	Income reduction arising from reduced contract activity driven by patient choice or loss of services through competition, and/or increased contractual penalties/ non-achievement of CQUIN schemes. Lack of support from commissioners to progress service redesign and community integration.	Maintain open and transparent relationship with commissioners, engagement strategy in plan delivery. Delivery of high quality patient care to ensure brand reputation. Reduction in cost base to ensure value for money.

Operational Delivery	Failure to achieve local and national quality and operational targets, leading to poor patient experience and outcomes, increased financial penalties and reduced staff satisfaction.	Sound accountability and performance framework for new directorates. Sustain performance against A&E action plan and further enhancement through ECIST visit.
	Lack of sufficient recurrent funding to support 7 day working	Working closely with commissioners to identify the financial impact of implementing 7/7 working
	Failure to deliver transformation (at reasonable pace)	PMO approach embedded with already well developed clinical engagement to drive the service model changes required. Close working relationships with Commissioners and other healthcare providers to support service model changes
	Impact of emergency care centre decision – in terms of relationships with stakeholders and capacity and capability of the organisation to deliver alongside other key priorities	Joint business case. Review of financial assumptions to inform decision making.
Cost Improvement Programme	Failure to deliver planned CIP, creating liquidity pressure and reputational damage. Non-delivery of schemes due to lack of clinical feasibility, unforeseen operational and implementation challenges	Implementation of PMO approach with capability and capacity to support plan delivery. QIA process and identification of additional CIPs to mitigate. 1% contingency. In addition service line reporting will be implemented to support a holistic view of performance at individual speciality level
Workforce	Leadership capacity and capability and delivering a workforce appropriately skilled to meet changes in service delivery models. Failure to attract the right staff due to the proximity of major teaching hospitals in the locality. Industrial action due to terms and condition, pension arrangements and/or working practices at local and/or national levels	Board Development Programme in place with strong clinical engagement secured. The workforce strategy is currently being developed to reflect the future requirements of the organisational needs. Staff engagement strategy and relationships with staff side
Regulatory	Breach of Monitor, CQC or other regulatory targets	Revised Board Assurance Framework with regular reporting, together with a recently revised and implemented Scorecard from Ward to Board

8 Conclusion

8.1 This Plan submission reflects and builds on the December 2013 5 Year Plan and Strategic Options submitted to Monitor. The December 2013 submission confirmed the decision of the Trust to pursue Option 1 which provided for the Trust to operate as a standalone entity in collaboration with partners as required to ensure clinical and financial sustainability. In choosing this option the Trust recognised the challenge that its pursuit presented in order to ensure the financial and clinical sustainability of the Trust, e.g. the need to achieve year on year cost improvement efficiencies against an historic record of non-achievement, the need to determine a future configuration of services which takes into account volume, performance, clinical, quality and

safety considerations, etc. In addition, the Trust also recognised that given the resources and demographics of the Local Health Economy the option to “standalone” would also need to be enhanced by the potential of collaborative working offered through the “Working Together” Programme.

8.2 As part of the Trust’s Enforcement Undertaking to Monitor, our on-going dialogue with the regulator has enabled the Trust to focus on the further steps which are necessary, and which are described in this submission, to ensure that the Trust can meet the financial and clinical sustainability challenge.

9 Communication Plan

In developing the strategic plan submitted to Monitor in December 2013 we consulted with a range of stakeholders including Governors, staff (clinical and non-clinical), staff side representatives and key Commissioners. Throughout the development of this 5 year strategic plan we have continued to consult all key stakeholders (staff, governors, members, key commissioners).

On final approval, this plan will be communicated internally and externally using an appropriate range of methods to reach the target audience. This will include planned briefing led by the Chairman and Chief Executive throughout the organisation. In addition a stakeholder engagement plan is being developed with additional communications expertise. This will incorporate a range of approaches to address internal/external audiences for example, Council of Governors and members, Trust Wide and public meetings, Medical Staff Committee and Listening into Action.

10 Performance Monitoring of the Strategic Plan

Throughout the development of this plan we have analysed the opportunities and threats to our organisation considering National, Regional and Local expected (or anticipated) impacts. As a consequence we have identified and described the necessary actions to strengthen our position in order to deliver financial sustainability whilst maintaining and sustaining high quality services across all our service lines. Critical to our success will be the performance management and monitoring against delivery of the plan.

Strategic/operational objectives and key priorities will be disseminated to all services across the organisation with a clear message that all staff (top down/bottom up) have a part to play in delivering our plan. Inclusion of these will be a mandatory requirement of individual Performance Development Reviews for staff at all levels throughout the organisation.

Trust Board will receive a formal quarterly up-date indicating current and projected performance against each objective. The frequency of reporting will be increased for areas identified as deviating from plan. The allocated lead Executive Director will take overall responsibility for reporting progress against their area of responsibility and, where deviances are identified (or projected), the reason for this and the mitigating actions to be taken. Trust Board will be responsible for determining any areas requiring increased or enhanced reporting.

Performance against objectives will be presented to other key Trust committees on a quarterly basis as described above. Each service (clinical and corporate) will also deliver a quarterly position statement via existing meetings.

As described throughout this document, we expect the NHS landscape to be fluid over the next 5 years and recognise that we need to remain flexible in our approach and be able to quickly adapt to rapidly changing and emerging situations. Issues affecting the strategic/operational objectives and/or key priorities set out in this plan may come via numerous routes e.g. NHSE Mandates, Commissioning arrangements/revisions, Clinical Networks, Local Authority etc. It is expected that a member of the TRFT executive team will be in receipt of formal communications relating to all potential avenues where new guidance might impact on the existing plan. As new issues emerge they will be reviewed to identify their impact on the existing objectives and where this is confirmed a review of that particular element will be undertaken to our strategic direction accurately reflect the national direction of travel. Any changes will be formally approved via Trust Board.

1.6 Appendices

Appendix 1 – SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Single provider of acute and community services across Rotherham • Ability to review, change and manage aspects of the care pathway across acute/community services • Review of Strategic Options relating to the future of the organisation completed • Strengthened Board capability and capacity including recent substantive appointments to Chair, CEO, non-executive Board members with further key executive appointments in progress • Fully operational Project Management Office to drive delivery of agreed projects and CIPs • Community Transformation project underway • Strong clinical engagement to support pathway and service model re-design • Positive and collaborative working relationships with commissioners • Coterminous boundary with Local Authority • Strong and supportive third sector • One of four Regional centres accredited to provide Adult and Paediatric Photopheresis, work which is also nationally and internationally recognised • Nationally recognised delivery model for integrated Ear Care Services • Ophthalmology service provision is strong • Positive learner feedback (particularly from student nurses) 	<ul style="list-style-type: none"> • Ability to attract and retain clinical staff as a medium sized provider with larger provider organisations within a short distance • Ability to fully staff medical rotas due to national shortages • Future clinical sustainability of relatively small sized services • Pace of change required to deliver transformation
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Collaboration and integration (Working Together Programme) • Service transformation • Tendering for services • Explore potential to work in collaboration • Better Care Fund • Ability to review, change and manage all aspects of the care pathway across acute and community services • Review of clinical services 	<ul style="list-style-type: none"> • Crowded Foundation Trust provider market across South Yorkshire • National Service Specification development (particularly for specialised services) • Reducing, decommissioning or tendering of services • Better Care Fund • Any Qualified Provider • Collaboration and integration (Working Together Programme) • Change in Commissioning landscape and/or personnel with implications for current positive relations • Unanticipated changes or variation to Payment by Results • Unanticipated changes in workforce requirements • Unexpected shifts in demographics

