Derby Hospitals NHS
NHS Foundation Trust

5 Year Strategy: 2014/15 – 2018/9

Re-inventing what we mean by a hospital

FINAL v5.0 June12 MH

Contents

Executive Summary

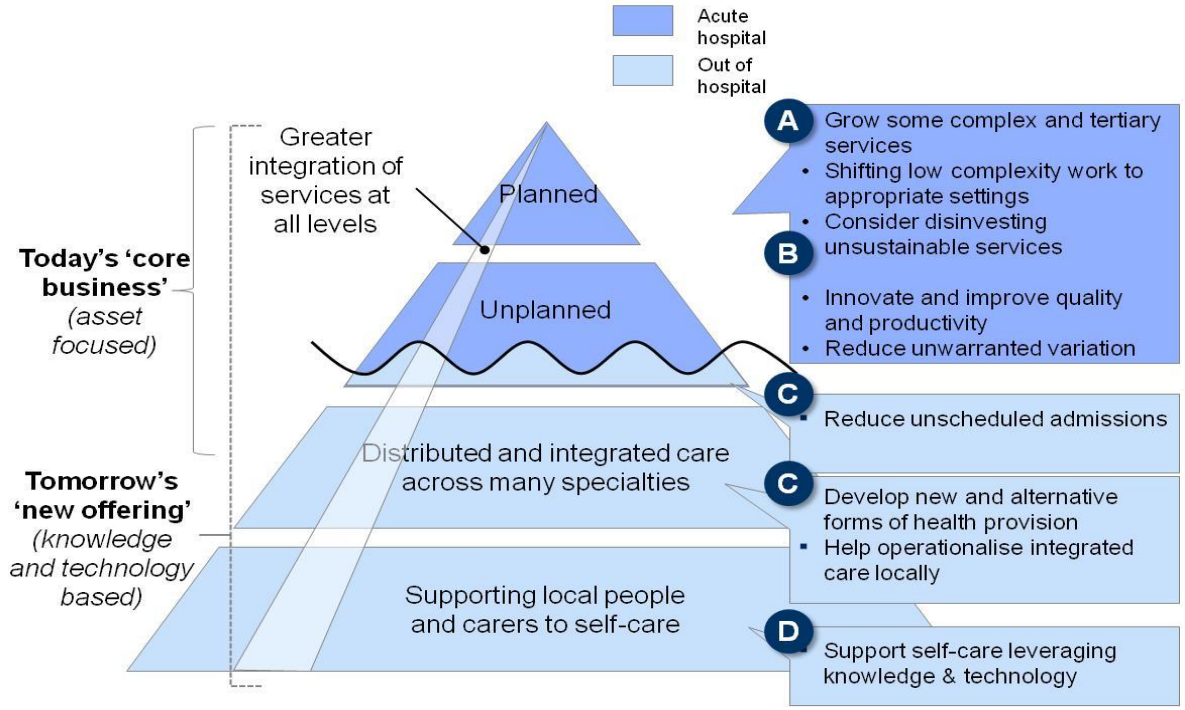
The Trust's 5 Strategy describes the scale of the operational and financial challenge facing the organisation (and the wider health local health economy) and how through significant system wide transformation, we seek to work collaboratively with commissioners and other health and social care providers to deliver a sustainable health and social care system.

The plan includes a detailed market assessment examining projected demand through population projections (based on demographic and activity growth trends) and using our current activity delivery models, compares an assumed level of funding available to deliver this care for the health community.

This shows that in a "do nothing" scenario, the growth as a whole would increase by around 6% for planned care, 5% for maternity services, and around 7% for non-elective services causing a financial challenge of £109m by 2018/19 (£83m to the Trust and £26m to Commissioners). This would consume significantly more resources, equating to 4,200 more outpatient clinics, 13,000 additional A & E attendances and 102 more beds to cope with the anticipated emergency admissions.

The strategy identifies that through existing plans, whilst this £109million gap can be narrowed, a residual funding shortfall would exist which would need to be closed by doing work differently, and organising ourselves differently to deliver care via new and improved models.

The Strategy therefore begins to articulate an approach to changing the way we deliver our core service offering to:



The Trust examines these programmes, attributing potential savings from these whole system redesign themes to bridge the residual health community affordability gap.

The Strategy explains the transformation governance requirements to support this vision including some key milestones, benefits, risks and mitigations, resourcing and enablers for delivering the

strategy such as a shared health and social care information platform and changing approaches to commissioning and provision structure (to create better incentives for system alignment and change).

1.0 Background and context

Derby Hospitals NHS Foundation Trust (DHFT) serves a population of over 600,000 people in and around South Derbyshire, with our specialist services attracting a wider catchment across the East Midlands Region (where the population base increases up to 1 million).

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.

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 coupled with a real increase in elective and emergency care demand. This has led to a decline in the Trust's financial position where the Trust is planning a deficit of c£22.6million in 14/15.

The quality agenda continues to gain momentum through Keogh's reforms (seven day working and emergency centres), the Chief Nursing Officer's Strategy as well as the ongoing national and local NHS response to Francis and Berwick and the resultant initiatives such as safer staffing.

The increasing and inevitable cost to deliver these quality improvements and the increased demand on services cannot be satisfied through the existing financial envelope. The Trust recognises that only through working across the Local Health Economy (LHE) that the changes needed to improve outcomes for patients (through improving standards in care), redesign of pathways and transformation of health and social care structures can be realised.

2.0 Declaration of sustainability

It is within this context that the Trust is now looking to develop and articulate its five year plan for 2014-2019.

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 5 year plan takes account of this wider strategic context and through our strategic imperatives (see below) helps realise the Trust's overall vision.

In considering our sustainability in the coming 5 years – the Trust has examined how it plans to meet future demand and has identified the key steps in meeting this aim:

- **Understanding our Population** - we have examined trends both current and projected which suggest that there will be an increased pressure on our services particularly given the ageing population and the increase in patients with multiple long-term conditions

- **Understanding the External Market** – There are a number of changes (as per the above) that will impact on the structure/marketplace in which we operate e.g. the establishment of Major Emergency Centres. Coupled with this, new market entrants, particularly private sector entrants will increasingly pose a challenge to our financial sustainability and so understanding who the competition are / the services they offer on a regular basis is important. However, our plan also describes how we feel that by working in partnership, we can provide a stronger proposition and solution to the health care needs of the South Derbyshire population.
- **Our Financial viability** - we have examined the impact of the above in a "do nothing scenario" and conclude that not only are resources going to be increasingly stretched, the health economy cannot afford to continue to fund services and so significant system wide transformation is required.
- **System Wide Transformation -** Identifying new and innovative ways of redesigning services and care pathways is critical both for efficiency savings and improving patient outcomes, particularly for the frail elderly population and patients with long-term conditions.

  Our 5 year strategy therefore considers a number of options which together outline a clinical vision for the Trust. Accordingly, we feel that re-designing our service offering so that it meets the needs of the population within a more integrated care pathway/community setting will look to mitigate financial and clinical risk and in doing so, support a sustainable health economy.

However, as implied above (NHS England's six characteristics) a declaration of sustainability cannot be assured if this is provided in isolation of the picture across the wider health economy. Accordingly, NHS providers and commissioners across Derbyshire commissioned an independent review of all two year and 5 year plans. From this assessment it was found that in terms of the direction of travel for future service provision, there is clear alignment between commissioners and providers on the key principles such as integrated care to deliver proactive rather than reactive care as close to the patient as possible, improved productivity and efficiency across pathways and concentration of expertise to drive up quality.

Therfore, identified below are critical schemes which the Trust anticipates will ensure the on going sustainability of the wider health economy. These are aligned to NHS England's six characteristics and as such, demonstrates the Trust's contribution to these aims.

Table 1: DHFTs contribution to sustainable health economy

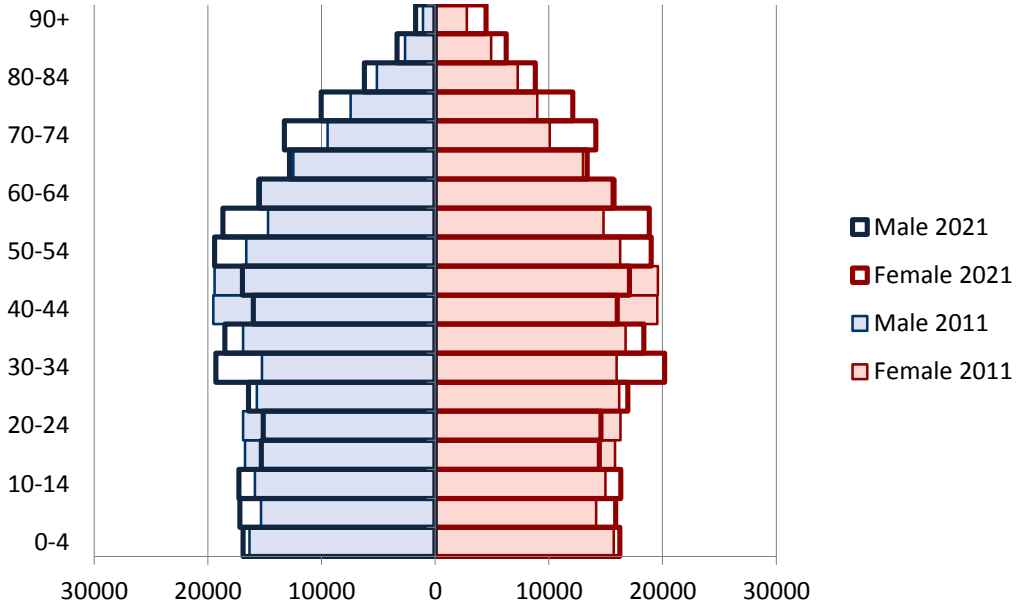
Characteristic	DHFT Plans
A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	• Patient Engagement and Experience Strategy– Utilises experience based design to inform future service provision. • This will be supported by patient forums and listening events in community settings (outside of hospital walls). • Working with local advocate and regulatory authorities to consult and co-design service change (eg. healthwatch and patient association). • Working with the wider membership through Governors • Empowering patients to manage their own care through health co-ordination.
Wider primary care provided at scale	• Managed via CCGs and NHS England
A modern model of integrated care	• Integrated Care Programme – further development of the Community Support Teams, develop a transfer to assess model, integration of community support services • Improvements made and plans around the Frail Elderly Pathway and implement community care co-ordination resulting in reduced admissions and improved ward occupancy levels. • Developing a new real time responsive model for specialities that deal with chronic disease to prevent de-compensation and admission • Improving integrated Therapy services(in acute and community settings). • Local Health Economy Providers working in alliance to support integrated/collaborative approaches
Access to the highest quality urgent and emergency care	• Redesigning short stay model for unplanned care, reduce waits for discharge medication and diagnostics, improve emergency surgery flow. • Plan to re-design and co-produce urgent care model (in line with Keogh) • Plan to become a Major Emergency Centre • Deliver 7 day services (emergency and urgent care) • Collaborate to develop hyper acute stroke pathway.
A step-change in the productivity of elective care	Planned Care Programme – • Referral management through triage and treatment models • Appropriate procedure settings- shift towards more daycase and outpatient procedures • Improve clinical pathways through Clinical Improvement Groups • Improving outpatient efficiency by reducing follow ups • Increasing capacity through the creation of a Elective Procedures Unit/ 23hr Short Stay ward and increased operating hours • Improving access to diagnostics including in the community • Preventing seasonal and unwarranted clinical variation in the access of patients with elective care • Expanding the role of physicians as described in the “future hospitals” paper in supporting the care of the elective patient
Specialised services concentrated in centres of excellence.	• Working as part of a wider network to ensure patients can access high quality specialised services e.g. spinal surgery and paediatric surgery • Grow more complex work in the hospital setting

3.0 Market analysis and context

3.1 Healthcare needs assessment

Currently, the population of Derbyshire CCGs is around 983,000 people. For the South Derbyshire (unit of planning includes Southern Derbyshire CCG and Erewash CCG) this equates to approximately a population of 600,000.

Southern Derbyshire CCG Population change over 10 years



The age profile compared with England as a whole demonstrates a slight over-representation of adults aged 65 and over. Residents aged 65+ account for around 18.3% of the population compared with 16.7% in England as a whole. This older age profile is likely to cause greater pressure on the health system seeing increased activity both in primary and secondary care, driving a large proportion of interactions with GPs, community services, and acute activity.

However, Derby City and Derby County's age demographics are in stark contrast with the county having a higher than national average of older people and the City with a significantly higher proportion of young adults.

Ethnically, English and Sikh residents are slightly overrepresented compared with the East Midlands and England as a whole. The more ethnically diverse areas are more concentrated within Derby city where the 2011 census identified that 13.8% of people in Derby were born abroad and 7.1% had been resident for less than ten years. The 'White British' ethnic group now makes up 75.3% of the total population of Derby City with the 'white other' ethnic group showing the most significant population change between 2001 and 2011, with an increase of 2.20%. This has implications for service design, particularly in community

Key Statistics – Derby City:

- 250,568 residents in 103,000 households
- 18,000 students
- 250 military personnel
- 8,000 single parents
- 357 couples in a same-sex relationship
- 335 British Sign Language Users
- 3,500 people without central heating
- 20% of the population with a long-term illness
- More than 180 nationalities.
- 13.8% of people in Derby were born abroad and 7.1% have been resident for less than ten years

services. Services more tailored to these groups may increase uptake and self-management of conditions such as diabetes and in turn, reducing non-elective admissions.

An in depth market insight report was recently commissioned from Experian to obtain a broader understanding of current and likely future market trends and how these might impact on the services that DHFT offer / may wish to offer in the future. A wide range of analysis was covered including: a full range of local, national, international trends – demography, economic, social and health (both now and in the future). Experian has devised "Mosaic" public sector lifestyle groups which it used in its analysis. From this, it can be found that there are three distinct groups most prominent within the Trust catchment area which, taken together, represent over 40% of the population:

- Mosaic Group B- Residents of small and mid-sized towns with strong local roots (12.7%).
- Mosaic Group J -Owner occupiers in older style housing in ex-industrial areas (14.4%).
- Mosaic Group K -Residents with sufficient incomes in right-to-buy social housing (13.4%).

These are of an older life stage, and are slightly less affluent than average. They are likely to have a more industrial background and have a less healthy lifestyle and diet. It may be within these groups that long-term conditions are beginning to emerge.

3.1.2 Wider determinants of health

Wider determinants of health have a direct relationship with health need (Marmot review). As such, they will have an impact on the services required by the local population. Experian analysed four lifestyle factors, and considered their potential impact on service demand: smoking; obesity; recreational drug use and alcohol. The size of the population within the Trust's catchment area that experience these unhealthy factors is set to increase this year, and again from 2014 to 2018.

Table 2: Estimated increase in unhealthy lifestyle choices

	Alcohol - 5+ alcoholic drinks in the last week	Recreational Drug Use - Ecstasy	Obesity - BMI over 30	Smoker
2011	265,558	218,494	256,185	218,494
2014	276,951	231,839	269,362	231,839
2018	287,955	241,993	280,705	241,993

Mosaic Groups B, J and K make up a significant proportion of the population in the Trust's catchment – for heavy smokers, Group K specifically shows a mean percentage of 12.14% this is compared to the UK average of 5.47%. Targeting areas with a high volume of these groups across the catchments with community services could help reduce the prevalence of COPD and therefore may reduce non-elective admissions.

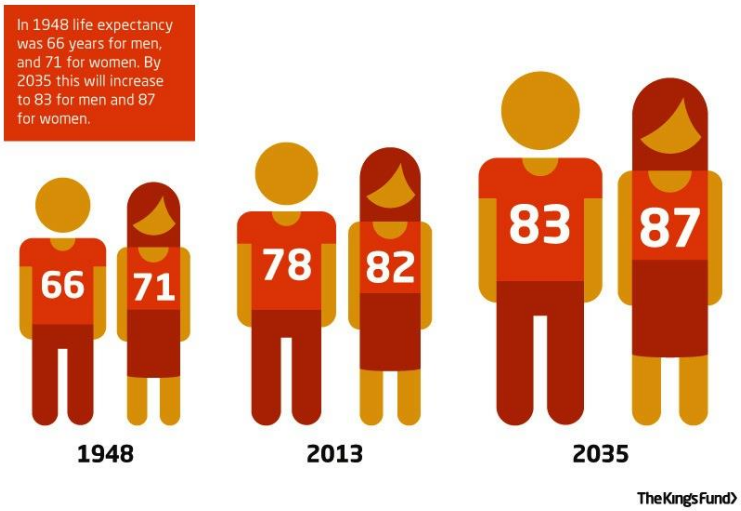
3.1.3 So what will the patient of the future look like?

"In five years' time we will have empowered citizens, able to access helpful information on a range of subjects that promote their independence and enable them to manage their long term condition/ risk to independence. They will be supported in this through a good network of family, friends and engaged community – perhaps with the help of a peer educator too."

Southern Derbyshire CCG, Statement of Intent (2014)

The population in England is living longer and on the whole is healthier than it was 20 years ago. In Southern Derbyshire, it is anticipated that the older age population will increase broadly in line with the national average but the working adult age (early 30s and 50s to early 60s) will increase at a greater rate.

The number of patients living with long term conditions (LTCs) is anticipated to remain static as a whole, however, the proportion of patients who go on to have two or more LTCs is expected to increase. This is evident across England, the East Midlands and the Derbyshire CCGs. Furthermore, the increasing uptake of assisted technologies has resulted in patients expecting a higher standard of care, closer to their homes.



In 5 Years, our patients are likely to be:

- Better informed, with higher expectations and a greater level of scrutiny
- Increased demand from the anticipated increase in elderly and younger ages (in the city).
- Patients with LTCs are likely to have two or more co-morbidities.
- Inequalities between poorer districts and richer districts will affect how patients access services

Our analysis has quantified a number of indicators of unhealthy behaviours and lifestyles. Ensuring that the right types of services are available to cater for these groups e.g. specialist community services for diabetes[1] (with diabetes expected to grow in Derbyshire by 9.9% by 2018), as well as linking in closely with healthy living and awareness campaigns through local authorities and Health and Wellbeing Boards will be key.

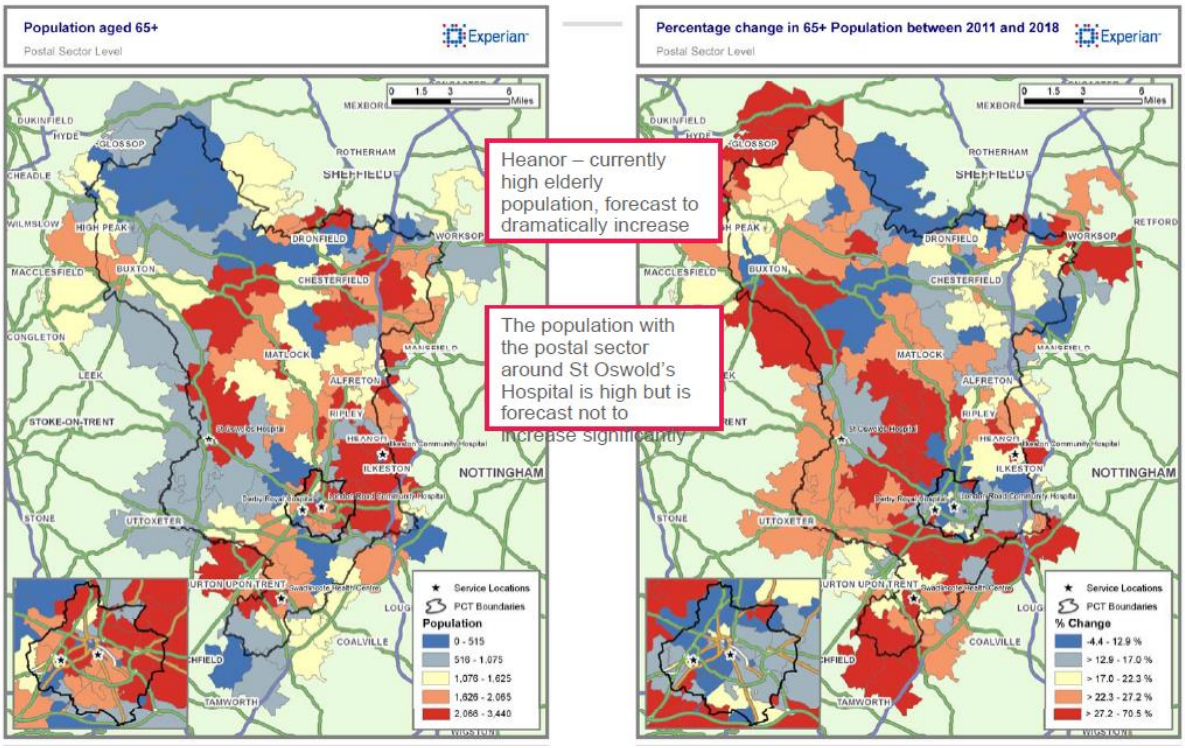
The ability of patients to choose from up to five hospitals for their care will continue to place much greater emphasis on ensuring that patient needs are met and further demand that the services offered are tailored to the local population and in places that are convenient for them to access.

Patients themselves are becoming increasingly demanding of high quality care. Through Big Data and the increasing use of the internet, patients are 'better' educated about their conditions and are scrutinising service delivery more closely. This again challenges the Trust to respond with higher quality service or else lose out to competitors in the health market who can deliver this.

[1] Diabetes episodes are predicted to grow by 9.9% between 2011 and 2018, with the Trust being impacted by an 11% increase in admitted patients and 4% in outpatients.

3.2 Forecasting demographic trends

The Trust's catchment population is forecast to grow 4.4% between now and 2018 (see maps below). Residents aged over 65 currently make up the largest population (18.3%), set to increase to 20.7% by 2018.



Source: Experian market insight report, 2012

However, it is important in planning terms to differentiate between older age groups. There are two key Mosaic public sector groups which are made up of elderly people:

- L-active elderly people living in pleasant retirement locations.
- M-elderly people reliant on state support.

Although these groups are similar in their age profile, they display different characteristics. Group L residents are likely to be more active, in relatively good health and financially comfortable. In contrast, group M residents are typically more deprived and more reliant on NHS services. The proportion of group M is higher in the Trust's catchment than in the East Midlands and England as a whole. This group is also growing faster.

Experian analysed non-elective episodes for six specialties (geriatric medicine, cardiology, general medicine, clinical oncology and orthopaedics). Patterns of demand across the catchment geography are similar for the six specialties. Areas of high demand tend to be located near the larger town centres. Derby city shows a high level of demand. The maps below show the distribution of estimated non-elective episodes for general medicine and geriatric medicine.

3.2.1 Forecasting Demand by Specialty

Within Derbyshire CCGs, not surprisingly General Medicine shows the highest demand of all the specialties, whilst clinical oncology shows the least. When looking at the estimated number of

episodes, patterns of demand across Derby Hospitals NHS Foundation Trust's catchment are similar. Demand on urgent care is set to rise significantly above the overall rate of population growth over the next 5 years. Assuming no changes are made to the way that services are configured, non-elective episodes for the key specialties identified within the Derby CCGs are set to increase (see below). This may be reflective of the population change within the different age groups. For example, Clinical Oncology and Trauma & Orthopaedics have a slightly younger age profile than elderly medicine or respiratory conditions.

Therefore a larger increase in these specialties may be attributable to the significantly ageing population.

Areas of high demand tend to be located near the larger town centres, in particular, Ilkeston, Heanor, Ripley, Alfreton and Chesterfield. Southern Derbyshire CCG shows a high level of demand.

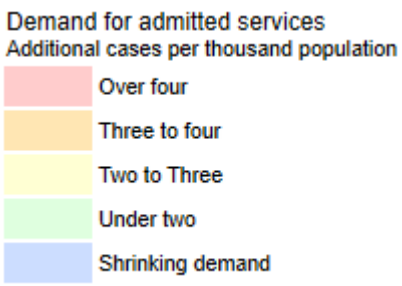
Given the anticipated increase in patients with long term conditions and the ageing population noted above, four key specialties of interest have been identified by Derby Hospitals NHS Foundation Trust for more in depth analysis: Medicine for the Elderly, Cardiology, Respiratory Medicine and Diabetes.

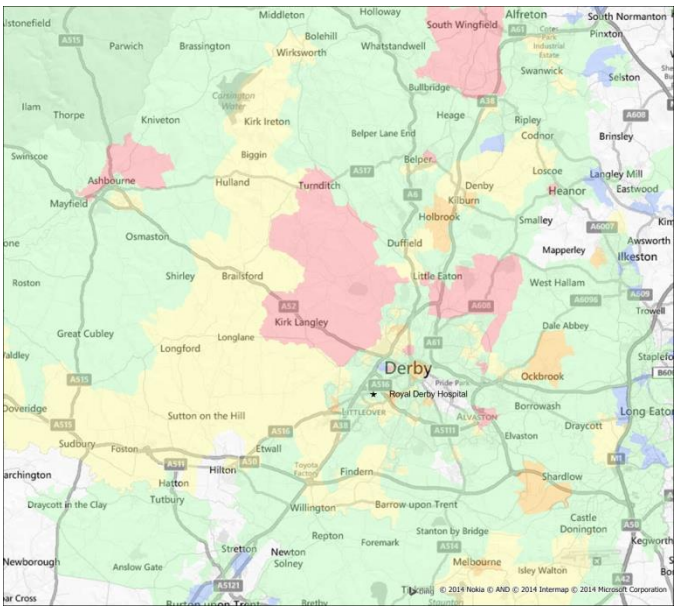
Population models from the Office for National Statistics were obtained by age group at the small statistical areas known as "Lower Super-Output Areas", and projected yearly to 2021. The ratio between current activity rates and population size was then taken for each age group in each area for each specialty, and applied to future population sizes in order to predict future activity levels. Over the whole five-year period, activity due to population growth as a whole increased by around 6% for planned care, 5% for maternity services, and around 7% for non-elective services.

Cardiology

Demand for admitted cardiology services (based on demographic analysis alone) shows an estimated growth of 15% based on population led demand modelling. This equates to approximately 290 additional cases per year by 2018.

Outpatient growth is expected to increase by 6% equating to 650 additional case per year with a total outpatient appointments rising to 11,400 per year by 2018.





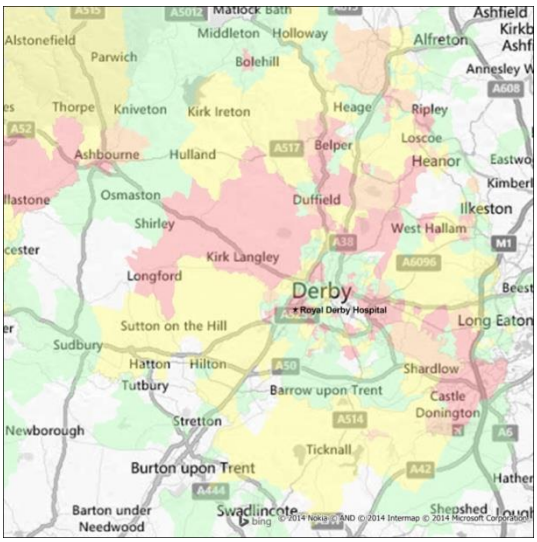
Demand for admitted cardiology services (demographic growth)

Medicine for the Elderly

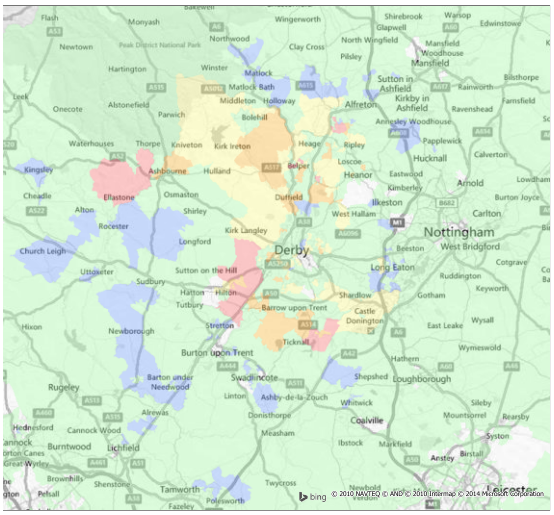
Demand for admitted elderly medicine services is set to increase by 22%. This equates to c170 additional cases per year rising to 950 admissions per annum by 2018.

Outpatient services would see a demographic growth of 11% equating to 230 additional cases per year by 2018.

Demand for admitted elderly medicine (demographic growth)



Demand for outpatient respiratory medicine services (demographic growth)



Respiratory Medicine

Anticipating growth of 16% for admitted services equating to c280 additional cases per year.

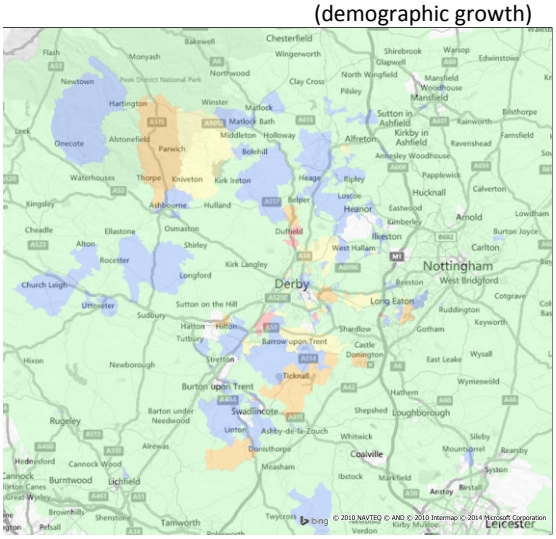
The map on the right shows that outpatient services would see an increase of 6% for respiratory medicine services over 5 years. The additional 600 cases per year would mean a rise to 10,400 outpatient appointments by 2018.

Diabetes

Although growth for admitted services is due to increase by 11% over 5 years, given the relatively low number of inpatient episodes, this would only equate to an additional 15 cases per year.

However, a 4% projected growth for outpatient services equates to 340 additional cases per year totalling 8,200 appointments by 2018.

Demand for outpatient diabetes services (demographic growth)



3.3 Capacity analysis

The demand for hospital-based activity within the local health community has been increasing year-on-year. For example, the Trust is now seeing:

- 12,000 more outpatient attendances than in 2010/11 (despite reducing follow up appointments by approximately 40,000 during the same period).
- Elective / daycase activity has increased by 1,700 cases in four years.
- A&E attendances have increased by 5,500 per year since 2010/11.
- Emergency attendances have increased by 2,000 since 2010/11 (although more of these are now triaged and rapidly discharged).

The Trust has responded to this rise in demand by increasing capacity levels, alongside delivering efficiency improvements such as reduced length of stay, lower follow up ratios and some procedures being transferred into an outpatient setting.

In the most recent 12 months (2013/14), some of the planned care increases in demand have been particularly high. Referrals for new outpatient appointments have increased by 9%. As a result, additions to the waiting list for a procedure have increased by over 800 compared to 2012/13.

This has placed significant pressure on the Trust's ability to deliver performance targets such as the 18 week referral to treatment and Cancer access targets. The number of patients waiting for inpatient / daycase treatment increased from 6,700 to 7,700 during 2013/14 with over 1,000 patients waiting longer than 18 weeks at the end of March 2014. The Trust recognises the need to deliver these performance targets however, in some cases the additional capacity comes at significant additional cost in the form of waiting list initiatives or outsourcing activity to alternative providers.

Additionally, the extra capacity allocated to Medicine specialties during winter in order to support the four-hour A&E target has further impacted on the Trust's ability to deliver some of the performance targets.

Without further significant transformation schemes, this recent pattern of increasing demand for activity is likely to continue. Data modelling of activity trends show increases in activity for all patient types based on both demographic change and local historic referral patterns.

However, the population growth demonstrated above, does not in itself sufficiently explain the historical bulge in demand seen over the past few years, the impact of which is likely to continue in the present year and into the future. In order to account for this, activity growth trends were compared to the yearly population increases, which allowed us to taper down from the current year-upon-year growth rates (at c. 3% per annum), down to the base population growth (c. 1.6%) by year five. Over the five year period, net tariff activity as a whole is predicted to increase from c.930,000 to c.1,020,000. Non-tariff costs were scaled into the model accordingly.

The published model is based upon the assumption that the rapid growth we have experienced over the past 18 months is a short-term spike in activity which will eventually taper off. However, should demand continue to increase at the rates we have experienced recently, we could see as much as 120,000 additional spells by year five, on top of those predicted by the model. This could generate additional costs of up to £53million. The table below shows how the likely changes would affect capacity:

Table 3: 5 year expected activity increase based on demographic changes

Patient Type	2014/15	2018/19	Variance	Impact	Estimated Cost (per annum)
A&E attendances	128,170	140,922	12,752	Additional staff	£1.9m
Outpatient Attendances	484,020	534,898	50,878	Additional clinics / staff	4,200 clinics £6.5m
Elective Admissions	19,473	21,990	2,517	Additional theatre lists / beds	28 beds £1.3m
Daycase Admissions	56,804	63,178	6,374	Additional theatre lists	24 additional daycases spaces
Emergency Admissions	65,151	73,527	8,376	Additional beds	102 beds £4.8m

In addition to the impacts highlighted in the table, increases in activity would also have an effect on support services including diagnostics, pharmacy, health records, portering, as well as the additional pressure placed on car parking.

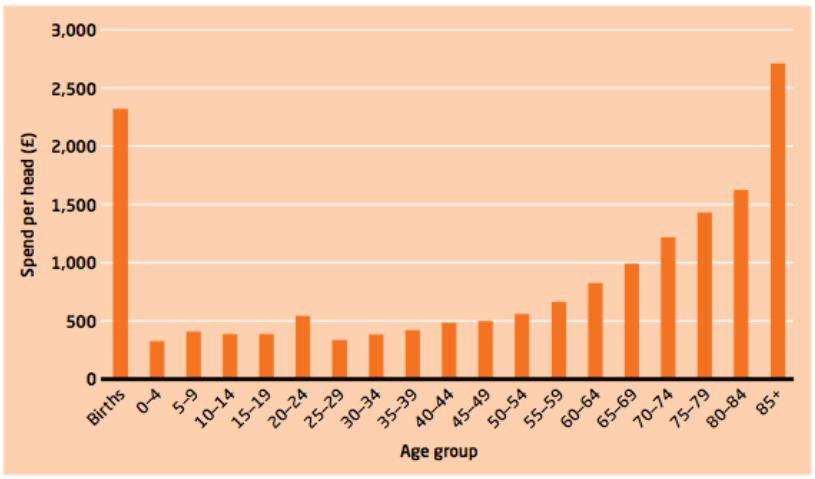
This additional activity, whilst incurring a significant cost to deliver, is also being paid for by Commissioners at a reduced level due to the 4% efficiency factor levied on tariff prices each year.

3.4 A Funding analysis /Alignment across the Local Health Economy

The Trust completed the financial year 2013/14 with a deficit position of c£9million and is forecasting a deficit in 2014/15 of £22.6 million.

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.

Figure 7 NHS expenditure per head in England, by age group, 2012



Source: Department of Health (2011)

However, the local picture shows that the cost of meeting the aforementioned increase in demand is anticipated to be greater than the planned income to be received. Whilst it is positive that people are living longer, the ageing population presents a number of challenges to the affordability of the local health a social care system with nearly two thirds of people admitted being over 65 years old, and once admitted, typically stay

longer and are more likely to be re-admitted. Additionally, patients with a long term condition (in general terms) make up a quarter of the population, but consume a disproportionate amount of NHS resources (estimated at 50% of all GP appointments, 70% of all hospital bed days and around 70% of total healthcare spend). This is likely to create further cost pressures to the local health economy as our residents become more complex and require more comprehensive management of their total health.

Further financial challenges will be placed on the Trust as health services respond to the increasing quality agenda. Keogh's reforms to create sustainable services (embodied in two key initiatives; seven day services and urgent care/emergency centre redesign) will require significant investment in capital and revenue infrastructure. However it remains unclear (and as such un-modelled) the impact on the Trust given wider changes required in the market place (for example, neighbouring Trust's ambitions on providing urgent/emergency care services).

One of the most significant financial impacts affecting the Trust will be the implementation of the Better Care Fund (BCF). 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 should lead to a focus on delivering packages of integrated care for the population we serve).

To facilitate an independent view of the alignment of Derbyshire's planning, the CCGs and providers in Derbsyhire commissioned an external consultancy firm (GE Finnamore) to undertake this. Examining the financial and activity plans, the following conclusions can be drawn:

3.4.1 Tariff Assumptions

Net tariff deflation/inflation %	Erewash CCG					South Derbyshire CCG				
	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	-1.4%	-1.1%	0.4%	-0.6%	-0.6%	-1.5%	-1.6%	0.4%	-0.6%	-0.7%
Mental Health	-1.7%	-1.4%	0.1%	-0.9%	-0.9%	-1.5%	-1.6%	0.4%	-0.6%	-0.7%
Community Care	-1.7%	-1.4%	0.1%	-0.9%	-0.9%	-1.5%	-1.6%	0.4%	-0.6%	-0.7%
Continuing Care	0.0%	0.0%	0.0%	0.0%	0.0%	-1.5%	-1.6%	0.0%	-0.6%	-0.7%
Primary Care	0.2%	0.3%	0.0%	0.0%	0.0%	-2.4%	-1.6%	0.0%	-0.6%	-0.7%

Years 1 and 2 (2014/15 and 2015/16)

- In 2015/16 Erewash CCG are planning on a 4% provider efficiency saving across Acute, Mental Health and Community, which is lower than the other CCGs in Derbyshire, and is also planning on lower provider efficiencies in Mental Health and Community Care. Giving a lower net tariff deflator.
- Southern Derbyshire has just focused on provider efficiency and therefore a net tariff deflator
- Southern Derbyshire CCG is the only CCG to make assumptions against provider efficiencies for Continuing Care and Primary Care.

Years 3, 4 and 5 (2015/16 to 2018/19)

- Erewash CCG has assumed the highest tariff deflator in 2016/17 and 2017/18 for mental health and community care across all Derbyshire CCGs.
- South Derbyshire CCG's net tariff deflator is broadly in line with the CCGs in the north, with the exception of having a tariff deflator against continuing care and primary care.

3.4.2 Financial Activity and QIPP Assumptions

Activity Growth - total (Demo, Non Demo and Other)	Erewash CCG					South Derbyshire CCG				
	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	3.9%	2.0%	2.0%	2.0%	2.0%	2.8%	2.8%	2.5%	2.8%	2.8%
Community Care	-6.5%	2.0%	2.0%	2.0%	2.0%	2.0%	2.1%	2.0%	2.0%	2.0%

QIPP Saving (activity reduction for provider)%	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	-1.8%	-1.1%	0.0%	0.0%	0.0%	-3.8%	-3.8%	-4.6%	-3.8%	-3.2%
Community Care	0.0%	0.0%	0.0%	0.0%	0.0%	-2.8%	-2.1%	-1.7%	-1.8%	-1.8%
Recurrent Investment	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.7%	3.9%	4.1%	3.6%
Community Care	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	47.4%	3.3%	3.0%	3.2%

Net Activity growth, QIPP saving and recurrent investment	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	2.1%	0.9%	2.0%	2.0%	2.0%	-0.9%	-0.4%	1.7%	3.2%	3.2%
Mental Health	-4.9%	2.0%	2.0%	2.0%	2.0%	2.0%	0.3%	3.1%	2.8%	2.7%
Community Care	-6.5%	2.0%	2.0%	2.0%	2.0%	0.7%	47.3%	3.7%	3.2%	3.5%
Continuing Care	7.8%	2.0%	2.0%	2.0%	2.0%	4.6%	-0.1%	-0.1%	0.0%	-0.1%
Primary Care	0.7%	0.4%	3.7%	3.7%	4.0%	2.6%	2.6%	2.9%	2.6%	2.6%

Years 1 and 2 (2014/15 and 2015/16)

- It can be seen above how the CCGs across the South "Unit of Planning" are planning on different recurrent growth assumptions (activity, QIPP and recurrent investment).
- South Derbyshire CCG is planning an overall reduction in acute recurrent growth across 2015/16 (-0.4%), whereas Erewash CCG is planning an increase (0.9%).
- South Derbyshire CCG is planning a large overall increase in Community Care (47%) in 2015/16. This level of overall investment is not see in Erewash CCG's plans in this area.
- Within the activity plan submissions Erewash CCG is forecasting a substantial reduction in non-elective admissions (c.14%). South Derbyshire CCG is forecasting a smaller reduction at c.8%. These reductions are considerably larger than those planned in the North Derbyshire Unit of Planning.
- Across Elective Admissions and Day cases Erewash CCG is forecasting small increases. Whereas South Derbyshire is forecasting reductions over 6% (see section 5 below)

- Across Outpatients Erewash is forecasting activity to remain broadly flat. South Derbyshire is forecasting substantial reductions, especially in follow-up (almost 15%). (see section 5 below)

Years 3, 4 and 5 (2015/16 to 2018/19)

- The CCGs are planning on different recurrent growth assumptions (activity, QIPP and recurrent investment) over years 3, 4 and 5.
- Across Acute, Mental Health and Community Care South Derbyshire is planning on larger overall growth than Erewash CCG. However it is planning on a lower level of growth than Erewash across Continuing Care and Primary Care.

3.4.3 Spend and Income Assumptions

	Erewash CCG					South Derbyshire CCG				
Spend %	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	-1.2%	-2.8%	2.4%	1.4%	1.4%	1.1%	-6.6%	2.1%	2.6%	2.5%
Community Care	-3.8%	-3.0%	2.1%	1.1%	1.1%	1.3%	42.7%	4.1%	2.6%	2.8%
Spend £k	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Acute	64,457	62,673	64,177	65,075	65,986	336,793	314,524	321,230	329,500	337,830
Community Care	9,777	9,194	9,387	9,491	9,595	71,259	101,683	105,846	108,617	111,607

LA Spend %	14/15	15/16	16/17	17/18	18/19
Derbyshire County Council	-2.6%	-3.0%	-5.9%	-1.8%	
Derby City Council	-2.3%	-5.0%	-4.4%		

LA Spend £k	14/15	15/16	16/17	17/18	18/19
Derbyshire County Council	522,253	506,652	476,557	468,198	
Derby City Council	217,929	207,038	197,888		

Years 1 and 2 (2014/15 and 2015/16)

- It can be seen from the above that the planned changes in spend by care setting between Erewash CCG and South Derbyshire CCG are quite different.
- The most significant difference is seen in the Community Care area in 2015/16 when South Derbyshire is planning a much greater increase in spend.
- Over this period Derbyshire County Council is assuming a 5.5% reduction in its budget. This doesn't include additional cost pressures. Derby City Council is assuming a 7.1% reduction in its budget.

2014/15 to 2018/19

- By 2018/19 both CCGs are planning on a small increase in spend in the acute sector (the area of Primary Care also sees similar increases in spend across the 5 years across the two CCGs)
- By 2018/19 Derbyshire County Council is forecasting a reduction in its budget of over 12%.

3.4.4 Implications and future joint work

This review clearly demonstrates the CCGs assumptions as part of the financial "read across" at the time of their 5 year plan submissions. However, given the additional modelling conducted by the Trust (which shows activity due to population growth as a whole increasing by around 6% for planned care, 5% for maternity services, and around 7% for non-elective services), this will require further alignment to ensure the necessary matching of our plans in future years.

3.5 The Unmitigated Position/ Doing Nothing Differently

" Doing nothing" in the face of growing demand for non-elective admissions will place heightened financial pressures on the trust...."

Our demographic analysis above demonstrates that the spatial pattern of non-elective admissions and demand for planned care services (although varying across the catchment) is due to grow.

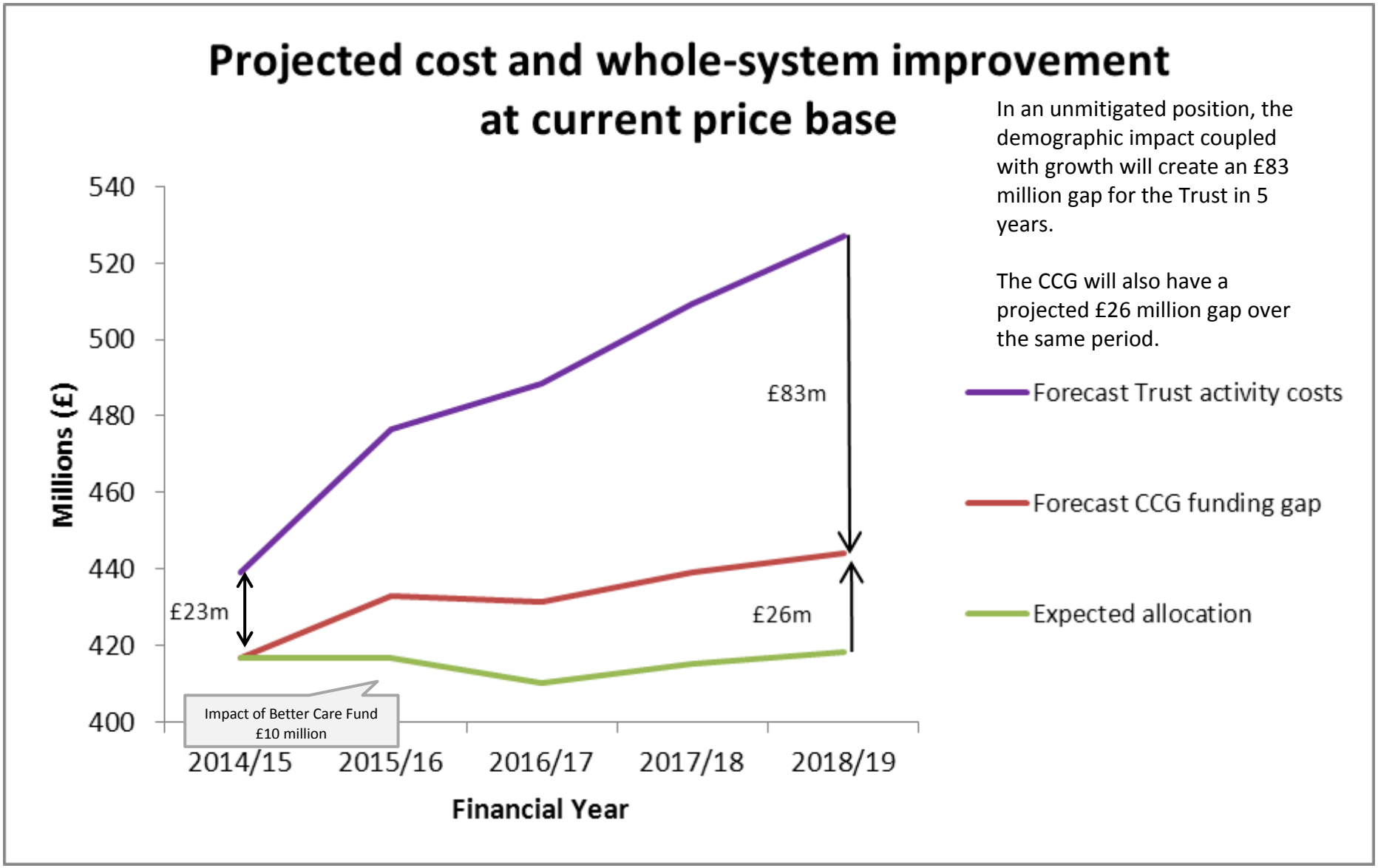
The capacity to meet this demand places increasing pressure on Trust services and cannot be met within the existing infrastructure or regulatory/contractual requirements (e.g. quality targets, RTT).

The financial position for acute services is anticipated to remain flat, with the net tariff deflation requiring the Trust needing to deliver more activity for less income. In contrast to this, the level of investment into community settings (on the whole) is due to increase, however, this is likely to be funded from acute contracts.

The diagram below therefore illustrates the unmitigated position of the Trust over the life of the 5 year plan should all partners (in the delivery of health and social care across the LHE) continue with the status quo.

This highlights the projected growth in demand (reflected in activity terms) increasing over the coming 5 years with planned income due to decrease (with a stepped decrease in 15/16 due to the Better Care Fund) resulting in a financial gap of circa £83 million for the Trust and £26 million for the CCG (£109 million in total). Although transformation plans are in place to mitigate the forecast decrease through internal productivity/CIP, it is anticipated that this will not bridge the gap fully.

Similarly, existing demand mitigation plans such as admission avoidance schemes and primary care triage and treatment will not arrest demand to the level which negates the impact of the forecast growth. It is also reasonable to assume that the impact of Integrated Care plans will not cause a shift for all services to transfer into community settings; with a need for services which require clinical infrastructure (such as cancers) anticipated to increase and also remain at the hospital site.


Projected cost and whole-system improvement at current price base
In an unmitigated position, the demographic impact coupled with growth will create an £83 million gap for the Trust in 5 years.
The CCG will also have a projected £26 million gap over the same period.
Millions (£)
540
520
500
480
460
440
420
400
£83m
£23m
£26m
Impact of Better Care Fund £10 million
2014/15
2015/16
2016/17
2017/18
2018/19
Financial Year
Forecast Trust activity costs
Forecast CCG funding gap
Expected allocation

3.6 Market Forecasting

This section of our strategy examines future market trends, developments that are likely to occur in the long and short term (including an assessment of "disruptive" forces such as policy change and possible service reconfigurations). From this, our plan will contextualise our ambitions in relation to future market positioning and consequently, potential business opportunities.

3.6.1 Market Drivers

South Derbyshire's health funding is commissioned predominantly by Southern Derbyshire and Erewash CCGs with social care procured by Derby City and Derby County Councils. However, the Trust's catchment area is greater than this immediate (although large) region given the nature and extent of its services.

As such, both national and regional changes can have a significant impact upon the Trust affecting its mid- to long term operation.

Keogh's **emergency care reform** focusses on the makeup 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.

Given its supporting infrastructure, the Trust anticipates that it becomes a major emergency centre with some peripheral smaller hospitals being classed as emergency centres. This will have an impact on patient flows and a resulting increase in the demand on the Trust's supporting services. Whilst Keogh's plans describe a repatriation to back to "referring" hospitals, this will need to be carefully planned across the health economy in order to ensure capacity is carefully matched and is therefore sustainable in order to allow such flows to occur efficiently.

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 is recommended are adopted across the NHS by the end of the 2016/17 financial year.

From the pilot sites, it was evident that whilst NHS services were investing in operational delivery at weekends, supporting systems in social care (for example social care services) were not equally established to meet the increase on demand on their services. Accordingly, to create sustainable seven day services, it is clear that providers and commissioners will need to work together to explore new ways of working resulting in a very different provision picture/market place than is seen today.

A further service **reconfiguration** planned for the future relates to the review of the provision of **specialist services**. Similar to the emergency care, there is a growing appetite to concentrate the provision of specialist care into "centres of excellence" to improve patient safety and clinical outcomes. Early thinking by NHS England set out in the Planning Guidance, Everyone Counts: Planning for Patients 2014/5 to 2018/9 suggests a reduction from the current landscape of provision by around 200 providers (with different levels of scale of specialist provision) to 15 to 30 specialised centres which could possibly be supported by networks of other providers.

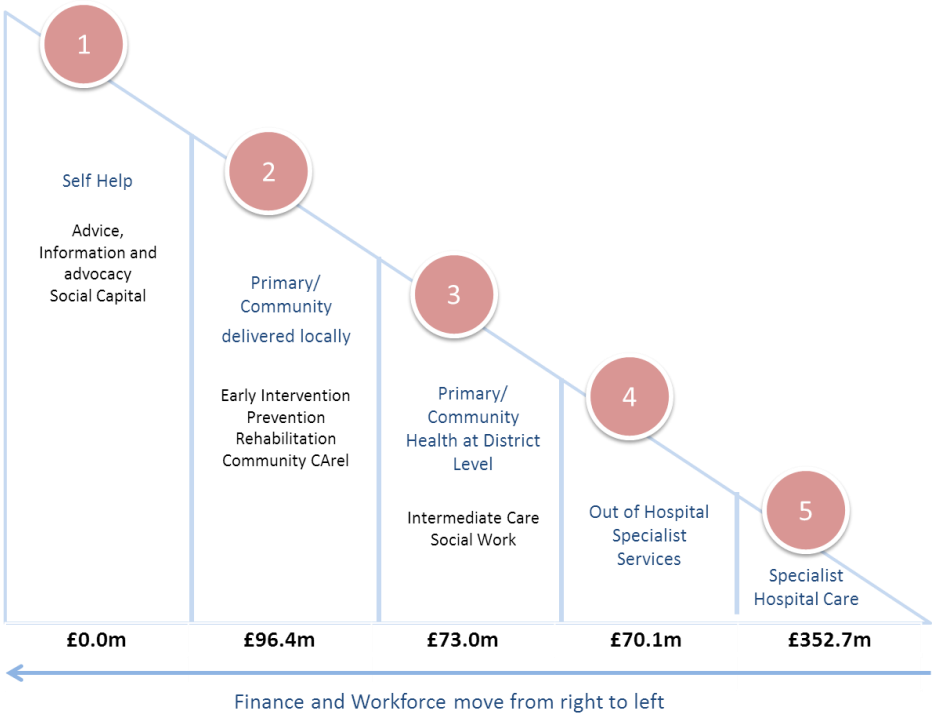
However, much like a house of cards, small and medium sized providers may be destabilised if they lose one, some or all specialist services, with the possibility that this could also impact upon their ability to provide other, non-specialised, services to their communities (for example, a HIV service (specialised) may also support sexual health services (commissioned by public health). At present it is unclear what impact any proposed changes will have on the health economy but material changes are possible which could compromise the clinical and financial sustainability of some hospitals.

The Better Care Fund in Southern Derbyshire equates to £32 million, (£10 million of which will impact upon acute services) - to be committed by 2015/16. CCG and local authority plans have broadly reserved one third of this allocation to protect existing social care services, a further third to protect existing health services with a further third being held to invest in new schemes. Although this will inevitably lead to a focus on delivering packages of integrated care for the population we serve, discussions to date are centred on pathways with detailed plans on how this will affect existing (or new entrants to the market place) still in their infancy.

However, what is clear is the health community wide backing for the shift of care from specialist services to self-care (where appropriate). The vision, known as **the "Wedge"** across the South unit of Planning, originally focussed on meeting the needs of the frail and elderly population and is now intended to cover all aspects of care, including health and social care, physical and mental health, adult and children's services, and planned and unplanned care.

*"The acute hospital [DHFT] will be free to focus on its **core purpose** and, as a result of the effectiveness of admission avoidance and supported discharge, will no longer need to expand its capacity to meet demand and may, in fact, be more compact than at present. Community staff will reach in to hospital to provide continuity of care and facilitate discharge; and acute clinicians will provide expert advice and support to community teams and primary care. There will be regular circulation of staff between acute and community settings."*

Southern Derbyshire CCG, Statement of Intent (2014)



Local commissioners have communicated their desire to engineer a step change in the following:

1. Increase the number of people who avoid formal care and support because they have their needs met through natural community support
2. Decrease the number of people with a long term condition(s) living without an informal network of support
3. Increase the role of peer support and educators to help people manage their condition and recover
4. Significantly reduce the number of unplanned admissions to hospital and care homes through effective admission avoidance interventions
5. Increase recovery outcomes across all client groups through increased and improved recovery services
6. Significantly reduce the number of people going into long term care from a hospital bed
7. Reduce delayed discharges through increased community-based services and effective care pathways
8. Timely and effective support to carers

What is clear from the above local intentions is the significant changes in *delivering integrated care*, the recognition that some services *must continue to be provided in a specialist hospital setting* and the impact that this will have on associated patient flows, patient experience and the impact of cost and efficiency.

To illicit the system wide change envisaged, local commissioners have also expressed their desire to promote collaborative rather than competitive working. Before we examine what this might mean – it is useful to consider the current competitive market and where areas of collaboration may exist.

3.6.2 Confidential

3.6.3 Working in Partnership

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.

It should therefore be noted that the analysis above demonstrates threats to competition, however, some of the services described should also be recognised as complementing the Trusts overall aims. For example, 111, Walk in Centre and minor injury services provide real alternatives and can arrest demand for otherwise emergency department access. Similarly, access to diagnostic and planned care pathways can complement existing Trust services without compromising market share when these are delivered in partnership (and in doing so ease the burden on Trust capacity)

Key themes in the Trust strategy are to develop sustainable acute healthcare working with Burton, Nottingham, Chesterfield and Derbyshire Community Health Services through:

- Expanding catchment and repatriating complex services
- Rationalising acute services across local networks
- Developing innovative models for out of hospital and Integrated care

The Trust has developed joint workplans with Nottingham and DCHS to further these aims which look to optimise areas such as joint training and joint staff (medical and nursing) appointments. Coupled with this, we are examining pathways, and delivering these in partnership to further manage demand whilst creating capacity for a more resilient multi-disciplinary team (and improve access for patients to local services).

Our collaborative recruitment plans for health professionals could 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 (see section 4).

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.

It should additionally be recognised noted that the Trust is also working in partnership with non acute providers and in particular – primary care. In 2013, Alexin was established. This is a GP Provider arm organisation which has shareholders from over 95% of the GP practices in Southern Derbyshire CCG. A joint workplan is being developed to explore how the trust can work in developing demand management models in order to triage and treat patients in primary care.

In addition to this, the Trust is also establishing a joint venture vehicle with Alexin to be called 'Alexin Derby Hospitals Integrated Services Ltd' to pursue integrated service opportunities. The integrated diabetes tender will be the first opportunity that will be answered under this partnership.

3.7 SWOT analysis

Given the above, a detailed SWOT analysis has been developed and is included below.

Strengths

Operational / Service Delivery

- Clinical skills and reputation
- State of the art building
- PMO approach to CIP and Transformation
- Embedding corporate aims and values, PRIDE, CARE

Financial / Business

- Use of SLM and PLICS
- Outreach models such as support to DCHS
- Strong Governance arrangements

Reputation / Customer Service

- Good senior management relationship with Commissioners
- Developing clinical relationships in primary care - CIGs
- Historical Reputation / Track Record
- Positive patient experience surveys
- Strong research and Medical School profile
- Low infection rates

Workforce

- Good leadership capability
- Good multi-disciplinary working
- Employment options in current climate
- Low staff turnover
- Forward focussed
- Skilled and committed workforce
- Improving staff survey results
- Clinical engagement
- Clinical leadership

Weaknesses

Operational / Service Delivery

- Capacity to meet demand- RTT & Cancer Performance, Diagnostics
- unwarranted variation
- Paediatric resilience
- Winter planning – affect on elective capacity
- Shortage of key personnel in some specialities and ability to recruit
- Delays to discharge

Financial / Business

- Financial position - deficit
- Information provision – lack of high quality business information and triangulation
- Implementation risks with Lorenzo
- Service sustainability – Loss making services
- Ability to deliver recurrent CIP / financial stability
- Costs of PFI
- Low staff turnover
- Slow decision making process

Reputation / Customer Service

- Negative press coverage due to financial and non-financial performance concerns
- Financial and quality concerns with regulators
- Complaints / patient experience
- Responsiveness to changes in customer needs

Workforce

- Specialisation has meant a less flexible workforce
- Middle management capacity
- Historic clinical engagement
- Transformation capacity in business units
- Succession planning
- “Cost” of training / teaching
- Inability to recruit junior doctors
- Impact of premium working – Waiting list initiatives

Opportunities

Operational / Service Delivery

- Integrated care models particularly in partnership with other health economy providers
- Networking / alliances with Burton, NUH, DCHS and Alexin (also drives pathway efficiencies)
- To further develop models as part of the "wedge"
- Ambulatory care models
- Demand management (supporting financial agenda)

Financial / Business

- Lorenzo – improved information system to support effective business decisions
- Urgent and Emergency care – Major Emergency centre
- Contract opportunities
- JVs, partnerships / alliances
- Expand on Self pay and private work
- Expansion of diagnostics
- Attraction of elective care services from a wider catchment

Reputation / Customer Service

- Research agenda
- Social marketing

Workforce

- Graduate Nurse Training / MDT led
- Integrated and joint working with community services and others
- Education and associated employment opportunities
- Sense the need to change especially around moving care outside of the hospital

Threats

Operational / Service Delivery

- Lack of clarity re system rules eg – what will happen with specialised centres/ emergency care centres
- Ability to respond quickly enough to seven day services
- Ability to compete
- Aging population / increasing demand and expectations
- Inability to deliver system wide transformation

Financial / Business

- Increased competition e.g. any qualified provider
- Draconian commissioning/ decommissioning if CCG finances threatened
- External financial climate - Tariff efficiency requirements
- GP commissioning (remains immature)
- Negative implementation of Better care fund

Reputation / Customer Service

- Regulation framework
- CIP impact on quality
- Public expectations
- Negative media

Workforce

- Uncertainty re education funding streams
- Immature change management capacity (whole system issue)
- Consultants working for the competition (business risk also)
- Ageing workforce - resulting in loss of expertise
- Fewer junior doctors

4.0 Risk to sustainability and strategic options

"I think just about everyone now accepts we're going to have to reinvent out of hospital care – however you define that – more broadly… given the ageing population and the rise of comorbid chronic health conditions"

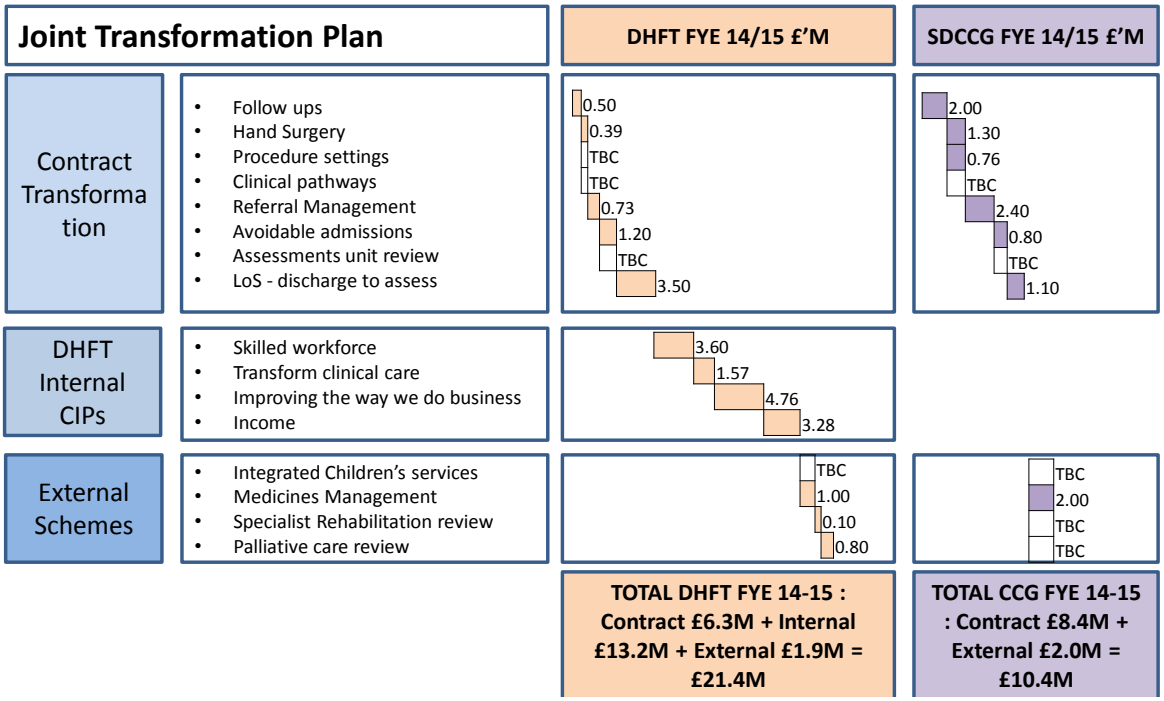
Simon Stevens –Interview with the HSJ, June 2014

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.

4.1 DHFT / SDCCG Joint Transformation planning

Internal transformation schemes seek to improve productivity against a backdrop of elective and emergency growth, however, it was recognised that internal efficiencies alone could not close the financial gap in 14/15. The Trust therefore developed a partnership transformation plan outlining whether schemes would be delivered:

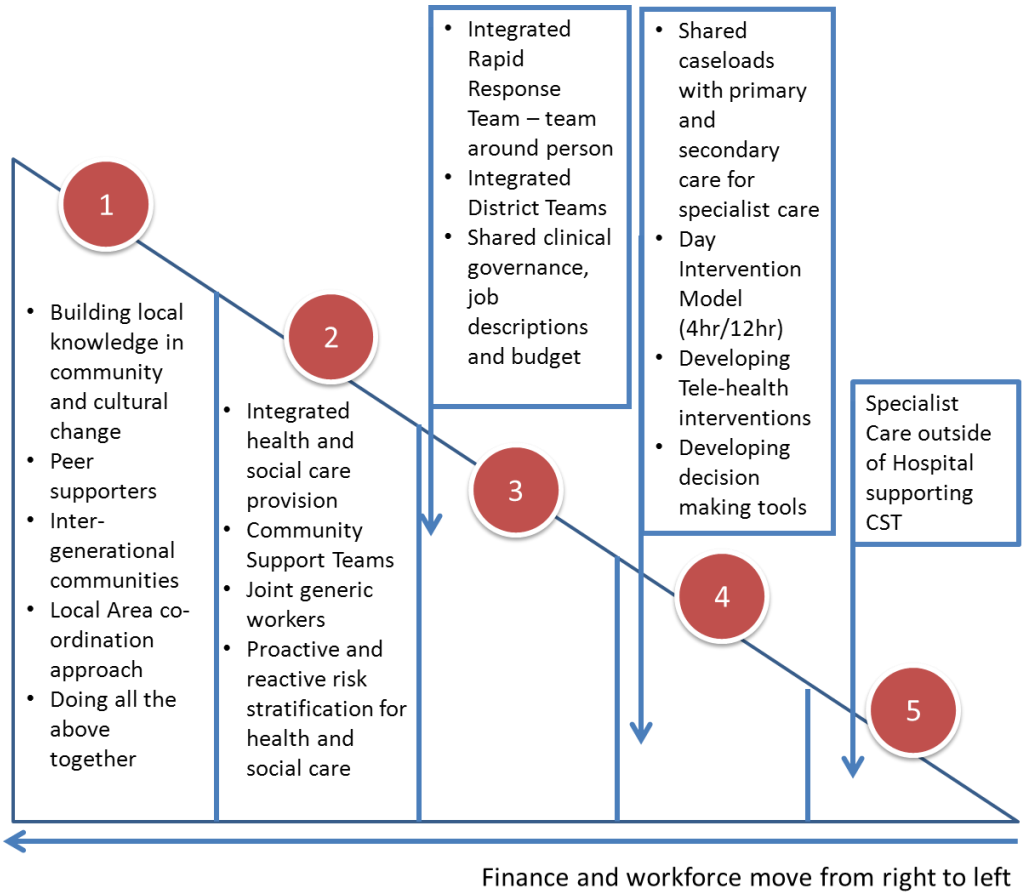
- internally by the Trust;
- externally in partnership with the CCG and the wider health economy;
- income generation schemes.



From this it can be seen that these savings will not satisfactorily bridge the "do nothing"/unmitigated position. System wide transformation (in partnership with other providers) will therefore be required to establish new models of care and efficiency.

4.2 System wide Transformation – Integrated Care

The local health economy integrated model



Given the demographic analysis, the main demand challenge relates to the predicted growth in chronic diseases and the frail elderly (although additional demand is also anticipated in planned care).

The unmitigated position identifies a financial pressure of £83 million facing the Trust (with a further £26 million projected for CCGs) and in turn, the local health economy. Recognising the future challenges facing the South Derbyshire population, and the declining financial position, the CCG outlined a statement of intent which encouraged providers to collaborate (rather than pursue a competitive procurement route) in order to present a collective response to the projected demographic situation.

In early June, Chief Executives and Board level representatives from acute, community, mental health, urgent care and council providers met confirming their intention to co-produce and co-deliver the change required for Southern Derbyshire.

A number of joint principles were agreed to frame this collaborative including:

- Co-production with local communities and staff to develop social capital and organisational engagement
- To work with commissioners to develop clear outcome- focused care with measurable KPIs

- Agree to use the same boundaries for local communities using resident rather than registered populations.
- A recognition that community needs and preferences are not a "one size fits all", and providers will therefore develop a system fit for variation
- Start small projects with a view that these can be scaled up (quickly)
- To work to develop a new model of commissioning and contracting which supports integrated person -centred care
- To develop future services with contributions based on respective strengths not historically defined boundaries
- Given the demand on GP services, GPs cannot accept an increase in workload. Providers therefore need to work with primary care to find different ways of delivering services
- To understand and share clinical and financial risk

A common vision was realised and the above model shows options for future working(the local health economy integrated model). This will act as a blueprint for future discussions and a combined future strategy. Clinical strategies which describe the transformational change must then be developed by providers in the local health community to describe what services will be provided (at a pathway level) along the steps of care, where these services will be provided (premises), who will provide them (which staff groups) and how they will be provided (e.g. remotely via tele-health models).

4.3 Scope for Transformation to meet the financial challenge

4.3.1 Potential for ongoing productivity savings

The Trust has a strong track record of managing effective internal CIP programmes delivering in year savings of £12m in 2011/12, £23m in 2012/13 and £20m in 2013/14. Consideration has been given to the potential for continued delivery of efficiency and productivity improvements during the life of this strategy. Table 6 below shows estimated projections for future CIP savings by area. Overall it is assumed that the overall scope for productivity improvement will diminish from the current rate of around 4% per annum to around 3% per annum. This is a reflection of the Trust optimising the efficiency of its processes over time. Specifically the scope for procurement and estates based savings reduce, however opportunities remain, via the implementation of new technology in the form of the Lorenzo system for example, to release further efficiencies through improving the flow through outpatients clinics and more effective use of administrative processes and staffing groups.

Table 6: Estimated future CIP savings by thematic area

	CIP	%	14/15 £,000	15/16 £,000	16/17 £,000	17/18 £,000	18/19 £,000
1	Workforce Productivity	25	3599	3023	2721	2449	2204
2	Length of Stay Reduction – Initiatives	15	2100	1764	1588	1429	1286
3	Coding	14	2000	1680	1512	1361	1225
4	Theatres	7	1000	575	518	466	419
5	Outpatient automation/transformation	11	1652	1533	1686	1855	2040
6	Estates	3	423	355	355	355	355
7	Procurement	17	2464	2070	1863	1677	1509
8	Shared Services	3	369	310	310	310	310
9	Income Generation	5	743	624	624	624	624
10	Other	1	79	66	824	1475	2028
	Total	100	14429	12001	12000	12000	12000

4.3.2 Potential joint transformation impact over five years

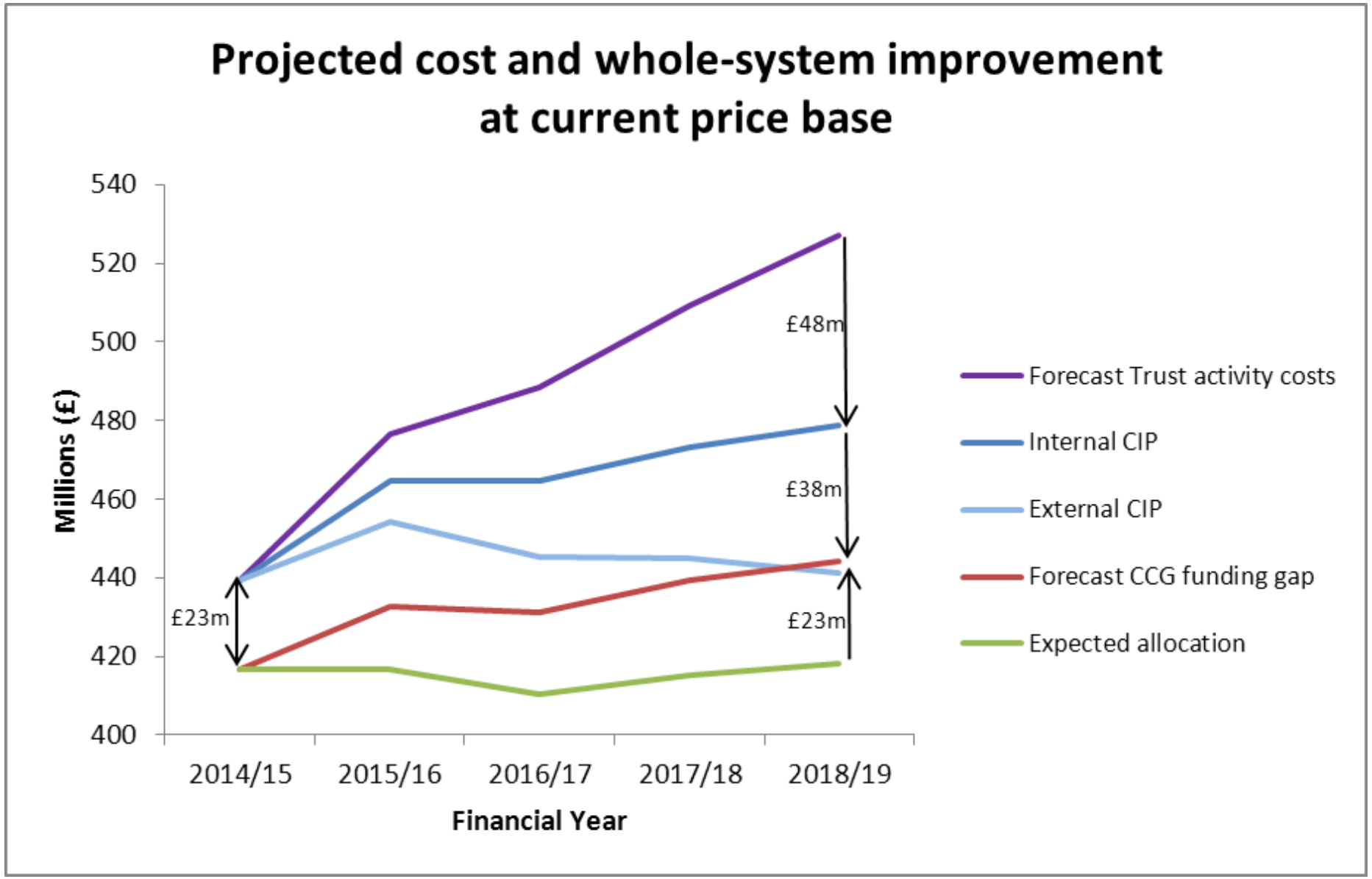
Whilst it is predicted that the scope for internal CIP schemes will diminish during the 5 year strategy period, the scope for realising savings to both the Trust and commissioners through system redesign and greater integration is increasing. Consideration has been given to the potential for expanding the 13/14 joint transformation schemes identified in 4.1 over the rest of the 5 year strategy period.

Most notably, the opportunities for greater integration with primary care, community services and social care are represented in both planned and unplanned pathways. In the case of planned care, this would happen through an expansion of triage and treatment to more effectively manage the demand for elective care. In the case of unplanned care, this would happen through building on the Southern Derbyshire community support teams in order to manage chronic disease more effectively in the community preventing attendance at ED and admissions to secondary care. Through expanding this activity savings are realised to the Trust in the form of marginal cost reduction and to the CCG in the form of the net impact of funding community based responses in comparison to secondary care tariffs.

Table 7: Estimated future joint transformation plans by thematic area

	INTERNAL					CCG				
Indicative Schemes	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Unplanned										
Avoidable Admissions	600	1200	1200	1200	1200	400	800	800	800	800
Assessment Unit Review	0	200	0	0	0	TBC				
Urgent Care Centre	0	500	500	0	0	0				
Planned										
Referral Management	730	1000	1000	1000	1000	2400	3000	3000	3000	3000
Follow Up Reduction	500	300	0	0	0	2000	1500	0	0	0
Procedure Settings	TBC	500	1000	1000	1000	756	1000	1000	1000	1000
Clinical Pathways	TBC	500	1000	1500	1500	TBC	500	1500	2000	2000
Hand Surgery	390	0	0	0	0	1300	0	0	0	0
Integrated										
Medicine Management	1000	1000	500	500	500	2000	2000	1000	1000	1000
Discharge To Assess	1700	1000	1000	1000	1000	723	1500	1500	1500	1500
Specialist Rehab	100	300	0	0	0	TBC				
Palliative Care	400	800	0	0	0	TBC				
CSTs - Fully Integrated Health & Social Care	0	500	1000	1000	1000	TBC				
Year of Care Contracts for Chronic Disease Pathways	0	500	1000	1000	1000	0				
Integrated ICT	0	0	500	500	1000	0				
Totals	5420	8300	8700	8700	9200	9579	10300	8800	9300	9300

Overlaying the impact of these changes can be seen overleaf which describes how these schemes contribute to bridging the £109 million funding gap identified through the projected activity and financial model.

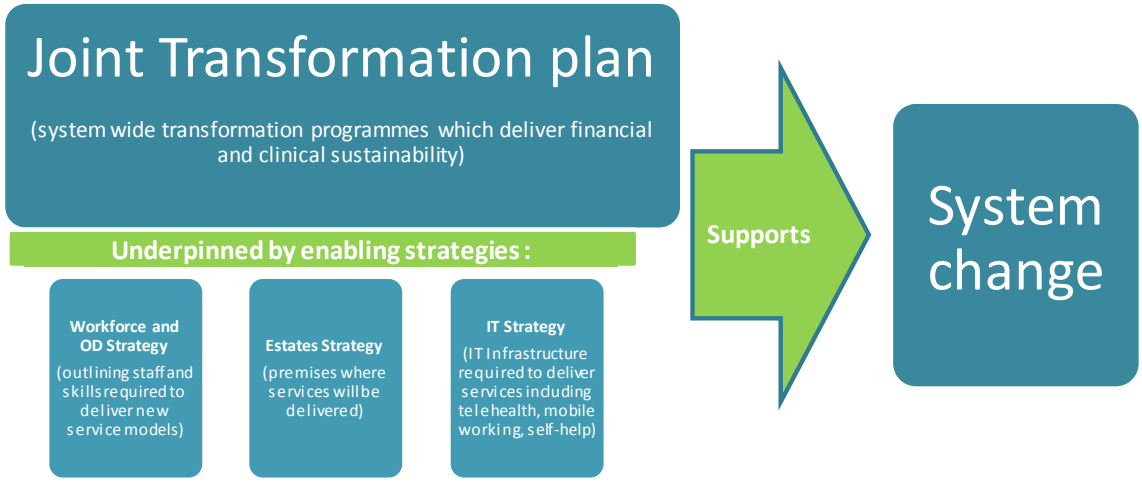

Projected cost and whole-system improvement at current price base
Millions (£)
540
520
500
480
460
440
420
400
2014/15
2015/16
2016/17
2017/18
2018/19
Financial Year
£48m
£38m
£23m
£23m
Forecast Trust activity costs
Internal CIP
External CIP
Forecast CCG funding gap
Expected allocation

4.3.3 What does this mean for secondary care in the current market?

The impact of both internal and external transformation described in sections 4.3.1 and 4.3.2 is an expansion of the community based workforce and service offer to both manage demand and provide more appropriate lower intensity services in community settings compared to higher intensity acute services. In addition, if demand remains within the levels predicted, then spare capacity will become available within DHFT. This capacity will allow the Trust to focus on income generation through the ability to provide a higher quality emergency and elective care service to a wider population catchment. In planned care, this will allow a more specialist elective service for a wider catchment with the highest levels of need. In unplanned care, this will allow the scope to focus on providing a greater level of hyper acute services to a wider catchment. Table 7 indicates potential increase in income as a result of this during the final three years of the strategy period.

4.4 Enabling the Change

Developing these transformational programmes together across organisations will not only support integrated models of care, but also support joined up thinking and solutions to common issues. It is therefore crucial that the local health economy develops shared enabling strategies/plans (see below) to support the system change.



Examples of such changes include (under system wide IT Strategy) developing an integrated care record across primary and secondary care services which will help reduce duplication, improve access to information and create a shared information platform for providing integrated health and social care services.

Through focussing on these areas of integrated care and chronic disease management, this should not only stem the predicted growth in demand but go towards reducing it.

4.4.1 Developing an Accountable Care Organisation (ACO)

This system wide transformation points towards describing how we will relate to and how relationships will work between organisations in the local health economy. However, we may need to consider further provision platforms to create sustainable and cost effective services. Such provision may be delivered via a single Accountable Care Organisation whose members currently provide significant elements of health and social care in the health economy.

However, four areas would need to be considered prior to any detailed work to establish an ACO.

For example, these are:

4.4.1.1 Collaborative Commissioning

It is likely that transforming health and social care pathways to be more seamless and integrated will be the key to unlocking value in the health economy by providing services in the right place at the right time in a cost effective manner.

In order to promote integrated provision the existing commissioners (the Clinical Commissioning Groups, NHS England and the Local Authority) will need to commission their services in a seamless way across multiple pathways (for instance spanning long term conditions) so placing the focus is on improving the outcome and experience for the individual. As such it is likely to be an essential pre-requisite (to promoting integrated care) for commissioners to jointly formalise the way they can commission services, measure outcomes and confirm common payment currencies. This can be potentially achieved through establishing a Joint Committee of commissioners and using current legislation to allow budget pooling with the Local Authority.

4.4.1.2 Outcomes Based Contracting

A different system/method for incentivising integrated provision should to be put in place. Such a contract is more likely to focus on the outcomes to be achieved for the individual, particularly those that are most at risk and thus consume a disproportionate amount of health and care resource. There also needs to be a growing emphasis on prevention to start sustainably improving health and the better use of scarce health and social care resource.

Providers could be encouraged to innovate and change current practice to improve outcomes and thus they would be rewarded against this measure rather than on numbers of outputs. In a future health economy where population change risk is held by commissioners (who are funded on a capitated basis) and cost and delivery risk is held by the collection of providers then the accountable provider needs to be able to transform costs across organisational boundaries in order to achieve better outcomes for the individual.

Thus future contracting should reward outcomes not outputs.

4.4.1.3 A single accountable provider

In order to transform provision to be more integrated then providers will need to work closely together at an operational level to change the current nature of provision.

This does not mean institutional mergers but more that organisations should enter “Joint Venture” style arrangements to create new delivery entities. These entities can then exist under agreed delegated limits from the partners to the Joint Venture.

Such arrangements are starting to be established through NHS Pathology Joint Ventures. These new pathology ventures are using the European Commission vs Germany case to meet the challenge that such arrangements are anti-competitive. The Germany case applies to public sector only join ventures where the aim is to improve public benefit and no one partner to the Joint Venture can gain a disproportionate advantage over the others.

Thus sustainable, multi member, operating arrangements will need to established that can meet the requirements of the competition regulator whilst transforming provision over multiple pathways.

4.4.1.4 The Scope of Services for an ACO

Finally in order to unlock value the commissioners should work with the providers to confirm what range of services should be involved in this transformation.

The key characteristics of these services should be that:

- They are connected at a patient level by known and understood co-morbidities;
- Improvement requires integration provision across health and social care;
- That prevention and not just treatment can improved;
- That they are of a scale such that service re-design can release significant cost and patient benefit.

As such there should be an appropriate analytical evidence base to support the range of services that can the focus of transformational change by both the commissioners and providers as described above.

We understand that much of this analytical base exists, so providing the building blocks for scoping the services to be jointly commissioned on an outcome basis.

4.5 Grow, Shrink, Merge, Collaborate and Transform

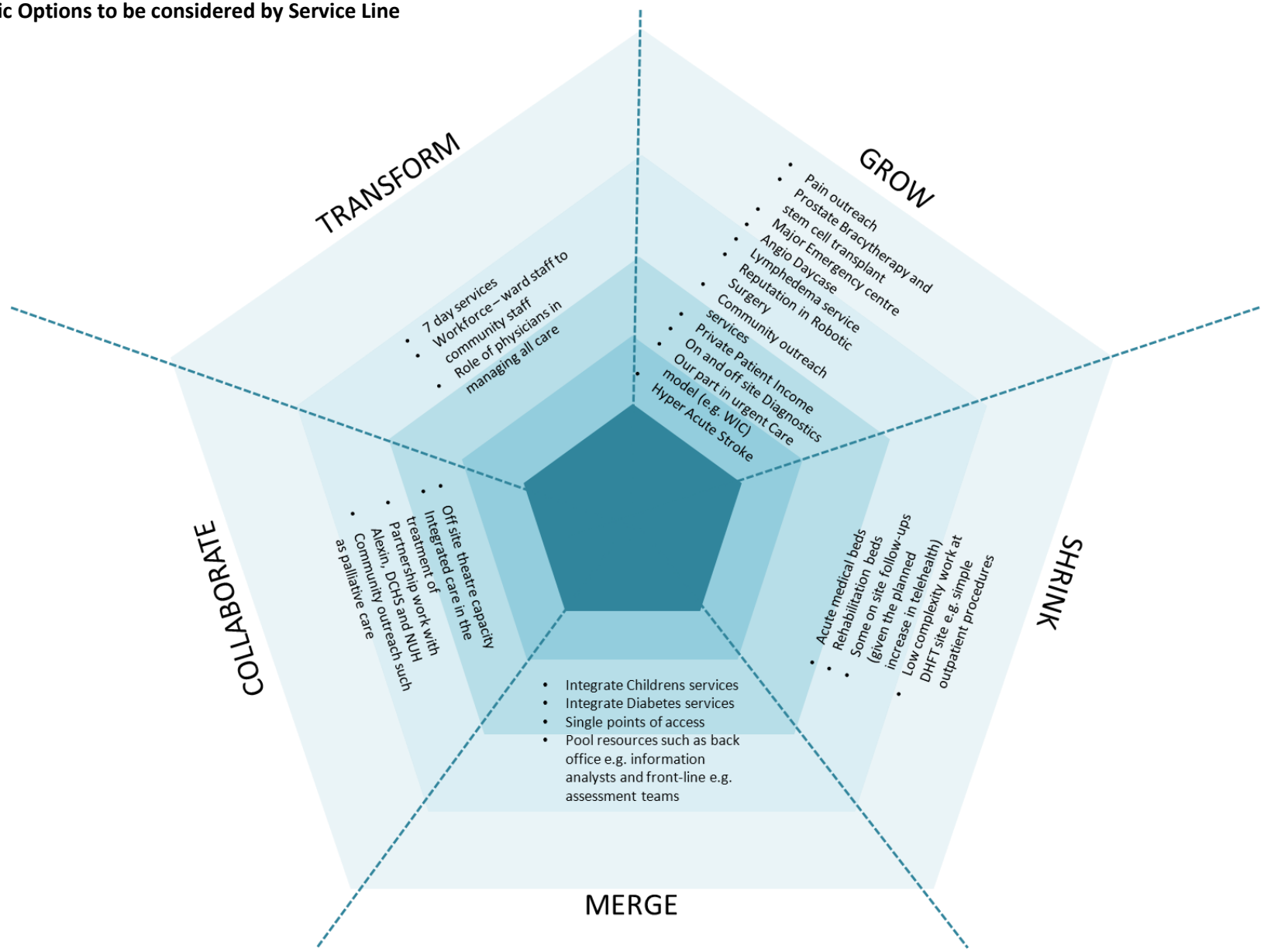
Given the above assessment of the likely impact of demographic changes, external challenges and utilising our transformation plans, there are three key actions that the Trust will seek to undertake across identified service lines to ensure ongoing long term sustainability of the Trust and the local health economy:

SHRINK – redesign of urgent care pathways and investment in integrated care models to result in less emergency and medicine beds

GROW – increase planned care capacity in community services and the Trust including specialist services such as cancer

TRANSFORM – utilise existing capacity differently in order to respond/implement national changes such as the seven day services, future hospitals programme and major emergency centres.

Strategic Options to be considered by Service Line



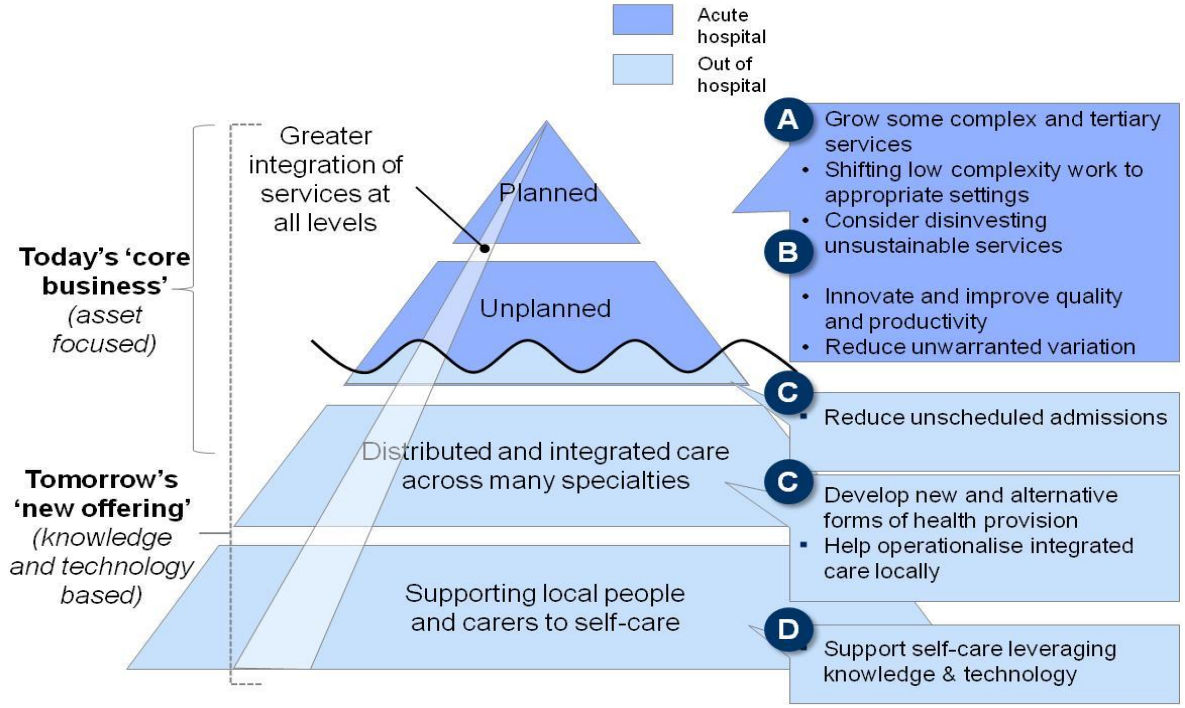
5.0 Strategic Plans

"Our role will be providing care for the most complex/ challenging patients for the Derbyshire community"

Sue James, CEO- DHFT

Our current core offering is not fit for the patient of the future. Our asset/hospital based service provision will not be the right model to either economically or qualitatively satisfy the growth in the ageing population or chronic diseases that we predict in the next 5 years and beyond. However, we will continue to provide (and expand) upon complex services which cannot otherwise be provided outside of a hospital setting.

Tomorrow's offering must therefore centre around developing integrated models of care which manage patients outside of the hospital walls (and in turn reduce admissions) but also support all aspects of community based care including self-care.



5.1 Planned Care

The Planned Care vision will see elective services looking very different to how they are now. Surgical pathways will be managed to ensure that only those patients who require specialist care are managed in a specialist/hospital setting.

To enable this, the Trust will focus on developing primary care based triage and diagnostic pathways to reduce demand and focus on new ways of working such as the implementation of telehealth in order to provide clinical advice and manage follow-ups.

This will create capacity within the Trust which (together with the capacity created from urgent care and integrated care programmes) the trust will use to focus on growing its complex and tertiary services further.

5.1.2 Grow some complex and tertiary services

The Trust currently provides a range of complex and specialist services. Although it is acknowledged that specialist services are to be reviewed (a consideration/proposal to move towards fewer centres of excellence), the Trust is in a strong position to link with its neighbouring tertiary centres to help manage the demand and provide a local hub for the region.

The Trust is already working with Nottingham Hospitals NHS Trust and University Hospitals Leicester in order to further this aim and will continue to explore partnership and collaborative models such as the developments in joint/rotational appointments.

This plan will be across medical and surgical pathways and linked to the major emergency centre ambition (below), as patients will be travelling further than the existing Derbyshire catchment, the Trust will concentrate the pathways and supporting infrastructure to focus on high quality and efficient care (in order to repatriate patients back to care and management of patient's local services).

Investment in technology will be key and interventional equipment (such as robotic surgery) will be equally as important as effective monitoring (for example patient track) to improve clinical effectiveness and improve health outcomes.

5.1.3 Shifting low complexity work to appropriate settings

The Trust already delivers surgical services (inpatients and outpatients) in its main hospital site at Royal Derby Hospitals and also in partnership with Derby Community Healthcare Services across a number of community hospital settings.

Today's utilisation of capacity will need to be very different to realise the vision of tomorrow. More effective triage and treatment of elective care patients could result in fewer patients coming into an acute hospital setting. The Trust is already exploring a project with a GP provider company (Alexin Ltd) in order to further this aim focussing on six specialties (MSK, Urology, Gynaecology, ENT, General Surgery, Hands). Matching this with an increase in primary care diagnostic (eg. ultrasound) and treatment options (such as physiotherapy and the development of other less complex interventions) should result in less demand being placed on secondary care services.

Coupling this with an increase in theatre (day case and short stay) capacity in community hospitals, will create real alternative pathways to existing patient flows and enable more capacity to be realised in the Royal Derby Hospital site.

5.1.4 Consider disinvesting in unsustainable services

The Trust has examined the sustainability of its services on a specialty basis. By categorising services which are profit/loss making[2] against an assessment of clinical criticality (how the service contributes/impacts on the delivery of other services), we are able to map services which:

- Are sustainable in terms of financial and clinical criticality (services which are profitable which we must provide)
- Which are financially sustainable (but not clinically critical to other services)

[2] In overall terms, losses can be attributed to those services funded via the Payment By Results National Tariff (Tariff services) and to services funded via a local cost based tariff mechanism (Non- Tariff services)

- Services which are loss making but are critical (so require improvements in efficiency or will create future risks to other services)
- Services which are loss making and are not critical (where we could focus on efficiency improvements or disinvest)

For 2013/14 losses calculated (excluding non-recurrent income sources) are identified as £8.6m relating to tariff services and £8.1m to non-tariff services.

However, dis-investing or improving efficiency through transformational change will require a collaborative approach with the CCG including:

- Service redesign including a review of service specifications and a review of any block funding arrangements
- Service transfer - to an alternative/better placed provider may create opportunities for financial sustainability eg. economies of scale for the health economy
- Service decommissioning – taking account of risks associated with service and pathway fragmentation and impact on other services

These areas of major transformation/service reconfiguration and possible disinvestment will be carefully considered in 14/15 with a service level plan being developed before any actions are taken together with the CCG.

5.1.5 Innovate and improve quality and productivity

The current planned care programme consists of a number of external and internal schemes focussing on making quality improvement, efficiency and productivity gains. Notable areas include:

External schemes

- Referral Management – to reduce referrals into the Acute Hospital and provide appropriate care in community settings.
- Procedure Settings – to review the setting for the delivery of certain high volume, high cost procedures and assess whether that setting is the most appropriate.
- Follow Ups – the Trust and the CCG are working together to reduce the volume and ratio of patients attending the Acute Trust for follow up appointments. This will require the development of alternative community-based settings for some of this activity.
- Clinical Pathway implementation – focused on the agreement, cascade, governance and monitoring of clinically agreed pathways. This is a key enabler to the other external Transformation schemes.

Internal Schemes

- Reduction in length of stay. Projects include:
    - The development of a Elective Procedures Unit / 23 hour ward facility to provide a short stay, facilitated discharge facility for appropriate patients.
    - The optimisation of the Surgical Daycase Unit to ensure that daycase patients are not unnecessarily using ward bed space.
    - Development of a community IV therapy service (OPAT).
- Increased theatre productivity / efficiency
    - Improved Pre-Operative planning and scheduling.
- Reduction in unwarranted variation between clinicians e.g. ordering of tests / scans.

- Development of technological solutions to improve efficiency and patient experience. Examples includes benefits realisation of phase 2 of the Lorenzo project and electronic pre-operative assessment screening.

However, these areas of "traditional" transformation will be further complemented by some emerging yet radical re-thinking of surgical models.

The *Future Hospitals Programme* points toward a model whereby the physician may have a "total care" role in managing all pathways. Therefore, for some existing surgical pathways, much like cardiology or severe and complex obesity pathways, a physician would be able to manage patient pre and post operatively with surgeons acting as technical experts for patient's surgery.

In this vision where physicians are managing all care, the approach could also redefine emergency pathways with surgical emergencies being managed on general emergency wards, protecting elective ward capacity (a significant pressure in winter). This would see surgeons rotating around patients, wherever they are in the hospital, and could also lead to general elective wards rather than sub-specialisms, again pooling capacity.

5.2 Urgent Care

The urgent care reforms instigated by Sir Bruce Keogh will see a radical change in the provision of urgent care centres and the creation of emergency and major emergency centres.

The Trust's ambition is to become a major emergency centre given the strength of its infrastructure and the complex nature of many of its existing pathways which it currently delivers. This could mean further growth in specialist emergency medical and surgical care from neighbouring Trusts (which could be graded as emergency centres) and will require a step change in capacity and the redesign and transformation of existing bed utilisation in order to satisfy this demand.

One example of this could be the transformation of assessment areas. The Trust currently has segregated medical and surgical assessment units, but under the plans above where physicians manage all care, these assessment areas could be merged with specialist input from relevant teams.

In addition to this, the planned transformation in integrated and urgent care pathways which are outlined below, will lead to reduced admissions, facilitated early discharge and a reduction in length of stay. This will ultimately mean that emergency admissions are limited to the hyper-acute phases with acute care being managed more proactively in alternative settings. This could in turn create bed capacity and in so doing, contain the growth anticipated in demographic changes and the consequential increase in demand from being designated as a major emergency centre.

Four unplanned care work streams have been established:

- Work stream 1 – Avoiding attendances and enabling diversion
- Work stream 2 – Assessment and enabling diversion
- Work stream 3 – High quality person centred acute care
- Work stream 4 – Better post-acute handover

Each of these work streams has its clinical leadership provided by a consultant lead and a GP lead. These work streams report to a health community wide Urgent Care Clinical Oversight Executive Committee and will continue to deliver a range of schemes to avoid admissions and improve quality. The top priority for each work stream is as follows:

- Work stream 1 – Scope the establishment of an urgent care centre
- Work stream 2 – Improve emergency surgical flow
- Work stream 3 – Review take-home medicines process
- Work stream 4 – Transfer to Assess

5.2.1 Reduce unwarranted variation

Reducing unwarranted variation is key to improving efficiencies not only in our own services but also in improving how quickly (and appropriately) patients access the right level of service in/from primary care.

We are looking to understand and address unwarranted clinical variation within the organisation. This encompasses variation in diagnostic and pathology requests, Length of Stay, follow-up ratios and internal referrals. We have implemented a Theatre dashboard that highlights productivity differences between surgical teams and have plans to roll-out patient level costing information.

5.2.2 Reduce unscheduled admissions

A critical part of the vision for the urgent and integrated care agenda will be monitoring patients who decompensate in a community setting and providing a rapid response in order to manage their care before they become more unwell and require an emergency hospital admission.

Key to this will be the identification of high risk patients (risk stratification) and a robust patient tracking/monitoring system such as the newly implemented early warning system in use on our hospital wards – "patient track".

In doing so, the Trust will have a virtual ward whereby patients can self-care but are always supported by a wide multi-disciplinary team of GPs (who in turn can gain telehealth advice from acute physicians), social workers and community support teams, in turn, enabling the integrated care agenda.

5.3 Integrated Care - Providing care inside and outside of hospital walls

Our vision will be to deliver an Integrated Health and social care system across Southern Derbyshire, ensuring we can keep patients healthy at home for as long as possible, promoting self-care, prevention and enablement leading to fewer hospital admissions and fewer patients in Care Homes.

In five years' time we will have empowered citizens, able to access helpful information on a range of subjects that promote their independence and enable them to manage their long term condition/ risk to independence. They will be supported in this through a good network of family, friends and engaged community – perhaps with the help of a peer educator too. The amount of social capital in our communities will have increased through the facilitation of the Local Area Co-ordinators and our voluntary, community and faith sector. Social philanthropy will have increased and contributors will be able to make informed decisions about donating through the Vital Signs philanthropic guide. Increased volunteering will make a valuable contribution to tackling social isolation and increasing informal forms of support. Every older person aged 85+ will be offered the opportunity to have an individualised "winter plan".

5.3.1 Develop New and Alternative Forms of Health Provision - Community Support Teams

The Community Support Teams (created through integrating social work, primary and community health services) will be at the heart of our community offer and will cover both physical and mental ill-health. They will have a close professional relationship with the Local Area Co-ordinators. They will be effectively **reducing planned and unplanned admissions** to hospital and care homes through rapid action to support frequent attenders and through proactive preventative work with people with long term conditions/ risks to their independence. Working with peer educators and citizen leaders will be a key part of this work as will the maximum usage of health and social care personal budgets. There will be close working between Community Support Teams and Care Homes for any individual who does need a short stay in a care environment.

General practice will be an integral part of Community Support Teams and provide clinical leadership. Practices will be working collaboratively to provide a wider range of services within each geographical area than is currently the case.

These teams will be complemented by a rapid response service obtained through a single point of access that GPs have confidence in because it guarantees it will see someone within 2 hours of referral and has a comprehensive spectrum of services it can call upon to support people at risk of an admission. The work of the service is ably supported by geriatricians who will spend a significant proportion of their practice time in the community. Health and social care support staff will work together to provide a single source of care for patients.

5.3.2 Help Operationalise Integrated Care Locally - Transforming Recovery

Recovery capacity and expertise will have increased across physical and mental ill health services. Rather than go to day centres, people with a mental health problem will go to Recovery College to gain the skills and confidence they need to overcome their illness. Rather than people be assessed in hospital to facilitate discharge, the default position will be to discharge people **home to assess**, ably supported with intensive support and night sitting if required in the first few days. Only by exception will people receive rehabilitation in a community hospital bed with greater use of care home capacity and people's own beds with peripatetic therapy support and care workers acting as agents of therapy. It is likely that we will need fewer buildings as services will be delivered in people's own homes.

5.3.3 Help Operationalise Integrated Care – Supporting Carers

A more effective involvement of carers at each level will contribute to meeting identified outcomes. Informal carers will be supported to continue their caring role for as long as they feel able or wish to. They will receive a carers assessment and from this support mechanisms to prevent carer breakdown. Increased investment in the carer emergency plan will reduce the 'cared for' being admitted to hospital or institutional care following a carer crisis. Clear pathways of support for the carer will reduce carer stress and the requirement for more dependent funded support from health or local authority.

There will also be an agreement to continue the support to carers who support people with dementia by securing current provision.

5.3.4 Support Self Care – leveraging knowledge and technology

The establishment of common, integrated social and clinical care information, centred on the citizen, is an ongoing ambition to underpin health and care community-wide integration and transformation initiatives. It will enable care professionals to work within and between their respective organisations, supporting the continuity of care across pathways and to provide the opportunity to support citizens access their care records so that they may more fully participate in their care.

The health and social care organisations in Derbyshire are at varying levels of digital maturity and as a consequence are not able to ensure that the various systems in use at the point of care across Derbyshire are easily and seamlessly able to exchange the necessary information to support the integration and transformation of local services.

So as not to inhibit greater service integration, the health and social care organisations and associated partner agencies in Derbyshire have committed to implement a platform solution that builds on the value of the capabilities and data contained within the current best of breed systems to present professionals delivering care in Derbyshire with a common and universal access, subject to appropriate governance, to care information from a wide variety of information sources and to support citizens to access their information. To ensure that the maximum value from this can be achieved at the earliest possible opportunity, the CCG's within Derbyshire are seeking support from the Integrated Digital Care Technology Fund for matched funding to accelerate the scope and pace of this critical initiative.

5.4 Required Investment

The delivery of the vision requires us to engineer a step change in the following:

- Increase in elective care infrastructure such as estate redesign (increase in elective wards, possible merging of ward specialties, merging of assessment areas)
- Review of London Road site to create further elective care (theatre and diagnostic) capacity
- Technological advancements to deliver radical changes to the Trust's interactions with patients including booking processes, scheduling and communication (e.g skype/facetime clinics).
- Increase the number of people who avoid formal care and support because they have their needs met through natural community support
- Decrease the number of people with a long term condition(s) living without an informal network of support

- Increase the role of peer support and educators to help people manage their condition and recover
- Significantly reduce the number of unplanned admissions to hospital and care homes through effective admission avoidance interventions
- Increase recovery outcomes across all client groups through increased and improved recovery services
- Significantly reduce the number of people going into long term care from a hospital bed
- Reduce delayed discharges through increased community-based services and effective care pathways
- Timely and effective support to carers

5.5 Impact on Trust and Wider Local Health Economy

The acute hospital site will be free to focus on its core purpose and, as a result of the effectiveness of admission avoidance and supported discharge, will no longer need to expand its capacity to meet demand through the re-utilisation of medical beds.

Community staff will reach in to hospital to provide continuity of care and facilitate discharge; and acute clinicians will provide expert advice and support to community teams and primary care. There will be regular circulation of staff between acute and community settings.

5.6 Programme Benefits

This will result in the following benefits:

- Reduced number of referrals to the Acute Trust
- Reduction in follow up appointments provided in an Acute setting.
- Streamlined number of clinically agreed primary / secondary care treatment pathways covering a wider range of clinical treatments.
- Reduced number of cancelled operations
- Reduced length of stay
- Increased daycase rate percentage
- Increased theatre throughput
- Increased theatre utilisation
- Improved performance against the three RTT targets
- Reduction in re-admissions of patients returning into hospital within 30 days if their initial stay
- An increase in self-reported patient satisfaction with both hospital and community support
- Reduction in overall number of Beds within the Health Community
- Reduction in acute stay
- Delivery of the 4 hour ED target
- Reduction in overall acute admissions
- Increased number of patients case co-ordinated in community
- Reduction in long term care
- Better in-reach support into care homes
- Workforce development through movement of staff into the community

5.7 Monitoring

5.7.1 Key Milestones

Ref	Workstream	Project Name	Dates	Project Description
1.	Planned Care	Community Triage and Treatment	July 2014	To arrest demand into secondary care through effective triage and primary care treatment models.
2.	Planned Care	Increased Surgical Capacity • Elective Procedures Unit /23 Hour Ward • Weekend Working (7 day services)	August 2014 2015	- Creating short stay surgical capacity - Making elective care as part of routine weekend working
3.	Planned Care	Increased Diagnostic capacity: • Internal • Community • Partnership	2015 2015 2015-2016	- Increasing MRI and Vascular interventional radiology capacity - Increasing MRI and ultrasound capacity - Increasing endoscopy and paediatric MRI capacity
4.	Planned Care	Improved use of technology: • Booking processes • Telehealth • Electronic Health Screening	2015/16 2014 – 2016 October 2014	- Streamlining booking processes to ensure efficient and effective patient connectivity - Consultations over skype including outpatient appointments and clinical advice for triage treatment pathways - Remote pre-operative health screening to improve surgical admission journey
5.	Planned Care	Specialised Services	2015/16 (indicative)	Support the reconfiguration of specialist services (details to be confirmed nationally and regionally)

6.	Planned Care	Options for dis-investing in loss making Services	2014-2016	Examine internal efficiency to improve service profitability. Work with commissioners to address the mitigated position including
7.	Planned Care	Redesign of elective wards	2015	Combine elective specialties onto generic wards to improve pooled resourcing and supporting processes Segregating emergency admissions from elective care management
8.	Planned Care	Role of physicians in managing all care	2017-2019	In line with future hospitals work, examine opportunities for redesign of the role and involvement of physicians in surgical pathways.
9.	Urgent Care	Major Emergency Centre reconfiguration	2015/16 (indicative)	Support the reconfiguration of emergency centre provision (details to be confirmed nationally and regionally)
10.	Urgent Care	Improved emergency admission management	2015-16	Combined assessment area for surgical and medical patients
11.	Urgent Care/ Integrated Care	Transfer to Assess	April 2014 – October 2014	Deliver pathways to ensure patients are assessed at home for on-going care.
12.	Urgent Care/ Integrated Care	Rapid Response and Access model	April 2014 – October 2014	- Review and design rapid response within community - Review existing and future workforce model
13.	Urgent Care/ Integrated Care	Enhanced Discharge	September 2012 – July/August 2014	To roll-out the Enhanced Discharge process across all medical wards and cancer wards to identified patients, acting as the co-ordinator between acute and primary care to case manage, educate and communicate care plans of identified patients to reduce the risk of them re-attending with the same or a similar condition.
14.	Urgent Care/ Integrated Care	Acute Frail Elderly Pathway	March 2013 – July 2014	Design and implementation of Frail Elderly pathway within acute services to identify Frail Elderly patients and deliver CGA

15.	Urgent Care/ Integrated Care	Home from Hospital (pilot)	October 2013 – May 2014	Develop and pilot a volunteer service to support patients for up to 6 weeks when discharged from Hospital
16.	Integrated Care	Health Community Wide Medicine Management	April 2014 – August 2015	To further develop the patient focused shared care approach across the Health Community (to include Acute Hospital, Primary care and Community Pharmacy) To ensure prescribing information is accurate, timely and shared across providers
17.	Integrated Care	Information Hub	March 2014 – March 2015	Develop an information hub where community services, health and social care and the voluntary sector work collaboratively to provide information and advice to support the needs of patients, relatives and carers.
18	Integrated Care	Palliative Care Review	June 2014 – March 2015	To review the Palliative Care Service and understand model and the scope of the service across the Health Community.
19	Integrated Care	Specialist Neurology Review	June 2014 – March 2015	To review the Specialist Rehabilitation Service and understand model and the scope of the service across the Health Community.
20	Integrated Care	Therapy Review	September 2013 – March 2016	To design and implement future Integrated Therapy services
21	Integrated Care	Development of Community Support Teams	November 2013 – November 2014	To recruit and implement community support teams across city localities. On-going Development Integrated teams
22	Integrated Care	Productive Community Services	September 2013 – March 2015	Delivery of Productive community project across all city district nursing team within the city

5.7.2 Dependencies

	Programmes/Projects dependant upon these programmes	Programmes/Projects that these programmes are dependant upon
Planned Care	**Urgent care Programme** To ensure improved hospital flow to support the delivery of the ED 4 hour target.	**Lorenzo Programme** To ensure we have a stable IT platform to enable us to process patients quickly, provide robust data / information and to allow the Trust to benefit from Lorenzo phase 2 opportunities
Planned Care		**Integrated Care programme** To establish the locality structure for community support teams, on to which Planned Care can build.
Planned Care		**Urgent care Programme** To ensure that sufficient urgent care demand is reduced to allow Planned Care to maintain it's bed base, particularly during winter, to facilitate delivery of the RTT target.
Urgent Care		**7 Day Working Programme** To create in-week capacity through better management of patients (including discharge) over the weekend
Urgent Care	**Integrated Care -** Reliant on urgent care models to support patient monitoring in the community providing specialist advice to manage decompensating patients before they become an emergency.	**Integrated Care** To arrest demand through the management of patients outside of the hospital.
Urgent Care	**Planned Care** Change in practice around surgical and medical assessments to improve urgent care flow	**Regional response to Major Emergency Centre Project** Will drive/change the "front door" complexity and supporting urgent care infrastructure in the hospital.
Integrated Care	**Urgent Care Programme** To ensure delivery of Integrated care model to reduce demand on acute services	**Urgent care Programme** to ensure a seamless transition of care and appropriate patients are identified
Integrated Care	**Planned Care Programme** To ensure the delivery of the locality structure to frame planned care work in	**Lorenzo Programme** To ensure we have a stable IT platform to enable us to Integrated Information across services

Integrated Care	**East Midlands Workforce Development Programme** To inform future direction of care to enable the appropriate development education programmes	**East Midlands Workforce Development Programme** To develop and deliver new training programmes for the new workforce required.

5.7.3 Risks and Mitigations

Ref	Description	Impact H/M/L	Likelihood H/M/L	Owner	Containment & Contingency Plan
1.	Demand for services is higher than the modelled baseline plan (eg. greater than £109 million gap assumed)	H	M	Senior Responsible Owner	Discuss with CCG options for redesign and possible suspension of services
2.	Primary Care does not have the sufficient capacity to deliver alternative models of care.	H	M	Programme Director	Models are produced with the appropriate training / resource transfer as a priority.
3.	Lack of progress within projects to deliver realise benefits within 14/15	H	M	Programme Manager	Ensure good project governance structure around work streams with project plans that are RAG rated and updated at least twice a month
4	Lack of shared Intelligence/data will not allow integrated work such as risk stratification and MDT assessments	H	M	Senior Responsible Owner	Shared buy-in to share data between providers, this will be managed as a priority as part of South Derbyshire Provider Steering Group
5.	Inability to re-train staff means less flexibility to move staff from acute to community services	H	L	Programme Director	Early identification of core competencies required, early engagement education and training

6.	Lack of engagement/ understanding from clinical staff of their role in new service models/pathways across all providers (including primary care GPs)	H	M	Programme Director	Involve relevant clinicians at planning stage & follow principles of good change management
7.	Lack of resource to deliver co-ordinated work programme including transformation resource/skills and management and clinical capacity	H	M	Programme Manager Programme Director	Early Identification of work stream leads, resource requirements and additional resource provided where necessary
8.	Any transfers of procedures allow DHFT to reduce costs to off-set the loss of income.	H	M	Programme Manager Programme Director	The financial impact on both organisations will be fully considered as part of the redesign of the patient pathway. Local prices can be negotiated as appropriate.
9.	Managing expectations of both patient / customer and staff expectations	H	M	Programme Manager	Ensure a robust communication strategy and Clearer link with transformational work streams in relation to improved provision of advice and information
10.	Failure to gain engagement for project from key partners across health community including shared vision and agreement on timings of projects	M	M	Senior Responsible Owner	Agree appropriate strategic approach with Execs and ensure key partners are members on project groups

5.7.4 Resourcing the Plan

The Trust has a track record of investing in a centralised transformation team within the Chief Operating Officers (COO) Department and supporting both corporate and frontline transformation schemes. This resource in 14/15 totals £1.3m inclusive of £300K from Southern Derbyshire CCG to support the coordination of the 14/15 external transformation schemes. It is proposed that this level of resource continues to be applied throughout the life of this strategy and that the following

additional resource is also invested to ensure the delivery of system wide redesign and other external transformation identified in 4.3.2 can be delivered:

- A further £1.3m is identified to support the creation of a multidisciplinary clinical team (medicine, surgery, primary care, nursing, social care and therapy) to accelerate the development of an effective model for managing chronic disease in the community as part of the Integrated Care Programme
- £600k identified to support additional nursing home bed capacity as a double running cost in 14/15 continues to be applied throughout the life of the strategy. This will provide a scale-able community bed base to ensure flow can be maintained at times of pressure while the community based care model is embedded
- £2m of capital investment is budgeted for in each of the financial years covered by this strategy to facilitate:
    - The redevelopment of London Road to support more elective work, urgent and ambulatory care and diagnostics
    - Further investment in IT systems and reception facilities to optimise outpatient flow and therefore both productivity and experience
    - Investment in IT systems and information sharing solutions to enable integrated community care between different providers

5.8 Monitoring Performance against the plans

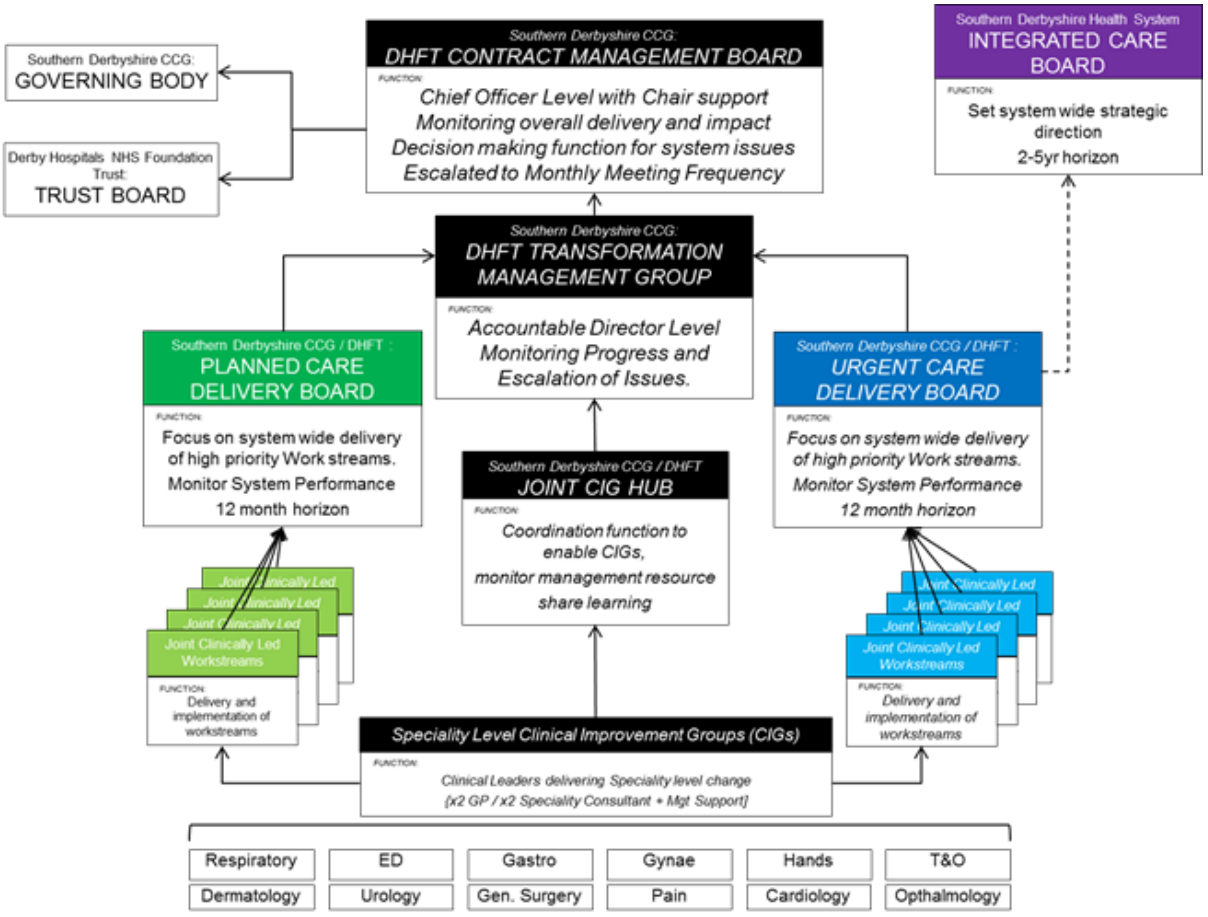
The Trust has established robust programme governance arrangements for ensuring that its transformation schemes deliver effectively during the plan period. Internally the Trust has focussed transformation review meetings chaired by the COO each week. Performance is captured on performance dashboards for each programme and is reported via division performance management meetings and the management executive.

In addition to this, each programme has a joint stakeholder board including representatives from the CCG and other providers in the system. These feed into a joint governance structure with the CCG to oversee external transformation activity.

As a system the learning gained from last year's successful turnaround of both the A&E performance, and also the system flow and quality issues, has been applied to the challenge now faced around planned care.

Learning showed that clinicians need to be central to the governance and delivery of the workstreams, and not in supporting roles as was often the case in previous less successful programmes. Managerially developed and imposed workstreams will not gain the buy in and necessary momentum from clinicians if they feel there is no empathy with the challenges faced caring for patients on a daily basis.

The following diagram identifies our governance model:



5.8.1 Clinically led delivery boards

Both the Urgent Care Delivery Board and the Planned Care Delivery Board have:

- Strong clinical Chairs
- An agreed range of workstreams which are jointly clinically led with commissioners and providers.
- Workstream leads held to account for delivery with this being the first line in escalation
- Skilled and dedicated management support to enable change,
- A robust structure to set high expectations for delivery and provide challenge where this is not achieved,
- Effective representation from all other stakeholders,

A whole range of benefits, in terms of improved patient experience, clinical outcomes, patient safety and savings will be delivered by the joint Transformation Programme. These benefits are in direct support of both SDCCG and DHFT's strategic intentions. The benefits are defined within the individual Project Outline Documents (PODs) and Project Initiation Documents (PIDs), together with a range of key performance indicators which will enable effective tracking and monitoring. Risks are also defined, together with mitigating actions, action owners and timescales for delivery.

To enable the delivery of transformation change at the point at which clinical decisions are made a series of Clinical Improvement Groups have been developed over the past three years. These groups are specific to clinical Specialties and consist of clinicians from both primary and secondary care, and the Clinical Leads of initiatives use these groups as a key resource. They meet on a monthly basis, and are supported by dedicated managerial capacity and are coordinated through a Joint CIG Hub.

This function of this meeting is to monitor delivery/ completion of actions etc. to ensure that progress is delivered at the required pace.

The Planned Care and Urgent Care Delivery Boards will upwardly report progress on a monthly basis into a Joint Transformation Management Group (TMG). This group will review progress from Transformation, and triangulate this with Financial Positions, Quality implications and current activity and performance issues.

5.8.2 Escalation and Oversight

This will then report a summary position into Contract Management Board at Chair and Chief Officer / Executive. The same reporting information will then be used internally by organisations to assure themselves of both the progress and the challenges being faced.

A whole system dashboard is being developed which will monitor the key performance indicators and measures of success providing a consistency of approach across organisations which will help each organisation in turn understand progress and manage risk.

5.9 Communicating Our Plans

Communicating the plan effectively will be critical in overcoming the risks around failing to engage stakeholders and clinicians and managing expectations of patients, commissioners and staff.

Once further detail of the plans contained within this strategy are developed, we will implement a communications plan across all stakeholders in order to support the realisation of the change that is required.

Glossary of Terms

Ambulatory Care: Is concerned with the management of conditions which if treated and managed effectively will not require admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness.

Better Care Fund: The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. For Southern Derbyshire CCG, this equates to £32 million with £10 million anticipated to affect hospital services.

Chronic Disease: A chronic illness is a disease or disorder of slow progression and long duration which causes continuous or episodic periods of incapacity.

CIP: Cost Improvement Plan - A plan to reduce costs while improving or maintaining patient care, patient satisfaction and safety. NHS Trusts are expected to make efficiencies of 4% every year and CIPs are developed in order to identify and realise these savings (whilst not impacting on service quality).

Clinical Improvement Groups (CIGs): The Clinical Improvement Groups (CIGs) bring together primary and secondary care colleagues to talk about the issues facing both groups of clinicians. Through working together, the groups are developing meaningful changes to services that are positive for both primary and secondary care whilst improving the patient experience and ensuring patients are treated in the most appropriate setting.

Community Support Teams (CST): The purpose of the CST is to co-ordinate the care of patients within a GP practice who have been identified as being at risk of their current situation breaking down leading to admission to an acute bed. A risk stratification tool will be used to identify at risk patients and to proactively manage from an MDT approach. The Team will be an effective communication link between other teams from health and social care to support patients.
The CST will consist of a Community Matron (CM), Care Co-ordinator, GP and will have access to Social Work support. There will be 14 Teams across Derby City.

COPD: Chronic Obstructive Pulmonary Disease

Day Intervention Model 4hr/12 hr: The development of a model which allows patients to be quickly assessed and then observed for a short period at a location other than the acute hospital.

DCHS: Derbyshire Community Health Services NHS Trust

Diagnostics: Any kind of medical test performed to aid in the diagnosis or detection of disease. Examples include x-rays, blood tests and ultrasound scans.

East Midlands Region: The area covering Nottinghamshire, Derbyshire, Leicestershire, Rutland, Northamptonshire and most of Lincolnshire.

Elective Care (also known as Planned Care): A term for routine care in the UK which can be planned or booked following a referral by a GP or an outpatient clinic.

Elective Procedures Unit (also known as 23 Hour Ward): This unit is for pre-booked medical/surgical patients who are anticipated to have a one night stay in hospital following their procedure. This unit will also accept daycase patients for whom same day discharge is not clinically appropriate following their procedure. Both post-procedure care and discharge will be nurse led and therefore admission to the unit will be restricted to patients for whom nurse led care/discharge is clinically appropriate. Discharge from the unit will normally take place by 10:00am the day following the procedure and if discharge is inappropriate at this point the patient will be transferred to another ward. The unit will be open from Monday morning at 8:00am until 12 noon each Saturday.

Emergency Care: Treatment for an immediately life threatening illness or condition.

Emergency Centres: Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary.

Follow-up: an outpatient attendance to the see the same consultant following a first attendance.

Four Hour A&E Target: At least 95 percent of patients attending an A&E department must be seen, treated, admitted or discharged in under four hours.

Frail Elderly: Likely to be aged over 65 years. Frailty is not really a disease but rather a combination of the natural aging process and a variety of medical problems. Someone who is frail may demonstrate a reduced ability to independently perform the activities of daily living as result of physical or mental illness or long term condition, combined with reduced resilience to life stresses.

Hyper-acute Stroke Pathway: A pathway created to deliver care for patients presenting with new onset of stroke symptoms.

Integrated Care: brings together delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

Integrated District Teams: The Trust envisages the expansion of the current Community Support Teams to include additional services such as Social Care and Mental Health. The teams will be organised according to geographic location as the Community Support Teams are currently.

Integrated Rapid Response Teams: The Trust currently has an Intermediate Care - Rapid Response Team which is an integrated team based at LRCH who provide the following services: Intermediate Care Nursing Team, District Nurses Out of Hours (Late shift), Service Navigation, Intermediate Care Clinical Support Workers, Community Phlebotomy Team. The Trust plans to expand these teams to involve other services such as Mental Health and Social Care to provide rapid assessment and access to a wider range of support services.

Intermediate Care: Nursing home, rehabilitation or home care services provided to ease the transition of the patient from hospital to home, from medical dependence to functional independence and to prevent unnecessary hospital admission and effective rehabilitation services closer to home.

Local Health Economy: The health and social care organisations within a defined region. For Southern Derbyshire this includes all commissioners and provider organisations including the councils, CCGs, NHS Trusts, GP practices, voluntary and independent sector bodies and so on.

Long Term Conditions: Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.

Major Emergency Centres: Major Emergency Centres will be much larger units than Emergency Centres, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services.

NUH: Nottingham University Hospitals NHS Trust

OPAT: Outpatient parenteral antimicrobial therapy (OPAT) is a method for delivering intravenous antimicrobials in the community or outpatient setting, as an alternative to inpatient care.

Pathway: A care pathway is "anticipated care placed in an appropriate time frame, written and agreed by a multidisciplinary team. It has locally agreed standards based on evidence where available to help a patient with a specific condition or diagnosis move progressively through the clinical experience. It forms part or all of the clinical record, documenting the care given. It facilitates and demonstrates continuous quality improvement.
It includes patient milestones and clinical interventions noted on the day or stage that they are expected to occur.

It will include all of the following standards or show evidence that it is working towards meeting these standards: multidisciplinary, single documentation, use exception, reporting, variance analysis, patient/user involvement, monitoring of utilisation, cross boundaries, standard format , outcome orientated, built in audit, evidence based." (National Leadership and Innovation Agency for Healthcare 2005, p.8)

Planned Care: See Elective Care

PLICS: Patient Level Information and Costing System- Patient-level costs are calculated by tracing resources actually used by a patient and the associated costs by using actual costs incurred by the organisation in providing a service or event. This approach is more sophisticated than the traditional allocation approach (based on averages and apportionments), as it is based on the actual interactions and events related to individual patients.

Peer Supporters: Peer support is a way of linking people living with a health/chronic condition such as diabetes. People with a common illness are able to share knowledge and experiences.

PFI : The private finance initiative (PFI) is a way of creating "public–private partnerships" (PPPs) in order to fund public infrastructure projects with private capital. The Royal Derby Hospital site is a PFI building.

PMO : Project Management Office – Part of the Transformation team, the PMO programme manages the overall CIP and transformation schemes in the Trust ensuring that they are developed, monitored and managed to ensure project delivery.

Re-Ablement : Support for people with poor physical or mental health or a disability to help them live as independently as possible by learning or relearning the skills necessary for daily living**.**

RTT: The Referral to Treatment (RTT) operational standards are that 90 per cent of admitted and 95 per cent of non-admitted patients should start consultant-led treatment within 18 weeks of referral.

In order to sustain delivery of these standards, 92 per cent of patients who have not yet started treatment should have been waiting no more than 18 weeks.

7 (Seven) Day Services: 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 is recommended are adopted across the NHS by the end of the 2016/17 financial year.

SLM: Service-line management is a system in which a hospital trust is divided into specialist clinical areas that are then managed, by clinicians, as distinct operational units/business units. SLM enables clinicians and managers to plan service activities, set objectives and targets, monitor financial and operational activity and manage performance. Service-line reporting (SLR) provides the necessary data on financial performance, activity, quality and staffing.

Specialised (also referred to as specialist) services: Those services provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

Specialised services account for approximately 10% of the total NHS budget, and the commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England. Examples of specialist services include bariatric surgery, liver transplantation and paediatric epilepsy.

Transfer to Assess: A 'discharge to assess' approach, where patients are discharged once they are medically fit and have their support needs assessed on arrival at home by members of the community intermediate care and social care teams. This enables them to access the right level of home care and support in real-time.

Triage: Referral triage is a pilot project whereby GP referrals in six specialties are reviewed by a Specialist GP, with access to a Consultant Surgeon. The review will determine a) the appropriateness of the referral and b) the most appropriate service for the patient to be referred to for further investigation or treatment (this may be within a community setting as opposed to the Acute Trust). The pilot will provide feedback to referring GPs regarding the quality of referrals, as well as providing information on possible Community treatment options for the future.

Urgent Care (also known as Unplanned Care): The range of responses that health and care services provide to people who require - or who perceive the need for - urgent advice, care, treatment or diagnosis (including hospital admission).

May also be described as unscheduled care and includes, but is not limited to, both daytime and out-of-hours GP visits in the community, as well as emergency 999 ambulance response and rapid access care including minor injuries units and A & E.

Appendix 1: Methodology for demographic analysis

Disaggregations:

Analysis by age group:
It is proposed that the age groups to be used for analysis of overall activity will focus on the following 10-year age bands: 0-9; 10-19; 20-29; 30-39; 40-49; 50-59; 60-69; 70-79; 80-89; 90+

Analysis by specialty:
Specialties which had a financial footprint of over £0.5m will be separated out for analysis- these are listed in detail in Appendix 1.

Analysis by locality:
Population and activity data will be broken down to LSOA level in order to model change, allowing for aggregation back to CCG, community or other post-hoc grouping of interest, as well as facilitating 'hot-spot' mapping once the appropriate software is in place.

Analysis of cost:
Based on tariff and non-tariff derived unit cost prices for the financial year 2013/14.

Method:

1. Extracted ONS mid year estimate for 2011 by age at local authority and LSOA level. Mapped distribution of ten-year age bands across LSOAs as a proportion of overall population within an LA area.
2. Obtained LA population projections 2011-2021 by five-year age band. Converted ages into ten-year bands and for each calendar year, decanted predicted changes for each LA area into its constituent LSOAs from the previous step, to give LSOA-level ten year age band projections from 2011-2021.
3. For each year, absolute population figures were transformed into relative growth rates using 2012 as a base. These rates were calculated for every LSOA-age band combination. For example, if the population of 20-29 year olds in an LSOA in 2012 was 200, and in 2014 it was 300, the relative growth co-efficient would be recorded as 1.50.
4. Activity from HES for the financial year 12/13 was extracted by PWC from three separate databases: outpatients, inpatients and A&E. Information Governance prevented full disclosure at an age group x LSOA x specialty x POD level. Hence several broad extracts were first extracted to determine overall numbers of New, Follow-up, Elective, Non-elective, Maternity, A&E attendances. Detailed extracts were then taken with counts less than five suppressed. These missing counts were modelled back into the detailed model later in the process.
5. From the OP database, new and follow-up appointments were filtered to exclude non-attendances. Data extracted from DHFT data warehouse outpatients and patient detail tables was used to derive an age- sensitive distribution of outpatient activity for the year 2013/14 across the PODs which do not appear in the HES dataset (primarily, OPPROC and OPPHONE).

These percentage splits were used to generate estimates for new appointments, follow-ups, OPPROCs and OPPHONE appointments at each specialty x age group x lsoa combination.

6. From the IP HES database, elective, maternity and non-elective activity was extracted and organised in similar fashion to the above.
7. The A&E database followed a similar procedure, with the exception of recording specialty.
8. For all suppressed cells, the missing totals across specialties and pods were identified through comparison with broad extracts and then were allocated based on age x specialty x pod (where appropriate) patient distributions, such that the grand total for each POD was within 0.1% of the values derived from the broad extract.
9. The demographic change weightings were then applied to the base activity figures at a LSOA x Specialty x POD x age group level, for 2014 and 2018 in the first pass, in order to derive overall growth for the five year period.
10. This was then factored down into a yearly demographic growth percentage to which was added a further activity growth factor. Given the disproportionate growth in Trust activity over the past few years in comparison to demographic growth, it was decided to apply a gradually reducing factor on top of demographic growth, calculated by commencing at the 13/14 model growth level in the first year, and reducing each year to end up at the base demographic growth level by 2019.
11. This combined growth factor was applied to all services across outpatient, elective, non-elective and non-tariff activity and costs, starting with the 14/15 plan.

Appendix 2: Competitor Market Position

	DHFT	Burton Hospitals FT	Nottingham hospitals	Derbyshire community Healthcare services	Nuffield (Derby)	Circle, Nottingham NHS Treatment Centre
Market share Derby City Inpatient spells Mar13-Feb14	91.5% of Derby City 24% Derbyshire 3% South staffs 2.4% Leics 0.12% Notts	Low Inpatient 0.3% (Derby City)	Low Inpatient 3.4% Trauma, heart and cancer Centre (Derby City) (8.5% of Derbyshire patient admissions)	Low Inpatient 0.5% (Derby City)	Low Inpatient 0.7% (Derby City)	Low Inpatient 0.5% (Derby City) (Circle have 18% of Notts admissions)
Market share Derby City Outpatient attendances Mar13-Feb14	90.8% Derby City 25.4% Derbyshire 3.6% South Staffs 2.8% Leics 2% Notts	Low 0.4% (Derby City)	Low 2.3% (Derby City)	Low 0.8% (Derby City)	Low 0.6% (Derby City)	Low 0.6% (Derby City)
Quality performance Safety, effectiveness and patient experience	Fair CQC inspection July 13 quality and management standard not met. Did meet standards at specific ophthalmology inspection Jan 14. PROMS health gain score for hip replacements (primary) of 8.168 is a negative outlier the EQ-	Fair/Poor As a result of the Keogh review, the Trust was placed into special measures. CQC inspection July 13 met all standards Met all relevant PROMS scores Family and friends Scores April 14 were 72 for Inpatient and 70 for A+E	Fair CQC Visit 26-28th November 2013, not compliant on clinical equipment maintenance and mandatory training levels. PROMS health gain score for hip replacements (primary) of 8.941 negative outlier on the EQ-VAS index 2013-14. Family and friends	Fair CQC inspection Feb - Mar 2014 – Compliance actions needed for 3 regulated activity standards not met 2012/13 Met 9 CQUINS targets	Good CQC inspection 30th Jan 14 Met all 5 standards. PROMS scores not an outlier.	Good PROMs score only for Groin hernias and is not an outlier. Average patient recommendation of 99.3% from responders

	DHFT	Burton Hospitals FT	Nottingham hospitals	Derbyshire community Healthcare services	Nuffield (Derby)	Circle, Nottingham NHS Treatment Centre
	VAS index measure 2013-14. Family and friends Scores April 14 were 70 (National 73) for Inpatient and 61 for A+E (National 55)		Scores April 14 were 76 for Inpatient and 75 for A+E			
Financial performance	Poor Projected overspend of £22.6 million 2014/15 on annual budget of £450 million	Poor 2012/13 accounts show deficit of £3.1m. Financial challenge of £24m over the three years Annual income £175 million	Poor As at May 14 a current year end forecast deficit of £19.1 million Annual income £824 million, 5.9 million surplus 2012/13.	Good Financial balance 2012/2013 Surplus 0.3 million at May 13.	Unknown as no information however, understand this to be Good given elective demand increase in Derby.	Poor 5 year contract from Feb 13 at Nottingham worth between £22m and £42m annually - a maximum value of £210m over five years. The company's overall pre-tax loss in 2012 was £30.4m, on revenues of £73.2m (largely due to Hinchingbrooke Hospital position)
Capability and resources	Fair Over 8,000 staff, 1,100 beds. 72,000 elective operations per year, Emergency department	Fair Cancer unit is not a centre Meeting A+E 4 hour target 95.75% May 14. Met RTT admitted	Fair 13,500 staff 87 wards, 1700 beds. Trauma, heart and cancer centre. Children's hospital.	Good 4,400 staff. Inpatient services at 12 hospitals in Derbyshire with 326 beds. Heanor Memorial Hospital currently closed due to asbestos	Good 50 beds,3 operating theatres, Oupatients for adults and children, surgery for children aged 4+ and adults No intensive care	Good Treatment centre only covering Day Case Surgery, endoscopy and outpatients seeing over 165,000 Outpatients annually

	DHFT	Burton Hospitals FT	Nottingham hospitals	Derbyshire community Healthcare services	Nuffield (Derby)	Circle, Nottingham NHS Treatment Centre
	around 350 patients every day 1,100 beds, However demand is outstripping supply with significant pressures on 18 weeks RTT and urgent care services.	April 14 95.8%	Not meeting A+E 4 hour target 90.8% March 2014 or 62 day cancer referral to treatment (81% Feb 14) Meeting all other cancer targets (Feb 14) Met RTT admitted April 14 with 97.3%	being found in the building. Meeting: 4 hour target in minor injuries unit 6 week diagnostics 18 weeks RTT	capability, limits complexity of patient/procedures	
Reputation	Fair	Poor Keogh report July 13 was 1 of 14 trusts with higher mortality rate	Excellent National and international reputation for many of our specialist services, including stroke, renal, neurosciences, cancer services and trauma.	Good	Good	Fair