Derbyshire Healthcare NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Derbyshire Healthcare NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

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Date	26th March 2014

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

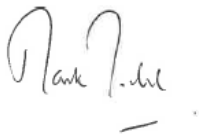
In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Mark Todd

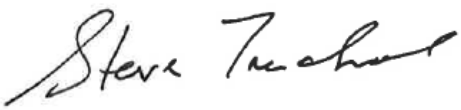
Signature



Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Steve Trenchard

Signature



Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Claire Wright

Signature

1.2 Executive Summary

Derbyshire Healthcare NHS Foundation Trust's Operational Plan outlines a number of key challenges facing the Trust and the Derbyshire health economy over the next two years, not least of which is the financial pressure facing all public sector organisations across the country. Nationally and locally, the challenges of providing quality health care to an ageing population, with a growing range of mental and physical health needs, within the current financial climate are well understood.

The Derbyshire health economy comes from a strong position of partnership working and a history of using a collaborative cross-organisational approach to meet the challenges it faces. This is already being employed in the whole system redesign, which is required to meet the health and social care needs of the community in the future. We have taken this approach to heart and, through our Transformation Change Process which governs internal redesign, have engaged with the local health and social care community on a five year transformational journey for Trust patient pathways from 2014/15 to 2018/19.

Derbyshire Healthcare NHS Foundation Trust will continue to work with our local health economy partners including the Derbyshire Nursing Cabinet and the Local Medical Council to ensure our work reflects the national agenda for the provision of care. We are fully compliant with the registration requirements of the Care Quality Commission (CQC), and have a rigorous approach to assure the Board of the quality of our services. Quality assurance is a key decision making criteria in our Transformation Change Programme, and is demonstrable through the delivery of cost improvements, with full quality impact assessments for all schemes. As part of our transformational change, we are committed to developing the social context in which compassionate cultures can flourish and which enable our people to deliver compassionate care.

Our forecast demand modelling for the next five years shows an ageing population across Derbyshire, with areas of continued deprivation. In response to this projection, we anticipate significant increased need for dementia and general mental health services. We are working to model services based in local communities for people of all ages that minimise the need for admission to hospital. This plan assumes that we are retaining the vast majority of our existing service portfolio over the life of the Operational Plan.

In recognition of the whole scale transformation required over the next five years, we have refocused our Transformation Change Programme on whole system redesign, which is supported by a dedicated Programme Assurance Office and governance structures reporting to the Board of Directors. The clinically led Pathway and Partnership Teams (PPTs) have defined their visions for all our pathways over the next five years, and how the pathways will support the delivery of the Trust strategy.

The financial challenges facing the organisation are in line with those faced across the NHS. However, this Operational Plan will enable us to continue to operate in line with our licence and to deliver a Continuity of Service Risk Rating of at least 3 for the life of the plan. In response to previous Annual Planning Review (APR) discussions with Monitor, our plan has an improving trajectory for liquidity and headroom. It also supports improved financial resilience.

This Operational Plan has been co-produced with Trust Board members and senior staff in line with the vision of the Trust, having had regard to the views of the Council of Governors. Iterations of the plan have been discussed and debated at Trust Board meetings and Board development sessions.

1.3 Operational Plan

The short term challenge

In Derbyshire, there is a long history of partnership working and good examples of integrated working. Although the purpose of integration is to improve the health and wellbeing of the population and to deliver services to support that, a key driver is the financial context. The financial challenges facing the public sector nationally over the next few years are unprecedented and require radical whole system solutions to meet the savings required in the health and social care economy. The challenges facing the Derbyshire health economy reflect the national picture, but our history of partnership working, and our open and collaborative approach to addressing the future challenges places us in a very strong position to meet the future needs of the health economy.

The Local Health Economy (LHE) view is that if organisations respond to the financial challenges in isolation there will still be a collective financial gap of approximately £500m over the next five years. As such, there is a commitment across the LHE to close the gap by doing things differently across pathways. Although there are financial pressures across the whole of the public sector, those faced by health and social care (particularly Local Authorities) are challenging and will only be addressed by collaborative redesign across the whole system.

The Chief Executives and Chief Operating Officers across the LHE have been meeting regularly to understand the pressures faced by current health and social care systems. We are working closely with Clinical Commissioning Group (CCG) officers and Local Authorities on the content, planning and prioritisation of the two Derbyshire proposals for the Better Care Fund, as well as whole system planning for services not yet impacted on by the Better Care Fund.

The vision for Derbyshire moving forward is based on a shared understanding of risk and opportunities for the organisations involved. A key element of this vision has been co-developed by National Voices, which places the local person at the centre of our actions. The definition of integration produced by National Voices is to be adopted by the care community in Derbyshire (both City and County Health and Wellbeing Boards) as a central tenet to the changes being developed:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Derbyshire County have moved the vision forward through discussions which have centred around three aspects:

- Maximising the health and wellbeing of the population
- Making best use of funding
- The nature of the organisations that administer the services, ensuring that organisational boundaries do not get in the way of delivering a seamless service for local people.

The objectives of Derbyshire County's strategy to achieve the vision are to deliver integrated services that:

- Build strong asset based communities
- Support people to remain independent and in control of their lives
- Provide support in the community when needed
- Reduce the need for hospitalisation or admission to long term care
- Improve outcomes and the quality of services provided
- Reduce inequalities
- Develop the necessary infrastructure to achieve the objectives.

Whilst the overall vision remains the same, Derby City have developed the following objectives to achieve the vision:

- To support people to remain independent and in control of their lives
- To provide co-ordinated support in the community when needed
- To put recovery at the heart of services
- To reduce the number of unplanned hospital admissions, and where people do go to hospital to ensure they get home as soon as possible
- To reduce admission to institutional forms of care wherever possible
- To ensure the health and social care system in Derby is equipped to deliver these service changes to the highest quality.

There is general agreement across the county that our goal is to achieve a seamless health and social care service and we will work together to overcome organisational boundaries to achieve this goal. To provide the foundation for this work, as a Trust we have triangulated our strategic and operational plans with CCGs, NHS England Local Area Teams, Local Authorities, the Health and Wellbeing Boards and Units of Planning.

Across Derbyshire there is agreement that the aim is to deliver integrated public sector services that:

- Support people to remain independent and in control of their lives
- Provide support in the community when needed
- Reduce the need for hospitalisation or admission to long term care
- Improve outcomes and the quality of services provided
- Reduce inequalities
- Are delivered within the resources available, ensuring that value for money is achieved.

The public-wide consultation across Derbyshire in 2012 established six principles upon which future service changes and developments would be based. The publically consulted and agreed *21st Century Derbyshire Principles* are:

- All services will be person-centred
- Care will be provided flexibly
- Assumptions will be challenged
- People will be treated with dignity and respect
- We will plan and deliver services in partnership
- Healthy lifestyles will be promoted.

The delivery teams from organisations within the Derbyshire health and social care system have committed themselves to working closely to review all possibilities and opportunities for closer integrated working, some of which include (but not limited to):

- A number of pilots which have already been commissioned around frail older people to prevent unnecessary admissions into hospital
- A commitment to reducing unnecessary bureaucracy and organisational boundaries
- An agreed set of principals through which organisations will work.

CCG's have involved us in population based needs modelling to determine a better understanding of health and social needs through a risk stratification process. We are also extensively engaged with Derby City Council looking at mental health, adult care and children's provision. This includes developing a strategy for shared clinical models and the implementation of Local Area Co-ordination (LAC), which is a model of community development introduced from the evidence in Western Australia. We have engaged with the County Council to support their plans around intermediate care and to agree opportunities for shared efficiencies and improvements to patients' experiences of our services.

We want to be at the forefront of influencing and setting the pace of change around the LHE integration agenda. We established a Transformation Project Board in July 2013 which has membership from all key stakeholders in voluntary and statutory organisations, including service users and carers, to review and agree clinical pathways to be implemented over a five year timeframe. The efficiencies and timeframes required are embedded in this transformation process.

Our strategy is to provide care to people in or as close to home as possible. The working assumption in Derbyshire is that approximately 25 - 30% of people presenting to Emergency Departments and being

admitted to acute care could be avoided. To support this, we have supported our health economy partners by developing a Liaison Service based on the RAID (Rapid Assessment, Interface and Discharge) model in both Derby and Chesterfield. This reduces admissions or lengths of stay for patients presenting at the acute sector providers with both mental and physical health needs. Our transformation plans include an initial increase to address demand, with a later reduction of mental health inpatient beds over the five year period as community care provision is increased.

We have embedded Service Line Reporting (SLR) in our Trust; enabling all clinical service lines to assess their contribution to the Trust's financial position. In addition, SLR information is used as part of a set of information in assessing service lines for their strategic fit with the organisational vision, their financial, clinical and operational viability.

Quality plans

Derbyshire Healthcare NHS Foundation Trust has quality plans in place the meet the short term challenges it faces as follows:

Patient experience
The experience of our patients, carers and their families is essential to our organisation, sustaining the high quality of care we deliver.

- We are committed to ensuring everyone has a positive experience of our care and we value direct patient feedback. We have been an early implementer of the Friends and Family test since 2012 and in 2014/15 we will deliver the new national mandatory requirements for Friends and Family, extending the question to all staff working in the Trust. This will provide assurance to our commissioners that we have plans in place to reduce the proportion of people reporting a poor experience through a 'you said, we did' methodology.
- Our Centre for Compassion was established in 2013 to develop and promote compassion focused research and therapy within the Trust. We will continue to build on our training in compassion in 2014/15 and work more closely with the Point of Care Foundation to extend Schwartz rounds and to raise our profile nationally. We are committed to strengthening our already strong staff engagement rating to further support consistent compassionate care delivery. The Schwartz Rounds were developed in America by Ken Schwartz, and provide an opportunity for staff to pause and reflect upon their work related experiences in a supportive environment.
- Service receivers and carers have been extensively involved in our quality visits to frontline services. We pride ourselves on our open and transparent culture, listening to our staff and service receivers in our care, to learn from what we have done well and where we need to do more. We will expand the number of Trust Governors involved in our quality working groups and in our visits, and challenge them to hold our organisation to account for their findings.
- Our Transformational Change Programme will continue to have significant engagement with people who use our services and our method of quality impact assessments will continue to specifically include direct patient feedback as a measure of transformational success.
- We have drawn upon those who have provided feedback about the care they receive and closed the loop. We have embedded a model where the Chief Executive Officer, or a member of the executive team, provide follow-up to those who have raised a concern, to ask whether their concerns have been resolved. We will continue to maintain this model to ensure that quality is maintained.

Safety
Our priority is to treat patients in a safe environment and protect them from avoidable harm.

- During 2014-16, our ambition is to reduce premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. Work will be completed in our inpatient areas and in the community teams including early intervention, assertive outreach and forensic services. We will utilise SMART objectives to provide the baseline for provider/commissioner agreement on quarter on quarter improvements, year on year.
- Although we have a relatively low proportion of patients with pressure ulcers, we will continue to build on our work to reduce their prevalence in 2014/15, and embed the safeguarding agenda further into our organisational practice. When patients are admitted or seen in the community with these care needs, we act quickly and effectively to improve skin integrity and prevent further harm in our care. This will ensure the high quality of our physical healthcare of patients will be sustained.
- There will be comprehensive work over two years looking at suicide and learning from serious incidents. With our health economy partners, we will be developing our innovative approaches to the prevention of suicide using the input of service users and carers into the design of our training, as experts by experience. We will continue our engagement in the Derbyshire-wide multi-agency suicide prevention strategy and utilise the skills and knowledge of national leads in this area of work to further enhance our learning.
- We will be further developing our approach to our quality and outcome measures, both clinician and patient reported, to develop and refine them to assure our Board that our values and priorities are being met.

Effectiveness

Learning lessons from national reports such as the Francis Report, Keogh and Berwick and from local incidents is central to sustaining high quality care.

- As part of our agreements with commissioners in April 2014 to March 2016, our ambition is to secure better outcomes for children by championing Think! Family practices through improved staff training, developing an improved supervision model and improving recording, communication systems and assessments. In 2014/15, we will undertake baseline assessments of practice and, using SMART objectives, set out continued improvements in practice for year two with the ultimate aim to ensure organisational, service and clinical level family inclusive practice.
- We are taking a multi-year approach to Commissioning for Quality and Innovation (CQUIN) planning with our commissioners, to make sure we provide the right types of care to each person using our services. During 2014/15 and 2015/16 we will continue to lead the local Derbyshire development of the clinical outcomes linked to the National Tariff Payment System (NTPS) for mental health services, whilst engaging nationally to influence future design.
- Our priority is to continue to promote recovery and learn from other inspiring recovery-oriented organisations. As a member of Implementing Recovery through Organisational Change (ImROC), we will embed this approach through every level of the organisation. We hope to develop educational resources to support other Derbyshire organisations in working effectively with those with a lived experience of mental distress, in our capacity as the largest provider of specialist mental health and community services in Derbyshire. We will draw upon our child health and Child and Adolescent Mental Health Service (CAMHS) resources to ensure the voice of the child and family is heard in this work.
- We will build upon our strong foundations in our children's services and build early intervention and detection models to ensure effective and, wherever possible, rapid treatment across all of our care pathways; from our universal services to our memory teams. This will form part of our key offer to developing our community resilience**.**

As defined in our Quality Account and Quality Strategy, we will build on our successful quality visit programme for the fifth year of operation. This programme of visits focuses on teams showcasing innovative practice that they are proud of, how they have learnt from adversity (such as complaints), and how the Trust vision is reflected in their day to day delivery of quality care. This programme directly links our Board (and other key stakeholders, senior staff and Governors) to all frontline teams on an annual basis. We will be revisiting the model and standards set, to raise the level that we require to include an additional focus upon family inclusive practice drawing upon the evidence of research (particularly in Recovery principles) and embedding emerging clinical practice that embraces advanced technology and innovation. In 2014/15 we will build on our firmly established Leadership and Engagement Strategy in partnership with our staff to sustain our positive national staff survey results. We will focus on care planning to improve our national patient survey results on overall care planning.

We are fully compliant with the conditions of our registration with the Care Quality Commission. In September 2013 the follow up to our annual visit resulted in no further actions and a positive outcome. In 2014/15 we will learn from the pilots of the new inspection regime and provide assurance of our ongoing compliance through our solid structure and processes of quality governance. An implementation plan sets out our plans to ensure staff are well prepared for the new inspections and harness the opportunity to showcase the high standards of care we provide.

The Board derives assurance on the quality of its services using a wide range of methods. The Board uses Monitor's Quality Framework to appraise the quality arrangements in place and commissions auditors to carry out routine reviews of the quality of our governance. Informal methods have also been developed such as inviting regular patient testimonies at Board meetings and a minimum of one Board member is on each of over 90 quality visits. This provides real time assurance of the quality of our service delivery through the voice of our staff, patients, carers and their families.

Our staff survey results for 2012 and 2013 have demonstrated notable progress in a number of key areas. We are particularly proud to share the results that reflect how staff perceive the Trust as a place to receive care. In 2013, 71% of respondents felt that patient care was our top priority – this was an increase in 6% from 2012, when we were already above the national average in response to this question.

The vast majority of our staff also said they would be happy for their friends or relatives to receive care from us, which is clearly an excellent reflection on the quality of care and values we hold as an organisation. Our score in this area was higher than the responses received to the same question last year and is also higher than the national average.

Similarly a higher number of people than average said they would recommend Derbyshire Healthcare as a place to work and that we always act on concerns raised by our service users.

We will work with the CCGs across Derbyshire, local communities, the voluntary sector and Local Authorities to develop new ways of working. We have a programme of ongoing engagement with key members and groups representative of our local communities to address issues of stigma associated with mental health and to develop plans to overcome resistance to accept mental health services. We are working with the Farming Community network to support and care for vulnerable and isolated people in our rural communities. We are committed to improving access to information for Deaf people and using mental health and wellbeing services. This work is currently being undertaken in partnership with the British Deaf Association.

We will continue to train our workforce to meet the demands of our patient populations and look within our

service areas at gaps in provision. We have to ensure that we have the correct psychological skills and capacity to meet the current and emerging demands of our communities. We will prioritise in our staff training that we need to meet the National Institute for Health and Care Excellence (NICE) recommended interventions and clinical pathways. We will undertake this work by using the intelligence we have gained from our work in the National Tariff Payment System (NTPS) and link our business intelligence data to our workforce plan.

In 2014/15 we will:

- Tackle stigma and prejudice by working together with partners to help our local community identify early signs of mental illness and distress, by raising awareness of conditions, sources of support and tackling stigma/prejudice associated with mental illness e.g. Dementia friendly communities.
- Increase the number of volunteers and peer support workers across the Trust and wider community.
- Co-produce education as part of our locality model with people with lived experience. We will develop Recovery Colleges and a variety of programmes, specifically developing our offer to parents, siblings, named significant others and carers. We will look for opportunities to expand this provision and evaluate the impact of these developments.
- Explore alternatives to traditional pathways to recovery.
- Continue to develop our children's universal services and seek opportunities to showcase their work as key part of our Think! Family agenda, whilst continuing to develop models of cross-fertilisation of best practice and innovation in systemic practice.

We have produced a response to the publication of the Francis Report. We have set out our plans for 2014/15 using the five key themes taken directly from the Statement by the Chair, Robert Francis QC. The themes are:

- Standards and measures of compliance
- Openness, transparency and candour
- Compassionate, caring and committed nursing
- Strong and patient centred healthcare leadership
- Accurate, useful and relevant information.

We will include in our work in 2014/15 learning from the subsequent responses and guidance published in 2013/14 as follows:

- The Government's response to the Francis Inquiry: *Patients First and Foremost* (March 2013)
- *Review of Best Practice on Complaints* (Ann Clywd MP and Tricia Hart)
- The Keogh Report '*Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England'*. (July 2013)
- The Cavendish review '*An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings'*. (July 2013)
- The Berwick Report *A Promise to Learn – a Commitment to Act* (August 2013)
- Hard Truths: '*The Journey to Putting Patients First'*. (January 2014)
- Closing the Gap: *How to get Better Value Healthcare for Patients* (October 2013)
- Closing the Gap: *Priorities for Essential Change in Mental Health* (January 2014)
- Mental Health Crisis Care Concordat**:** *Improving Outcomes for People Experiencing Mental Health Crisis* (February 2014).

As a result of the Keogh recommendations, we will strengthen our compliance visits to wards and teams and expand the clinical and patient voice within the compliance team. These visits have a different approach, format and style to our quality visits, based on the Care Quality Commission's inspection model. They are unannounced assurance visits to measure our ongoing compliance with the 16 essential

standards of quality and safety in specific teams and wards.

In 2014/15 we aim to maximise our use of data at service line level within our reporting process, highlighting exceptions and outliers. We will review our quality indicators set out in the Quality Framework to ensure our indicators include measures for outcomes and recovery for the people that use our services, as well as for regulatory and contractual requirements.

The risks for delivery to our quality plans are:

- The careful balancing of resources to deliver national targets and standards against the drive for quality improvements at a local level
- The perceptions of our patients may deteriorate as a result of events not within our control (such as changes in Local Authority services). This is a risk to our quality plans to improve patient feedback
- A lack of synergy between transformational change and timelines for quality improvement targets.

Contingency plans that we will build in to our quality plans are:

- To harness the high level of skills, knowledge and expertise of staff working within the Trust and to maximise this resource flexibly
- We will work with our partners in the LHE to optimise our resources to decrease duplication and transform the way we deliver services
- We will use the quality impact assessment framework firmly established for each project to monitor and measure our progress
- To gain further assurance, the Board representatives are undertaking additional scrutiny with service line managers and clinicians to reflect on the proposed changes, sense check and recheck any plans to mitigate any risks. A panel will have the authority to confirm service changes, suggest alternative plans, and to pause and halt any proposed changes that require further planning to maintain the quality and patient safety of the service. This panel consists of the Medical Director, the Director of Nursing and Patient Experience and a Non-Executive Director. We believe this approach gives further assurance, checks and challenge of our work, to plan and consider any unexpected consequences or interdependencies of our organisation's proposed plans.

What our quality plans mean for the Trust's workforce

Our workforce plan will include the following key areas of focus to support the quality plan.

Engagement.

We have a good foundation for engagement, as evidenced by the 2013 staff survey results. This is reflected by the Trust being identified by IPA as a good practice case study for engagement.

Future plans include testing an approach developed at Harvard, and centred on 'reporters' - volunteer staff who 'interview' colleagues, asking two questions 'what's it like to work here' and 'what would you like to change?' Reponses will be grouped, and staff will be involved in further improvement work.

We will also establish an employee led engagement committee, and will include staff 'reporters' and others to ensure that the approaches we adopt are rooted in what matters to our staff. We will continue to develop and enhance our relationship with our staff side partners through our newly reinvigorated engagement approach.

One of the early activities will be to refine the staff recognition scheme, where patient focus, safety and effectiveness will be recognised.

Management of change
We will support deployment of transformational change, building on the work which has involved nearly 500 Trust staff in the development of a future plan for their own work area.

Values based and compassionate leadership across all levels

Our core values are a central strand to the delivery of our strategy. A key action for us is to embed the values in day-to-day service delivery throughout all levels of the organisation. We operate a values based recruitment process to ensure that future employees can demonstrate the personal values required by the Trust. We are also strengthening the voice of non-qualified staff; this includes ground-breaking work which has been undertaken with Health Care Assistants (HCAs), and this will be developed further with the "My 20 Commitments to Compassionate Care and Living the Values" initiative. We are committed to providing leadership development for every member of staff, regardless or role or grade via our Values to Leadership initiative. A further strand of our Values to Leadership strategy is coaching. We have continued to develop coaching in the Trust - both as a development tool and as our preferred leadership style - to reflect our values and underpin a culture that promotes compassion and excellent patient care.

The extension of the Friends and Family test to staff will ensure our staff consider what it would be like to put themselves in the patient's shoes, impacting positively on the care we provide. The continuation of Schwartz Rounds will provide a mechanism to support the wellbeing of our staff. We will continue to train staff in physical healthcare to ensure the good physical health of our patients and to impact positively on patient safety. Sustaining and developing Think! Family practices will require further training in this approach and in supervision. Staff will continue to have access to leadership development in order to support our Quality Strategy. Our 'training passport' will be used to ensure these training elements are embedded within roles so that the approach is sustainable in the event of staff leaving or moving roles.

Right time, right place
We will continue to work with partners to ensure that we are doing the right things, at the right time, in the right place to ensure that service users have a safe and positive experience in our care. Our direction of travel, in line with our strategy of earned autonomy, is to place decision making closer to patient care and we will develop our policy and practice to support local ownership. We will use e-rostering to assure real time safe staffing and our locally developed capacity management system to ensure we have sufficient available resources. We will increase our use of permanent staff to bring greater stability into our workforce.

Our Trust Governors provide a key assurance role within the Trust and will continue to be directly involved in the Trust's quality visits. The four Governor working groups will be reviewed into 2014/15. We will further develop our bespoke training programme for our Trust Governors to continue to support them in terms of education and development, so that they are equipped with the skills and knowledge they require in their capacity as Governors.

Operational requirements and capacity

Forecast health, demographic and demand changes
a) Current situation

- Derbyshire has an older than average population, though the age profile of the city is younger than that elsewhere in Derbyshire
- Derbyshire has above average deprivation, though rates vary between wards
- Black and ethnic minority (BME) populations differ between the city and the rest of Derbyshire, with

the overall average being a lower proportion of BME people than the national average.

b) Developments likely in next two years include:

- Rapid population growth in the over 65s, which will make the age profile of Derbyshire older
- Difficult economic conditions mean deprivation is likely to remain at present levels
- Derbyshire's BME population is likely to grow, though the profile is unlikely to change dramatically
- Projected population growth of 0.7% each year within Derbyshire, with significant growth in Southern Derbyshire (up to 1%).

c) Our likely demographics after two years include:

- Our elderly population is predicted to have increased to 20% of Derbyshire's population by 2016 (against a national average of 18%).
- Deprivation will remain higher than the national average in certain urban wards, driving continued demand for our services.
- Our ethnic mix will remain broadly similar, with a slight increase likely in BME populations.

Based on our forecasts we believe demand for dementia services in Derbyshire will expand, hence we are focusing on the development of an integrated pathway for dementia. In addition, the greater than national deprivation in Derbyshire will mean that end-user demand for general mental health services will remain high.

Key outputs from the collaborative Transformation Programme sessions have included a long term drive towards a reduction in inpatient bed capacity usage (for both adults and older adults), which will be replaced by a greater provision of community based services.

Our staff will work collaboratively across patient pathways with Primary Care and other partners, supporting an integrated care model that is both accessible and easily understood by both the patient and their carer.

An increase in Home Treatment capacity will allow for more effective and efficient transition of patients out of hospital and the further development of a rapid response and home treatment function will result in less beds being required going forward.

We will work with commissioners within the CCG and Local Authorities on the Integrated Behaviour Pathway development work for children and young people, remodelling services to meet the changing requirements and to ensure that service demand can be met within the resources available.

We are expecting crisis caseloads to increase across the whole of the county over the life of this two year plan.

Our approach ensures that we continue to work proactively with our commissioners to make certain that we are able to respond effectively to changes in demand for services, including the delivery of specific local solutions to address specific local issues. Whilst our strategy covers a five year period, we remain focused on addressing the needs of our population well beyond the lifetime of the strategy.

Key local commissioning intentions

The key developments which have been commissioned through the 2014/15 contracting round include:

- To address a current national and local shortage, and to assist commissioners with their repatriation agenda, an additional adult acute inpatient ward has been commissioned to open at the beginning of 2014/15. This will increase overall inpatient bed provision, whilst also reducing the bed numbers on the existing wards within the unit, enhancing the environment and clinical care

pathway. The funding for the additional beds is structured to share the financial risk between ourselves and commissioners for out of area placements.
- North Derbyshire Liaison Service – we will extend our current liaison service model to North Derbyshire, based on the service model operating in Derby
- Health Visitors – we will continue to meet the workforce plan for Health Visitors
- Dementia Memory Assessment Service – we will continue the current service level, and further develop a permanent Memory Assessment Service.

Despite a challenging financial environment, we have continued to develop the range of services that we offer, addressing both the expectations and requirements of our commissioners, patients and our primary care colleagues. We have maintained our revenue levels through ensuring that we respond to competitive market opportunities and work closely with commissioners on the development of existing services. We are a dynamic organisation which has steadily grown in response to the needs of the local health community and in response to market changes.

We are seeing an increased expectation from our commissioners that providers are able to respond to challenging demands and to work with them to develop services and drive efficiencies whenever such developments become a commissioning priority. We are committed to this approach and to working closely with our local commissioners to ensure that:

- We remain flexible and proactive in our response to service change
- We remain committed to partnership working and integrated care
- We support our commissioners by providing accurate data and evidence.

Whilst we will deliver this mandate through the existing close working relationships with our local commissioners, which we have worked hard to maintain, we have also implemented a much greater level of clinical engagement into the contracting process. We have Clinical Directors for each of our operational divisions, who are supported by a number of Associate Clinical Directors, with clinical responsibility for each specific service line. We have therefore created a robust structure of clinical leadership within the Trust who, working closely with their nursing and operational management counterparts, support the interface with clinical commissioning colleagues and General Practitioners.

Changes to contracting and reimbursement processes

The vast majority of our clinical services are currently commissioned via block contracts. This framework is expected to continue for the duration of the Operational Plan. We will continue to work with the patient choice agenda and the ongoing development of Mental Health National Tariff Payment System (NTPS).

Where applicable, activity-related volatility in revenue streams has been modelled and mitigated in our financial planning. Our Improving Access to Psychological Therapies (IAPT) service continues to operate under the Any Qualified Provider (AQP) framework.

Nationally the implementation of Mental Health NTPS continues, with the focus being on improved data and the roll out of quality indicators as part of contracting. Our position has always been that NTPS is beneficial in several ways; including a way of calculating costs, payments and also of embedding quality and evidencing improved outcomes in a transparent way, offering improved access to clinical information for the people who use our services, staff, and stakeholders. We have updated our pricing and policy approach in line with the 2014 NTPS guidance from Monitor. Furthermore, we are a member of both the National (DH) Mental Health Quality and Outcomes Group and the Care Pathways and Packages Project (CPPP) Quality and Outcomes Group. We have also participated in the Department of Health's (Capita) audit/review of the 2012/13 reference costs submission; and clustering activity data covering all clusters for patients in service between 1 April 2013 and 30 September 2013. We continue to be one of the

leading Trusts in terms of the percentage of patients clustered.

We now provide NTPS information on the Trust's Core Care Standards website and we will be using the principles used to develop this in order to provide equivalent information about all our services over the forthcoming years.

In line with our strategic direction, we will proactively consider new service provision opportunities which demonstrate an affinity with our existing services and by which we can provide a quality service with a positive financial return. We do not, during the period of the plan, anticipate significant diversification from our core portfolio of services. Instead our strategy is based primarily on a need to meet growing and changing demand for our existing services, and to offer dynamic solutions to market opportunities, as they arise.

Productivity, efficiency and CIPs

Whilst historically we have successfully achieved our CIP programmes, future significant savings can only be delivered as a result of large scale transformational change; redesigning the services and pathways to be modern, efficient, and working to best practice. This requires processes and time to fully engage with stakeholders, including staff, carers and service users, and to ensure safe business continuity and full compliance with legal and employment obligations and good practice. The Transformational Programme for 2014-19 was therefore designed to plan major service change over a five year timescale. To enable clinical services to develop the transformational change visions for sustainable alterations to pathways, a proportion of the 2013/14 CIP schemes were delivered non-recurrently. The financial impact of this has been recurrently addressed in 2014/15 planning and plans are already in place for full delivery from 1 April 2014.

The Trust has a proven track record of delivering transformational change projects. 2010/11 was the commencement of the current system for co-ordinated programme delivery of CIPs, following the establishment of the Programme Assurance Office (PAO) in 2009. The biggest single transformation was the reconfiguration of Adult Community Mental Health Services, creating the new Pathfinder teams, and progressing to reconfigure Assertive Outreach.

Ensuring alignment with our Trust's strategic objectives
Once identified, and aligned with our 'Pillars for Improvement' (which are key factors that underpin our strategic outcomes), schemes are managed, reported, delivered and assured in one of the following three categories which directly support our strategic objectives. The key objective for all projects is to protect/improve quality whilst realising efficiencies. If this is not possible then mitigations will be put into place to allow the scheme to continue, or an alternative that does not adversely affect quality will be sought.

<u>1 Transformational projects</u>
Derbyshire Healthcare NHS Foundation Trust implemented its approach to service transformation at the end of July 2013, with the first of the Pathway and Partnership planning days occurring in October 2013.

This approach has been developed in order to:

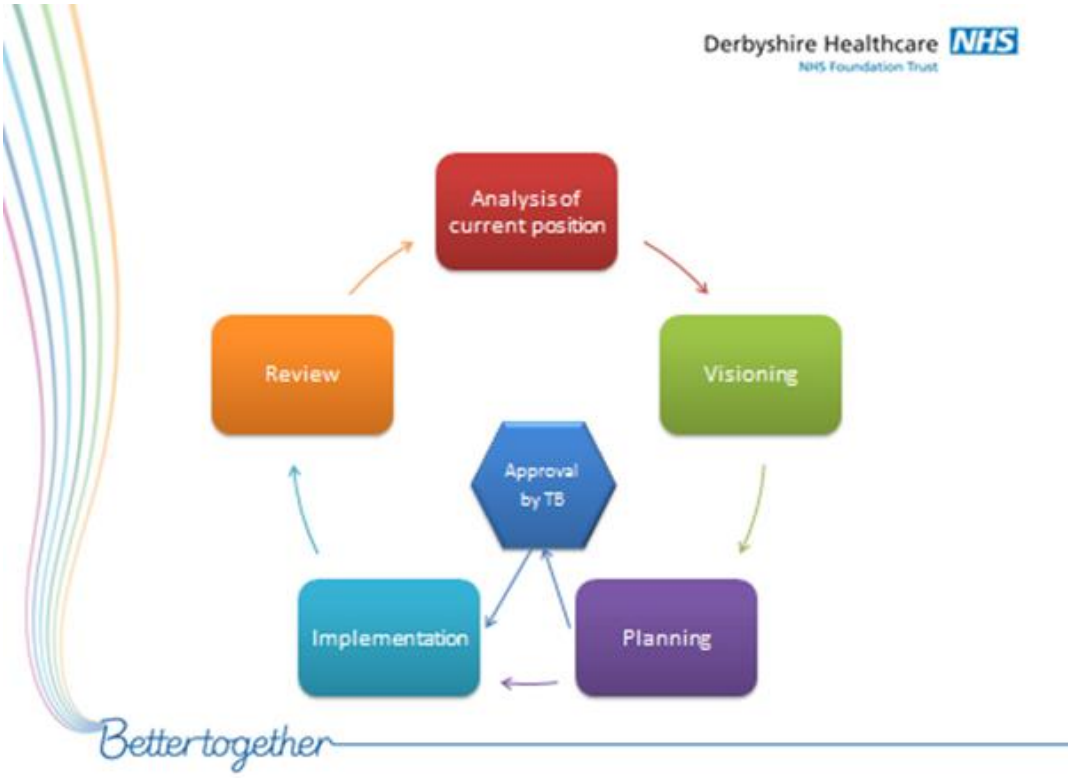
- Ensure continuous improvement in the quality of the care delivered, with demonstrable benefits to patient outcomes being the result
- Recognise, learn from, keep and protect current quality care and provide opportunities for sharing

best practice

- Provide a clear and transparent process for engaging our clinical and operational staff, service users, carers and external stakeholders in the design of future service configurations.
- Simplify the delivery of care and support through;
    - Promoting internal integration between teams and services as well as integration within the wider health and social care community
    - A focus on promoting wellness and supporting local communities to develop assets that enable mutual self-support and drive a focus away from actual or virtual institutional care
    - Preparation for outcome based payment structures
    - Reductions in cost every year for Derbyshire Healthcare Foundation Trust.

The model allows for each pathway to develop an understanding of what their current position is. This is then analysed and discussed to ensure a shared understanding amongst all attendees. Our second stage is to undergo a facilitated visioning session during which all attendees are supported in describing what their pathway will look like in 2019; the third stage enables the pathway to articulate this as a plan, identifying key milestones for delivery of the vision across five years.

Once plans are developed these are presented into our Transformation Board (TB) for approval and each pathway enters an implementation stage. This is demonstrated in the model below:



2 Traditional projects

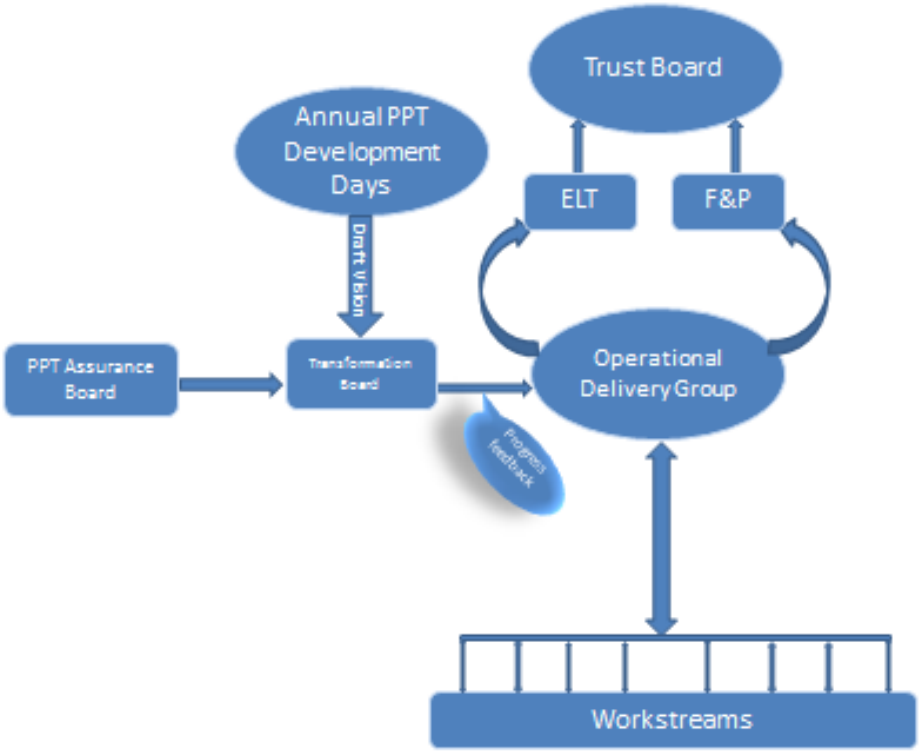
These are pay and non-pay projects, directly supporting the Estate Strategy, IM&T Strategy and Procurement Strategy. Procurement contracts are annually reviewed to minimise costs, contracts are closely monitored, and renegotiated as necessary. This year we have devolved the management of clinical inter-trust contracts into relevant operational divisions, to maximise clinical oversight, control and efficiency. We are working through a rolling programme to optimise our estate, and moving towards much greater flexibility of workforce that works in an increasingly agile way. As indicated above, the detail within the year one plans has created an opportunity for some transformational savings to be identified. However, as anticipated, there is a recognised requirement to have enabling schemes in place which will support each PPT to develop more and more transformational plans each year that deliver the required

level of savings. The Operational Delivery Group will enable the co-ordination of these plans and, through being held to account by the Executive Leadership Team, will ensure that the group is held to account on delivery of revised service models (time, quality and finance).

3 Enabling projects

These are bespoke pieces of work within projects which analyse, develop guidance, policies etc. and are specifically required (mainly by transformational projects) to "enable" other projects to further develop their efficiencies. A number of these cross-cutting projects that may or may not achieve savings directly are being identified through the Transformational Change Programme. The most wide-ranging of these is the Electronic Patient Record Programme (EPR).

The image below demonstrates how the Operational Delivery Group supports the overarching opportunity to understand in detail cross PPT opportunities for transformation or efficiency, whilst maintaining the excellent vehicle for the engagement of internal and external stakeholders within the PPTs and Transformational Board. This model allows for continued co-ordination of alliances between packages of work in the workstreams and drives forward delivery with respect to time, quality and finance. The Operational Delivery Group will monitor each PPT on progress against their vision and will support quarterly reporting to Transformational Board on progress. The Operational Delivery Group feeds into both the Executive Leadership Team and the Finance and Performance Committee, which both in turn report to the Trust Board.



Quality, Innovation, Productivity, Prevention (QIPP) and demand management

We continue to significantly contribute to the CCGs' QIPP requirements, which we have delivered through reducing commissioner expenditure on out-of-area treatments and acute mental health and rehabilitation inpatient care. This has been achieved through the development and implementation of creative and innovative alternative models of care, such as extending the role of our Home Treatment service and through the use of bespoke care packages. The net impact of these initiatives has resulted in a significant

saving for our commissioners through an investment into our services. For the lifetime of this plan, we anticipate this practice continuing, particularly with the impact of the new inpatient ward.

We will, for example, continue to actively repatriate patients from out-of-area placements back into Derbyshire, ensuring that local services can respond rapidly to specific individual needs both in terms of inpatient and community based care. In addition we will continue to plan for the expansion and development of particular community services, particularly around Eating Disorder Services, Autistic Spectrum Disorder Services and Attention Deficit Hyperactivity Disorder Services, where there is a direct correlation between the lack of community investment and an increasing level of out-of-area inpatient costs. This will be undertaken jointly with clinical commissioning colleagues.

During 2014/15 we will also see the consolidation of the newly commenced Liaison Service into the Royal Derby Hospital, where the new service commenced in 2013. A corresponding service for the North of the County at the Royal Hospital in Chesterfield has now also been commissioned and will commence in 2014/15. These liaison services represent a significant investment for our Trust with the net result for the local health economy being a significant saving for commissioners, better patient flows for the Acute Trusts and improved quality of care for patients and carers. The approach supports our commissioners' view that, by working collaboratively with the Trust, we act as a solution to addressing some of the efficiency requirements elsewhere in health community.

Productivity and efficiency gains

The overall level of planned activity for the period remains generally stable, with the exception of the number of occupied bed days within adult acute mental health inpatient services, where the activity in the plan is increased to reflect the additional bed capacity that will be available from April 2014. Our plan is to ultimately reduce bed capacity (adults and older adults) through a corresponding investment in community based services.

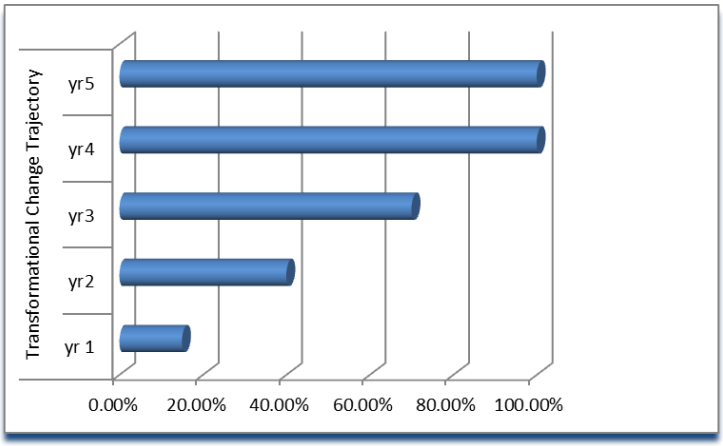
The plan assumes lower levels of bank and agency cover as the costs are included in the permanent staffing budgets. Prompt appointment to vacancies will reduce the need for temporary staffing. We are also in the process of rolling out e-rostering to all our inpatient services and crisis teams; this will also support and evidence improved efficiency in staffing planning and reduced need for bank and agency staff in those areas.

The Transformation Programme is redesigning pathways across the organisation, with related changes in team structures. A key driver is improving efficiencies in these pathways. For example, Children's and Young People's Services are removing duplication and points of hand-over through implementing a single point of entry; Urgent Care are redesigning flows through inpatient units by clarifying assessment, treatment and discharge phases, linking to redesigned community services. Over the five years of the programme, this is ultimately expected to result in a decrease in the number of inpatient beds required. Dementia services will develop community services to support people living in their own homes, again reducing the requirement for inpatient services.

CIP governance

CIPs are monitored using a dedicated Programme Assurance Office and governance structures reporting to the Board of Directors. This system is now in its fifth year and has to date delivered 100% of its CIPs to plan, with no assessed decrease in quality over 165 projects. The Pathway and Partnership Teams have agreed the five year visions for all service lines and these have been signed off for delivery by our Transformation Board. Work streams to ensure that the transformational plans are delivered have been formed, within a robust programme management and assurance process.

As expected, transformational plans identified within year one account for 15% of cost improvement, the remaining 85% has been identified as traditional. This allows the development of work streams to ensure that the enabling transformational plans are in place for delivering an upward trend of transformational savings year on year. The graph below indicates an expected trajectory, based upon discussions within the PPTs.



Financial Plan

Assessment of Trust's current financial position
The Trust is forecasting to end the 2013/14 financial year with an underlying surplus of £1.9m, which is above plan by £0.6m.

Under the previous Financial Risk Ratings (FRR), the Trust achieved a FRR of 3 in the first two quarters and following the changes to the Risk Assessment Framework achieved a CoSRR of 3 in the third quarter. The Trust is forecasting to retain a CoSRR of 3 at the end of the financial year as per plan. The forecast includes full delivery of the Trust's Cost Improvement Programme. £1.1m of CIP in 2014/15 has been found non-recurrently against a recurrent plan. Cash is forecast to be £6.9m which is ahead of plan by £0.6m and the Trust did not utilise its working capital facility (WCF).

The forecast financial performance of the Trust for 2013/14 is summarised below:

- EBITDA ahead of plan by £0.65m
- Net surplus behind plan by £0.33m due to a higher than planned impairment (underlying surplus ahead of plan)
- Cash ahead of plan by £0.6m.

Summary of Operational Financial Plan for 2014/15 to 2015/16
The Trust is planning on an underlying surplus of £1.56m in 2014/15, with an impairment of £1.2m generating a net surplus of £0.36m. EBITDA is planned to be £7.76m which equates to 6.1% of total income. The Trust's plans include CIP delivery of £4.3m which is 3.4% of total expenditure.

Year 2 of the Operational Plan is mainly driven by an assumed level of tariff deflation, pay and non-pay inflation, the full year effect of service developments from the previous year and Cost Improvement Plans. These assumptions generate an underlying surplus of £1.8m (net surplus of £1.5m), with an EBITDA of £8.0m which equates to 6.37% of total income.

The Trust is planning to achieve a CoSRR of 3 in both years of the Operational Plan. The plan also delivers a CoSRR in all quarters of the two year plan. The plan does not assume the use of the WCF.