Operational Plan Document for 2014-16

Derby Hospitals NHS Foundation Trust

Operational Plan for y/e 31 March 2015 and 2016

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

Name	**Mohammed Hussain**
Job Title	**Associate Director – Business Development**
e-mail address	**mo.hussain1@nhs.net**
Tel. no. for contact	**01332 786361**
Date	**4th April 2014**

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

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational 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 Operational 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; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

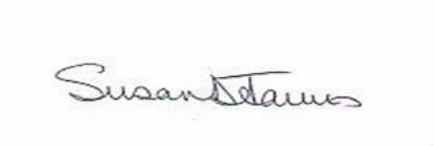
Name ***(Chair)***	**John Rivers**

Signature

Approved on behalf of the Board of Directors by:

Name ***(Chief Executive)***	**Susan James**

Signature



Approved on behalf of the Board of Directors by:

Name ***(Finance Director)***	**Lee Outhwaite**

Signature

1.0 Executive Summary

1.1 Introduction

This operational plan has been prepared in line with Monitor's guidance and sets out how Derby Hospitals NHS Foundation Trust (DHFT) intends to deliver appropriate, high quality and cost-effective services for patients over the next two years as part of delivering our broader strategy.

Our strategy for 2013-18 "Quality Through Partnership" takes account of the wider national and local context and through our strategic imperatives (see top right) helps realise the Trust's overall vision.

In preparing its operational plan, the Trust has considered key changes to commissioning strategies and coupled with risks identified through our Board Assurance Framework, our Plan on a Page consolidates a set of priorities to address not only how these challenges will be met, but also details how we plan to change our services in order to realise our ambition of a being a beacon for healthcare in the 21st Century.

The short term challenges

- Worsening national and local financial position
- Keogh's quality agenda including: 7 day services and Urgent/Emergency Care review
- Greater demand and more complex conditions
- Better Care Fund £32 million for Southern Derbyshire CCG
- Mitigating Loss Making Services
- Improving operational performance in access targets and quality measures

1.2 Delivering Quality in Everything We Do

Key to delivering this agenda will be maintaining and improving upon the quality of our services. Our current Quality Strategy runs until October 2014 and is based on the key principles of patient safety, clinical effectiveness and patient experience.

The Trust has a robust structure of groups and committees which feed into the Executive Quality Review Committee (QRC) along with quality reports from the Divisions. This is being further enhanced through our divisional performance management meetings which will include a focus on quality in line with the 5 CQC domains of safe, caring, effective, responsive and well led.

The Trust is developing the Quality Strategy for 2014-2019 with key objectives being developed with wider stakeholder engagement taking into account learning from the Francis Inquiry, the Keogh and Berwick reviews and the new CQC key lines of enquiry.

A number of priorities will be reflected within this Strategy including:

- Protecting patients from C.Difficile
- Continuing to drive down mortality rates
- Introducing public ward staffing and safety information
- Embedding the Trust's inter-professional standards
- Reducing opportunities for clinical variation
- Rolling out the fundamentals of care education programme
- Enhancing opportunities to use real time experience feedback to drive improvements
- Ensuring that our complaints process is responsive and demonstrates a shift to a learning organisation

1.3 Transformation, Creating Networks and Developing Integrated Care

The Trust has developed its transformation programme over three clinical work streams, Planned (elective care), Unplanned (urgent and emergency care) and Integrated (intermediate care). Many of these work streams are internally and externally transformational but seek to maximise productivity, improve quality and patient experience and aim to create a more resilient health economy.

In support of this agenda, during 2012/13 the Trust and Southern Derbyshire CCG established Clinical Improvement Groups (CIGs) to drive clinical engagement and service transformation. GPs and hospital consultants meet regularly to identify service issues and redesign service models.

Key successes of the transformation programme to date include:

- Delivering IV anti-biotic therapy in the community
- Fewer last minute cancellations contributing to improved theatre utilisation
- Daily board rounds mean that there is better co-ordination of care
- Staff consistently reporting improved communication and flow from MAU earlier in the day
- Improved occupancy in medical wards compared to last winter
- Implementation of the Frail Elderly Assessment Pathway
- Single point of access service for GPs
- Development of Community Support Teams
- Hospital from Home Service

Internal transformation schemes seek to improve productivity against a backdrop of elective and emergency growth. Demand for local health services is increasing in line with the national trend of an ageing population and increasing co-morbidities with an unprecedented (and unplanned) increase in referrals into the Trust's planned care services (circa 7.2% Trustwide) coupled with a 2% increase in emergency department attendances and emergency admissions (particularly amongst the elderly) of around 5%.

Given the scale of the challenge noted above, the Trust has developed 12 system-wide Project Outline Documents (PODS) in conjunction with Southern Derbyshire CCG (see summary on the right) to support the movement of healthcare from hospital settings and in doing so, integrate services to improve the consistency of care and experience for patients.

System Wide Transformation

Avoidable admissions- reduction related to reducing re-admissions - linked to overall 100 bed reduction

LOS - Discharge to Assess - CCG non elective activity reduction proposed at marginal rate - linked to overall 100 bed reduction

Assessments Unit Review - Full review of services to be carried out

Follow-up reduction - Based on 2:1 ratio, 25,000 follow-ups

Hand Surgery Review - Reduction of contract value to £5m with potential to repatriate activity from other providers

Integrated Children's Services- Full review of service provided

Medicine Management Health Community - Integrate and streamline the prescribing of medications across the Health Community.

Neuro Rehab Service Review - Assessment of service provided

OP procedure settings & Facets - Procedure setting/reduction in Facet injections and review of Procedures of Limited Clinical Value (PLCV)

Palliative Care Review- Assessment of service provided

Clinical Pathways - The review of high volume, high cost pathways within, and between, specialties, identifying opportunities for improvement.

Referral Management - Reduce elective activity levels by 10,000 through demand management

Outcomes from this work should include a reduction of 4 inpatient wards across the health economy, improving referral/demand management between primary and secondary care and reviewing how integrated children's services and neuro-rehabilitative services may be provided in future.

In line with our Strategy for developing clinical networks and Integrating care, the Trust is exploring how it can deliver either by itself or in tandem with existing providers across the local health economy planned care in community settings, closer to patient's homes. The Trust already provides outpatient, diagnostic and surgical services in a number of community hospitals, however, this can be expanded.

By providing services such as ultrasound, endoscopy and short stay surgery in partnership with other providers, the Trust can maximise estate, skills and ultimately increase capacity whilst also managing demand and referrals. The Trust is working with Derby Community Healthcare Services Trust in order to meet this aim.

Additionally, identifying the capacity required to meet this growth in demand requires thorough and robust workforce planning. This is not only in terms of increasing access to physical capacity but also ensuring the staff are appropriately skilled and can support the transformational culture required to improve productivity and efficiency gains. This will in turn deliver higher quality care and respond to the short to mid-term challenges facing the local health economy and the wider NHS. As such, the Trust is developing an Organisational Development framework to bring together a range of trust-wide programmes that have been designed to develop our culture and engagement with patients, service users and staff.

Coupled with this, in workforce planning terms, the demand noted above may not necessitate a full-time appointment and attracting, developing and retaining a highly skilled workforce is a challenge facing many Trusts today. Therefore, another way in which the Trust is looking to optimise the networks we are part of is to look towards joint training and joint staff (medical and nursing) appointments.

Furthermore, examining pathways, and delivering these in partnership is a further way in which Trust's can manage these problems, create capacity for a more resilient multi-disciplinary teams and improve access for patients to local services. The Trust, together with Nottingham University Hospitals Trust and (separately with) Burton Hospitals NHS Foundation Trust is exploring some of these potential opportunities (eg. General surgery, hepatobiliary and paediatrics), and in doing so, looks to mitigate risks through creating sustainable clinical services.

1.4 Financial Planning

The Trust Financial Plan for 2014/15 has been summarised as follows;

- Planned deficit of £23.7m, prior to mediation/arbitration.
- Capital spend of £11.6m
- £14.4m CIP planned with £12.4m schemes confirmed and further schemes being developed. It is likely the total value of the CIP will be £18.9m, after dealing with cost reductions associated with dealing with successful implementation of further demand management work
- Continuity of Service Risk Rating (CoSSR) 1 in all quarters
- Cash outflow before external support, of £35.8m planned in year due to deficit and capital programme
- Southern Derbyshire CCG contract;
    - PbR compliant, with realistic agreed activity base plan, prior to RTT backlog and Transformation schemes that effect overall activity.
    - No support in 2014/15 from non-recurrent CCG resources.
    - 70% MRET plans not agreed
    - Funding contribution to non-tariff margin withdrawn
    - The Trust is in continued talks on RTT backlog, MRET, loss making services and demand management and a further full update on all of these issues will be available by 24th April 2014.

1.5 Conclusion

Our plan demonstrates that the Trust understands its risks to short term stability and plans to respond to these to ensure resilient services.

In submitting this Plan, the Board confirms 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;
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1.6 Derby Hospitals NHS Foundation Trust Plan on a Page 2014/15

PUTTING PATIENTS FIRST
• Further develop seven day services
• Fully implement 'Your Moment Matters', enhancing both patient and staff experience
• Transform the elective care pathway to improve patient experience and productivity and reduce waiting
• Whole system service developments to improve care for: - Bariatric patients - Frail elderly people (inside and outside hospital) - Stroke patients - People who need Bowel Screening - Cancer and palliative care
RIGHT FIRST TIME
• Review planned care pathways to improve referral management and reduce premium working
• Increase the level of outpatient and day case procedures
• Develop our plans for becoming an Urgent Care Centre
• Develop 'discharge to assess' service
• Implement 'community care co-ordination' programme to reduce emergency admissions
• Embed new 5 year Quality Strategy
INVESTING OUR RESOURCES WISELY
• Create a 23 hour ward to maximise day surgery
• Improve the depth of clinical coding
• Fully realise the benefits of Lorenzo
• Upgrade other key clinical informatics systems to transform clinical and administrative processes
• Introduce contribution accounting and refine patient level costing data so Business Units can see impact of investment decisions
• Maximise the income potential of the Private Patients' Unit
• Further develop our flexible workforce focussing on : - Integrated Service Provision / 7 days services and - Aligning terms and conditions to service needs
DEVELOPING OUR PEOPLE
• Develop a new medical workforce strategy and reduce dependence on locum and agency staff
• Ensure robust, timely and transparent medical job planning for medics and appraisal for all staff groups
• Transform therapy services to deliver care outside hospital
• Introduce new and generic roles, and a staff development framework to support their recruitment and retention, eg. Advanced Clinical Specialist
• Ensure that Business Unit focus is maintained and strengthened clinically and managerially via talent mapping and succession planning
ENSURING VALUE THROUGH PARTNERSHIPS
• Develop pharmacy services to support discharge and integrated care
• Work with CCGs to deliver new transformation schemes to reduce demand and unwarranted clinical variation
• Work with other provider partners to develop a shared response to 'Better Care Fund' commissioning intentions
• Develop 'Western Hub' Pathology Alliance
• Develop strategic partnerships with other acute hospitals
• Develop partnerships across the health community providing workforce solutions to recruitment and retention challenges

2.0 Introduction

This operational plan document has been prepared in line with Monitor's guidance. The plan sets out how Derby Hospitals NHS Foundation Trust (DHFT) intends to deliver appropriate, high quality and cost-effective services for patients over the next two years as part of delivering our broader strategy.

Our plan demonstrates that the Trust understands its risks to short term stability and plans to respond to these to ensure resilient services.

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- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

2.1 Background to the Trust

Derby Hospitals NHS Foundation Trust (DHFT) serves a population of over 600,000 people in and around Southern Derbyshire, with our specialist services attracting a wider catchment across the East Midlands Region.

The Trust has an annual turnover of c£450 million and is one of the largest employers in the region with more than 8,000 staff. DHFT provides a range of hospital based and community services from its main bases in Derby City (Royal Derby Hospital and London Road Community Hospital) as well as across a number of community hospitals across Derbyshire in partnership with local NHS providers.

Vital statistics 2013/14

- Outpatient attendances: (including therapies): 703,000
- Outpatient attendances outside clinic: 66,000
- Emergency Department attendances (excluding eye casualty) : 118,000
- Inpatient stays: 123,000
  Of which:
- Emergency admissions: 53,000
- Elective operations: 71,000 (80% were daycase)
- Number of babies born: 6,000

2.2 The short term challenge

NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

Our strategy for 2013-18 "Quality Through Partnership" takes account of this wider strategic context and through our strategic imperatives (see below) helps realise the Trust's overall vision. In preparing its operational plan, the Trust has considered key changes to national and local commissioning strategies and examined their impact on the Trust factoring these considerations into its plans.

Our Vision

To be a national beacon for all that is best in the NHS delivering 21st century healthcare. We will be part of a flourishing network of health and social care partners to integrate care for our patients, deliver clinically excellent results and be financially sustainable.

Our Strategic Imperatives

Deliver quality in everything we do; safety, effectiveness and patient experience	**Transform services to maximise productivity and efficiency**	**Create networks for acute and complex care**	**Develop integrated care for people with long term conditions to help them stay as healthy as they can**

There are a number of changes affecting the Trust resulting in a number of short-term challenges. The financial position is worsening nationally, far more rapidly than previously anticipated with a real need to work in an integrated way across health and social care to address system wide issues. The weak financial position is especially seen across the Midlands with 14 out of 38 Trusts forecasting a financial deficit (54 out of 147 nationally) and CCG's allocations across Derbyshire being comparatively worse off than their counterparts.

This position is neither affordable nor sustainable. Demand for local health services is increasing. The national trend of an ageing population and increasing co-morbidities is seen across Derbyshire exemplified through demand for GP consultations (expected to increase by 4% per annum) [1] and the unprecedented (and unplanned) increase in referrals into the Trust's planned care services (circa 7.2% Trustwide). As our capacity was not prepared for such an increase (1.3% growth factored Trustwide), the Trust has seen the waiting lists for some services significantly increase, with national access times, 18 weeks from referral to treatment (also known as RTT) not being met for some patients and the Trust failing to meet its RTT targets in Q2, Q3 and Q4 of 2013/14.

Emergency attendances have also seen a 2% increase (affecting our ability to meet the 4 hour access target) with ongoing pressure placed on the Emergency Department and emergency admissions (especially amongst the elderly) growing by around 5%. These unplanned pressures have an adverse impact on our planned care pathways as routine operations are cancelled with medical patients occupying surgical beds (compounding the operational performance noted above such as the 18 week RTT position).

This situation of unplanned growth is not satisfactory for the either the Trust, CCGs and most importantly patients. Additionally, the cost of meeting this demand is greater than the income received as the income for the growth in emergency admissions is capped as per national PbR guidance (Marginal Rate for Emergency Tariff). This is coupled with the fact that this is unaffordable for the CCG (see below).

Conversely, the quality agenda in the NHS continues to gain momentum with Keogh's reforms to create sustainable services embodied in two key initiatives; seven day services and urgent care/emergency centre redesign.

[1] Nottinghamshire and Derbyshire Local Area Team 5 Year Plan -2014

In December 2013 NHS England set out a plan to drive seven day services across the NHS over the next 3 years, starting with hospital urgent care and supporting diagnostic services. This aims to address a national picture of significant variation in outcomes for patients at the weekend. The plan sets out new clinical standards which it recommends are adopted across the NHS by the end of the 2016/17 financial year.

To do this it is clear that providers and commissioners will need to work together to explore new ways of working. Initially this is focussed on hospital services, however it is clear that over time the whole NHS system will have to work differently.

Inevitably this type of change will necessitate considerable adjustment for staff working in the NHS, in particular across the medical and allied health professional populations.

Within the East Midlands, acute providers are working together to take a strategic approach to the issues and the intent is that by Summer 2014, a baseline assessment and gap analysis in support of this initiative will have summarised the full implications for the region of delivering seven day services.

Similarly, Keogh's reform of urgent and emergency care seeks to re-enforce resilience in primary care in order to take some of the stress away from highly pressurised A & E departments. The review will examine the role of urgent care pathways including looking to improve self-care, the role of GPs and other primary care services such as 111 and pharmacy services. Further reform focusses on the make up of existing A & E (and ultimately services in hospitals) departments with the development of emergency care networks and two types of centres planned for the future - Emergency Centres and (between 40-70) Major Emergency Centres. The latter will have a need to provide highly specialist treatment over and above assessment and initiation of treatment. These plans seek to ensure that patients receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.

Other examples of the emphasis on high quality care can be seen in the Chief Nursing Officer's Strategy, the ongoing national and local NHS response to Francis and Berwick and resultant initiatives such as safer staffing.

Improving Performance

The Trust will need to respond to the changes in demand whilst remedying the underperformance seen across a number of areas of quality in 2013/14.

Further to independent assurance and scrutiny from Public Health England (C. Difficile), IMAS (18 Weeks) and ECIST (emergency care), the Trust has enacted remedial plans to improve performance for 2014/15 in the following areas:

- 18 weeks RTT
- 95% ED access
- C. Difficile
- Cancer 62 day wait

Together, all of these changes raise the bar in improving health outcomes for patients through improving standards in care, redesign of pathways and transformation of health and social care structures.

However, the aforementioned financial position creates a juxtaposition whereby the increasing and inevitable cost to deliver these quality improvements cannot be satisfied through the existing financial envelope. Locally, the Trust is in dialogue with its commissioners to discuss how it mitigates the impact of loss making services. These are largely community/rehabilitative based healthcare services mostly funded on a non-PBR basis and as can be seen in the context of the Trust's reference costs, are efficiently operated. The challenge of financial sustainability for these services requires joint dialogue, especially in the climate of austerity but also in light of the pressing integrated care agenda.

On a national level, it is recognised that the NHS must save an unprecedented £30 billion in efficiency gains by 2021 in order to stand still and it is unlikely that any mechanisms over and above the tariff will be made available to aid in realising this plan. Radical reform on a system-wide level is required across health and social care.

Accordingly, as part of the government's drive to provide better local efficiencies across services and a more co-ordinated experience of care for patients, a £3.8billion Better Care Fund will be made available in 2015/16 to support the integration of health and social care services locally.

For Southern Derbyshire CCG (SDCCG), this equates to £32 million to be committed by 2015/16. In order to access this money, local authorities and the local NHS health economy will have to entrust to joint commissioning, better data-sharing, seven-day working across health and social care services and the protection of social care services. This will inevitably lead to a focus on delivering packages of integrated care for the population we serve.

However, further transformational change is necessary to not only arrest the demand the Trust has seen, but also respond to the system vision of the Nottinghamshire and Derbyshire Local Area Team, so that;

"everyone has greater control over their health and their wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving"

For Derbyshire patients, the most common conditions are hypertension, obesity, asthma, diabetes mellitus and depression. Life expectancy at birth amongst men and women in Derby City falls below the national average with the most common causes of death being pneumonia and cerebrovascular disease.

Key to tackling these long-term conditions will be developing care models which link between traditional primary and secondary care settings. The community services that we provide across the City are pivotal in meeting this aim. District nursing and community support teams are now working alongside GPs to manage at a practice level (with a typical population size of around 20,000 people) a caseload of complex patients.

This is reflected in Southern Derbyshire and Erewash CCG's plans through their system objectives which look to:

- Build strong asset based communities
- Support people to remain independent and in control of their lives
- Provide support in the community when needed and reduce the need for hospitalisation or admission to long term care
- Improve outcomes and the quality of services provided – promote recovery
- Reduce inequalities

These objectives will be delivered through a range of interventions (see appendix 1) which align to the Trust's strategic intentions such as increasing the range of diagnostic and treatment services in the community and expanding integrated health and social care.

However, more than this, and in line with our strategic imperative to develop integrated care, the Trust is coming together with other providers across Derbyshire (such as mental health, community and social care services) to understand how as an economy we can respond to the challenges identified above. As a collective, we have already commissioned a piece of work which analyses the contact that a patient has had with individual agencies as they pass through various pathways. In doing so, we will be able to isolate the types of services that patients interact with and identify where duplication can be removed and a "total care" approach (where we can target and optimise contacts such as prevention and other care management principles) can be embedded. This is an important step towards our strategy to provide care closer to home and away from a hospital setting where appropriate.

Managing Risk

The Trust's Board Assurance Framework reflects our strategic imperatives and in doing so, identifies risks and mitigations to the organisation.

Key risks include:

- Our ability to meet key areas of performance such as 18 weeks RTT, Cancer targets and ED access targets
- Developing a sustainable and affordable financial plan
- Responding to quality concerns such as complaint management and tackling HCAIs
- Developing our community services to better integrate care

From this and from our operational plans there are a number of resultant risks. A summary of our Board Assurance Framework is attached (see appendix 2) which outlines some of the operational risks and how these are being mitigated by the organisation. In order to respond to these operational

risks and the short term challenges above, **a set of priorities** have been developed in line with our Pride Objectives (which are then meaningful to our stakeholders). Our operational plan therefore consolidates through these priorities not only how these challenges will be met, but also details how we plan to change our services to realise our ambition of a being a beacon for healthcare in the 21st Century.

- **P**utting patients first
- **R**ight first time
- **I**nvesting our resources wisely
- **D**eveloping our people
- **E**nsuring value through partnerships

DERBY HOSPITALS NHS FOUNDATION TRUST
DRAFT PLAN ON A PAGE 2014/15

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3.0 Quality plans

Deliver quality in everything we do; safety, effectiveness and patient experience	Transform services to maximise productivity and efficiency	Create networks for acute and complex care	Develop integrated care for people with long term conditions to help them stay as healthy as they can

3.1 Quality Strategy

In 2011 the Trust Board approved its 2011-14 Quality Strategy to continuously improve quality and provide a clear statement to patients, staff and stakeholders on its delivery. The strategy set out what is to be done and how it is to be measured.

The strategy is based on the key principles of patient safety, clinical effectiveness and patient experience and is linked to the corporate objectives.

Board accountability lies with the Medical Director and the Director of Patient Experience and Chief Nurse. A supporting structure is in place to ensure ownership of the quality agenda throughout the organisation. This includes the Quality Assurance Committee, a sub-committee of the Board plus a structure at Divisional level.

Delivery of the strategy is through quality improvement tools and methodologies including the Productive Series, PDSA, Leading Improvements in Patient Safety and ward assurance tool. A monthly Quality Report is submitted to the Board detailing progress against the agreed priorities.

Quality Strategy 2014-2019

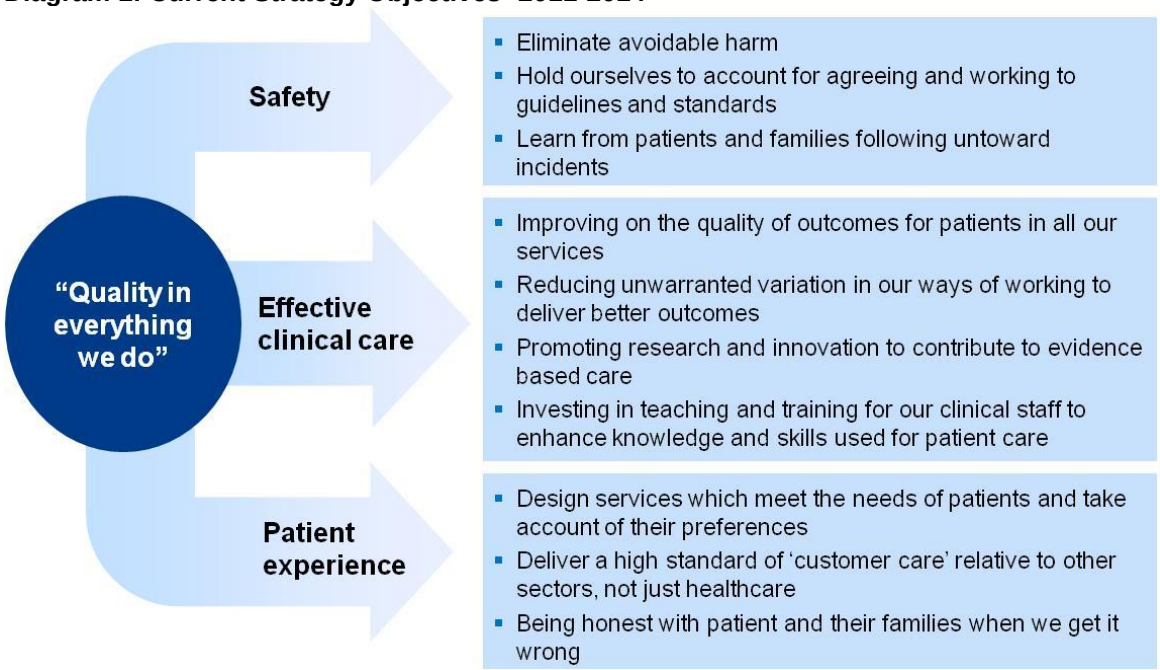
The current Quality Strategy runs until October 2014. Accordingly, the Quality Strategy is currently under review to identify the key priorities to deliver the Trust's overall strategy for the coming 5 years.

Key objectives will be developed with wider stakeholder engagement taking into account learning from the Francis Inquiry, the Keogh and Berwick reviews and the new CQC key lines of enquiry.

For planning purposes, this section of the plan will focus on the current strategy whilst acknowledging the imminent development and implementation of the Strategy for 2014-2019.

During 2012, we renewed our corporate strategy. One of the four strategic imperatives for the Trust is to deliver quality in everything we do, set out in the diagram below.

Diagram 1: Current Strategy Objectives- 2011-2014

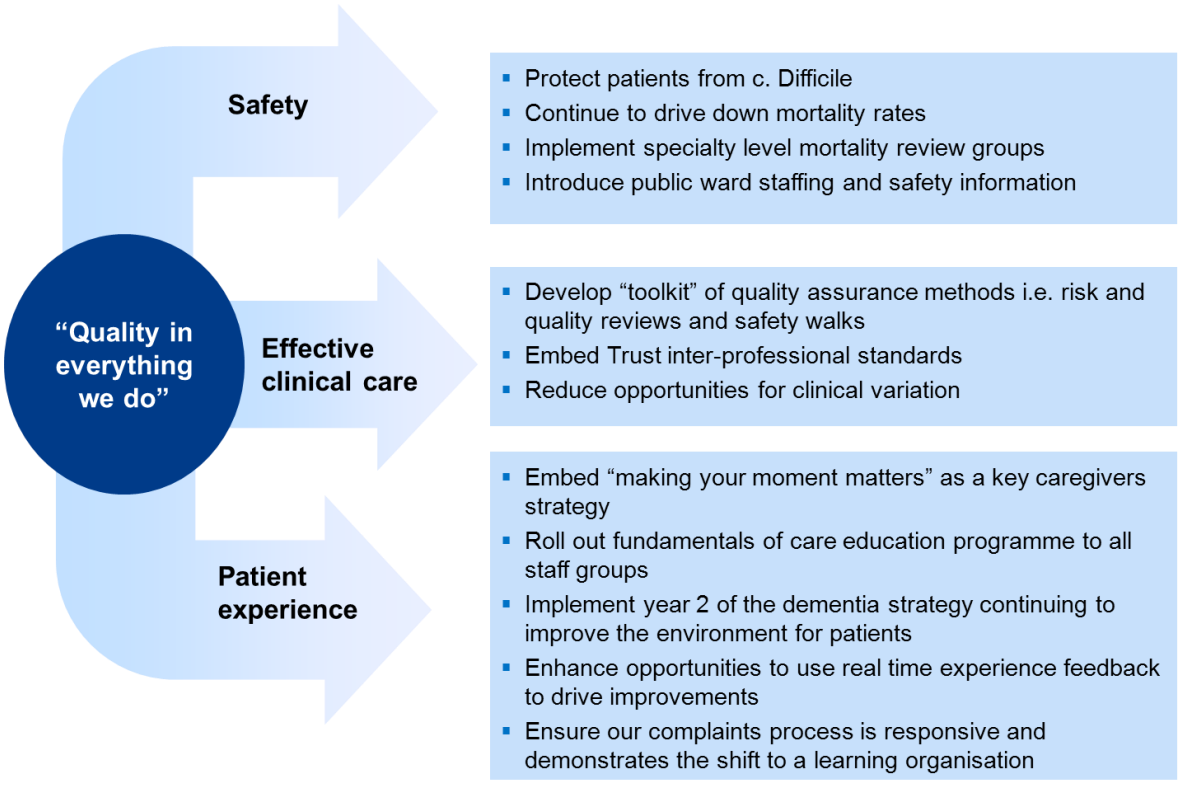


The Trust is committed to ensure that the lessons learnt from the Francis Inquiry, Berwick and Keogh reviews are transparent in the next 5 years of the Trust's Quality Strategy.

The key outcome measures identified through the next strand of the quality strategy will form part of the performance management arrangements for each Division and will be subject to review and scrutiny through the Trust Quality Committee and reported to Trust Board. This will be supported by a comprehensive quality dashboard.

The following priorities will be reflected in the new **Quality Strategy**

Diagram 2: Quality Strategy Priorities - 2014-2019



3.2 An outline of existing quality concerns

Identified below are a number of concerns identified by either the CQC or other parties and our remedial plans to return to respond to them.

- **Cancer Peer Review**

On the 15th January 2014, 3 tumour site teams had external visits by the National Peer Review Team. Five serious concerns were raised by the team, which were lower than the 10 expected. The serious concerns were consistent with the internal validation process and there were no unexpected serious concerns highlighted as part of the review process.

A letter of response has been sent to the National Peer Review Team identifying the mitigating actions that will be taken. All tumour sites have agreed to the mitigating actions and the Cancer Centre will ensure the actions are implemented in a timely fashion so as to ensure future compliance.

- **CQC minor concerns relating to:**
  - **complaint management**
  - **documentation and record keeping**

A detailed review and re-organisation of the Trust complaints policy has been undertaken with key performance indicators monitored directly through Trust Board each month.

A complaints improvements plan focussed on responsiveness and organisational learning is in place and is monitored through the Trust Quality Review Committee.

The Trust's nursing documentation was reviewed and re-launched in 2013. This is monitored through the monthly ward assurance audits.

Accordingly, the Trust has enacted plans to address the concerns raised by the CQC and is awaiting a re-inspection to formally confirm our compliance.

- **Clostridium Difficile**

The Trust has faced significant challenges in achieving its C. Difficile objective. The Trust commissioned two external reviews from Public Health England and has a C. Difficile recovery plan in place.

3.3 Key quality risks and how these will be managed

Clinical and Quality priorities take into account the views of commissioners, staff and patients. We are working closely with commissioners on a number of areas, most notably the reduction of 30 day readmissions and the development of a care pathway for the frail elderly. In addition to this, the Trust is entering into a significant period of transformational change. Section 5.4 of this plan describes 12 system wide transformation schemes (affecting pathways between secondary and primary care) and how they and any associated risks will be managed.

The current quality priorities, their milestones and actions, together with risks and mitigating actions are shown on the table in appendix 3.

These will be updated over the next three months to reflect the next 5 years of the Trust Quality Strategy.

3.4 An overview of how the board derives assurance on the quality of its services and safeguards patient safety

Our strategy has the overarching theme of "quality in everything we do". A Quality Impact Assessment was developed in early 2012 to assess the safety implications of cost improvement schemes and changes in delivery of care. The second Francis Report into Mid Staffordshire NHS Foundation Trust has been examined and appropriate recommendations are in the process of being assimilated into the current governance structures, training and leadership initiatives of the Trust.

We have a robust structure of groups and committees (see quality governance structure below) which feed into the Executive Quality Review Committee (QRC), along with quality reports from the Divisions. This allows triangulation of information and an ability to develop recommendations and action for any issues. QRC reports through performance and scrutiny management meetings and also to the sub-Board Quality Committee. This is being further enhanced through our divisional performance management meetings which will include a quality focus on the meeting agenda and a quality dashboard used by Business units. This will in turn feed into our Management Executive and Trust Board which actively monitor quality metrics in line with the 5 CQC domains of safe, caring, effective, responsive and well led.

We have on two occasions, carried out the Monitor's Quality Governance Framework Self Assessment. This intensive self assessment process, which required detailed and thorough reflection

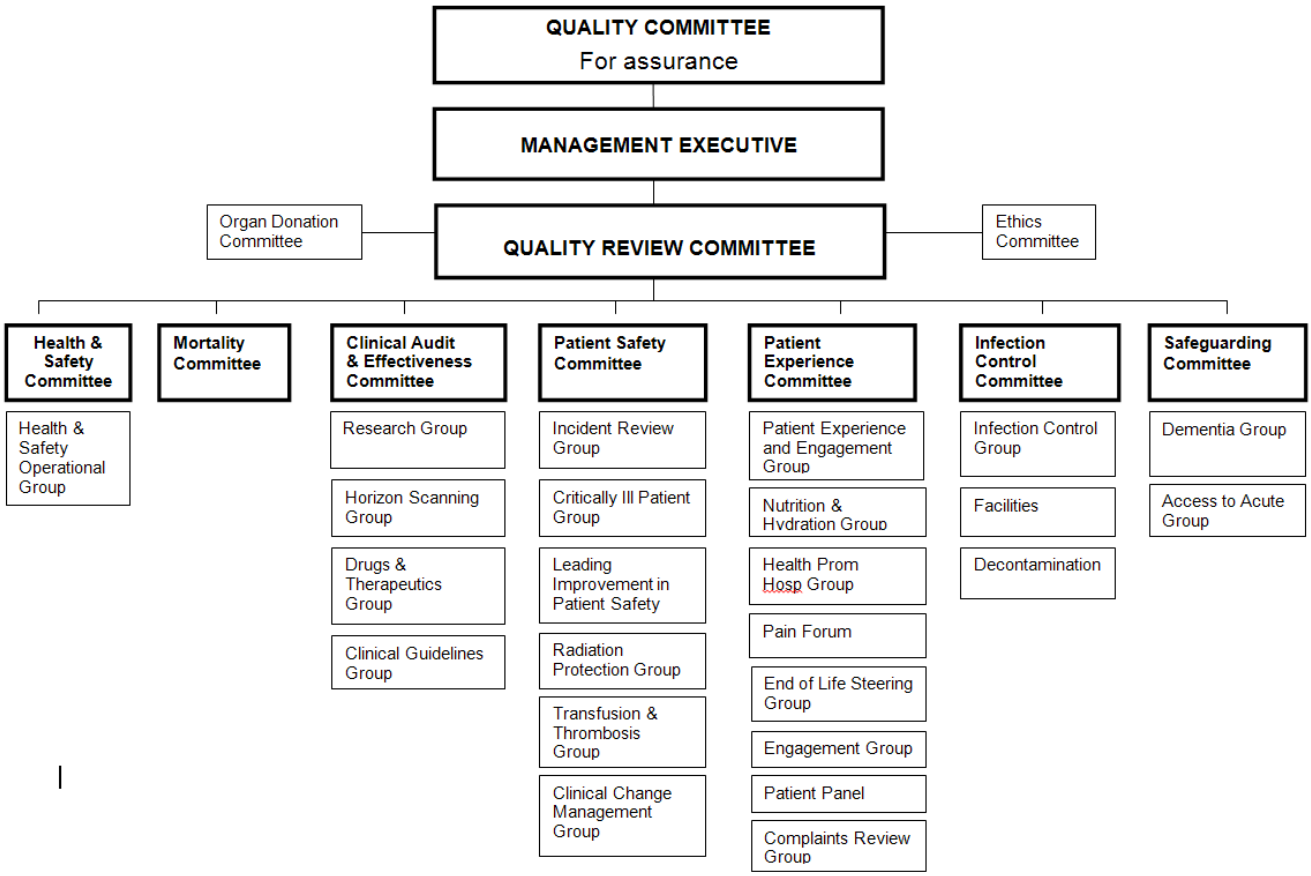
and deliberation, demonstrated that the Trust Board had acquired an increased emphasis on quality governance and has robust mechanisms in place to monitor quality.

An example of this assurance can be seen in the improvement management of C. Difficile. In 2013/14 the Trust exceeded its trajectory for C. Difficile. Monthly monitoring of performance against this target is reported through the infection control committee (ICC) and the Trust quality committee. All C. Difficile cases are subject to a full root cause analysis(RCA), chaired by the Executive Medical Director or Chief Nurse, with subsequent action plans presented to the ICC. Each division and business unit is expected to take a zero tolerance approach to C. Difficile. Any avoidable episode will be challenged through the divisional performance monitoring meeting. The Trust has commissioned an external review into its C. Difficile performance. Key actions for 2014/15 will focus on:

- Clinical Leadership and Ownership
- Anti-biotic Stewardship
- Isolation and Environment
- RCA and organisational learning

Internal and external auditors routinely incorporate quality assurance into their annual audit plans. All internal audit reports are reported to Board committees and to the Board by audit committee minutes. The Trust's annual quality report is audited by PwC.

Diagram 3 – Quality Governance Structure



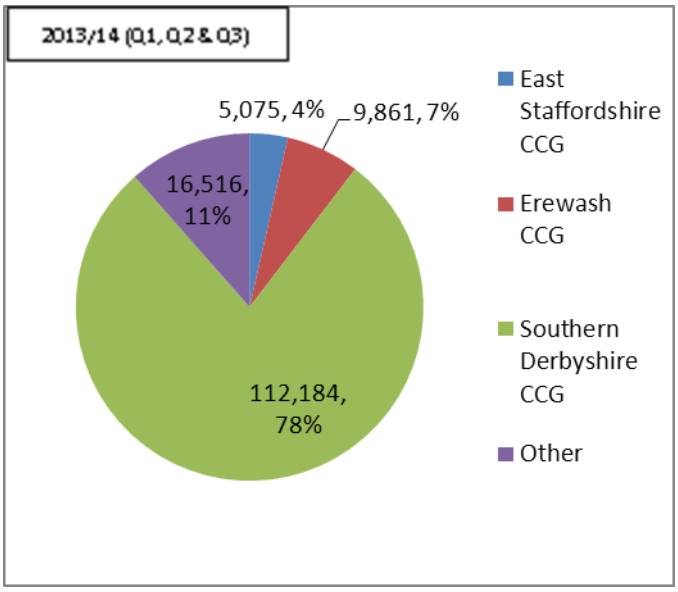
4.0 Operational requirements and capacity

In 2013/14 a risk share agreement developed with our main commissioner Southern Derbyshire CCG (SDCCG) was adjoined to the NHS contract with the intention of funding modelled activity whilst supporting a joint transformation plan. Whilst the commissioner and provider have been working together to deliver this, demand has increased in both elective and urgent pathways (see below) causing additional unplanned pressure on capacity. This has had a consequential impact on other key performance Indicators (KPIs) with 18 week RTT targets, and Cancer targets being adversely affected. There is an ongoing risk of delivering these targets as we enter into 14/15 with Cancer 62 day wait compliance expected to return in Q2.

4.1 Planned Care Demand

There has been an overall year on year increase in referrals at DHFT (comparing 2012/13 Q1-Q3 and 2013/14 Q1-Q3) of 9.60 %. When these Non-Tariff services are excluded (mainly Physio, OT & Audiology), this falls to 8.41%. This is not the growth level that is used for planning purposes. Calculating growth for planning purposes requires using a longer time period of at least 3 years to set a more reasonable level of growth. Using a 3 year trend the current referral growth would be between 2% to 4% depending on the period used. In contrast, 1.3% growth was factored (trust-wide) into the contract for 2013/14 and this is having a direct consequential impact on the Trust's financial overspend and operational under-performance.

Diagram 5: Referrals by CCG



The proportion of total referrals remains constant in areas such as screening programmes and other providers. The proportional increase in GP and Dental referrals however has had the most significant impact, also increasing the volume of referrals between healthcare professionals.

The table below shows the total number of referrals to date compared to the previous year:

Table 1: 12/13 vs 13/14 Referral Source Comparison

Trust	YTD 13/14	YTD 12/13	Difference	% Change
Derby Hospitals NHS Foundation Trust	**144,450**	**131,796**	**12,654**	**9.60%**
Heath Care Professional to Health Care Professional (C2C)	34,481	31,599	2,882	8.36%
GP & Dentist	83,940	75,219	8,721	10.39%
A&E & Emergency	12,255	11,368	887	7.24%
Other (inc Other Provider, Community Midwives)	11,223	11,070	153	1.36%
Screening Programmes	2,434	2,424	10	0.41%
Without Non-Tariff Specialties	**125,954**	**116,181**	**9,7773**	**8.41%**

Examining this in more detail on a CCG level shows that whilst all CCGs have seen a proportional increase (in volume terms) the vast majority of the increase in referrals relates to SDCCG. There are 5 Specialties that make up almost half of the increase in referrals. The table shows the key specialties and change in referrals between Q1 - Q3 for 2012/13 and Q1 - Q3 for 2013/14:

Specialty	YTD 13/14	YTD 12/13	Difference	% Change
Hand Surgery	13,487	12,021	+1,466	+12.20%
Orthopaedic	12,831	11,325	+1,505	+13.30%
Physiotherapy	11,956	10,800	+1,156	+10.70%
Paediatrics	4,032	3,187	+845	+26.51%
Gastroenterology	3,685	2,863	+822	+28.71%
Ophthalmology	9,350	9,581	-231	-2.41%
Obstetrics	5,709	5,933	-224	-3.78%

Table 2: Referral Growth by Service Specialty

The timely treatment of patients (in line with 18 Weeks RTT) is further prohibited by unplanned admissions (see below) as the Trust has seen surgical beds filled with medical outliers. The inevitable impact on 18 weeks RTT from the increase in referrals and shortage of inpatient bed availability means that individual sub specialty trajectories have been developed to understand capacity shortfalls (in addition, a downside model has been developed to assess the impact of a severe Winter).

4.1.1 Key Risks

Risk	Mitigation
Failure to deliver clinically urgent care	- Internal analysis and management of the waiting list ensures that patients who are urgent/whose conditions' worsen are prioritised for treatment - Similarly, cancelled routine operations due to bed pressures are categorised in terms of clinical urgency
Delivery of 18 weeks RTT and Cancer 62 day targets	- Additional internal capacity created to respond to demand through waiting list initiatives - Additional external capacity (for non-cancer) created through the identification of suitable alternative providers (to support patient choice and timely treatment) - Remedial action plan for cancer in progress with compliance set to return in Q2 14/15.
Capacity to meet growth is not sufficient/sustainable	- The additional capacity created remains insufficient to address the growth seen. - The Trust is working with commissioners to identify and put plans in place to arrest demand, remedy the backlog and fund a sustainable position going forward.
The growth in demand is unaffordable for the CCG	The Trust, together with CCG is working on a joint planned care transformation programme. This will look to identify how some referrals could be better managed in primary care as well. In addition to this, the Trust is in discussions with the CCG to remunerate the Trust in order to eliminate the waiting list backlog.

4.1.2 Responding to the demand – Immediate Operational Responses

The Trust continues to operate an extended elective week in order to create sufficient capacity to meet this demand, but our trajectories show that the demand outstrips our existing supply. As such,

additional activity has been scheduled for the daycase services. Recent activity is showing a weekly upward trend of 20% further supported by the opening of a 23 hour ward facility in January 2014.

A concerted focus continues related to effective discharge planning. An increase in Junior Doctor cover where appropriate, to expedite discharges is taking place. Additional ward rounds and patient reviews are also taking place.

Furthermore, in order to satisfy the constitutional requirement that patient's are offered choice should their treatment pathway not be delivered within 18 weeks, the Trust has worked with local providers to utilise their capacity. This has seen the more timely treatment of ENT patients, some General Surgical cases and Bariatric cases.

4.1.3 Responding to the demand – Managing Pathways

During 2012/13 the Trust and CCG established Clinical Improvement Groups (CIGs) to drive clinical engagement and service transformation. GPs and hospital consultants meet regularly to identify service issues and redesign service models. Key priorities for the Planned Care CIGs (which have seen an increase in referrals) will be understanding the demand and looking at alternative management models.

Examples include changes to the coeliac pathway which due to alternative diagnostics being put in place, will mean around 80 fewer patients will require a diagnostic endoscopy. This will expedite treatment with the longer term ambition that follow up of these patients can be managed in primary care.

Focus of Planned Care CIGs

- Referral Management
- Increasing the utilisation of Outpatient and Daycase Procedure Settings
- Improving Clinical Pathways
- Reducing Follow-ups

Further to this, two planned care summits have been held (in January and March) between consultants and managers in the Trust and GPs and managers in the CCG. This examined the increase in demand seen across the local health economy (LHE) and options to respond to this jointly given the unsustainable financial and operational positions.

It was agreed that a joint Planned Care Board will take forward areas of transformational work including a primary/secondary care hub which improves access to diagnostics and ensures that any referrals to secondary care have had the appropriate requirement of investigations conducted and could not be otherwise managed in primary care.

In line with our Strategy for developing clinical networks and Integrating care, the Trust is exploring how it can deliver either by itself or in tandem with existing providers across the LHE, planned care in community settings, closer to patient's homes. The Trust already provides outpatient, diagnostic and surgical services in a number of community hospitals, however, this can be expanded. By providing services such as ultrasound, endoscopy and short stay surgery in partnership with other providers, the Trust can maximise estate, skills and ultimately increase capacity whilst also managing demand and referrals. The Trust is working with Derby Community Healthcare Services Trust in order to meet this aim.

Demand for services in one Trust alone may not necessitate a full-time medical appointment and attracting, developing and retaining a highly skilled workforce is a challenge facing many Trusts today. Therefore, another way in which the Trust is looking to optimise the networks we are part of is to look towards joint training and joint staff (medical and nursing) appointments. Coupled with this, examining pathways, and delivering these in partnership is a further way in which Trust's can manage these problems, create capacity for a more resilient multi-disciplinary team and improve access for patients to local services. The Trust, together with Nottingham University Hospitals Trust and (separately with) Burton Hospitals NHS Foundation Trust is exploring some of these potential opportunities (eg. General surgery, hepatobiliary and paediatrics), and in doing so, look to mitigate risks through creating sustainable clinical services.

4.2 Urgent Care Demand

At the start of 2013/14 the Trust experienced significant difficulties in delivering the A&E 4 hour standard. DHFT has seen a 1.9% year on year increase overall in urgent care activity at a Trust level with Emergency Department (ED) attendances being 2% higher than in 12/13. In particular, the resuscitation patients have increased by 11% compared to the previous year.

There has also been an increase in non-elective admissions (around 5% Trust-wide) with up to 18% more admissions in the specialty of Hands, and 12% in General Surgery.

The case mix for both A&E and non elective activity have increased as can be seen below from the comparison of 12/13 activity rebased at 13/14 tariff prices with the 13/14 actual activity.

This demonstrates that the complexity of our patients has also increased perhaps reflective of the increasing number of over 80 year olds attending ED (11%).

Table 3: Change in Derbyshire Average Price Per Patient

Point of Delivery	2012/13 Activity at 2012/13 Prices	2012/13 Rebased at 13/14 Prices	2013/14 Activity at 2013/14 Prices	Increase In Acuity Per Patient	Impact of Tariff Deflator Per Patient
A&E Months 1-6	£106.34	£103.00	£108.11	£5.11	-£3.34
NEL Months 1-5	£1,885.82	£1,809.48	£1,852.32	£42.84	-£76.34

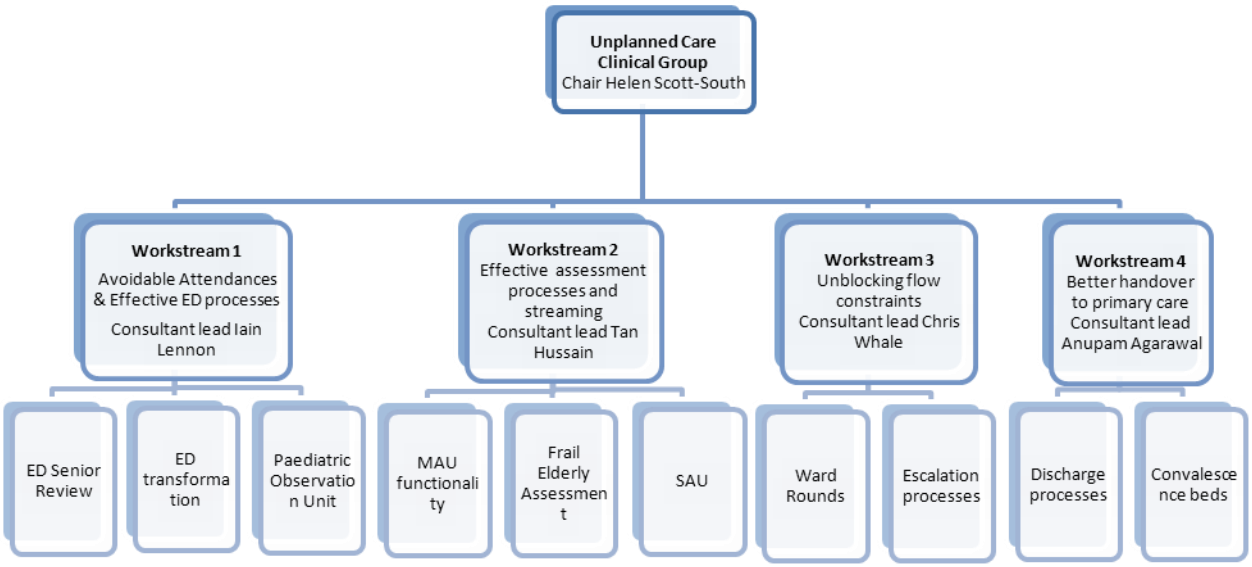
4.2.1 Key Risks

Risk	Mitigation
Delivery of ED 95% 4 hour target.	The Trust (together with commissioners) has invested in a number of transformational programmes to support flow through ED and into the wider hospital and admission avoidance. The latest independent report from the Emergency Care Intensive Support Team has recognised the extensive work that has been undertaken over the year.
Timely transfer/treatment of patients	Key actions to facilitate flow have been incorporated into the transformation programme.
Impact on elective care	Integrated care programme looks to support avoidable attendances, admission and facilitated early discharge. There has been an impact on elective care during the winter months due to surgical wards transferring to medicine.
Delayed Discharges	A 'pull team' has been implemented which pulls together key staff from the hospital, community services and social services to facilitate improved discharge. The increased focus has led to a reduction in delayed discharges.

4.2.2 Responding to the demand – Managing Pathways

The Trust's unplanned care Group examines four workstreams in order to manage a positive impact on the Trust's urgent care performance.

Diagram 6: Unplanned Care Transformation Workstreams



Specific actions:

Work stream 1: Improvement of ED internal processes, including the implementation of a new streaming model in minors and an innovative approach to the recruitment of middle grade doctors. Pilot of primary care co-location service next to ED

Work stream 2: Introduction of an escalation process to the Medical Assessement Unit, with specified triggers and actions for inflow and outflow. Introduction of SHARP principles for handover. Junior doctor involvement in the development of training information.

Work stream 3: introduction of structured board rounds across Medicine, based on SHOP (Sick, Home, Other, Plan) principles. Implementation of flow visualisation system and revised operational management. Agreement of internal professional standards.

Work stream 4: development of a video and 5 a day training package for staff. Re-launch of the use of estimated date of discharge and improved discharge information.

Emergency Care Intensive Support Team (ECIST) support

DHFT requested input from the ECIST team in May 2013 to support the unplanned care agenda. ECIST visited the Trust on 15th July and 7th August 2013 and made a series of recommendations in a report received in September 2013.

The team carried out a further visit on the 4th February 2014 to review the implementation of recommendations made in their earlier visits. ECIST identified the following priority areas for further improvement on the day of their visit:

- Continue to develop and embed early senior decision making in Majors ED
- Consider developing a 7 day work stream to explore reasons why Sunday discharges still significantly lower and short/medium and longer term actions
- Apply same improvement approach to Surgery to explore and resolve pathway issues particularly with the Surgical Assessment Unit.
- Continue work on internal delays to increase number of patients discharged earlier in the day
- Develop an improvement work stream for therapy services. Front load therapists in ED, taking handover from ambulance staff and starting collateral history.
- Increase use of home based discharge pathways.

The ECIST team have recognised the progress that has been made in unplanned care at the Trust and acknowledge a range of good practice. ECIST will continue to support the Trust in improving Surgical unplanned care and then anticipate ending the formal support to the Trust.

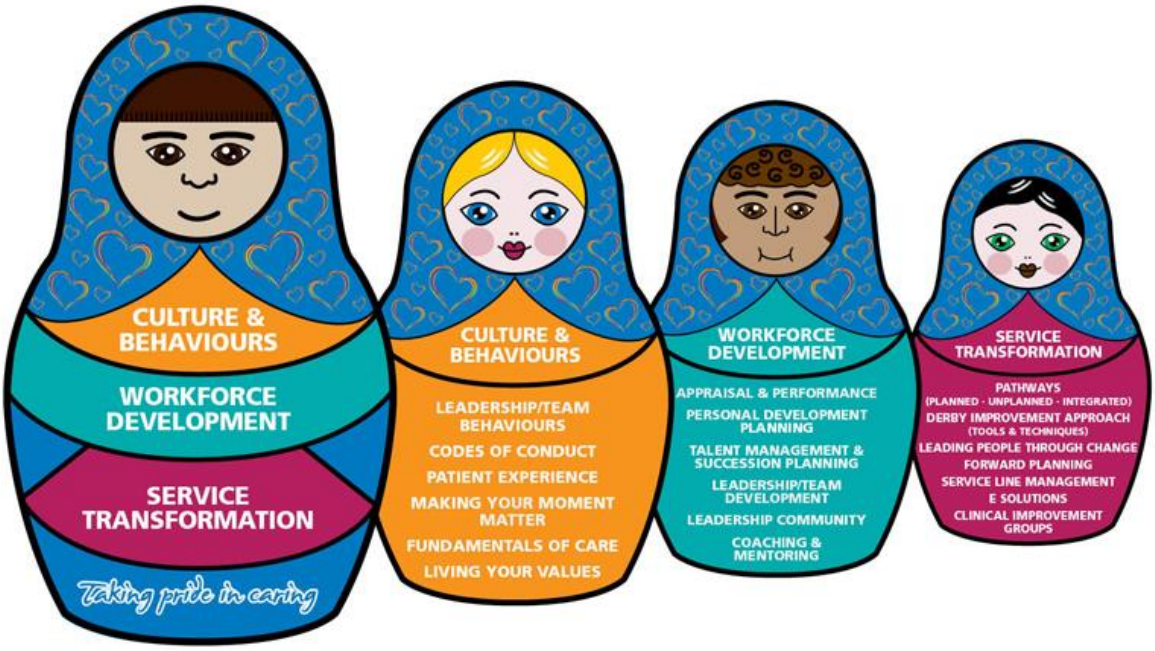
4.3 Workforce Planning and Organisational Development

Identifying the capacity required to meet this growth in demand requires thorough and robust workforce planning. This is not only in terms of increasing physical capacity but also ensuring the staff are appropriately skilled and can support the transformational culture required to improve productivity and efficiency gains in order to deliver high quality care and respond to the short to mid-term challenges facing the local health economy and the wider NHS. As such, we are developing our Organisational Development framework to bring together a range of trust-wide programmes that have been designed to develop our culture and engagement with patients, service users and staff. The framework builds on our already well-established CARE values and PRIDE objectives and supports our vision to become a beacon for all that is best in 21st century healthcare.

This Organisational Development approach will continue to develop our service line management infrastructure, building upon our leadership/team behaviours, and ensure we have in place talent and succession planning processes.

Our aim is to create a positive and supporting culture of continuous learning, where openness and transparency is encouraged to ultimately improve both the experience of patients and staff. We want all staff to feel empowered to put forward ways to deliver better and safer services. In order to do this, we plan to strengthen our existing engagement structures (eg face2face, surveys, team meetings) by exploring ways in which we can involve more staff in the improvement of services, patient feedback, learning from complaints and incidents.

Diagram 7: DHFT Organisational Development Programme Components



As part of the annual workforce planning cycle, we review and develop workforce plans to tease out key strategic concepts for developing and shaping our workforce. From this, we have identified five key themes that require further examination and refinement for our 2014 – 2019 Workforce Plan:

4.3.1 Service Capacity and Delivery.

As noted above, matching capacity to demand is an important theme in the development of our future workforce plans. In particular we must consider what we know about the delivery of our services now and in the future to enable us to identify how we can shape our workforce to meet these challenges.

In particular we are currently considering:

The development of **7-day services** that enable us to respond to the growing demand for our services and the changing needs of our patients. Increasing our service capacity through increased availability of services (i.e. 24/7) will enable us to respond, specifically to the need to improve the levels of productivity and utilisation of our theatres as well as facilitating improvements in the ED pathway. This will be a complex piece of work both in terms of service provision but also staff engagement and some of the challenges with current employment models.

4.3.2 Service Location and Integration of Pathways

Innovation and challenging the 'norm' are common themes emerging from many of our Business Unit level plans. Identifying different models of care, improved pathway planning between services and reviewing the location of services are particular areas of focus.

Many of our plans focussed on where our services are best delivered. In particular the following services have been identified as those that may be better provided from a community location rather than within the Acute Trust setting. Studies do demonstrate that patient outcomes are improved where patients are supported to recover and rehabilitate in more familiar surroundings and this can apply equality to both Transitional Care services as well as community outreach services.

It is important that we understand both the opportunities and the challenges that are inherent in the delivery of integrated models of care. In particular, if integrated care models are to achieve their full potential we must:

- Develop a shared vision, with local care partners and providers, of how integrated care will be established for each care pathway and in terms of workforce planning - **who should be involved** in the development and **delivery of the care pathway** (acute, community and primary healthcare, social care, voluntary services)?
- There will be challenges to breaking down **existing cross-sector boundaries** and we will need to **support and develop all care professionals to work in a more holistic and patient-focussed way** and this may include **developing new roles and new ways of working**;
- From existing experience we know that flexible services are valued most by patients, particularly when they are provided at a time and location convenient for the patient/ service user, their families or carers and **workforce models and roles will be crucial in developing** this **flexibility** and
- **Training staff** in all services about the range of care services they refer patients/ service users to or are referred by will improve understanding and build productive and positive working relationships across the system which in turn will result in improved quality of care and specifically improvements in the **transitions from one service to another**.

4.3.3 Strategic and Operational (Delivery) Partnerships

Two of our strategic imperatives examine working to develop networks and to work in partnership in order to improve pathways for patients. The Trust continues to develop relationships to meet this aim such as diagnostic pathways in pathology (across the East Midlands collaborative) to working in co-operation with Burton Hospital, Chesterfield Hospital, Nottingham University Trust and Derbyshire Community Healthcare Services across a range of acute and complex care schemes.

There is also mention of more strategic partnership concepts including collaboration in the **recruitment of health professionals** which will lead to the development of **rotational posts that move and develop staff between and across organisations** and sharing specialist roles with the aim of improving the quality of care and patient outcomes across the county. In tandem with the Better Care Fund, our strategic intentions are therefore examining the development of a workforce that is able to work across organisational and geographical boundaries. This could (and arguably, should) include working across social care, other public sector care services, private healthcare and the voluntary sector.

4.3.4 Pathway Workforce Planning / Workforce Solutions

Building on the theme above, the Trust will look at how therapy roles can move along pathways, potentially delivering care on parts of the pathway (that we do not currently control) to enhance recovery and thereby the patient experience. Initial emphasis will be placed upon multi-skilled staff and utilisation of generic workers across traditional professional boundaries

4.3.5 Electronic Solutions

Our plans moving forward will look at how we can equip staff to deliver healthcare services for the future. Key to this will be identifying ways that we can use technology to enhance pathways and support different delivery models, enabling us to manage demand for our services (i.e. through e-Pharmacy, e-Prescribing, tele-health and Tetra-radiology).

Further innovation in the development of our workforce systems, in particular the "Skills Passport", to enhance awareness and encourage our staff to take responsibility for their own mandatory training will also enhance and influence the way in which our workforce are led, coached and encouraged to continually improve the quality of care to the Derbyshire Community.

4.4 Developing Learning and Education

Our operational plan over the next two years will look at how we develop further learning and education opportunities that enhance the skill set of our existing workforce; building a future workforce that is able to respond to the changing needs of our patients and our services. Central to this will be:

- Expanding our Advanced Practitioner (nursing and scientific) roles, for example **non-medical prescribing** to release doctor's time.
- As **New Nursing Models** are developed to respond to national and local needs, the training that we provide and commission will need to evolve to ensure our nursing staff are able to continue to provide high quality, compassionate care to our patients.
- There are a number known **shortage occupations** and this causes difficulties in the delivery of services as well as recruitment. Current shortage occupations that directly affect our Trust include: Radiography, Occupational Therapy, Operating Department Practitioners and qualified district nursing roles. Work needs to be undertaken to develop new training models to support new roles which may include development of rotational posts between community and acute services and will inevitably require us to look at developing a more generic worker.
- **Commissioning Education** for most professions in the East Midlands has remained static, with the exception of Adult Nursing (small increase). We will need to continue to influence education commissioning to ensure that places on courses are increased sufficiently to enable us to meet the demand for our services. Most recently, we have recruited from local labour markets (i.e. Nottingham and North Staffordshire) to fill our vacancies because there are insufficient nursing and midwifery graduates in Derbyshire. This in turn impacts upon our local health economy partners.
- Many of our Business Units are reviewing their **band 1 - 4 workforce** with a view to expanding the scope of these roles and develop multiple skill-sets. As a Trust we will look to support this with an appropriate and flexible qualification pathway and in turn this will provide us with a more flexible workforce that is able not only to respond to increases in demand, but also to the changing needs of our patients.
- We have identified the need for **Leadership Development** at a more junior level. The rationale is very much to support **succession planning** and ensure we have staff ready to make the next move into the next levels of management and leadership positions. Our approach to begin to support **developing talent pipeline** will be to work across Derbyshire to develop an aspiring General Manager programme open to staff in the health, social care and Private/Voluntary sectors. In the more immediate future, we have also identified that there are still a number of leaders across the Trust that need to **develop coaching skill sets** and further work is already taking place to build on this.

5.0 Productivity, efficiency and CIPs

One of our four strategic imperatives is to transform services to maximise productivity and efficiency.

Deliver quality in everything we do; safety, effectiveness and patient experience	**Transform services to maximise productivity and efficiency**	Create networks for acute and complex care	Develop integrated care for people with long term conditions to help them stay as healthy as they can

To do this the Trust is examining internal and external areas of efficiency.

Internal plans are based on improving productivity to either release savings or create capacity to improve efficiency. However, as noted in the short term-challenges, the increase in demand that the Trust has seen is unaffordable for the LHE and as such, the Trust is working to develop external transformational plans which examine:

- Working more closely in primary care
- Working with Intermediate care (across organisational boundaries such as local government).
- Working with other Providers/hospitals

5.1 Transformation governance

The Transformation Programme, reporting to the Chief Operating Officer, is firmly embedded in the Trust, with a dedicated Transformation Team in place. This team incorporates the PMO function which is responsible for tracking and reporting on the development and delivery of CIP plans. Progress on the Programme is monitored weekly at a Transformation Programme Review (TPR) meeting, and reported monthly to the Management Executive (ME) team – as well as to the Trust Board. Each transformation scheme has an Executive Director as sponsor and all clinically related schemes have a named clinical lead

Transformation ideas are generated continuously throughout the Trust. These originate from a variety of sources, including staff suggestions through the Trust Intranet, patient feedback, benchmarking opportunities, ongoing progression of prior year schemes and from the Business Units Management teams and individual Clinicians and Nurses.

Risk to delivery of schemes is identified through divisional review meetings with individual scheme owners and at the weekly TPR meeting. They are reported as part of the above mentioned progress report.

Savings over the last two years have totalled £12m in 2011/12 and £23m in 2012/13. Forecast savings for 13/14 are £20.5m against a £23.2m target.

Plans for 2014/15 are in the region of £19m and are being assessed through the Programme Governance process.

5.2 Transformation enablers

Clinical leadership is integral to our divisional management structure. Each division has its own Medical Director and, within Divisions, each Business Unit includes a Clinical and Assistant Clinical Director. These posts play a key role in the agreement and subsequent delivery of the transformation plans for their Business Units and Divisions.

Clinical involvement is key to delivery of transformation schemes and major clinical schemes such as development of the frail elderly pathway and theatre productivity have had an extremely high level of engagement.

The Trust continues to benchmark performance against other similar organisations across a range of metrics and accessing a variety of forums (ie NHS Benchmarking, AUKUH). Specific areas include

Theatre Utilisation, Corporate Services, Clinical Coding, Clinical Variation and Length of Stay which then helps to inform the rolling Transformation Programme.

A new Patient Administration System has been recently implemented. In the coming months the Transformation Team and Business Units will be assessing the impact and identify a range of technology based improvement projects and opportunities. This could include how we support the NHS ambition of being paper-light within the next 5 years.

The Transformation Team supports a rolling programme of rotational secondments. This encourages diverse staff from within the Trust to work with the Transformation Team on improvement projects for a six month period. Individuals gain a range of new skills and experiences on which they can build and become advocates for positive change and improvement on return to their substantive position. The Transformation Team has also developed its own training programme for project management known as the Derby Improvement Approach. This takes staff through a five stage process for successfully implementing and sustaining improvement projects. The team has developed an e-learning package and also run a two-day training course to roll-out this key message

5.3 Internal Transformation Programmes

Summary of Top 5 CIP Schemes - Internal

Depth of Coding Review – £2m PYE, £3m FYE
The objective is to increase depth of coding in order to ensure mortality and outcome statistics are accurately reflected and also to ensure that the appropriate PBR tariff is received.

Theatres Maximisation - £1m PYE
The review includes productivity, workforce, pre-operative process, daycase utilisation and non-pay.

Procurement £1m PYE
Assessment of a range of procurement contracts Trust-wide

Trust wide administrative review - £750k PYE, £1,500k FYE
The output of this review will be a workforce plan for admin staffing which supports service need, has a patient focus, modernises roles, provides a clear career pathway and demonstrates value for money.

Medicines Management- £500k PYE
Review of drugs procurement and prescribing protocols.

5.3.1 Corporate Transformation

5.3.2 Facilities Management

There are a range of schemes focusing on efficient resource utilisation and energy reduction. These include clinical waste disposal, reduction in carbon footprint and electricity costs through voltage optimisation. Soft services schemes include savings against portering, security, linen and catering services.

5.3.3 Synergy Contract

This includes a pricing policy review, reorganisation of theatre instruments and review of instrument usage to enable a more streamlined service to theatres and reduce costs.

5.3.4 Workforce re-design for Admin and Clerical staffing

This workstream concentrates on creating a patient-pathway based approach to focus all resource on improving access and communications with patients. The redesign will create a more standardised approach across all the specialties so the patient's journey will feel seamless between services. An

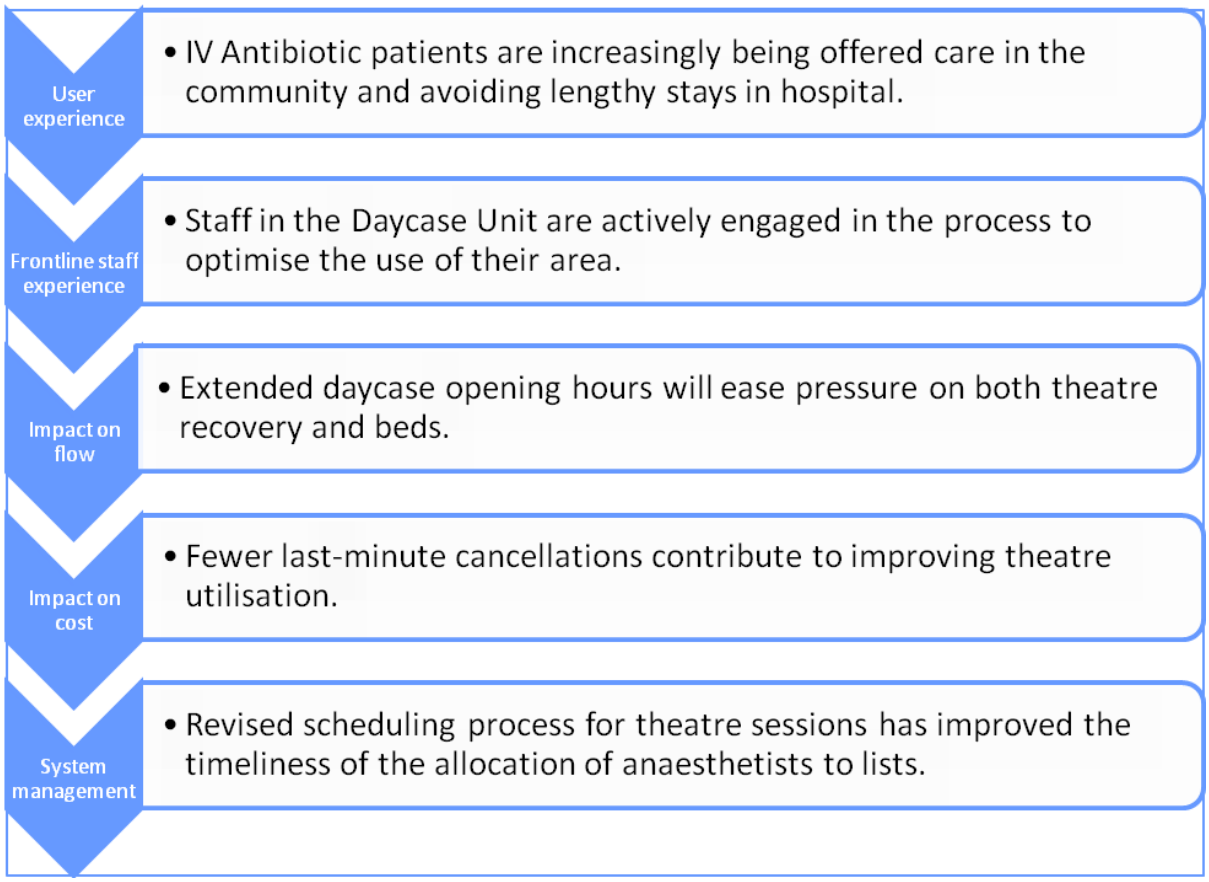
element of role re-design will be required to match this staff group with the needs of the patient and take advantage of new technologies. A Trust-wide approach is being taken in this review.

In addition to its Corporate Transformation Plans, the Trust has developed its transformation programme over three clinical work streams, Planned (elective care), Unplanned (urgent and emergency care) and Integrated (intermediate care) – Many of these schemes are internally and externally transformational (summarised in the table 4 below).

5.4 Internal and External Transformation Programmes

5.4.1 Planned Care Programme

In 2013/14, the Planned Care transformation programme delivered a number of successful improvements including:



The Planned Care transformation programme for 2014/15 remains focused on internal efficiency as well as collaborative schemes with commissioners.

The Trust and the CCG have established a Joint Planned Care Board which has agreed four workstreams as the focus of the transformation work during 2014/15. Much of the necessary transformation will be delivered at specialty-level and to facilitate this there are Clinical Improvement Groups (CIGs) which include hospitals consultants and GPs. Four CIGs are being prioritised initially for specific focus: Orthopaedics, Urology, Ophthalmology and General Surgery, but it is anticipated that all CIGs will consider the opportunities that are available under the four workstream headings. Each workstream will also have a nominated lead with responsibility for monitoring progress across the CIGs. The four workstreams are:

1. Demand Management

This workstream will focus on schemes to appropriately manage demand and the scope will include referrals from all sources. This may include working collaboratively on referral triage schemes for example, or providing alternative options for referrers outside of the acute Trust.

2. Procedure Settings

This work will consider the most appropriate setting for current hospital planned activity to be undertaken. This could involve moving activity into the community, for example, for outpatients or simple procedures. Similarly, this workstream will lead on driving appropriate moves from inpatient to daycase care and into outpatient procedure settings.

3. Clinical Pathways

The CIGs will continue to focus on high volume or time-pressured pathways, such as cancer, to challenge current process and deliver speedier, more efficient care. This will include the role of diagnostic investigations both pre- and post referral. A key part of this will be to assess and reduce both the internal and external variation / duplication in tests ordered.

4. Follow Ups

The Trust has successfully reduced follow up appointments over the last 4 years by around 10,000 each year. The aspiration is to reduce this ratio further and reduce up to 25,000 more follow ups from the hospital setting. This may involve removing non value-adding appointments completely or, through the CIGs, agreeing alternative models of care for patients.

From an internal viewpoint, work continues on the Theatre Project. The project structure and clinical engagement is now well embedded within the organisation and priorities for 2014/15 have been identified for each of the project's sub-groups.

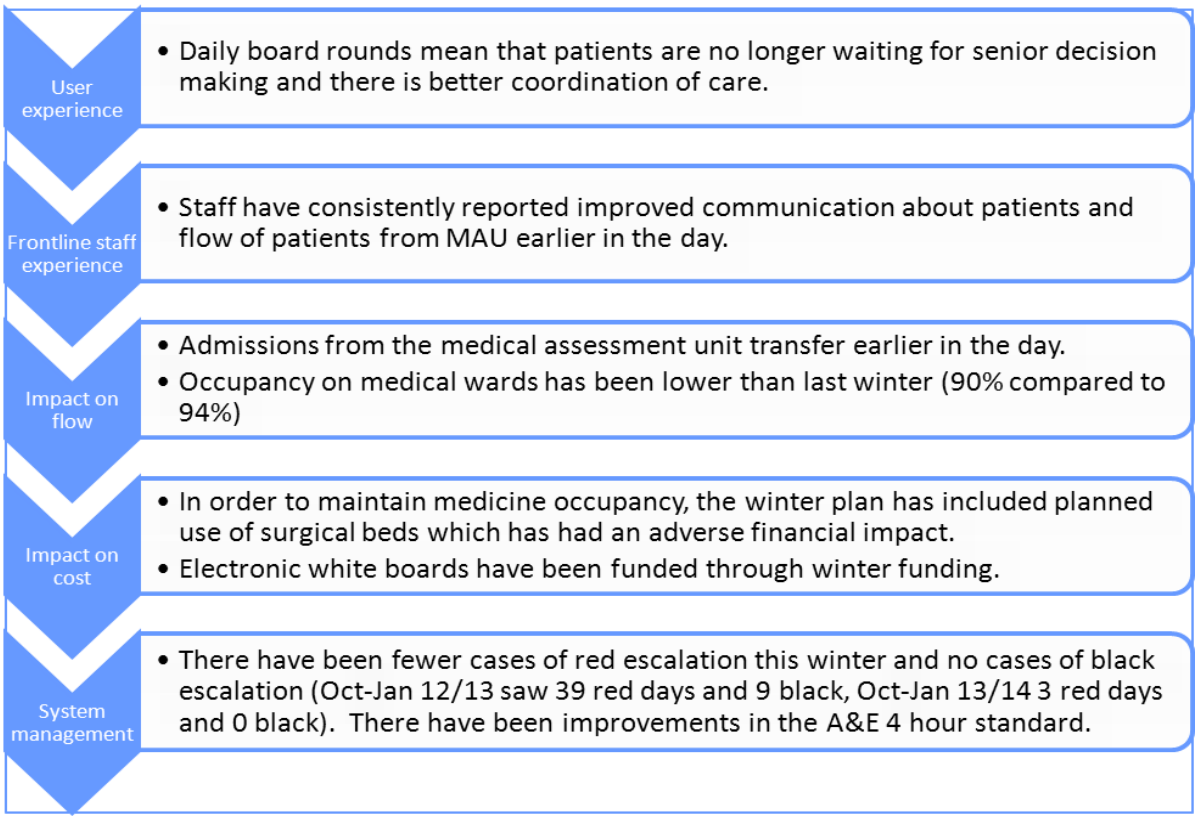
One of the key priorities is clearly to maximise the utilisation of in-week theatre sessions and an essential component of delivering that priority is to maintain surgical flow through the hospital. Many of the projects being driven through the theatre workstream are designed to deliver improved patient flow including the opening of a 23 hour ward, the optimisation of the daycase unit and a focus on issues affecting the theatre recovery areas.

5.4.2 Unplanned Care Transformation

Key Successes for this year:-

- Introduced a new streaming model into Minors in the Emergency Department
- New escalation process for the Medical Assessment Unit
- Introduced daily structured board rounds
- Agreed 10 core internal professional standards.

The difference this made include:-



Transforming urgent care pathways

Four unplanned care work streams have been established each with clinical leadership provided by a consultant lead and a GP lead. The work streams report to a health community wide Urgent Care Executive and will continue to deliver a range of schemes to avoid unnecessary admissions including further development of ambulatory care, a frail elderly assessment team and improved functionality of the Medical Assessment Unit. Work is continuing with the ward based teams to embed daily board rounds and the use of estimated dates of discharge to coordinate planning for discharge.

Key projects for this year include:

Redesign the short stay model for unplanned care patients

The new model aims to ensure that appropriate patients are admitted onto the short stay unit and aims to take direct admissions from ED where patients fit the criteria for the unit. This will reduce the numbers of transfers and ensure discharge processes are efficiently implemented.

Reduce internal waits for discharge medication and diagnostics

A specific task and finish group has been established to review the internal processes for discharge medication. The group includes junior doctors, pharmacists and ward staff and aims to identify and eliminate waste and speed up processes. A project has also been established to identify delays during inpatient stays to support clinical decision making and reduce waiting.

Improve emergency surgery flow

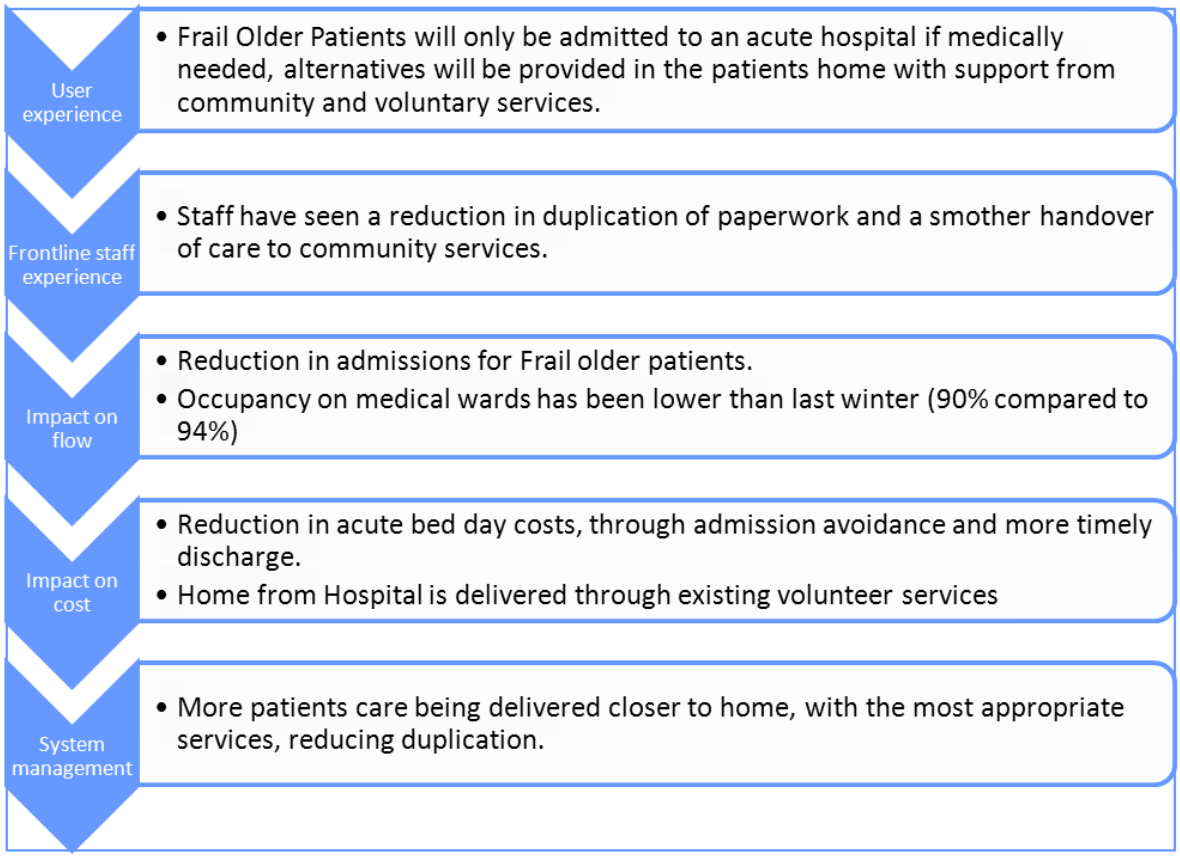
Much of the work to date has been on the unplanned pathways in the medical specialities. The increase in unplanned surgical attendances requires the extension of this work to improve flow through the surgical pathways.

5.4.3 Integrated Care Transformation

Key Success for this year:-

- Implementation Frail Elderly Assessment Pathway
- Single Point of Access service for GP's 8am – 8pm 7 days a week
- Development of Community Support Teams
- Hospital from Home Service

The difference this has made includes:-



Integrated Care Pathway Development

This workstream focuses on developing pathways that span across primary and secondary care, improve patient outcomes and reduce duplication. **Further development of the Community Support Team Model** is planned. This development includes alignment of our current community teams into community support team localities. This will see the development of current acute services aligned with teams including diagnostics, phlebotomy, respiratory, cardiology and DME. To do this, the Trust is investing in a workforce model, integrating teams and roles. Further to this, the Trust is looking to **Develop a Discharge to Assess Model** with the concept that all patients have a period of rehab and no patient goes from an acute bed into long term care. The delivery of these models will be focused initially on 12 of the 23 Community Support Teams.

The aims of the Model are to:-

- The Local Health Community "Need" to Transform services to enable patients to receive the care they need in the most appropriate environment.
- We will do this by using a locality based model wrapped around primary care and identifying the Localities that are high users to focus these changes on.
- This will enable us to deliver a reduction of 100 beds across the Health Community before December 2014.

Integration of Community Services is also a priority with work required to streamline our current community services, re-defining teams and roles and further roll-out of productive community. Early

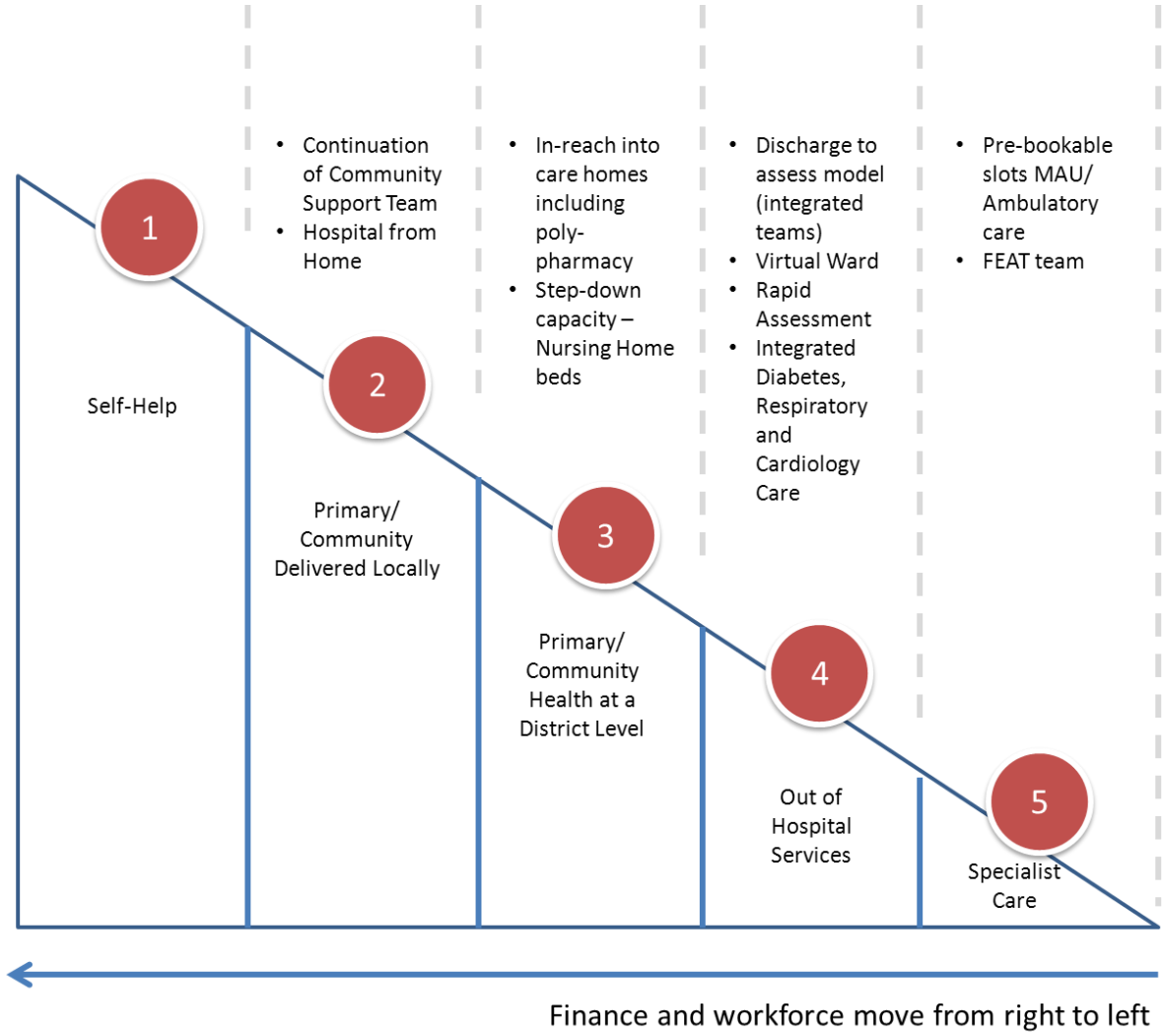
successes with productive community for community matrons have seen a reduction of non-patient facing time by 45 minutes per day per team. This could equate to 69 additional hours per week in district nursing alone. Alongside this is the continued **work on the Frail Elderly Pathway.** The second phase of this project will focus on the sustainability of current model, rotation of nursing and therapy staff between hospital and community service and ensuring onward care into the community delivering a comprehensive geriatric assessment.

5.4 System Wide Transformation

As per the national direction, SDCCG's system objectives (see appendix 1) demonstrate a strategic intention to create strong community asset bases, a reduced reliance on hospital services and the need to promote independence and control of individuals in their own lives.

In order to meet these aims, there will be a need for system wide transformation to shift current programme spend from hospitals (step 5) across steps 1-4 (see diagram 8 below). Outlined below are a number of areas/models which the Trust feels it can explore and enhance pathways in order to realise some of this change.

Diagram 8: Generic Service Model – Levels of Care



In line with this and given the scale of the challenge, the Trust has developed 12 Project Outline Documents (PODS) in conjunction with SDCCG. These aim to further quantify and support the movement of healthcare from hospital settings and in doing so, integrate services to improve the consistency of care and experience for patients (see table 4).

Table 4: External Transformation Programmes

		Associated Impact/Saving		
Joint Schemes		**CCG £k**	**DHFT PYE(14/15) £k**	**DHFT FYE(15/16) £k**
1. Avoidable admissions	Reduction related to reducing re-admissions - linked to overall 100 bed reduction	800	600	1,200
2. LOS - Discharge to Assess	CCG NEL activity reduction proposed at marginal rate - linked to overall 100 bed reduction	1,100	2,300	3,500
3. Assessments Unit Review	Full review of services to be carried out	To be determined following comprehensive review of services		
4. Follow-up reduction	Based on 2:1 ratio, 25,000 follow-ups, DHFT impact at marginal rate	2,000	500	500
5. Hand Surgery Review	Reduction of contract value to £5m with potential to repatriate activity from other providers	1,300	390	390
6. Integrated Children's Services	Full review of service provided	To be determined (estimated at around £2million)		
7. Medicine Mgt Health Community	Integrate and streamline the prescribing of medications across the Health Community.	10,000	1,000	1,000
8. Neuro Rehab Service Review	Assessment of service provided	To be determined (estimated at around 3-4% of CCG neuro rehab spend)		
9. OP procedure settings + Facets	Procedure setting/reduction in Facet injections PLCV	756	TBC	TBC
10. Palliative Care Review	Assessment of service provided	TBC		
11. Clinical Pathways	The review of high volume, high cost pathways within, and between, specialties, identifying opportunities for improvement.	TBC		
12. Referral Management	Reduce elective activity levels by 10,000 through demand management, marginal rate assumption	2,400	730	730
	TOTALS	**18,356**	**5,520**	**7,320**

5.5 Quality Impact Assessment (QIA) of CIPs

We have a robust process in place for assessing the quality impact of all CIP schemes. All schemes are subject to a QIA screening process which assesses the potential impact on clinical effectiveness, patient safety, patient experience and workforce. All schemes receive a risk score and schemes scored as higher risk undergo a full Quality impact assessment.

A full QIA identifies all potential risks of implementing the scheme, identifies mitigating actions and KPIs to monitor the impact of the scheme. The QIAs are signed off by the Medical Director and Nursing Director prior to the scheme proceeding. The KPIs are monitored monthly and actions taken to minimise adverse effects. The process is developing incrementally and the Trust continues to improve the monitoring of quality impacts. If a scheme fails its QIA it will be removed or reworked as necessary to ensure it does not have a negative impact on patient care.

6.0 Financial & Investment Strategy

6.1 Assessment Of The Trust's Current Financial Position

The financial position for the year ended 31 March 2014 for the purposes of the APR submission is a £9m deficit. This is the operational forecast position after 9 months actual results. There are a number of mitigating items that may still reduce this deficit closer to £6.5m. This is consistent with the Monitor initiated PWC review of the Trust position and forecast outturn that was based on 7 months actual data. As the APR template is driven from this forecast outturn position, the Trust will reconcile between the actual year end position and the forecast £9m once actual results are known. The forecast deficit is on a turnover of £466m. The Trust's forecast deficit for the year of £9m compares to the planned surplus of £3.8m. The Trust is therefore £12.8m away from the planned position.

The variance from plan is largely attributable to two key issues:

- Higher than planned levels of activity, especially Non Elective activity. This has led to a Marginal Rate Emergency Tariff rebate of around £11m. This is £7m more than in the base plan for 2013/14.

- This increase in Non-Elective work has also disrupted the delivery of planned activity, leading to additional costs of providing lost capacity.

Despite these difficulties the Trust managed to save over £20m from its Transformation Programme in 2013/14.

At 31 March 2014 the Trust had a cash balance of £4.5m and a working capital facility of £33m in place. Due to the adverse Income and Expenditure position the year end cash position was less than planned but due to stringent cash management the Trust did not need to make use of its working capital facility during the year.

Projecting forward to 2014/15 and beyond, the landscape continues to look challenging. Despite a CIP programme of £14.4m (£18.9m, after dealing with cost reductions associated with dealing with successful implementation of further demand management work). The Trust continues to project a deficit for 2014/15. It should be noted that this income reduction is not currently modelled into the financial plan in 2014/15 as further work is underway with the CCG to assess its impact. The Trust is then currently forecasting a further CIP requirement in 2015/16 of £16m. Despite this, prior to the outcome of mediation/arbitration on MRET and loss making services, the Trust is forecasting deficits of £24m in 2014/15 and £20m in 2015/16.

Cash support of c £32m is required in 2014/15 to finance the revenue deficit (after CIP) and capital programme, before the arbitration/mediation outcome on contractual issues is understood.

6.2 Key Financial Priorities/Investments And Link To Overall Trust Strategy

The Trust Financial Plan for 2014/15 has been summarised as follows;

- Planned deficit of £23.7m, prior to mediation/arbitration.
- Capital spend of £11.6m
- £14.4m CIP planned with £12.4m schemes confirmed and further schemes being developed. It is likely the total value of the CIP will be £18.9m, after dealing with cost reductions associated with dealing with successful implementation of further demand management work
- Continuity of Service Risk Rating (CoSSR) 1 in all quarters
- Cash outflow before external support, of £35.8m planned in year due to deficit and capital programme

- Southern Derbyshire CCG contract;
  - PbR compliant, with realistic agreed activity base plan, prior to RTT backlog and Transformation schemes that effect overall activity.
  - No support in 2014/15 from non-recurrent CCG resources.
  - 70% MRET plans not agreed
  - Funding contribution to non-tariff margin withdrawn
  - The Trust is in continued talks on RTT backlog, MRET, loss making services and demand management and a further full update on all of these issues will be available by 24th April 2014.

6.3 Key Risks To Achieving The Financial Strategy And Mitigations

As in 2013/14, the key risk to delivering the financial strategy is the level and type of activity that actually presents. In addition to this is the ability of the Trust to deliver its Transformation Plan and the level of required savings. The Trust has modelled two down side scenarios on the sensitivity sheets of the financial plan template and has highlighted a number of variables and risks to the financial plan.

- Additional increase in the level of Non-Elective activity over plan. (Additional income at 30% equals £1.2m, additional cost at £5m, worsens the position by £3.8m.)
- Additional premium cost of meeting elective activity due to disruption of non-elective work. (No additional income but £2.2m additional cost, worsens the position by £2.2m.

The total of the above results in £6m further deficit.

Additional further risks to the position are:-

- Divisional failure to manage within financial budget constraints including non-achievement of CIP Plan
- CQUIN Risk
- Other Contract penalties

The Trust has a £2m contingency within the plan.

This downside plan will be presented and discussed at the next Finance and Investment Committee. The various downside risks identified following review of income and expenditure issues, result in a total estimated downside value of £6m.

In dealing with this difficult financial position in both 2013/14 and that forecast in 2014/15, the Trust is working closely with the Southern Derbyshire CCG (SDCCG) on trying to reduce the level of clinical activity the Trust is currently delivering. For unscheduled care workload the current view of the MRET means that activity beyond the 2008/09 threshold is worsening the Trust's position. For scheduled care demand the workload currently being delivered for SDCCG is described as unaffordable. For both of these reasons the Trust is participating fully in the whole health economy planned, unplanned and integrated care Boards which are seeking to change the way care is delivered.

In the nearer term the Trust's approach to financial risk management has three key facets.

i. Mediation/Arbitration on MRET and Loss making Services
ii. The Trust is seeking PDC support.
iii. Assessment of Service Portfolios

These are described in the following sections:-

Section One - Mediation/Arbitration on MRET and Loss Making Services

This section sets out the mediation/arbitration case for the Trust and provides a summary of the MRET issues which the Trust considers to be of sufficient materiality so as to warrant a potential arbitration process.

The mediation/arbitration case for MRET by the Trust is multi-faceted but includes:-

- In 2013/14 commissioners have not administered the 70% balance on MRET for local investment.
- In 2013/14 and 2014/15 these processes are still not at all transparent
- In 2013/14 and 2014/15 insufficient work was and has been conducted with providers on how to maximise benefits for patients.
- Engagement in 2013/14 happened exceptionally late for specialist commissioners, or not at all for minority commissioners; which does not give confidence for the process in 2014/15.
- Final plans for 2013/14 and 2014/15 have not been agreed with the Area Team, and have not had sufficient engagement from providers.
- In some areas the MRET threshold applies to patients which are not avoidable admissions (surgery and other acute areas including cancer) which means the MRET threshold should be rebased or the 70% invested in current acute services.
- Still the commissioners have not answered key questions on the implementation of their policy including:-
    - With no reinvestment either planned by commissioners for MRET or agreed, is MRET value retainable by the provider? The key issues here for Derby are around the approach of the Specialist Commissioner and Minority Commissioners.
    - When MRET moves ahead of plan what should happen?
    - If MRET is due to acuity increases since 2008 or increases in surgery with no community interface service appropriate what should the approach to the calculation be? In both of these instances there may be no alternative to secondary care
- As a consequence of all of the above the Trust has proposed an MRET rebasing to ensure provider/commissioner risks are more appropriately attributed.

Section Two - The Trust Is Seeking PDC Support

During 2014/15, the Trust is seeking PDC Revenue support of £31.8m. This is as a result of the operating I&E deficit of £23.7m and the capital expenditure plan of £8.8m of Non PDC funded expenditure. A total cash requirement of £32.5m in 2014/15

The Trust starts the year with a cash balance of £4.5m of which £2.7m relates to PDC funding received in 2013/14 for capital expenditure projects which will be completed in Q1 2014/15.

The Trust's effective free cash balance in starting the year is actually therefore £1.8m.

Whilst depreciation of the PFI and Non PFI assets charged to I&E in 2014/15 totals £10.5m, repayments for the PFI and FTFN loans account for £7.78m of this in cash. In addition the balance remaining after these loan payments of £2.72m is accounted for by the repayment in cash of £2.35m to the CCG for Work in Progress prepayment and the non-cash impact of the donated assets of £0.95m included in the I&E surplus.

This leaves a negative impact to cash of £0.58m.

			£M
Opening Cash Balance	01/04/2014	A	4.5
PDC 92013/14 funded) Capital expenditure		B	-2.75
Net Cash Balance Available		C	1.75
Depreciation Charges for the year			10.5
Loan repayments			-7.78
CCG Repayment			-2.35
Donated Assets - non cash impact			-0.95
		D	-0.58
Net Cash balance	(C+D)	E	1.17
I&E Deficit			-23.7
Capital Expenditure requirement			-8.82
		F	-32.52
PDC Funding Requirement	(E+F-G)		-31.85
Required Closing Cash Balance		G	0.5

Net Cash available to fund the I&E deficit £23.7m and capital expenditure programme of £8.8m and retain a closing cash balance of £0.5m is £1.17m. This requires resultant PDC support funding of £31.85m

Section Three - Assessment of Service Portfolios

If PDC support is not forthcoming the Trust will need to look at its service portfolio and reduce those areas that are regarded as non-core, but no risk assessment has yet taken place on the impact of this course of action.

The Whole Health Economy approach to redesign and the work with other healthcare providers described elsewhere in the plan will give rise to further financial benefits which are in the process of being further developed and scoped.

Overall Conclusion

Beyond these broader strategic issues the Trust will continue to deliver potential mitigation actions for financial risks that have already been developed and are being implemented. These mitigation plans include;

- Maintenance of Current Management Control regime
- Maintenance of Current Contingency Reserve
- Delaying planned capital investment
- Reduction of Discretionary Expenditure
- Increase in Other Income Streams
- Revenue impact to delays to capital programme

Also, the financial plan, as described and submitted does not include the cash benefits associated with the land sale of the DRI site, despite the fact the contractual conversations with the residential and retail developer continue to progress satisfactorily. This could represent up to a £12m cash upside in year and also lead to a reduction in PDC payment with a further income and expenditure and cash benefit.