



**Strategic Plan Document for 2013-14**

**Derby hospitals NHS Foundation Trust**

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## EXECUTIVE SUMMARY

### Introduction

This strategic plan document has been prepared in line with Monitor guidance. It reflects the three-year plan for the Trust and is consistent with the recently agreed five-year strategy: "Quality Through Partnership". The Board confirms that :

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

### Strategic context and direction

The Trust's vision is:

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

The Trust has four key strategic imperatives, which underpin the clinical plans for the Trust. The three clinical Divisions have developed three-year plans which are aligned to these strategic goals:

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

In preparing its plan Trust has reviewed its position relative to peer Trusts and has assessed its areas of strength and weakness. Changes in forecast health, demographic and demand for services have been considered and incorporated into future plans for the Trust.

Following the NHS reorganisation in April 2013 local services are commissioned by Southern Derbyshire Clinical Commissioning Group. Provider and commissioner jointly work to agreed principles:

- To protect core services for our patients maintaining quality and equality of access, within a challenging financial envelope.
- Continue to tackle long standing health community issues.
- More effective integration across organisational boundaries to remove blocks in the system and contracts set up to work towards incentivising this.

- Support the provider to ensure that patients will be treated in the most appropriate setting
- Support primary care and secondary care clinicians through Clinical Improvement Groups to minimise unnecessary clinical or operational variation.
- Ensure the risk and incentives for delivering transformation are shared across the health community, and that these will be embedded within contracts.
- Specialised services are now commissioned by the Leicestershire and Lincolnshire local area team

The Trust has considered key changes to local commissioning strategies and their impact on the Trust and has factored these considerations into its strategy. The Trust strategy for 2013-18 "Quality Through Partnership" takes account of the strategic context and is based upon a rigorous process of review, analysis and stakeholder engagement.

The Trust's demand profile and activity mix has been analysed. Despite demand management initiatives throughout 2012/13, the Trust has seen an increase in planned care demand. In respect of urgent care, we have experienced increased pressure throughout the Trust. The pressures in the emergency department have been particularly significant. Admission avoidance measures have helped to contain growth in attendances but the department has felt additional pressure because of increased acuity of patients attending A&E. A variety of measures are in place including developing case management and supporting primary care developments for the frail elderly population. The Trust is redesigning internal systems using recently published guidance from NHS England. However, at this stage the Trust cannot guarantee that it will meet the required four-hour standard at year end, although every effort will be made to do so.

The Trust has a good reputation for whole system working with its commissioners and neighbouring providers with well established networks and a number of formal partnerships in place, working as a core member of the health community. The Trust plans to integrate services to provide better care and increase efficiency.

## Quality






One of the four strategic imperatives adopted by the Trust is "quality in everything we do." As demonstrated in the diagram below



This approach to quality is central to all the Trust's activities, with clear accountability and governance structures in place. The Trust has clearly articulated its quality objectives for 2013-15, and has identified milestones for achievement, actions, risks to delivery and mitigating actions for each of these. A clear system of Board assurance is in place

## Clinical strategy

The Trust's five-year strategy was agreed during 2012 and is underpinned by strategic goals. That's the Trust seeks to achieve by 2018. These are framed around the acronym "PRIDE", as shown below:

|   |  |   |
|---|--|---|
|    | <b>Putting patients first</b>              | <ul style="list-style-type: none"> <li>Top decile performance for patient experience surveys</li> <li>Patients will be able to access and interact with hospital IT systems</li> <li>External recognition for the active role patients play in managing their care</li> <li>Business Units to have implemented at least three opportunities for empowering patients</li> </ul>  |
|    | <b>Right first time</b>                    | <ul style="list-style-type: none"> <li>Top decile performance for patient safety</li> <li>Top decile performance for clinical effectiveness</li> <li>All registered LTC patients receive care according to agreed, integrated care package</li> <li>Reduce emergency admissions by over 3%</li> <li>Agreed and implement annual targets for reduction of unwarranted clinical variation</li> <li>Exceeding top decile delivery of contract performance targets</li> </ul> |
|  | <b>Investing our resources wisely</b>      | <ul style="list-style-type: none"> <li>Achieve an annual surplus of at least 2% and deliver a return on investment of at least 5%</li> <li>Top decile performance for operational productivity</li> <li>Real-time, accurate and comprehensive data that supports clinical and managerial decision making (SLM and PLICS)</li> <li>Reduction in use of agency staff by 50%</li> </ul>  |
|  | <b>Developing our people</b>               | <ul style="list-style-type: none"> <li>Top decile performance for staff productivity and staff satisfaction</li> <li>Derby rated as top hospital in LETB for clinical training</li> <li>A skilled and diffused leadership workforce throughout the Trust</li> <li>Named as one of the 20 best providers to work for in the NHS</li> <li>External awards for people development</li> <li>Reward strategy aligned with productivity achievement</li> </ul>                  |
|  | <b>Ensuring value through partnerships</b> | <ul style="list-style-type: none"> <li>Vibrant and developing strategic alliances with Burton, Chesterfield, Nottingham, DCHS and Derbyshire Healthcare</li> <li>Business Units will have arrangements for clinical engagement and vertical/horizontal integration</li> <li>Contribute to measurable improvements in population health across southern Derbyshire for patients with diabetes, COPD and dementia</li> </ul>  |

The immediate priorities for year one of the plan are depicted on our "plan on a page," for 2013/14. This is shown on the next page.

| PLAN ON A PAGE-2013/14  |
|---|
| <b>PUTTING PATIENTS FIRST</b>   |
| Improve clinical outcomes for our patients by setting and ensuring adherence to professional, safety and clinical standards   |
| Implement evidence based design of urgent care pathways and services delivered through the Transformation Programme   |
| Redesign the elective pathway to improve the experience of care for our patients using the available research and evidence to inform the process.                         |
| Develop the patient experience framework as part of the overall quality strategy to improve the use of patient feedback in improving the overall quality of care          |
| Ensure that 'Personal, Fair and Diverse' means that our organisation, services and staff are culturally aware   |
| <b>RIGHT FIRST TIME</b>   |
| Develop the next five year Quality Strategy in line with our strategy <i>Quality through Partnership</i> and lessons learned from the Francis enquiry                     |
| Implement an improved integrated model of care for frail older people who we care for within our acute and community services ensuring alignment with the wider programme |
| Implement key priorities to improve the services and understanding of the needs of those with dementia and their carers   |
| Deliver our Transformation plan   |
| Review our maternity services model to improve patient experience and safety promoting midwifery led care   |
| <b>INVESTING OUR RESOURCES WISELY</b>   |
| Transform our services by embedding Service Line Management to devolve decision making closer to service delivery   |
| Replace our Patient Administration system (PAS) and upgrade key clinical systems to enable improved clinical and administrative process efficiency                        |
| Deliver a financial surplus to enable developments and sustainable medical equipment replacement  |
| Develop better information to enable improved service performance and management of unwarranted variation   |
| Complete our plans for rationalising our estate providing benefits to the local community   |
| <b>DEVELOPING OUR PEOPLE</b>  |
| Build and sustain an open and honest culture where patient care is central and our staff are supported in maintaining their health and wellbeing                          |
| Value, recognise and reward our staff as appropriate for the work that they do identifying and supporting the development of talent                                       |
| Develop a flexible and skilled workforce to ensure we can manage variation in demand more safely and cost effectively to meet the needs of our patients                   |
| Continue to build and develop our leadership community throughout the Trust   |
| <b>ENSURING VALUE THROUGH PARTNERSHIPS</b>  |
| Understand the changes to the commissioning of specialist services and work to ensure that appropriate services are provided in Derby                                     |
| Develop strategic partnerships with local Trusts to ensure our clinical networks are robust and patients receive the best care  |
| Work with other agencies involved in health and social care to ensure that we create integrated systems focused on helping individuals to be as healthy as they can be    |
| Inspire and encourage our local people into NHS careers through our engagement with the local community and in particular, education providers                            |
| Develop and agree a workable solution for sharing patient information   |

In addition, the clinical Divisions have developed their three-year plans, and have also described more detailed ambitions for year one-2013/14. A summary of these is shown below and on the following pages.

| <b>Business Unit</b>                                   | <b>Deliver quality in everything we do; safety, effectiveness and patient experience</b>                           | <b>Transform services to maximise productivity and efficiency</b>  | <b>Create networks for acute and complex care</b>  | <b>Develop integrated care for people with long term conditions to help them stay as healthy as they can</b>             |
|--|--|--|--|--|
| <b>Divisional and business unit priorities 2013/14</b> |  |  |  |  |
| <b>Surgery</b>   |  |  |  |  |
| <b>General Surgery</b>                                 | Redesign the Elective patient pathway to improve the patient experience  | Embed and develop acute surgical assessment model<br>Transform theatres & related services   | Develop clinical relationships in Urology with other Trusts<br>Maintain and seek new contracts for Bariatric surgery and become a nationally commissioned centre for obesity | Develop new models to support management of long term conditions to avoid unnecessary attendances at surgical assessment |
| <b>Maternity &amp; Gynaecology</b>                     | Develop a Birth Centre , delivery of midwifery led care ; Maternity 24/7 assessment Centre                         | Remodel and expand the Gynaecology Assessment Unit<br>Transform theatres & related services  | Work with Public Health to better meet the needs of pregnant women with complex care requirements  | Working with GPs to develop an integrated care model for those living with HIV   |
| <b>Orthopaedics</b>                                    | Improve patient experience by reducing waiting times   | Increase capacity to meet demand and reduce additional capacity payments – Ortho (5 <sup>th</sup> spinal) & Hands (+1 consultant); Transfer daycase procedures to an outpatient setting where clinically appropriate | Expand our catchment population by developing peripheral service spokes  | Development of an integrated orthogeriatric service for fractured neck of femur & other fragility fractures              |
| <b>Specialist Surgery</b>                              | Establish patient 'experience by design' listening groups in each specialty to improve the quality of our services | Improve theatre utilisation and continued shift from Inpatient to Daycase and Daycase to Outpatient setting  | Increase partnership working with other local organisations to deliver joint services to improve the efficiency and effectiveness of services                                | Work with local commissioners to increase the delivery of care closer to home, where appropriate                         |



| Business Unit                                   | Deliver quality in everything we do; safety, effectiveness and patient experience | Transform services to maximise productivity and efficiency   | Create networks for acute and complex care   | Develop integrated care for people with long term conditions to help them stay as healthy as they can |
|---|---|--|--|---|
| Divisional and business unit priorities 2013/14 |   |  |  |   |
| Clinical Support Services & Cancer              |   |  |  |   |
| <b>Anaesthetics</b>                             | Reduced unwarranted variation   | Understand demand & capacity and introduce robust management processes   | Ensuring we continue to engage with the Critical Care Network within the new specialist commissioning arrangements | Develop new models of integrated care for patients with long term chronic pain                        |
| <b>Cancer</b>                                   | Implement Patient Pathway Coordinator   | Scope future needs of cancer services, taking into account the increasing demands for Chemotherapy                               | Expand Lymphoedema service across the East Midlands  | Develop integrated service for haematology, palliative medicine and lymphoedema in the community      |
| <b>Imaging</b>                                  | Prepare the Business Unit for National ISAS Accreditation                         | Understand the implications and opportunities associated with the introduction of the unbundled Imaging Tariff to best advantage | Establish interventional radiology for vascular hub ensuring clinically effective pathways                         | Support new model of care introduced by community business unit                                       |
| <b>Pathology</b>                                | Improve access and turnaround time of appropriate tests                           | GP Direct Access- respond to regional procurement  | Extend Histopathology resources (11 <sup>th</sup> Consultant) to meet the demand of increased MDTs                 | Extend the scope of "Shared Care Pathology" to further conditions                                     |
| <b>Pharmacy</b>                                 | Complete implementation of ePMA & ICM planned discharge project.                  | Develop plans to support innovative care models: Pharmacist Rxer (prescribers) / consultant roles                                |  | Further develop the Discharge Hub to appropriately refer patients to Community Pharmacy               |
| Medicine  |   |  |  |   |
| <b>Paediatrics</b>                              | Improve discharges  | Develop Service Level Agreement with Surgical Services to ensure delivery of   | Enhance relationships with tertiary centres  | Review patient pathways (KITE team) for   |



| <b>Business Unit</b>                                   | <b>Deliver quality in everything we do; safety, effectiveness and patient experience</b> | <b>Transform services to maximise productivity and efficiency</b>                                 | <b>Create networks for acute and complex care</b>                        | <b>Develop integrated care for people with long term conditions to help them stay as healthy as they can</b> |
|--|--|---|--|--|
| <b>Divisional and business unit priorities 2013/14</b> |  |   |  |  |
|  |  | Paediatric surgery capacity   |  | chronically ill children, to enhance integrated care   |
| <b>Rehab Medicine and community</b>                    | Agree a model for the management of the frail and older person within the Trust          | Develop a complex discharge team to support timely discharge of complex patients within the Trust | Review specialist rehab services to enable focus on areas of excellence. | Identify priority patient pathways to develop across primary and secondary care and progress year 1 priority |
| <b>Specialist Medicine</b>                             | Introduce Medicine Liaison Nurses to improve patient flow and reduce outliers            | Increase Diabetes Medical capacity (x 2 Consultants)  | Develop and maximise CIGs for Respiratory, Cardiology and Dermatology    | Expansion of Pulmonary Rehab services  |
| <b>Acute Medicine</b>                                  | Introduce ED assistants to improve internal flow   | Review MAU Triage model and the gate keeping function   |  |  |

## **Productivity and efficiency**

The Trust has developed its transformation plan to improve productivity and efficiency and has projected their financial impact. A range of schemes for 2013/14 are aimed at delivering improved productivity and efficiency. These include:

- Surgical pathways
- Medicine avoidable admissions
- Theatre productivity
- Outpatient transformation
- Workforce redesign for admen and clerical staff
- Integrated care pathway development
- Facilities management
- Synergy contract

We set out in section four arrangements for transformation governance, the top five Cost Improvement Schemes (CIP) for 2013/14, transformation enablers and how the Trust assures itself of any quality impact of transformation schemes.

## **Financial and investment strategy**

The financial and investment strategy contains an assessment of the Trust's current financial position, key financial priorities and investments and how these link to the Trust's overall strategy, as well as key risks to achieving the financial strategy and mitigations.

# 1 STRATEGIC CONTEXT AND DIRECTION

## 1.1 The Trust's strategic position within local health economy

We have developed our new five-year strategy. **"Quality Through Partnership"**

Our vision is:

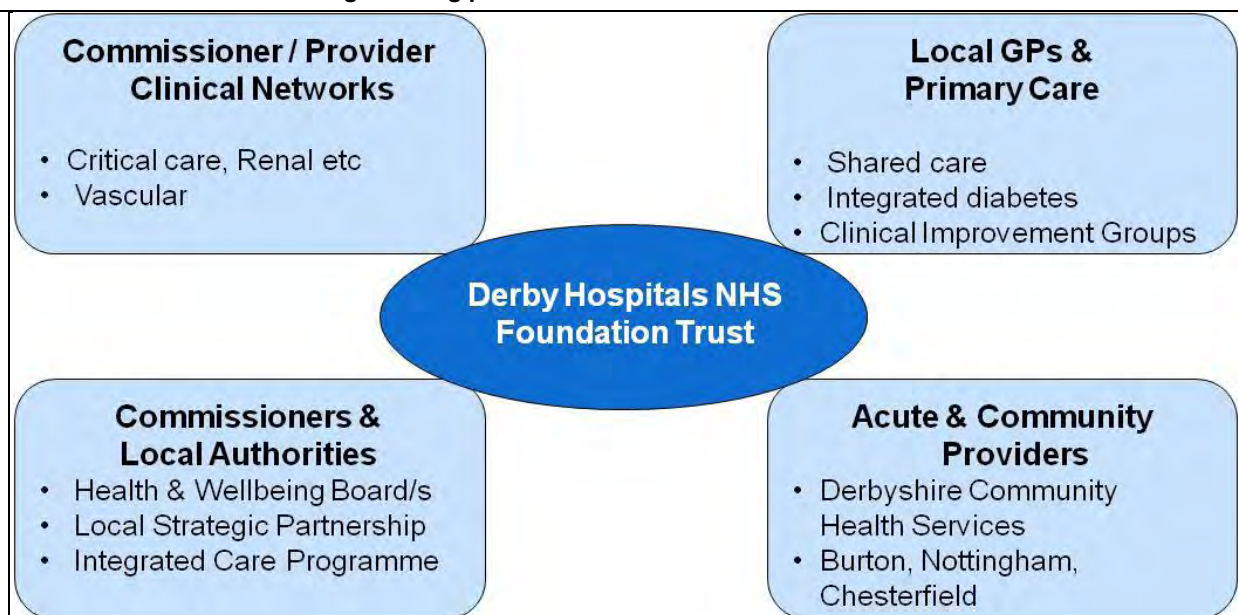
**'To be a national beacon for all that is best in the NHS delivering 21st century healthcare. We will be part of a flourishing network of health and social care partners to integrate care for our patients, deliver clinically excellent results and be financially sustainable.'**

Much of what we have achieved over the past five years will help us to achieve our vision.

Our strategy has four key strategic imperatives:

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

*Derby has a strong and respected reputation for whole system working with its commissioners and neighbouring providers*

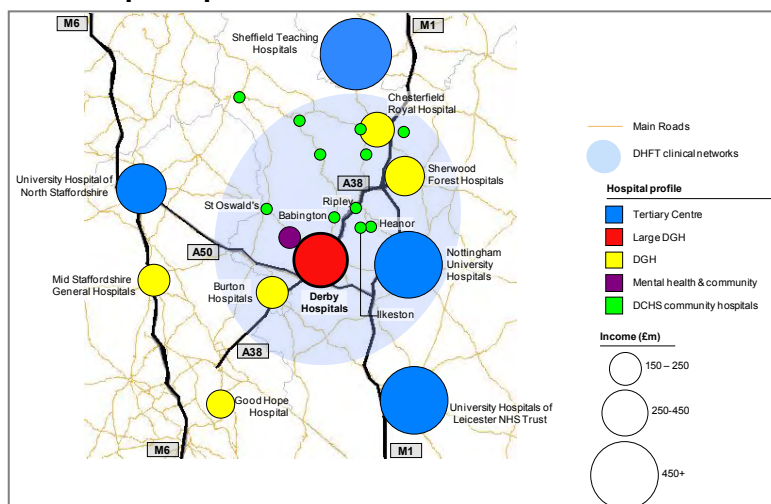


### 1.1.1 An overview of the Trust's key competitors and an assessment of the Trust's key areas of strength/weakness relative to the key competitors;

Derby is the most central city in England. The map below shows its geographical relationship to neighbouring tertiary centres and DGHs. We are also well located relative to major transport routes. 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 care

## Landscape of providers within the local network



### 1.1.2 Forecast health, demographic, and demand changes

#### Local demographics

The Trust's main commissioner is Southern Derbyshire Clinical Commissioning Group (SDCCG), which comprises the former Derby City and the southern part of the former Derbyshire County PCTs and serves a population of over 600,000. The age profile of SDCCG 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.

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. This has implications for service design, particularly in community services. Services more tailored to these groups may increase uptake and self-management of conditions such as diabetes, reducing non-elective admissions.

The SDCCG affordability envelope for elective services will also have to be considered in relation to managing our waiting times. The Health and Social Care Act 2012 puts greater emphasis on competition but there is also an increased focus on developing innovative care pathways, particularly for patients with Long Term Conditions (LTCs). This places an even greater focus on integrating services through strategic partnerships and joint ventures. The Act emphasises the need for greater patient choice. All of these factors and the changing health landscape mean that our response needs to be adapted to ensure that market share is maintained in innovative ways.

The number of patients living with LTCs is increasing. The increasing uptake of assistive technologies has resulted in patients expecting a higher standard of care, closer to home. Diabetes episodes are predicted to grow by 9.9% between 2011 and 2018, reinforcing a need to improve access to services in the community. LTCs can be managed more effectively in a community setting or with assistive technologies. Through partnerships we are able to maintain market share in LTCs. We are a partner in two award winning limited co companies delivering integrated diabetes care (Intercare Health and First Diabetes). In 2013-14 commissioners are likely to commission this model for the population. There is also further potential in delivering renal service particularly focusing on prevention.

The Trust recognises the value in ensuring that the right types of services are available for these groups as well as linking closely with local authorities and Health and Wellbeing Boards.

## **1.2 Threats and opportunities from changes in local commissioning intentions**

The commissioning landscape has changed for 2013/14 with separate commissioning intentions and arrangements from the SDCCG and the EMSCG.

### **1.2.1 Southern Derbyshire Clinical Commissioning Group**

SDCCG intends that locality clinicians will continue to engage with provider clinicians to develop service and pathway improvements through the establishment of Clinical Improvement Groups (CIGs). Managerial support in both organisations will play a key role in facilitating and implementing this joint work between GP's and consultants to redesign care for the 21<sup>st</sup> century.

Clinical engagement between clinicians in both the provider and commissioner organisations has been strengthened, as have links between clinicians and managers across both organisations. Innovative ways have been developed to share information and knowledge, through the "GPApp" (see section 3.3.1) and the CIGs. These are leading to new, sustainable and deliverable solutions that support the aims of both commissioner and provider.

Both provider and commissioner continue to work to the following principles:

- To protect core services for our patients maintaining quality and equality of access, within a challenging financial envelope.
- Continue to tackle health community- wide issues.
- More effective integration across organisational boundaries to remove blocks in the system and contracts set up to work towards incentivising this.
- Support the provider to ensure that patients will be treated in the most appropriate setting
- Support Primary Care and Secondary Care through CIGs to minimise unnecessary clinical or operational variation.
- Ensure the risk and incentives for delivering transformation are shared across the health community, and that these will be embedded within contracts.
- Whilst the long term affordability envelope for the CCG for acute care is lower than the volume of activity currently commissioned, they have now cleared their legacy debt. SDCCG and the Trust have agreed to work together actively in year to transform both urgent elective care to ensure services are fit for purpose, with streamlined pathways driving value and sustainability for both parties.

### **1.2.2 East Midlands Specialised Commissioning Group**

Specialised services are now commissioned nationally and managed through 10 nominated NHS England Area Teams. The Leicestershire and Lincolnshire AT is responsible for contracting for DHFT. NHS England will encourage equity in outcomes and access for patients across the country.

A single set of Identification Rules for counting and coding activity has been implemented. Harmonisation of non-tariff prices within providers is to ensure the same price for the same service for all activity commissioned by NHS England from 1 April 2013. However, a number of services at DHFT that should be eligible for specialised tariff, such as selected spinal work, are not yet registered as a specialist service and are being put through the derogation process. In the interim, such services will continue to be contracted by the CCG at a less favourable tariff. During 2013/14, the Trust will evaluate the future delivery of these services against its strategy, working with commissioners and the relevant consultant staff.

### **1.2.3 An overview of the key changes to local commissioning strategy and intentions and their anticipated impact on the Trust, including:**

#### **i. QIPP & demand management:**

In recent years, the PCT/CCGs have identified significant demand management assumptions to achieve an affordable contract. Whilst major achievements have been made, including the levelling off of non-elective work and achievement of £4 million savings in elective care efficiency, the full target savings were not achieved.

During 2012/13 the Trust and CCG established Clinical Improvement Groups (CIGs) to drive clinical engagement and service transformation. GPs and hospital consultants meet regularly to identify service issues and redesign service models. The A&E CIG continues to address and respond to challenges around delivery of the A&E target. Progress made in developing CIGs means that the Trust and CCG have been able to take a different approach to the 2013/14 contract.

The modelled activity, including assumed demographic growth has been commissioned. A service improvement plan is being agreed, which will outline the health community's transformation projects in 2013/14 and beyond. As service transformation and demand management influence configuration and volume of service, any changes will be enacted through contract change notices.

The key priority for 2013/14 is the whole system plan to manage pressures on emergency services, particularly amongst the ageing population:

- Development of the full integrated care model to support frail and older people and those with LTCs to be as healthy as they can be and remain supported in the community where possible
- Agreeing a whole-system urgent care transformation plan resulting from a joint urgent care summit; SDCCG has agreed to reinvest the EMRET 70% monies (£3.5 million) within the hospital or community services to support the Trust in managing emergency pressures; this investment is in recognition of the impact of the ageing population on delivery of four hour waits in A&E. This resource is being invested in internal and external services to support delivery.
- Agreement of work programmes with CIGs to review and develop new elective care models
- A new urgent care oversight group to develop plans and monitor delivery with the integrated care programme board overseeing investments in community to develop integrated care case management.

#### **ii. Decommissioning:**

Commissioners have not indicated any services that they wish to decommission. Should the Trust lose any further contracts tendered through AQP (see below) which it currently provides, these services would need to be decommissioned. The CCG has served notice of its intention to tender several services in 2013/14 including phlebotomy, integrated diabetes and has formally served notice on our contracts for these services.

#### **iii. Potential "Any Qualified Provider" Tenders**

Increased competition under Any Qualified Provider (AQP) means the potential for new entrants to the market could potentially be a threat to our market share. Whereas this was a significant concern a year ago commissioners locally indicate that they do not have any planned AQP tenders planned in the next year.

#### **iv. Shifting care delivery outside hospitals:**

We are rolling out "productive community services" for Derby city, and are working in partnership with Derbyshire Community Health Services in respect of the County. This will ensure fitness for

purpose of services to respond to the recommissioning of the TCS contract next year. The initiative is being rolled out initially with district nurses and community matrons. We are working with Commissioners on frail elderly services and long-term conditions, as part of the health community integrated care programme

**v. Reconfiguration plans.**

We are not aware of any local proposed reconfigurations of services.

**1.2.4 An explanation of how the Trust has factored these considerations into its strategy;**

In 2012/13 we revised and developed our new strategy for 2013-18: "**Quality Through Partnership**". We took account of the strategic context, through a rigorous process of review and analysis. We undertook extensive stakeholder engagement and development with the board, governors, staff and stakeholders.

The new strategy focuses on four strategic imperatives critical to the successful development of the Trust over the next five years, with a new vision to take the organisation forward. We realigned our internal structures. Clinical Divisions, and their Business Units developed clinical service strategies consistent with the vision and strategic imperatives. This enables them to provide a clear vision of their aspirations and direction of travel for their services; they have also developed 3 year clinical service plans. The Trust strategy, the five-year planned outcomes and the one-year plan are described in more detail in the clinical strategy in section 3.

**1.2.5 Analysis of how the Trust's demand profile and activity mix has evolved over recent years, and what changes are forecast**

**i. Planned Care**

Despite demand management initiatives throughout 2012/13, the Trust saw an increase in referrals of 0.8%, with in excess of 1300 more referrals than the previous year. There was a 5.6% increase in GP/GDP referrals, totalling 5164 more than the previous year. In particular, the biggest area of growth in volume of referrals was Urology (1396 – 34%), with Paediatrics and Gastroenterology leading the specialties that experienced significant increases. Overall, nearly 6100 more outpatient attendances took place than the previous year, despite the implementation of numerous telephone consultation services.

With the ongoing work to change procedure setting, there was a small decrease in volume of elective activity (-704) coupled with a significant increase in daycase and outpatient procedure activity (+4281 and +2041 respectively).

Compared with the previous year, there was a 3.26% increase in referrals for suspected cancer, with a corresponding increase in the 62 day urgent cancer treatment of 5.42%. There was also a 21.35% increase in subsequent surgical treatments. The number of subsequent radiotherapy treatments fell by 18.95%.

**ii. Urgent Care**

The ED had a challenging year, with not only an increase in activity of nearly 2%, but a marked change in the density of case mix through the department. Throughout the winter months, the Trust saw a 21% increase in 90+ year olds attending ED and an 8% increase in Majors in ED. Achievement of the A&E four hour target has been particularly challenging. Looking ahead, The planned trajectory will not see the Trust hitting 95% in May or until at least the end of June 2013, as many of the plans detailed in the latest action plan will not be realised until that point.



Admissions to Medicine saw a 6% increase in 80+ year olds and a month on month increase in relative value unit (RVU). Taken together, these represent a substantial increase in acuity which is not immediately apparent by looking simply at the numbers admitted.

Medical Admissions Unit (MAU) activity increased by 39.84% with 1614 additional attendances, and non-elective activity increased by 8.25% (4122 cases).

The overall footfall into the Trust, which includes all types of attendances, was 1.42% higher than the previous year. The demand, coupled with the increased RVU has proved an additional challenge to meeting the performance targets. There are action plans in place to address the ongoing non-achievement of the ED and Cancer 62 day targets.

## 1.2.6 Details of how the Trust is diversifying its income streams

The Trust continually reviews potential new income streams through its Programme Management Office arrangements. These are recorded as potential income generation opportunities.

## 1.3 Collaboration, Integration and Patient Choice

### 1.3.1 Plans to integrate services to provide better care and/or increase efficiency;



The health community has agreed that a key success factor in reducing inappropriate admissions will be the development of an integrated care system for frail and elderly whose health-care needs are driving the most significant pressure on health care services and resources and whose social and health care needs are least well met by the current structures and service delivery model.

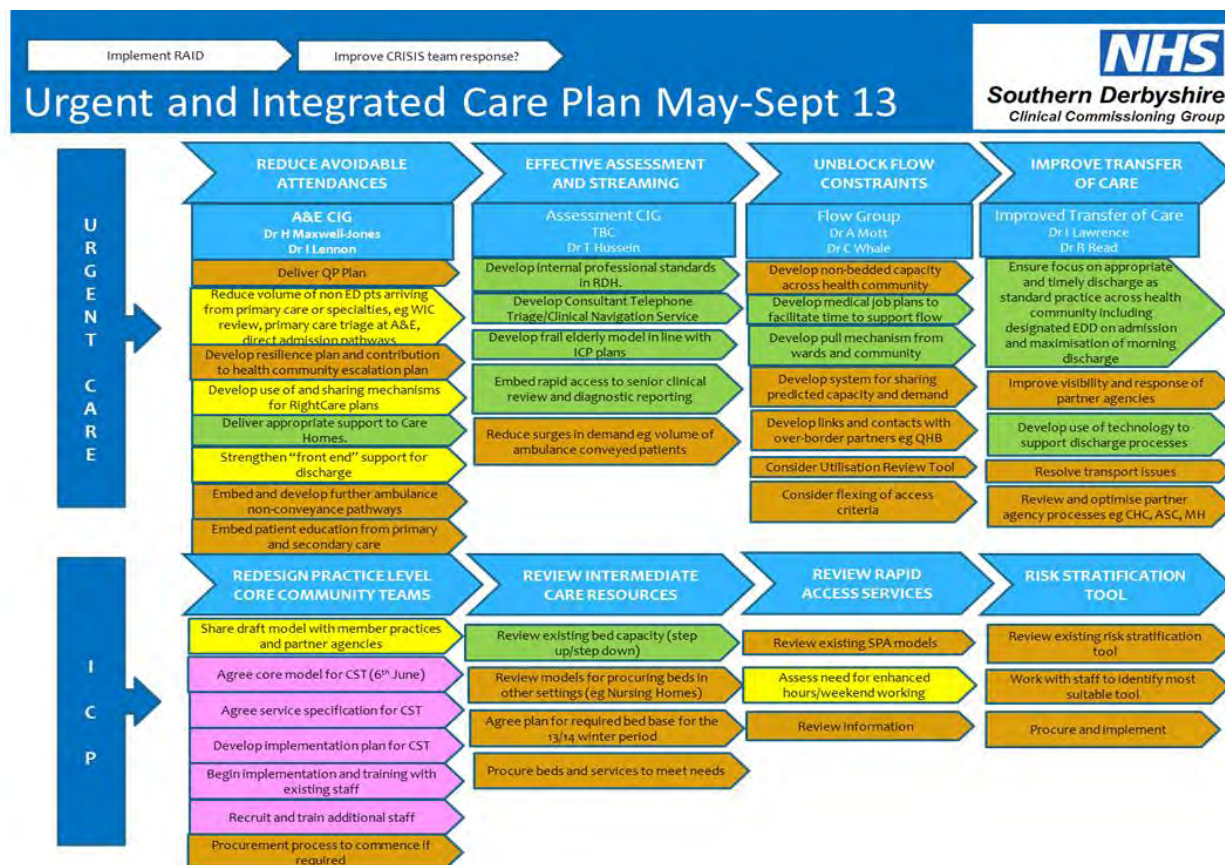
We are working as part of the health Community wide Integrated Programme Board on a Frail Elderly pathway and LTCs. We will further develop services for our frail elderly population, from early identification of risk factors for ill health, prevention and self-care, through to clear pathways to escalate care and avoid inappropriate admissions. The majority of these changes will take place in the primary care, intermediate care and social care systems, rather than in the acute hospital service which has been the focus of schemes in the past.

The objectives of the integrated model are to:

- Support the elderly to be as healthy as they can be

- Identify those at risk of poor health and support them at the earliest possible stage
- Maximise patient independence and enable the elderly to remain in their own homes where at all possible
- Provide timely and appropriate escalation of care to and within intermediate care in the home or to the appropriate level of care
- Ensure timely response
- Prevent avoidable hospital admissions

We have agreed with partners and urgent and integrated care plan across the Southern Derbyshire community, as shown below:



### i. Vertical Integration

Adult community services in Derby City were transferred to DHFT in April 2011 under the TCS programme. We have established a Community Business Unit and community staff base in London Road Community Hospital and are realigning services to improve pathways and integration.

### ii. Derbyshire Community Health Services NHS Trust

Derbyshire Community Health Services NHS Trust (DCHS) delivers community services across Derbyshire and support patients in South Derbyshire who use our services. We have worked with DCHS over many years to support service delivery in the community, and provide significant support to their 5 community hospitals in our location. and during 2011 agreed a strategic alliance with them to facilitate development of improved pathways and experience for our mutual patients.

### iii. Delivering high quality and effective planned care

We have been working with commissioners for 2 years to understand the demand for planned care, reduce clinical variation in primary and secondary care and ensure cost effective pathways. During 2012 primary and secondary care clinicians have met as CIGs to review

pathways and model service changes. There have been some excellent achievements in some areas and the intention is to expand and embed the model during 2013/14

### **1.3.2 Development of partnerships and collaborations with other providers**

#### **i. DHFT/DCHS partnership**

We have a formal partnership with DCHS which is governed through a partnership board. The Board has Chief Executive, non-executive and Executive Director level input. The partnership has developed a formal programme of work to deliver care which is as seamless as possible from the patients' perspective.

Agreed Priority areas for joint working

- Community & Older People
- Planned Care & Elective Services
- Unplanned & Emergency Care
- Back Office & Support Services
- Responding to the Market

#### **ii. Inter Care Health/First Diabetes**

We are a shareholder and founding partner in two joint venture companies which provide integrated diabetes care to approximately 13,000 adults with diabetes resident within Derby city.

The service is due to be retendered in 2013/14 covering the whole of the Southern Derbyshire CCG population.

#### **iii. Collaboration with Burton Hospital NHS FT**

We are currently working with Burton Hospital to strengthen its existing clinical networks in relation to oncology, renal and oral-maxillofacial services. We are committed to exploring any further potential areas for clinical engagement between the two Trusts, and are currently working with them to identify future opportunities.

### **1.3.3 Consideration of impact of proposals in relation to competition rules (CCP etc.) and patient choice, where applicable**

We are aware of and adhere to competition rules when proposing and developing services. Under our Monitor Provider Licence we are obliged to consider Section 3:C1 and C2 relating to the rights of patients to make choices and consider the effect of our decisions to prevent, restrict or distort competition.

The new Choice and Competition Framework produced by The Cooperation & Competition Directorate of Monitor will be followed, ensuring that our services are offered in a fair and transparent manner, with the patient being at the centre of all decisions. Current and future guidance relating to the application of competition rules to Integrated Care, Unilateral Conduct, Agreements and Clinical Networks will be reviewed for any future developments.

## 2 APPROACH TAKEN TO QUALITY

### 2.1 Quality strategy

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

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

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

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

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





## 2.2 Summary of external regulation

The care quality commission (CQC) conducted a routine inspection of Royal Derby Hospital on 16th and 17 October 2012. The findings were that the following standards were met:

- Consent to care and treatment.
- Care and welfare of people who use services.
- Meeting nutritional needs.
- Safeguarding people who use services from abuse.
- Supporting workers

CQC identified that action was needed in respect of the following two standards:

- Complaints
- Records

We confirm that the Care Quality Commission have stated to us that the Trust is currently compliant with the Care Quality Commission registration requirements, and accordingly it is appropriate for us to declare this in our Annual Governance Statement.

Since the visit, we have taken action on the following standards:

### 2.2.1 Routine inspection October 2012 - complaints,

- i. The Trust policy on complaints has been reviewed and key Trust staff have been involved in the consultation process.
- ii. The review has concluded with a rewrite of the current policy and a Standard Operating Procedure (SOP) has been developed.
- iii. As part of the new policy a supporting document has been developed with guidance and templates to help staff when dealing with complaints and concerns. The revised policy, SOP and supporting information is currently in the Trust's ratification process.
- iv. An awareness of complaints is being introduced into the Trust induction programme and a staff leaflet on dealing with concerns has been developed and this is to be distributed to all staff as part of the re-launch of the revised policy and process, planned for June 2013.
- v. A review of the Trust Datix system, which is currently used to log complaints, has also been undertaken. The outcome of the review has been the purchase of a new specific complaints module which will support the management of complaints flow and improve tracking. Phased implementation plan has been developed and initial training for staff is to be undertaken.
- vi. The Trust launched the "Your Views Matter" Campaign with a range of initiatives. Pull up stands advertising the campaign were placed across the Trust, and each ward has been given posters to display to raise awareness of feedback mechanisms for patients and visitors.
- vii. As part of the overall review the Trust has moved to a 25 day standard response time, with a view to achieving this with 85% compliance for complaints by April 2014. This has been monitored and reported monthly at Trust and Divisional level reporting through the newly established Complaints, Concerns and PALs Review Group; it is also reported to the Trust

Quality Committee and Trust Board. A new Quality Dashboard is under development and will incorporate key complaints performance indicators.

- viii. A complainant feedback survey has been developed and will be rolled out following the launch of the revised complaints policy, identified to be in use from July 2013.

#### **2.2.2 Routine inspection October 2012 - Care Records**

- i. The Nursing Documentation Group have reviewed:
  - Current care plan booklet overall
  - Reviewed each section for individual care needs
  - Identified adaptations to ensure that we capture the individual patient care needs
- ii. A pilot of the adapted documentation will be completed by 10th June 2013.
- iii. The Nursing Documentation Group will review the pilot results and make recommendations for:
  - The education, training and communication strategy required
  - How the nursing documentation will be completed within practice
  - Audit of practice to evidence the individual care given by the nursing staff to the patient reflects care needs.
- iv. Ward Senior Sisters will be accountable for completion of nursing documentation to the agreed standard.
- v. Compliance against individual nursing care evidenced within the nursing care plan will be assessed monthly through Ward Assurance audits. The Matron will be responsible for monitoring quality of nursing care plans within their clinical areas and will action any issues with their Senior Sisters and nursing teams. Issues will be escalated to the Heads of Nursing and within the Matrons' monthly report to the Chief Nurse.

#### **2.2.3 Announced Mental Health Act Monitoring visit –March 2013**

CQC conducted an announced mental health act Monitoring visit on 7th March 2013. The visit report has been received and the Trust has responded on actions identified, which include: improved training, education and documentation; clear and concise timelines for recording timing and lead clinicians for Sections.

### **2.3 Quality risks**

Clinical and Quality priorities take into account the views of commissioners, staff and patients. We are working closely with commissioners on a number of areas, most notably reduction of 30 day readmissions and the development of a care pathway for the frail elderly.

The quality priorities, their measures milestones and actions, together with risks and mitigating actions are shown on the table on the next page.

## Priorities for 2013 -15

| Quality Objective  | Measure  | Milestones   | Actions   | Risks  | Mitigation   |
|--|--|--|---|--|--|
| <b>Section 1: Clinical Effectiveness</b>   |  |  |   |  |  |
| Continue to drive down the Trust Mortality to improve the Trust rates  | HSMR<br>Target <100<br>Crude hospital mortality rate   | As a minimum maintain position year on year – Trust reflects an 'As expected' position<br>HSMR Apr-Jan 13 is 97.7  | Data review through Mortality Group, identifying any outliers. Review through quality structure of potential causes for concern.  | Risks identified of high level bed occupancy rates. Increasingly elderly population.         | Review and scrutiny of data through Mortality Group and Quality Review Committee. Evidence of action taken on any cause for concern. |
| To further develop the integrated care pathways for respiratory, dementia, end of life, falls and learning disabilities and to initiate appropriate new pathways such as frail elderly | Redesigned pathways<br>Integrated care   | Work with commissioners to extend integrated pathways throughout 2012/13<br>Implement new pathways where appropriate during 2013/14 and 2014/15            | Work with Clinical Improvement Groups and integrated care board to develop new pathways<br>Work with commissioners and other stake holders to develop and implement integrated care.                      | Availability of community support<br>Stakeholder involvement                                 | Agree developments and milestones with commissioners   |
| Improving timely discharge to optimise a patients length of stay   | Key discharge measure form part of the divisional dashboard including Length of Stay, Morning Discharges, EDD recorded in 48 hours | Stretch targets set for each division<br>Delivery of discharge CQUIN in 13/14  | Regular Monitoring through Divisional and Business Unit Individual Performance Agreements   | Non achievement of operational and financial targets   | Agree developments and milestones<br>Performance management system   |
| <b>Section 2: Patient Safety</b>   |  |  |   |  |  |
| Improve safety for patients whilst in the care of the Trust by reduction in avoidable harm   | Measurement of avoidable harm by the Global Trigger Tool   | 2011/12 target- Reduction of avoidable harm by 50% by April 2012 (delivered)<br>Harm reduced by 67% and sustained through 2013/14-to be kept under review. | Sustained programme of actions to standardise practice and zero tolerance to outliers   | Themes of harm emerging that are as yet unaccounted for                                      | Projects identified for focussed action. Trigger tool audit and incident data to identify new themes                                 |
|  | VTE risk assessment is carried out in line with national guidance (national CQUIN indicator) on eligible patients                  | Achieve and sustain 90% or above each month<br>2013/14 increase to 95% and achieve increasing completion of RCAs for HATs.                                 | Increased emphasis at Induction of Junior Doctors regarding the need to carry out risk assessment and record electronically.<br>Root cause analysis developed for use all cases of hospital acquired VTE. | Failure to record assessments electronically. Failure to complete RCAs.<br><br>CQUIN payment | Focus on electronic data collection support. Specific personnel to Monitor progress with CQUIN.                                      |



| Quality Objective  | Measure   | Milestones  | Actions  | Risks  | Mitigation   |
|--|---|---|--|--|--|
| Work on improved and sustained achievement of mandatory training for clinical staff in order to standardise practice, ensuring that by 2013/14 all clinical staff have a robust personal development plan supporting appropriate continuous professional development | Achievement levels set for each specific subject  | <p>Monthly Monitoring of compliance for each subject</p> <p>Compliance with all mandatory training subjects by July 2013 in line with the NHSLA minimum standards and working towards full compliance.</p> <p>Local induction is slowly increasing compliance, however a plan will be created to increase these further</p> <p>Safeguarding brochures have been published for all staff, distribution will be complete by end of May 2013; staff will all be compliant to standard level. Enhanced Safeguarding training for some clinical staff is required, these training dates have now commenced</p> <p>2013/14 all staff have a Personal Development Plan</p> | <p>Concerns regarding infection Control Levels 2 and 4 have been escalated; Quality Improvement Lead (QILs) are working with Mandatory Training Leads to encourage use of the blended training available. Additional bespoke training is also taking place in some areas.</p> <p>High risk areas presented to the Education, Development and Training Group (ETD) for scrutiny</p> | <p>Potential to compromise patient care and safety</p> <p>Not achieve NHSLA Level 3 requirements</p> | <p>Subject specific action plans put in place for any areas not achieving – monitoring through ETD and reported, it is escalated through the Workforce Performance Committee</p> <p>Winter pressures have left some areas with no Professional Development Advisors/Facilitators in post which has led to the reduction in the amount of Mandatory Training delivered.</p> |
| To improve and sustain electronic discharge communications with General Practitioners and the wider health and social care community   | To undertake a review of the timeliness and quality of discharge summaries, clinic letters, ED attendance summaries sent electronically | <p>Establish timeliness of all discharge summaries and clinic letters.</p> <p>Rollout the new improved iCM e-discharge summaries to all relevant areas in line with the Trust's roll out plan.</p> <p>Establish specialties with a high backlog of clinic letters and undertake some process mapping.</p>   | <p>Continue the use of the CIGs</p> <p>Widen the membership of the Improving Patient Level Clinical Information group to include more GPs and junior doctors.</p> <p>Use the GP representatives on the group to cascade key messages on new developments to electronic transfer of letters.</p>  | Reputational risks if there is poor communication.   | Continue to use the current PLCI to monitor the timeliness and quality of letters and to work towards setting up a portal/email address whereby GPs and other health and social care professionals can contact the Trust on queries/errors in the discharge summaries. This group will then report back to the Discharge Steering Group and CCG.                           |

| Quality Objective   | Measure   | Milestones  | Actions  | Risks   | Mitigation  |
|---|---|---|--|---|---|
|   |   |   |  |   |   |
| Reduce medication errors and resultant harm   | Medication errors. Audit of type, reason, time and place.                   | Statistically significant reduction of medication errors using SPC principle to achieve national median (5.9/100 admissions). | Implementation of Electronic Prescribing across Trust Ward by ward implementation plan in place  | Patient safety issues arising from implementation of new system   | Quality Impact Assessment, on-going monitoring, resolution of issues.   |
|   |   |   | Learning from Medication Error incidents to inform practice<br>Review of monthly IR1 data within Divisions highlighting top 3 actions to be undertaken | Reduction of incidents recorded due to reduction in reporting, rather than improvement  | Audit of medication process and outcomes to substantiate improvement  |
| Section 3:Patient Experience  |   |   |  |   |   |
| To continue to improve the patient's journey through the Trust so that the number of patients who would be happy to recommend the Trust increases year on year                          | National Annual Inpatient Survey – overall rating of care                   | Seeking year on year improvements   | Divisional action plans  |   | Real time data capture including use of Friends and Family question provides live information at ward level. Review of data and action planning as required |
|   | National Annual Inpatient Survey – national CQUIN indicator                 | As identified in annual contracting round   |  | CQUIN payment   |   |
|   | Implementation of the Friends and Family questions – real time data capture | Demonstrate implementation and improving results  | Implementation across the organisation – monthly 10% footfall. Review of data to highlight any areas needing action                                    | CQUIN payment   | As above<br>Ongoing work to ensure 10% footfall achieved.   |
|   |   |   | Antibiotic prescribing – ensuring in line with policy  |   |   |
| Invest in a ward assurance tool to provide demonstrable evidence of delivery of high standards of clinical – all areas which are important to the patient experience and patient safety | Continued improvements in levels achieved in Ward Assurance                 | Threshold of 95% across all areas.  | Monthly audit across all areas   | Heavy reliance on paper based systems   | Actions plans by Matron to Chief Nurse for any gaps in practice   |
|   | Reduce infections – MRSAb   | Delivery against national target  | Key procedures embedded across organisation<br>Regular audit and review of practice  | There is a zero tolerance approach to MRSA cases in the National Contract, with the Monitor target remaining as a deminimis of 6. | Key infection control procedures<br>Infection Control audit programme   |
|   | Reduce infections – C.difficile<br>Delivery against national                | Monthly Monitoring of target  | Divisional trajectories – monthly Monitoring and   | Target of no more than 42 for 13/14 – financial   | Focus particularly on Antibiotic prescribing  |

| Quality Objective   | Measure   | Milestones  | Actions   | Risks   | Mitigation   |
|---|---|---|---|---|--|
|   | target  |   | RCA for each case   | risk if not achieved will range from £46k to £2.1m.   | Case by case RCA work undertaken   |
| Empower front line staff to respond positively to every patient and carer concern every time  | Feedback from staff and evidence where possible of empowerment        | Review of complaints and PALs information   | Ensure workforce appropriately trained and see link between their role and organisational objectives  | Increased number of complaints  | Focus on staff accountability and leadership role                            |
| Ensure patients who are at the end of their life receive the most appropriate care for example Liverpool Care Pathway, End Of Life care, Right Care | Achievement of CQUIN Feedback – patient or carer                      | Quarterly achievement of 84% (to be reviewed at the end of Q1) – CQUIN target   | Systems in place to evidence the number of people who died in their preferred place of care on the District Nurse caseload.                               | Failure to deliver the End Of Life CQUINs could result in a risk of £1.1m, including the Community End of Life CQUINs.                          | Project Manage via CQUIN to ensure all data collected, recorded and reported |
| Through partnership ensure that the patient pathway and experience of care is seamless through the acute sector and between acute and community.    | Improved patient experience<br>Redesigned pathways<br>Integrated care | Develop ambulatory care pathways<br><br>Develop Interqual model to ensure patients receive the right care, in the right place – linking acute, community and other agencies | Systems in place to ensure seamless handover between Business Units (internal) and external agencies.<br><br>Involvement of clinicians and other agencies | The Community BU are not able to develop the services required.<br><br>Other agencies are unable to support community services to deliver care. | Working closely with commissioners and project managed through PMO structure |

## 2.4 Overview of Board assurance

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

We have a robust structure of groups and committees which feed into the Executive Quality Review Committee (QRC), along with quality reports from the Divisions. This allows triangulation of information and an ability to develop recommendations and action for any issues. QRC reports through performance and scrutiny management meetings and also to the sub-Board Quality Committee. We have on two occasions, the last one being October 2012, carried out the Monitor’s Quality Governance Framework Self Assessment. This intensive self assessment process, which required detailed and thorough reflection and deliberation, demonstrated that the Trust Board had acquired an increased emphasis on quality governance and has robust mechanisms in place to monitor quality.

Currently, we have noted an increase in mortality rates, both HSMR and crude. The HSMR for the year April-January is 97.7 for the Basket of Diagnoses and 100 for all Diagnoses. The crude mortality rate for February showed improvement at 1.84% down from the January level of 1.95%, Mortality rates are scrutinised on a monthly basis. The Trust Mortality Group goes through all the deaths recorded in a previous month and trends noted from this, the Trust’s crude mortality analysis and the Dr Foster data. This group reports through to the Quality Review Committee, chaired by the Executive Medical Director. In addition, the Executive Medical Director meets regularly with information analysts to examine the Dr Foster and crude data in detail. Mortality rates are reported on a monthly basis in the Quality Report to Board.

Following the rise in HSMR in September and October, in addition to the usual scrutiny as detailed above, having not found any specific diagnosis or department causing this elevation, but a general increase across the Trust, the Executive Medical Director further scrutinised whole hospital issues. In particular, outliers and bed occupancy rates were considered.

Having noted the increase in bed occupancy rates across the year despite the opening of 116 beds sequentially through winter, the Executive Medical Director, Chief Operating Officer and Director of Strategy & Partnership are now re-examining capacity and in particular, by modelling appropriate bed occupancy rates in different specialities, are aiming to provide appropriate bed numbers across the year. Models of care are being developed regarding the frail elderly and work continues with SDCCG around integrated care.

The pressures in the Emergency Department have seen considerable and unrelenting pressures over a number of months. We are looking to invest further in both consultant and nursing staffing, audits are in progress in conjunction with SDCCG to identify any issues in pre-hospital care with the acutely ill elderly and further work is on-going in ambulatory care. We are developing case management and supporting primary care to supplement frail elderly out-of-hospital care, also redesigning internal systems using recently published Emergency Care Intensive Support Team (ECIST) principles for A&E improvements, and using the NHS England framework on improvements to A&E performance (Gateway reference 00062).

In 2012/13 Trust exceeded its trajectory for C-difficile. Monthly monitoring of performance against this target is reported through the infection control committee (ICC) and the Trust quality committee. All avoidable cases are subject to a full root cause analysis, chaired by the divisional medical director, with subsequent action plans presented to the ICC. Each division and business unit is expected to take a zero tolerance approach to see different seal. Any avoidable episode will be challenged through the divisional performance monitoring meeting.

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

## 3 CLINICAL STRATEGY

### 3.1 Service Line Management Strategy:

#### 3.1.1 "Quality Through Partnership"

*The Trust vision and four strategic imperatives drive the year-on-year implementation of the strategy. The strategic imperatives are supported by key enabling strategies.*

#### Our Vision

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

#### Enabling Strategies

- Partnership working
- Systems and infrastructure
- Workforce
- Transformation

#### Our Strategic Imperatives

Deliver quality in everything we do; safety, effectiveness and patient experience

Transform services to maximise productivity and efficiency

Create networks for acute and complex care

Develop integrated care for people with long term conditions to help them stay as healthy as they can

*The Trust has strategic goals to achieve by 2018 framed around the acronym "PRIDE" shown below:*

**P**

#### **Putting patients first**

- Top decile performance for patient experience surveys
- Patients will be able to access and interact with hospital IT systems
- External recognition for the active role patients play in managing their care
- Business Units to have implemented at least three opportunities for empowering patients

**R**

#### **Right first time**

- Top decile performance for patient safety
- Top decile performance for clinical effectiveness
- All registered LTC patients receive care according to agreed, integrated care package
- Reduce emergency admissions by over 3%
- Agreed and implement annual targets for reduction of unwarranted clinical variation
- Exceeding top decile delivery of contract performance targets

**I**

#### **Investing our resources wisely**

- Achieve an annual surplus of at least 2% and deliver a return on investment of at least 5%
- Top decile performance for operational productivity
- Real-time, accurate and comprehensive data that supports clinical and managerial decision making (SLM and PLICS)
- Reduction in use of agency staff by 50%

**D**

#### **Developing our people**

- Top decile performance for staff productivity and staff satisfaction
- Derby rated as top hospital in LETB for clinical training
- A skilled and diffused leadership workforce throughout the Trust
- Named as one of the 20 best providers to work for in the NHS
- External awards for people development
- Reward strategy aligned with productivity achievement

**E**

#### **Ensuring value through partnerships**

- Vibrant and developing strategic alliances with Burton, Chesterfield, Nottingham, DCHS and Derbyshire Healthcare
- Business Units will have arrangements for clinical engagement and vertical/horizontal integration
- Contribute to measurable improvements in population health across southern Derbyshire for patients with diabetes, COPD and dementia

### 3.1.2 Trust-wide leadership through clinical Divisions

During 2012 we implemented a revised structure for our clinical Divisions to increase clinical engagement and encourage clinical leadership. Our transformation team supports the Divisions. Service Line Management (SLM) is being implemented with a strong performance culture to drive quality improvement.

Divisions are managed by a Divisional Director supported by a Divisional Medical Director, and a Head of Nursing as the lead triumvirate. Each member will be required to work in partnership with each other and there are clear criteria for success and consequences for poor performance. Decision rights within Divisions ensure that:

- Divisions are empowered to drive service performance
- Control functions are in place to alter these decision rights according to performance
- A clear framework of decision rights is in place
- Management capabilities and capacity are assessed before rights are devolved
- Links to performance management

The three clinical Divisions are key to how the Trust provides services to patients and they operate in line with the following principles:

- All Divisional Clinicians will hold responsibility for realising the clinical, operational and financial objectives of the Division.
- Clinical engagement is a critical component of Divisional leadership
- The Divisional Director needs to ensure that the team has sufficient high calibre support from a management accountant, HR manager, planning manager and information analyst
- Each Division will have an Internal Performance Agreement (IPA) with the Trust, linked to External Contracts, the income and budget around activity, quality, timeliness and service change.
- Each clinical Business Unit will have an IPA with the Division
- Performance management will be in place to ensure the Divisions meet the agreed targets within the contracts
- Poor performance at any level whether clinical or non-clinical will be addressed



### 3.1.3 Our “Plan on a Page” for 2013/14

| PLAN ON A PAGE-2013/14  |  |
|---|--|
| <b>PUTTING PATIENTS FIRST</b>   |  |
| Improve clinical outcomes for our patients by setting and ensuring adherence to professional, safety and clinical standards   |  |
| Implement evidence based design of urgent care pathways and services delivered through the Transformation Programme   |  |
| Redesign the elective pathway to improve the experience of care for our patients using the available research and evidence to inform the process.                         |  |
| Develop the patient experience framework as part of the overall quality strategy to improve the use of patient feedback in improving the overall quality of care          |  |
| Ensure that ‘Personal, Fair and Diverse’ means that our organisation, services and staff are culturally aware   |  |
| <b>RIGHT FIRST TIME</b>   |  |
| Develop the next five year Quality Strategy in line with our strategy <i>Quality through Partnership</i> and lessons learned from the Francis enquiry                     |  |
| Implement an improved integrated model of care for frail older people who we care for within our acute and community services ensuring alignment with the wider programme |  |
| Implement key priorities to improve the services and understanding of the needs of those with dementia and their carers   |  |
| Deliver our Transformation plan   |  |
| Review our maternity services model to improve patient experience and safety promoting midwifery led care   |  |
| <b>INVESTING OUR RESOURCES WISELY</b>   |  |
| Transform our services by embedding Service Line Management to devolve decision making closer to service delivery   |  |
| Replace our Patient Administration system (PAS) and upgrade key clinical systems to enable improved clinical and administrative process efficiency                        |  |
| Deliver a financial surplus to enable developments and sustainable medical equipment replacement  |  |
| Develop better information to enable improved service performance and management of unwarranted variation   |  |
| Complete our plans for rationalising our estate providing benefits to the local community   |  |
| <b>DEVELOPING OUR PEOPLE</b>  |  |
| Build and sustain an open and honest culture where patient care is central and our staff are supported in maintaining their health and wellbeing                          |  |
| Value, recognise and reward our staff as appropriate for the work that they do identifying and supporting the development of talent                                       |  |
| Develop a flexible and skilled workforce to ensure we can manage variation in demand more safely and cost effectively to meet the needs of our patients                   |  |
| Continue to build and develop our leadership community throughout the Trust   |  |
| <b>ENSURING VALUE THROUGH PARTNERSHIPS</b>  |  |
| Understand the changes to the commissioning of specialist services and work to ensure that appropriate services are provided in Derby                                     |  |
| Develop strategic partnerships with local Trusts to ensure our clinical networks are robust and patients receive the best care  |  |
| Work with other agencies involved in health and social care to ensure that we create integrated systems focused on helping individuals to be as healthy as they can be    |  |
| Inspire and encourage our local people into NHS careers through our engagement with the local community and in particular, education providers                            |  |
| Develop and agree a workable solution for sharing patient information   |  |

### 3.1.4 Priorities of Divisions and Business Units 2013/14

The clinical Divisions have aligned their specific one-year priorities to the Trust's vision and strategic imperatives, which are given below. The Trust's plan on a page is described at divisional and business unit level to ensure that the top-level ambitions are fed through to divisional, business unit and ultimately individual level objectives. In turn these are reflected through the Internal Performance Agreements.

| <b>Business Unit</b>                                   | <b>Deliver quality in everything we do; safety, effectiveness and patient experience</b>   | <b>Transform services to maximise productivity and efficiency</b>  | <b>Create networks for acute and complex care</b>  | <b>Develop integrated care for people with long term conditions to help them stay as healthy as they can</b>             |
|--|--|--|--|--|
| <b>Divisional and Business Unit priorities 2013/14</b> |  |  |  |  |
| <b>Surgery</b>   |  |  |  |  |
| <b>General Surgery</b>                                 | Redesign the Elective patient pathway to improve the patient experience                    | Embed and develop acute surgical assessment model<br>Transform theatres & related services   | Develop clinical relationships in Urology with other Trusts<br>Maintain and seek new contracts for Bariatric surgery and become a nationally commissioned centre for obesity | Develop new models to support management of long term conditions to avoid unnecessary attendances at surgical assessment |
| <b>Maternity &amp; Gynaecology</b>                     | Develop a Birth Centre , delivery of midwifery led care ; Maternity 24/7 assessment Centre | Remodel and expand the Gynaecology Assessment Unit<br>Transform theatres & related services  | Work with Public Health to better meet the needs of pregnant women with complex care requirements  | Working with GPs to develop an integrated care model for those living with HIV   |
| <b>Orthopaedics</b>                                    | Improve patient experience by reducing waiting times                                       | Increase capacity to meet demand and reduce additional capacity payments – Ortho (5 <sup>th</sup> spinal) & Hands (+1 consultant); Transfer daycase procedures to an outpatient setting where clinically appropriate | Expand our catchment population by developing peripheral service spokes  | Development of an integrated orthogeriatric service for fractured neck of femur & other fragility fractures              |
| <b>Specialist Surgery</b>                              | Establish patient 'experience by design' listening groups in each specialty to improve the | Improve theatre utilisation and continued shift from Inpatient to Daycase and Daycase to Outpatient setting  | Increase partnership working with other local organisations to deliver joint services to improve the efficiency and  | Work with local commissioners to increase the delivery of care closer to home,   |

| Business Unit                                   | Deliver quality in everything we do; safety, effectiveness and patient experience | Transform services to maximise productivity and efficiency   | Create networks for acute and complex care   | Develop integrated care for people with long term conditions to help them stay as healthy as they can |
|---|---|--|--|---|
| Divisional and Business Unit priorities 2013/14 |   |  |  |   |
|   | quality of our services   |  | effectiveness of services  | where appropriate   |
| Clinical Support Services & Cancer              |   |  |  |   |
| <b>Anaesthetics</b>                             | Reduced unwarranted variation   | Understand demand & capacity and introduce robust management processes   | Ensuring we continue to engage with the Critical Care Network within the new specialist commissioning arrangements | Develop new models of integrated care for patients with long term chronic pain                        |
| <b>Cancer</b>                                   | Implement Patient Pathway Coordinator   | Scope future needs of cancer services, taking into account the increasing demands for Chemotherapy                               | Expand Lymphoedema service across the East Midlands  | Develop integrated service for haematology, palliative medicine and lymphoedema in the community      |
| <b>Imaging</b>                                  | Prepare the Business Unit for National ISAS Accreditation                         | Understand the implications and opportunities associated with the introduction of the unbundled Imaging Tariff to best advantage | Establish interventional radiology for vascular hub ensuring clinically effective pathways                         | Support new model of care introduced by community business unit                                       |
| <b>Pathology</b>                                | Improve access and turnaround time of appropriate tests                           | GP Direct Access- respond to regional procurement  | Extend Histopathology resources (11 <sup>th</sup> Consultant) to meet the demand of increased MDTs                 | Extend the scope of "Shared Care Pathology" to further conditions                                     |
| <b>Pharmacy</b>                                 | Complete implementation of ePMA & iCM planned discharge project.                  | Develop plans to support innovative care models: Pharmacist Rxer (prescribers) / consultant roles                                |  | Further develop the Discharge Hub to appropriately refer patients to Community Pharmacy               |
| Medicine  |   |  |  |   |

| <b>Business Unit</b>                                   | <b>Deliver quality in everything we do; safety, effectiveness and patient experience</b> | <b>Transform services to maximise productivity and efficiency</b>  | <b>Create networks for acute and complex care</b>                        | <b>Develop integrated care for people with long term conditions to help them stay as healthy as they can</b> |
|--|--|--|--|--|
| <b>Divisional and Business Unit priorities 2013/14</b> |  |  |  |  |
| <b>Paediatrics</b>                                     | Improve discharges   | Develop Service Level Agreement with Surgical Services to ensure delivery of Paediatric surgery capacity | Enhance relationships with tertiary centres                              | Review patient pathways (KITE team) for chronically ill children, to enhance integrated care                 |
| <b>Rehab Medicine and community</b>                    | Agree a model for the management of the frail and older person within the Trust          | Develop a complex discharge team to support timely discharge of complex patients within the Trust        | Review specialist rehab services to enable focus on areas of excellence. | Identify priority patient pathways to develop across primary and secondary care and progress year 1 priority |
| <b>Specialist Medicine</b>                             | Introduce Medicine Liaison Nurses to improve patient flow and reduce outliers            | Increase Diabetes Medical capacity (x 2 Consultants)   | Develop and maximise CIGs for Respiratory, Cardiology and Dermatology    | Expansion of Pulmonary Rehab services  |
| <b>Acute Medicine</b>                                  | Introduce ED assistants to improve internal flow   | Review MAU Triage model and the gate keeping function  |  |  |

### 3.1.5 Service Line Management (SLM)

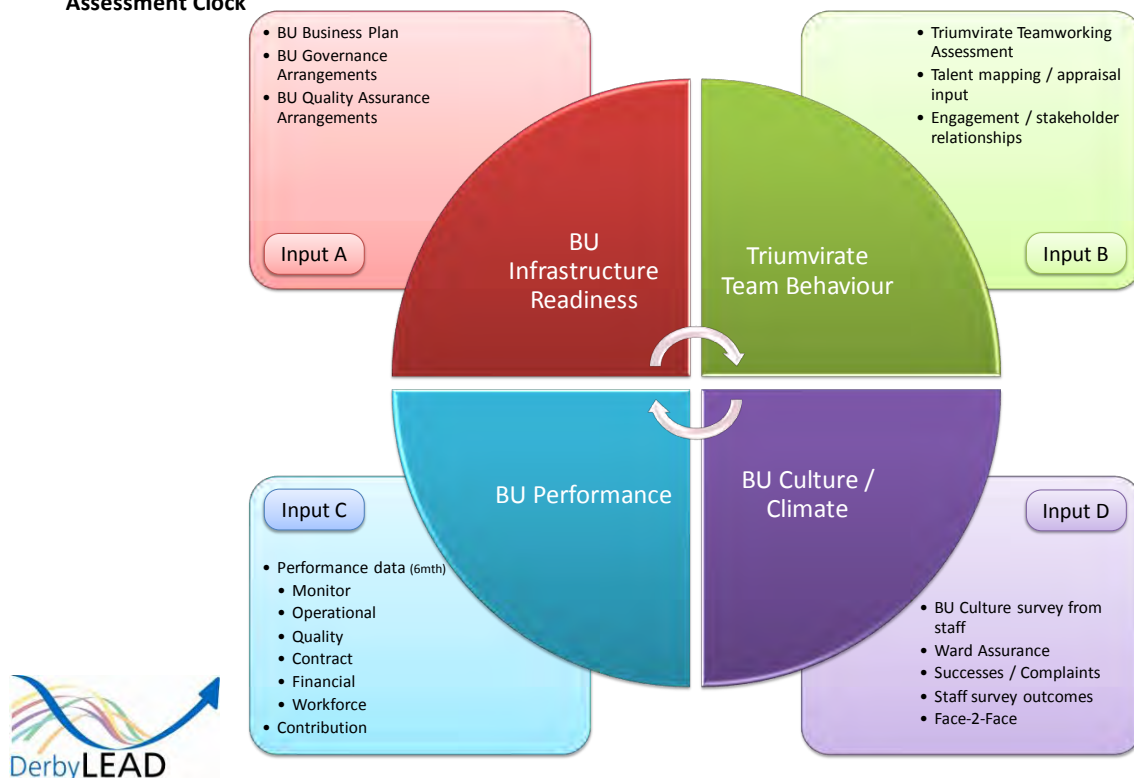
Service Line Management (SLM) is recognised as a critical enabler of good performance and is characterised by clinical leaders having the information, capability, accountability and decision rights to manage services within a framework of earned autonomy. A set of key principles were agreed:

- i. Business Units will have devolved authority for decisions according to the concept of 'earned autonomy' based on assessments of competency and performance
- ii. Performance of Business Units will be judged on the basis of a balanced set of measures, ensuring that the new model is focused on quality as well as financial performance
- iii. Financial performance of Business Units will include income earned, direct expenditure and internally recharged costs
- iv. Personal and organisational incentives will be used to recognise good performance against agreed key performance indicators across a balanced range of measures
- v. There will be a clear process of how the organisation will deal with poor performance of Divisions and Business Units
- vi. The culture of SLM is focused on participation of clinical staff in leadership and decision making at all levels of the organisation
- vii. SLM will deliver access to relevant, accurate and timely information for Divisional and Business Unit teams and will be improved and adapted according to the needs of those teams
- viii. Corporate strategy formulated in a way that Business Unit strategies are taken into account and in a form so that Business Units will understand their contribution
- ix. Annual plans will always be clearly linked to Business Unit Internal Performance Agreements

Earned autonomy across the Business Units is an integral part of assessment of their performance.

*Business units' performance is reviewed through the "assessment clock":*

#### BU Performance Review "Assessment Clock"



Implementation was divided into a three phase project plan and the work tasks were categorised under five general subject areas:

- i. Organisational Model
- ii. Culture & Capabilities
- iii. Information management
- iv. Incentivising and Managing Performance Improvement
- v. Annual Operational Planning and Strategic Planning

Specific phases have been implemented as below

- i. Phase one “Getting Ready for SLM” (2011 to March 2012), - foundations in place and included an organisation structure transformation
- ii. “Getting Going with SLM” (April 2012 to March 2013), - new information flow mechanisms developed including Service Line Reporting (SLR) and Business Unit specific performance agreements.
- iii. Phase three “Embedding SLM” (April 2013 onwards) - refining and further development of these new ways of working specifically focussing on earned autonomy

This work has been supported by a major OD programme picking up on development and enhancement of leadership across all staff groups, clarification of personal accountability and building on staff engagement.

The Trust routinely conducts benchmarking and an environmental scan as part of its service line management, and is assisted in this by McKinsey consulting.

## 3.2 Clinical Workforce Strategy

### 3.2.1 Workforce Strategy

Our Workforce Strategy 2013 to 2015 – Quality through Workforce underpins our transformation plans and enables the development of our workforce in continuing to provide high quality care in partnership with our patients and service users both now and in the future. Our Workforce Strategy has been developed to enable delivery of the Trust organisational strategy and applies across all staff groups within the Trust.

The diagram below clearly demonstrated the ways in which Our Workforce Strategy compliments and supports the organisational vision and strategic aims:



### 3.2.2 Medical Workforce

Changes in medical postgraduate training and regulations such as European Working Time Directive have resulted in the traditional model of a consultant-led service being increasingly difficult to deliver. The Academy of Medical Royal Colleges published a comprehensive review of consultant delivered care. The review concluded that there are evidence based benefits of moving towards consultant delivered care, including rapid and appropriate decision making, improved outcomes and better use of resources.

This has been the strategy of this Trust for the past 5 years, with a significant increase in consultant numbers in order to improve the ability to have a consultant-based service with the



resulting impact of strengthening patient care. This has resulted in the ability to have consultant presence on site 7 days with extended working into the late evening and resident overnight consultants in some specialties. The move to a consultant-delivered service has a significant impact short term on salary costs. These posts are essentially replacing a trainee (50% salary from Deanery) or a specialist doctor - lower salary cost. There should however be reductions in costs in the longer term, due to use of only appropriate investigations, admission avoidance and shortened length of stay.

Our aim is to continue this approach and to strengthen the sub-consultant workforce which has seen a major reduction in the ability of trainees to provide service and a gradual reduction of trainees.

The Centre for Workforce Intelligence report of August 2010 identified that the East Midlands has a particularly low level of doctors, particularly trainees. East Midlands Deanery information demonstrated that this Trust has a particularly low allocation of trainees, compared with other large Trusts in the old East Midlands region. It is these particular issues which led to an early move to consultant delivered care with 7/7 service, overnight residence, and development of ANP and Physicians' Assistant posts.

### **3.2.3 Strategic Workforce Objectives**

Our Workforce strategy will deliver sustainable performance improvement through our people and further builds on the links between organisational development, culture, performance and investment in leadership development to deliver transformation through the Trust.

There are six strategic objectives that underpin the strategy:

- i. Services will be transformed by embedding Service Line Management to enable the Trust and the workforce to achieve their full potential;
- ii. Our leaders will build and sustain an open and honest culture where talent is developed and succession planning is encouraged;
- iii. Our workforce will respond flexibly to meet the needs of our patients through engagement, development and education;
- iv. Our staff will feel valued and rewarded because they are recognised for the work they do and supported to maintain their own health and well-being as well as that of the patients they look after;
- v. Our future workforce will be inspired and encouraged into NHS careers through our engagement with the local community and in particular, education providers and
- vi. Our strategies will ensure that 'Personal, Fair and Diverse' means that our patients and our staff are treated with dignity and respect at all times.

The strategic objectives outlined in Our Workforce Strategy have clear milestones set out for development and achievement over the next five years. Each of the objectives require a substantial amount of innovation, transformation and development to enable the organisation to respond to the changing needs of our patients and the aspirations of our staff. This will include considering increased workforce flexibility to support fluctuations in service demand and development of strategic partnerships to enable seamless transfer of patients and staff between services.

### **3.2.4 Workforce Priorities**

The current workforce plan was finalised in July 2012. Across the health community work is underway to update it with agreed priorities. The annual refresh of the workforce plan will be presented to the Trust Board in July 2013.

The plan links with Divisional transformation plans, highlights workforce risks, plans to mitigate them, and informs local education planning. All plans are equality and quality impact assessed at Divisional level.

Workforce cost improvement schemes are discussed at the Trusts Organisational Change forum and staff side representatives are fully engaged. Full equality and quality impact assessments are completed for any workforce changes. Nursing and Medical workforce schemes are signed-off by the Medical Director and/or the Director of Quality and Patient Experience/Chief Nurse. The planned effect of workforce related cost improvements are included in the financial schedules. The financial impact of the changes to Agenda for Change Terms and Conditions (i.e. the removal of automatic progression and changes to occupational sick pay entitlements) will be assessed in the first quarter of 2013/14.

The Trust ran a second MARS scheme late in 2012 and this resulted in a considered reduction in whole time equivalents. It is anticipated further schemes will be run in the future.

Medical workforce expenditure is monitored on a monthly basis by the Medical Director against budget. Divisional reports are made to Management Executive and the Finance and Investment Committee. The financial model includes Consultant Contract incremental pay drift calculated during the budget setting process for 2013/14.

During 2012/13 we have completed a full review of our nursing workforce, informed by a review of acuity and reviews of Clinical Nurse Specialist and Educator roles. During the first quarter of the 2013/14 financial year standardised shift and break times will be implemented in rostering and through this nursing utilisation.

We have established a Leadership Community from a variety of senior leaders in all areas and disciplines. The Community provides a forum for openness and engagement to input and receive feedback and organisational messages. A minimum of two leadership events are held annually with smaller events also arranged to support key topics and challenges. The Leadership Community provides networking and development opportunities.

### **3.2.5 Workforce Plan**

The key themes for the 2013/14 Workforce plan are:

- i. developing cross organisational / health community working to address challenges with delivering district nursing services
- ii. Developing our pathway working focussing on the Frail Elderly pathway – in particular urgent care elements
- iii. addressing gaps in the medical workforce
- iv. developing and introducing new roles – such as Physicians Assistants
- v. Focus on the Unregistered Workforce in the light of the recommendations set out in the Francis Inquiry
- vi. Advanced clinical practice and non-medical prescribing
- vii. Leadership development and succession planning

The Workforce Plan for 2013 onwards explains our priorities and describes the direction of travel in order to ensure that the Trust meets the needs of our patients and the expectations of our

commissioners. A number of transformation schemes have been identified and these are included in our plans.

### **3.2.6 Key Risks to Implementation**

There are four key risks associated with the successful implementation of the Workforce Strategy:

- i. Transition to more flexible employment options, in particular the risks associated with recruiting to temporary posts, availability of staff to meet service needs and demands and ensuring that staff are appropriately and adequately trained to carry out their roles;
- ii. Embedding key elements of the strategy that challenge existing practice including the development of talent management and succession planning, reward packages and changes in the way education is designed and commissioned;
- iii. Known local and national staff group shortages could result in a smaller pool of staff to recruit from, specifically when linked to the use of more flexible and responsive employment models;
- iv. Developing generic skills to enable practitioners to work across specialties which will need to be carefully planned to avoid loss of specialist skills within the workforce and
- v. Delivering workforce transformation that delivers improvements in the quality of care, whilst also balancing the needs for a productive and cost effective workforce.

Each of these risks will be assessed and mitigated against and where appropriate, escalated to the Workforce Performance Forum.

## **3.3 Clinical Sustainability**

An increasing issue for the Trust is the delivery of the A&E targets, which has a whole system impact. There are also internal issues regarding medical staffing of the Emergency Department (ED); this is both in consultant recruitment and with junior doctors. ED is becoming an increasingly unpopular specialty with only 47% of training posts in the East Midlands filled. It has led to a significant reduction in allocation of ST3 and above posts to the Trust, which in turn has posed significant problems, particularly for out of hours care in ED.

This situation poses problems both for middle grade service in the department and has an impact on the possibility of recruitment to consultant posts in the future. It has resulted in major cost pressures in employing locums, particularly as recruiting good specialty doctors is not easy. A number of initiatives have been pursued, for example developing posts as Clinical Teaching Fellows in order to attract trainees coming out of core training. We also plan to develop specific training for Advanced Nurse Practitioners (ANP) to aid recruitment to this role, and we are piloting a rotational scheme to develop Physicians' Assistants

We have invested significantly into consultant posts in order to sustain and improve the service, but this situation, which has been developing for some time, clearly has had "knock on" effects for consultant recruitment and will continue to do so.

The other service that is becoming increasingly important is the Department for Medicine for the Elderly (DME). This year in particular, we have seen a rise in frail elderly patients (e.g. 21% more patients aged 90+ than last year). Again, recruitment is an issue. We have been active in developing innovative care, both on its own and in conjunction with other partners.

### **3.3.1 Innovations in care delivery**

- i. Integrated care models

We have worked with partners to develop innovative models of integrated care, as described above, in section 1.3.1. .

ii. Clinical Improvement Groups (CIGs)

Clinical Improvement Groups were established to improve the dialogue between primary and secondary care clinicians. Having originated from discussions regarding options for the reduction of hospital based follow up appointments, they have developed into wider pathway discussions. There are now CIGs proposed in 15 specialties with 12 of these having met at least once and many meeting regularly, with a CIG hub group to oversee issues that are relevant across the groups. The specialty-level groups are made up of GPs and Consultants supported by Trust and CCG management colleagues. Common discussions involve clarifying referral criteria and patient pathways, understanding referral patterns and investigating variations in expected activity levels.

iii. GP mobile phone “app”

Derby Hospitals has launched an innovative new mobile phone app for GPs and other primary care staff in the East Midlands. Believed to be the first app of its kind developed by an acute Trust anywhere in the country, it aims to build stronger relationships between hospital doctors, nurses, local GPs and community services.

The free app acts as an information hub, pulling together key information about the Trust’s staff and services and other key services within South Derbyshire – such as key departments, care protocols, consultant contact details and urgent care access numbers. Connecting health care professionals in this innovative way helps ensure that patients receive the most appropriate care at the right time and has been widely praised by local GPs. The app also enables GPs to e-mail condition-specific leaflets to patients to support their self-care and informed decision making.

## 4 PRODUCTIVITY & EFFICIENCY

### 4.1 Overview of potential productivity and efficiency gains built into plans, including financial impact of projected gains

We have identified a range of schemes for 2013/14 aimed at delivering improved productivity and efficiency. These include:

#### 4.1.1 Surgical Pathways

This includes a range of projects focused on reducing the number of occupied bed days spanning both urgent and planned care. Examples include developing an agreed pathway for earlier discharge of patients on IV antibiotics with continued treatment at home. Further focus includes daycase optimisation, the increased use of outpatient procedures where appropriate, and increased use of ambulatory care for emergency surgical patients.

#### 4.1.2 Transforming Urgent Care Pathways

This will be delivered through a focus on schemes that reduce occupied bed days. This includes enhanced discharge, leading to a reduced level of readmissions and the development of schemes to avoid unnecessary admissions including further development of ambulatory care, a frail elderly model, frail elderly assessment and improved functionality of the Medical Assessment Unit to reduce unwarranted internal waits for patients. Schemes looking at reducing delayed discharges and improved pathways for mental health patients are also in place.

#### 4.1.3 Theatre productivity

This workstream focuses on all aspects of operating theatres, including patient experience. A key aim will be to deliver an increased usage of planned sessions and increased utilisation of sessional time. Other elements include a detailed review of non-pay costs within theatres. A governance structure with strong clinical engagement is in place.

#### 4.1.4 Outpatient transformation

This workstream focuses on improving patient experience by improving communications and access to appointments. New technologies will be used as tools for service delivery and as an interface between hospital, patient and GP. This will include development of a telehealth initiative. Efficiency will be improved within clinics by using protocol based treatment planning, seeing the right clinician first time with upfront access to diagnostics and the development of one stop services to avoid multiple clinic attendances for the patient.

#### 4.1.5 Workforce re-design for Admin and Clerical staffing

This workstream concentrates on creating a patient-pathway based approach to focus all resource on improving access and communications with patients. The redesign will create a more standardised approach across all the specialties so the patient's journey will feel seamless between services. An element of role re-design will be required to match this staff group with the needs of the patient and take advantage of new technologies.

#### 4.1.6 Integrated Care Pathway Development

This workstream focuses on developing pathways that span across primary and secondary care, improve patient outcomes and reduce duplication. The first pathway selected is the Frail Elderly pathway, ensuring these patients are identified early, undergo a Multi Disciplinary Comprehensive Geriatric Assessment to enable them to stay at home longer with reduced admissions into hospital.

#### 4.1.7 Facilities Management

There are a range of schemes focusing on efficient resource utilisation and energy reduction. These include clinical waste disposal, reduction in carbon footprint and electricity costs through

voltage optimisation and installation of wind turbines. Soft services schemes include savings against portering, security, linen and catering services.

#### **4.1.8 Synergy Contract**

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

#### **4.1.9 Therapy Workforce Review**

A capacity and demand analysis of all therapy services within the organisation is currently underway. A workforce review of Physiotherapists and Occupational Therapists will then follow to ensure a workplace plan is in place to ensure the delivery of a cost effective, patient focused support service.

### **4.2 Transformation governance**

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

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

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

Savings over the last three years have totalled £9m pye/£12m fye in 2010/11, £12m pye/£10m in 2011/12 and £23m pye/£21m fye in 2012/13.

Overall, there are currently £17.3m of schemes identified against the £23.2m target for 2013/14, resulting in a residual balance of £5.9m. The balance equates to around 25% of the target and places the Trust in a similar position to previous years in relation to the level of plan development in place as it enters the year.

In respect of closing this gap, there are several schemes identified which are at various stages of development. These include policy change benefit in respect of sick pay enhancements, Theatre staffing workforce review, Trust wide unregistered workforce review, Medicine beds requirement, Outpatient f/up review linked to benchmarking data and a Medical Equipment Library review. At this time and until further detailed analysis has been done it is difficult to allocate a financial value to these particular schemes but based on experience in previous years the Trust is confident these and other schemes in development will realise sufficient value to bridge the gap.

All formally identified schemes are approved through the Management Executive team.

Delivery is measured by the removal of budget, actual implementation of the schemes and then performance management against those cost codes. Quality metrics identified in Project Initiation Documents are reviewed to ensure schemes deliver their intended benefits without compromising clinical care.

A follow-up report from Internal Audit (published Feb 2013) reviewing the Trust's Transformation Programme and governance arrangements recognised the significant amount of work that had

been undertaken to strengthen processes in relation to the co-ordination and management of performance of delivery and confirmed that there were no actions outstanding

### **4.3 CIP profile**

The top 5 CIP schemes for 13/14 are included in the table in Appendix 2. The most significant ones in terms of a step change in process are:

Standardisation of Nursing Shift Patterns – this is being implemented to improve continuity of care, facilitate easier deployment of staff (substantive and bank) and will remove inconsistency in working patterns, handover periods, crossovers and breaks. This has recently been through a full consultation process and implementation is currently underway.

Integrated care and frail elderly pathways – the new pathway will proactively identify frail elderly patients before they become acutely unwell, develop primary care services and assessments within their own home and provide ongoing support. The effect will be fewer patients being admitted into hospital.

### **4.4 Transformation enablers**

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

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

The Trust continues to work with McKinsey to benchmark performance against other similar organisations across a range of metrics and has also began work with a number of other acute Trusts on work comparing the use of medical resources within a wide range of specialties.

We are implementing a new Patient Administration System in the coming months and the Transformation Team and Clinical Divisions are involved in the scoping meetings and the roll out plan in order to ensure that any potential improvements are realised and maximised. The new system is intended to support a number of planned technology-based improvement projects.

The Transformation Team supports a rolling programme of rotational secondments. This encourages diverse staff from within the Trust to work with the Transformation Team on improvement projects for a six month period. Individuals gain a range of new skills and experiences on which they can build and become advocates for positive change and improvement on return to their substantive position.

The Transformation Team has also developed its own training programme for project management. Known as the Derby Improvement Approach. This takes staff through a five stage process for successfully implementing and sustaining improvement projects. The team has developed an e-learning package and also run a two-day training course to roll-out this key message

### **4.5 Quality Impact Assessment of CIPs**

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

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



## 5. FINANCIAL & INVESTMENT STRATEGY

### 5.1 Assessment of the Trust's current financial position.

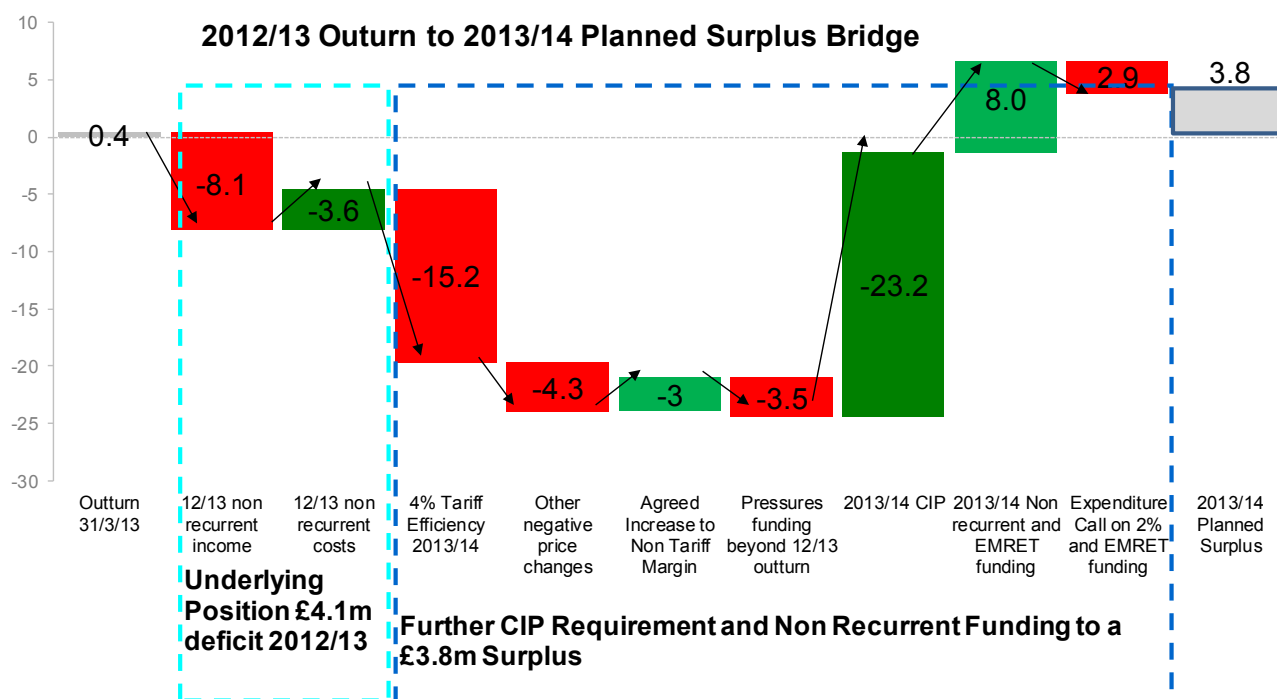
The financial position for the year ended 31 March 2013 resulted in a small financial surplus £0.2m on a turnover of £454.6m. The Trust's surplus for the year of £0.2m compares to the planned surplus of £0.6m. The Trust is therefore £0.4m away from the planned position, and has delivered a Financial Risk Rating of 3 for the year as planned. This small surplus has been generated despite the difficult trading conditions associated with ensuring the Derby City Primary Care Trust lived within their available level of funding. The Trust has now managed to work with the PCT on reducing their spend to a more affordable level. The Trust managed to save £23.4m from its Transformation Programme in 2012/13.

At 31 March 2013 the Trust had a cash balance of £15.9m and a working capital facility of £33.0m in place. This gave cash headroom in excess of £49m. The year end cash position was ahead of plan and the Trust did not make use of its working capital facility during the year.

The financial performance of the Trust in 2012/13 has been summarised as follows;

- Ahead of Normalised EBITDA plan by £0.6m
- Behind Actual EBITDA, solely due to agreed repayment to PCT of £1m non recurrent funding
- Cash ahead of plan at year end by £4.9m
- Excess demand managed through the Winter within affordable funding levels
- Southern Derbyshire CCG starts the year with no legacy debt

The bridge below shows the key movements to the planned surplus in 2013/14 of £3.8m.



Projecting forward to 2013/14 and beyond, the landscape continues to look challenging; but the ability of the Trust to deliver the required level of Transformation savings of £23.4m in 2012/13 gives ground for confidence. Again we will work closely with primary care to try and ensure they are keeping within their affordable funding envelope. Importantly, for this year, however the Clinical Commissioning Group starts the year in recurrent balance with no legacy debt. The strategy of the Trust has been mapped to an indicative view of the way in which the Trust will be able to derive savings over the next five years which has now been refreshed, as follows;

## 5.2 Key financial priorities / investments and link to overall Trust strategy

The key financial priority for the Trust now that the PCT/CCG financial position has been stabilised is to achieve an appropriate surplus level to deliver a sustainable capital programme. In the respect 2013/14 is a key transitional year for the Trust. The Trust financial plan has been summarised as follows;

- Planned surplus of £3.8m allowing capital spend of £6m (Trust internally generated capital)
- £23.2m CIP planned with £17.3m schemes confirmed with further schemes being developed
- FRR 3 (Q1 and Q2) and RAF 2 (Q3 and Q4) planned
- Small cash outflow planned in year due to creditor unwind from 31/3/13
- Southern Derbyshire CCG contract;
  - PbR compliant, with realistic activity plan, with no reliance on demand management schemes to achieve “affordable” contract
  - Support from non recurrent for key transformation and EMRET plans agreed
  - Funding contribution to non tariff margin and risk agreement agreed

Within this overall position, however, a number of key areas of investment have been made into the recurrent expenditure budgets of the Trust (£20m), via the Trusts annual planning and budget setting round. We start the year with no requirement for shared demand management initiatives with primary care, and this means that a number of key areas of revenue investments have been made, including;

- Additional ward capacity to deal with increased unscheduled care patient demand (£4.2m)
- Additional midwifery staffing to deal with rising birth rate and caseload complexity (£0.5m)
- Additional elective orthopaedic capacity to deal with rising demand (£2.5m)
- Five additional A&E consultant staff for demand and complexity in A&E (£0.5m)
- Further medical staffing costs to deal with rising workload (£2.0m)

All the above investments link closely to the overall Trust strategy, and the more sustainable contractual position with the CCG has enabled a material investment in revenue resource to address capacity and quality of care issues which have been discussed at Finance and Investment Committee and Board.

For 2013/14 the underlying position of the Trust is a forecast surplus of £2.9m. This is the planned surplus of £3.8m adjusted for non recurrent income (£4.6m) and costs (£3.7m), as follows;

- EMRET Funding is a recurrent income stream to the CCG and therefore the Trust "2%" Funding should be classed as Non Recurrent for planning purposes, which is £4.6m in 2013/14
- The budgets in the cost plan that can be classed as non recurrent are £3.7m, including;
  - Time limited staff pay protection costs (£0.4m)
  - Transformation Team Budget (£1.4m)
  - Non Recurrent support to Medical costs (£1.6m)
  - Non Recurrent Costs at former DRI site (£0.3m)

## 5.3 Key risks to achieving the financial strategy and mitigations.

As always the key risk to delivering the financial strategy is the ability of the Trust to deliver its Transformation Plan and the level of required savings. The Trust has prepared a down side case to the financial plan and has highlighted a number of variables and risks to the financial plan, under the following categories:

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

- Additional increase in the level of Non Elective activity over plan
- Additional elective activity to meet targets delivered at premium cost.
- Other Contract penalties

This downside plan will be presented and discussed at the next Finance and Investment Committee. The various downside risks identified following review of income and expenditure issues, result in a total estimated downside value of £10.0m.

Potential mitigation actions for these risks are included to an estimated value of £11.1m. These mitigation plans include;

- Maintenance of Current Management Control regime
- Utilisation of Current Contingency Reserve
- Utilisation of Current Surplus and delaying planned capital investment
- Reduction of 30% in Discretionary Expenditure
- Increase in Other Income Streams
- Revenue impact to delays to capital programme

Also, the financial plan, as described and submitted does not include the cash benefits associated with the land sale of the DRI site, despite the fact the contractual conversations with the residential and retail developer continue to progress satisfactorily. This could represent up to a £9m cash upside in year and also lead to a reduction in PDC payment with a further income and expenditure and cash benefit.

If Non Recurring funding is removed in future years, the Trust believes that although it would be an option to remove the Transformation Team, it would be more beneficial to retain it (£1.4M), as an aid to the delivery of the required levels of future CIP, even though this will result in a higher target level of CIP schemes being required.

## CONCLUSION

Our “**Quality Through Partnership**” strategy embodies a clear direction for the Trust through to 2018. We have reinforced our core values and refined our ambitions following detailed analysis of our strategic position, demographic changes and the changing external context of both the NHS restructuring and the wider economy.

We have set a clear vision, supported by four strategic imperatives and four enabling strategies which underpin our five-year strategy:



Through well-established and rigorous processes, and the analysis we have undertaken over the past year, we have a granular understanding of the risks that we face with mitigations and action plans set out for them.