NHS
Derby and Derbyshire
Clinical Commissioning Group

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 9th January 2020 – 9.15am to 11.00am

Venue: Conference Room, Toll Bar House, Ilkeston, Derbyshire DE7 5FH

Questions from members of the public should be emailed to DDCCG.Enquiries@nhs.net and a response will be provided on the day or will be sent within seven working days

Item	Subject	Paper	Presenter	Time
GBP/1920/182	**Welcome, Apologies & Quoracy** Jill Dentith, Bruce Braithwaite, Dean Wallace, Dr Emma Pizzey	**Verbal**	**Dr Avi Bhatia**	**9.15**
GBP/1920/183	**Questions from members of the public**	**Verbal**	**Dr Avi Bhatia**	
GBP/1920/184	**Declarations of Interest** • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary	**Papers**	**Dr Avi Bhatia**	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/1920/185	**Chair's Report**	**Paper**	**Dr Avi Bhatia**	**9.20**
GBP/1920/186	**Chief Executive Officer's Report**	**Verbal**	**Dr Chris Clayton**	
FOR DECISION				
GBP/1920/187	**Planning and Contracting Overview 2020/21**	**Paper**	**Zara Jones**	**9.40**
CORPORATE ASSURANCE				
GBP/1920/188	**Finance and Savings Report – Month 8**	**Paper**	**Richard Chapman/ Sandy Hogg**	**10.00**
GBP/1920/189	**Finance Committee Assurance Report – 2 January 2020**	**Verbal**	**Andrew Middleton**	

GBP/1920/ 190	**Quality and Performance Committee Assurance Report – 19 December 2019**	**Paper**	**Dr Buk Dhadda**	
GBP/1920/ 191	**Engagement Committee Assurance Report – 4 December 2019**	**Paper**	**Martin Whittle**	
GBP/1920/ 192	**Primary Care Commissioning Committee Assurance Report – 18 December 2019**	**Paper**	**Prof Ian Shaw**	
GBP/1920/ 193	**Risk Register Report – 31st December 2019**	**Paper**	**Helen Dillistone**	
GBP/1920/ 194	**Joined Up Care Board Update Report – December 2019**	**Paper**	**Dr Chris Clayton**	
FOR INFORMATION				
GBP/1920/ 195	**Derby Special Education Needs Inspection (SEND) Written Statement of Action**	**Paper**	**Zara Jones**	**10.30**
GBP/1920/ 196	**Ratified Minutes of Corporate Committees:** • Audit Committee – 19 September 2019 • Governance Committee – 12 September 2019 • Engagement Committee – 2 October 2019, 6 November 2019 • Primary Care Commissioning Committee – 27 November 2019 • Quality and Performance Committee – 28 November 2019	**Papers**	**Committee Chairs**	
GBP/1920/ 197	**Minutes of the Joined Up Care Derbyshire Board Meeting – October and November 2019**	**Paper**	**Dr Avi Bhatia**	
GBP/1920/ 198	**South Yorkshire & Bassetlaw Integrated Care System (ICS) Health Executive Group – November 2019**	**Paper**	**Dr Avi Bhatia**	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/1920/ 199	**Minutes of the Governing Body Public meeting held on 5th December 2019**	**Paper**	**Dr Avi Bhatia**	**10.45**
GBP/1920/ 200	**Matters arising from the minutes not elsewhere on agenda:** • Action Log	**Paper**	**Dr Avi Bhatia**	

GBP/1920/ 201	**Forward Planner**	**Paper**	**Dr Avi Bhatia**	
GBP/1920/ 202	**Any Other Business**	**Verbal**	**All**	**10.55**

Date and time of next meeting: - Thursday 6th February 2020 at 9.15am - Conference Room, Toll Bar House, Ilkeston, Derbyshire, DE7 5FH

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY REGISTER OF INTERESTS 2019/20

NHS Derby and Derbyshire Clinical Commissioning Group

*denotes those who have left the CCG, who will be removed from the register six months after their leaving date

Name	Job Title	Committee Member	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
				Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Bhatia, Dr Avi	Clinical Chair (also a member of Erewash Place Alliance Group; Derbyshire Primary Care Leadership Group; and Derbyshire Place Board)	Governing Body	GP Partner at Moir Medical Centre	✓				2000	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
			GP Parter at Erewash Health Partnership	✓				April 2018	Ongoing	
			Spouse works for Nottingham University Hospitals in Gynaecology				✓	Ongoing	Ongoing	
			Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				Ongoing	Ongoing	
Blackwell, Dr Penny	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Derbyshire Primary Care Leadership Group; Derbyshire Place Board; Dales Health & Wellbeing Partnership; and Dales Place Alliance Group)	Governing Body	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales		✓			Feb 2019	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
			GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse	✓				Ongoing	Ongoing	
			GP lead for Shared Care Pathology, Derbyshire Pathology		✓			2011	Ongoing	
Braithwaite, Bruce	Secondary Care Specialist (also a member of Audit Committee; Clinical & Lay Commissioning Committee; and Remuneration Committee)	Governing Body	Shareholder in BD Braithwaite Ltd, which provides clinical services to Ilkeston Community Hospital and provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines)	✓				Aug 2014	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
			Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients.	✓				Aug 2000	Ongoing	Declare interest in relevant meetings
			Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts.	✓				July 2007	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
			Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis.		✓			Aug 1992	Ongoing	No action required
			Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands.		✓			Aug 2009	Ongoing	No action required
Chapman, Richard	Chief Finance Officer (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Financial Recovery Group; and Primary Care Commissioning Committee)	Governing Body	Nil							No action required

Clayton, Dr Chris	Chief Executive Officer (also a member of Clinical & Lay Commissioning Committee; Financial Recovery Group; and Primary Care Commissioning Committee)	Governing Body	Spouse is a Director at PWC					2001	Ongoing	Declare interest at relevant meetings
Cooper, Dr Ruth	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Finance Committee; North East Derbyshire & Bolsover Place Alliance Group; Derbyshire Primary Care Leadership Group; CRHFT CQRG; GP Workforce Steering Group; and Conditions Specific Delivery Board)	Governing Body	GP Partner at Staffa Health, Tibshelf. Roles in the practice: Senior partner; Prescribing Lead; Adult Safeguarding Lead; Lead for Frailty and integrated care; PCN practice lead; interest in Dermatology and contraception including fitting of IUDs and Implants Shareholder in North East Derbyshire Health Ltd Sessional GP for DHU	✓ ✓ ✓				1992 2016 1995	Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith, Jill	Lay Member for Governance (also a member of Audit Committee; Finance Committee; Governance Committee; Primary Care Commissionig Committee; and Remuneration Committee)	Governing Body	Self-employed through own management consultancy business trading as Jill Dentith Consulting Providing part time consultancy service to Conexus (a GP Federation in Wakefield) Providing part-time management consultancy support to Sheffield Health and Social Care NHS FT	✓ ✓ ✓				2012 16 Jan 19 28 Oct 19	Ongoing 31 Aug 19 31 Mar 20	Declare interests at relevant meetings
Dhadda, Dr Bukhtawar S	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Quality & Performance Committee; and Clinical Policy Advisory Group)	Governing Body	GP Partner at Swadlincote Surgery	✓				2015	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
Dillistone, Helen	Executive Director of Corporate Strategy & Delivery (also a member of Engagement Committee; Financial Recovery Group; and Governance Committee)	Governing Body	Nil							No action required
Edwynn, Dr Cate	Director of Public Health, Derby City Council (also a member of Derbyshire Place Board)	Governing Body	Member of Health and Wellbeing Board, Derby City Council Member of Stronger Communities Board, Derby City Council Employee of Derby City Council	 ✓	✓ ✓			Ongoing	Ongoing	Declare interests at relevant meetings
Gibbard, Ian	Lay Member for Audit (also a member of Audit Committee; Clinical & Lay Commissioning Committee; Governance Committee; and Remuneration Committee)	Governing Body	Nil							No action required

Hogg, Sandy	Executive Turnaround Director (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Financial Recovery Group; and Primary Care Commissioning Committee)	Governing Body	Nil							No action required
Jones, Zara	Executive Director of Commissioning & Operations (also a member of Clinical & Lay Commissioning Committee; Financial Recovery Group; Quality & Performance Committee; and CRHFT Contract Management Board)	Governing Body	Nil							No action required
Lloyd, Dr Steven	Medical Director (also a member of CVD Delivery Group; Clinical & Lay Commissioning Committee; Conditions Specific Delivery Board; CRHFT Contract Management Board; EMAS Quality Assurance Group; Finance Committee; Financial Recovery Group; Primary Care Commissioning Committee; and Quality & Performance Committee)	Governing Body	GP Partner and sessions x2 per week at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓				2012 Ongoing	Ongoing Ongoing	Declare interests at relevant meetings
Middleton, Andrew	Lay Member for Finance (also a member of Audit Committee; Finance Committee; Quality & Performance Committee; and Remuneration Committee)	Governing Body	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group Lay Member for Governance at South West Lincolnshire CCG Lay Chair of Performers List Decision Panels for NHS England Central Midlands	✓ ✓ ✓				Jan 2017 June 2017 May 2013	Mar 2020 Mar 2020 Ongoing	Declare interest at relevant meetings There is no overlap of direct commissioning responsibilities but as with most East Midlands CCGs there may be services commissioned for the region through a lead CCG. In such cases this interest will be declared. Will not sit on any case which has knowledge of the GP or their practice.
Orwin, Gillian	Lay Member for Patient and Public Involvement (also a member of Clinical & Lay Commissioning Committee; Engagement Committee; Primary Care Commissioning Committee; Quality & Performance Committee; and Remuneration Committee)	Governing Body	Patient at Wingerworth Surgery			✓		Mar 2017	Ongoing	Will not take part in any decisions relating to Wingerworth Surgery
Pizzey, Dr Emma	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Governance Committee; Quality & Performance Committee; Erewash Place Alliance Group;and DCHS Clinical Quality Review Group)	Governing Body	Partner at Littlewick Medical Centre, with an interest in diabetes (but not clinical lead)	✓				2002	Ongoing	Declare interest at relevant meetings
Shaw, Ian	Lay Member for Primary Care Commissioning (also a member of Clinical & Lay Commissioning Committee; Engagement Committee; Primary Care Commissioning Committee; and Primary Care Enhanced Services Review Group)	Governing Body	Professor at the University of Nottingham	✓				1992	Ongoing	Declare interest at relevant meetings

Stacey, Brigid	Chief Nurse Officer (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Financial Recovery Group; Primary Care Commissioning Committee; Quality & Performance Committee; CRHFT Contract Management Board; CRHFT Clinical Quality Review Group; UHDB Contract Management Board; EMAS Quality Assurance Group; and Maternity Transformation Board (Chair))	Governing Body	Daughter is employed as a midwifery support worker at Burton Hospital				✓	Aug 2019	Ongoing	Declare interest at relevant meetings
Strachan, Dr Alexander Gregory	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Governance Committee; Quality & Performance Committee; and CRHFT Clinical Quality Review Group)	Governing Body	GP Partner at Killamarsh Medical Practice Member of North East Derbyshire Federation Adult and Children Safeguarding Lead at Killamarsh Medical Practice	✓ ✓	 ✓			2009 2016 2009	Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
Wallace, Dean	Director of Public Health, Derbyshire County Council (also a member of Derbyshire Place Board)	Governing Body	Panel Member for Active Derbyshire part of a local charitable organisation		✓			April 2019	Ongoing	Declare interest at relevant meetings
Watkins, Dr Merryl	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Joint Area Prescribing Committee; and Quality & Performance Committee)	Governing Body	Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital				✓	1992	Ongoing	Declare interest at relevant meetings
Whittle, Martin	Lay Member for Patient and Public Involvement (also a member of Engagement Committee; Finance Committee; Governance Committee; Quality & Performance Committee; and Remuneration Committee)	Governing Body	Nil							No action required

REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

Meeting	Date of Meeting	Chair (name)	Corporate Secretary/CCG Meeting Lead	Name of person declaring interest	Agenda item	Details of interest declared	Action taken

Glossary	
A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
ASTRO PU	Age, Sex and Temporary Resident Originated Prescribing Unit
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BME	Black Minority Ethnic
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CBT	Cognitive Behaviour Therapy
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CCE	Community Concern Erewash
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CETV	Cash Equivalent Transfer Value
Cfv	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CSE	Child Sexual Exploitation
CSU	Commissioning Support Unit
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSF	Commissioner Sustainability Funding
CTR	Care and Treatment Reviews
CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCCPC	Derbyshire Affiliated Clinical Commissioning Policies
DCHSFT	Derbyshire Community Healthcare Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United
DNA	Did not attend

DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Service
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care – the number of days a patient deemed medically fit is still occupying a bed.
ED	Emergency Department
EDEN	Effective Diabetes Education Now
EDS2	Equality Delivery System 2
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service NHS Trust
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
ENT	Ear Nose and Throat
EOL	End of Life
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRG	Financial Recovery Group
FRP	Financial Recovery Plan
GAP	Growth Abnormalities Protocol
GBAF	Governing Body Assurance Framework
GDPR	General Data Protection Regulation
GNBSI	Gram Negative Bloodstream Infection
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
GPSOC	GP System of Choice
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HLE	Healthy Life Expectancy
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies

ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICP	Integrated Care Provider
ICS	Integrated Care System
ICU	Intensive Care Unit
IGAF	Information Governance Assurance Forum
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework
JSNA	Joint Strategic Needs Assessment
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGB&T	Lesbian, Gay, Bi-sexual and Trans-gender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LOC	Local Optical Committee
LPC	Local Pharmaceutical Council
LPF	Lead Provider Framework
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHMIS	Mental Health Minimum Investment Standard
MIG	Medical Interoperability Gateway
MIUs	Minor Injury Units
MMT	Medicines Management Team
MOL	Medicines Order Line
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHAIS	National Health Application and Infrastructure Services
NHSE	NHS England
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NOAC	New oral anticoagulants
NUH	Nottingham University Hospitals NHS Trust
OJEU	Official Journal of the European Union
OOH	Out of Hours
ORG	Operational Resilience Group
PAD	Personally Administered Drug

PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Information
PCDG	Primary Care Development Group
PCNs	Primary Care Networks
PEARS	Primary Eye care Assessment Referral Service
PEC	Patient Experience Committee
PHB's	Personal Health Budgets
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PIR	Post-Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Point of Delivery
PPG	Patient Participation Groups
PPP	Prescription Prescribing Division
PRIDE	Personal Responsibility in Delivering Excellence
PSED	Public Sector Equality Duty
PSO	Paper Switch Off
PwC	Price, Waterhouse, Cooper
QA	Quality Assurance
QAG	Quality Assurance Group
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
QP	Quality Premium
Q&PC	Quality and Performance Committee
RAP	Recovery Action Plan
RCA	Root Cause Analysis
REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT Admitted	The percentage of patients waiting 18 weeks or less for treatment of the patients on admitted pathways
RTT Non admitted - The percentage if patients waiting 18 weeks or less for the treatment of patients on non-admitted pathways	
RTT Incomplete - The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period	
ROI	Register of Interests
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SHFT	Stockport NHS Foundation Trust
SFT	Stockport Foundation Trust
SNF	Strictly no Falling
SOC	Strategic Outline Case

SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRG	Systems Resilience Group
SIRO	Senior Information Risk Owner
SRT	Self-Assessment Review Toolkit
STAR PU	Specific Therapeutic Group Age-Sec Prescribing Unit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital Foundation Trust
STOMPLD	Stop Over Medicating of Patients with Learning Disabilities
STP	Sustainability and Transformation Partnership
TCP	Transforming Care Partnership
TDA	Trust Development Authority
T&O	Trauma and Orthopaedics
UTC	Urgent Treatment Centre
UEC	Urgent and Emergency Care
UHDBFT	University Hospitals of Derby and Burton Foundation Trust
YTD	Year to Date
111	The out of hours service delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home.
52WW	52 week wait

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 185

Report Title	Chair's Monthly Report
Author(s)	Dr Avi Bhatia
Sponsor (Director)	Dr Avi Bhatia

Paper for:	**Decision**		**Assurance**		**Discussion**		**Information**	X
Assurance Report Signed off by Chair				**N/A**				
Which committee has the subject matter been through?				**N/A**				

Recommendations

The Governing Body is requested to **NOTE** the contents of the report.

Report Summary

Understanding, identifying and addressing the causes of ill-health and inequality in the City and County in conjunction with tackling the financial challenge are the most important priorities for our Derbyshire system. Primary care has a vital role to play in supporting the development of the strategy for change that will be required to achieve these priorities and ensuring that our membership has a voice is critical. We are working to create the right opportunities to directly involve clinicians in shaping the new priorities and clinical models that will transform care, tackle inequity and see improved outcomes for our patients.

Further to my commitment last month to update on the development of Primary Care Networks (PCNs), progress continues with the Primary Care Leadership Group chaired by our Deputy Medical Director Dr Sam Taylor. The group includes all clinical directors, the Local Medical Committee, the GP Task Force and CCG representatives and operates as a forum to share best practice and national guidance. The current focus continues to be on recruiting the Clinical Pharmacists and Social Prescribing Link Workers and delivering the first year of the PCN GP contract requirements.

Workforce planning is a major priority for our CCG and the Derbyshire system. The process of analysing the current workforce, determining future workforce needs and understanding the gap between the present and the future will support the identification and implementation of solutions to our workforce challenge. I am pleased to confirm that all Derbyshire practices are signed up to the National Workforce Reporting System (NWRS) and it is envisaged that the latest reporting modules will support workforce planning requirements to a greater level of detail than previously. New components include reporting on General Practice workforce absences and vacancies, along with the new PCN roles.

As with all analytics, it is vital that the data is uploaded accurately and in a timely manner and colleagues across the system are working hard to achieve this. CCG colleagues are also working on a local workforce dashboard which will facilitate the production of workforce reports at individual practice, PCN and/or Place level. On behalf of the system I would like to acknowledge the work that our practices have delivered to date.

Are there any Resource Implications (including Financial, Staffing etc)?
None
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 187

Report Title	Planning and Contracting Overview 2020/21
Author(s)	Craig Cook, Deputy Director of Commissioning Operations
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**	X	**Assurance**		**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				None				

Recommendations

The Governing Body is requested to **APPROVE** the objectives and tactical approach, to set the parameters within which the CCG's Finance and Contracting Teams will work to deliver 2020/21 Contract Agreements with Providers.

Report Summary

Context

The negotiation process to secure Contract Agreements with Providers for the provision of NHS Services in 2020/21 will be complex, given a range of strategic and operational imperatives, particularly in relation to:

- Delivering our financial targets for 2020/21;
- The transition to a functioning Integrated Care System (ICS); and
- Overcoming the performance deficit in planned, cancer and urgent care.

Objectives

In the light of this, it is proposed that the CCG's Finance and Contracting Teams focus its work to secure Contracts which:

- Are affordable, with the value set within the resource allocated to the CCG;
- Create the necessary incentives to promote integrated care; and
- Establish a credible performance improvement plan for urgent and emergency care, cancer and elective care.

Tactical considerations

Finance and Efficiency

- Establishing affordable contracts will mean that the concept of devising and agreeing "flat-cash" financial envelopes becomes paramount alongside the need to establish clear decision rules on the allocation of growth monies.

  We will therefore develop our Contract Offers so that:

  (i) Mandatory requirements for allocation growth monies are achieved;
  (ii) There is due regard to deficit reduction; and
  (iii) Investment decisions have a clear positive payback which enhances the overall productivity of the health system.

- A fundamental pre-requisite for applying the principles described above, is the need for there to a comprehensive agreement in place between all major parties within Joined Up Care Derbyshire, for system collaboration and financial management, so that financial risk can be effectively controlled.

- The CCG will seek to negotiate the terms of such an agreement and enshrine it in our final 2020/21 NHS Standard Contracts with Providers. The form and function of such an agreement will be based on the model proposed by NHS England (see Appendix A for further information).

Quality and Performance

- Governing Body Members will be aware of the ongoing national review into NHS Standards for access to key services. Field testing of revised standards (for urgent and emergency care, mental health, cancer and elective care) is being undertaken and a summary of these standards is detailed at Appendix B for further information.

- For **urgent and emergency care**, where the field testing has been running longer and will be able to conclude sooner, the intention is to support the NHS to begin any recommended changes from 1 April 2020. It is therefore proposed that Operational Planning and Contracting activities over the next three months focus on ensuring that all Contracted Providers are in a position to mobilise from the 1 April 2020.

- For **elective care and cancer**, implementation is likely to be during mid 2020/21. It is therefore proposed that Operational Planning and Contracting activities over the next three months focus on ensuring that all Contracted Providers are (i) delivering against the current 85% threshold for 62 day wait for first cancer treatment and (ii) maintaining the size of RTT waiting list at the March 2020 level.

- In **mental health**, where completely new standards are being proposed, implementation will be to a longer timeframe, as testing is likely to continue in 2020/21. It is therefore proposed that the current access targets, relating to

Improving Access to Psychology Therapies and specialist early intervention for people experiencing a first episode of psychosis, will remain the focus of planning work over the next months.

Service Transformation

- The recently published 5 year plan for Joined up Care Derbyshire sets out the service transformation agenda to deliver the objectives of the NHS Long Term Plan.

- It is therefore proposed that the Service Development Improvement Plan, as a core component of the NHS Standard Contract, captures the specific measureable improvements in care expected across the following 8 domains:

1. "Out of Hospital Care" and fully integrated community based care
2. Reducing pressure on hospital emergency services
3. Giving people more control over their own health and more personalised care
4. Digitally enabled outpatient care
5. Improving Cancer Outcomes
6. Improving mental health services
7. Shorter waits for planned care
8. Better chronic disease management – Respiratory, Diabetes, Cardiovascular.

Are there any Resource Implications (including Financial, Staffing etc)?

No explicit resource implications arise from the content of this Paper.

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

Not applicable

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

Not applicable

Has an Equality Impact Assessment (EIA) been completed? What were the findings?

Not applicable

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below

Not applicable

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below

Not applicable

Have any Conflicts of Interest been identified/ actions taken?

Not applicable

Governing Body Assurance Framework
To plan and commission quality healthcare that meets the needs of our population and improves its outcomes
Identification of Key Risks
No explicit risks arise from the content of this Paper.

2020/21 Contracting Approach

1. Context

1.1. The negotiation process to secure Contract Agreements with Providers for the provision of NHS Services in 2020/21 will be complex, given a range of strategic and operational imperatives:

- **Establishing an Operational Plan and supporting Contract Agreement to deliver the financial position.** The requirement to deliver the 2020/21 Contract Total is extremely challenging and there are a number of material risks which need credible plans to mitigate, before the submission of detailed operational plans and Contract Agreements by 31 March 2020.

- **The transition to functioning as an Integrated Care System (ICS).** It is imperative that we build on the intentions of all parties in Joined up Care Derbyshire to plan and design services in a collaborative fashion. This will mean that we will have to conduct our business - strategic and operational planning, resource allocation and contracting - in a fundamentally different way over the next three months.

- **The need to overcome the performance deficit.** Whilst there have been some marked improvements in performance this year in mental health delivery, there has been a deterioration in cancer and elective care access. The emergency and urgent care position is also very fragile with supply side change not keeping pace with the stepped increase in demand that we have seen in 2019-20.

2. Purpose

2.1. In the context of the above, the purpose of this paper is to propose a series of relatively high level objectives and tactical considerations, to set the parameters within which the CCG's Finance and Contracting Teams will work to deliver 2020/21 Contract Agreements with Providers.

3. Objectives

3.1. It is proposed that the CCG's Finance and Contracting Teams focus its work to secure Contracts which:

3.1.1. Are affordable, with the value set within the resource allocated to the CCG. This will require the Commissioner and Providers to jointly manage financial risk and prioritise the investment of growth monies into areas that enhance the overall productivity of the health system.

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3.1.2. Create the necessary incentives to promote integrated care. As we move to establish the operation of an Integrated Care System (ICS), it is vital that we design a Contracting Framework to support. This will require the Commissioner and Providers to adopt a planning and delivery approach which:

- **Redefines the scope of payments**. This will start to see us moving from an episodic, discrete input reimbursement model, to one which is tailored to reimburse Providers for delivering a range of *bundled* interventions, spanning multiple care sectors e.g. community and acute, and covering a longer time period e.g. a year.

- **Expands the coverage of Providers that are party to the agreement**. This will start to see us pooling resource which may have historically been seen as "sector specific", into an overarching payment mechanism which distributes resource to all Providers within the participating sectors, e.g. all primary and secondary care services, within specific areas e.g. PLACE and/or PCN level.

- **Payment measures reward the delivery of improved health outcomes.** This will start to see us moving the focus away from monitoring the process of care delivery to maximising the health outcomes that matter most to patients.

3.1.3. Establish a credible performance improvement plan for urgent and emergency care, cancer and elective care. This will require Commissioners and Providers to be open and transparent about where sub-optimal care is currently being provided and a clear plan established in order to deliver sustained improvement against the key access standards.

4. Tactical response

4.1. In order to deliver the objectives highlighted in section 3, it is proposed that a number of tactical responses are formed over the coming weeks, as we submit formal offers to Providers.

4.2. Finance and Efficiency

4.2.1. Establishing affordable contracts will mean that the concept of devising and agreeing "flat-cash" financial envelopes becomes paramount, alongside the need to establish clear decision rules on the allocation of growth monies.

4.2.2. We will therefore develop our Contract Offers so that:

- Mandatory requirements for allocation growth monies are achieved;
- There is due regard to deficit reduction; and
- Investment decisions have a clear positive payback which enhances the overall productivity of the health system.

4.2.3. A fundamental pre-requisite for applying the principles described above, is the need for there to a comprehensive agreement in place between all major parties within Joined Up Care Derbyshire, for system collaboration and financial management, so that financial risk can be effectively controlled.

4.2.4. The CCG will seek to negotiate the terms of such an agreement and enshrine it in our final 2020/21 NHS Standard Contracts with Providers. The form and function of such an agreement will be based on the model proposed by NHS England (see Appendix A for further information).

4.3. Quality and Performance

4.3.1. Governing Body Members will be aware of the ongoing national review into NHS Standards for access to key services. Field testing of revised standards (for urgent and emergency care, mental health, cancer and elective care) is being undertaken and a summary of these standards is detailed at Appendix B for further information.

4.3.2. NHS England and NHS Improvement have committed to a process of public engagement on revised standards and sets out an indicative timetable as follows.

(i) For **urgent and emergency care**, where the field testing has been running longer and will be able to conclude sooner, the intention is to support the NHS to begin any recommended changes from 1 April 2020. It is therefore proposed that Operational Planning and Contracting activities over the next three months focus on ensuring that all Contracted Providers are in a position to mobilise from the 1 April 2020.

(ii) For **elective care and cancer**, implementation is likely to be during mid 2020/21. It is therefore proposed that Operational Planning and Contracting activities over the next three months focus on ensuring that all Contracted Providers are (i) delivering against the current 85% threshold for 62 day wait for first cancer treatment and (ii) maintaining the size of RTT waiting list at the March 2020 level.

(iii) In **mental health**, where completely new standards are being proposed, implementation will be to a longer timeframe, as testing is likely to continue in 2020/21. It is therefore proposed that the current access targets, relating to Improving Access to Psychology Therapies and specialist early intervention for people experiencing a first episode of psychosis, will remain the focus of planning work over the next months.

4.4. Service Transformation

4.4.1. The recently published 5 year plan for Joined up Care Derbyshire sets out the service transformation agenda to deliver the objectives of the NHS Long Term Plan.

4.4.2. It is therefore proposed that the Service Development Improvement Plan, as a core component of the NHS Standard Contract, captures the specific measureable improvements in care expected across the following 8 domains:

1. “Out of Hospital Care” and fully integrated community based care
2. Reducing pressure on hospital emergency services
3. Giving people more control over their own health and more personalised care
4. Digitally enabled outpatient care
5. Improving Cancer Outcomes
6. Improving mental health services
7. Shorter waits for planned care
8. Better chronic disease management – Respiratory, Diabetes, Cardiovascular.

5. Next steps

5.1. Operational Planning guidance from NHSE/I is currently in development and is expected to be published following the conclusion of the strategic planning round.

5.2. However, the high level draft timetable for operational planning is outlined below. Over the next few weeks work will take place to ensure that this timetable is better developed to support functional and locality teams to manage the activities that will support the delivery of a successful Operational Planning Round.

Milestone	Date
Initial system planning submission	By 27 September 2019
Tariff Engagement Document published	October 2019
S118 Tariff Consultation published	December 2019
Further operational and technical guidance ready for issue	January 2020
Publication of the national implementation programme for the LTP	January 2020
NHS Standard Contract consultation opens	December 2019
National tariff published	Mid- January 2020
First submission of draft operational plans	Early February 2020
NHS Standard Contract published	Mid- February 2020
System Led review of submissions	End February 2020
Contracts signed	31 March 2020
Final submission of operational plans	Early April (LTP said 'By end March 2020' but plans would usually be submitted after contract are signed. An early April submission date would accommodate this)

5.3. The CCG's Executive Finance Recovery Group will manage the delivery of the CCG's Operational and Contracting work. Regular updates on progress of negotiations will be provided to following Committees:

- Finance Committee
- Quality and Performance
- Clinical Lay Commissioning

Appendix A

Draft NHS Standard Contract 2020/21

Agreement for system collaboration and financial management 2020/21

Version number: 1

First published: December 2019

Updated: NA

Prepared by: NHS Standard Contract Team
england.contractsengagement@nhs.net

Classification: Official

Publication Approval Number: 001184

[SYSTEM NAME]

AGREEMENT FOR SYSTEM COLLABORATION AND FINANCIAL MANAGEMENT 2020/21

Date:

The CCGs and Providers listed below are members of the [ ] ICS/STP and have agreed with NHS England and NHS Improvement a System Financial Trajectory for 2020/21. NHS England is not a member of the ICS/STP, but as commissioner of [specialised and other directly-commissioned services] from [list relevant Providers] its commissioning expenditure and commissioning decisions will have an impact on the System's ability to meet the System Financial Trajectory or 2020/21 and to plan for a sustainable financial position in the longer term.

We have therefore agreed:

1. Our Objectives

We are committed to using our collective resources as efficiently and effectively as possible to meet the health and care needs of the people served by our System, provide high-quality services and improve health outcomes.

Our **Objectives** are:

1.1 To do so while achieving the System Financial Improvement Trajectory for 2020/21, on the shared understanding that a failure to do so is a failure of us all; and

1.2 To plan in an integrated and co-ordinated fashion for a sustainable financial balance for our System for 2021/22 and beyond.

2. How We Will Work Together

2.1 We will work together collaboratively to pursue and achieve our Objectives, providing whatever support and assistance we can to each other to do so. We will act with utmost good faith towards each other.

2.2 In pursuit of our Objectives, and in all matters connected with this Agreement, we will seek solutions and agree and take actions which offer the most effective and efficient use of our collective resources in the best

interest of our System and the people we serve, even where those solutions and actions may not be in the immediate best interests of any one or more of us individually.

2.3 We will ensure that our respective operational plans and plans for spending within the System for 2020/21 and beyond are aligned and are in keeping with our Objectives, so that successful delivery of each operational and spending plan is a success for all of us and contributes towards achieving our Objectives.

2.4 We will each perform our respective obligations under the contracts details of which are set out in Schedule 1 (our **Contracts**). This Agreement supplements our Contracts. This Agreement does not qualify or waive any of our respective obligations under our Contracts.

2.5 We will be as open and transparent with each other as we are with our own board members/Regional leadership. We will, on an open-book basis, provide each other with all information that is reasonably required to pursue and achieve our Objectives and to enable appropriate mutual scrutiny and challenge. In particular, we will share the information described in Schedule 2. We will each comply with the further provisions set out in Schedule 2.

2.6 We will hold each other to account. We will scrutinise and challenge each other, and we will each be open to scrutiny and challenge by others. We will support each other in meeting those challenges.

2.7 In pursuing our Objectives, we will engage and co-operate with other commissioners and providers of health and care services for the people served by our System (including commissioners and providers of primary care and social care services), giving due consideration to their views and suggestions in relation to any matter we discuss under this Agreement. In pursuing our Objectives, we will use our reasonable endeavours to ensure that we do not have a negative impact on other Systems.

2.8 For the purposes of this Agreement we will be represented by our respective Representatives. Our Representatives will meet and will conduct business at their meetings in accordance with Schedule 3.

2.9 We will operate the mechanisms for system financial management set out in and from time to time agreed by our Representatives in accordance with Schedule 3. We will (subject to our own governance processes and to implementation under our Contracts, as required) individually and collectively take the actions recommended by our Representatives in accordance with Schedule 3 in pursuit of our Objectives.

2.10 The provisions set out in Schedule 4 will apply to this Agreement.

2.11 We are conscious of the rights of patients enshrined in the NHS Constitution and of our respective responsibilities and duties under the NHS Constitution, the NHS Act 2006, the Health and Social Care Act 2012, the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, the Public Contract Regulations 2015 and the NHS Provider Licence. Nothing in this Agreement or the manner in which we conduct ourselves under it is intended to infringe or compromise those rights, responsibilities and duties, and we will do everything we can to ensure that it does not do so.

The CCGs		
[ ] CCG [Address]	…… Authorised signatory	[Representative] (Chief Executive/Director of Finance/Chief Financial Officer)
[ ] CCG [Address]	…… Authorised signatory	[Representative] (Chief Executive/Director of Finance/Chief Financial Officer)
[Add further commissioners as necessary]		
The Providers		
[ ] NHS Foundation Trust [Address]	…….. Authorised signatory	[Representative] (Chief Executive/Director of Finance/Chief Financial Officer)
[ ] NHS Trust [Address]	…….. Authorised signatory	[Representative] (Chief Executive/Director of Finance/Chief Financial Officer)
[Add further providers as necessary]		
NHS England, as commissioner of specialised other directly commissioned services		
NHS England and NHS Improvement [local office address]	…….. Authorised signatory	[Representative] (Regional Finance Director/ Regional Director of Commissioning)
Other signatories		
[Add as agreed locally][1]		

[1] System Leaders and/or other organisations may be added as signatories either: (a) Where they have specific oversight or other roles in relation to the matters covered by the Agreement agreed and documented locally as an addition to this template, and/or (b) To simply acknowledge what has been agreed between CCGs and Providers within the local system

SCHEDULE 1

OUR CONTRACTS

This Agreement relates to the following contracts (the **Contracts**) and to the services commissioned under them by the CCGs and NHS England (the **Services**):

	Parties	**Services**
NHS Standard Contract dated [ ]	[ ] CCG [ ] CCG [ ] CCG [ ] NHS Trust	[Acute, A&E]

SCHEDULE 2

TRANSPARENCY[2]

1. We have shared and will share with each other the following information on an open-book basis:

   1.1 our opening financial and operational plans for 2020/21 (which, in the case of NHS England, means those plans relating to its expenditure on specialised and other directly commissioned services within the System only), including;

   - planned expenditure against income/allocation, reflecting agreed contract values and any reserves
   - key assumptions on which plans are based, including about activity levels, workforce, premises, investment/de-investment programmes, other cost drivers and cost improvement/QIPP plans
   - analysis of key risks to delivery of those plans;

   1.2 monthly in-year reports summarising the position against all of the above, showing projected year-end position against Financial Improvement Trajectories, highlighting any significant (and new/changed) risks and describing action in hand to address them; and

   1.3 (subject to paragraph 4 below) any further information which may reasonably be required to be available to us all in order for us to pursue and achieve our Objectives.

2. We will, except as permitted below, keep information shared under this Agreement confidential and will not use it for purposes other than those contemplated by this Agreement.

3. We will each be entitled to disclose to third parties information shared by another party to this Agreement only if:

   3.1 the information is in or comes into the public domain other than by breach of this Agreement; or

[2] NOTE: There is a risk that the providers and commissioners sharing financial information and potentially putting in place mutual financial management controls may be seen to favour incumbent providers of services and could potentially breach the procurement principles of transparency and equal treatment of all potential providers. If an incumbent provider is involved in developing requirements for a services contract and this ultimately leads to them gaining an unfair advantage over other providers in the market, such as on a re-procurement of a services contract, this could be grounds for challenging a procurement procedure. Care should therefore be taken that that arrangements put in place under the SCFMA are not favouring incumbent providers over other potential providers. Commissioners will need to consider how they can ensure that, when services contracts are procured, they can neutralise any incumbent advantage from being party to the SCFMA as much as possible in order to ensure all potential providers are treated equally.

3.2 it is necessary to do so to comply with any applicable legal requirement or government policy in relation to transparency; or

3.3 the disclosure is made in response to a request from an appropriate regulatory or supervisory body; or

3.4 the party which shared the information consents to it being disclosed.

4. We will not share information which, if it is shared between providers, would allow providers to forecast or coordinate commercial strategy or behaviour in any market or might otherwise be considered competition sensitive, nor otherwise act in a manner contrary to the requirements of Condition C2 (Competition Oversight) of the NHS Provider Licence.

5. We acknowledge that we are each subject to the requirements of the Freedom of Information Act 2000 and the Environmental Information Regulations 2004. We agree that:

5.1 we will assist and co-operate with each other to enable us to comply with our disclosure obligations under those Acts;

5.2 if any of us receives a request for information under either Act that relates to this Agreement then the party that receives the request for information will be responsible for responding to it;

5.3 if the request for information relates to information that was shared by one of us, the party that receives the request for information will notify the party that shared the information and will not respond directly to the request for information without their permission, unless it is required to do so in order to comply with its obligations under either Act; and

5.4 except for any information which is exempt from disclosure in accordance with the provisions of FOIA, or for which an exception applies under EIR, the content of this Agreement is not confidential information.

6. We will not share any personal data under this Agreement, and none us will act as a processor of personal data on behalf of any of the others.

SCHEDULE 3

SYSTEM FINANCIAL MANAGEMENT

Note: This Schedule should set out how the parties' Representatives will engage with each other and the financial management mechanism they have agreed and will operate. It should set out the actions that the parties will take to resolve in-year risks to achieving their System Financial Improvement Trajectory and ensure longer-term financial sustainability for the System as a whole.

This Schedule is to be populated locally, but in doing so the parties should consider and cover at least the following:

Meetings of Our Representatives

Note: this section should detail when, how and on what basis the parties are to meet to discuss matters under this Agreement. In particular:

- *Who must and who may attend those meetings*
- *Quoracy requirements*
- *Where and when those meetings will be held (monthly is recommended)*
- *Who will chair meetings*
- *Who will take minutes, and when and to whom minutes will be distributed*
- *How and when this group will report within the local System (assuming there is a higher overarching System forum to which this one reports).*

Where appropriate, this could be by reference to existing ICS/STP governance arrangements, but must allow for the involvement of NHS England in its role as commissioner within the System.

Insert locally-agreed text here

Review and discussion of performance against our Objectives, risks to achieving them, opportunities for action or investment

Note: this section should detail what is to be reviewed and discussed. In particular:

- *Describe the business to be conducted at these meetings, which should routinely include review of the monthly reports and other information shared under Schedule 2 and consideration on an open and transparent basis of actions needed to address risks identified which may jeopardise delivery of the Objectives*

- *Describe what other business may be brought to meetings by any member, which could include*

o *open and transparent sharing of views on actual and contingent risks and pressures, and of potential opportunities and mitigations*

o *issues where one party sees an opportunity for action or investment (by some or all the other parties) which can lead to an improved position against the FIT*

o *issues where one party believes that the actions of one or more other parties are making overall achievement of the System FIT less possible (whilst perhaps prioritising delivery of their own Organisational FIT).*

Insert locally-agreed text here

Actions and decisions in pursuit of our Objectives

Note: this section should set out the range of issues which the System may face, and how the parties might respond. In particular, this Schedule should:

- *establish a principle of subsidiarity, with the onus on each party to deliver its services plans and Organisational FIT and making clear that the Representatives will only consider issues where a) it is clear that the individual party raising the issue is doing all it can to tackle that*

issue itself and b) that, where relevant, the "place" affected has also sought to address the issue, before it is raised at "system" level

- *describe the different types of in-year pressure which may emerge and the possible responses which the group may, in principle, agree in respect of how they should be managed.*

  In-year pressures could include:

  - *QIPP or CIP schemes do not deliver the planned savings*
  - *new cost pressures emerge*
  - *demand for services higher than planned*
  - *there are significant changes in patient flows between providers*

In principle responses to such pressures should include:

Instigating further investigation (joint where appropriate) of the facts and possible responses, to inform decisions on future action	*No party should unreasonably withhold agreement to such action*
Agreeing recommendations to relevant Boards/NHSE Regional team as to actions which parties can take to help to address the issue at no cost to themselves (for example, clinically-appropriate measures to manage demand for services)	*No party should unreasonably withhold agreement to such action or its implementation under its Contract*
Agreeing recommendations to relevant Boards/NHSE Regional team as to actions which parties can take to help to address the issue at reasonable cost to themselves and where, at system level, the aggregate saving can reasonably be expected to exceed the aggregate cost (for example ….)	*No party should unreasonably withhold agreement to such action or its implementation under its Contract*
Where a "System risk reserve" has been established, agreeing recommendations as to how/whether any of this should be deployed to address a particular issue	*No party should unreasonably withhold agreement to such action or its implementation under its Contract*
Agreeing recommendations for more radical redesign of services to deliver improved efficiency, with a view to informing commissioning and provision of services in 2021/22 and beyond	*Subject to agreement and documentation in Contracts*

Agreeing System-wide business cases for investment proposals in pursuit of Objectives	*Subject to sign-off in accordance with individual governance requirements (SFIs etc)*
Agreeing recommendations to change levels or basis of contractual payment between specific parties	*Subject to agreement and documentation in Contracts and to compliance with National Tariff rules and principles*
Agreeing recommendations for reinvestment by commissioners of sums withheld from providers for breach of National Quality Requirements/Operational Standards/RAPs and/or for Information Breaches	*No party should unreasonably withhold agreement to such action*
Agreeing recommendations for investment by commissioners of sums allocated to CQUIN payments but unearned due to CQUIN indicators not being met	*No party should unreasonably withhold agreement to such action*
Agreeing recommendations to adjust (or ask NHSE/I for an adjustment to) the individual FITs which make up the system FIT	*No party should unreasonably withhold agreement to such action or its implementation under its Contract*

Insert locally-agreed text here

SCHEDULE 4

OTHER MATTERS

1. This Agreement relates to the financial year 2020/21 only. Our current expectation is that we will enter into a new agreement covering the same or similar matters in respect of the financial year 2021/22. On that basis, we do not expect there to be any extension of this Agreement. We will, however, continue to abide by it for as long as relevant matters relating to the financial year 2020/21 remain to be dealt with by us.

2. This Agreement may be varied by unanimous agreement between us. Any variation must be documented in writing and confirmed in writing by each of our authorised signatories.

3. We are sharing our intellectual property in the form of the information that we share under this Agreement, and we will collectively have the right to use that intellectual property but only for the purposes of this Agreement. None of us will acquire the intellectual property of any other of us.

4. We intend that the rights in any intellectual property created by any of us specifically for the purposes of this Agreement will belong to the party that created it. We will collectively have the right to use that intellectual property but only for the purposes of this Agreement.

5. We do not intend this Agreement to be legally binding, and no legal obligations or legal rights will be created between us by it, but we each enter into this Agreement intending to honour all our obligations set out in this Agreement.

6. Nothing in this Agreement is intended to, or will be deemed to, establish any partnership or joint venture between us, constitute any of us as the agent of any of the others, nor authorise any of us to make or enter into any commitments for or on behalf the others.

7. We agree that each of us will remain individually liable for any losses or liabilities incurred due to our own (or our employee's) actions and none of us intends that any of the others will be liable for any loss suffered by any of us as a result of this Agreement.

8. We acknowledge that each Party remains accountable to its own regulatory body (NHS England or NHS Improvement, as appropriate), and may be subject to actions on the part of the appropriate regulatory body in respect of its own acts, omissions and performance, regardless of this Agreement.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Appendix B – Proposed Access Standards for Mental Health, Cancer, Elective and Cancer Care and Urgent Care.

Mental Health

Proposed Standard	Clinical Rationale	Implications for Patient Care
Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.	While for many people with urgent mental health needs, A&E is appropriate; consensus among clinicians, patients and commissioners is that many urgent mental health needs could be met more effectively in the community. Appropriate response times will need to be explored as part of testing. Many local areas have already set a local target of four hours, for example. However, the severity and need of individual patients will need to be taken into account – some patients will need a quicker response.	Rapid assessment of needs to determine urgency, and clear communication of expected next steps to the patient or referrer. Many needs will be met on the telephone or by facilitating access to non-urgent support. When people are assessed as having urgent or emergency needs, they will need timely face-to-face assessment from a specialist mental health professional.
Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.	Patients of all ages presenting in A&E in crisis require quick assessment to determine risk. If they are not seen quickly, the A&E environment can exacerbate symptoms and they may leave without treatment, potentially with risk of serious harm or suicide. Managing patients who have not been assessed adds pressure and anxiety to staff	Someone experiencing a mental health crisis would receive a response from the liaison mental health service within one hour
Four-week waiting times for children and young people who need specialist mental health services	Waits for treatment for children and young people's mental health services vary significantly from referral to treatment. Long waits can impact both clinically and on the individual waiting for treatment	Maximum of four weeks from referral to an assessment and start of treatment or plan in NHSfunded services and/or appropriate sign posting or interface with other services, including outside the provider and specialist

		community services.
Four-week waiting times for adult and older adult community mental health teams	Clear waiting times are to be incorporated into the design of new integrated primary and community mental health services, to ensure that all individuals are seen within a clinically appropriate time.	Maximum of four weeks from referral to an assessment and start of treatment or plan in NHSfunded services and/or appropriate sign posting or interface with other services including outside the provider and specialist community services.

Cancer

Proposed Standard	Clinical Rationale	Implications for Patient Care
Faster Diagnosis Standard: Maximum 28- day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.	Urgent cases include: • those referred by their GP with urgent cancer symptoms; • those referred by their GP with breast symptoms; • those referred by cancer screening services. It is important that people are diagnosed quickly after referral so they can start treatment as soon as possible. Patients will need to have their first appointment with a consultant well before the 28- day point to ensure communication of diagnosis within that timeframe.	More explicit focus on measuring and incentivising early diagnosis, which is linked to improved survival rates. Improves on current two-week waiting time, as measures time to receive diagnosis, rather than time to be first seen by a consultant. Brings together existing urgent referral routes into one simple standard.
Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening.	Includes urgent cases as above. Having a single headline measure, and ensuring the clinical guidance governing inclusion within it reflects modern clinical practice, adds clarity and greater focus on what really matters.	Brings together three existing urgent referral routes into one simplified standard.
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	All cancer patients need to begin treatment quickly after the decision to treat is taken.	Maintains guarantee of swift start to treatment for all cancer patients. Brings together four existing treatment standards into one simplified standard.

Urgent and Emergency Care

Proposed Standard	Clinical Rationale	Implications for Patient Care
Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments).	Focus on patient safety prioritisation and streaming to the most appropriate service, including liaison psychiatry and community mental health crisis services. This needs to be easily understandable for patients, and is regarded by the public as important.	This will identify life-threatening conditions faster. It ensures timely clinical assessment to identify anybody who is in need of immediate treatment, and allows patients to be directed to the service and practitioner best able to meet their needs at an early stage in the patient's journey.
Time to emergency treatment for critically ill and injured patients.	Highest priority patients get high-quality care with specific time-to-treatments, with proven clinical benefit.	Complete a package of treatment in the first hour after arrival for lifethreatening conditions such as: • stroke; • heart attack (MI-STEMI); • major trauma; • critically ill patients (including sepsis); • acute severe asthma; • mental health presentation
Time in A&E (all A&E departments and mental health equivalents).	Measure the mean waiting time for all patients. Strengthen rules on reporting prolonged trolley waits for admission, including reporting to the CQC.	Measures the time all patients are in A&E. Reduce risk of patient harm through long waits for admission or inappropriate admission. Reduce very long waits for those who need care.
Utilisation of Same Day Emergency Care.	Incentivise avoidance of overnight admission and improve hospital flow	Identifies a group of patients with urgent healthcare needs who would benefit from rapid assessment and review by a senior clinician. The aim is to complete all diagnostic tests, treatment and care that are required in a single day, in order to avoid an unnecessary overnight hospital stay. Reduction in overnight admissions and improved patient experience.
Call response standards for 111 and 999	Assure a rapid response, and match patients (including mental health patients) to the service that best meets their needs.	Ensures that a patient's call is answered and assessed promptly when seeking help by telephone. Encourages patients to access out

		of hospital services, and to make use of telephone triage.

Elective Care

Proposed Standard	Clinical Rationale	Implications for Patient Care
Maximum wait of six weeks from referral to test, for diagnostic tests1.	Ensure that patients are accessing diagnostic tests quickly, so that a diagnosis can be reached and treatment can begin in a timely manner.	Need for more consistent achievement in all places. Achieve opportunity for faster overall pathway to diagnosis and decision and create a clear plan for treatment earlier.
Defined number of maximum weeks wait for incomplete pathways2, with a percentage threshold. OR Average wait target for incomplete pathways.	Will test both approaches to consider the impact on prioritisation of care and reduction of long waits. Every week counts for all patients in achieving an average, hence keeps focus on patients at all stages of their pathway.	Measure from the point of referral until treatment. Clock stops and starts will reflect new arrangements for outpatients.
26-week patient choice offer.	Ensures that patients who have not accessed treatment within recommended timeframe, are able to choose whether to access faster treatment elsewhere in a managed way.	Faster care for many patients by re-directing to providers who can treat them more quickly.

1Current standards have set the threshold for this at 99%. The Review does not propose any changes to this at this stage.

2Current standards have set the maximum wait at 18 weeks, and the threshold at 92% of patients who are on incomplete pathways. Field testing will consider whether these values are appropriate

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 188

Report Title	Summary Finance and Savings Report 1st April 2019 – 30th November 2019
Author(s)	Richard Chapman / Sandy Hogg
Sponsor (Director)	Richard Chapman / Sandy Hogg

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Finance Committee				

Recommendations

The Governing Body is recommended to **NOTE**:

- the year to date and forecast financial performance at month 8
- the month 8 savings position
- the level of risk to the outturn which is described within the report

Report Summary

At month 8 the CCG is reporting year to date and forecast positions that are in line with plan. The CCG remains on course to achieve its control total.

If the CCG's expenditure remains within plan it can receive up to £18.9m of further available CSF.

The month 8 savings information shows year to date delivery of £32.3m (against a phased plan of £39.8m) and a forecast savings delivery of £48.1m against the full year plan of £69.5m.

Are there any Resource Implications (including Financial, Staffing etc)?

N/A

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

N/A

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

N/A

Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None identified
Governing Body Assurance Framework
This paper supports the strategic objective of supporting the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
Identification of Key Risks
Financial risks are identified in Section 5 of the report.

Governing Body – 9th January 2020

Summary Finance and Savings Report 1st April 2019 – 30th November 2019

Finance Summary

1. Introduction

The purpose of this report is to inform Governing Body members of the financial performance of NHS Derby and Derbyshire CCG, including delivery of the savings plan for the eight month period ending 30th November 2019. The detailed Finance and Savings Delivery reports were presented to the Finance Committee on 19th December 2019 and a separate assurance report is provided to Governing Body by the Chair of that Committee. This report summarises the key messages from those reports.

The information in this report is based on the month 8 information provided to NHS England through the monthly Non-ISFE submission and to the Finance Committee via the Finance Report.

2. Financial Performance Summary

At month 8 the CCG is reporting a year to date and forecast outturn position in line with its control total and financial plan.

Table 1 – Summary of performance against key CCG financial duties

Statutory Duty/ Performance	Target	Result	Achieved
Hold a 0.5% risk reserve (inc. PCCC)	£8.112m	£8.112m	✓
YTD achievement of control total in-year deficit (original plan)	(£9.183m)	(£9.183m)	✓
Forecast achievement of control total in-year deficit (original plan adjusted for CSF)	(£18.850m)	(£18.850m)	✓
Forecast delivery of the Savings Target	£69.500m	£48.142m	✗
Forecast - remain within the Running Cost Allowance	£22.457m	£16.219m	✓
Underlying Position	(£46.400m)	(£51.100m)	✗
Remain within cash limit	Greatest of 1.25% of Drawdown, or £0.25m	0.66%	✓
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8	✓

3. Financial Position and Key Variances

Table 2 – Summary Operating Cost Statement

	YTD				Full Year and FOT			
	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	Annual Budget	Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	538,437	546,826	(8,389)	(1.56)	795,574	823,166	(27,592)	(3.47)
Mental Health Services	122,135	123,777	(1,642)	(1.34)	183,002	185,006	(2,005)	(1.10)
Community Health Services	94,329	93,182	1,147	1.22	141,442	139,779	1,663	1.18
Continuing Health Care	68,762	64,251	4,511	6.56	101,358	93,944	7,414	7.31
Primary Care Services	132,064	132,889	(825)	(0.62)	197,663	198,461	(798)	(0.40)
Primary Care Co-Commissioning	93,173	90,331	2,842	3.05	140,665	137,660	3,005	2.14
Other Programme Services	44,146	42,788	1,358	3.08	78,740	65,263	13,477	17.12
Total Programme Resources	**1,093,045**	**1,094,044**	**(999)**	**(0.09)**	**1,638,444**	**1,643,279**	**(4,835)**	**(0.30)**
Running Costs	11,663	10,664	999	8.57	18,624	16,219	2,405	12.92
In-Year Allocations	0	0	0		1,850	1,850	0	0.00
0.5% Contingency (excl co-comm)	0	0	0		7,409	4,979	2,430	32.80
In year Planned Deficit (Control Total)	(19,333)	0	(19,333)	100.00	(29,000)	0	(29,000)	100.00
CSF Received	10,150	0	10,150		10,150	0	10,150	
Total In-Year Resources	**1,095,525**	**1,104,708**	**(9,183)**	**(0.84)**	**1,647,477**	**1,666,327**	**(18,850)**	**(1.14)**

- The year to date and forecast overspend positions of £9.183m and £18.850m respectively are in line with the CSF adjusted control total.
- The year to date position includes savings under delivery of £7.460m and the forecast position includes savings under delivery of £21.358m.
- £2.430m of the CCG's £8.1m mandated contingencies have been used in the forecast position (nil in the year to date position).
- If the CCG's overall position remains within plan it will receive up to a further £18.850m of Commissioner Sustainability Funding (CSF).
- Any underspends or spare budget will not be re-committed without the approval of the Chief Finance Officer.

Within the reported financial position the key highlights are as follows:

Acute Services

- University Hospitals of Derby and Burton – The year to date position is an underspend of £0.492m and the forecast is an overspend of £3.217m. Issues remain with the latest monitoring data which impacts mainly on outpatients. The year to date position includes an estimated credit of £2.67m for the partial recovery of contract challenges raised with the Trust along with £0.3m for partial achievement of CQUIN. The forecast is an improvement of £0.2m from last month and includes a full year credit of £3.4m for the recovery of activity challenges and a reduction of £0.5m for PLCV/IPG delivery. In addition to the 2019-20 contract position, a credit of £0.9m has been included in the forecast for the settlement of agreed challenges raised in 2018-19.

- Chesterfield Royal Hospital has a year to date underspend of £0.429m. A benefit of £0.914m from finalising the 2018-19 position has been recognised as March 2019 activity came in lower than expected. This benefit has been partially offset by an overspend in non-elective and urgent care activity. The forecast is an underspend of £0.855m which includes the prior year credit and a further anticipated credit relating to 2018-19 CQUIN failure and frailty activity. The forecast underspend has decreased by £0.980m since last month due to the non-achievement of savings and increased activity levels seen in the last two months.

- Sheffield Teaching Hospitals - the year to date position is an overspend of £1.254m with £0.99m relating to current year activity for elective, non-elective and critical care. There is a cost of £0.264m following finalisation of previous year balances which has been included in both the year to date and forecast positions. The forecast outturn is an overspend of £1.67m, an increase of £0.384m from last month, and assumes that the overspend seen to date will continue at current levels with the exception of critical care which is expected to remain at planned levels for the remainder of the year.

- Savings – the recognition of savings under delivery is predominantly in the Acute area.

Mental Health Services

- The mental health position shows a year to date overspend of £1.642m and forecast overspend of £2.005m relating mainly to high cost patients and Section 117 cases. These overspends are both due to caseload and are partially offset by a £2.0m forecast underspend against the investment budget held for the Mental Health Investment Standard (MHIS).

Community Services

- There is a year to date underspend of £1.147m and a forecast underspend of £1.663m. The position includes a year to date underspend of £1.0m and forecast underspend of £1.5m for Derbyshire Community Health Services FT (DCHS) based on anticipated activity levels and non-achievement of CQUIN. The underspend is partially offset by overspends for non-NHS providers for ophthalmology and for Derby Urgent Care Centre.

Continuing Healthcare

- The year to date variance is an underspend of £4.511m and a forecast underspend of £7.414m. The underspends relate to prior year benefits now being recognised in the position, and 2019-20 activity forecasts based on confirmed current caseload. These benefits are partially offset by pressures on children's package costs, and savings schemes which have not commenced as planned.

Primary Care

- The year to date variance at month 8 is an overspend of £0.825m with a forecast overspend of £0.798m. The prescribing budget continues to show an overspend position with £2.646m year to date and £3.359m forecast for the full year. This is mainly due to cost pressures relating to Category M drugs along with cost and volume variances. These overspends are expected to be mainly offset by underspends across other primary care areas.

Primary Care Co-Commissioning

- There is a year to date underspend of £2.842m and a forecast underspend of £3.005m. The majority of the underspends both year to date and forecast relate to £2.325m of prior year benefits, mainly for rent reviews. The position also includes expected underspends for demographic growth on contracts.

Running Costs

- The running cost budget of £18.624m was set well below the running cost allocation of £22.457m. The streamline budget reflects savings and efficiencies. It also prepares the CCG for mandated Running Cost reductions in 2020-21. The latest forecast position is an underspend of £2.405m against budget, and £6.238m against allocation, relating to vacancy slippage and reduced CSU costs.

4. Underlying Position

The CCG's underlying (UDL) position compares the recurrent funds available against the recurrent expenditure baseline. The difference between the two will result in either an underlying surplus or deficit for the CCG. This is an indicator of the underlying financial health of the organisation. The CCG's underlying position is directly affected by the delivery of recurrent savings and underspends against budget (improvement in position) or non-delivery of recurrent savings and overspends against budgets (deterioration).

Table 3 – Underlying Position Summary

	£'m
Control Total	(29.0)
Non-Recurrent Savings	(9.4)
Other Non-Recurrent Transactions	(12.7)
Forecast 2019/20 Exit Underlying Position	**(51.1)**
UDL as a Percentage of Recurrent Allocation	(3.2%)

These figures exclude the full year effect of savings.

5. Risks and Mitigations

The CCG is reporting a fully mitigated risk position. Identified activity/financial risks totalling £5.7m are mitigated by the unused 0.5% contingency.

Table 4 - Risks & Mitigations

	£'m
Risks	
Activity Risk	1.4
Acute Services	1.5
Mental Health Services	0.3
Prescribing	2.0
Other Programme Services	0.5
Total Risks	**5.7**
Mitigations	
0.5% Contingency Held	5.7
Total Mitigations	**5.7**
Net (Risk) / Mitigation	**0**

6. Savings Programme Year to Date and Forecast Outturn Position at Month 8

As at month 8 the CCG has delivered cash-releasing savings of £32.3m against a year to date target of £39.8m, an underperformance of £7.5m (18%), compared to a year to date shortfall at Month 7 of £3.5m (11%). This position reflects the fact that the phasing of the CCG Efficiency programme included delivery of 65% of the financial benefit in the last two quarters of the year.

At Month 8 the total risk assessment has increased overall by £1.1m to £21.4m. This is shown as risk inside the forecast outturn position with no risk reported outside of forecast related to individual schemes. Table 5 summarises the risk reported to NHS England.

Table 5 – Summary of Savings Programme Risk Assessment

Total Savings Risk Reporting to NHS England	M3 £'m	M4 £'m	M5 £'m	M6 £'m	M7 £'m	M8 £'m	Diff M7 – M8 £'m
Risk included in FOT	Zero	2.2	9.4	13.7	20.3	21.4	(1.1)
Risk not included in FOT	10.6	10.6	3.3	3.9	0.0	0.0	0.0
Total Savings Risk	**10.6**	**12.8**	**12.8**	**17.6**	**20.3**	**21.4**	**(1.1)**

Table 6 – Summary of Savings Programme Results Month 8 and Month 7 on Annual Savings Target of £69.5 million

	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	Forecast Outturn £'m	Risk Inside FO £'m	Risk outside FO £'m	Total Risk £'m	CTAP Adjustment included in Forecast Outturn £'m
Month 7	32.2	28.7	(3.5)	49.2	20.3	0	20.3	2.0
Month 8	39.8	32.3	(7.5)	48.1	21.4	0	21.4	2.2
Variance	7.6	3.6	(4.0)	(1.1)	1.1	0	1.1	0.2

The monthly run rate required for Months 9 to 12 is £3.9m, which is in line with the average delivery from Months 1-8 of £4.0m. Based on the current forecast outturn projections, the CCG will deliver £48.1m of savings against a target of £69.5m at 31st March 2020, an underperformance of £21.4m. The CCG needs to deliver £15.8m of savings in Months 9 to 12 to achieve this forecast outturn although the organisation will continue to seek to exceed this position.

Table 7 – Run Rate on Savings Programme

	M1 £'m	M2 £'m	M3 £'m	M4 £'m	M5 £'m	M6 £'m	M7 £'m	M8 £'m	Total M8 YTD £'m	Total M9 – 12 Delivery £'m	Total Forecast Outturn £'m
Delivery Value	2.6	3.3	3.6	3.7	4.9	5.8	4.9	3.6	32.3	15.8 *Average £3.95m per month*	48.1

Table 8 summarises the Month 8 year to date position and variance between the SRO forecast outturn and straight-line forecast.

Table 8 – Comparison of forecast outturn and straight line forecast at Month 8

	Month 8 YTD Plan £'m	Month 8 YTD Actuals £'m	Variance to Target £'m	December £'m	January £'m	February £'m	March £'m	SRO Forecast to M12 £'m	Straight line Forecast to M12 £'m	Variance from SRO Forecast to Straight line £'m
Total CHC	3.119	4.422	1.303	1.184	0.889	0.594	0.438	7.527	6.633	0.894
Total Community	1.733	1.886	0.153	0.131	0.100	0.098	0.098	2.313	2.829	(0.516)
Total Long Term Conditions	0.556	0.020	(0.536)	0.005	0.004	0.003	0.006	0.038	0.030	0.008
Total Medicines Management	7.825	10.502	2.677	1.348	0.967	1.023	1.014	14.854	15.755	(0.901)
Total Mental Health	0.335	0.102	(0.233)	0.002	0.015	0.015	0.016	0.150	0.153	(0.003)
Total Organisational Efficiency	6.542	8.281	1.739	0.868	0.861	0.862	0.862	11.734	12.422	(0.688)
Total Place	2.425	0.331	(2.094)	0.099	0.115	0.133	0.153	0.831	0.497	0.334
Total Planned Care	9.385	5.448	(3.937)	0.795	0.761	0.712	0.594	8.310	8.171	0.139
Total Primary Care	0.959	0.980	0.021	0.221	0.221	0.222	0.238	1.882	1.470	0.412
Total SBR	3.830	0.227	(3.603)	0.027	0.029	0.028	0.029	0.340	0.341	(0.001)
Total Urgent Care	3.055	0.105	(2.950)	0.015	0.015	0.015	0.014	0.164	0.158	0.006
Grand Total	**39.764**	**32.304**	**(7.460)**	**4.695**	**3.977**	**3.705**	**3.462**	**48.143**	**48.459**	**(0.316)**

The reduced run rate positon at Month 8 has been particularly impacted by the management of reporting in a key scheme – MSK Phase 1: This scheme commenced in 2018-19 with the full year effect benefit of £4m however the original plan did not set out the investment profile for the service, impacting on the net financial performance of the scheme. To ensure this scheme is reported correctly as an 'invest to save' scheme, the full 2019-20 investment is reported against delivery in Month 8.

The net forecast outturn variance of £21.4m equates to £30.3m of risk relating to underperformance on approved savings schemes including £1.6m of closed schemes, offset by £8.9m of over-performing schemes/new schemes. Table 9 shows the savings performance by programme and across system and CCG.

Table 9 - Savings Programme Performance

Delivery Board	Annual Plan £'m	Forecast Outturn £'m	Variance Plan to Actual £'m	SRO delivery risk (£'m)	Total Delivery Risk (£'m)
CCG Led Programmes					
Medicines Management	13.2	14.9	1.7	0	1.7
Continuing Health Care	5.5	7.5	2.0	0	2.0
Organisational Efficiency	2.2	4.0	1.8	0	1.8
18/19 Operational Budget Review	7.7	7.7	0.0	0	0.0
Primary Care	2.2	1.9	(0.3)	0	(0.3)
Long Term Conditions	1.0	0.0	(1.0)	0	(1.0)
Service Benefit Reviews	4.9	0.3	(4.6)	0	(4.6)
System Led Programmes					
Planned Care	16.3	8.3	(8.0)	0	(8.0)
Urgent Care	5.5	0.2	(5.3)	0	(5.3)
Community	2.2	2.3	0.1	0	0.1
Place	5.2	0.8	(4.4)	0	(4.4)
Mental Health	0.5	0.2	(0.3)	0	(0.3)
London Road and Stroke Rehab Pricing Schemes	3.1	0.0	(3.1)	0	(3.1)
TOTAL	**69.5**	**48.1**	**(21.4)**	**0**	**(21.4)**

In relation to the £30.3m of underperforming schemes, £26m relates to system facing schemes, £2.7m to internal schemes and £1.6m closed schemes. The CCG remains challenged in delivery of:

- System Clinical Transformation Schemes including Long Term Conditions – shortfall £18.4m
- Pricing Schemes relating to London Road and Stroke Rehabilitation – shortfall £3.1m
- Service Benefit Review programme – shortfall £4.5m

The System Savings Group has focused on a number of the clinical transformation schemes in order to understand risk and develop recovery action plans. Table 10 sets out the clinical transformation schemes being actively managed through the System Savings Group.

Table 10 – System Clinical Transformation Schemes

Programme Area	19/20 Net Target £'m	Predicted Shortfall in FOT £'m
DW422 Development of an Integrated Model of Care in Place Phase 1	1.850	(1.155)
DW542 Development of an Integrated Model of Care in Place – phase 2	1.998	(1.998)
DW518 Implementation of Evidence Based Pathway (Ambulatory Care)	4.787	(4.598)
DW444 RDH Frailty Unit	0.475	(0.475)
DW495 Outpatients Modernisation Programme	4.500	(3.102)
DW098 MSK Phase 1	4.056	(0.446)
DW429 MSK Phase 2	2.216	(2.216)
Disease Management and Long Term Conditions:	1.015	(0.831)
TOTAL	**20.897**	**(14.821)**

There remains significant over achievement against plan in relation to Continuing Health Care (CHC), Medicines Management, and Organisational Efficiency.

Table 11 - Summary of Over Achieving Schemes

	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	Annual Plan £'m	Forecast Outturn £'m	Annual Over-Achievement £'m
Medicines Management	6.6	9.8	3.2	10.2	13.4	3.2
Continuing Healthcare	1.1	3.1	2.0	1.4	2.9	1.5
Organisational Efficiency	1.2	3.0	1.8	1.9	3.8	1.9
Other Positive variances	0.7	1.0	0.3	1.0	1.6	0.6
Total	**9.6**	**16.9**	**7.3**	**13.6**	**21.7**	**7.2**

Table 11 only includes schemes where there is over achievement and excludes schemes in these programmes which are on target or under target.

7. Summary and Recommendations

At month 8 the year to date and forecast positions are in line with plan.

£2.430m of the CCG's £8.1m mandated contingencies have been used in the forecast position, with nil in the year to date position.

Any overspend or under delivery of savings at this point in the year will be supported by robust mitigation plans or alternative savings. These will be reported through the FRG and Finance Committee.

Risks of £5.7m are being mitigated by unused contingencies, whilst recovery actions are also continuing to be pursued.

The month 8 savings information shows year to date delivery of £32.3m (against a phased plan of £39.8m) and a forecast savings delivery of £48.1m against a planned total of £69.5m.

The Governing Body is recommended to:

- Note the year to date and forecast position as at month 8 (as shown in Table 2)
- Note the month 8 savings delivery of £32.3m and forecast of £48.1m described in section 6 - table 5
- Note the month 8 level of risk as shown in table 4

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 190

Report Title	Quality and Performance Committee Assurance Report - Month 7
Author(s)	Jackie Carlile, Head of CCG Performance and Assurance Laura Moore, Deputy Chief Nurse
Sponsor (Director)	Brigid Stacey, Chief Nursing Officer Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair								

Recommendations

The Quality and Performance Committee are asked to **NOTE** the key performance and quality highlights and the actions taken to mitigate the risks.

Report Summary

The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.

The Integrated Quality and Performance report has been split out so that in January the activity section will be reviewed separately by the committee to enable more detailed discussions, with a particular focus on data quality issues and their impact on the reported position.

Key Messages:

Performance:

Urgent & Emergency Care

A&E standard was not met at a Derbyshire level, with both main providers failing to achieve the 95% target in November 2019. CRH achieved 80.2% (YTD 86.8%) which is a decrease from October performance. UHDB performance was 78.7% (YTD 82.7%), a decrease from October. None of our associate providers achieved the standard during November.

There were 6x 12-hour trolley breaches at CRH during November (due to the unavailability of medical bed and side rooms for patients with infection risks) and there were 2 breaches at UHDB (all due to the unavailability of suitable mental health beds).

EMAS is non-compliant in 5 out of 6 national standards for Derbyshire. EMAS regional performance was non-compliant in five standards. Both of these are deterioration on the previous month when Category 4 response times were compliant.

Planned Care

18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at both our acute trusts.

CRHFT performance was 90.5%, a slight improvement on the previous month and UHDB performance is showing at 87.5%.

Derbyshire CCG and both acute providers had no patients waiting over 52 weeks at the end of October – the second time since the merger of the CCGs. Unvalidated data is showing that there were no 52 weeks at the end of November.

Diagnostics – CRHFT achieved this standard at 0.7% and UHDB had a much improved position of 3.9% for October.

Cancer

6 of the 9 standards were non-compliant at Derbyshire level in October 2019.
All Cancer Two Week Waits were met at Derbyshire level (95.4%).
Breast symptomatic was compliant at 96.1%, a significant improvement on 58.5% for the previous month.
31 days diagnosis to treatment was non-compliant at 95.2%, although UHDB are now compliant.
31 days subsequent surgery improved but was still was non-compliant at 89.3%. This was due to non-compliance at CRH, UHDB, NUH and Sheffield.
62 day - Urgent GP Referral performance continues to be non-compliant at Derbyshire level (76.1%). None of our providers are compliant.
The number of patients waiting over 104 days for treatment during October at both our main providers is 5 at CRH and 17.5 at UHDB.

Quality:

CRHFT - MSA breaches:
During October there were 4 cases of mixed sex accommodation breaches. All breaches occurred on the same day when the Trust was experiencing bed pressures and on OPEL 4 alert

UHDBFT - MSA breaches:
During October 2019 there were a total of 15 MSA breaches across 5 sites. 9 breaches occurred on the Derby sites; Ward 407 (8) and ICU (1). 6 occurred on the Burton sites in ICU (6).

12 hour trolley breaches:
5 adult and one child mental health trolley breaches were reported by the ED at Derby Hospital due to waits for mental health beds (October Data)

DCHSFT - Q2 CQUIN Achievement: DCHS achieved three national and one local CQUIN for Q2 (3a, b, c & LCQ 1). The High impact action to prevent falls CQUIN was not met in Q1 or Q2. An improvement plan with timescales to achieve this CQUIN will be developed by the trust and monitored through quality meetings with commissioners.

DHcFT - Out of Area – Psychiatric Intensive Care Units (PICU): Since June 2019 there has been a continued reduction in the number of patients who have been placed in a PICU facility

Out of Area – Acute Placements: October saw an increase in demand for acute beds which increased the number of OOA acute placements during October to an average of 11 patients per day

EMAS - Derbyshire pre hospital handover position during October 2019 saw a slight deterioration compared to the September 2019 position. The average pre handover time was 21 minutes and 8 seconds during October 2019 and lost hours due to pre handovers were 1,030. The division continues to experience delays predominantly at Royal Derby Hospital and this is being actioned through the local A&E delivery board.

OEIPB Update

Assurance Opinion from the Workstream Lead(s)
We are assured that there are appropriate plans and monitoring in place to ensure that the actions identified in the programme plan as reported to the OEIPB are on track.

Work in progress

- UHDBFT have not been able to fill the Designate Dr role which is due to become vacant in January 2020, recruitment plans are in progress
- Work is underway to explore alternatives to the named GP role, which has become vacant in the North
- Discussion is underway with clinical leads regarding requirements from other disciplines – eg midwives to support the clinical leadership team
- Recruiting to Place lead for Derby

Urgent Care

The committee received an urgent care update which included the Winter plan and both acute Trust A&E improvement plans. There was significant discussion about the plans, bed base and operational issues, including consideration of how OPEL 4 is communicated to Primary care and the processes and impact of this.

Safeguarding

The committee were fully assured by the Childrens and Adults annual safeguarding reports and the updates provided on the current position.

Stockport Breast Surgery

The Stockport breast service was closed completely at the end of September. The committee were assured that all patients have been notified and given appropriate alternative options and that transfers are in progress. Patient engagement activity has been undertaken to identify lessons learnt from the process.

Are there any Resource Implications (including Financial, Staffing etc)?

No

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

Not Applicable

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not Applicable
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not Applicable
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not Applicable
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Yes in relation to the Stockport breast service closure – a meeting was held at Blythe House to discuss patient experiences of the transfer and identify lessons learned
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
Quality and Performance address the first three GBAFs, which are monitored by the Quality and Performance Committee.
Identification of Key Risks
Nursing and Quality Directorate Risk Register.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Month 7
Quality & Performance Report
2019/20

19th December 2019

Contents Page

EXECUTIVE SUMMARY

Key Messages	• The tables on slides 6-9 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	• A&E standard was not met at a Derbyshire level, with both main providers failing to achieve the 95% target in November 2019. CRH achieved 80.2% (YTD 86.8%) which is a decrease from October performance. UHDB performance was 78.7% (YTD 82.7%), a decrease from October. None of our associate providers achieved the standard during November. • There were 6x 12-hour trolley breaches at CRH during November (due to the unavailability of medical bed and side rooms for patients with infection risks) and there were 2 breaches at UHDB (all due to the unavailability of suitable mental health beds). • EMAS is non-compliant in 5 out of 6 national standards for Derbyshire. EMAS regional performance was non compliant in five standards. Both of these are a deterioration on the previous month when Category 4 response times were compliant.
Planned Care	• 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at both our acute trusts. • CRHFT performance was 90.5%, a slight improvement on the previous month and UHDB performance is showing at 87.5%. • Derbyshire CCG and both acute providers had no patients waiting over 52 weeks at the end of October – the second time since the merger of the CCGs. Unvalidated data is showing that there were no 52 weeks at the end of November. • Diagnostics – CRHFT achieved this standard at 0.7% and UHDB had a much improved position of 3.9% for October.
Cancer	• 6 of the 9 standards were non compliant at Derbyshire level in October 2019. • All Cancer Two Week Waits were met at Derbyshire level (95.4%). • Breast symptomatic was compliant at 96.1%, a significant improvement on 58.5% for the previous month. • 31 days diagnosis to treatment was non-compliant at 95.2%, although UHDB are now compliant. • 31 days subsequent surgery improved but was still was non-compliant at 89.3%. This was due to non compliance at CRH, UHDB, NUH and Sheffield. • 62 day - Urgent GP Referral performance continues to be non-compliant at Derbyshire level (76.1%). None of our providers are compliant. • The number of patients waiting over 104 days for treatment during October at both our main providers is 5 at CRH and 17.5 at UHDB.

EXECUTIVE SUMMARY

Trust	Key Issues - Quality
Chesterfield Royal Hospital FT	MSA breaches: During October there were 4 cases of mixed sex accommodation breaches. All breaches occurred on the same day when the Trust was experiencing bed pressures and on OPEL 4 alert
University Hospitals of Derby and Burton NHS FT	MSA breaches: During October 2019 there were a total of 15 MSA breaches across 5 sites. 9 breaches occurred on the Derby sites; Ward 407 (8) and ICU (1). 6 occurred on the Burton sites in ICU (6). 12 hour trolley breaches: 5 adult and one child mental health trolley breaches were reported by the ED at Derby Hospital due to waits for mental health beds
Derbyshire Community Health Services FT	Q2 CQUIN Achievement: DCHS achieved three national and one local CQUIN for Q2 (3a,b,c & LCQ 1). The High impact action to prevent falls CQUIN was not met in Q1 or Q2. An improvement plan with timescales to achieve this CQUIN will be developed by the trust and monitored through quality meetings with commissioners.
Derbyshire Healthcare Foundation Trust	Out of Area – Psychiatric Intensive Care Units (PICU): Since June 2019 there has been a continued reduction in the number of patients who have been placed in a PICU facility Out of Area – Acute Placements: October saw an increase in demand for acute beds which increased the number of OOA acute placements during October to an average of 11 patients per day
East Midlands Ambulance Trust	**EMAS** - Derbyshire pre hospital handover position during October 2019 saw a slight deterioration compared to the September 2019 position. The average pre handover time was 21 minutes and 8 seconds during October 2019 and lost hours due to pre handovers were 1,030. The division continues to experience delays predominantly at Royal Derby Hospital and this is being actioned through the local A&E delivery board.

QUALITY & PERFORMANCE DEEP DIVE SCHEDULE

subject to change		
Month	Area	Lead
Sep-19	Patient Experience	Sarah Macgillvery
Oct-19	Mental Health	Phil Sugden
Nov-19	Medicines Safety	Steve Hulme
Dec-19	End of Life	Steph Austin
Jan-20	RTT	Craig Cook
Feb-20	Maternity	Ali Cargill
Mar-20	CHC	Nicola MacPhail
Apr-20	Care Homes	Steph Austin
Jun-20	Patient Safety	Lisa Falconer
July-20	HCAI	Sally Bestwick
August-20	Childrens	Mick Burrows

PERFORMANCE OVERVIEW MONTH 8 (19/20) – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:			
	Performance Meeting Target	↑	Performance Improved From Previous Period
	Performance Not Meeting Target	→	Performance Maintained From Previous Period
	Indicator not applicable to organisation	↓	Performance Deteriorated From Previous Period

EMAS Dashboard for Ambulance Performance Indicators

	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure)				EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2019/20				NHS England		
					Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Current Month	YTD	consecutive months of failure
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Nov-19	↓	00:07:43	00:07:29	28	00:08:05	00:07:35	16	00:07:25	00:07:32			00:07:28	00:07:11	6
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Nov-19	↓	00:14:03	00:13:03	0	00:14:39	00:13:38	0	00:13:12	00:13:32			00:13:11	00:12:37	0
		Ambulance - Category 2 - Average Response Time	00:18:00	Nov-19	↓	03:30:35	00:48:49	28	00:36:10	00:29:58	21	00:26:37	00:30:19			00:26:02	00:22:44	28
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Nov-19	↓	01:01:39	00:53:24	28	01:15:24	01:02:15	28	00:55:25	01:02:45			00:53:45	00:46:34	28
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Nov-19	↓	03:54:53	02:57:31	5	04:25:55	03:27:36	27	02:40:50	03:42:11			03:20:03	02:45:21	19
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Nov-19	→	03:13:03	02:46:23	2	03:54:58	03:08:41	2	02:37:27	03:04:55			03:47:24	03:12:17	3

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			Derbyshire Community Health Services FT			NHS England		
					Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Nov-19	↓	79.1%	83.1%	50	80.2%	86.8%	17	78.7%	81.7%	50	100.0%	100.0%	0	83.3%	86.5%	50
		A&E 12 Hour Trolley Waits	0	Nov-19					5	14	1	5	27	21	0	0	0	1112	4436	50
	DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Oct-19	↑				1.55%	1.48%	0	3.20%	3.39%	0	4.80%	4.69%	5	4.40%	4.14%	7

PERFORMANCE OVERVIEW MONTH 7 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months of failure	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months of failure	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months of failure	Derbyshire Community Health Services FT Current Month	Derbyshire Community Health Services FT YTD	Derbyshire Community Health Services FT consecutive months of failure	NHS England Current Month	NHS England YTD	NHS England consecutive months of failure
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-19	↓	88.6%	89.7%	21	90.5%	90.7%	6	87.5%	88.6%	22	94.1%	95.2%	0	88.6%	85.6%	45
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-19	↓	0	11	0	0	0	0	0	16	0	0	0	0	1321	8087	150
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-19	↑	3.53%	6.63%	17	0.72%	0.75%	0	3.98%	8.49%	11	0.00%	0.00%	0	3.08%	3.73%	74
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Oct-19	↓	95.4%	90.9%	0	Cancer 2 Week Wait Pilot Sight - not currently reporting			96.8%	88.1%	0				91.4%	90.4%	8
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Oct-19	↑	96.1%	68.0%	0				98.1%	51.6%	0				89.9%	82.5%	20
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Oct-19	↑	95.2%	95.4%	3	94.1%	97.8%	2	96.9%	95.9%	0				96.2%	96.1%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Oct-19	↓	89.3%	90.0%	8	90.9%	97.5%	1	93.9%	93.1%	1				91.1%	91.4%	15
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Oct-19	↑	100.0%	99.1%	0	100.0%	100.0%	0	100.0%	98.9%	0				99.2%	99.2%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Oct-19	↑	93.8%	94.1%	2				94.1%	92.6%	0				96.5%	96.4%	0
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Oct-19	↓	76.1%	75.4%	18	67.3%	79.1%	3	75.8%	73.8%	18				77.1%	77.7%	1
		First Treatment Administered - 104+ Day Waits	0	Oct-19	Currently Unavailable Not Displayed in National Data				5	20	18	17.5	111.0	43						
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Oct-19	↓	63.9%	78.3%	7	64.9%	76.8%	6	74.5%	83.9%	7				83.0%	86.4%	19
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Oct-19	↑	93.6%	88.5%		100.0%	91.8%		90.6%	86.5%					82.0%	82.6%	
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	19-20 Q2	↑				10.8%	10.5%		0.5%	10.0%					7.4%	9.3%	
		Number of Urgent Operations cancelled for the 2nd time	0	Oct-19	→				0	0	0	0	0	0				18	104	31

PERFORMANCE OVERVIEW MONTH 7 – PATIENT SAFETY

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
Performance Meeting Target	
Performance Not Meeting Target	
Indicator not applicable to organisation	
Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services FT				NHS England			
					Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure		Current Month	YTD	consecutive months of failure		Current Month	YTD	consecutive months of failure		Current Month	YTD	consecutive months of failure	
Patient Safety	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Oct-19	↓	11	60	31	4	4	1		15	81	13		0	0	0		1840	10072	31	
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Oct-19	→	0	3	0	0	1	0		0	1	0						78	460	31	
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Oct-19	↓		287			31				113										
			Actual				147	1		10	0			43	0							8008		
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Oct-19	↑	64	556		18	170			40	355							3763	26531		
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Oct-19	↓	22	140		1	12			3	24							1019	7229		

PERFORMANCE OVERVIEW MONTH 7 – MENTAL HEALTH

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

Mental Health

Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months of failure	Derbyshire Healthcare FT Current Month	Derbyshire Healthcare FT YTD	Derbyshire Healthcare FT consecutive months of failure								NHS England Current Month	NHS England YTD	NHS England consecutive months of failure
Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	50.0%	Oct-19	↓	90.0%	85.2%	0	90.0%	86.2%	0								73.5%	75.8%	0
	Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	50.0%	Oct-19	↑	100.0%	84.0%	0	100.0%	84.0%	0								25.3%	42.1%	1
Mental Health	Dementia Diagnosis Rate	67.0%	Oct-19	↑	72.1%	71.9%	0											68.5%	68.5%	0
	Care Program Approach 7 Day Follow-Up	95.0%	19/20 Q2	↓	94.7%	96.2%	1	96.2%	96.7%	0								94.5%	96.1%	1
	CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		19/20 Q2	↑	82.8%	82.5%														
	CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		19/20 Q2	↓	72.2%	78.2%														
	Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	Mar-19	↑	3.0%	3.1%	2													
	Mental Health - Out Of Area Placements		Sep-19	↓	405	3810														
	Physical Health Checks for Patients with Severe Mental Illness	60%	19/20 Q2	↓	29.1%	29.5%	2													
Area	**Indicator Name**	**Standard**	**Latest Period**		**NHS Derby & Derbyshire CCG**			**Talking Mental Health Derbyshire (D&DCCG only)**			**Trent PTS (D&DCCG only)**			**Insight Healthcare (D&DCCG only)**			**NHS England (D&DCCG only)**		
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Oct-19	↓	1.83%	12.83%														
		Actual			2.44%	15.96%	0													
	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Oct-19	↓	53.9%	54.7%	0	55.6%	53.5%	0	52.2%	55.5%	0	56.4%	55.9%	0		51.9%	52.1%	0
	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Oct-19	↑	88.0%	86.6%	0	91.2%	97.1%	0	84.1%	72.2%	0	99.3%	97.4%	0		87.3%	89.4%	0
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Oct-19	↓	99.9%	100.0%	0	99.9%	100.0%	0	100.0%	100.0%	0	100.0%	99.8%	0		98.7%	99.0%	0
Area	**Indicator Name**	**Standard**	**Latest Period**		**Derbyshire Healthcare FT**															
DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Oct-19	↑	0.00%	0.88%	0													
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-19	↑	94.0%	93.6%	0													
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-19	→	0	0	0													
Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Oct-19	→	0	0	0													

Quality Overview

QUALITY OVERVIEW M7

Trust	Key Issues
Chesterfield Royal Hospital FT	MSA breaches: During October there were 4 cases of mixed sex accommodation breaches. All breaches occurred on the same day when the Trust was experiencing bed pressures and on OPEL 4 alert. The 4 patients affected were on HDU and had been assessed as fit to transfer to a medical ward but were not transferred within the 4 hour timeframe as stipulated in the NHSE guidance. The patients remained in HDU and transferred to the appropriate ward later the next day. Providers are aware of the revised Mixed Sex Accommodation revised guidance, and the CCG will monitor adherence. Essential training: The Trust remain under their trajectory of 90 % for all staff to have completed their essential training. An action plan is in development to improve compliance and this will be monitored via the CQRG .
University Hospitals of Derby and Burton NHS FT	Never Events: No never events reported for October 2019. The CCG Quality team form part of the review group addressing previous reported events. Actions and updates continue to be reviewed through CQRG. MSA breaches: During October 2019 there were a total of 15 MSA breaches across 5 sites. 9 breaches occurred on the Derby sites; Ward 407 (8) and ICU (1). 6 occurred on the Burton sites in ICU (6). All breaches were due to lack of available beds to transfer patients into to commence or continue their care. There was no harm experienced and no adverse effects on experience or safety were reported. Providers are aware of the revised Mixed Sex Accommodation revised guidance, and the CCG will monitor adherence. 12 hour trolley breaches: 5 adult and one child mental health trolley breaches were reported by the ED at Derby Hospital due to waits for mental health beds. The CCG Quality Team continue to be assured that those affected by breaches are being cared for appropriately while awaiting transfer.

QUALITY OVERVIEW M7 continued

Trust	Key Issues
Derbyshire Community Health Services FT	• Q2 CQUIN Achievement: DCHS achieved three national and one local CQUIN for Q2 (3a,b,c & LCQ 1). The High impact action to prevent falls CQUIN was not met in Q1 or Q2. In Q1 NHS England acknowledge a delayed national roll out of full guidance for this CQUIN and as a result instructed that providers should not be penalised for non/reduced achievement at Q1. For Q2 DCHS have not achieved collective required thresholds across all actions with a wide variance on achievement. Therefore no payment will be made. An improvement plan with timescales to achieve this CQUIN will be developed by the trust and monitored through quality meetings with commissioners.
Derbyshire Healthcare Foundation Trust	• Out of Area – Psychiatric Intensive Care Units (PICU): Since June 2019 there has been a continued reduction in the number of patients who have been placed in a PICU facility - from 23 in June to an average of 6 patients per day in October. • Out of Area – Acute Placements: October saw an increase in demand for acute beds which increased the number of OOA acute placements during October to an average of 11 patients per day. October saw occupancy levels of just under 99% across the adult acute wards, which meant there was a decrease in the number of available beds, reducing the capacity to repatriate patients from out of area acute beds. The Trust Acute Services Management Team have clear systems and processes to ensure the flow of patients is planned to reduce the amount of time patients are out of area and to optimise beds in the acute units. Out of Area placements are monitored through the normal contractual monitoring meetings.
East Midlands Ambulance Trust	• Handovers: The regional pre hospital handover positon during October 2019 was 25 minutes and 38 seconds which was a deterioration compared to September 2019 (21 minutes and 35 seconds). This is being driven primarily by an increase at Leicester Royal Infirmary. At the recent Service Delivery Board a number of actions were agreed in relation to improving pre and post hospital times, including liaising with A&E Delivery Boards, specifically Lincolnshire and Leicestershire, and using internal PIN reporting to improve internal efficiencies. Derbyshire pre hospital handover position during October 2019 saw a slight deterioration compared to the September 2019 position. The average pre handover time was 21 minutes and 8 seconds during October 2019 and lost hours due to pre handovers were 1,030. The division continues to experience delays predominantly at Royal Derby Hospital and this is being actioned through the local A&E delivery board. County plans for Pre-Handover actions are been taken to the next Quality Assurance Group. Commissioners and EMAS have identified a number of actions to reduce post-handover times and these are monitored by the EMAS commissioning team.

QUALITY OVERVIEW M7

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

Dashboard Key:	
	CCG assured by the evidence
	CCG not assured by the evidence

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	↔
Performance Deteriorated From Previous Period	↓

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT					University Hospitals of Derby & Burton FT					Derbyshire Community Health Services					Derbyshire Healthcare FT				
				Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Nov-18					Jun-19					May-19					Jul-18				
		Outcome	N/A	Good					Good					Outstanding					Requires Improvement				
Adult	FFT	Staff 'Response' rates	15%	19-20 Q2	↓		7.6%	8.6%	19-20 Q2	↓		10.1%	10.2%	19-20 Q2	↓		2.7%	21.7%	19-20 Q2	↓		3.2%	18.1%
		Staff results - % of staff who would recommend the organisation to friends and family as a place to work		19-20 Q2	↓		56.4%	64.5%	19-20 Q2	↓		70.2%	65.7%	19-20 Q2	↓		50.4%	70.5%	19-20 Q2	↓		57.3%	66.7%
		Inpatient results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Oct-19	↑		98.0%	97.6%	Oct-19	↑		97.2%	96.1%	Nov-19	↑		100.0%	98.4%					
		A&E results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Oct-19	↓		74.1%	77.4%	Oct-19	↑		84.2%	80.5%	Nov-19	↓		99.2%	99.4%					
	Complaints	Number of formal complaints received	N/A	Oct-19	↑		33	223	Sep-19	↑		63	420	Oct-19	↑		10	80	Oct-19	↑		11	97
		% of formal complaints responded to within agreed timescale	N/A	Oct-19	↑		100.0%	99.6%	Sep-19	↓		65.2%	59.0%	Oct-19	↓		93.0%	92.0%	Oct-19	↔		100%	87.02%
		Number of complaints partially or fully upheld by ombudsman	N/A	Oct-19	↔		0	0	19-20 Q2	↔		1	2	Oct-19	↔		0	0	Oct-19	↔		0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Oct-19	↑		11	63	Sep-19	↑		48	302	Oct-19	↑		96	708	Oct-19	↑		0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Oct-19	↑		2	26	Sep-19	↓		20	106	Oct-19	↓		41	302	Oct-19	↔		0	0
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Oct-19	↔		0	0	Sep-19	↑		0	1	Oct-19	↓		6	29	Oct-19	↔		0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Oct-19	↓		5	16	Sep-19	↑		16	94	Oct-19	↓		69	315	Oct-19	↔		0	0
		Medical Device pressure ulcers - numbers developed or deteriorated							Sep-19	↓		4	20	Oct-19	↑		8	59	Oct-19	↔		0	0
		Number of pressure ulcers which meet SI criteria	N/A	Oct-19	↔		3	17	Sep-19	↔		0	4	Oct-19	↓		2	16	Oct-19	↔		0	0
	Falls	Number of falls	N/A	Oct-19	↓		115	753	Data Not Provided in Required Format					Oct-19	↑		31	252	Oct-19	↓		29	190
		Number of falls resulting in SI criteria	N/A	Oct-19	↑		3	12	Sep-19	↑		0	19	Oct-19	↔		1	5	Oct-19	↔		0	0
	Medication	Total number of medication incidents	?	Oct-19	↓		65	485	Sep-19	↑		180	1314	Oct-19	↔		0	0	Oct-19	↓		74	435
	Serious Incidents	Never Events	0	Oct-19	↓		1	4	Sep-19	↑		0	6	May-19	↔		0	0	Oct-19	↔		0	0
		Number of SI's reported	0	Oct-19	↔		10	49	Sep-19	↑		7	115	Oct-19	↑		9	90	Oct-19	↔		7	51
		Number of SI reports overdue	0	Oct-19	↔		0	0	May-19	↓		19	28	May-19	↔		0	0					
		Number of duty of candour breaches which meet threshold for regulation 20	0	Oct-19	↑		0	2	May-19	↔		0	0	Oct-19	↔		0	0					

QUALITY OVERVIEW M7

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators cont.

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust					University Hospitals of Derby & Burton FT					Derbyshire Community Health Services					Derbyshire Healthcare FT				
				Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Oct-19	↓		3	9	18 - 19 Q1	↔		2	2						Sep-19	↔		0	0
		% Risk Assessments of all inpatients	90%	19-20 Q2	↑		97.5%	97.7%	19-20 Q2	↓		96.6%	96.2%	19-20 Q2	↑		99.6%	99.8%					
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Not Higher Than Expected	Oct-19	↓		105.4		Jun-19	↔		92.7	92.7										
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Jul-19	↑		0.982		Jul-19	↓		0.944											
		Crude Mortality		Oct-19	↑		1.23%	1.26%	Sep-19	↔		1.20	1.28										
Maternity	FFT	Antenatal serivce: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Oct-19	↑		100.0%	98.5%	Oct-19	↓		83.3%	94.2%										
		Labour ward/birthing unit/homebirth: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Oct-19	↓		96.2%	98.4%	Oct-19	↓		97.2%	97.7%										
		Postnatal Ward: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Oct-19	↑		100.0%	98.7%	Oct-19	↓		95.0%	97.7%										
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Oct-19	→		100.0%	98.8%	Oct-19	↑		100.0%	96.9%										
Mental Health	Dementia	Dementia Care - % of patients ≥ 75 years old admitted where case finding is applied	90%	Sep-19	↑		98.0%	98.5%	Sep-19	↑		92.1%	90.2%										
		Dementia Care - % of patients identified who are appropriately assessed	90%	Sep-19	↓		100.0%	100.0%	Sep-19	↑		87.6%	83.0%										
		Dementia Care - Appropriate onward Referrals	95%	Sep-19	↓		100.0%	100.0%	Sep-19	↓		100.0%	100.0%										
	Inpatient Admissions	Under 18 Admissions to Adult Inpatient Facilities	0																Oct-19	↔		0	0
Workforce	Staff	Staff turnover (%)		Oct-19	↓		9.1%	9.2%	Sep-19	↔		9.7%	9.95%	Oct-19	↔		9.1%	9.1%	Oct-19	↓		10.2%	10.1%
		Staff sickness - % WTE lost through staff sickness		Oct-19	↑		4.2%	4.9%	Sep-19	↓		4.4%	4.3%	Oct-19	↓		5.3%	4.7%	Oct-19	↓		8.3%	7.1%
		Vacancy rate by Trust (%)		Sep-17	↓		1.9%	1.3%	Dec-18	↓		8.3%	7.3%	Oct-19	↑		6.0%	6.0%	Oct-19	↓		11.07%	10.06%
		Agency usage	Target																Oct-19	↓			
			Actual																			0.95%	0.95%
		Agency nursing spend vs plan (000's)		Oct-19	↓		£386	£2,082	Oct-18	↑		£723	£4,355	Oct-19	↑		£83	£1,263					
		Agency spend locum medical vs plan (000's)		Oct-19	↓		£729	£4,809															
	Training	% of Completed Appraisals	90%	Oct-19	↔		95.9%	74.9%	Sep-19	↓		86.3%	89.1%	Oct-19	↓		88.1%	90.6%	Oct-19	↑		81.8%	79.0%
		Mandatory Training - % attendance at mandatory training	90%	Oct-19	↑		73.4%	69.6%	Aug-19	↓		85.4%	89.1%	Oct-19	↑		97.0%	96.8%	Oct-19	↓		87.0%	86.4%
Quality Schedule		Is the CCG assured by the evidence provided in the last quarter?	CCG assured by the evidence																				
CQUIN		CCG assurance of overall organisational delivery of CQUIN	CCG not assured by the evidence																				

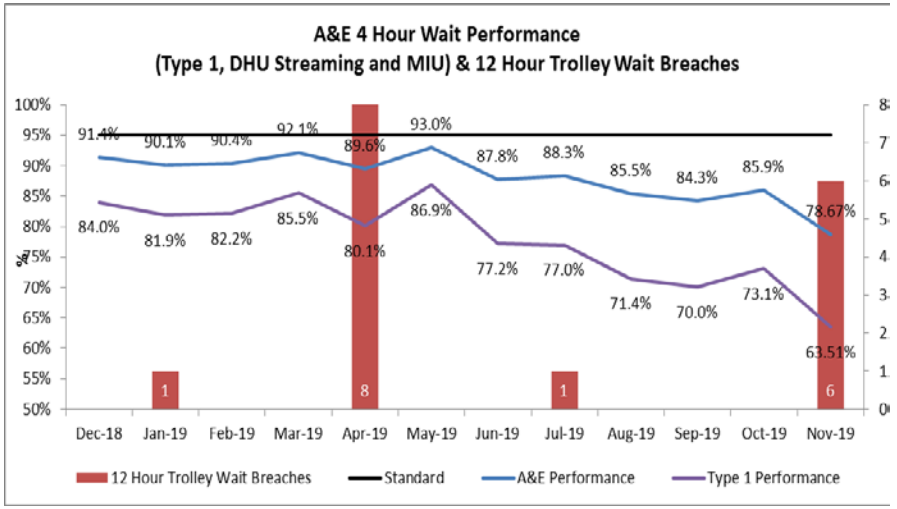
Urgent & Emergency Care

CRHFT A&E PERFORMANCE – PERCENTAGE OF PATIENTS SEEN WITHIN 4 HOURS (95%)

Performance Analysis

During November 2019 the trust did not meet the 95% standard, achieving 78.7% which is a rapid decline since the October performance of 85.9%. The Type 1 element of these are 63.5%, a downturn from October.
(Nov19 data is unvalidated)

There were 6x 12 hour breaches during November, due to unavailability of medical beds (3 patients) or the unavailability of side-rooms for patients with infection risks (3 patients). Breach reports have been received.



November 2019 performance is unvalidated

Metric	Aug	Sept	Oct	Nov	Actual change	%change
A&E attendances (Type 1)	6,349	6,334	6,427	6,458	31	0%
A&E Breaches (Type 1)	1,813	1,936	1,728	2,399	671	39%
Primary Care Streaming	1,920	1,771	1,807	1,749	-58	-3%
MIU attendances	3,220	3,366	2,893	3,173	280	10%
Total Att.	11,489	11,471	11,127	11,380	253	2%

What are the issues?

	18/19	19/20	Diff	%Diff
Aug	5,916	6,349	433	7.3%
Sep	5,867	6,334	467	8.0%
Oct	6,075	6,427	352	5.8%
Nov	5,784	6,458	674	11.7%

- The trust continue to experience a high number of attendees compared to 2018/19 with 11.7% more attendances during Nov2019, resulting in OPEL4 being declared during the month.
- Many of these extra patients are frail elderly or patients with respiratory conditions, with a noted rise in abdominal pain presentations..
- The acuity of the attendances is increasing, with 20.3% of A&E attendances resulting in admission to either an assessment unit or a ward during November.
- Difficulty recruiting to middle grade and consultant medical posts.

What actions have been taken?

- The ORG (Organisational Resilience Group) meet on a weekly basis with representation from all relevant Urgent Care providers in the Derbyshire System.
- Senior Review in the ED Pitstop area is now established as Business As Usual.
- Additional beds were opened over winter and have remained open since, with additional capacity opened ahead of schedule to cope with demand.
- The Discharge Hub works with partner agencies to facilitate discharges, which is further supported by clinically facing Bronze Command staff.
- Roll-out of the Ticket To Ride scheme in Orthopaedics and EMU, whereby HCAs are able to take patients to base wards and free up space in assessment areas.
- Rolling out Criteria-Led Discharge to streamline speedier discharge from Medical wards.
- Continued work with the Improvement Academy across discharge pathways.

What are the next steps and when will they impact?

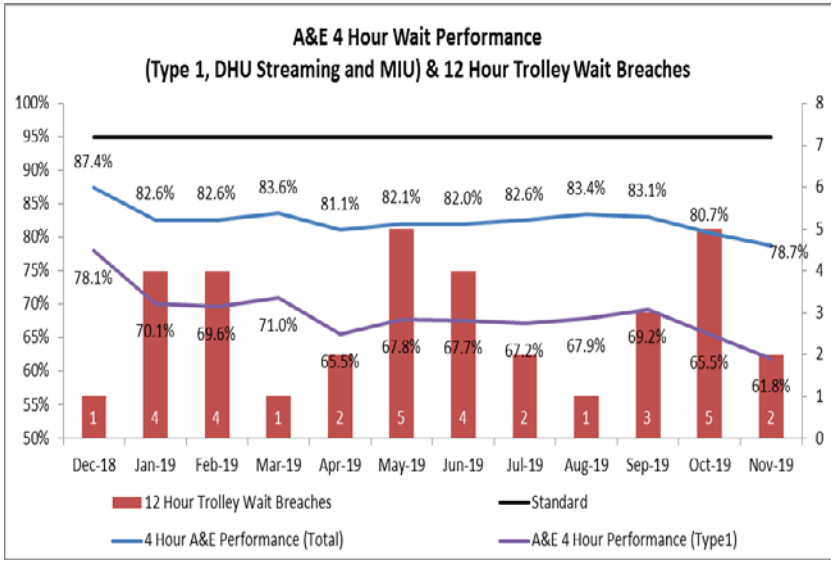
- Establishing a Surgical Assessment Unit to improve flow.
- Implementation of new rotas following the MetricAid A&E medical rota work .
- Consideration of the business case for a permanent ED-based MSK practitioner.
- Devising a way of measuring & reporting acuity in a more timely way, by Dec19.
- The ORG Winter Planning sub-committee focus on capacity planning, effective communications and preventative measures.
- The ORG take a PMO approach for projects improving urgent care. These include: Capacity & Demand analysis, direct booking of GP appointments via 111, reduced ambulance conveyances, focussing on High Intensity Users & Care Home patients, increasing input from mental health services and increasing capacity to administer IV antibiotics in the community. The ORG report to the A&E Delivery Board.

UHDBFT A&E - PERCENTAGE OF PATIENTS SEEN WITHIN 4 HOURS (95%)

Performance Analysis

During November 2019 performance overall did not meet the 95% standard, achieving 78.5% (Network figure) and 63.3% for Type 1 attendances, a further decrease on the October positions.
(Nov19 data is unvalidated)

There were 2x 12 hour trolley breaches during November 2019 due to unavailability of appropriate mental health beds.



Metric	Aug	Sep	Oct	Nov	Actual change	% change
A&E attendances (Type 1)	11,586	12,130	12,644	12,397	-247	-2%
A&E Breaches (Type 1)	4,319	4,329	4,893	5,179	286	6%
Primary Care Streaming Attendances	1,498	1,356	1,123	1,281	158	14%
DUCC attendances	5,281	4,792	4,981	4,928	-53	-1%
MIU attendances	6,881	6,195	5,490	5,316	-174	-3%
Total Att.	25,246	24,473	24,238	23,922	-316	-1%

What are the issues?

- The volume of patients has increased with an annual 6.7% increase of Type 1s, averaging at 25 more patients per day and reaching as many as 589 attendances one Monday (25th November).
- The Children's ED has experienced higher attendances, with 8.6% more than in November 2018.
- The acuity of the conditions presented has also increased, with 47.2% of attendances classed as Major and an average of 29 patients per day classed as Resus.
- 24.7% of attendances result in admission to either an assessment unit or an inpatient ward. In actual terms there are an average of 9 extra admissions per day compared to 2018/19 (an 11.2% rise).
- There has been an overall rise in patients classed as Major, with a rise in the numbers of these patients being treated by the appropriate clinicians but in the Minors area.
- On a day-to-day basis the numbers of patients arriving at ED rises during the morning and arrivals remain high through the afternoon & evening. Discharges of minor patients are also high during this time but the major & resus discharges are not, culminating in a higher number of patients classed as 'In Department' by late afternoon. This coincides with more inpatient discharges being delayed until around 4pm, reducing the bed capacity and therefore delaying admissions from ED.

What actions have been taken?

- The ORG (Organisational Resilience Group) meet on a weekly basis with representation from all relevant Urgent Care providers in the Derbyshire System.
- Development of the Pit-Stop model to cover triage and further assessment & diagnostics.
- Piloting of an ED Nurse directly streaming patients via ACC pathways or directly to specialties (e.g. directing gynae patients to Gynaecology Assessment Unit who would normally go via GP streaming).
- Acute physician 'In-Reach' to ED at expected peak times.
- Continued employment of a B7 Duty Escalation Manager for out-of-hours and weekends.
- Additional Ambulatory Care pathways to bypass the department when appropriate.
- Continued 'Safety Huddles' throughout the day to facilitate flow.
- Reduced CT Scanning waits due to the streamlining of processes.

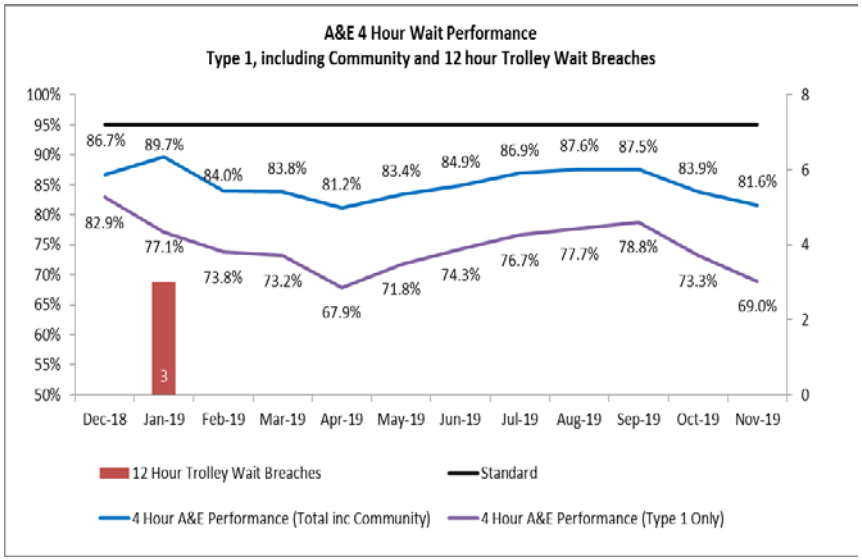
What are the next steps

- Within ED the Trust are investigating physical expansion of Majors into current Minors space.
- Outside of ED the Trust are looking to expand physical capacity within the current footprint.
- Increasing GP Streaming capacity to reduce unnecessary attendances .
- Establishing an Orthopaedic Assessment Unit to improve flow.
- Conduct a Workforce Review to include medical rotas and nursing establishment.
- Reviews of the attendance at ED Huddles and the subsequent escalation processes.
- The ORG Winter Planning sub-committee focus on capacity planning, effective communications and preventative measures.
- The ORG (Organisational Resilience Group) take a PMO approach for projects improving urgent care. These include: Capacity & Demand analysis, direct booking of GP appointments via 111, reduced ambulance conveyances, focussing on High Intensity Users & Care Home patients, increasing input from mental health services and increasing capacity to administer IV antibiotics in the community. The ORG report to the A&E Delivery Board.

UHDB – BURTON HOSPITAL A&E - PERCENTAGE OF PATIENTS SEEN WITHIN 4 HOURS (95%)

Performance Analysis

During November 2019 performance overall did not meet the 95% standard, achieving 69.0% A&E or 81.6% including community hospitals. The Type 1 performance is a further deterioration on October 2019's performance of 73.3%, following a gradual improvement since the April 2019 dip.
(Nov19 data is unvalidated)



What are the issues?

- The volume of attendances has increased by 9.4% year on year, with attendances exceeding 200 on most days and topping at 243 attendances one Monday (25th November).
- The acuity of attendances has increased – during November 50.2% were classed as Major/Resus and 45.2% of Type 1 attendances resulted in an inpatient admission.
- A shortage of mid-grade medical staff has reduced departmental activity.
- Delayed inpatient discharges reduce the bed availability and therefore delays admissions from A&E.

What actions have been taken?

- Analysis of potential streaming processes and development of a Business Case to implement them substantially.
- Working groups review the attendance data, clinician throughput and productivity to align staff rotas.
- Active covering of vacant shifts by local middle grades.
- Single Point of Access (SPA) process and initial phone assessment process both revised and relaunched, based on findings during the Test Of Change week.

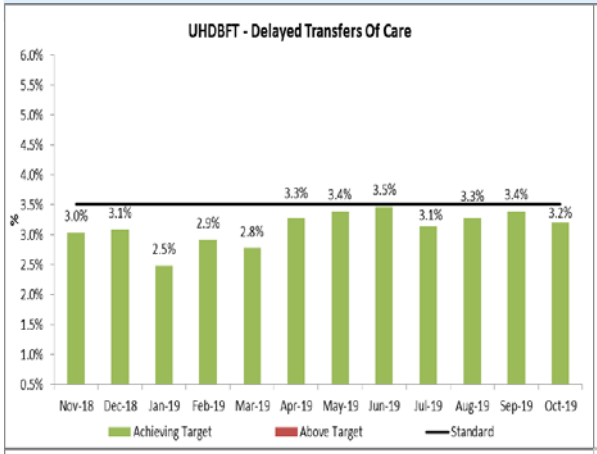
What are the next steps?

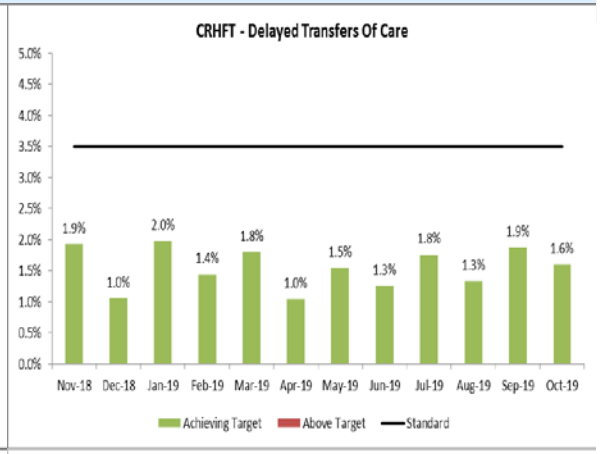
- Piloting GP triage models to manage patients who attend the hospital having been discussed with another clinician. This is being conducted as part of a PDSA cycle.
- Deliver the proposed model by NHS England for streaming and achieve improvement in the number of patients streamed.
- Exploring the possibility of expanding the HALO (WMAS onsite manager) capacity to attend 7 days a week, to improve turnaround times.
- Continued piloting of alternative ways of working in Minors during December 2019, based on findings from the Emergency Care Intensive Support Team (ECIST) test of change week during Sep19.
- Conducting a full assessment of Same Day Emergency Care services, identifying improvement opportunities for 0day LOS patients and Ambulatory Care Sensitive Conditions. The schedule for this has yet to be agreed.
- The ORG (Organisational Resilience Group) take a PMO approach for projects improving urgent care. These include: Capacity & Demand analysis, direct booking of GP appointments via 111, reduced ambulance conveyances, focussing on High Intensity Users & Care Home patients, increasing input from mental health services. The ORG report to the A&E Delivery Board.

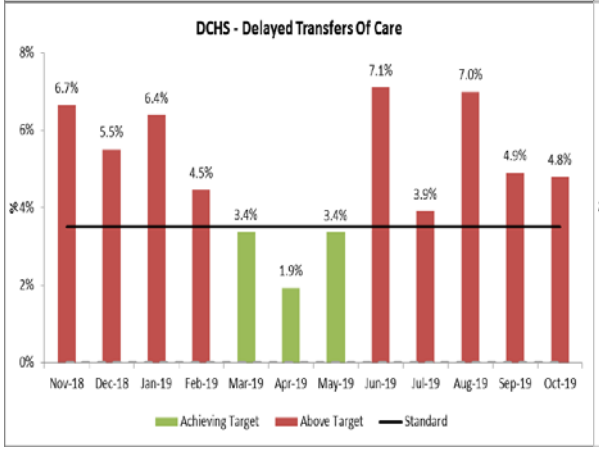
DELAYED TRANSFERS OF CARE (<3.5%)

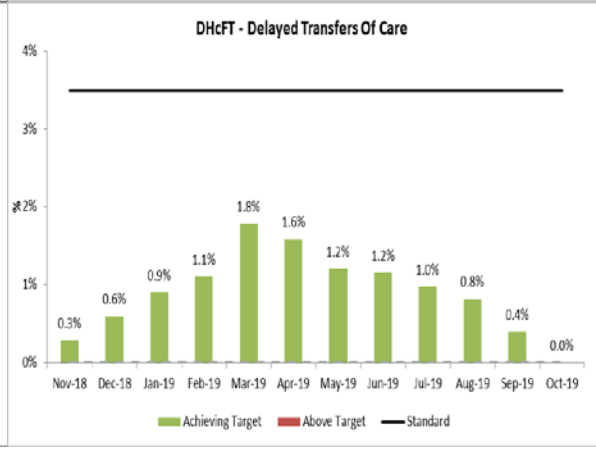
Performance Analysis

The Delayed Transfer of Care (DTOC) standard (<3.5%) was met by three of the four main providers during October 2019. Derbyshire Community Health Services (DCHS) failed this standard with a performance of 4.8% which is a slight increase in performance compared to 4.9% in September.









DCHS

What are the issues

Within DCHS the overall DTOC figure for October 2019 was 4.8%. The year to date score is 4.7% which also exceeds the national target.

During October there were 148 delayed days attributable to NHS. The delays related to 17 patients. The greatest delays were family and patient choice – 103 days (12 patients), waiting for care packages – 22 days (2 patients), awaiting nursing care home placement – 15 days (1 patient) and waiting for public funding – 8 days (2 patients).

Actions

The trust have previously been able to achieve the national target through implementing measures to address DTOC across the community hospitals and OPMH. As reported previously, the plan is to continue with the successful measures which have included:

- Automated daily DTOC reports.
- Weekly conference calls between the community hospital matrons.
- Regular top delay JONAH meetings with General Managers.
- Monthly DTOC meeting of DCHS and partner agencies including Derbyshire County Council Adult Care; Continuing Health Care; CCG; to address delays in transferring patients from community hospitals.
- Conference calls to identify potential delays as early as possible and measures to mitigate them – Ward managers and Transformation Lead.
- DCHS continues to work in partnership with Derbyshire County Council (DCC) to expedite discharges when patients are medically fit for transfer and a regular DTOC meeting between senior managers from DCHS & DCC is held to seek to resolve specific issues & to identify themes across Derbyshire affecting transfers.
- Consistent implementation of the “Transfer of Care” protocol.

NHS 111 – Month 7

Performance Summary

- DHU111 have achieved their contractual KPIs of average speed of answer and abandonment rate each month for Year Three of the contract (October 2018 to September 2019) and have continued this trend into Year Four.
- The 95% of all calls answered in 60 seconds national standard has not been fully achieved since June 2019.

Key performance indicator	Standard	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Average speed of answer (seconds)	≤27 s	8	7	8	24	16	15	11
Abandonment rate (%)	≤5%	0.9	0.8	0.9	3%	2.1%	1.6%	1.2%
Calls answered in 60 seconds DHU111 (%)	≥95%	96.2	96.7	96.5	87.4	90.5%	91.3%	94.0%
Calls answered in 60s England Ave. (%)	≥95%	87.6	86.4	86	80.5	83.30%	82.20%	82.00%

What are the issues?

- DHU111 are achieving the contractual performance standards of average speed of answer and abandonment rate. DHU111 are not contracted to deliver the answered in 60s national standard, at the time of contract award this standard was not a national must do. Performance against this standard is reported on a daily basis and monitored by the commissioning team, this is compared with national performance also. Although DHU111 are not meeting the standard their performance when compared with others nationally is very good.
- Actual activity is below plan for Call Offered and above plan for Clinical Calls.

What actions have been taken?

- DHU111 have completed a comprehensive winter plan complete with expected call volumes for the winter period.
- Staffing for the winter period is in place.
- Activity is being monitored on a daily basis.

What are the next steps?

- Continue to closely monitor performance against contractual standards.
- Continue regular communication with the provider around activity levels and any mitigating actions that can be taken to manage activity.
- Await the publication of the NHSE/I revised IUC KPIs which should remove the answered in 60 seconds standard and replace it with an average speed of answer standard. The proposed threshold for average answered time has not been confirmed by NHSE/I. Expected for April 2020.

AMBULANCE – EMAS PERFORMANCE – Month 7

October 2019		Category 1		Category 2		Category 3	Category 4
		Average	90th centile	Average	90th centile	90th centile	90th centile
National standard		***00:07:00***	***00:15:00***	***00:18:00***	***00:40:00***	***02:00:00***	***03:00:00***
EMAS Actual		00:07:45	00:14:03	00:32:50	01:07:28	04:09:24	**04:06:31**
Derbyshire	**Actual**	00:07:39	00:12:58	00:28:31	00:58:18	03:48:24	03:14:34

October 2019	Pre Handovers		Post Handovers		Total Turnaround	
	Average Pre Handover Time	Lost Hours	Average Post Handover Time	Lost hours	Average Total Turnaround	Lost hours
Burton Queens	00:21:12	70:06:36	00:14:20	28:59:02	00:35:31	79:59:16
Chesterfield Royal	00:21:29	322:18:34	00:17:01	219:14:07	00:38:30	442:44:56
Macclesfield District General Hospital	00:27:35	15:50:30	00:10:18	0:39:27	00:37:54	12:17:44
Royal Derby	00:20:22	514:04:06	00:17:22	415:38:22	00:37:45	765:31:34
Sheffield Northern General Hospital	00:26:07	29:36:14	00:16:44	13:44:04	00:42:51	37:09:18
Stepping Hill	00:24:41	77:58:18	00:14:33	24:20:56	00:39:15	83:00:42
Derbyshire TOTAL	**00:21:08**	**1029:54:18**	**00:16:51**	**702:35:58**	**00:37:59**	**1420:43:30**

October 2019	NTPS Activity						
DERBYSHIRE	**2019/20 Actual**	**18/19 Actual**	**19/20 Actual vs 18/19 Actual**	**19/20 Actual vs 18/19 Actuals (%)**	**19/20 Plan**	**19/20 Actual vs 19/20 Plan**	**19/20 Actual vs 19/20 Plan (%)**
Calls	18,463	16,636	1,827	11.0%	16,396	2,067	12.6%
Total Incidents*	13,084	-	-	-	12,501	583	4.7%
Total Responses	12,186	11,478	708	6.2%	11,537	649	5.6%
Duplicate Calls	3,813	2,880	933	32.4%	2,556	1,257	49.2%
Hear & Treat	2,458	2,278	180	7.9%	2,303	155	6.7%
See & Treat	3,147	3,260	-113	-3.5%	3,338	-191	-5.7%
See & Convey	9,039	8,218	821	10.0%	8,199	840	10.2%

**Please note that the incident count cannot be compared to the 18/19 incident count due to changes in the way incidents are counted for 19/20.*
Discussions are ongoing with regards the best way to count ITK/Other Call activity and the report will be updated as soon as possible.

What are the issues?

- Derbyshire did not meet the national standards for C1 mean, C2 mean, C2 90th centile , C3 90th and C4 90th centile during October 2019.
- The contractual standard is for the division to achieve national performance on a quarterly basis. Based on Quarter Three to date, Derbyshire is on track to achieve one of the six national standards; C1 90th centile .
- Activity in October 2019 is below plan for See &Treat, but above plan for Hear &Treat and See & Convey.
- Vehicle off Road (VoR) continues to see an increase and in October 2019 this rose to (2,120 hours) compared to September 2019 (1,799 hours).
- Pre hospital handover times during October 2019 were above the 15 minute national standard (21 minutes and 8 seconds) across Derbyshire, which is a slight deterioration compared to September 2019 (20 minutes and 50 seconds). The-division continues to experience significant delays at Royal Derby Hospital.
- Post handover times during October 2019 (16 minutes and 51 seconds) saw an improvement compared to September 2019 (17 minutes and 30 seconds), however remain above the 15 minute national standard.

What actions have been taken?

- With regards performance, following on from the Contract Performance Notice that was raised by the coordinating commissioning team as a result of failure to achieve Quarter Two performance standards, the County Contract Meeting agenda has been amended to facilitate a more in depth exploration into the four key areas impacting on performance (Demand, External Efficiencies, Internal Efficiencies and Resourcing) and the actions taking place on each of these key areas.
- With regards increased activity, this is being picked up via the conversations taking place via the contract management group. There are also a number of pieces of analysis taking place looking at alternative pathways, activity being passed from 111 to 999, analysis of patients who were conveyed to A&E and discharged with no intervention in order to understand where this demand is coming from in more detail.
- With regards VoR, whilst the lost hours to VoR continue to increase, this is as a direct result of the division having more staff and vehicle s available to respond to demand and therefore VoR has naturally increased due to more resources being on the road.
- With regards handovers, EMAS attend the monthly Royal Derby Hospital Handover meeting and these have become more focused now that commissioners are also involved in the meeting. Commissioners have requested action plans from both Chesterfield Royal and Royal Derby addressing pre hospital handover delays which is due to be received by 21st November 2019.

What are the next steps

- The Coordinating commissioning team is pulling together a matrix capturing the actions taking place against the four pillars and this will be shared once complete for review.
- The matrix will be discussed at the regional wide Contract Review Meeting on 18th December 2019 where the group will assess the actions taking place, and determine if any further actions are required. Once this work is carried out, these may form part of a Remedial Action Plan (RAP).

Planned Care

DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

During October 2019 Derbyshire RTT performance was 88.6%.
The Derbyshire waiting list at end of October 2019 stood at 61,978.
This is not a true reflection as the Derbyshire patients who were at that time under the care of DCHS are not included in that figure. These patients will be included for end of November as they have now moved to UHDB.

Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2019 Waiting List	Movement from March 19
General Surgery	5067	4474	593	88.30%	4891	176
Urology	3280	2862	418	87.26%	3314	-34
Trauma & Orthopaedics	8952	7559	1393	84.44%	7477	1475
ENT	3880	3469	411	89.41%	3820	60
Ophthalmology	6814	6159	655	90.39%	6367	447
Oral Surgery	1	1	0	100.00%	0	1
Neurosurgery	430	380	50	88.37%	299	131
Plastic Surgery	471	405	66	85.99%	468	3
Cardiothoracic Surgery	113	104	9	92.04%	101	12
General Medicine	1401	1190	211	84.94%	1275	126
Gastroenterology	3081	2814	267	91.33%	3492	-411
Cardiology	2857	2517	340	88.10%	2627	230
Dermatology	3900	3480	420	89.23%	3725	175
Thoracic Medicine	1278	1195	83	93.51%	13896	-12618
Neurology	1663	1495	168	89.90%	1085	578
Rheumatology	1492	1271	221	85.19%	1651	-159
Geriatric Medicine	168	164	4	97.62%	1654	-1486
Gynaecology	3715	3458	257	93.08%	367	3348
Other	13391	11876	1515	88.69%	3831	9560
All specialties	61954	54873	7081	88.57%	60340	1614

What are the issues?

The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally. 70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%).

The RTT standard was not achieved by CRH, UHDB, East Cheshire, Sherwood Forest Hospital and Stockport FT. In addition Nottingham University Hospitals did not achieve it for the first time this year.

NHSE mandate states that the total number of incomplete pathways at March 2020 should be at or below the March 2019 figure. This is being measured at CCG and provider level.

The number of CCG patients on an incomplete waiting list has increased at UHDB, Sherwood forest, NUH and Stockport.

CCG Actions

- Recovery plans / Trajectories are all in place for each provider.

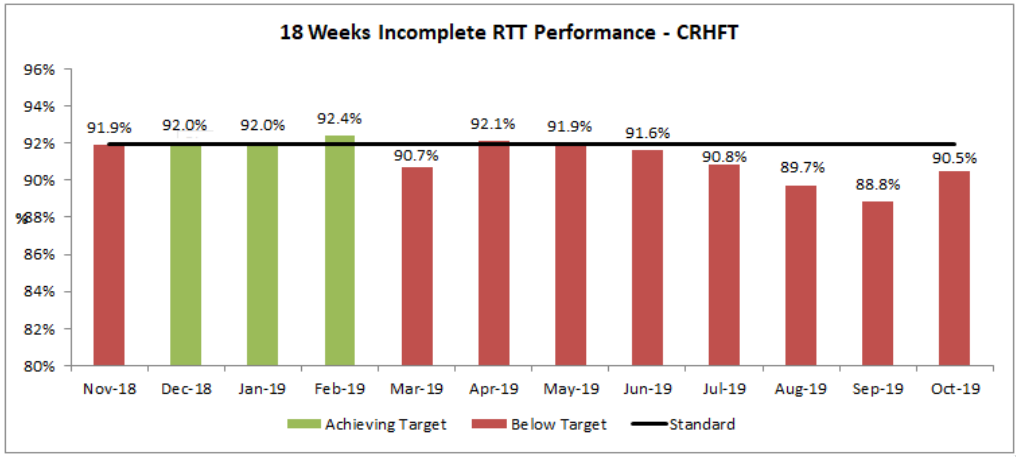
What are the next steps and the point of impact?

The CCG will continue to performance manage the main providers within Derbyshire for the RTT target and to also review waiting list numbers.
Associate providers will continue to be monitored through our associate CCG colleagues.

CRHFT – INCOMPLETE PATHWAYS PERFORMANCE (92%)

Performance Analysis (un-validated)
During October CRHFT failed the RTT standard, achieving 90.51% which is an improvement on the September figure of 88.81%.

As predicted the waiting list decreased at the end of October showing an un-validated figure of 15,392 which is 556 above the March 2019 figure.



Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2019 Waiting List	Movement from March 19
General Surgery	2423	2197	226	90.67%	2251	172
Urology	1095	941	154	85.94%	1193	-98
Trauma & Orthopaedics	1098	1042	56	94.90%	800	298
ENT	1240	1150	90	92.74%	1312	-72
Ophthalmology	1520	1417	103	93.22%	1332	188
Oral Surgery	792	643	149	81.19%	571	221
General Medicine	709	661	48	93.23%	586	123
Gastroenterology	941	794	147	84.38%	1263	-322
Cardiology	620	546	74	88.06%	593	27
Dermatology	1226	1180	46	96.25%	1298	-72
Thoracic Medicine	488	442	46	90.57%	393	95
Rheumatology	400	369	31	92.25%	405	-5
Gynaecology	1068	970	98	90.82%	1090	-22
Other	1771	1579	192	89.16%	1749	22
All specialties	15391	13931	1460	90.51%	14836	555

What actions have been taken?

Urology – Review of 50 notes showed that only two patients could be discharged. Currently reviewing workforce model. There continues to be locum cover.
Gastro - Medinet continues to provide clinical support. This has enabled the waiting list to reduce. Staffing structures are to be reviewed.
Rheumatology – Medinet continuing to provide additional support. Staffing structures are to be reviewed.
Dermatology – During November, December and January 2 extra clinics per month will be run to reduce the backlog. Business case has been submitted for a second specialist nurse. Priority is to implement tele-dermatology in connection with clinical connect. A meeting is to take place on the 9th January. Trust will be running two large clinics during December/January to help with the backlog. Each clinic will be able to see around 50 patients.
Waiting List – Validation team are reviewing the waiting list now that they are at full capacity again, although two still in training. Trust have indicated to the CCG that they will employ additional validation capacity if necessary.

What are the issues?
Urology – Demand and capacity issues due to the increasing referrals. Cancer patients take priority which is affecting elective patients.
Gastro – ASI's are no longer an issue although there is a backlog of patients waiting to be seen. Consultant now gone off on maternity leave and a locum to be recruited.
Rheumatology – Continued **I**ncrease in referrals although managing to maintain waiting list.
Dermatology – Referrals have continued to stabilised despite still struggling with the backlog. Dermatology 2WW referrals seen within 7 days resulting in a backlog for other patients. The service continues with vacant posts.

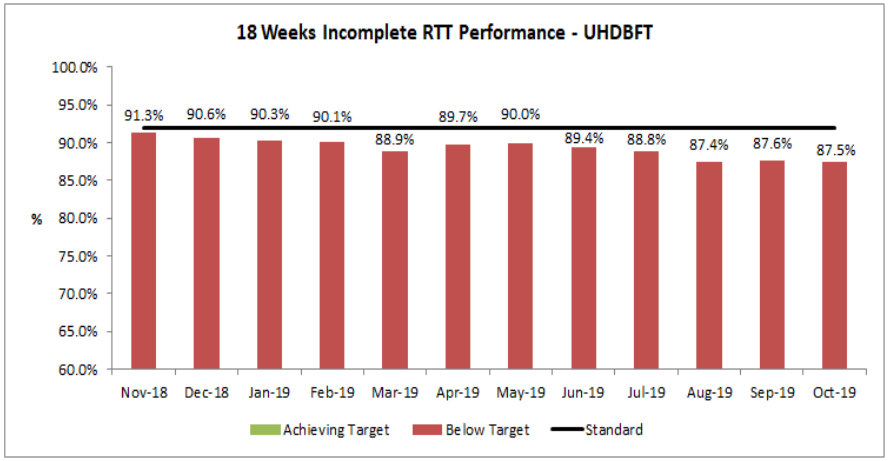
What are the next steps –
The CCG will continue to monitor the size of the waiting list. A recovery plan has been received and the CCG have asked for target dates for the actions and the staff responsible for the actions.

UHDB – INCOMPLETE PATHWAYS PERFORMANCE (92%)

Performance Analysis (un-validated)

During October the trust failed to achieve the incomplete pathway standard (92%) achieving 87.49%. Site performance was: Derby 86.09%, Burton 89.93%.

At the end of October the un-validated waiting list figure was 51,791 which is above their trajectory. The normal level of validation could not be undertaken during October as the validation team were in the process of moving DCHS patients over to Lorenzo as part of the strategic shift.



Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2019 Waiting List	Movement from March 19
General Surgery	3077	2572	505	83.59%	2955	122
Urology	2410	2165	245	89.83%	2090	320
Trauma & Orthopaedics	8849	7246	1603	81.88%	7264	1585
ENT	3471	3104	367	89.43%	3580	-109
Ophthalmology	5723	5001	722	87.38%	5457	266
Oral Surgery	833	739	94	88.72%	780	53
Neurosurgery	95	57	38	60.00%	73	22
Plastic Surgery	259	215	44	83.01%	289	-30
Cardiothoracic Surgery	4	3	1	75.00%	11	-7
General Medicine	174	171	3	98.28%	35	139
Gastroenterology	2438	2326	112	95.41%	2189	249
Cardiology	2571	2376	195	92.42%	1886	685
Dermatology	3044	2688	356	88.30%	2994	50
Thoracic Medicine	510	475	35	93.14%	514	-4
Neurology	935	880	55	94.12%	1192	-257
Rheumatology	1454	1182	272	81.29%	1413	41
Geriatric Medicine	171	169	2	98.83%	159	12
Gynaecology	3189	2923	266	91.66%	2999	190
Other	12584	11022	1562	87.59%	11553	1031
All specialties	51791	45314	6477	87.49%	47433	4358

What are the issues?

General Surgery - Colorectal – The issues remain the same as reported last month with increasing ASI due to consultant sickness and interim/locum Consultant now in place short term.

UGI & Bariatrics - Ongoing long waits particularly for bariatric surgery. A number of over 40weeks are being monitored closely. Issues continue with sourcing theatre staff.

Urology – Improvements have been made for RTT in month. Issue with ASI continue. 11th Consultant commenced this month however, anaesthetist availability and theatre staffing are a particular restraint.

Ophthalmology - Increased volume of urgent patients has required more Eye Casualty sessions, taking middle grades out of routine activity at Derby. Demand is struggling to be met due to staffing constraints. Long and short term sickness in Eye Daycase team has reduced numbers on the lists.

Trauma and Orthopaedics – RTT slightly improved for October however, is expected to decrease again in November. Locum Lower Limb Consultant now appointed to substantive post with appropriate timetable being developed. Elective ward provision at Burton is delayed until early February. Already lost some beds due to winter pressures.

Actions:

Colorectal - Outpatient Sister continues to triage patients to minimise risk and send straight to test where possible. WLI day case lists ongoing where possible to treat long waiters.

UGI & Bariatrics - . There were seven additional clinics in the month to include converting clinic/day case time to inpatient theatre lists where possible.

Urology Additional clinics are being provided where possible. Work is ongoing in terms of validating the RTT long waiters.

Ophthalmology - Recruited to 3 consultant posts (2 at Burton & 1 at Derby). One to start this year, two next Summer. Doctor posts have just been appointed to include 3 at Derby and 1 at Burton.

Significant volume of WLIs being carried out at both sites but still not enough to match demand. Backlog at Burton is still a concern and the CCG is in discussion with the trust.

Trauma and Orthopaedics – Discussions on-going around amendments to theatre timetable. Clinic sessions being converted to theatre when space allows. Collaborative discussions to support the effective integration of community services via Strategic shift.

What are the next steps?

The CCG continue to have weekly conversations with the trust around the waiting list position. ERS capacity alerts will continue on the choose and book system for T&O Lower Limb procedures until further notice. March 19 baseline and target for March 2020 to be adjusted as a result of the strategic shift of patients from DCHS to UHDB.

DERBYSHIRE COMMISSIONER - 40+ WEEK WAITERS

Performance Analysis
At the end of October 153 patients were declared as waiting over 40 weeks for treatment in Derbyshire which is an improvement from the 190 reported in September.

Out of the 153 patients, 100 were Derbyshire CCG patients, 21 specialised commissioning cases waiting for Maxillo Facial surgery at UHDB and CRH, leaving 32 Derbyshire patients waiting for treatment at associate providers.

52 week waits:
There has been a significant improvement in the monitoring of patients approaching a 52week wait and none have been reported as waiting over 52 weeks at either the main or associate providers during October.

Un-validated reports indicates there will also be no Derbyshire patients waiting over 52 weeks at the end of November.

NB: UHDB/CRH figures for all patients. Associates – DCCG Patients only
October – Un-Validated.

Provider	40-51 ww		Total 40+ww	Total 52+ww
	TCI	No TCI		
Derby & Burton	**68**	**24**	**92**	**0**
Chesterfield	**15**	**28**	**43**	**0**
Nottingham	**6**	**3**	**9**	**0**
Sheffield Teaching	**0**	**0**	**0**	**0**
Sherwood Forest	**2**	**3**	**5**	**0**
Stockport	0	0	0	**0**
East Cheshire	**1**	**3**	**4**	**0**
Leeds	0	0	0	**0**
Sheffield Children's	0	0	0	**0**
Total	**92**	**61**	**153**	**0**

CCG patients – Trend – 52 weeks													UN-VALIDATED
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
DCCG	16	8	11	9	8	4	2	3	3	2	2	0	0

Issues and actions:

UHDB - There are 92 of the 153 patients waiting for treatment at UHDB.
Paediatric long waiters are increasing due to the patients being reluctant to have surgery before Christmas. Overall the highest reporting specialities at UHDB are Maxillo-Facial and Upper Gastrointestinal. The number of Bariatric long waiters is increasing.
Actions: Maxillo-Facial are specialised commissioning cases and are being closely managed by NHSE/I. With regards to Upper GI 7 additional sessions have taken place in October, clinic/day time cases have been converted to theatre lists where possible and workforce issues are continuing to be addressed.
Bariatric patients are being listed in January to prevent any 52 week breaches.

CRH - There are 43 of the 153 patients waiting for treatment at CRH.
The highest reporting specialities at CRH is Urology and Ophthalmology.
Actions: Weekly meetings are continuing to include all patients over 36 weeks.

Next steps
- The CCG have weekly engagement with the two main providers to ensure sufficient monitoring is in place for all patients waiting over 40 weeks and a clear focus on ensuring no patients reach 52 weeks.
- Improvements have been made with regular reporting processes in place with associate providers to ensure all Derbyshire patients waiting for treatment is captured in the data being reported. However, further Derbyshire patients have been identified as waiting for treatment at other providers across the Country. Additional processes are currently being considered to ensure all Derbyshire patients waiting over 40wks are captured.
- A summary of the overall CCG position to include all providers is reported to NHSE/I on a weekly basis.

DERBYSHIRE COMMISSIONER – 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1%)

Performance Analysis

Derbyshire CCG diagnostic performance during October 2019 was 3.5% which is an improvement when compared to the September performance at 6.3%.

UHDB performance has improved but still account for most of the non-compliance, along with Nottingham University Hospital and Stockport.

The key non-compliant test in Derbyshire continues to be Echo-Cardiography, although this is improving in performance from last month along with Cystoscopy and Urodynamics (although the performance of these service areas effect the overall compliance of Diagnostics the numbers within these two areas are relatively small compared to other tests).

CCG Actions

The CCG will continue to performance manage the main providers within Derbyshire to ensure improvement in the position at bottom line and test level

Associate providers will continue to be monitored.

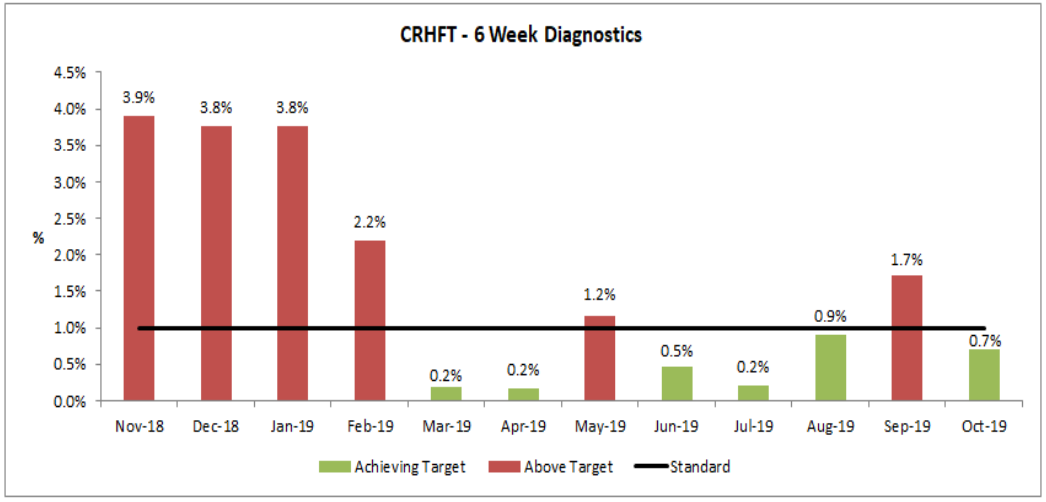
Diagnostic Test	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	September 6+ Weeks	Movement September to October 6+ Weeks	Percentage waiting 6+ Weeks
Audiology - Audiology Assessments	556	4	1	3	1	0.72%
Barium Enema	1	0	0	0	0	0.00%
Cardiology - Echocardiography	2,368	463	84	817	-354	19.55%
Colonoscopy	534	31	16	26	5	5.81%
Computed Tomography	2,126	3	0	4	-1	0.14%
Cystoscopy	258	4	3	12	-8	1.55%
DEXA Scan	379	0	0	0	0	0.00%
Flexi Sigmoidoscopy	222	1	0	4	-3	0.45%
Gastroscopy	726	15	4	14	1	2.07%
Magnetic Resonance Imaging	3,010	6	0	8	-2	0.20%
Neurophysiology - Peripheral Neurophysiology	317	0	0	1	-1	0.00%
Non-obstetric Ultrasound	5,007	10	0	2	8	0.20%
Respiratory physiology - Sleep Studies	108	6	2	3	3	5.56%
Urodynamics - Pressures & Flows	68	10	2	20	-10	14.71%
Total	15,680	553	112	914	-361	3.53%

Diagnostic Test	University Hospitals of Derby & Burton	Chesterfield Royal Hospital	Stockport Hospital	Sheffield Teaching Hospital	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire Hospitals
Magnetic Resonance Imaging	0.20%	0.00%	0.00%	0.00%	0.80%	1.00%	0.00%
Computed Tomography	0.00%	0.00%	0.00%	0.00%	1.00%	0.80%	0.00%
Non-obstetric Ultrasound	0.00%	0.40%	0.00%	0.00%	0.00%	0.20%	0.00%
Barium Enema	0.00%						
DEXA Scan	0.00%	0.00%	0.00%	0.60%	0.40%	0.00%	
Audiology - Audiology Assessments	0.30%	0.00%	0.00%	1.20%	0.60%	7.50%	0.00%
Cardiology - Echocardiography	23.00%	4.00%	0.00%	0.00%	0.20%	2.10%	0.00%
Neurophysiology - Peripheral Neurophysiology	0.50%		0.00%	0.00%		0.00%	
Respiratory physiology - Sleep Studies	0.80%		10.30%	0.60%	1.60%	0.00%	
Urodynamics - Pressures & Flows	11.70%	0.00%	0.00%	0.00%	0.00%	5.90%	0.00%
Colonoscopy	0.00%	0.00%	38.60%	0.00%	1.10%	0.50%	3.40%
Flexi Sigmoidoscopy	0.40%	0.00%	21.70%	0.00%	0.90%	0.00%	1.70%
Cystoscopy	3.10%	0.00%	0.00%	0.00%	13.90%	0.00%	0.00%
Gastroscopy	0.60%	0.00%	23.20%	0.20%	1.10%	2.20%	1.90%
Total	3.98%	0.72%	6.21%	0.06%	0.95%	1.27%	0.53%

CRHFT DIAGNOSTICS - 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1% of pts should wait more than six weeks

Performance Analysis

Unvalidated figures show that the trust achieved this standard with a performance of 99.3%. The trust had issues with Echocardiography in previous months and did not expect to achieve the standard until November.
The trust are expecting to achieve this standard again in November.



What are the issues?

Echocardiography – There are currently no issues although the trust are monitoring the number of referrals into the service. They are undertaking extra clinics to keep the waiting list to an acceptable level.

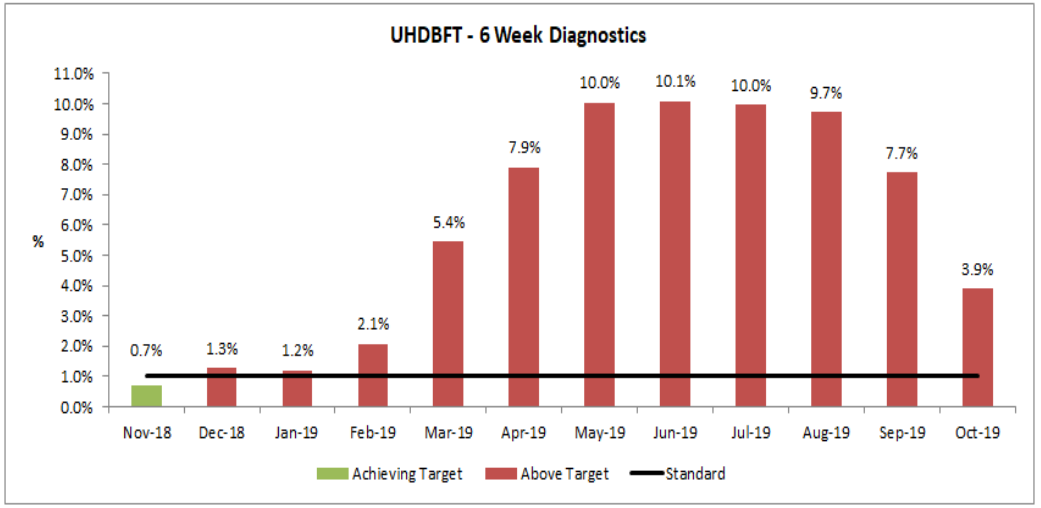
What actions have been taken?

- There is currently an open Contract performance notice and the CCG will continue to monitor performance at the trust.

UHDB DIAGNOSTICS - 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1% of pts should wait more than six weeks

Performance Analysis
UHDB continue to fail the diagnostic standard and have done so for a total of 11 consecutive months. The **un-validated** performance figure for October is 3.9% which is a significant improvement to Septembers position which was reported at 7.7% non compliant .

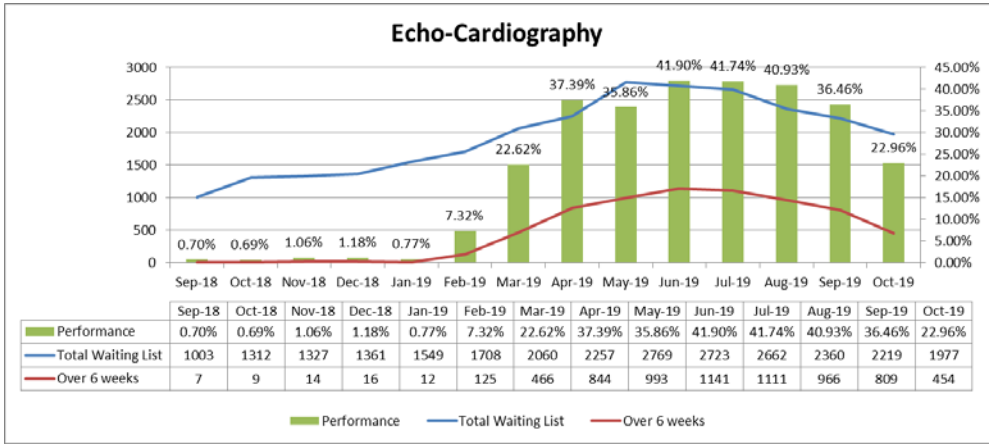
A further improvement is expected for November with the aim to be fully compliant by December.



Echo-Cardiography continues to be the biggest contributor to the Trusts non-compliance to the diagnostics target.

Echocardiography
The waiting list has decreased again this month, resulting in improved progress for five consecutive months. The un-validated data at the end of October shows the number of patients waiting over 6 weeks stands at 1977 with 454 patients waiting over 6 weeks for their test. This is a significant improvement of a decrease in 355 patients from the previous month. The Trust have provided assurance that the decrease in patients waiting over 6 weeks for tests is continuing on their weekly reports.

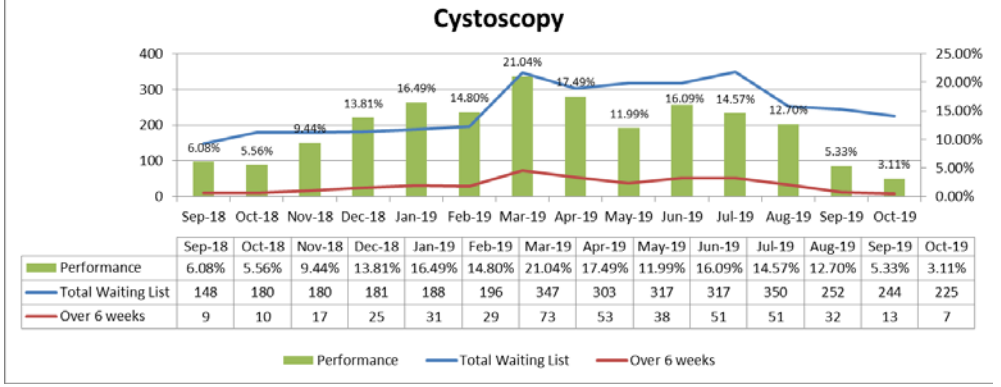
Issues/Actions:
Recovery – the Recovery plan with a trajectory for the Echo waiting list to all be below 6 weeks by the end of December 2019 continues to be on track and no major concerns have been raised around delivery.
External Contractor – Two external contractors are continuing to work through outstanding capacity.
Recruitment – Workforce issues are being closely monitored and actioned accordingly in particular with overseas recruitment being considered.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Performance	0.70%	0.69%	1.06%	1.18%	0.77%	7.32%	22.62%	37.39%	35.86%	41.90%	41.74%	40.93%	36.46%	22.96%
Total Waiting List	1003	1312	1327	1361	1549	1708	2060	2257	2769	2723	2662	2360	2219	1977
Over 6 weeks	7	9	14	16	12	125	466	844	993	1141	1111	966	809	454

Cystoscopy
The waiting list for Cystoscopy is continuing to decrease and there are no major concerns around this service area in terms of failing the Trust.

Issues/Actions: Additional clinics are taking place to assist where possible. Robust booking processes and validation of patients are continuing to be sustained. The possibility of running cystoscopy lists in outpatients is being explored however, staffing restraints may prevent this.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Performance	6.08%	5.56%	9.44%	13.81%	16.49%	14.80%	21.04%	17.49%	11.99%	16.09%	14.57%	12.70%	5.33%	3.11%
Total Waiting List	148	180	180	181	188	196	347	303	317	317	350	252	244	225
Over 6 weeks	9	10	17	25	31	29	73	53	38	51	51	32	13	7

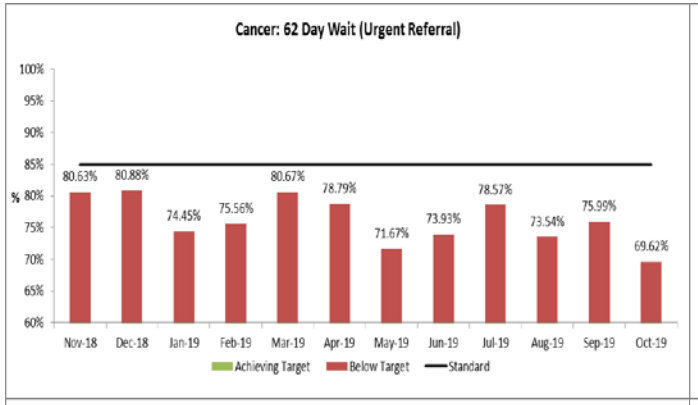
Next Steps:
- NHSE/I and the CCG are in communications with the Trust to ensure the trajectory for being fully compliant in December is on track.

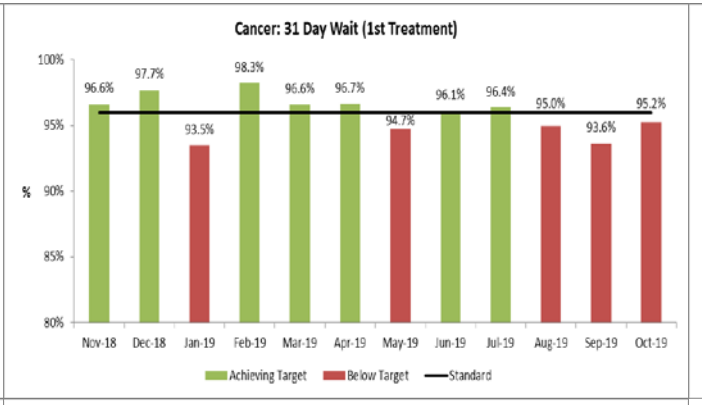
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

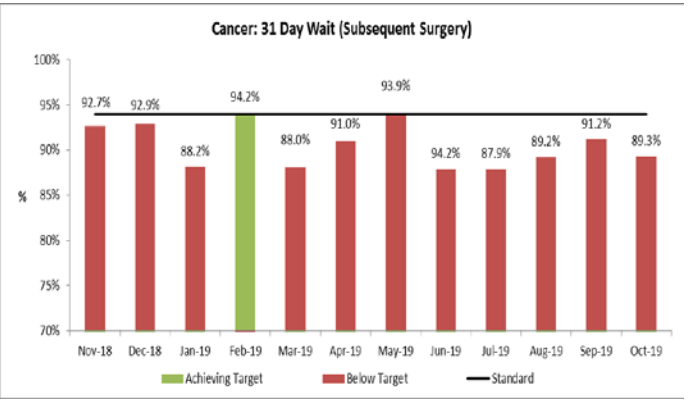
Performance Analysis

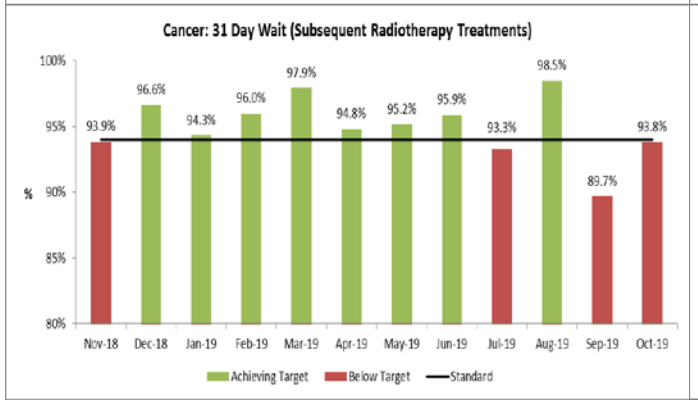
During October 2019 Derbyshire was non compliant in 5 of the 9 Cancer standards:

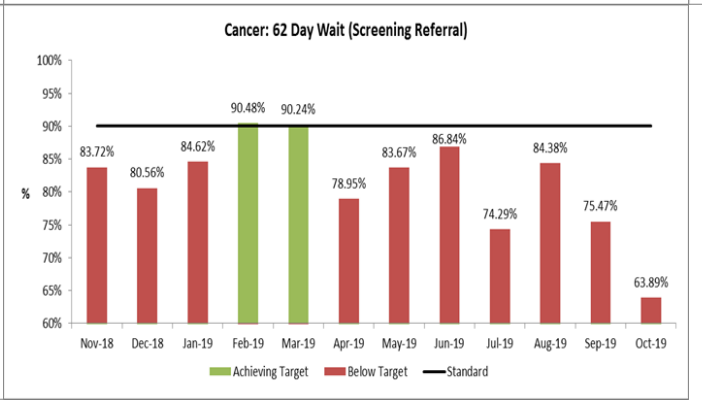
- **62 day Urgent GP Referral** – 69.6% (85% standard) – None of the Trusts were compliant.
- **31 Day First Treatment Administered** – 95.2% (96% standard) – UHDB, Sherwood, Stockport and East Cheshire were compliant.
- **31 day Subsequent Surgery** – 89.3% (94% standard) – Sherwood, Stockport and East Cheshire were compliant.
- **31 day Subsequent Radiotherapy** – 93.8% (94% standard) – UHDB & Nottingham were compliant and Sheffield were non compliant.
- **62 day Treatment from Screening Referral** – 63.9% (90% standard) – Stockport were the only compliant trust.











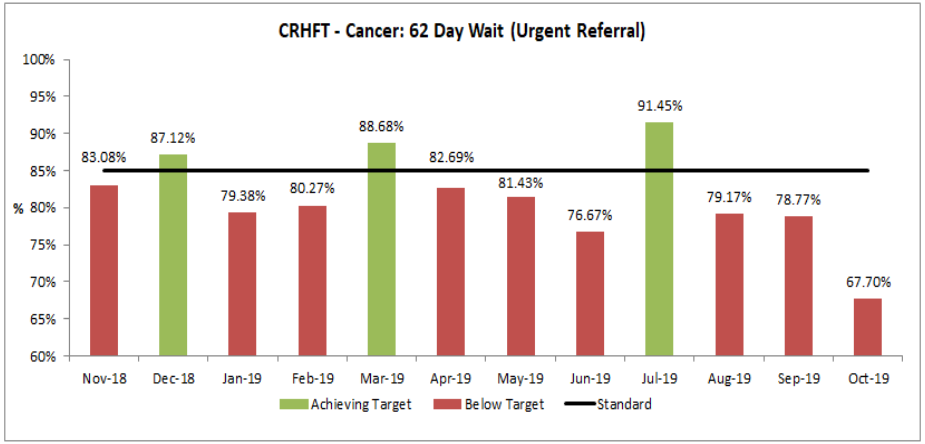
CCG performance data reflects the complete cancer pathway which for many Derbyshire patients will be completed in Sheffield and Nottingham.

CRHFT - CANCER WAITING TIMES (62 Day Waits)

Performance Analysis

The trust performance deteriorated during October with an unvalidated performance of 67.7%.

During October there were 119 patients treated at the trust which is the highest number known. The normal treatments are between 70-80 per month.



Tumour Type	Total Pts Seen	>62 Days	% Performance
Breast	19	7	63.2%
Gynaecological	3	1	66.7%
Haematological (Excluding Acute Leukaemia)	9	4	55.6%
Head and Neck	7	1	85.7%
Lower Gastrointestinal	15	11	26.7%
Lung	4	1	75.0%
Skin	26	0	100.0%
Upper Gastrointestinal	13	8	38.5%
Urological (Excluding Testicular)	23	9	60.9%
Total	119	42	67.7%

What are the issues?

- Delays to imaging and reporting, particularly for CT scans.
- Patient choice and capacity for diagnostic tests an issue for Lower GI.
- Delays as a result of outpatient capacity at STH. The theatre capacity issue is much improved.
- Breast follow up capacity continues to delay pathways compounded by patient choice.
- Lower GI – Gaps in consultant capacity due to maternity leave. Also theatre capacity for the numbers that are coming through the service.

What actions have been taken?

- Breast capacity has been an issue for quite a while. Funding has now been received for a Breast CNS to work in oncology. The trust are also now recruiting an additional consultant and until that time a locum will be recruited.
- In relation to the delays at STH, discussions are being held with the oncology team to reduce delays.
- The trust are reviewing the pathways for referrals to ensure Inter-provider transfer (IPT) patients are referred within 38 days.
- The trust are outsourcing some CT scans during December. The first one of these to take place week beginning 15th December.
- Imaging reporting continues to be outsourced to pull waiting times down (also covers patients on RTT pathway).
- Improvement plans are in place and are reviewed at the bi-monthly cancer steering group which is attended by CCG representatives.

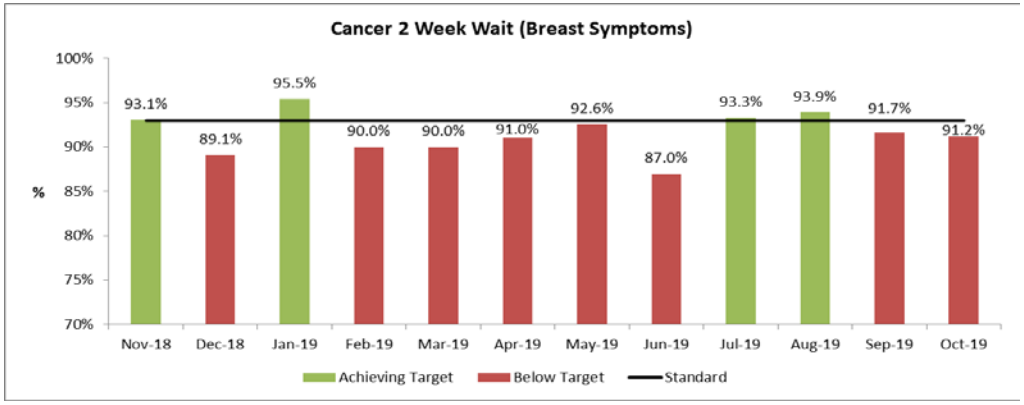
What are the next steps

- The findings from the visit at Frimley have been shared with the trust who are reviewing how to take forward.
- The trust have received some funding from the East Midlands cancer alliance for oncology support in breast and also other nurse specialist support.
- Trust representatives have been invited to be part of the Improvement group at UHDB.

CRHFT – CANCER WAITING TIMES (Breast symptomatic patients seen within 2 weeks of referral)

Performance Analysis
The trust unvalidated performance was 91.2% against a standard of 93%.

5 of the 52 patients seen where after 14 days.



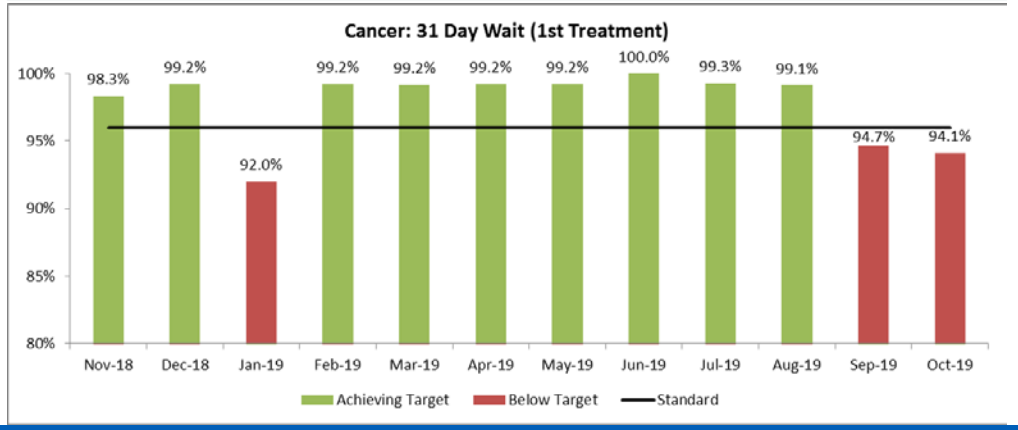
What are the issues?

Four of the breaches were due to patient choice with one breach due to outpatient capacity.

What actions have been taken?
Funding has been agreed for an additional breast consultant.

CRHFT – CANCER WAITING TIMES (First Treatment Administered within 31 Days of Diagnosis)

Performance Analysis
The trust performance was 94.1% against a standard of 96%.



What are the issues?

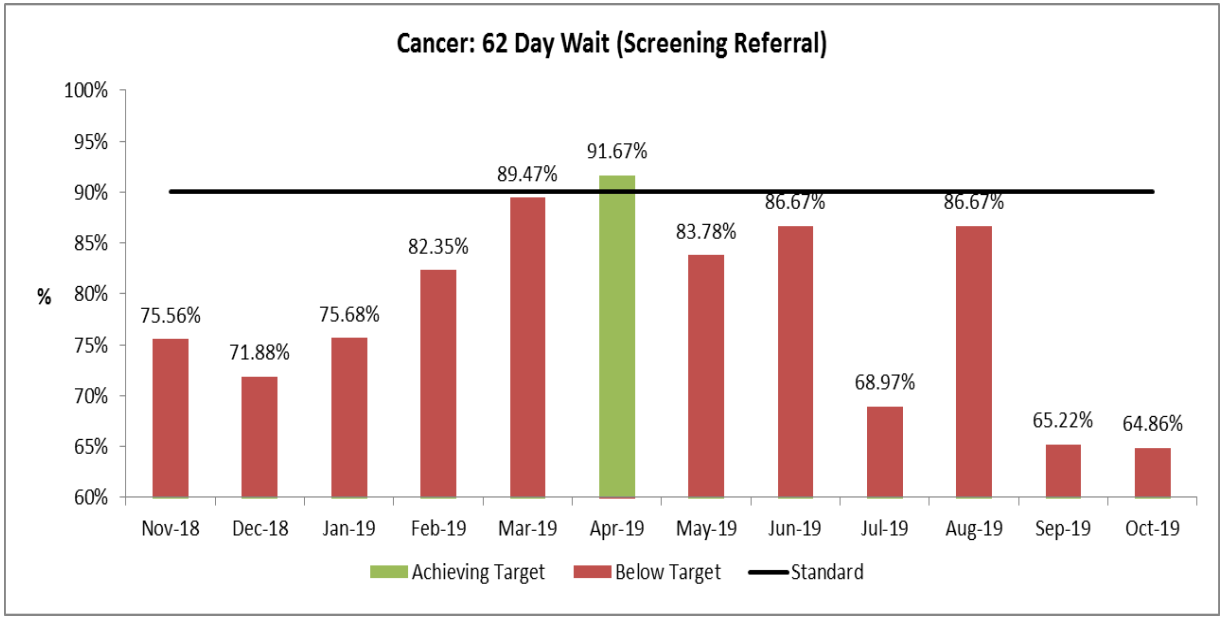
There were 9 breaches of this standard.

8 in the breast service:
- 6 capacity
- 2 complex medical

1 in Lower GI – Patient choice

What actions have been taken?
Funding has been agreed for an additional breast consultant.

CRHFT - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Screening)



Performance Analysis

62 day screening performance was 64.9% during October.

There were 18 accountable treatments in October with 6 breaches (7 patients).

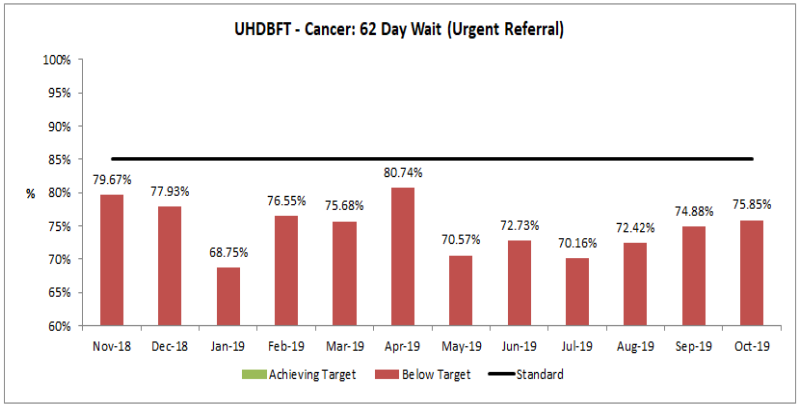
What are the issues?

4 X Breast – 3 as a result of elective capacity and one complex medical delay.
3 x Lower GI – 1 Patient choice, 1 elective capacity and 1 complex medical delay.

UHDB - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis –

62 day performance during October was non compliant at 75.85%. This is a increase from last month's figure of 74.94%. The trust has failed this standard (of 85%) for the 18th consecutive month.



Tumour Type	Total Pts Seen	>62 Days	% Performance
Breast	37.5	1.5	96.0%
Gynaecological	14	5	64.3%
Haematological (Excluding Acute Leukaemia)	16	8	50.0%
Head and Neck	12	1	91.7%
Lower Gastrointestinal	26	8	69.2%
Lung	16	7	56.3%
Sarcoma	1	0	100.0%
Skin	28	1	96.4%
Testicular	1	0	100.0%
Upper Gastrointestinal	17	5	70.6%
Urological (Excluding Testicular)	38.5	13.5	64.9%
Total	207	50	75.85%

What are the issues?

- Oncology capacity – delays continue within Urology and Upper GI Clinical Oncology clinics due to demand and workforce / recruitment issues.
- Urology – robotic capacity continues to be an issue due to a continued high number of referrals received with this type of surgery being a preferred choice for many patients.
- Gynaecology – capacity issues due to workforce issues.
- Haematology – medical complexity and capacity issues due to an increase in demand.
- Lower GI – medical complexity and capacity issues due to staffing issues and increased number of referrals. The speciality continues to raise concerns over incomplete 2ww referrals being received.
- Lung – 3 breaches were due to tertiary referrals being received late in the pathway and were treated by the trust within 24 days. 3 breaches due to medical complexity &1 due to patient choice.

What actions have been taken?

- Medical oncology capacity has been escalated within the trust and added onto the trust's Risk Register due to staffing issues. A locum lung clinical Oncologist has been recruited but will also focus on Prostate which will increase capacity and help to clear the backlog in Urology & Upper GI.
- Gynaecology – extra clinics have been arranged.
- Haematology – extra clinics implemented.
- Lower GI – extra clinics in place to increase capacity.
- DDCCG continue to support to improve the quality of 2WW referrals from GPs to the trust.
- Robotic capacity - extra urology lists are being facilitated. 2nd robot is planned.
- Staff training and events continue for clinical and administrative staff to improve understanding of the cancer pathway and the impact of their role on achievement of the Cancer targets

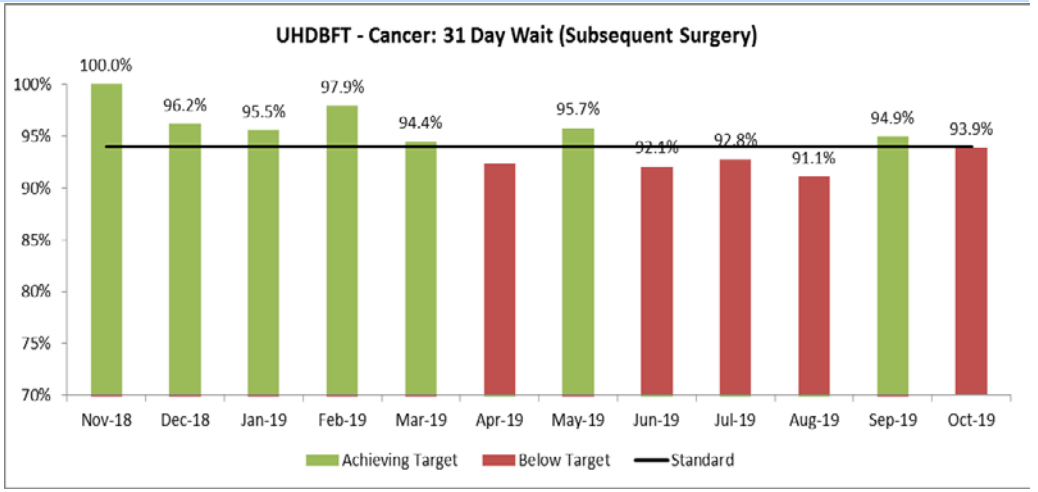
What are the next steps?

- As previously reported, DDCCG formally closed the existing CPN in November 2019, in respect of Cancer 62 day performance, as commissioners viewed that a reset and revision of current action plans was required. A reissue of the CPN has been completed.
- A high level Remedial Action Plan was previously received from the Trust for the original CPN and fortnightly calls are in place.
- An initial draft of the new Remedial Action Plan template has been received from UHDB and DDCCG are working with the trust to establish a more robust improvement plan for the 62 day target through benchmarking their processes against Frimley's Health NHS FT (this trust has been consistently achieving the 62 day standard).
- Monthly cancer improvement group workshops have been implemented and started on 7th November. The workshops discuss and plan how the learning and outcome of a visit to Frimley can contribute to the revised Remedial Action Plan.
- October breaches are to be reviewed by DDCCG and the trust on 18th December 2019.

UHDB – 31 Day CANCER WAITING TIMES (Subsequent Surgery)

Performance Analysis –
Performance for 31 day for subsequent surgery during October 2019 was non compliant at 93.88% (standard is 94%). The trust was compliant with this standard last month.

There were 3 breaches for 31 day for subsequent surgery (2 in Lower GI and 1 in Urology). If 1 more patient had been treated within the 31 days then the trust would have been compliant with this standard (achieving 95.92%). All breaches were due to capacity.



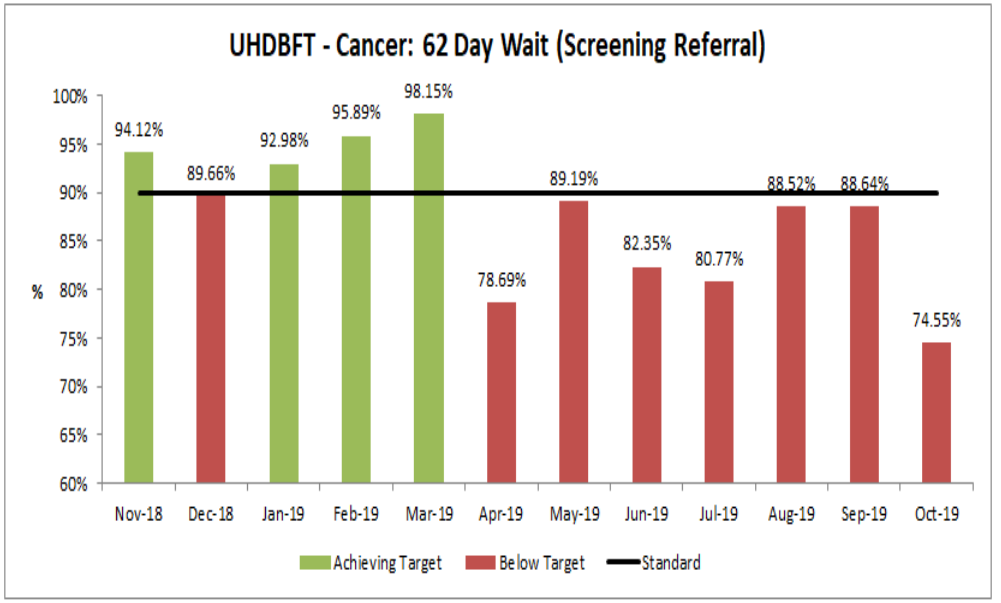
UHDB - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Screening)

Performance Analysis –
62 day screening performance during October was non compliant at 74.55% (against a standard of 90%), a decrease from last month's figure of 88.6%.

There were 7 breaches for 62 day screening performance in October (5 in Lower GI, 2 in Breast).

The Trust treated 27.5 patients and 20.5 were treated within 62 days of screening. If 5 more patients had been treated within the 62 days then the trust would have been compliant with this standard.

- The 3 breaches in Lower GI were due to capacity and 2 due to patient choice.
- The 2 breaches in Breast were due to capacity.



Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M6 – ASSOCIATE PROVIDER CONTRACTS

Derbyshire Wide Provider Assurance Dashboar

Key:
- Performance Meeting Target
- Performance Not Meeting Target
- Indicator not applicable to organisation

- Performance Improved From Previous Period ↑
- Performance Maintained From Previous Period →
- Performance Deteriorated From Previous Period ↓

Part A - National and Local Requirements

Provider Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals				Nottingham University Hospitals				Sheffield Teaching Hospitals FT				Sherwood Forest Hospitals FT				Stockport FT			
					Direction of Travel	Current Month	YTD	# months of failure	Direction of Travel	Current Month	YTD	# months of failure	Direction of Travel	Current Month	YTD	consecutive months of failure	Direction of Travel	Current Month	YTD	consecutive months of failure	Direction of Travel	Current Month	YTD	consecutive months of failure
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Nov-19	↓	75.1%	76.8%	17	A&E pilot sight - not currently reporting 4 hour breaches				↓	81.8%	83.8%	43	↓	88.3%	90.8%	14	↓	61.3%	70.3%	54
		A&E 12 Hour Trolley Waits	0	Nov-19	→	0	8	0	↑	14	23	2	→	0	0	0	↑	17	20	1	↑	87	275	8
	DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Oct-19	↑	5.88%	4.33%	30	↑	2.83%	3.19%	0	↑	2.64%	2.91%	0	↓	4.54%	4.86%	5	↑	4.27%	3.76%	2
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-19	↑	85.7%	83.6%	26	↓	91.7%	92.5%	1	↓	92.9%	93.0%	0	↓	86.6%	88.7%	26	↑	81.1%	82.8%	21
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-19	→	0	10	0	↑	2	12	1	→	0	0	0	→	0	0	0	→	3	25	18
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-19	↑	0.53%	5.57%	0	↓	1.27%	2.44%	7	↑	0.06%	1.02%	0	↑	0.95%	1.47%	0	↓	6.21%	3.32%	4
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Oct-19	↑	94.7%	79.0%	0	↑	93.4%	93.6%	0	↓	95.6%	94.7%	0	↑	94.8%	93.9%	0	↓	95.8%	90.4%	0
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Oct-19	↑	92.2%	48.6%	10	↓	100.0%	99.0%	0	↓	96.7%	93.2%	0	↑	95.6%	95.6%	0	↓	100.0%	19.7%	0
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Oct-19	↓	100.0%	100.0%	0	↑	93.1%	93.0%	10	↑	95.7%	94.3%	3	↑	97.1%	96.6%	0	↑	98.3%	97.5%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Oct-19	↑	100.0%	98.6%	0	↑	88.9%	82.1%	18	↑	93.9%	90.8%	16	↑	100.0%	83.3%	0	↓	100.0%	94.6%	0
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Oct-19	↓	100.0%	92.3%	0	↓	100.0%	99.6%	0	↑	99.7%	99.6%	0	↓	100.0%	100.0%	0	↓	100.0%	100.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Oct-19					↓	97.8%	99.0%	0	↑	91.1%	93.8%	2								
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Oct-19	↓	62.5%	73.7%	1	↑	80.0%	75.9%	17	↑	70.1%	73.2%	50	↓	76.6%	76.8%	7	↓	72.3%	51.5%	6
		First Treatment Administered - 104+ Day Waits	0	Oct-19	→	2.0	16.5	8	↓	12.5	72.5	43	↑	11.5	84.5	43	↓	7.5	37.0	18	↓	3.5	20.5	6
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Oct-19	↓	81.8%	89.0%	1	↓	72.3%	84.4%	1	↓	79%	88.8%	2	↓	66.7%	78.5%	4	↓	100%	62%	0
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Oct-19	↓	85.2%	80.3%		↓	78.7%	84.8%		↑	82.8%	78.0%		↑	86.5%	88.5%		↑	90.3%	75.0%	
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	19-20 Q2	↑	0.0%	0.0%		↓	6.6%	4.6%		↑	1.5%	5.0%		↓	6.1%	10.4%		↓	2.0%	7.6%	
		Number of Urgent Operations cancelled for the 2nd time	0	Oct-19	→	0	0		→	0	0		↓	1	2		→	0	0		→	0	0	
Patient Safety	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Oct-19	↑	31	267	16	→	0	0	0	→	0	0	0	→	0	0	0	→	0	0	0
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Oct-19	↑	0	1	0	→	0	1	0	→	0	0	0	→	0	0	0	→	0	0	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Oct-19	↓		2		↓		10		↑		14		↑		7		↓		4	
			Actual				1	0			16	0			4	0			1	0			5	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Oct-19	↓	16	94		↓	79	467		↓	65	427		↑	29	198		↓	20	126	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Oct-19	↑	0	4		↑	5	56		↓	10	36		↑	1	15		↓	1	6	

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 191

Report Title	Engagement Committee Assurance Report – 4th December 2019
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	Martin Whittle, Vice Chair and Lay Member for PPI

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Martin Whittle, Vice Chair and Lay Member for PPI				
Which committee has the subject matter been through?				Engagement Committee				

Recommendations

Governing Body are asked to **NOTE** the contents of this report for assurance, including the assurances given on progress with the Organisational Effectiveness and Improvement 30/60 day action plans.

Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 4th December 2019. This report provides a brief summary of the items transacted for assurance.

Wound Care Update

Following a presentation earlier in the year on the implementation of the new wound care pathway across Derbyshire, Engagement Committee received an update on progress. Since the last meeting work progressed considerably. Clinics in most areas have been set up successfully.

Of 21 Friends and Family Test forms completed about the service, 17 of those were extremely likely to recommend, 3 likely, 1 neither likely nor unlikely. Comments had included that staff were professional and service was efficient and overall feedback was very positive. Three complaints had been received, one around travel and two relating to clinical concerns, currently under investigation.

The only issue is around Derby City clinics due to difficulties in identifying more clinics and in recruiting staff. Demand is much higher than expected and service is struggling to meet demand. The team are working with practices to develop an interim care model based on shared care between DCHS and practices to ensure patient safety is not compromised.

A further update was requested; however it was felt appropriate that this is handed over to the Quality & Performance Committee as this relates to matters of patient experience, rather than patient engagement.

NHS 111

The Committee received a presentation on the NHS 111 service and was asked for advice and guidance how to engage further with the local population. A number of suggestions were made that can be factored into our ongoing engagement around all urgent care services. A particular theme related to the possibilities of educating young people about service use to influence the conversations they may have with their parents and also their own behaviour in future years.

Engagement In Belper

The Committee received a briefing on the plans to conduct further engagement with people in Belper. This has resulted following a change of location of the proposed new health development in the town, from the original Derwent Street site to a new facility on the site of the existing Belper Health Clinic. Staff and PPG briefings took place on 17 December, followed by a drop-in session for local people on 8 January 2020. This was discussed as a confidential item, due to the restrictions placed upon the CCG by the purdah guidance issued in the pre-election period.

Communications and Engagement Strategy

A presentation was given on the initial thinking to support both the CCG and Joined Up Care Derbyshire Communications and Engagement Strategies which are now in development. Articulating the challenges presented to our communications and engagement, including the challenges local people face in navigating a complex health and care system, and the cultural shift from an illness to a wellness service delivered increasingly in communities will help to inform the efforts of communications and engagement professionals in the County.

Organisational Effectiveness and Improvement 30/60 Day Actions

The Engagement Committee received an update on Quarter 3 communications and engagement actions identified for delivery by the Organisational Effectiveness and Improvement Board:

- the development of a revised Communications and Engagement Strategy for the CCG; and
- the parallel requirement for robust engagement programme to support the development of the CCG's Commissioning Strategy.

Risk Report

The Engagement Committee received its routine risk report following discussion at previous meetings about the papers presented to the committee on risk. The following amendments were made to the risks:

- Risk 31, which relates to the engagement processes to support place, has been reworded to ensure it captures the need to engage in and promote the mechanisms of Place Alliances, in comparison to the separate need to ensure there is real engagement in the potential transformation of services that are driven through Place.
- Risk 33 related to the engagement required to support the refresh of the STP Plan, ahead of submission to regulators in November. A comprehensive engagement programme was delivered, and this risk has now been closed. Two new risks will be developed in relation to the STP for review at the January meeting of the Engagement Committee:
    - Engagement processes to support the implementation of the STP Plan - (transformation/service delivery risk)
    - Engagement processes to support the strategic direction towards becoming an Integrated Care System (ICS) – (planning risk)

Citizen's Panel – Results from first Digital Survey

The results from the first official survey run through the Citizens' Panel were presented to the Committee. The survey related to Online Access to Health Services and produced some

interesting insights, which have been shared with the system's digital work stream.

Teething problems were experienced with the data collection, with the results of self-selecting members of the panel being combined with non-self-selectors, therefore making the differentiation of views impossible. This is a key test of the panel, seeking to establish whether the opinions of those traditionally giving their views on local healthcare differ from people who haven't previously been involved or asked. This issue will be ironed out for future surveys.

Joined Up Care Derbyshire Plan Refresh

The Committee was informed that the refreshed STP plan was submitted to regulators on 15 November 2019. There would be a delay in publishing the final version due to election and the timings with national aggregated announcements. A summary version of the plan was in production, to be brought to the January Engagement Committee for review.

Are there any Resource Implications (including Financial, Staffing etc)?

None identified.

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

A PIA is not found applicable to this update. This report is for assurance and information.

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

A QIA is not found applicable to this update. This report is for assurance and information.

Has an Equality Impact Assessment (EIA) been completed? What were the findings?

An EIA is not found applicable to this update. This report is for assurance and information.

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below

Not applicable to this update. This report is for assurance and information.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below

Not applicable to this update. This report is for assurance and information but describes a range of patient, public communications and engagement activity across the breadth of CCG work.

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

Identified risks are progressing for inclusion in the GBAF. Any further risks highlighted and assigned to the Engagement Committee will be linked to the Derbyshire Board Assurance Framework.

Identification of Key Risks

Noted as above.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 192

Report Title	Primary Care Commissioning Committee Assurance Report
Author(s)	Hannah Belcher, Assistant Director GP Commissioning and Development
Sponsor (Director)	Clive Newman, Director GP Commissioning and Development

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Gillian Orwin, Chair (Deputy)				
Which committee has the subject matter been through?				Primary Care Commissioning Committee				

Recommendations

The Governing Body is requested to **NOTE** the following reports were presented to the Primary Care Commissioning Committee (PCCC) public meeting held on Wednesday 18th December 2019:

- Terms of Reference for Primary Care Commissioning Committee (for discussion)
- Finance report for Month7 (for assurance)
- Update on Overseal Surgery Practice Closure (for assurance). Overseal Surgery will be closing to patients with effect from the 31st January 2020 following the retirement of the partners

Report Summary

Monthly finance report with the month 7 position was presented to the PCCC public meeting for assurance and the Terms of Reference for PCCC were discussed. The committee also received a copy of the patient letter regarding the closure of the Overseal Surgery following the retirement of the partners for information and assurance.

The ratified minutes of the PCCC are included on the agenda for the Governing Body on a monthly basis. The minutes includes the detail and decisions relating to the discussion on each agenda item considered by this Committee. The ratified minutes from the November public meeting of the PCCC meeting is included within the Governing Body papers. The ratified minutes of the Primary Care Commissioning Committee meeting held on Wednesday 18th December 2019 will therefore be received at the February Governing Body meeting.

Are there any Resource Implications (including Financial, Staffing etc)?
N/A
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
Declaration provided at the beginning of the meeting and raised for any specific agenda items and recorded in the minutes.
Governing Body Assurance Framework
Considered for each agenda item.
Identification of Key Risks
Considered for each specific agenda item – no risks identified for the PCCC finance report this month.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 193

Report Title	Risk Register Report – 31st December 2019
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager
Sponsor (Director)	Helen Dillistone – Executive Director Corporate Strategy & Delivery

Paper for:	**Decision**	X	**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	Engagement Committee – 4th December 2019. Clinical & Lay Commissioning Committee – 12th December 2019. Primary Care Commissioning Committee – 18th December 2019. Finance Committee – 19th December 2019. Quality and Performance Committee – 19th December 2019.							

Recommendations

The Governing Body is asked to **RECEIVE** and **NOTE**:

- the Risk Register Report;
- Appendix 1 as a reflection of the Very High Risks of the organisation as at 31st December 2019; and
- Appendix 2 which summarises the movement of all risks during December 2019.
- **APPROVE** closure of Risks 033 and 035.

Report Summary

This report presented to the Governing Body is prepared as a Risk Register Report to highlight the areas of organisational risk that are recorded in the Derby and Derbyshire CCG Corporate Risk Register (RR) as at December 2019.

The RR is a live management document which enables the organisation to understand its comprehensive risk profile, and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a Committee who review new and existing risks each month and agree removal of fully mitigated risks. The

Very High Scoring Risks (15-25) are presented to the Executive Team meeting on a monthly basis. For the purpose of this report, all current risks to the organisation are presented to the Governing Body.
Are there any Resource Implications (including Financial, Staffing etc)?
The Derby and Derbyshire CCG prioritises effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this update.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this update.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this update.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update.
Governing Body Assurance Framework
Risks recorded in the Risk Register are aligned to the appropriate Strategic Risk recorded in Governing Body Assurance Framework.
Identification of Key Risks
The paper provides a summary of the very high scoring risks as at 31st December 2019.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 31 DECEMBER 2019

1. INTRODUCTION

This report describes all the risks that are facing the organisation.

In order to prepare the monthly reports for the various committees who own the risks, updates are requested from the Senior Responsible Officers (SRO) for that period, who will confirm whether the risk:

- remains relevant, and if not to be closed;
- has had its mitigating controls that are in place reviewed and updated;
- has been reviewed in terms of risk score.

All updates received during this period are highlighted in red within the Very High Risk Register in Appendix 1.

The Executive Team also received the Very High Risk Report and updates at their meeting on 11th December 2019.

2. DERBY AND DERBYSHIRE CCG RISK PROFILE – DECEMBER 2019

The table below provides a summary of the current Derby and Derbyshire CCG risk profile.

Derby and Derbyshire CCG Risk Register as at December 2019

Risk Profile	Very High (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)	Total
Total number on Risk Register reported to GB for December	6	13	2	2	23
New Risks	0	0	0	0	0
Increased Risks	0	0	0	0	0
Decreased Risks	0	0	0	0	0
Closed Risks	0	1	0	1	2

Appendix 1 to the report details the very high scoring risks (15-25) for the CCG. Appendix 2 to the report details all the risks for the CCG and the movement in score and the rationale for the movement.

3. COMMITTEES – DECEMBER VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

Three Quality and Performance Committee risks are rated as very high (15-25).

Risk 002: The risk score is 20 (Probability 5, impact 4):

The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in failure to meet the Derbyshire wide CCG constitutional standards and quality statutory duties.

December Update

The current Remedial Actions Plans have been reviewed and are updated on a monthly basis for discussion at Contract Management Delivery Group (CMDG).

The system-wide Organisational Resilience Group (ORG) meets on a weekly basis to discuss & escalate Urgent Care issues and take a PMO approach to projects to remedy current issues.

Risk 007: The risk score is 16 (Probability 4, impact 4):

Transforming Care Plans (TCP) are unable to maintain and sustain the performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst the CYP TCP is rated Green. The main risks to delivery are within market resource and development, with workforce provision as the most significant risk for delivery.

December update

The national expectations for CCGs were revised in September, and identify a CCG requirement to visit all Out Of Area placements every 6/8 weeks. New guidance in support of this delivery is awaited.

Risk 030: The risk score is 15 (Probability 5, impact 3):

The description of the risk is: Non-compliance of completion of Initial Health Assessments (IHAs) within statutory timescales for children in care due to the increasing numbers of children/young people entering the care system. This may have an impact on children in care not receiving their initial health assessment as per statutory framework**.**

December Update

Compliance for IHAs continues to improve slightly, although it has been acknowledged by the local area that further work is required. An IHA

pathway multi-agency meeting was held on 13th December 2019 to explore the barriers. The outcome of this is to be included in the January 2020 update.

3.2 Finance Committee – Very High Risks

One Finance Committee risk is rated as very high.

Risk 027: The risk score is 15 (Probability 3, impact 5):

DDCCG has a £61m underlying deficit at the start of 2019/20, an in year deficit control total of £29m and £69.5m of approved savings plan. There is a significant risk that the CCG will fail to meet its statutory financial duties in 2019/20.

December Update

This risk remains live and continues to be discussed in relevant meetings to ensure financial risks are mitigated and understood.

At month 8 the CCG reported a YTD overspend of £9.2m which is in line with the plan. The CCG has now received the 2nd quarter of Commissioner Sustainability Fund (CSF), which means the forecast outturn is now £18.9m overspent which is again in line with the planned CSF adjusted Control Total. If the financial position remains in line with the plan the CCG is eligible for £29m of CSF, of which £10.2m has been received to date. If this happens the CCG will be able to report a breakeven position. Within this position the CCG has reported £5.7m of risk, which includes £2.9m related to Acute Provider activity and £2.0m on Practice Prescribing. This is being mitigated by contingencies, none of which is being used to support the YTD position.

There remains a genuine risk that the CCG will fail to meet its statutory financial duties in 2019/20, although as we get closer to the end of the financial year this risk reduces. We are about to enter the winter months when any significant increases in activity are traditionally seen, therefore it is not possible to fully forecast the financial position. After assessing the M8 QIPP savings delivery position the CCG is now reporting a £21.4m end of year under-delivery against the £69.5m plan. The CCG has undertaken a thorough assurance process of all QIPP savings schemes and all risk is now included in the forecast position. No additional risk to QIPP savings has been reported but should any risk materialise, sufficient mitigation should be available.

Whilst the current level of forecast risk can be mitigated there is no other mitigation available if the forecasted financial position were to deteriorate further.

3.3 Primary Care Commissioning Committee – Very High Risks

Two Primary Care Commissioning Committee risks are rated as very high.

Risk 009: This risk score is 16 (Probability 4, impact 4*):*

The description of the risk is: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.

December Update

An update will be provided for Governing Body, following the Primary Care Commissioning Committee on 18th December.

Risk 015: This risk score is 20 (Probability 4, impact 5):

The description of the risk is: Due to the increased pressures around workload, workforce and financial concerns, there is a risk to General Practice in providing quality primary care services to patients.

December Update

This risk remains static. An update will be provided for Governing Body, following the Primary Care Commissioning Committee on 18th December.

4. DECEMBER OVERVIEW

4.1 Increased risk(s) since last month

No risks have increased in score since last month.

4.2 Decreased risk since last month

No risks have decreased in score since last month.

4.3 Target Risk Scores

There are no risks with a risk score lower than the target score.

4.4 Closed risk since last month

Two risks have been closed since the last report.

1. Risk 033: Lack of engagement in Derbyshire STP refresh in 2019, may mean the Derbyshire system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development.

The Engagement Committee reviewed this risk at its meeting on 4th December and agreed to close the risk now that the STP Plan Refresh has been submitted.

2. Risk 035: The current Gamete Storage policy does not include provision for gamete storage for transgender patients. Under the Equality Act – Transgender is a protected characteristic and as such should not be discriminated against. To update the policy would require agreement at CPAG and FRG (investment required).

   At the Clinical and Lay Commissioning Committee (CLCC) held on 14th November 2019, the policy was ratified including the protected characteristic. The policy was uploaded to website, PALs informed and Engagement planned.

   At CLCC this risk was recommended for closure to December Governing Body.

4.5 New risks since last month

No new risks are identified since last month.

5. RECOMMENDATION

The Governing Body is asked to **RECEIVE** and **NOTE**:

- The Risk Register Report;
- Appendix 1 summary as a reflection of the very high risks facing the organisation as at 31st December 2019;
- Appendix 2 which summarises the movement of all risks in December 2019; and
- **APPROVE** closure of Risks 033 and 035.

Appendix 1 - Very High Risks - December 2019

NHS
Derby & Derbyshire
Clinical Commissioning Group

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
002	**19/20**	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	Quality and Performance	Constitutional Standards/ Quality	3	4	12	1) **Governance of Operational/Performance Management:** Derby and Derbyshire CCG representatives chair the monthly Operational Resilience Group (ORG) which is represented by all NHS Provider Organisations and both Local Authorities. The ORG is charged with the responsibility of proposing a series of mitigating actions to the drivers of adverse A&E 4 hour performance, to the A&E Delivery Board. 2) **Provider led mitigations:** The CRH, working closely with Community and Local Authority Organisations, are focussing on methods to reduce Delayed Transfers of Care as a means to provide bed capacity to promote better flow. In addition, the CRH continue to open a number of extra "winter" beds to meet demand. The UHDB are using agency staffing as a way of mitigating the shortfall in Tier 4 Registrar Capacity (where the current vacancy rate is 3.44 WYE).	ORG/A&E Delivery Board Actions: Taking a PMO approach to system-wide projects including: - Undertake a system wide demand and capacity analysis to understand the drivers of performance at both the CRH and UHDB. - Enabling the direct booking of GP appointments via 111, when clinically appropriate. - Increased Clinician to Clinician contact availability to assist EMAS clinical decision making and avoid unnecessary conveyances. - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. - Proactively manage High Intensity Users of urgent care to avoid their need to use emergency services. - Providing PCN-based enhanced care in Care Homes to improve quality and reduce unwarranted referrals. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - Expanding the mental health Crisis Service and enhancing the home treatment offer to improve gatekeeping. - Increasing A&E Mental Health Liaison team capacity to speed up response times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Establishing an Orthopaedic Assessment Unit at RDH to treat patients in a more appropriate setting and improve flow. - Establishing a Surgical Assessment Unit at CRH to treat patients in a more appropriate setting and improve flow. - Increased GP Streaming at UHDB through commissioning changes and staff upskilling. - Embedding a weekly review process for patients with a length of stay of 21+ days in acute trusts. - Understanding Community demand and capacity to support the Improving Flow D2A pathways in South and City. - Increase OPAT capacity to enable more patients to be discharged from acute hospitals on IV antibiotics. - Altered handovers to enable more timely transfers from MAU/AAC to base wards at UHDB. CRH Actions: Maintain a level of "winter" bed provision as necessary and focus on Red2Green delivery. UHDB Actions: Maintain a level of "winter" bed provision as necessary and focus on Red2Green delivery. In addition, all staff, except for ANP staff, are now using the MetricAid electronic rostering system to ensure maximum staffing of shifts.	December update: November - CRH reported 62.9% (YTD 74.7%) and UHDB reporting 63.3% (YTD 68.2%). CRH - The trust continue to experience a high number of attendees compared to 2018/19 with 11.7% more attendances during Nov2019, resulting in OPEL4 being declared during the month. Many of these extra patients are frail elderly or patients with respiratory conditions, with a noted rise in abdominal pain presentations. The numbers of these are being clarified. The acuity of the attendances is increasing, with 20.3% of A&E attendances resulting in admission to either an assessment unit or a ward during November. There is continued difficulty recruiting to middle grade and consultant medical posts. UHDB - The volume of patients has increased with an annual 6.7% increase of Type 1s, averaging at 25 more patients per day and reaching as many as 589 attendances one Monday (25th November). The acuity of the conditions presented has also increased, with 47.2% of attendances classed as Major and an average of 29 patients per day classed as Resus. 24.7% of attendances result in admission to either an assessment unit or an inpatient ward. In actual terms there are an average of 9 extra admissions per day compared to 2018/19 (an 11.2% rise). There has been an overall rise in patients classed as Major, with a rise in the numbers of these patients being treated by the appropriate clinicians but in the Minors area. On a day-to-day basis the numbers of patients arriving at ED rises during the morning and arrivals remain high through the afternoon & evening. Discharges of minor patients are also high during this time but the major & resus discharges are not, culminating in a higher number of patients classed as 'In Department' by late afternoon. This coincides with more inpatient discharges being delayed until around 4pm, reducing the bed capacity and therefore delaying admissions from ED. The current Remedial Actions plans have been reviewed and are updated on a monthly basis for discussion at CMDG. The system-wide Organisational Resilience Group (ORG) meet on a weekly basis to discuss & escalate Urgent Care issues and take a PMO approach to projects to remedy current issues.	5	4	**20**	5	4	**20**	**3**	**3**	**9**	CRH - March 2019 - UHDB ongoing issues	Linked to Strategic Risks 1, 3, 4, 5, 6	Dec-19	Jan-20	Zara Jones Executive Director of Commissioning Operations	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations
007	**19/20**	TCP Unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated Green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality and Performance	Quality/ Reputational	3	4	12	• System leadership group meets bi-monthly to review performance and address system issues, chaired by CCG SRO. • System wide plan developed identifying priorities for joint action and delivery • Additional funding and capacity in place for crisis response and forensic • Quality standards in place within contracts for NHS providers monitored monthly • Investment in Speech and Language Therapist for mental health wards to improve formulation in mental health care. • Contractual recovery plan for NHS LD specialist inpatient assessment and treatment to be completed by end June with expert input from national leads 9 July 2019. • Weekly system pressures meetings in place with CCG and system partners.	• NHSE assurance meetings continue monthly. * TCP Executive Board has increased frequency to meet monthly * TCP Delivery Group agreed to meet weekly during October/November * AMH OOA plan in place and agreed with NHS E/I * Reduction in monthly admissions into AMH beds required * Improvements in discharge planning required	* We remain non-compliant to the revised national trajectory. * New national monitoring arrangements announced in September 19, CCG requirement to visit all OOA placements every 6/8 weeks * Programme identified as "challenged" by NHS E/I in relation to achievement of trajectories. * Detailed stock-take undertaken and recovery action plan completed and submitted to NHS E/I * Monthly review and monitoring of agreed actions through programme delivery group * Qualitative service review visit undertaken 17 & 18th Sept by national LD leads, EBE and regional TC manager confirmed system wide areas for improvements * Specialist Supported living providers market development undertaken in Oct 2019 to support procurement process. * £245k Additional monies received from NHS E to support reduction in admissions and expediting discharges. * Attendance at regional meeting with national TCP lead and regional perfotrmance lead highlighting areas for improvements * Additional monies available to expedite discharge. All cases beign reviewd to confirm clinical appropriateness of expediting discharge plans * New guidance expected following publication of findings following review of Bethany's case by NHS i/E and House of commons human rights committee * TCP Executive Board meeting monthly * TCP Delivery Group meeting weekly * December 19 Update - No further update required	4	4	**16**	4	4	**16**	2	3	**6**	April 2020	Links to Strategic Risks 1, 3, 4, 5, 6	Dec-19	Jan-20	Brigid Stacey - Chief Nursing Officer	Jennifer Stothard - Transforming Care Delivery Manager for Learning Disabilities and/or Autism Programme Derbyshire Partnership
009	**19/20**	Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.	Primary Care Commissioning	Primary Care	5	4	20	**Early warning systems**: CCG works with LMC and other partners to systematically identify and support practices that may be in trouble, including: reviewing information on practice performance via an internal, cross directorate review of practices looking at a range of data sources; linking with the LMC to pool soft intelligence on practice 'health' and to jointly support struggling practices; directly approaching practices identified as at risk **CCG support: C**CG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. These include: monitoring and funding additional workforce; delivering training and support to improve resilience; funding increased capacity; supporting practices to manage workload **Peer support:** the Primary Care Networks will provide a way that practices can support each other in smaller groups. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices who are not willing to approach the CCG directly **Strategy**: implementation of the CCG's primary care strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual practice failure	The Derbyshire wide Primary Care Strategy agreed and in place. Primary Care Networks (PCNs) established county wide. PCNs undertaking self-diagnostic to establish current position and development needs. Funding identified to support development. First cross directorate review meeting of practice data set for September. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV workstreams. Assurance provided to NHS England/JUCD through monthly returns and assurance meetings.	Development and implementation of Derbyshire wide Primary Care Strategy. Implement STP/Derbyshire wide plans to invest in and develop practices at scale Continue to work with LMC, Federations and emerging groups to support sustainability of general practice. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support / resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV workstreams. Assurance provided to NHS England / JUCD through monthly returns and assurance meetings. Rationale for the Very High Risks Scores It is the view of the Primary Care Team and the Primary Care Commissioning Committee that the risks need to remain at their current risk scores. Whilst the CCG continues to mitigate the risks in this area we do not feel we can downgrade the risk at the moment. There are a number of reasons for this: the number of GP practices; the independent nature of GP practices; the disproportionate effect that even a single practice closure would have on its registered patients. Even one small practice out of the 115 failing to deliver can have a disproportionate effect on the registered list population. The Primary Care Commissioning Committee will keep the very high risks scores under review and will update the Governing Body accordingly. Reviewed September 2019, no further update but revised target date. The risk is discussed at PCCC every month , currently the committee is satisfied by the mitigation that are being applied to manage the risk It is the opinion of the committee that the risk is maintained at this level Update will be provided for December following Primary Care Commissioning Committee on 18th December 2019	4	4	**16**	4	4	**16**	4	3	**12**	November 2019	Links to Strategic Risks 1, 3, 4, 5, 6	Dec-19	Jan-20	Dr Steve Lloyd - Medical Director	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
015	**19/20**	Due to the increased pressures around workload, workforce and financial concerns, there is a risk to General Practice in providing quality primary care services to patients.	Primary Care Commissioning	Primary Care	4	5	20	**Primary Care Quality Team**: team providing monitoring of and support to practices county wide **Primary Care Quality and Performance Committe**e: to oversee monitoring and support to practices and identify risks to quality at an early stage **Cross directorate internal review (hub) process** - agreed to bring together multiple data sources and teams to gain collective view on quality of care offered and identify areas of best practice and areas of concern where support or intervention is needed **Supporting Quality Improvement visits:**18 month rolling programme of practice visits with a focus on quality and support **Clinical Governance leads meetings** established to share best practice and be conduit for best practice and practice concerns **Quality Schedule**: being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding - following model developed with acute and other provider organisations	Primary Care Quality Team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well. Work is ongoing on development of quality schedule. Production of a Primary Care dashboard being finalised, review of quality resporting methodology and governance structures to PCCC being undertaken.	Primary care quality team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well Work ongoing on development of quality schedule Production of a Primary care dashboard being finalised , review of quality reporting methodology and governance structures to PCCC being undertaken. Rationale for the Very High Risks Scores It is the view of the Primary Care Team and the Primary Care Commissioning Committee that the risks need to remain at their current risk scores. Whilst the CCG continues to mitigate the risks in this area we do not feel we can downgrade the risk at the moment. There are a number of reasons for this: the number of GP practices; the independent nature of GP practices; the disproportionate effect that even a single practice closure would have on its registered patients. Even one small practice out of the 115 failing to deliver can have a disproportionate effect on the registered list population. The Primary Care Commissioning Committee will keep the very high risks scores under review and will update the Governing Body accordingly. No update for September 2019. The risk is discussed at PCCC every month , currently the committee is satisfied by the mitigation that are being applied to manage the risk It is the opinion of the committee that the risk is maintained at this level Update will be provided for December following Primary Care Commissioning Committee on 18th December 2019 This risk remains static.	4	5	**20**	4	5	**20**	4	4	**16**	March 2020	Links to Strategic Risks 1, 2, 3, 4, 5	Dec-19	Jan-20	Dr Steve Lloyd - Medical Director	Marie Scouse - Assistant Chief Nurse Primary Care
027	**19/20**	DDCCG has a £61m underlying deficit at the start of 2019/20, an in year deficit control total of £29m and £69.5m of approved savings plan. There is a significant risk that the CCG will fail to meet its statutory financial duties in 2019/20	Finance	Finance	5	5	25	• The CCGs have in place a medium term financial recovery plan that sets out the projected financial 'do nothing' position and the QIPP schemes to mitigate this position to enable delivery of the assumed control total. • The GB have approved £69.5m of savings in 2019/20. These schemes are support by PIDs and where possible have been included in provider contracts • The Executive led Finance Recovery Group, accountable to the Derbyshire Finance Committee, meets weekly to oversee progress on the plan and instigate actions where necessary. • The JUCD Chief Executives meet regularly to oversee progress against setting, agreeing and delivering a system 2019/20 plan. • At plan stage the Derbyshire CCGs are holding a 0.5% uncommitted risk contingency • Medium term financial plan and annual financial plan have been signed off by the Governing Body • Budgets have been set with budget holders and then approved by the Governing Body • The budgets are aligned to Executive Directors ensuring senior oversight and management of budgets. • There is a budget escalation process in place overseen by the FRG and the Derbyshire Finance Committee	• Regular reporting to Derbyshire Finance recovery Group, Finance Committee and Governing Body. • Regular reporting on planning progress to JUCD Board • Regular discussions internally and externally to assess the delivery and robustness of the system finances	This risk remains live and continues to be discussed in relevant meetings to ensure financial risks are mitigated and understood. At month 8 the CCG reported a YTD overspend of £9.2m which is in line with plan. The CCG has now received the 2nd quarter of Commissioner Sustainability Fund (CSF), which means the forecast outturn is now £18.9m overspent which is again in line with the planned CSF adjusted Control Total. If the financial position remains in line with plan the CCG is eligible for £29m of CSF, of which £10.2m has been received to date. If this happens the CCG will be able to report a breakeven position. Within this position the CCG has reported £5.7m of risk, which includes £2.9m related to Acute Provider activity and £2.0m on Practice Prescribing. This is being mitigated by contingencies, none of which is being used to support the YTD position. There remains a genuine risk that the CCG will fail to meet its statutory financial duties in 2019/20, although as we get closer to the end of the financial year this risk reduces. We are about to enter the winter months when any significant increases in activity are traditionally seen, therefore it is not possible to fully the financial position. After assessing the M8 QIPP savings delivery position the CCG is now reporting a £21.4m end of year under-delivery against the £69.5m plan. The CCG has undertaken a thorough assurance process of all QIPP savings schemes and all risk is now included in the forecast position. No additional risk to QIPP savings has been reported but should any risk materialise, sufficient mitigation should be available. Whilst the current level of forecast risk can be mitigated there is no other mitigation available if the forecasted financial position were to deteriorate further.	3	5	**15**	3	5	**15**	**2**	**5**	**10**	March 2020	Links to Strategic Risks 1, 2, 6	Dec-19	Jan-20	Richard Chapman, Chief Finance Officer	Darran Green-Assistant Chief Finance Officer
030	**19/20**	Non-compliance of completion of initial health assessments (IHA's) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	Quality and Performance	Corporate	5	3	15	Implementation of additional medical advisor capacity. Monthly and quarterly analysis of performance.	Completion of Multi-agency IHA Action Plan. Increasing numbers of children/young people entering care. Multi-agency compliance with timescale pathway.	The multi-agency action plan continues to be implemented by the Children in Care team at Chesterfield Royal Hospital and Derbyshire County Council. There requires a period of time for the new pathway to be embedded. There was meeting planned for this week between all agencies to review and update the action plan but this has been rearranged due to the inspection at Derbyshire County Council this week. The risk is anticipated to be reduced as the new pathway becomes embedded into multi-agency practice. The risk currently remains as the compliance rate continues to drop for Initial Health Assessments therefore we are not in a position to reduce the risk at present. Action plan continues to be implemented - performance stable as of the end of June 2019. The multi-agency pathway is now in place, however performance has yet to show improvement therefore the risk remains the same until the pathway becomes fully embedded into practice. <u>September update:</u> Perfomance has improved slightly at the end of July as a result of the multi-agency pathway being embedded. There is currently sufficient clinic capacity to provide appointments within the 20 working day statutory timescales, however this has been reliant on a low number of children entering care during August and continues to be reviewed. The risk remains at 15 as the current improvement is yet to be sustained. October Update - perfomance has been stable but low at 32% compliance therefore risk remains high until improvements in complaince seen. There is currently sufficient clinic capcity to meet need. November Update: There is sufficient clinic capacity to meet the demands of children coming into care. There is another partnership meeting with Local Authority, CRH and Designated Professionals the beginning of December to explore how further improve compliance and processes within the system and review the IHA pathway (making any changes required). Performance is remaining stable but no significant improvements at this time. December update: Compliance for IHAs continues to improve slighthy, although it has been acknowledged by the local area that further work is required. IHA pathway multi-agency meeting held on 13/12/2019 to explore the blockages. Outcome to be included in January 2020 update	5	3	**15**	5	3	**15**	3	1	**3**	December 2019	Links to Strategic Risks 1, 2, 3, 4, 5	Dec-19	Jan-20	Brigid Stacey - Chief Nursing Officer	Heather Peet, Designated Nurse Looked After Children

Appendix 2 - Movement during December 2019

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason for Movement	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
002	**19/20**	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	**20**	5	4	**20**	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations
005	**19/20**	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	**12**	3	4	**12**	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Ed Ronayne - Safeguarding Adults Manager
007	**19/20**	TCP Unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated Green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	4	4	**16**	4	4	**16**	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Jennifer Stothard - Transforming Care Delivery Manager for Learning Disabilities and/or Autism Programme Derbyshire Partnership
009	**19/20**	Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.	4	4	**16**	4	4	**16**	⟷		Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
013	**19/20**	Wait times for psychological therapies for adults and for children are excessive. This risk has been reset from a general concern at availability of psychology and Mental health staff -concerns for which actions have been taken in 2017-19.DHcFT have made significant efforts to address recruitment and retention for nursing staff and their workforce planning is good despite a context of a nationally poor picture in available workforce) The difficulty appears to be a combination of varied productivity, poor data to make analysis of the problem outdated specifications and activity requirements coupled with significant and rising demand and national work force training issue. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care)	4	3	**12**	4	3	**12**	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Dave Gardner - Assistant Director of Procurement & Commissioning
014	**19/20**	Demand for Psychiatric intensive Care Unit beds PICU has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	4	3	**12**	4	3	**12**	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Dave Gardner - Assistant Director of Procurement & Commissioning
015	**19/20**	Due to the increased pressures around workload, workforce and financial concerns, there is a risk to General Practice in providing quality primary care services to patients.	4	5	**20**	4	5	**20**	⟷		Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Marie Scouse - Assistant Chief Nurse Primary Care

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason for Movement	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
018	**19/20**	There is a risk of failure to implement and embed compliance activities required in UK Data Protection Legislation.	2	4	**8**	2	4	**8**	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker, Director of Corporate Delivery
019	**19/20**	There is a risk of a successful cyber-attack, causing widespread disruption to systems and therefore the provision of services.	3	4	**12**	3	4	**12**	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Paul Hetherington - Associate Director of Digital Development, Chrissy Tucker - Director of Corporate Delivery
020	**19/20**	If the CCG does not maintain and review existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	**8**	2	4	**8**	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery
024	**19/20**	If the CCG fails to engage with the membership and does not put in place succession planning relating to recruitment to clinical support roles, this will lead to gaps in the organisation and decrease in performance.	1	3	**3**	1	3	**3**	⟷		Helen Dillistone, Executive Director of Corporate Strategy and Delivery	Governance	Beverley Smith, Director of Corporate Strategy & Development
027	**19/20**	DDCCG has a £61m underlying deficit at the start of 2019/20, an in year deficit control total of £29m and £69.5m of approved savings plan. There is a significant risk that the CCG will fail to meet its statutory financial duties in 2019/20	3	5	**15**	3	5	**15**	⟷		Richard Chapman, Chief Finance Officer	Finance	Darran Green-Assistant Chief Finance Officer
028	**19/20**	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	**9**	3	3	**9**	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning /Jennifer Stothard, TCP Delivery Manager
029	**19/20**	The Derbyshire CCGs incurred a significant recurrent underlying deficit in 2018/19. The CHC financial position continues to be challenging in 2019/20 and there is a risk that the underlying position could deteriorate, putting pressure on the achievement of the financial targets and increasing the gap on the 2020/21 financial plan.	3	3	**9**	3	3	**9**	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Nicola MacPhail, Assistant Director of Quality

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason for Movement	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
030	**19/20**	Non-compliance of completion of initial health assessments (IHA's) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	5	3	**15**	5	3	**15**	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Heather Peet, Designated Nurse Looked After Children.
031	**19/20**	Failure to develop engagement methods and process at Place level. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development.	2	3	**6**	2	3	**6**	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
032	**19/20**	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development.	2	4	**8**	2	4	**8**	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
033	**19/20**	Lack of engagement in Derbyshire STP refresh in 2019, may mean the Derbyshire system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development	3	4	**12**	3	4	**12**	⟷		Vikki Taylor -	Engagement	Sean Thornton Assistant Director Communications and Engagement
035	**19/20**	The current Gamete Storage policy does not include provision for gamete storage for transgender patients. Under the Equality Act – Transgender is a protected characteristic and as such should not be discriminated against. To update the policy would require agreement at CPAG and FRG (investment required).	1	1	**1**	1	1	**1**	⟷		Steve Hulme, Director of Medicines Management & Clinical Policies	Clinical & Lay Commissioning	Tom Goodwin, Head of Medicines Management and Clinical Policies & Decisions
036	**19/20**	Because the CCG has not yet made a decision regarding the provision of a Data Protection Officer for General Practice a required by NHS England, there is a risk of reputational damage and damage to GP relationships with the CCG where effective provision is not in place, leading to risks of non-compliance with UK data protection law.	2	3	**6**	2	3	**6**	⟷		Steve Lloyd, Medical Director	Governance	Paul Hetherington - Associate Director of Digital Development
038	**19/20**	Because of a lack of formal committee oversight of NECS performance reporting, the CCG is not receiving assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	4	**8**	2	4	**8**	⟷		Helen Dillistone, Executive Director of Corporate Strategy and Delivery	Governance	Paul Hetherington - Associate Director of Digital Development
039	**19/20**	The CCG and the System is facing significant pressure in relation to S117 aftercare costs. At M7, the CCG reported a forecast overspend of £3.1m to budget (there was some significant budget setting error at the beginning of the year and cost shift from CHC in year but real growth remains a concern) Derbyshire CC are O/S 1.5m to budget and Derby City circa £500k O/S to budget. (Generally S117 costs are split 50-50). S117 will also become a right to have as a Personal Health Budget from December 2019.	3	4	**12**	3	4	**12**	⟷		Zara Jones, Executive Director of Commissioning Operations	Quality and Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning /Dave Stevens, Head of Finance
040	**19/20**	Data Quality issue with University Hospitals Derby Burton (UHDB) with incorrect data being provided for several consecutive months during the current financial year.	3	4	**12**	3	4	**12**	⟷		Zara Jones, Executive Director of Commissioning Operations	Quality and Performance	Helen Wilson, Deputy Director of Contracting and Performance

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 194

Report Title	Joined Up Care Derbyshire Board Update
Author(s)	Vikki Taylor, Derbyshire STP Director
Sponsor (Director)	Chris Clayton, Chief Executive

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	X
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	Joined Up Care Board							

Recommendations

The Governing Body is asked to:

- **NOTE** the update provided from the Joined Up Care Derbyshire Board meetings held on 21 November 2019 and 19 December 2019; and
- Provide **COMMENT** on the content of the report to help inform information updates provided in future.

Report Summary

Joined Up Care Derbyshire (JUCD) Sustainability and Transformation Partnerships (STP) Strategic Plan Final Submission

The final plan was submitted on 15 November 2019, with a further window or revision opened to 6 January, where minor amendments were made. Publication of the report was delayed following the announcement of the General Election and publication will now take place in mid-January.

The system has worked hard together to ensure all submission deadlines have been met, including where guidance on submissions was delayed. The various programme leads, through discussion within their respective work-streams, have produced the outline business cases that have formed the basis of the plan. Subsequently, to meet the requirements in relation to the metrics, activity, workforce and finance, system planning leads have met on a weekly basis. The inclusion of workforce, finance and performance leads alongside the planning leads, working as one team, has proven to be an extremely effective approach in ensuring a better understanding of system and organisational issues and collectively coming up with solutions to address these.

Lessons learned from the process should be built upon to enable the way of working to improve as we move forward into the operational planning stages and continuing thereafter.

System Development and Board Effectiveness Review
JUCD Board is discussing the ways in which the system needs to develop as a partnership so that our staff and communities are supported to adapt to the new models of care delivery. Working together across organisations is a priority and must address the past barriers to change, including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and people-centred perspectives. We must make system-level working the default option - 'business as usual.

A system development plan Board effectiveness review is underway to support our aim to become an ICS by April 2021.

JUCD STP Governance
The JUCD Board ratified the Terms of Reference (ToR) for the key groups within the governance arrangements in October 2018. Following the ICS development programme, the overarching governance arrangements were amended; with approval in July 2019 that interim governance arrangements would be established to strengthen the arrangements, whilst we progress towards ICS status. All groups within the interim structure have formal ToR which have been approved through the Board and/or the System Executive CEOs group where they have been newly established since the October 2018 Board review.

A formal review of all groups will take place in the new year to align with the Board Governance and Effectiveness review.

JUCD STP Work-stream Challenge and Confirm meetings
A series of challenge and confirm sessions are underway with the JUCD work-streams to review progress and identify any emerging themes and issues that need system consideration or response. A full report on the outputs of the meeting will be presented to the January 2020 JUCD Board.

Gearing Up for 2020/21: The Next Five Months
The main focus of the last few months has been on developing the Five Year Plan. The focus of the next five months needs to be on three things:

- Delivering this year, particularly winter and the system control total.
- Refine the 5 Year Plan:
    - Agreeing the priorities where system working adds value and the transformation ask in these areas;
    - Further assurance on the triangularisation of activity, workforce and finance;
    - Implementation plans for next year around the areas we need to work as a system.
- Build the system capacity and capability so we enter 2020/21 in a stronger position to deliver and to give us a year to further strengthen our capacity and capability before we become an Integrated Care System (ICS) in April 2021;

Financial Position
The system is forecasting delivery of £100m of savings for this financial year. This is a significant achievement, although balanced somewhat by the fact that we are forecasting we will be £48m away from the final savings target for the year. The

CCG can take some measures to achieve its control total and financial balance this year, but those measures are not available to our acute trusts. The system continues to work together to understand and manage the risks to financial delivery.

Work is also underway across the system to understand how we will tackle the ongoing system financial challenge as we move to 2020/21, with an event held across all partner organisations to review the approach and begin to gather ideas, featuring constructive conversations about how the system will tackle the plan through working together to transform care.

Winter Plan
The Winter Plan for the Derbyshire Health System has been produced following extensive collaboration between partners across JUCD.

The plan seeks to address the core six asks of NHS England:
1. This winter the goal should, wherever possible locally, be more General and Acute (G&A) hospital beds open, to reflect increased levels of patient need and admissions.
2. Work with Local Authorities to ensure the same or more care packages and nursing /residential home beds are available over the winter period than last year, with the same level of visibility and dual sign-off of on these plans.
3. GP out of hours services should be expected to deliver services from 8pm to 8am 7 days per week, and critically, over bank holidays.
4. Ensure mental health services can respond quickly and comprehensively, particularly in relation to ED presentations.
5. Community health services able to operate to the same “clock-speed” of responsiveness as acute emergency services, e.g. 2 hour home response where that would avoid hospital admissions or speed discharge.
6. Improving the uptake of the flu vaccine.

Whilst each provider organisation in JUCD has its own operational plan for winter, this document draws together and links the planning activities of each to provide assurance that the system can provide an effective response to winter pressures.

With winter not yet in full flow, the system is already under significant pressure and the Board expressed its thanks all staff in health and social care who are working to ensure high quality care continues to be provided to people in Derbyshire.

Integrated Care Providers
The JUCD Board has approved a recommendation which will take our integration of joined up care for Derbyshire patients into a new domain. The Board has agreed a recommendation to develop four Integrated Care Providers (ICPs). The ICPs will require providers to increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place/PCN levels. The four ICPs will reflect the current Place Alliances in the following areas:
- Chesterfield, North East Derbyshire and Bolsover
- Derby City
- South Derbyshire, Amber Valley and Erewash
- Derbyshire Dales and High Peak

A detailed briefing to help colleagues understand how ICPs will work within an Integrated Care System, and the ongoing work of Place Alliances and Primary Care Networks will follow early in the New Year, and there will be detailed discussions taking place with all partners, including district and borough councils, ahead of a detailed proposal coming back to Board in March. Early priorities will be for the ICPs to understand their leadership teams and to reflect on the population health issues that are affecting their local populations.

Midlands System Review Meeting with NHS Improvement/ England
The recent Derbyshire System Review meeting was focused on operational in-year performance, the NHS long term plan, strategic service transformation and the Integrated Care System development plan.

There was support for the financial planning approach taken within Derbyshire in our STP Plan submission, and recognition of the work to date to develop our system ways of working, particularly ICP development. Key areas highlighted as requiring greater system focus and resolution included 12 hour breaches, waiting times for cancer patients, as well as reducing long length of stay to support the management of winter pressures.

In terms of planning, the intended development of a local Psychiatric Intensive Care Unit (PICU) facility by 2023/24 was noted. Workforce was highlighted a number of times during the discussion as requiring greater focus, in particular a need to model the impact of our future workforce plans, for example on projected agency spend.

Patient Stories
JUCD Board hears a patient story at the start of each meeting; in November, the Board heard what is perhaps a fairly standard story of patient journey from admission to discharge, where the care provided was excellent and the outcomes were good.

The issues lay in the non-clinical elements, which might have been more efficient. These included the ready availability of equipment and the use of taxis to transport medication. The Board reflected on how these elements can be addressed and respective organisations who share the patient stories will take forward any actions with partners, but where we think there may be further opportunities to reflect and address the issues highlighted, the appropriate programme boards will be asked to take forward.

In December the Board heard Mark & Rebecca's Story, which focussed on Mark's diagnosis with lung cancer, and how latterly it had spread to his brain. Having received good care from the NHS, Mark, Rebecca and their family received exceptional home care from Blythe House to support them in Mark's final weeks of life.

The story highlighted the way in which services get things right for patients, how services can ask 'what matters to patients', rather than 'what is the matter with them' and emphasised how we are working through the STP to linkup our operational plans to implement the system's End of Life strategy, including care beyond traditional health care services.

Health of the Population
There has been a number of discussions at Board and also between the CCG and local authorities. There are a few NHS organisations which are further head in engaging with this agenda and recent research published by The Health Foundation describes an approach being adopted across a number of these organisations.

This focuses on the NHS as an employer, a purchaser and commissioner of social value, a land and capital asset holder, a leader for environmental sustainability and a partner across place. We need to agree what the role of the ICS is in prevention and addressing the health determinants and how we work across the ICS and with other partners to do this. In doing this we need to ask how we enhance district, borough, City and County collaboration.

With the development of the STP and the Five Year Plan there is a need to look at how we strengthen and develop how we:

- Hear the voice of the public and patients, building on the work to date.
- Strengthen the voice of clinicians across the system and enhancing clinical leadership. Discussions have been had with clinicians from across the system as to how we can further strengthen the clinical voice and further discussions are planned for December. Dr Bhatia has been coordinating these discussions.
- Enhancing district, borough, City and County collaboration.
- Refresh communications and engagement strategic approach.

Proposals on these areas will come to the Board early in the New Year.

Developing Strategic General Practice Provider Leadership across Derbyshire
The CCG and General Practice have agreed a funding arrangement to enable the development of strategic general practice leadership. The key purpose of this funding is to form a representative mechanism connecting the forming Primary Care Networks (PCNs) at a Place and Derbyshire level to ensure that the voice of General Practice provision is heard, influences and has ownership and shared accountability for delivering the forming Derbyshire model of care. This includes providing a consistent and coherent representative General Practice provider voice at all of the required Derbyshire and Place based groups and at the required strategic meetings with the commissioner.

Cancer Alliance Transformation Funding Award
The Derbyshire STP will be allocated £1,224,000 transformation funding for projects to support delivery of cancer priorities as outlined in the 2019/20 Planning Guidance. A new accountability framework underpins the funding and provide a mechanism to oversee, support and monitor achievement of national cancer standards and priorities.

Following sign-off and endorsement of this accountability framework by both parties, the East Midlands Cancer Alliance (EMCA) will liaise with JUCD to enable the release of funding to support agreed cancer transformation projects. In receiving transformation funding the STP is expected to support delivery of projects in a way that supports equalities and reduce inequalities for their populations.

Transformation monies must be used to support immediate improvements in implementing national best practice pathways and ensure systems and processes are in place to enable the achievement of definitive diagnosis of cancer for all patients by day 28, by 2020. All trusts within JUCD are required to ensure delivery of all national cancer constitutional standards and develop project plans for the whole pathway of care to ensure compliance.

Experience and Lessons from Elsewhere
The NHS Confederation hosted a meeting of ICS/STP leaders. JUCD is encountering similar issues to other area in establishing our system working, but as a partnership and a Board we are more advanced in many areas. There are some areas however where there are opportunities to look at what is happening elsewhere including:

- Development of financial regimes and payment methods such as Staffordshire and Bradford;
- Working with Health and Wellbeing Boards in Coventry and Warwick.

As part of the system effectiveness work over the next three months, the JUCD Board will be looking at what can be gleaned from experience elsewhere. We are also planning to share experience with Nottinghamshire ICS (a first wave ICS) to see what we can learn from their experience, and Staffordshire.

Hearing the Voice of, and Engaging with, Key Stakeholders
Meetings of the JUCD Chair and local clinicians will result in a report which will (i) recommend ways to strengthen the way the Clinical and Professional Reference Group provides advice and assurance to the JUCD Board and workstreams, and the way the JUCD Board operates to enable this to happen and (ii) provide a map of clinical leads across the system.

As with clinical leadership, there has been some good work in developing mechanisms and strengthening communications with patients and the public. This is however work in progress and we are looking at how to build on this, learn from community engagement experience in local authorities and align this with the developing system architecture.

JUCD has been invited to be part of a 2nd cohort of STP's/ICS's looking at improving partnership working with the VCS, enhancing the role of the sector in strategy development and the design and delivery of integrated care. The 1st cohort has been evaluated and from this has emerged a model of good practice that they wish to roll out to a 2nd cohort. The programme recognises that the voluntary sector are a key strategic voice in the delivery of integrated and personalised care, helping to reduce health inequalities and deliver population health management, and are also a service provider in the broader pathway.

A meeting took place with key partners in the voluntary sector in November to progress this and it was agreed that we would align this work with the Integrated Volunteering Programme, which is focused on maximizing the contribution and impact of volunteering. The group agreed to form the steering group to drive this work forward.

Local Authorities
One of the themes emerging from the discussions with other ICS/STP chairs is the variable maturity in building collaboration with local authorities and building a vision which the NHS and local authorities as well as other stakeholders can own. We have begun meeting with members, chairs of Health and Wellbeing Boards and other key leaders to discuss this.

PICU Development
Work is progressing to enable the building of a new Psychiatric Intensive Care Unit (PICU) facility within Derbyshire. This will mean that patients will be able to be treated in Derbyshire rather than have to be treated outside of the county, as is the case now. The ambition is for the new build to be completed by quarter 3 of 2021/22.

Derbyshire Healthcare Foundation Trust are leading this development with the draft Outline Business Case due to be presented to their Trust Board in February 2020 for review and sign off. This is a significant development with an ambitious timeline, as such there are a number of caveats to delivery including financial, building considerations and planning approvals, stakeholder engagement, contractual and operational (recruitment).

Joined Up Careers Derbyshire
The first of our rotational health and social care apprentices have successfully completed the programme. The aim has been to develop individuals who have an understanding of health and social care, to prepare them for working in a more integrated, person centred way. The apprentices have completed placements at Royal Derby Hospital, London Road Community Hospital, Kingsway Hospital, St Oswald's Hospital, Perth House, the A&E streaming service and District Nursing Teams with DHU, and within the Private, Voluntary and Independent sector with Inspirative Arts, Derby Private Health and Derwent Lodge (Rethink).

All individuals have secured roles in Assistant Clinical Physiologist, Healthcare Assistant and Therapy Assistant positions. The support and commitment of teams across the system in supporting the placements and the programme is gratefully acknowledged. We are currently planning for a second, larger cohort to commence in March 2020.

System Quality & Performance Reporting
Understanding the measures of success across the health and care system is crucial to our understanding about how effectively we are working and ensuring we are delivering the best possible joined up care for local people.

The JUCD Board discussed in detail proposals for how we will begin to measure systematically the quality and performance of services in a collective manner, with the aim of bringing one single quality and performance report, informed through all partners, to the JUCD Board.

Improving Healthy Life Expectancy
There is currently an average of 17 years of a Derbyshire person's life that are lived in ill health, with one or more health conditions. There is detailed work taking place to understand what is driving this, to both increase life expectancy and reduce the

number of years lived in ill health. Working across CCG and Local Authority commissioners, we are looking to prioritise more spending and any available investment into these areas to benefit our population, and the Board will hear more about that at the February meeting.

Board Meetings in Public
Joined Up Care Derbyshire Board meetings will be held in public from January 2020. The first meeting will take place at The Hub, South Normanton on 16 January from 9am. Staff are welcome to attend and more information is available at **www.joinedupcarederbyshire.co.uk**

Are there any Resource Implications (including Financial, Staffing etc)?
None as a result of this report.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this report.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this report.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this report.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this report.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this report.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this report.
Governing Body Assurance Framework
To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
Identification of Key Risks
Not applicable to this report.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 195

Report Title	Derby Special Education Needs and Disability (SEND) Inspection - Written Statement of Action
Author(s)	Scarlett Milward, Senior Commissioning Manager and Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	X
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	Executive Team 4/11/2019 Quality and Performance Committee 28/11/19							

Recommendations

Governing Body are asked to **NOTE** the following:

- the Written Statement of Action (WSOA) has been shared with the Quality and Performance Committee and the Governing Body for assurance prior to publication;
- the WSOA was submitted to Ofsted and CQC to approve (ahead of the deadline 26th November);
- Ofsted and CQC have now formally accepted our local area WSOA as fit to tackle the 5 areas of weakness and noted our high priority in driving improvements;
- our plan has been published on Local Area websites and work has commenced to complete the actions;
- the Neurodevelopment assessment pathway is a key action in the WSOA for Health to consider. It is recommended that a separate paper be developed outlining options on this matter be submitted to FRG and CLCC for consideration; and
- the new governance arrangements.

Report Summary

Background

Inspection by CQC and Ofsted into the local Area provision of Special Educational Needs and Disability (SEND) took place in June 2019. As a consequence of regulators identifying areas of concern, Derby City Council and CCG were required to produce a Written Statement of Action (WSOA) to demonstrate how areas identified by the inspection can be improved. A repeat inspection will occur in 18 months' time.

The WSOA was produced in collaboration with partners across the Derby City system. The WSOA was submitted to Ofsted and CQC to approve (ahead of the deadline 26th November).

The regional director of OFSTED has now replied (letter dated 5th December) and confirmed that the plan has been accepted as fit to address the areas of weakness identified. It was noted that the WSOA has focus on driving improvement and has a good emphasis on

engagement with children and their families. Greater clarity on milestone dates was suggested as a helpful way to show progress.

This GB report provides assurance that DDCCG and Derby City Council have worked with key stakeholders to develop our Local WSOA. Our WSOA successfully identifies how, as a local area, we will address the five key areas identified and ensure we are effectively meeting the needs of Children and Young People with SEND.

The five key areas identified by regulators were:

1. Joint commissioning requires improvement.
2. A co-produced SEND strategy.
3. Improvements to the quality of Education Health Care Plans and their timeliness of delivery.
4. Systemic wait time issues.
5. Poor parental engagement and dissatisfaction.

In order to develop our local area WSOA, we held a series of key stakeholder events with parents, carers and frontline staff from health providers, schools, colleges and social care. The purpose of events was to gather feedback and to ensure that the WSOA addresses the key issues systematically and effectively.

As a local area we nominated two leads to co-author the plan, one from DDCCG and one from Derby City Council. To support delivery of the WSOA, we have had weekly WSOA catch up sessions with leaders from DDCCG and Derby City Council to ensure the development is on track.

New Governance
As introduced in earlier reports to GB and CLCC previously, as WSOA has now been accepted, the Governance arrangements to support delivery will change as proposed. The new SEND Board now has an independent chair and parent representation. The updated governance arrangements are as follows:

<u>Derby Local Area SEND Board:</u>

- Purpose to provide strategic direction and assure improvements are secured in accordance with the WSOA.
- Participate in the Department of Education and NHSE quarterly update meetings, Health and Wellbeing Board, Children and Families Learner Board and STP as required.
- DDCCG membership of the SEND Board to be Executive Director for Commissioning Operations supported by the Director for Mental Health, LD and CYP.

<u>Derby Local Area SEND Delivery Group:</u>

- Purpose to ensure the implementation of the key actions in the WSOA and report into Derby Local Area SEND Board.
- DDCCG membership: Head of Service Children's Commissioning – Mental Health and Wellbeing, Senior Commissioning Manager – with responsibility for SEND, Designated Clinical Officer.

<u>Derbyshire Footprint Health SEND Delivery Group</u>:

- Purpose to deliver the changes required to improve wait times to key health assessments, and report into Derby Local Area SEND Delivery Group.
- DDCCG Chair: Senior Commissioning Manager – with responsibility for SEND.

Work to deliver our plan within the next 18 months is progressing and reporting regularly into the SEND board and Joined Up Care Derbyshire Board Quarterly. DDCCG has developed a SEND action plan that is progressing through the re-established Footprint Health SEND Steering Group.

Internal Assurance Process
The WSOA has been shared with the Quality and Performance Committee (Q&P) on 28th November. A look back and evaluation/review paper will be presented on to Quality and Performance Committee in the New Year; further reporting will be through Q&P.

Are there any Resource Implications (including Financial, Staffing etc)?

There are a number of potential resource implications for DDCCG. The Executive Team have agreed that separate business cases should be developed and where appropriate submitted through relevant sub-committees for consideration. These relate to:

- improvements to the Neuro-development pathway to address issues related to capacity, demand and pre and post assessment support. The Neurodevelopment assessment pathway delivered by University Hospital of Derby and Burton requires review. This is a key action in the WSOA for Health to consider. It is anticipated that a mixture of capacity and demand management will be required as well as developing pre-assessment offers and services;
- capacity is required by DDCCG to improve and assure the quality of Education Health and Care plans. Additional Designated Clinical Officer time, as recommended in national guidance, may be required; and
- improvement in our communication and communication methods with parents, carers and front line staff will also be required.

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

N/A

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

N/A

Has an Equality Impact Assessment (EIA) been completed? What were the findings?

N/A

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below

N/A

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below

Parents Forum has produced an extensive review of parents' views in the "In My Shoes" report. The issues raised within this and in the inspection are being addressed within the WSOA and in a wider SEND strategy.

Have any Conflicts of Interest been identified/ actions taken?

None

Governing Body Assurance Framework
N/A
Identification of Key Risks
As set out in the inspection report if improvements set out in the WSOA are not delivered.

Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF DERBY AND DERBYSHIRE AUDIT COMMITTEE
HELD ON 23 SEPTEMBER 2019

ROBERT ROBINSON ROOM, SCARSDALE, CHESTERFIELD AT 2.30PM

Present:

Jill Dentith	Lay Member (Governance) Chair
Andrew Middleton	Lay Member (Finance)

In Attendance:

Richard Chapman	Chief Finance Officer
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Janet Dean	Client Manager, 360 Assurance
Ian Morris	Counter Fraud Specialist, 360 Assurance (part)
Frances Palmer	Corporate Governance Manager
Suzanne Pickering	Head of Governance
Simon Stanyer	Audit Manager, KPMG
Tim Thomas	Director, 360 Assurance
Carl Twibey	Senior Finance Manager (Reporting)
Martin Whittle	Lay Member (PPI and Vice CCG Vice Chair)

Apologies:

Bruce Braithwaite	Secondary Care Consultant
Niki Bridge	Deputy Chief Finance Officer
Ian Gibbard	Lay Member (Audit Chair)
Darran Green	Assistant Chief Finance Officer
Chrissy Tucker	Director of Corporate Delivery

Item No	Item	Action
AC/1920/159	**Welcome and Apologies** The Chair welcomed members to the Derby and Derbyshire Finance Committee Apologies were received from Ian Gibbard, Bruce Braithwaite, Darran Green, Chrissy Tucker and Niki Bridge.	
AC/1920/160	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	Declarations made by members of the Derby and Derbyshire Finance Committee were listed in the CCG's Register of Interests and included with the meeting papers. The Register was also available either via the Corporate Secretary to the Governing Body or the CCG's website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from today's meeting There were no declarations of interest made. The Chair declared that the meeting was quorate.	
AC/1920/161	**Minutes of the Derby and Derbyshire Audit Committee held on 23 May 2019** The Minutes of the Derby and Derbyshire Audit Committee held on 23 May 2019 were presented. **The Minutes from the Derby and Derbyshire Audit Committee held on 23 May 2019 were agreed and signed by the Chair.**	
AC/1920/162	**Matters Arising – not elsewhere on agenda** The Chair referred to item AC/1920/152 External Audit reports and in particular to the highlighted recommendations at the bottom of page 9 of the minutes; the Chair asked whether the recommendations had been picked up by the Governance Team. Helen Dillistone confirmed that they had. **There were no further matters arising not elsewhere on the agenda.**	
AC/1920/163	**Derby and Derbyshire Audit Committee Action Log** **AC/1920/136 Review of Losses and Special Payments:** It was requested that the owner of this action be amended to read Richard Chapman and Janet Dean. This action would be reviewed and reported to the next meeting of Audit Committee in November 2019. **AC/1920/137 Draft CCG Annual Report Including AGS and Accounts:** It was noted that the AGS benchmarked data had been sent out by email as requested. This item could now be closed. **AC/1920/139 Internal Audit Reports: Mandatory Training:** Helen Dillistone reported that Mandatory Training had been reviewed at the last Governance Committee meeting. Helen Dillistone confirmed that a report had been done and would be circulated by her as a post meeting note to Audit Committee members. Andrew Middleton was keen to ensure that the CCG met its targets for mandatory training of staff and Governing Body members. Helen Dillistone to report back to Audit Committee at	RC/JD

	its meeting in November with regard to progress made against the target. This item to remain open. **AC/1920/139 Internal Audit Reports: Review of Compliance with the Procurement, Patient Choice and Competition Regulations 2013 and Public Contract Regulation 2015:** The owner of this action was to be transferred to Richard Chapman. Richard Chapman reported that Darran Green was currently working with Craig Cook to deliver the register and a first draft had been prepared. Audit Committee to be given an update at its next meeting. This item to remain open. **There were no further actions**.	HD RC
AC/1920/164	**Waiver of Standing Orders and SFI's** **The Light House:** Richard Chapman explained that the Light House was an integrated disabled children's service which was jointly funded by Derby City Council and the CCG. The Light House provided residential short breaks/respite for children with a wide range of disabilities. The existing provider DHcFT had served notice on the contract to cease this service on 31 May 2019. The CCG had advertised the opportunity to the open market and had only received one response. On further review of the response, the provider then declined to participate. Other local providers delivering similar services (the UHDB KITE Team) were approached and had also declined and the incumbent would not continue the service without promise of longevity of a contract and committed funds. Due to time constraints and the market not generating options on the process above. The Procurement Team had advised us to approach a capable provider directly who could deliver the services required in a cost and clinically effective way within parameters acceptable to commissioners. A six month contract was consequently awarded to the value of £167k to a provider and during this six month period the CCG would be consulting on a long term service model to ensure a longer term viable service could be provided. It was noted that the Clinical Commissioning Committee were overseeing this process. Richard Chapman reported that this was a very niche market and therefore the range of suppliers for this service was limited. It was noted that the CCG should have been able to foresee this situation happening and it was hoped that by developing a complete contracts register highlighting which contracts were due to expire, we would have more time to ensure that the CCG operated at a more strategic level and ensure the best value when awarding new contracts. **Audit Committee APPROVED the application form for the Waiving of Standing Orders and Standing Financial**	

	Instructions to Authorise Appointment of a Supplier following Receipt of Less than Requisite number of Quotes. **Minor Eye Conditions Service:** Richard Chapman reported that this contract was £105k (£87k for delivery of the clinical service) for 12-month duration; during which, an evaluation would take place to inform future commissioning intentions and onward procurement at that point. £18m had been allocated from STP/NHSE funding for High Impact Interventions Programme which was an element of the Planned Care Team's QIPP and covered operational/training elements which were not part of the original PID. It was noted that procurement advice was that it was so far below threshold (in excess of £600k) and taking a proportionality approach, it would not make sense to go out to procurement for this value when it could cost £70k - £100k for a procurement process. Furthermore, there was unlikely to be risk of challenge as at the time of enquiry, the procurement team were not aware of any other providers potentially interested in this. **Audit Committee APPROVED the Waiving of Standing Orders and Standing Financial Instructions to Authorise Appointment of a Supplier following Receipt of Less than Requisite number of Quotes.**	
AC/1920/165	**Internal Audit Reports:** **Internal Audit Progress Report:** It was noted that this progress report covered the work carried out during the period May 2019 to September 2019. Janet Dean highlighted the following key messages: • It was noted that two reports and a memo had been issued since the last Audit Committee: QIPP Interim Report, Head of Internal Audit Opinion Stage One and Merger of the Ledger (Memo). • The Head of Internal Audition Opinion was a three part review – with no opinion at this stage. • The QIPP report was done as an interim report and a follow up would be done in October 2019. This would give a final opinion and test the number of actions that had been addressed from the interim report. • Merger of the Ledger (Memo) – a formal project was initiated to oversee the merger process of the four Derbyshire CCGs, which included the development a single ledger for the merged CCG (which was managed as a separate project). Internal Audit provided project assurance roles both for the wider merger project and the implementation of the single ledger and updates had been provided to the Audit Committee on a regular basis. • A follow up electronic tracker of agreed actions had gone live in July 2019. CCG staff had been given training and	

	support in its use with written instructions and guidance. A full summary of the position of all recommendations had been included within the papers as Appendix D. • 360 Assurance were holding an event in January 2020 on Workforce Assurance for Non-Executive members. • Client briefing had been issued as Appendix E for this quarter. • Pages 3 and 4 of the report detailed days used to date from the plan and the summary of work completed. • Page 5 detailed work in progress and stages reached. • Page 6 detailed Terms of Reference that had been discussed and agreed with CCG Officers. • It was noted that the DOF from CRH NHSFT, as the lead system-wide DOF, had asked 360 Assurance to define the potential scope and carry out a review of 2019-20 operational planning at JUCD. The review was being funded by all Derbyshire NHS bodies and would be shared with all these organisations once completed. This would also be shared with JUCD Board. • From a DDCCG Audit Committee perspective, we had no mechanism to challenge whether actions from this report would be picked up by other Derbyshire NHS bodies or JUCD – the CCG could not hold these organisations to account. • Helen Dillistone reported that there was no MOU between the Derbyshire NHS bodies; it was more of an agreement/set of principles. JUCD was not a statutory organisation at present. • It was noted that from 360 Assurance review it was possible that they would recommend that a MOU be set up between the Derbyshire NHS bodies. • Post Payment Verification work was due to start shortly with GP practices. Hannah Belcher was lead officer for the CCG on this work. • Page 21 reported the status of agreed actions as at 16 September 2019. • Andrew Middleton referred to the action tracker and highlighted that the Communications and Engagement Reviews were very overdue. Helen Dillistone agreed to engage with Beverley Smith regarding these delays. • The Chair requested that members of staff be reminded and encouraged to update the action tracker. **Audit Committee:** • **NOTED the key messages and progress made against the Internal Audit Plan since the last meeting.** • **RECEIVED the information and guidance papers produced by 360 Assurance.** **Head of Internal Audit Opinion Stage 1:** Tim Thomas reported that he would provide the Head of Internal Audit Opinion, incorporating an assessment of the design and operation of the Assurance Framework towards the year-end in accordance with	HD HD

	the reporting requirements to support the CCG's Annual Governance Statement. Tim Thomas referred to the Assurance Framework governance questions sent out to members via email this morning, which would be discussed in more detail later in the agenda today under the Governing Body Assurance Framework item. **Counter Fraud:** It was noted that this was the first progress report presented to Audit Committee for 2019/20 and covered work carried out during the period 1 April - 31 August 2019. Ian Morris highlighted the following key messages: • Completion and submission of the NHSCFA Self Review Tools for the 4 former Derbyshire CCGs had been undertaken; all had self-assessed as green overall. • There was now a requirement on CCGs to own fraud risks; fraud risks would now have to be placed on localised fraud risk registers. The CCG would now own those risks. • 360 Assurance were currently undertaking a benchmarking exercise to review fraud risks across their client base. It was intended that a paper be produced to inform the Audit Committee about the CCG's risk scores relative to similar organisations to enable it to seek assurance that risks were being managed in line with the CCG's own risk management policies. There was, however, no timeline for this exercise at present, but the Chair asked that this be put on the forward planner for September 2020. • The CCG had been provided with a new animated counter fraud training video which had been produced as a method of raising fraud awareness across all areas of the CCG. CCG staff were participating in mandatory training. • No cases had been referred to Counter Fraud which had required formal investigation, but incidents had been reported where advice had been given. • Five local fraud warnings, intelligence bulletins and fraud prevention notices had been issued to the CCG. • There had been a lot of mandate frauds and phishing emails and GP practices had been targeted, eg requesting changes to bank account details. Unfortunately Practice Managers were changing bank account details without making the necessary checks. Richard Chapman asked whether there was scope within the counter fraud plan to ensure that we were providing appropriate support and testing our key suppliers for their exposure to counter fraud. Richard Chapman and Ian Morris to discuss this issue further at their introductory meeting. Tim Thomas reported that here had been a benchmarking exercise across 4 trusts on phishing emails – a report had been produced and would be shared. • There had been a significant amount of time put in the work plan for a national procurement exercise that the NHSCFA had put in place, to then be told that this was for	DD RC/IM TT

	Providers only and not Commissioners. There would be some work on procurement but not as a national exercise. • Andrew Middleton raised a question regarding the requirements for IR35 – had the CCG got Consultants working for them and had we properly evaluated them for IR35? Carl Twibey confirmed that DDCCG had carried through the processes established by the former Derbyshire CCGs – every contractor or agency member of staff went through an IR35 review to see whether they were inside or outside of scope. • Andrew Middleton raised an issue with regard to PHB's: It was noted that PHB's had been raised at various Committees and Brigid Stacey had been tasked to find out whether appropriate CCG policies and procedures were in place. Helen Dillistone felt that there needed to be a wider conversation about the whole strategy related to PHB's and whether we as an organisation were behind it or not. It was noted that CLCC had received a paper last week on Non-CHC PHB's. **Audit Committee:** • **NOTED the key messages and progress made against the Counter Fraud Plan.** • **RECEIVED the information contained within the paper and gained assurance that sufficient controls and management mechanisms were in placed within the CCG to mitigate fraud, bribery and corruption risks.** • **SUPPORTED the work by 360 Assurance by challenging CCG Officers to ensure that identified risks and system weaknesses were adequately mitigated in line with recommendations made by 360 Assurance and/or NHSE Counter Fraud Authority.** Ian Morris left the meeting.	
AC/1920/166	**Annual Audit Letters (KPMG)** Simon Stanyer presented the Annual Audit letters for the four legacy Derbyshire CCGs. The Annual Audit letters summarised the audit outcomes from the 2018-19 audits and replicated the ISA260 reports which were presented to Audit Committee in May 2019. Carl Twibey asked if the Annual Audit letters could be sent to him as four separate files, in order that they could be sent to NHSE this week. Simon Stanyer agreed to this request. It was noted that the CCG could now publish these letters on its website with immediate effect. Suzanne Pickering agreed to organise this. **The Audit Committee NOTED the Annual Audit letters of the four legacy CCGs.**	SS SP

AC/1920/167	**Finance Report** Richard Chapman gave a verbal update in terms of a finance report and highlighted the following: • At M5 the year to date overspend was £9.183m and remained in line with plan • The forecast overspend position of £26.100m remained in line with plan • The CCG needed to remain on target with plan to receive further CSF monies and there was a further £26.1m available • The YTD savings delivery was £18.0 which was £2.1m below plan • The full year savings forecast was revised to £60.1m which was £9.4m below plan • Any overspend or under delivery of savings at this point in the year would be supported by robust mitigation plans or alternative savings. • The underlying position was a deficit of £47.5m (2.9%) • None of the mandated contingencies had been used in the M5 or forecast position. These were required to mitigate risk which currently stood at £8.1m • The CCG had implemented a Control Total Action Plan approach to delivery of the £29m deficit control total, which mitigated the maximum assessed potential risk value. (.5% reserve held by the CCG was available to cover risk that was currently outside of FOT and as such we had a relatively high degree of confidence that we would deliver the £29m deficit position). • It was noted that with regard to the 2019-20 position - this was not a message to the organisation that we could relax on QIPP as the recurrent position we had real concerns over. • The CCG had to achieve plan on a quarterly basis in order to receive CSF funding • In previous years a percentage of PSF had been linked to urgent and emergency care performance, Richard Chapman was not clear that this was still the case. • There was a need to utilise the System Leadership Group to drive the savings and to ensure that the Group was intelligence led. • There was a need to ensure that the Clinicians were brought on board to do more transformational work. • Martin Whittle reported that he had attended the last STP Board where a single finance report was presented by Lee Outhwaite, the commentary read like it was 4/5 reports bolted together, whereas the Board was looking for a system view. • Further in-depth conversations on the CCGs finances would take place at Finance Committee later this week. **Audit Committee NOTED this verbal Finance Report.**	

AC/1920/168	**Governing Body Assurance Framework Q1** Suzanne Pickering presented Governing Body Assurance Framework (GBAF) report for Q1 and highlighted the following: • Governing Body had approved the strategic objectives and strategic risk at its meeting on 6 June 2019. • We now had 6 strategic risks which had been assigned to the responsible Executives/Committees as detailed in the full assurance framework. • Following the approval at the June Governing Body, the Executive Directors and Functional Directors had refreshed and populated the full GBAF as at the end of June 2019, this included the GBAF summary together with the individual GBAF Risk schedule detailing the key controls, sources of controls, gaps in controls, gaps in assurance and the mitigating action being taken to address the gaps. • The Governing Body were asked to receive the GBAF for assurance and challenge and to provide any additional comments at the July meeting. The responsible Committee would approve the GBAF risk schedules and report the GBAF quarterly to the Governing Body and Audit Committee for assurance and challenge. The process of reporting the assigned Committee GBAF risks commenced in July 2019. • The responsible Committees were the owners of the strategic risks assigned to that Committee. The GBAF was also reviewed at the relevant Committee and any updates reported to the Governance Team. • The CCG would measure the successful delivery of the strategic objectives against the strategic risks. • Quarter 2 updates were due to be reported to Governing Body in October/November. • Strengthening of the GBAF was currently taking place, together with a review of how the CCG measured strategic risks to the achievement of the strategic objectives. • A presentation had been given to the Engagement Committee, (who had many external members), in order to help with the understanding of risk management. • The format and layout of the GBAF had been developed over a period of years and the inclusion of graphs was found to be very helpful. **The following questions were put to Audit Committee in order to gain thoughts and responses from members:** • **Are we clear about what the Assurance Framework was for and how it should be used?** It was noted that from a Committee perspective, members were clear what the framework was for and how it should be used. • **Are we satisfied that we were rigorously testing the assurances that the organisation relied upon to effectively assess the risk to which it was exposed?**	

	Who else/what other group's do we think could use it? Members felt that because we had the committee structure and had allocated the risks associated with the objectives to that committee structure, we had a rigorous process. It was a standing item for each committee. • **What do we think about our assurance framework:** **Does it do what it's supposed to?** Committee felt that it did what it was supposed to. **Was its format easy to follow and clear?** Committee felt that it was clear and easy to follow. **What areas did we think needed changing, if any and how would we change them?** Committee felt that the Governing Body Assurance Framework was clear and that our Governing Body owned it. However, the CCG occasionally struggled to deliver strategic objectives with NHS partners, as we had no authority to hold them to account, other than by using contractual levers and persuasion. **What is the process for adding new items to the framework?** Executive Directors and Functional Directors regularly refresh and populate the GBAF**.** It is then presented to Governing Body for assurance and challenge and to provide any additional comments. **Are all areas covered, including 3rd party assurance?** Committee felt that we had some elements involved but there was a need to bolster this through governance arrangements, the STP process and JUCD. • **How much comfort does it give us in relation to the running of the organisation?** Committee felt that the GBAF was a tool that the CCG used effectively. • **What else gives us comfort and how can we capture those things on the Assurance Framework?** It was noted that these were captured through third party reports which were then triangulated. There was a need to keep the GBAF current, live and interesting. • **How does it link with the risk register? Are there updates/actions against the risks? How does the wording/process get changed?** – Governance Team to review wording/process mechanism of GBAF (by building in measures) for Quarter 2 for approval by Governing Body. **Audit Committee RECEIVED and gained assurance from the Q1 Governing Body Assurance Framework.** Tim Thomas requested that thought be given to producing a report detailing the work done by other Sub Committees which would help Audit Committee discharge its role of informing Governing Body what it felt about the governance/risk management control systems. Tim Thomas agreed to email an anonymised example	HD/SP TT/HD /SP

	of such a report from one of his CCG clients.	
AC/1920/169	**Risk Register Update September 2019** Suzanne Pickering presented the Risk Register report covering the period April to August 2019, and highlighted the following key areas: • A monthly Risk Register was presented to Governing Body highlighting very high risks to the CCG. • There were 20 risks on the Risk Register for the CCG • All risks on the Risk Register were allocated to a Committee. • The high risks recorded on the Register had been relatively stable over the last few months. • Senior Responsible Officers were asked to update the risks on a monthly basis. • Very high scoring risks were presented to the Executive Team meeting on a monthly basis. • The CCG had an established Risk Group. The Risk Group reviewed the current risks, identified new risks and provided assurance to Governing Body and Committees that the Risk Register was being monitored and managed and that the Risk Management process was firmly embedded within the organisation. • For the purpose of the report, only those current risks rated as very high (15-25) to the organisation were presented to the Audit Committee and were detailed in Appendix 1. It was noted that Committee members found this report very hard to read and it was requested that the Governance Team review its format and demonstrate it in a table. Risk 14 was highlighted on page 5; the description of the risk did not make sense. It was thought that the Risk Lead had changed the description and it did not now make sense. Suzanne Pickering agreed to revise the description. Risk 20 was highlighted on page 9: This risk had three positive actions, but the score had increased. Suzanne Pickering explained that the Business Continuity Plan was still in draft and had been presented to Governing Body for approval last week, as a result the score was expected to decrease. **Audit Committee RECEIVED and NOTED the Exception Risk Register Report and Appendix 1 summary as a reflection of the very high risks facing the organisation as t 31 August 2019.**	HD/SP SP
AC/1920/170	**Conflict of Interest Update Report** Suzanne Pickering presented the Conflict of Interest report which incorporated the following:	

	• Staff Register of Interests • Governing Body & Committee Register of Interests • Confidential Register of Interests • Gifts & Hospitality Register • Procurement Register • Breach Declaration Register This report summarised the activity that the CCG had undertaken since April 2019 to fulfil its obligations in regards to managing its conflicts of interest. CCG employees had individually received personalised Declaration of Interests forms via email. As of 16 September the CCG had received 80% of staff forms, and the complete register was shown as Appendix 1 attached to this report. It was noted that an email had been distributed to CCG employees on 28 May 2019, which included the Standards of Business Conduct & Managing Conflicts of Interest Policy; details regarding the Conflicts of Interest Guardian, Freedom to Speak Up Guardian, and other key facts. This email would be repeated in November 2019. A piece of work was also being done to identify all GP Partners, salaried GPs, Associate GPs and Locum GPs within Derbyshire practices. Once complete, forms would be distributed and a register would be created and uploaded to the CCG's website. It was noted that all but one Governing Body member had returned their forms and a few external colleagues who attended the Engagement Committee were yet to return theirs. The register for Governing Body and Committee Members was attached at Appendix 2. A confidential register was also kept (Appendix 3) for those people who did not wish to publish their interests. It was noted that no declarations had been made on the Gifts and Hospitality Register since we moved to Derby and Derbyshire CCG. The Chair was surprised that no declarations had been received and asked the Governance Team to reinforce the Policy on the staff bulletin. With regard to breaches, as part of the NHSE Conflicts of Interest Indicator Quarter 2 Submission, the CCG had notified the NHSE Locality Director of a breach of the CCG's policy within one of its meetings. This breach had been published on the CCG's website and detailed in Appendix 6 (within the Breach Declaration Register). Jill Dentith would be asked to sign off this Submission on behalf of Ian Gibbard. It was noted that the deadline to submit the NHSE Conflicts of Interest Indicator was 10 October 2019. With regard to training, all members of staff were mandated to complete Level 1 for Conflicts of Interest; the target was 100% by	HD/SP

	January 2020 and we were currently at 73.38%. Training for Levels 2 and 3 (aimed at decision makers), currently stood at 24.14%. With regard to political party membership of clinicians at GP surgeries, the Chair asked whether there was a requirement for a declaration to be made. The Governance Team agreed to check whether this was a requirement. **Audit Committee NOTED the Conflicts of Interest Update Report, for assurance; and RECEIVED the following registers:** • **Staff Register of Interests** • **Governing Body & Committee Register of Interests** • **Confidential Register of Interests** • **Gifts & Hospitality Register (nil return)** • **Procurement Register** • **Breach Declaration Register**	HD/SP
AC/1920/171	**Any Other Business** There was no further business.	
AC/1920/172	**Forward Plan** **Ad hoc items to be included on the Forward Planner/Standard Items to be added:** Self-Assessment and Analysis – Annually (Governance)	SP
AC/1920/173	**Assurance Questions** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes? Yes. 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations? Yes. 3. Were papers that have already been reported on at another committee presented to you in a summary form? No. 4. Was the content of the papers suitable and appropriate for the public domain? No.	

	5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow Committee members to review the papers for assurance purposes? Yes. 6. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No. 7. What recommendations does the Committee want to make to the Governing Body following the assurance process at today's Committee meeting? Audit Committee were picking up a whole range of different issues; Audit Committee felt that we had a robust assurance process in place; from work done it was felt that Audit Committee could give the Governing Body assurance, but were exploring how we could extend that level of assurance in respect of system working.	
AC/1920/174	**Date of Next Meeting** Thursday 21 November 2019 at 9.30am in the Committee Room, Scarsdale, Chesterfield.	

Signed: …….. Dated: ……

MINUTES OF GOVERNANCE COMMITTEE MEETING HELD ON 12 SEPTEMBER 2019 IN BOARDROOM, TOLL BAR HOUSE, 1 DERBY ROAD, ILKESTON DE7 5FH AT 13:10 TO 15:00

Present:		
Martin Whittle (Chair)	MW	Governing Body Lay Member – Patient and Public Involvement, DDCCG
Dr Emma Pizzey	EP	Governing Body GP, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Gill Orwin	GO	Lay Member PPI - DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Chrissy Tucker	CT	Director of Corporate Delivery, DDCCG
In Attendance:		
Ilona Davies (Minutes)	ID	Executive Assistant to the Executive Director of Corporate Strategy and Delivery, DDCCG
Rosalie Whitehead	RW	Risk Management and Legal Assurance Manager, DDCCG
Ruth Lloyd	RL	Information Governance Manager, DDCCG
Frances Palmer	FP	Corporate Governance Manager, DDCCG
Apologies:		
Ian Gibbard	IG	Governing Body Lay Member – Audit, DDCCG
Jill Dentith	JD	Governing Body Lay Member – Governance, DDCCG
Lisa Butler	LB	Complaints and PALS Manager, DDCCG
Richard Heaton	RH	Business Resilience Manager, DDCCG
Suzanne Pickering	SP	Head of Governance, DDCCG

Item No.	Item	Action
GC/1920/46	**WELCOME, APOLOGIES & QUORACY** MW welcomed the members of the Committee to the meeting and confirmed that the meeting was quorate. Apologies were noted and recorded as above.	
GC/1920/47	**DECLARATIONS OF INTEREST** MW reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Governance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from today's meeting No declarations of interest were made.	
GC/1920/48	**EU EXIT UPDATE** CT presented the paper relating to preparations for EU Exit. The CCG is working with national and regional teams. On call colleagues will be kept informed to ensure they are aware of the process for completing and returning assurance templates.	

	A query was raised regarding supply of medicines and whether the risk should be recorded as financial or quality. Given the primary impact will be on cost the risk was within Financial Committee remit. It was noted that the CCG did not envisage any staffing issues however, the providers may experience staffing issues. The impact of those cannot be predicted at the moment. HD clarified that the CCG's role was about coordination of information and reporting up the chain; how the organisations work as a system in Derbyshire and how any pressure points are flagged up. NHSE/I the main leadership role. The CCG is connected to the Derbyshire Local Resilience Forum chaired by the Police. The biggest risks identified are among others: traffic, transport, fuel and medicines. The latter is on the CCG risk register. The Committee discussed an issue of medicines shortages and if there was a process in place for notifying the CCG of the shortages. CT will query with Steve Hulme. **ACTION: CT** CT will keep the Committee sighted on the ongoing work in preparation for EU Exit through regular updates. **The Governance Committee NOTED the contents of this report for information and assurance.**	**CT**
GC/1920/49	**BUSINESS CONTINUITY AND EMERGENCY PLANNING RESILIENCE AND RESPONSE** CT presented the paper relating to EPRR Core Standards, The CCG have assessed and provided evidence against all the standards and fully comply with all but three areas, which rely on the EPRR Policy Statement, Business Continuity Plan and the Business Continuity Policy Statement being approved by the Governance Committee. Once the documents are approved the CCG's compliance will change from "substantial" to "full". It is a requirement that Governing Body is aware of and understands the CCGs self-assessment against the National Core Standards, which will be affirmed following the "confirm and challenge" process. There is also a requirement to publish the level of compliance within the Annual Governance Statement contained within the Annual Report and Accounts. CT added that SP was at a confirm and challenge meeting with NHSE/I today. Business Continuity Plan – A revised single Business Continuity Plan has been developed for Derby and Derbyshire CCG. Each team has been asked to complete Business Impact Assessment to support the plan. Business Continuity Policy – The policy describes arrangements that the CCG has in place as Category 2 responders. GS commented that whilst the Plan was thorough plan, he would not like his mobile number published outside of the organisation. CT assured that the document was confidential and it was for internal use only. FP added that historically CCGs used text messaging to communicate during incidents and the mobile numbers will be used only for the purpose of communicating within the CCG to ensure prompt response in the event of incident. MW suggested adding his title as Vice-Chair of the CCG in case, the Chair of the CCG was not available to contact. **ACTION: RL/FP**	**RL/FP**

	EPRR work plan – MW suggested adding learning from Whaley Bridge Dam incident. **ACTION: CT** **The Governance Committee** • **NOTED the contents of this report for information and assurance;** • **APPROVED the draft EPRR Core Standards submission for 2019/20 subject to any amendments made as part of the Confirm and Challenge process with NHSE and RECOMMENDED to the Governing Body for final approval;** • **APPROVED the Business Continuity Plan (main content);** • **APPROVED the Business Continuity Policy;** • **APPROVED the EPRR Work Plan for 2019/20;** • **APPROVED the EPRR Policy Statement.**	**CT**
GC/1920/50	**INFORMATION GOVERNANCE AND GDPR UPDATE REPORT** RL presented the report. The Information Governance Team had been working with colleagues on closing gaps in information governance and developed a confidentiality agreement for non-contracted staff. The agreement has been approved by the CCG's Caldicott Guardian. Training sessions have been taking place across the organisation for IAOs and IAAs to enable complete understanding of data flow and how it is secured. *James Lunn joined the meeting.* There were no reportable IG breaches for the period 15th June to 30th August 2019. It is intended that the incidents will be grouped and reported as themes to the Committee from next meeting. The CCG is required to undertake an interim submission of the Data Security Protection Toolkit at the end of October 2019, to indicate the current and planned position. In support of this, 360 Assurance will undertake an interim audit (without an opinion) for which the terms of reference have been agreed. The outcome of this review will be received at IG Assurance Forum, and upwards to Governance Committee. GO queried if the ability to edit patient letters on the GP system had been resolved. RL said that she was awaiting a response from NHS Digital. **The Governance Committee** • **APPROVED the annual reports of the Caldicott Guardian and Data Protection Officer;** • **APPROVED the confidentiality agreement for non-contracted staff;** • **RECEIVED the update regarding actions and compliance activities;** **There were no further actions to advise required of the IG team not identified within the report.**	
GC/1920/51	**NOTES AND ACTIONS FROM IG ASSURANCE FORUM ON 28 JUNE 2019** The Committee requested a paragraph summary of any key points from the meeting of IG Assurance Forum instead of the notes. A highlight report will be brought to the next meeting and going forward. **ACTION: RL/EH** **The Governance Committee NOTED the notes and actions from IG**	**RL/EH**

	Assurance Forum presented for information and assurance.	
GC/1920/52	**HEALTH AND SAFETY REPORT QUARTER 2** CT informed the Committee that Quarter 2 report describes activities in respect of health and safety for that period and provides assurance that the work is in progress. The following key points were noted. • Health and Safety training figures have been received from ESR for August 2019 and are shown later in the report. • Five Display Screen Equipment Assessments have been undertaken. • No Maternity Assessments have been undertaken. • Four Occupational Health referrals have been received and processed. • There have been no accidents, incidents or near misses reported. • One school placement occurred at Cardinal Square between the 16th July and 19th July. • Following a site visit to Cardinal Square at the end of July 2019, a requirement for refresher training for first aiders and fire wardens has been identified. Quotes have been requested from DCHS with regards to fire warden training and St John's Ambulance will potentially deliver first aider training. The training will be delivered in quarter 3. GO asked if both first aiders were on leave, and there was an emergency would people know what to do. CT said that she would look into cross cover arrangements as these should be in place. **ACTION: CT** It was noted that the CCG's Health and Safety Policy and Procedures, and Employee Safety Handbook will be brought back for Committee's approval in November. **ACTION: Agenda item - ID** **The Governance Committee** • **NOTED the Health AND Safety Report and Actions for Quarter 2;** • **RECEIVED ASSURANCE that Derby and Derbyshire CCG is coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation;** • **APPROVED the request for First Aider refresher training;**	**CT** **ID**
GC/1920/53	**HR POLICIES (FOR APPROVAL)** JL explained that the policies are part of the continuation of the process of aligning policies from all 4 CCGs. There were no comments from Trade Unions in relation to these policies. The policies will be communicated to staff via a series of briefings at each CCG location. The policies will be available on the CCG's intranet. GO queried if flexi time policy and agile working policy were separate policies. JL confirmed that the CCG has three policies in relation to flexi time and agile working and that they support one another. **The Governance Committee APPROVED the aligned policies below with no changes:** • **Professional Registration Policy;** • **Secondary Employment;** • **Retirement Policy.**	

	JL left the meeting.	
GC/1920/55	**RISK REGISTER EXCEPTION REPORT AS AT END OF AUGUST 2019** It was agreed that this item will precede item GC/1920/55 – Procurement Highlight Report. *LI joined the meeting.* This report is presented to the Committee to highlight the areas of organisational risk that are recorded in the Derbyshire Corporate Risk Register (RR) and aligned to the Committee during July and August 2019. RW said that the Committee had 4 risks assigned in June 2019. • No risks have increased since the last report. • No risks have decreased since the last report. • No risks have been closed since the last report. There are 3 new risks, which have been brought back with revised forms following virtual approval conversation. • Data Protection Officer – high risk. • GP IG Service – high risk. • Contract Management with NECS – very high risk. GS queried whether the CCG were assured that the 115 GP practices had adequate DPO provision. RL confirmed that the CCG was assured through Data Protection Toolkit standards. A discussion took place regarding the risk associated with Contract Management with NECS. The CCG is yet to appoint an accountable Director with responsibility for the registration authority. HD said that she would take on that role and asked for her name to be assigned. **ACTION: RW** **The Governance Committee** • **RECEIVED and DISCUSSED the governance risks assigned to the Committee as at 31st August 2019;** • **APPROVED the three new governance risks to be included on the corporate risk register.**	**RW**
GC/1920/54	**DERBY AND DERBYSHIRE CCG PROCUREMENT HIGHLIGHT REPORT** It was noted that CFO's name on the report would be amended to Richard Chapman going forward. LI presented the report. The following projects are with high risk at present for the CCG: • Integrated Urgent Care (On Day, Extended Access and Care Co-ordinators); • PICU Male Beds – contract terminated due to quality issues identified by CQC. This is a priority being actively managed to recommission and reprocure this service. • Children's Continence Services – awaiting CCG signatures on contract. There are no immediate risks identified.	

	EP declared conflict of interest in respect of Integrated Urgent Care service provision formerly commissioned in Erewash CCG. As there were no actions taken or decision made in respect of this item, the Committee agreed for EP to stay in the meeting. The Committee noted the following projects, which are in the Pipeline: • Diabetes Services Review, • Early Stroke Support Discharge, • MSK Triage Service, • Vasectomy Services, • The Keep / Horizon. LI brought to the Committee's attention the Patient Transport Service, which is coming to an end in November 2019. There are provisions in place however, it is important to ensure the commissioners follow regulations and compliancy. **The Governance Committee** • **REVIEWED the Highlight report for Derby and Derbyshire CCG.** • **NOTED status of projects - Pipeline, In-progress and Completed** • **NOTED the priority status of service** • **REVIEWED key issues and activities over the current period** *LI left the meeting*.	
GC/1920/56	**NON-CLINICAL ADVERSE INCIDENTS** There have been no incidents since last meeting.	
GC/1920/57	**MINUTES OF THE MEETING HELD ON 11 JULY 2019** **The Governance Committee APPROVED minutes of the meeting on 11 July 2019 as a true and accurate record of the meeting.**	
GC/1920/58	**MATTERS ARISING** None.	
GC/1920/59	**ACTION LOG** **The Governance Committee REVIEWED the action log. Actions were updated and recorded.**	
GC/1920/43	**ANY OTHER BUSINESS** <u>Estates Strategy (CT)</u> – It was noted the paper was a late submission due to a meeting with a landlord the day before. The Governing Body agreed to move from 3 buildings into 2. Following feasibility studies the CCG is looking at an additional space at Cardinal Square, which has been identified as fit for purpose and in line with CCG's requirements, and offers a cost effective solution. Discussions with NHS Property Services and the landlord are ongoing. CT added that the space at Toll Bar House is currently utilised mainly as a meeting space and MOL team based at Toll Bar House will be relocating to Littlewick Practice. Given parking requirements, additional 13 onsite parking spaces will be secured at Cardinal Square. **The Governance Committee NOTED the contents of the paper and AGREED that negotiations relating to the additional space at Cardinal Square should be progressed.**	

GC/1920/45	**ASSURANCE QUESTIONS** • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes, noting IG Forum notes to be reformatted as a summary report for next meeting. • Was the content of the papers suitable and appropriate for the public domain? Yes, noting telephone numbers will be for internal use only and not published. • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes, noting additional late paper to provide most up to date information. • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None, other than usual report.	
NEXT MEETING		
Date: Thursday 14 November 2019		
Time: 13:00 – 15:00		
Venue: Meeting Room 5 (ground floor), Cardinal Square, Derby DE1 3QT		

MINUTES OF ENGAGEMENT COMMITTEE MEETING HELD ON 2 OCTOBER 2019 IN CONFERENCE ROOM, TOLL BAR HOUSE, 1 DERBY ROAD, ILKESTON DE7 5FH AT 10:00 TO 12:30

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Bernard Thorpe	BT	DCHS Lead Governor
Beth Soraka	BS	Engagement Officer, Healthwatch, Derby
Beverley Smith	BS	Director of Corporate Strategy & Development
Denise Weremczuk	DW	Public Governor and Lead Governor, CRH
Gill Orwin	GO	Governing Body Lay Member, DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Ian Mason	IM	Lay Representative, Chair of High Peak PPG Network
Jocelyn Street	JS	Lay Representative
John Morrissey	JM	Governor, Derbyshire Healthcare Foundation Trust
Karen Ritchie	KR	Head of Engagement, Joined Up Care Derbyshire (JUCD)
Ruth Grice	RG	Lay Representative
Sean Thornton	ST	Assistant Director Communications and Engagement, DDCCG and JUCD
Trevor Corney	TC	Lay Representative
In Attendance:		
Claire Haynes	CH	Engagement Manager, DDCCG
Ilona Davies – Minutes	ID	Executive Assistant to the Executive Director of Corporate Strategy and Delivery, DDCCG
Kate Hyde	KH	Engagement Manager, DDCCG
Apologies:		
Ian Shaw	IS	Governing Body Lay Member, DDCCG
Lynn Tory	LT	Partner Governor, CRH
Ram Paul	RP	Group Manager – Commissioning, Derbyshire County Council
Vikki Taylor	VT	Director, STP

Item No.	Item	Action
EC/1920/82	**WELCOME, APOLOGIES AND QUORACY** MW introduced himself as the Chair of the Committee and welcomed all to the meeting. A round of introductions took place. Apologies were noted as above. MW declared the meeting was quorate.	
EC/1920/83	**Standing Item: DECLARATIONS OF INTEREST** MW reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Engagement Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from today's meeting	

	No declarations of interest were made.	
EC/1920/84	**URGENT CARE REVIEW** CH gave the presentation. Apologies were noted from the Urgent Care team members who had not been able to attend due to conflicting meetings. The review of urgent care services is part of the nationally driven NHS Five Year Forward View. There is no additional money but it can be spent differently. The review is Derbyshire wide and the approach is to base it on need. No decision will be made until consultation is completed. Work undertaken to date: • Work to understand patient behaviours – Public confirm and challenge event held on 21 March 2019; • Patient/public research March – April 19 at the following sites: o Derby Hospital ED, o Chesterfield Hospital ED, o Derby Urgent Care Centre, o Ilkeston Minor Injury Unit, o Whitworth Minor Injury Unit, o Buxton Minor Injury Unit, o Ripley Minor Injury Unit. Pre-engagement work has been has been scoped out and the following next steps are planned: • Agree materials and plan; • LRG to test out 'different' ways to engage; • Start pre-engagement via questionnaires and hold at least 1 meeting/workshop per Place; • Involve Healthwatch and local voluntary sector groups; • Hold Clinical engagement workshops with stakeholders across the system - EMAS crews, DHU OOH clinicians, mental health staff, NHS111, Clinical directors of PCN's (if appointed), acute staff, GP's, MIU/UTC staff, PHE, etc. The Committee discussed how younger people might express their views. It was noted that much younger users would be normally accompanied by adults into the services however, the 16 to 18 year olds might be targeted separately via questionnaires to schools/colleges, etc. There was a suggestion to include staff in the research and approaching Trust Governors as they were users of urgent care services too. It was noted that national guidance for migrants stipulated their entitlement to emergency care. CH said that Citizens Panel will be used as well. It is expected that pre-engagement will conclude by end of December 2019 and the consultation will commence in April 2020. MW concluded that the review provided an opportunity for the CCG to use money more wisely and ensure people were being treated in the right place. IM expressed concern whether the review would result in redesign based on Derbyshire needs or based on parameters set nationally by NHSE/I, which are one size fits all and in his opinion one size did not fit all.	

	MW said that there was certainly an opportunity to scope local needs however, the national consultation will determine the outcome. The CCG will be able to put a case forward to NHSE/I, if there was a strong need for the locally designed service. HD said that the CCG would be looking at how efficient the services were in addition to how people were accessing them, and noted that some of the work was about changing behaviours. The CCG needs to consider how it will support people to use the services differently. MW summarised the discussions. Overall there is a fairly broad engagement approach with some nuancing around children/younger people. The work is to include model of care. The CCG needs to be very clear about what they are asking people to engage in, and be clear about the expectations of the national model versus how it can be influenced by local needs. Presentation to be circulated to the Committee post meeting. **ACTION: CH** **Post meeting note: Action completed on 2 October. Closed.** **The Engagement Committee NOTED the work on the Urgent Care review.**	
EC/1920/85	**CONFIDENTIAL – JOINED UP CARE BELPER PROJECT UPDATE** ST explained that for reasons of commercial sensitivity the item had been marked confidential. ST provided a verbal update. Further update will follow in November. **ACTION: ST** **The Engagement Committee NOTED the verbal update.**	
EC/1920/86	**Standing Item: ENGAGEMENT COMMITTEE RISKS** MW informed the Committee that the first paper was from the CCG's Governance team and stated the risks assigned to the Committee and their status in September. The second paper summarises the risks and suggests changes to the risk scores as evidence by actions undertaken. MW had discussed both papers with HD and ST and given some duplication it is intended to have one paper in the future. MW asked the Committee to note that the numbers in paper two differed slightly and risk 31 in paper two is risk 32 in the first paper. **1. EXCEPTION RISK REPORT** The following key points were noted from the report. • No risks have increased. • No risks have decreased. • No risks have closed. • No new risks have been identified since the last report. **2. RISK REVIEW AND UPDATE** The Committee reviewed the risk noting the following key points. <u>Risk 31 (32 in the Exception Risk Report)</u> – Actions taken this month: • Training for Engagement Committee members on consultation law completed.	

	• Audit completed on S14Z2 form completion – low numbers clarified as relating to low numbers of new QIPP projects emerging since implementation to S14Z2. AD Comms and Engagement to follow-up how projects proceed outside of QIPP processes. • Comprehensive business plan in place to ensure Engagement Committee is sighted on relevant projects. • Progress made on implementing comprehensive training programme for CCG staff on commissioning cycle, including engagement elements to standardise CCG processes. **The Committee agreed to reduce risk likelihood score from 3 to 2.** JS asked to see a completed section 14 form. CH suggested the form completed for urgent care review and agreed to circulate. **ACTION: CH** **Post meeting note: Action completed on 2 October. Closed.** <u>Risk 32 (31 in the Exception Risk Report) – Actions taken this month:</u> • Establishment of Place Engagement Workstream as part of Place Delivery Board allowing focussed attention on development of engagement approach between communications and engagement team and Place management team. • Engagement process from PPG through to Engagement Committee developed with Lay Reference Group and Engagement Committee and now in implementation phase. • Engagement model previously agreed by Engagement Committee now formerly lodged with Place via Place Engagement Workstream and work in progress to ensure model if mainstreamed. It was noted that Place refers to Place Alliance. **The Committee felt that due to places being at different stages of development it was too early to change the risk score. To be reviewed again next month.** <u>Risk 33 – Actions taken this month:</u> • Engagement in JUCD planning now reflected in emerging STP Refresh document • Clear delivery plans now available for all JUCD Delivery Boards • Mobilisation of system communications and engagement leads to link with delivery boards and establish outline requirements for engagement by 14 October. • Citizens Panel has entered operational phase, supplying people for Confirm and Challenge sessions and inaugural survey circulated on the use of digital technology in health. **There were not changes to the score.** The Committee expressed formally its thanks to Karen Ritchie for the training on consultation law, which the Committee found very useful. **With regards to the first paper, the Engagement Committee REVIEWED and UPDATED the Engagement Committee risks assigned to the committee as at 30 September 2019, and CONSIDERED whether the Committee wished to deep dive any of the assigned risks with the relevant lead, in more detail at the next meeting around the management of the risk for further assurance.** **With regards to the second papers, the Engagement Committee NOTED**	

	the risks managed by the Committee, and REVIEWED and APPROVED the proposed changes to risk scores as noted above.	
EC/1920/87	**360 STAKEHOLDER SURVEY RESULTS** ST presented the paper. The annual 360 Stakeholder Survey is undertaken nationally by Ipsos Mori on behalf of all CCGs. The survey was conducted in the first quarter of 2019 and saw a 59% response rate overall, a 7% increase on the previous year. It was noted that the view from stakeholders was disappointingly low however, there was recognition of the impact of CCG's difficult financial positon. The recommendation was to improve relationships with most stakeholder groups but especially GPs, NHS Providers, Healthwatch, voluntary sector and other patient groups by way of, among others, improved communication and engagement, reinforced systems and processes in developing projects, and more structured approach to stakeholder relationship management. **The Engagement Committee NOTED the summary of the 360 survey and proposed actions.**	
EC/1920/88	**Standing item: ORGANISATIONAL EFFECTIVENESS AND IMPROVEMENT – 30/60 DAY ACTION PLAN** ST presented the papers. It was noted that the Committee received a paper in August outlining the initial actions required to support the work of the Organisational Effectiveness and Improvement Programme Board (OEIPB). The Engagement Committee has been tasked with overseeing developments relating to short-term priority actions with the focus on three areas: • Public Engagement • Stakeholder Relationship Management • Proactive Communications These elements have been split into eight distinct projects, with deadlines between now and the end of quarter 2, progress on which had been detailed in appended paper. There were not questions. **The Engagement Committee RECEIVED an update on the communications and engagement actions identified for priority attention during quarter 2 of 2019/20.**	
EC/1920/89	**CONFIDENTIAL – JOINED UP CARE DERBYSHIRE PLAN REFRESH** It was noted that the draft plan was not in the public domain and therefore was marked confidential and not for further dissemination. The draft plan was presented for information. ST said that the agreed approach in Derbyshire was for the plan to be considered a 'refresh' rather than a re-write; fundamentally because the model of care remained valid and provided the foundations on which the plan was based. However, the plan was being developed to ensure that the requirements set out in the NHS Long Term Plan were addressed e.g. how systems will deliver the required transformation activities to enable the necessary improvements for patients and communities as set out in the Long Term Plan.	

	GO felt the plan should be more accessible if it is intended for public domain. ST noted the comment. BT queried if there would be sufficient time for DCHS to respond and comment, given they would receive the draft plan on 31 October and the final submission to NSHE/I was on 15 November. ST assured BT that the plan had been worked on for months and DCHS would have already been sighted on developments at different stages. **The Engagement Committee** • **NOTED the summary of the STP refresh requirements,** • **NOTED that owing to the delay in guidance being received and scheduling the draft plan was still in development and ACKNOWLEDGED the submission would come to meetings for approval in October/early November,** • **SUPPORTED the direction of travel set out in the journey to become an Integrated Care System by April 2021.**	
EC/1920/90	**MINUTES OF THE MEETING HELD ON 4 SEPTEMBER 2019** The Committee accepted the minutes as a true and accurate record of the meeting subject to the following amendment: Page 1 – DW's title to state Public Governor and Lead Governor, CRH.	
EC/1920/91	**MATTERS ARISING** None.	
EC/1920/92	**ACTION LOG FROM THE MEETING HELD ON 4 SEPTEMBER 2019** The Committee reviewed the action log. Actions were updated and recorded.	
EC/1920/93	**ANY OTHER BUSINESS** 1) Issue in High Peak area (ST) – Breast Services have ceased by the provider. The engagement was not feasible due to the nature of closure however, given the CCG is the associate commissioner its Comms and Engagement team would like to do post-decision engagement with patients affected to inform the CCG. The Committee is asked to note that there will be engagement work that will not follow the standard process. NOTED. 2) Nursing specification review (ST) – ST asked for the Committee's opinion on the proposed move to clinical based care from the home based care for catheter service. MW asked if there were any conflicts of interest and if BT was conflicted on this issue. BT confirmed he was. The Committee asked BT to step out of the meeting for the duration of discussion. *BT stepped out of the meeting.* **The Committee discussed the service change and concluded that this was a significant service change and therefore should follow appropriate process for engagement**. It was suggested that practice	

	nurses were included in the engagement process. *BT re-joined the meeting.* 3) Ear syringing service (RG) – RG queried whether ear syringing service was still provided under the NHS. It was thought the service was provided by GP surgeries however, ST will confirm and respond to RG. **ACTION: ST** There was no other business.	
EC/1920/94	**FUTURE MEETINGS – DATES AND TIMES** • Wednesday 6 November 2019, 10:00-12:30, Conference Room, TBH • Wednesday 4 December 2019, 10:00-12:30, Conference Room, TBH **As agreed in today's meeting, the meetings in 2020 will move to the Strutts Centre in Belper. Further information is to follow.** • Wednesday 8 January 2020, 10:00-12:30 • Wednesday 5 February 2020, 10:00-12:30 • Wednesday 4 March 2020, 10:00-12:30	
EC/1920/95	**ASSURANCE QUESTIONS** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. Is the Committee assured on progress regarding actions assigned to it within the Organisational Effectiveness and Improvement action plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? None 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None	

MINUTES OF ENGAGEMENT COMMITTEE MEETING HELD ON 6 NOVEMBER 2019 IN CONFERENCE ROOM, TOLL BAR HOUSE, 1 DERBY ROAD, ILKESTON DE7 5FH AT 10:00 TO 12:30

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Andy Kemp	AK	Head of Communications and Engagement, DDCCG
Bernard Thorpe	BT	DCHS Lead Governor
Beth Soraka	BS	Engagement Officer, Healthwatch, Derby
Gill Orwin	GO	Governing Body Lay Member, DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Ian Mason	IM	Lay Representative, Chair of High Peak PPG Network
Ian Shaw	IS	Governing Body Lay Member, DDCCG
Jocelyn Street	JS	Lay Representative
John Morrissey	JM	Governor, Derbyshire Healthcare Foundation Trust
Ruth Grice	RG	Lay Representative
Trevor Corney	TC	Lay Representative
Vikki Taylor	VT	Director, STP (part meeting)
In Attendance:		
Ilona Davies – Minutes	ID	Executive Assistant to the Executive Director of Corporate Strategy and Delivery, DDCCG
Amy Ward	AW	Commissioning Manager, Urgent Care, DDCCG
Debbie Bostock	DB	Service Development Lead for Medicines Order Line (MOL), DDCCG
Kate Needham	KN	Assistant Director of Medicines Optimisation and Delivery, DDCCG
Marie Davies	MD	Lead Medicines Optimisation Technician - Repeat Prescribing Project, DDCCG
Sarah Kennedy	SK	Commissioning Officer, Urgent Care, DDCCG (part meeting)
Ruth Thomason	RT	Corporate Administration Manager, DDCCG
Apologies:		
Beverley Smith	BS	Director of Corporate Strategy & Development, DDCCG
Helen Henderson-Spoors	HHS	Business Intelligence Manager, Healthwatch Derbyshire
Sean Thornton	ST	Assistant Director Communications and Engagement, DDCCG and JUCD

Item No.	Item	Action
EC/1920/96	**WELCOME, APOLOGIES AND QUORACY** MW introduced himself as the Chair of the Committee and welcomed all to the meeting. A round of introductions took place. Apologies were noted as above. MW informed the Committee that HD was on her way and noted that the meeting was not quorate. The meeting became quorate from the point of HD's arrival.	
EC/1920/97	**Standing Item: DECLARATIONS OF INTEREST** MW reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might	

	conflict with the business of the CCG. Declarations declared by members of the Engagement Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from today's meeting No declarations of interest were made. MW clarified that following last meeting when BT was asked to leave the room due to a potential conflict of interest, he thought on reflection that it was not necessary as BT is a Committee member in his capacity as a lay member and not representing DCHS. Following a brief discussion it was agreed that any potential conflicts of interest would be considered and appropriate actions decided on the day. *HD joined the meeting.* The meeting was declared quorate from this point forward. MW steered the meeting to item 98 and advised that item 104 – Confidential – Urgent Care Review – Engagement Process Update will be taken after.	
EC/1920/98	**JUCD PUBLICATION AND SUMMARY** VT presented the paper. The purpose of this paper is to provide the Engagement Committee with an update in relation to the JUCD STP Refresh of the Strategy as the plan moves towards the publication stage. It is about setting a strategic direction of travel for Derbyshire and our spend of £1.6 billion budget on the system. The delivery will be a separate piece of work. The feedback on the first draft was generally very positive and the draft plan was shared with other STPs in England as an example of good practice. The key information missing from that document was around what it means in terms of money for the system over the next five years, what it means in terms of activity and what it means in terms of workforce numbers. The second draft was submitted on 1st November. The final draft is required by 15th November. The publication date as a result of the national election will be after 12th December. This is a significant change. As part of the feedback on the original plan the work around establishing Citizens' Panel had been recognised as particularly positive. The Committee provided the following feedback and VT noted the comments. • A discrepancy in numbers of additional investment on pages 17 and 24 needs rewording as it may be misleading. • On page 24 "Derbyshire STP called Joined Up Care Derbyshire" created confusion by calling the same thing two names. • Overuse of acronyms. • There was no mention of plan to address recruitment. – VT confirmed that	

	in the updated version of the plan there was a strong mention of workforce and about addressing recruitment and staff support issues. • A map to aid visual understanding of what the system will look like as an Integrated Care System/Integrated Care Partnership (ICP). – VT responded that it was included in the latest version of the plan however, the ICPs as geographical footprints have not been as yet agreed locally. • Number of beds on pages 18 and 26 was inconsistent and needs to be corrected. • Words in inverted commas on page 19 did not require inverted commas. Discussion took place around ICPs and PCNs and the difficulties about marrying provider interests and community interests from the service perspective. JS added that it would be helpful if the Integrated Care boundaries could be the same as Place boundaries. VT will bring back the final version and potentially a draft of an abridged version of the plan to the next meeting. **ACTION: VT** **The Engagement Committee REVIEWED and MADE COMMENTS on the draft summary of the Derbyshire STP, and REVIEWED and MADE COMMENTS on the publication plan for the Derbyshire STP.** *VT left the meeting.*	**VT**
EC/1920/104	**<u>CONFIDENTIAL</u> – URGENT CARE REVIEW – ENGAGEMENT PROCESS UPDATE** (Confidential due to purdah.) Amy Ward and Sarah Kennedy updated the Committee on Urgent Care Review and the engagement process. The following key points were noted. • Engagement activities to date show emerging themes around mental health, self-care, need for timely treatment, range of clinical skills and MDT expertise in urgent care services, increased diagnostics services in the community, signposting and referrals to local services, and effective triage service. • Feedback will put in a report and will be used to support any future decision making processes for the design and implementation of UTCs, and to improve the urgent care offer. • Patient engagement will continue until the end of January 2020. • The findings will be shared with the relevant CCG committees and the system where appropriate. • The information collected will support the UTC rebrand in April 2020. JM noted that GP practices have not been included. AW/SK noted for action. IS queried if demographic of who attends the Emergency Care was considered and engagement consultations aligned as per demographic. AW said that data analysis on patient demographic had been undertaken and they would be focusing on that at a later stage. GO observed that from her experience of engagement activities it was astonishing how many people did not know or understand NHS111 service. GO also noted that three or four people she had spoken with told her they had been sent by GP to emergency department.	

	AW and SK referred to the tabled survey document and asked for Committee's feedback. IM suggested using Citizens' panel and asked why it was not used. AK and AW confirmed it would be used. IM asked what engagement would take place where potential service changes were happening. AW confirmed that there would be events in the High Peak to engage with public and seek feedback. SK added all that they were approaching various groups across the whole of Derbyshire. Committee members put forward suggestions of such groups as CBS, parish councils and PPG networks. RG made a point that if the CCG was engaging with people, it was important to make them aware of what is available at those centres. HD noted that the debate highlighted how complex this piece of work was and that they need to ensure that a model of care meets the needs of Derbyshire population. HD suggested a presentation to the group about the new pharmacy contract, and about their role in the community. MW thanked AW and SK. A further update will be provided in March, when the report on findings will also be shared with the Committee. **ACTION: AW/SK** **The Engagement Committee NOTED the presentation on Urgent Care review and engagement process.** *AW and SK left the meeting.* *KN, DB, MD joined the meeting.* ***Post meeting note: Presentation and survey circulated to the Committee on 13 November 2019.***	**AW/SK (March agenda)**
EC/1920/100	**COMMISSIONING INTENTIONS** HD informed the Committee that a Commissioning Intentions document will be submitted to the Governing Body's public session the following day. The document sets out how the CCG intends to commission with the system in the forthcoming year and to provide headline areas to the providers. This year the focus was on working as a partnership, more collaboratively with providers and signal potential areas of change to the providers. This document is produced each year and required to be issued to providers by the end of September. The document will be circulated to the Committee members post meeting. **ACTION: ID** ***Post meeting note: Document circulated to the Committee on 13 November 2019. ACTION COMPLETED*** JM queried if the same services e.g. drug and alcohol would be commissioned or would a county wide approach be taken to the issues. HD responded that the CCG's Governing Body had been having more strategic conversations around wider determinants of health and working in much more formal way with Local Authorities to address some of those wider issues. The CCG's role has changed and it is emerging as a strategic commissioner in a system.	**ID**

	The Engagement Committee NOTED the verbal update on the CCG's Commissioning Intentions.	
EC/1920/101	**Standing Item: EXCEPTION RISK REPORT** The following key points were noted from the report. • No risks have increased in October 2019. • Two risks have decreased in October 2019, these are as follows: o Risk 031 - Failure to develop engagement methods and process at Place level. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development. This risk has reduced from a high 9 to a low 6. The reason for the reduction in score is that based on the identification of agreed engagement processes and the establishment of a focussed Place Engagement Workstream, the likelihood of the risk materialising is reduced from 3 to a 2. o Risk 032 - Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development. The reason for the reduction in score is that based on the confirmation of PMO viewing the absence of S14Z2 as a key milestone, the likelihood of the risk materialising is reduced. • No risks have closed during October 2019. • No new risks have been identified since the last report. Following a discussion the Committee recorded that there was still concern around risk 31 and Place development. MW asked for a review of risk 31 outside of this meeting. **ACTION: AK/ST** IS pointed out that in respect of risk 33 year 2019 should be deleted to show the risk was ongoing. **The Engagement Committee REVIEWED and UPDATED the Engagement Committee risks assigned to the committee as at 31 October 2019, and CONSIDERED whether the Committee wished to deep dive any of the assigned risks with the relevant lead, in more detail at the next meeting around the management of the risk for further assurance.**	
EC/1920/102	**GOVERNING BODY ASSURANCE FRAMEWORK (GBAF) QUARTER 2** It was noted the wording of GBAF Risk 5 has been changed following feedback from the Committee. JS suggested "priority" as a better word then "need". There were no other comments.	

	The Engagement Committee DISCUSSED and REVIEWED the updated for Quarter 2 (July to September) Governing Body Assurance Framework Strategic Risk owned by the Engagement Committee.	
EC/1920/103	**Standing item: ORGANISATIONAL EFFECTIVENESS AND IMPROVEMENT ACTION PLAN AND HIGHLIGHT REPORT** HD presented the paper to the Committee for assurance. The report sets out in Quarter 2 some of the projects and actions that had been under way and had been closed off. MW clarified that the Committees role is to provide an oversight on the assigned actions and reassure the Governing Body in respect of those. **The Engagement Committee RECEIVED an update on the communications and engagement actions identified for priority attention during quarter 3 of 2019/20.**	
EC/1920/105	**Standing item: DEEP DIVE – REPEAT PRESCRIBING PROCESS 1:32** KN, DB ad MD gave a presentation on the repeat prescribing process. The following key points were noted. • Medicines waste is a significant drain on NHS. It is intentional and unintentional. • Approx. £108m will be spent on repeat prescriptions in 2019/20 across Derbyshire. • Waste is generated in three broad areas: GP surgery systems, third party ordering and patients' use of services. Minimising waste requires work in all these areas. • **Medicines Order Line (MOL)** – central telephone medicines ordering point acts as an alternative route for patients to order repeat medicines and supports stopping of third party ordering of prescriptions MOL is currently based at Toll Bar House in Ilkeston and in Scarsdale building. • **Practice Medicines Co-ordinators (PMCs)** – trained staff working in (or remotely with) individual practices to support practices in stopping third party ordering where they are not able to participate in MOL; improve systems within the practice, and work with local pharmacies. JS asked if dispensing practices were included in MOL. KN confirmed that they took on dispensing practices but were not able to take calls from dispensing patients due to system issue occurring nationally. It will be reviewed in future. IS noted that NHS did not allow re-use of medicines, which has been allowed in some European countries. DB responded that one of the challenges was storage. KN added that it was a national position and as such would have to be changed nationally. GO suggested adding quietest times for the MOL to the leaflet as a way of managing the queues. *Ian Shaw left the meeting.* Forecasted savings for 2019/20 as at Month 6 are around £1.95m.	

	GO noted that younger people, who are working, might be interested but they often did not know about it. DB said they were able to send intermittent text messages to that particular group to engage with the service. IM queried if there was any evidence from the practices which signed up to the service, that it had reduced the pressure on their telephone lines. DB responded that they had had feedback from one of the practices to confirm this. KN clarified that the medicines review conducted by the services was not a clinical one but a stock review. TC stated that they already had a system at his surgery that worked well and there was no need for them to sign up to the service. DB answered that there were many systems in surgeries good and not so good however, it was about achieving consistency and the practice embedded in the process. GO asked if a patient from Derby was temporarily in Newcastle and ordered a prescription locally, would the MOL service be able to send it to Newcastle so they pick it up upon return. MD confirmed that MOL could send the prescription anywhere in the UK. **The Engagement Committee NOTED the presentation.** *KN, DB, MD left the meeting.* ***Post meeting note: Presentation circulated to the Committee on 13 November 2019.***	
EC/1920/106	**MINUTES OF THE MEETING HELD ON 2 OCTOBER 2019** The Committee accepted the minutes as a true and accurate record of the meeting.	
EC/1920/107	**MATTERS ARISING** None.	
EC/1920/108	**ACTION LOG FROM THE MEETING HELD ON 2 OCTOBER 2019** The Committee reviewed the action log. Actions were updated and recorded.	
EC/1920/109	**ENGAGEMENT COMMITTEE PLANNER FOR DISCUSSION/AGREEMENT** Noted. No comments.	
EC/1920/110	**ANY OTHER BUSINESS** It was noted that a discussion about Lay Patient Representatives' ongoing involvement post December would be held in December. **ACTION: December agenda** MW reminded the Committee of the enforced period of purdah, which impacts on communications. In view of purdah there may not be a meeting in	**ID**

	December however, this will be confirmed once the agenda has been drafted. There was no other business.	
EC/1920/111	**FUTURE MEETINGS – DATES AND TIMES** Wednesday 4 December 2019, 10:00-12:30, Conference Room, CCG Offices, Toll Bar House, 1 Derby Road, Ilkeston DE7 5FH Meetings in 2020 will be moved to the following dates to align with CCG's internal process – venue to be confirmed. Wednesday 22 January 2020 Wednesday 19 February 2020 Wednesday 18 March 2020 Wednesday 22 April 2020 Wednesday 20 May 2020 Wednesday 17 June 2020 Wednesday 22 July 2020 Wednesday 19 August 2020 Wednesday 16 September 2020 Wednesday 21 October 2020 Wednesday 18 November 2020 Wednesday 16 December 2020 Wednesday 20 January 2021 Wednesday 17 February 2021 Wednesday 17 March 2021 Wednesday 21 April 2021	
EC/1920/112	**ASSURANCE QUESTIONS** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. Is the Committee assured on progress regarding actions assigned to it within the Organisational Effectiveness and Improvement action plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? None 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None	

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 27th November 2019

VENUE: The Hub, Room 3, South Normanton, at 11:30am

Present:

Ian Shaw (Chair)	(ISh)	Lay Member Derby & Derbyshire CCG
Hannah Belcher	(HB)	Head GP Commissioning & Development, Derbyshire CCG
Gillian Orwin	(GO)	Lay Member, Derby & Derbyshire CCG
Greg Crowley	(GC)	Executive Director, Derby & Derbyshire LMC
Jill Dentith	(JED)	Lay Member Derby & Derbyshire CCG
Steve Lloyd	(SL)	Medical Director, Derby & Derbyshire CCG
Joe Lunn	(JL)	Head of Primary Care, NHS England
Kathryn Markus	(KM)	Chief Executive, Derby & Derbyshire LMC
Abid Mutmaz	(AM)	Head of Commissioning, Public Health
Clive Newman	(CN)	Director of GP Development, Derby & Derbyshire CCG
Jill Savoury	(JS)	Assistant Chief Finance Officer, Derby & Derbyshire CCG
Marie Scouse	(MS)	Assistant Director of Nursing Quality & Primary Care
Kerrie Woods	(KW)	NHS England

In Attendance:

Pauline Innes	(PI)	Executive Assistant to Steve Lloyd
Paul Hetherington	(PH)	Associate Director of Digital Development

Apologies:

Richard Chapman	Chief Finance Officer, Derby & Derbyshire CCG
Sandy Hogg	Turnaround Director, Derby & Derbyshire CCG
Gillian Orwin	Lay Member, Derby & Derbyshire CCG
Brigid Stacey	Chief Nurse, Derby & Derbyshire CCG

Item No.	Item	Action
PCCC/1920/204	**WELCOME AND APOLOGIES** The Chair welcomed Committee Members to the meeting and introductions took place. Apologies were received from Sandy Hogg and Gillian Orwin in advance of the meeting and presented at the meeting for The Chair confirmed that the meeting is quorate. There were no members of the public present.	
PCCC/1920/205	**DECLARATIONS OF INTEREST** The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Primary Medical Clinical	

	Commissioning Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk **Declarations of interest from today's meeting** No declarations of interest were made.	
FOR DECISION		
PCCC/1920/ 206	**No items for decision this month**	
FOR DISCUSSION		
PCCC/1920/ 207	**No items for discussion this month**	
FOR ASSURANCE		
PCCC/1920/ 208	**Finance Report** Niki Bridge (NB) presented an update on the financial position highlighting salient areas of interest for the Committee to note. **The Primary Care Commissioning Committee RECEIVED and NOTED the update on the Finance position**	
PCCC/1920/ 209	**GP Commissioning and Development Work Plan and Governance Structure** Marie Scouse (MS) provided an update from the shared paper, the purpose of which is to provide assurance on the work that feeds in to the Primary Care Commissioning Committee, including • 2019-20 Work Plan – which features the plan for delivery of the strategic objectives of the directorate and the committee and gives assurance on progress. • Team Structure – nb vacancies have all now been filled except the apprenticeship role that has just been recruited. • Governance Process – the meeting flow that underpins the assurance process • Forward Planning – details the report structure **The Primary Care Commissioning Committee RECEIVED and NOTED the update**	
PCCC/1920/ 210	**Quarter 2 Primary Care Quality and Performance Assurance Report** Marie Scouse (MS) provided an update from the shared paper. **The Primary Care Commissioning Committee RECEIVED and NOTED the update**	

MINUTES AND MATTERS ARISING		
PCCC/1920/ 211	**Minutes of the Primary Care Commissioning Committee-in- Common meeting held on 28th August 2019** The minutes of 27th November 2019 were agreed as an accurate record of the meeting.	
PCCC/1920/ 212	**Matters Arising and Decision Log** There were no outstanding actions from the meeting held on 28th August 2019.	
PCCC1920/ 213	**Assurance Questions** **1.** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes? **2.** Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations? **3.** Were the papers sent to the Committee at least 5 working days in advance of the meeting to allow the members to review the papers for assurance purposes? **4.** Does the Committee wish to deep dive any area on the agenda, in more detail at the next Committee meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **5.** What recommendations does the Committee want to make to the Governing Body, or to the Meeting in Common of the Governing Bodies, following the assurance process at today's Committees in Common meeting?	
PCCC/1920/ 214	**Any Other Business** There were no items of any other business.	
DATE AND TIME OF NEXT MEETING Wednesday 18th December, 11:30am to be held in the Robert Robinson Room, Scarsdale.		

Derby and Derbyshire Clinical Commissioning Group

MINUTES OF QUALITY AND PERFORMANCE COMMITTEE

HELD ON 28th NOVEMBER 2019 , CONFERENCE ROOM, TOLL BAR HOUSE, AT 9.30AM

Present:		
Dr Buk Dhadda	BD	Chair, GP Governing Body Member
Ali Cargill	AC	Assistant Director of Quality - DDCCG
Helen Hipkiss	HH	Deputy Director of Quality - DDCCG
Zara Jones	ZJ	Executive Director of Commissioning Operations
Andrew Middleton	AM	Lay Member, Finance
Hannah Morton	HM	Healthwatch
Gill Orwin	GO	Lay Member, Patient and Public Involvement
Jo Pearce (Minutes)	JP	EA to Brigid Stacey -DDCCG
Suzanne Pickering	SP	Head of Governance- DDCCG
Dr Emma Pizzey	EP	GP South
Maria Riley	MR	CRHFT – Cancer Team
Dr Greg Strachan	GS	GP North
Phil Sugden	PS	Assistant Director of Quality - DDCCG
Martin Whittle	MW	Vice Chair and Lay Member, Patient and Public Involvement
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
Apologies:		
Richard Chapman	RC	Finance Director - DDCCG
Dr Steve Lloyd	SL	Medical Director - DDCCG
Laura Moore	LM	Deputy Chief Nurse - DDCCG
Craig Cook	CC	Deputy Director of Commissioning - DDCCG
Meryl Watkins	MW	GP City
Brigid Stacey	BS	Chief Nurse Officer -DDCCG
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG

Item No.	Item	Action
Q&P 1920/150	**Welcome, Apologies & Quoracy** Apologies were received as above. BD declared the meeting quorate.	
Q&P 1920/151	**Declarations Of Interest** BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from sub-committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
FOR ASSURANCE		
Q&P 1920/152	**Integrated Report and Deep Dive on Performance** HW presented the performance section of the report to the Committee. **Urgent & Emergency Care** A&E standard was not met at a Derbyshire level, with both main providers failing to achieve the 95% target in October 2019. Chesterfield Royal Hospital Fast Tracks (CRHFT) achieved 85.9% (YTD 87.8%) which is an improvement on the September performance. University Hospital Derby & Burton FT (UHDBFT) performance was 80.7% (YTD 82.1%), a decrease from September. None of the associate providers achieved the standard during October. The figure for November was 61.3% for November. There were no 12-hour trolley breaches at CRH during October but there were 6 breaches at UHDB (all due to the unavailability of suitable mental health beds). The figure for November was 66.7% for November. EMAS is non-compliant in 5 out of 6 national standards for Derbyshire. EMAS regional performance was non-compliant in 5 standards. Both of these are a deterioration on the previous month when Category 4 response times were compliant. **Planned Care** 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant across Derbyshire at 88.6%, a decrease from the previous month. Year-to-date CRHFT performance was 90.8% and UHDBFT 88.8%. Derbyshire CCGs had no patients waiting over 52 weeks at the end of September. **Cancer** 6 of the 9 standards were non-compliant at Derbyshire level in September 2019. All Cancer Two Week Waits were met at Derbyshire level (95.2%). Breast symptomatic was 90.9%, a significant improvement on 58.5% for the previous month. Non-compliance at UHDBFT and East Cheshire has resulted in the	

target not being hit.

31 days diagnosis to treatment dropped to non-compliance at 93.6%. 31 days subsequent surgery improved but was still was non-compliant at 91.2%. This was due to non-compliance at East Cheshire, Nottingham University Hospitals (NUH), Stockport and Sheffield.

62 day - Urgent GP Referral performance continues to be non-compliant at a Derbyshire level (76.1%). Of the CCG providers only East Cheshire are meeting the standard. The number of patients waiting over 104 days for treatment during August at both the main providers is 5 at CRHFT (3 breaches) and 16 at UHDBFT.

Chesterfield Royal FT
12 hour trolley breach: One breach occurred in September relating to a delay in transfer to a bed. No harm was identified by the Trust; the patient spent a total of 15 hours in the department for which the patient and family received an apology. The CCG Quality team are monitoring the action plan and assurance is sought through the Clinical Quality Reference Group (CQRG).

University Hospital of Derby Burton FT
Mixed Sex Accommodation (MSA) breaches:
During September 2019 there were a total of 15 MSA breaches across the Trust sites. 9 breaches occurred on the Derby sites (Ward 407), 6 occurred on the Burton sites (ICU). The CCG Quality team have noted the breaches and are investigating. These two areas reported MSA breaches during August 2019. All breaches were due to lack of available beds. No harm or adverse effects on experience or safety were reported. Following new national guidelines (Sept 19) UHDBFT have reviewed their definition of a justified and unjustified breach. Only the patients that no longer require Level 2 and Level 3 care will be submitted and reported as breaches. All breaches are monitored through CQRG.

12 hour trolley breaches:
Two trolley breaches were reported by Derby Emergency Department due to a wait for mental health beds. The CCG Quality Team continues to be assured that the people affected by breaches are being cared for appropriately while awaiting transfer. A system working group is developing a new approach to prevent breaches for mental health beds.

Derbyshire Healthcare FT
Out of Area (OOA) – Acute Mental Health Placements: The average number of patients in an OOA acute bed was maintained at 8 for July, August and September 2019. October saw an increase in requests for acute beds to an average of 13 patients at any time. The Acute Services Management Team has clear systems and processes to facilitate the flow of patients is planned to reduce the amount of time patients are out of area and to optimise beds in the acute units. Acute OOA Mental Health beds are monitored through the CCG contracting meetings.

	East Midlands Ambulance Service Serious Incidents: There has been an increase in the number of Serious Incidents reported this year with 27 reported to date. 18 of these were reported during Quarter Two, compared to 11 reported in the same quarter in 2018/19. The majority of these serious incidents related to a delayed response, with the coordinating commissioner team continuing to monitor this closely. In conjunction with EMAS, the coordinating commissioning team are undertaking a review of prolonged waits and harm reviews as well as quality visits and audits. **Derbyshire Community health Services** Delayed Transfer of Care (DTOC): The overall figure in October was 4.8% which is above the NHS England & Improvement target of 3.5%. The Year to Date figure is 4.7%. There were 148 delayed days across all wards. The number of days attributable to Health was 115 days and to Social Care 33 days. The main reason for delays was patient and or family choice which equated to 103 days. DTOC figures are monitored through CQRG, with an action plan in place. ZJ referred to the A&E position and the level of scrutiny that it is being given confirming that weekly Chief Executive level escalation calls take place between the Trust and CCG discussing long length of stay patients. GO noted the drop for CRHFT and asked if there is a reason behind this. ZJ stated a mix of reasons with nothing in particular standing out. BD referred to the capacity in other parts of system to take on the increasing demand and stated that this should be looked at on a system level. EP asked about the plans for winter, ZJ responded confirming there is currently a significant bed gap at Royal Derby Hospitals FT and there are mitigations in place for this. Key interventions have been put in place. BD stated the assurance that he would want as a commissioner is confirmation that no patient who is presenting with a level of acuity which requires more urgent assessment and treatment is being put at risk. **Action** - HW will obtain evidence to confirm that there is no patient harm as a result of patients requiring more urgent assessment and treatment. AM referred to the 15 minute handover process which is in place at QMC and asked if this should be adopted in other A&E departments. ZJ replied stating protocols are in place and there are processes that would need to be followed to implement this. PS added as part of EMAS Quality Assurance Group the A&E Delivery Board has tasked both Acute Trusts to explain what action is being taken around pre hospital handover delays. Royal Derby Hospitals	**HW**

	FT is also looking at capacity to ease the pressure on EMAS and release vehicles back into the system. EP asked for figures on how long the crews are spending with patients before conveying. BD noted the internal review being carried out by EMAS which will come back to this Committee. **Action** - BD reflected on the conversations and confirmed that he would like to explore acuity of presentation, ensuring patients are being dealt with in a timely manner and assurance that the CCG statutory obligation to meet the March 2019 level for RTT by March 2020. HH then presented the quality aspect of the integrated report. There were 15 mixed sex accommodation breaches at UHDBFT in September and a paper is being presented at this meeting. There is a shift in the definition of mixed sex accommodation which gives more clarification. There has been a slight increase in October in the out of area placements for Acute MH. The MH Trust is putting everything they can in place to keep patients in area. The peak is not unprecedented over the Christmas period. The number of SI has increased for the ambulance service and this is due to delays in responses. The Commissioning team are exploring patient harm and the findings will be presented to the 999 Quality Board and Quality and Performance Committee in the new year. HM joined the meeting BD noted the Committee need to have an oversight of the SI reviews and emerging themes around patient harm. **Action** - Nicola Smith will present the findings from the SI review to the Quality and Performance Committee. The Committee noted and approved the contents of the Integrated Report.	**NS** **NS**
Q&P 1920/153	**Remedial Action Plan** HW presented the report to the Committee The purpose of the paper is to have an overview of the protocol that is followed by the CCG. BD noted the current process and pointed out the process may change as we work towards system working.	

Q&P 1920/154	**Cancer Governance** HW presented the paper to the Committee. The report documents the actions being taken to improve patient outcomes and performance for those patients referred to the Trust on a cancer pathway. The document gives high level detail on the intended actions and details of the different work streams. The CCG will be receiving an outline of the new improvement plan at the end of November which will be shared with the Quality and Performance Committee. This is driven by the Frimley Health visit with Royal Derby Hospitals FT having a revised structure to manage this. There is system wide involvement including representatives from CRHFT as well as Royal Derby Hospitals FT and the CCG. BD noted the positivity of the contents of the document and the committee's full support.	
Q&P 1920/155	**Deep Dive – Medicines Safety – Antibiotic Awareness** HM presented the report. This report details implemented and planned local actions by the organisation to support achievement of the UK's 20-year vision on antimicrobial resistance (AMR), published in January 2019. The organisational plan was informed by the 2019–2024 national action plan, outlining the 5 year strategy to ensure progress towards the 20-year vision for containment and control of AMR. The report also includes an update on the CCG position and prescribing trends with reference to national targets for primary care antibiotic prescribing across Derbyshire. This is based on the latest available prescribing data. Data collected will be circulated to the PCN at a local level and support will be offered to prescribers to improve their antimicrobial prescribing. The Derbyshire wide picture will be included on a quarterly basis in the medicines quality and safety report and will also be reported to the Quality and Performance Committee. A more detailed report will be submitted to the Derbyshire Prescribing Group. BD noted the overall picture for Derbyshire looks promising however there is still a lot of work to be done. MW referred to the table on page 68 and questioned the figures for the North East of the county and asked if this was related to	

	policies from the previous four CCGs. HM replied stating it is not understood how the demographics of the different populations affect prescribing. Individual work would need to be done within practices to further understand the issues. BD commented that DDCCG are doing well as a county based on the national criteria. In addition, the work being carried out at PCN level is presenting more opportunities to make improvements.	
Q&P 1920/156	**Maternity** AC presented the paper to the Committee CRHFT and UHDBFT are continuing to work across organisations to ensure assurance around quality. Joint reviews of incidents are also being explored. There are ongoing challenges around Continuity of Carer (CoC) which is due to workforce issues and the Acute Trusts are currently going through organisational change to look at roles and responsibilities and changes to job descriptions. The CCG are still aiming to reach the target of 35% continuity by March 2020; however it is felt that this may be unachievable for both UHDBFT and CRHFT due to the current staffing levels. AC also noted the work which has been done with the JUCD team around Maternity Transformation and the outputs from the Saving Babies Lives Care Bundle which is reporting a positive picture with reductions in still births. BD noted the positive content of the paper and agreed that the CoC target was going to be difficult to achieve.	
Q&P 1920/157	**CQC Inspection report on Cygnet Acer** PS presented the paper to the Committee. PS noted that a detailed response from around Acer is included in the confidential section of the meeting.	
Q&P 1920/158	**Continuing Health Care (CHC)** HH noted continued improvements around Fast Tracks with significant reductions in numbers which is having an impact on QIPP delivery. AM noted the risk around issuing Personal Health Budget (PHB) for CHC. HH noted that there are QIPP savings attached to the CHC PHB's and robust processes are in place to monitor including patient reviews every 12 months or earlier if required. The CCG are over performing in this area. GO noted the high level of assurance from the Committee members around Continuing Health Care.	

Q&P 1920/159	**LeDeR** PS presented the report to the Committee. Confirmation has been received that LeDeR is now pronounced nationally as "*Leader*". At the recent LeDeR quality review it was confirmed that the trajectory of 12 cases to review has been met, the cases were a combination of new and backlog cases. The backlog has reduced since August from 52 to 18 cases. The staffing levels of reviewers have been increase by one day per week and therefore that backlog is on trajectory to be met by February 2020 in line with NHSE expectations. The next step is to identify how the steering group can look at the learning that comes from the quality, themes and trends.	
Q&P 1920/160	**CRHFT Cancer Team** Maria Riley presented to the Committee. AM noted the growing interest in system working and asked if there is any generic lessons being learned around persuading others to share best practice between different organisations. MR noted that any pathway work carried out is approached on a system wide basis. System events have been successful in getting a clinically led change with a collaborative approach and agreeing a way forward. GO referred to recruitment and asked how confident CRHFT are in recruiting staff to enable the service to be expanded. MR replied to say that there are historical and ongoing struggles to recruit consultants to the Chesterfield area and therefore a different approach has been taken to the workforce redesign with two Nurse Consultants coming into the prostate service.	
Q&P 1920/161	**Transforming Care Partnership** JS presented the paper to the Committee. JS highlight to the Committee the recent national announcement around the care and treatment for people with LD and ASD. There has been a change in guidance from NHSIE following the findings from the Wharton Hall investigation in May 2019. Findings were similar to those at Winterbourne Hall. The NHSIE guidance includes changing oversights for out of area placements which means that the quality team now have oversight for any MH provider in our area. Work has already started in terms of quality assurance visits. Another change to the guidance is around any patient with LD or ASD who is placed in a MH bed outside of our area. The patient must have regular reviews carried	

	out by the CCG and the individuals care is overseen by the CCG. JS added that agreement is being sought by the Quality and Performance Committee for an additional layer of assurance to be added to the case management of these patients. JS noted that the change to guidance must be in place by December 2019 and JS assured the Committee that this should be achieved. JS went on to talk about the House of Commons Human Rights Committee who have reviewed the care of young people receiving MH care. The findings are damning and highlight failures across the system. The recommendations from the review by NHSIE should be published early in the new year. Guidance from NHSIE and HEE has been issued around training for all people around autism. Since the issued guidance in 2009 it is a statutory duty for employers to ensure all staff are trained to understand autism better. It is know that this is not in place in some areas and guidance issued makes clear the responsibility of the CCG. During the last quarter a qualitative review has been carried out at Ashgreen and there were significant challenges and improvements need to be seen in the follow up visit in three months' time. The target to achieve a reduced number of patients in beds has not been met and the CCG are in escalation status with NHSIE. RAPS have been submitted which details what actions will be taken to get back to the expected position. The action plans are being monitored through the LD ASD Executive Board which is a work stream of JUCD. Referring to performance, JS noted that as at end November 2019 the number of patients in beds was 19 against an expected 24. It is not expected that the target will be met by the end of the year. This has been communicated to NHSE and to the LD ASD Executive Board. One long stay patient who has been receiving in patient care for 6.5 years was discharged and it is expected that another three patients will be supported in their discharge this year. PS referred to the changes in guidance and oversight arrangements and stated NHSIE will be providing a quality toolkit in the coming year which means all CCGs will be working to the same standards and will ensure some element of consistency.	
Q&P 1920/162	**DHU 111 CQC Inspection Report** HH highlighted the satisfactory inspection carried out by CQC and the ongoing reviews with DHU.	
Q&P 1920/163	**Exception Risk Report**	

	SP presented the report to the Committee. There are 3 x high risks for the Quality and Performance Committee which are being managed but do not require reducing at this stage. 1 new risk, Risk 39, around section 117 after costs and the pressure impacts has been added to the Risk Register and agreement is sought from the Committee for the addition of this risk. There are no closed risks this month. The Committee noted the risks and agreed for the addition of risk 39 to the Risk Register. **Action** – SP will bring more details for Risk 39 around S117 to the next committee meeting.	**SP**
Q&P 1920/164	**Change in oversight arrangements for Quality of Inpatient Care for people with a learning disability and / or autism** The Committee received and noted the contents of the paper.	
Q&P 1920/165	**Delivering same-sex accommodation – policy update** The Committee received and noted the contents of the paper.	
Q&P 1920/166	**Community Infection Prevention & Control Service Specification** The Committee received and noted the contents of the paper.	
Q&P 1920/167	**Q2 Patient Complaints Report** The Committee received and noted the contents of the paper.	
Q&P 1920/168	**IRP** The Committee received and noted the contents of the paper.	
Q&P 1920/169	**Organisation, Effectiveness and Improvement 30/60 day action plan.** The Committee received and noted the contents of the paper.	
Q&P 1920/170	**National / Regional Guidance** – none received	
Q&P 1920/171	**Minutes Received from other sub-committees:** • UHDB CMB Draft Minutes 12/09/19 • 111 CQRG Minutes 28/08/2019 • DHU CQRG Minutes 18/11/2019	

Q&P 1920/172	**Minutes of the meeting held on 31st October 2019** The minutes of the meeting on 31st October 2019 were accepted as a true and accurate record of the meeting.	
Q&P 1920/173	**Matters Arising / Action Log not elsewhere on the agenda** The actions on the action log were reviewed. Updates were given and actions closed where appropriate.	
Q&P 1920/174	**Any Other Business** There were no other items for discussion.	
Q&P 1920/175	**Assurance Questions** • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • Was the content of the papers suitable and appropriate for the public domain? Yes. • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? The risk on section 117 will be discussed in more detail. • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None • Is the Committee assured on progress regarding actions assigned to it within the Organisational Effectiveness and Improvement action plan? Yes	

DATE AND TIME OF NEXT MEETING
Date: 19th December 2019
Time: 9.30am to 12.30pm
Venue: Conference Room, Toll Bar House, Ilkeston

Joined Up Care Derbyshire Board
Minutes of the Meeting held on
Friday 18 October 2019 09h00 to 12h00
Charnos Hall, Ilkeston Hospital
CONFIRMED

Present:		**Designation:**	**Organisation:**	
Angie Smithson	AS	Chief Executive	Chesterfield Royal Hospital NHSFT	
Chris Clayton	CC	Chief Executive	NHS Derby & Derbyshire CCG	
Deborah Widdowson	DWi	Senior Delivery & Improvement Lead	NHS England & Improvement	
Duncan Gooch	DG	Chair	Derbyshire GP Alliance	
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	
Helen Jones	HJ	Director of Adult Social Care	Derbyshire County Council	
Kathy Mclean	KMc	Chair	University Hospitals Derby and Burton NHSFT	
Karen Ritchie	KR	Head of Engagement	Joined Up Care Derbyshire	
John MacDonald (Chair)	JM	Chair	Joined Up Care Derbyshire	
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT	
Martin Whittle	MW	Engagement Committee Chair	NHS Derby & Derbyshire CCG	
Phil Cox	PC	GP & Non-Executive Director	Derbyshire Health United	
Prem Singh	PS	Chair	Derbyshire Community Health Services NHSFT	
Sean Thornton	ST	Assistant Director, Communications & Engagement	Joined Up Care Derbyshire; NHS Derby & Derbyshire CCG	
Stephen Bateman	SB	Chief Executive	Derbyshire Health United Care	
Sukhi Mahil	SKM	STP Assistant Director	Joined Up Care Derbyshire	
Tracy Allen	TA	Chief Executive	Derbyshire Community Health Services NHSFT	
Vikki Taylor	VT	STP Director	Joined Up Care Derbyshire	
William Legge	WL	Director of Strategy & Transformation	EMAS NHSFT	
In Attendance:				**Deputy on behalf of:**
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG	
Claire Wright	CW	Deputy Chief Executive	Derbyshire Healthcare NHSFT	Ifti Majid
Helen Hipkiss	HH	Deputy Director of Quality	Derby & Derbyshire CCG	
Linda Garnett	LG	Workforce and OD Lead	Joined Up Care Derbyshire	
Paddy Kinsella	PK	GP	GP Alliance	
Pauline Tagg	PT	Chairman	EMAS NHSFT	
James Betteridge-Sorby	JBS	GP	LMC Derbyshire	Kath Markus
Julie Knight	JK	Head of Home First	Derby City Council	
Lisa Marshall	LM	Discharge & Integration Manager	Derbyshire Community Health Services NHSFT & UHDB	
Rebecca Spray	RS	Integrated Community Manager	Derbyshire Community Health Services	
Richard Wright	RW	Non-Executive Director	Derbyshire Healthcare NHSFT	Caroline Maley
Ruth Dawes	RD	ICM	Derbyshire Community Health Services	
Shanice Bailey	SBa	Programme Support Officer	Joined Up Care Derbyshire	
Apologies:				
Andy Smith	AS	Strategic Director of People Services	Derby City Council	
Avi Bhatia	AB	GP & Chair	Derby & Derbyshire CCG	
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT	
Cate Edwynn	CE	Director of Public Health	Derby City Council	
David Whitney	DWh	Chair	Derbyshire Health United Care	
Dean Wallace	DWa	Director of Public Health	Derbyshire County Council	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital	

Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
Jane Chapman	JC	Head of Assurance and Delivery (Derbyshire)	NHS England/Improvement	
Jane Ide	JI	Non-Executive Director	EMAS NHSFT	
Kath Markus	KM	Chief Executive	LMC Derbyshire	
Sara Hares	SH	Specialist Commissioning	NHS England & Improvement	
Steve Lloyd	SL	Medical Director	NHS Derby & Derbyshire CCG	

181019/1	**Apologies and Minutes of Previous Meeting**	**Action**
	The Chair welcomed members to the meeting and introductions were made. Apologies for absence were noted as reflected above. The Chair confirmed the meeting was quorate. The minutes from the meeting held on Friday 20 September 2019 were agreed as an accurate record.	
181019/2	**Action Log**	
	None of the items on the action log required an update. All of the actions were either future agenda items or were in progress.	
181019/3	**Declarations of Interest**	
	The Declarations of Interest were considered; the purpose was to record any conflicts of interest and confirm any other conflicts requiring inclusion. The Board reviewed the register and confirmed it was fully reflective and accurate. No further declarations pertinent to the agenda were made.	
181019/4	**Patient Story: The Road to Integration**	
	Julie Knight, Head of Home First for Derby City Council, Lisa Marshall, Discharge & Integration Manager for Derbyshire Community Health Services NHSFT & UHDB and Rebecca Spray, Integrated Community Manager for Derbyshire Community Health Services attended the JUCD Board to showcase the integration between DCC/DCHS that covers the Discharge to Access/Rapid response approach. The team demonstrated how they brought 3 organisations together to work collaboratively with service user at the centre; joint working, passion and a commitment to achieve the optimal patient journey. JK provided some context around the work so far involving the teams who prevent admission or facilitate discharge in Derby City. The teams involved were the integrated discharge team in the hospital, home first service (pathway 2 and 1) and the community intermediate care team at DCHS; the teams came together to create an intermediate pathway through an alliance of multi-agency staff. The model started four years ago when each way of working was in silos and was not joined up. It became apparent to Home First that they could not deliver what was best for the patients or reduce waiting list by tweaking services, a complete change in the team and approach was needed and was done whilst delivering the service to patients. Home First changed every job, process and working arrangements and created a single team to work across the beds in the community to ensure a seamless patient experience. Working alongside DCHS meant that when a patient was identified in the hospital that needed a certain type of intervention, the team managed that pathway inclusively. The patient reviews, assessments, screening and care were all done in one model, an alliance of multi-agency staff without formal commissioning working towards one vision. *The team highlighted the following points of the road to integration journey:* • Radical redesign of the Derby City health and social care discharge pathway from tradition	

to innovation
- Leading and delivering integrated working across professional boundaries at all levels
- Organisational integration by alliance and collaboration; patient centred, timely and effective

The team showcased two different case study examples of how the newly developed integrated team had prevented admissions. The journey so far was described as challenging but the success had been through changing the mind-set of staff from the 'old' way of working to the new. The joined-up approach to integrated working to facilitate the best outcomes and settings for patient assessment and recovery provided a wholly inclusive service.

The teams achievements so far have been award winning and are outlined below:

- **LGC Awards 2019 Business Transformation Derby City Council** - Winners
- **DCHS Extra Mile Awards 2019** - Rapid Response Team Shortlisted Extra Mile Award for Clinical Team of the Year 2019
- **HSJ Awards 2019 Finalist** - Home First, DCC & Derbyshire Community Health Services 'Road to Integration'
- **Social Worker of the Year Awards Gold 2018** - Jane Haywood Adult Services Team Leader of the Year 2018 Gold Award
- **Social Worker of the Year Awards Silver 2017** - Hospital To Home Team of the Year Adult Services 2017 Silver Award

GB commented that this was a fantastic team that has had an enormous impact on the care the patients had been given. Various professionals, organisations and agencies were involved but none could be told apart as there were clear team workings. GB suggested this model was a great example of a microcosm of what the STP was about; organisationally agnostic, people working together regardless of the organisation that had employed them.

JB queried whether there had been a notable difference in the readmission rates. LM explained the rates did spike until the team got better at understanding what the pathways were, as services could then be better wrapped around patients so rates then improved.

CC queried the link with County on a practicable basis and queried if there were any geography issues. LM confirmed the County council were within the integrated discharge team and a lot of work had been done on the redesign of services in Derby City to ensure they are community services. GB added, the team works to support the discharge of all the patients that need support; more about making sure there was a supply as the means of getting the patient to the right place was present. The boundaries were therefore less of an issue but whether the provision was there was the bigger challenge.

LO expressed interest in the submissions for joint working and queried the permissions for this work. JK explained that DCHS and City reviewed the model and as operational leaders they built up a business case as they went along and did not ask permission but felt it was the right thing to do for the patients.

JM acknowledged that this was the second patient story brought before the board where permission was not asked. PS expressed feeling captivated by the initiative people had taken without management input. PS felt the question of 'how do we avoid ourselves over managing and over contracting where we interfere too much and expect things to happen in a different way' needs to be addressed as the system was still preoccupied with testing pilots of which were not then embedded; mind-sets need to be challenged and the mind-set to enable staff needs to be applied.

SB asked what the most important ask of the JUCD Board would be. JK suggested for the IT issues faced to be taken forward as Perth house has System One and social care has the LAS system and

TA/HJ/GB

	the team have been trying for over 2 years for staff to have read only access and this was yet to be sorted and was currently the biggest restriction in terms of moving forward. JM thanked the team for their presentation and summarised that the change in mind-set had clearly been accomplished for the team to get to where they have to date. The job of management was to acknowledge the barriers that have been highlighted and assist in solving these. JM encouraged that future stories brought before the board continue to highlight barriers, and the board would need to consider how to resolve these issues to support staff in delivering optimal care.	
181019/5	**System Oversight: Chairs Report**	
	The Chair's report provided an update on key developments related to the STP on the period since the last JUCD STP Board. JM highlighted the following points: 1. Feedback from NHSE/I on the draft STP Refresh: SKM summarised that the Plan was well received and NHSE/I wanted to share the plan with others as an example of good practice. Areas that were highlighted as requiring further work including Finance, Activity and Workforce triangulation. 2. JM confirmed an upcoming meeting involving clinicians to discuss how to strengthen the clinical engagement and clinical leadership across JUCD. 3. JM confirmed his attendance at the upcoming CCG Governing Board meeting due to take place on Thursday 7 November to provide an update on the system position. 4. NHSE/I have launched a programme to support development of integrated volunteering approaches to enhance delivery of the NHS Long Term Plan commitments. JUCD have been successful in securing funding for year one of this initiative (£40,500). 5. A new scheme was being offered as a pilot to 4 Derbyshire practices which supported the development and implementation of a bespoke wellbeing package. The programme was funded by NHS England Retention monies and will be delivered though the new single Primary Care Training Hub for Derbyshire. 6. JM reiterated the importance of becoming an ICS by April 2021 and the need to be bedding down some of the architecture and thinking through how to work and build the teams in the right places was crucial. By April 2020, JM would expect to see this architecture established n shadow form but acknowledged this would not be fully developed; discussions should take place over the next couple of months to enable this to happen. It was felt that the 2020/21 commissioning intentions recently issued should be brought back as an agenda item for further discussion around the implications for system working and the opportunities for commissioning in a new financial framework. Chris Clayton agreed to present this at a future meeting.	**CC**
181019/6	**Delivering Today: Derbyshire System Financial Delivery**	
	LO provided an update to the STP Board on the performance against the Derbyshire STP financial plan at month 6, and the work and monitoring performed by the Systems Savings Group on the aggregate savings required by the DDCCG and five NHS Derbyshire providers, including EMAS. The system was reported as being off plan at the end of month 6. The Chesterfield position continued to be off plan due to the complexities of the tariff change (year on year assessment and the move to the blended tariff for unscheduled care in year and the year to date over performance). UHDB was now reporting as being on-plan year to date performance, but this was largely due to the utilisation of a provision from 2018/19 year end, which had now been fully released into the year to date position. LO is continuing to engage with Local Government Treasurers on the inclusion of the adult social	

	care spend and LO would be meeting with the County Council Treasurer on the 25th October. TA referred to the Financial Position in Month 6 (by CCG Spend Type) table within the report. As the ambition of the JUCD Board was to shift spend in order to shift care, TA suggested this table needed more attention each month as currently it highlights our actual spend does not support the intended shift. GB noted his agreement with TA's comments and suggested the driving force was growth, demand and tariff change. TA expressed investment into Primary Care (in its broadest sense) was needed in order to be able to shift the curve. PS in full agreement with TA's comment queried how the risk share was playing out in the first year and felt the answer would point to the table in discussion. PS requested an analysis on how the risk-share agreement was progressing and how it aligns with the commissioning intentions be undertaken as a priority. CC confirmed the Derbyshire health economy was overspent by 3%, taking into account it was already receiving 3% over allocation. HJ addressed the fact that the report referred to adult social care but not public health funding and queried whether the task was to get both adult social care and public health funding. LO confirmed this was correct and needed to be included in order to provide a more holistic view. LO and HJ to have a discussion outside of the meeting. KMc queried whether there was a message in the numbers that suggested all partner energy be turned to one transformational programme that could make a difference, as opposed to trying to address multiple different issues. DG acknowledged the report now included more providers and commented that there were still many numbers that could not be seen. DG expressed if the Board was presented with numbers that were inherently lacking across the system it would then make it harder to take a system view. GB expressed feeling apprehensive about Winter and questioned whether there was an opportunity to do a cross system review looking at what major pieces of work could be accelerated to give benefits and turn down demand as Winter approaches. There was general support and agreement for this approach. JM suggested Chief Executive Officers to identify the priorities to focus more resource around delivery.	**LO** **HJ/LO** **CEOs**
181019/7	**Delivering Today: System Risk Management**	
	SKM presented the quarterly review of the risk register to highlight risks scoring above 12 and any changes since the last review. Key issues of note in relation to the register were: • ***R010: There is a risk that the actions set out in the winter plan will not provide sufficient system capacity to cope with demand*** had been closed as agreed at the last Board review and has been replaced with ***R016: There is a risk that the system does not have sufficient and flexible capacity to cope with peaks in demand (including winter).*** This was to better reflect overall system capacity. • Following discussion at the last review in relation to ***R012: There is a risk that failure to deliver the prevention agenda and advance care planning for people with known conditions, including frailty, will increase non-elective activity unsustainably;*** the risk was taken back to CPRG as the originators of the risk for further consideration. It was confirmed that advance care planning element of this risk should be separated. The risks had now been amended as follows: o ***R012: There is a risk that failure to deliver the prevention agenda by embedding within all areas of work will fail to deliver the upstream changes required to improve longer term sustainable outcomes.*** The risk score remains at 20 due to	

	Public Health funding being cut for prevention services. o ***R014: There is a risk that ineffective advance care planning for people with known conditions, including frailty, will continue to increase non-elective activity unsustainably*** All remaining risks on the register had a score of 12 or above and were therefore highlighted to the Board. Particular attention was drawn to the following: • ***R003: There is a risk that insufficient programme resourcing across the system compromises delivery and implementation at the pace and scale required.*** The risk rating remains unchanged; although work had taken place to begin releasing capacity to dedicate resource to workstreams, significant gaps remain which continue to be reviewed through the CEOs group. • ***R005: There is a risk that implementation will be compromised due to insufficient workforce plans.*** The risk rating had been adjusted from 16 to 12; the reason being that capacity had been secured to support the development of the workforce strategy and the improved alignment to each of the workstreams. • ***R006: There is a risk that service delivery and transformational change programmes are compromised due to inadequate digital technology strategy and operationalisation.*** The risk rating had also been adjusted from 16 to 12. This was due predominantly to the revised governance arrangements which were now gathering momentum to facilitate change, ensuring stronger links with workstreams and the development of the digital strategy. During the STP refresh process, the lack of effective business intelligence data and capacity to support workstreams became even more evident and therefore a new risk was added to the register: • ***R015: There is significant risk to effective planning, monitoring and use of resources, exacerbated by the lack of a whole system approach to knowledge and intelligence -*** score 20. The initial assessment of this risk was based on ongoing challenges at various levels within the system and the need for effective data, knowledge and intelligence to support decision making and resource allocation. This was an important area which the system needed to resolve and through discussion with Dean Wallace as the SRO proposals are being developed which take account of the capacity in place and how it was currently utilised which should address how this gap could be resolved. SKM asked the Board to note the risks scoring 12 or above and propose any amendments to the risks identified and agree additional system level actions required to manage the risks. KMc made a global observation stating the ambition seemed to be much greater than the ability to achieve and therefore suggested for a more radical approach to mitigating some of the risks. KMc suggested the risk appetite should be considered. SKM agreed with the comments made and felt a review should take place that could link with the risk appetite conversation.	**SKM**
181019/8	**Delivering Today: System approach to Quality Impact Assessment**	
	BS was invited to attend the JUCD Board to provide an overview of the progress to date in regards to aligning QIA/EQIA processes across Derbyshire. The Quality Impact Assessment (QIA) process ensures that quality remains at the heart of Cost Improvement Programmes (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) programmes that aim to deliver high quality care in a tighter economic climate and save money without impacting on services and patient safety. In 2018/19 a review of QIA processes across the then four Derbyshire CCGs and provider organisations identified that although there were recognisable processes in place in all	

	organisations, they varied dramatically. In addition, governance processes for sign off of CIP and QIPP programmes and associated projects did not provide full assurance that robust assessment on the impact on quality of proposed savings plans. BS confirmed the single system-wide QIA process would commence with the CCG and Providers. It was intended that QIAs for the Local Authorities and smaller providers would be incorporated into the process as soon as the systems were established and working well. BS explained that when an organisation identifies through internal QIA/EQIA potential impacts upon cross system partner organisations, the relevant QIA/EQIA should be discussed at the Senior Nurses Leadership Group and escalated to CPRG should additional mitigation not be identified and the Quality Impact risk remains high. PS suggested that the impact assessment for quality and equality needed to be aligned around the quadruple aim including workforce implications and public health shifts. BS confirmed that the tool included these areas of consideration. GB asked if there was a risk of completing a QIA that could satisfy the risk for that individual organisation but might be unacceptable for another organisation. BS confirmed the tool had been refined to pick up triggers of cross system impacts. GB suggested for a question to be factored into the QIA, such as 'does this have an impact on any other organisation?' BS agreed with GB's comment and confirmed this suggestion would be taken forward. JM felt all comments had been useful and advised for QIA to come back in 6 months with a live demonstration of the toolkit. SBa to agenda.	**BS** **SBa**
181019/9	**Building for Tomorrow: End of Life**	
	HH presented the STP End of Life Work Stream Strategy. The End of Life (EoL) work stream was established to bring together system-wide clinicians, providers and commissioners to discuss and address EoL issues in Derby and Derbyshire. It was recognised by the Board, CCG and the CPRG that there was a need for a formal EoL Strategy for the STP, which set out the clear aims and objectives for EoL and the commissioning intentions to deliver those. In response, an EoL Board was established and chaired by the CCG Chief Nursing Officer. A new operational group was due to start in October 2019 to deliver the actions required for the work stream. HH confirmed that only 54% of people in Derby and Derbyshire die where they wish to. The majority of people that choose to die outside of hospital still die inside of a hospital. The EoL Strategy aims to turn this on its head and allow patients to die in the community, if this is their choice. HH explained within the strategy it was clear that there was a need to ensure that the EoL service responded to need quickly, and wrapped around the patient, enabled through the fast track service. JB suggested a need for coordination with the wider family regarding end of life preference needed to be improved as there was often occasions where the patient was not in a position to make decisions; relatives would therefore have to make important decisions on the patient's behalf. HH concurred and explained part of the strategy contains a digital strategy aim to share information across the system; an electronic form for EMAS to look at to state whether or not the patient was EOL and where they would like to die. CC commented on the 'last year of life' part of the strategy and queried whether this definition was too restrictive. HH reassured CC that the 'last year of life' was a mandatory national strategy used but the strategy did in fact start low down within communities long before someone was in their last year of life.	

	HJ asked for assurance on the 'all staff is prepared to care' section of the strategy and queried whether the strategy targeted people who saw themselves delivering EoL care or the entire workforce that had interaction with that person. HH confirmed it was for the entire workforce that would potentially have contact with the patient and therefore needed to be aware of the strategy and its ambition. HJ therefore suggested for the sentence to be amended to be made more specific and clear. HH was in agreement. WL felt information sharing was key as it would improve EMAS decision making and the expectation on the ambulance crews. PK queried whether any GP input had been involved. HH confirm Dr Pauline Love was the clinical lead for the EoL pathway and had been heavily involved. HH confirmed lay members were present on the operational groups. BS added that the EoL strategy went to the STP citizen's panel which was well received. BS chairs the STP work-stream for EoL and confirmed the new constituted Board plan to have a rotating member of the public attend due to the amount of interest. DG felt this was a good opportunity to get staff talking about their own mortality. SB felt it was imperative to endorse and support the strategy to enable a person to die in their place of choice. JM summarised that there was general support for the strategy and there was now a need to develop an implementation framework of how it would be delivered.	
181019/10	**Building for Tomorrow: 5 year Strategy Delivery Plan**	
	VT provided the JUCD Board with an update on the development of the Joined Up Care Derbyshire five year Strategy Delivery Plan refresh. VT reconfirmed that the draft narrative plan had been shared with the JUCD Board during its development and the initial draft was submitted to NHSE/I on 26 September 2019. The plan continues to be developed and the latest version was shared with members. The regional assurance review meeting took place on 10 October 2019 where feedback in relation to the draft submission of 26 September was received. VT confirmed that the narrative plan was well received, but there were some programme specific areas where suggestions were made to strengthen demonstrable delivery of the LTP commitments. VT advised whilst regulators could see the planning assumptions that had been used to get to the unmitigated activity, finance and workforce model for the system, the key area of concern was the modelling of the mitigation work, via the workstreams, and this is currently being developed. VT reiterated that the final submission deadline was still 15 November but an additional interim submission date to regional NHSE/I colleagues of 1 November 2019 has been requested. VT explained how this therefore changed the original approvals timeline, as a result VT recommended that the System Executive: CEOs group be given delegated authority to approve the detailed modelling and triangulation required to be incorporated into the plan narrative. This would ensure that contentious issues were understood by system partners and could be collectively managed with appropriate risk mitigations where necessary. JM added there was an expectation for Chief Executives to ensure they have gained the support and approval of their respective Boards/Health and Wellbeing Boards. JM queried engagement and appropriate approvals through primary care. DG confirmed that he had shared the draft plan with all of the PCN Clinical Directors and Place Leads and the strategy had been to the Primary Care Leadership group. JM asked for all feedback to come back through VT and SMa to ensure all feedback was included in the revised version. CC made it clear that the CCG did not represent general practice provision; the CCG and general practice have jointly set out a mechanism for the general practice voice to be heard	

	independently. JM clarified that the final submission deadline of the 15th November remains the same but the interim submission needs to be submitted to regulators on 1st November. In response to the discussion, ST agreed to send out a short summary of the key changes since the first draft was shared to support Board level discussions. LO confirmed that the financial modelling for the long term plan assumes delivery of the 2019/20 Derbyshire financial plan, including all the required 2019/20 savings. This was a key risk and sensitivity to the model. LO made members aware that if the system was unable to deliver £151m in 2019/20, 2020/21 and beyond will be more challenging as a result of this shortfall. This work has generated a broadly triangulated, activity, workforce and financial model, prior to mapping the impact of the required transformational changes. The system believes it could consume the provider CIP requirement of either 1.1% (or 1.6% in the case of UHDB) via the delivery of reduced unit costs for the existing models of care. At this stage there was also a tentative assumption around the unplanned, planned and place workstreams delivering £10m of savings in each of the four financial years. This would leave a residual system challenge of £32m, £34m, £32m and £39m between 2020/21 to 2023/24. To deliver the savings modelling work, senior finance support had been identified to model the potential impact of the workstreams to mitigate the agreed growth rates. This work would provide the basis of the update included in the final JUCD STP Refresh. ST and KR updated on key elements relating to JUCD communications and engagement activity. KR highlighted the steps taken to date to engage people in the development of the plans during the STP Refresh process, creating unprecedented opportunities for stakeholders to get involved in planning. KR noted the ongoing work to continually strengthen engagement: 1. The concept of continuous engagement - ensuring people and patients are at the heart of integrated care, involving them at every level of decision making, from idea conception, through to implementation, and at evaluation. 2. Fully utilising intelligence from patient experience and involvement - moving towards integrated/joined up health and care services, with the aim of ironing out duplication, gaps, and inefficiencies in services, making care and treatment more seamless, and focused on the needs of patients and not organisations. 3. Engagement Committee - this committee started 1 May 2019 and meets monthly. The meeting is in two parts; the first dealing with NHS Derby and Derbyshire CCG business, the second JUCD business. The meetings are attended by JUCD officers, lay representatives from across Derby and Derbyshire, along with Foundation Trust Governors. The committee reports directly the JUCD Board although does not provide a formal report. JM felt it would be pragmatic for the outputs to be shared with the JUCD Board as part of the Communications and Engagement report. As the architecture of the system develops, this might need reshaping, given the importance of communications and engagement. KR recommended that the Derbyshire system train patient leaders (who would represent the diverse views of people living in Derbyshire) to support every level of decision making within the emerging ICS. In addition, local patient experience and involvement teams will increasingly be working together to collate intelligence that can inform the redesign of care around patients and individuals, focusing where possible on what we already know. The intelligence derived will need to feed in to the system quality and performance committee and the transformational workstream. It was previously mooted that Joined Up Care Derbyshire Board might begin to hold its meetings	**ST** **ST**

	in public to support increased transparency in the planning and decision-making process. ST presented a format for how those meetings could be managed, with a proposal that JUCD Board moves to a 'meetings in public' model from January 2020. ST outlined some principles of how meetings held in public would be manged going forward. JM felt this approach should be taken forward in the new year. Members of the Board were in agreement with this recommendation.	
181019/11	**Standing Agenda Items: Any Other Business**	
	JM suggested the following 4 key messages to be shared with stakeholders and staff: 1. Patient story 2. Challenges this year 3. 5 year plan 4. EOL SB informed members that Derbyshire NHS 111 is provided by DHU and received an outstanding CQC rated service. No other AOB items were discussed.	
	Date of Next Meeting	
	The next meeting was scheduled to take place on Thursday 21 November 2019, 9.00am to 12.00pm, Conference Room, Toll Bar House, Ilkeston.	

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

9th January 2020

Item No: 198

Report Title	South Yorkshire and Bassetlaw Integrated Care System (ICS) Health Executive Group
Author(s)	Various
Sponsor (Director)	Helen Dillistone – Director of Corporate Strategy and Delivery

Paper for:	**Decision**		**Assurance**		**Discussion**		**Information**	x
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				South Yorkshire and Bassetlaw ICS Health Executive Group.				

Recommendations

The Governing Body is requested to **NOTE** the recommended papers from the December 2019 meeting of the South Yorkshire and Bassetlaw ICS Health Executive Group.

Report Summary

The following reports are provided for information:

- The ratified minutes of the November 2019 meeting
- An ICS system leader update
- Developing South Yorkshire and Bassetlaw 5 Year Strategy for 2019-24
- The progress on closing the gap on Trust financial trajectories
- Integrated Assurance Report – Delivery

Are there any Resource Implications (including Financial, Staffing etc)?

N/A

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

N/A

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

N/A

Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
N/A
Governing Body Assurance Framework
To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
Identification of Key Risks
N/A

South Yorkshire and Bassetlaw Integrated Care System

Meeting of the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Health Executive Group

09.00 – 13.00, Tuesday, 12 November 2019

at the Boardroom, NHS Sheffield CCG

Minutes

Present:

Name	Organisation	Designation	Present	Apologies
Sir Andrew Cash, CHAIR	South Yorkshire and Bassetlaw Integrated Care System (ICS)	Chief Executive	✓	
Rod Barnes	Yorkshire Ambulance Service	Chief Executive	✓	
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓
Des Breen	South Yorkshire and Bassetlaw Integrated Care System	Medical Director	✓	
Clive Clarke	Sheffield Health and Social Care NHS Foundation Trust	Interim Chief Executive	✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw Integrated Care System	Chief Operating Officer	✓	
Jeremy Cook	South Yorkshire and Bassetlaw Integrated Care System	Director of Finance	✓	
Mike Curtis	Health Education England	Local Director		✓
Alan Davis	South West Yorkshire Partnership NHS Foundation Trust	Director of HR and Estates	✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group (CCG)	Accountable Officer	✓	
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director		✓
Steve Hackett	Rotherham, Doncaster and South Humber NHS Foundation Trust	Executive Director Finance and Performance	✓	
Andy Hilton	Primary Care Sheffield	GP/Chief Executive	✓	
Terry Hudsen	NHS Sheffield Clinical Commissioning Group (CCG)	Chair	✓	
Tony Jamieson	Yorkshire and the Humber Academic Health and Science Network	Director of Transformation and Improvement deputising	✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓	
Lisa Kell	South Yorkshire and Bassetlaw Integrated Care System	Director of Commissioning	✓	

Alison Knowles	NHS England and NHS Improvement - North	Locality Director	✓	
Carole Lavelle	NHS England and NHS Improvement	Director of Nursing	✓	
Kirsten Major	Sheffield Teaching Hospitals NHS Foundation Trust	Chief Executive	✓	
Angie Smithson	Chesterfield Royal Hospital NHS Foundation Trust	Chief Executive	✓	
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Chief Executive	✓	
Jackie Pederson	NHS Doncaster Clinical Commissioning Group (CCG)	Accountable Officer		✓
Chris Preston	The Rotherham NHS Foundation Trust	Deputy Chief Executive	✓	
Kathryn Singh	Rotherham, Doncaster and South Humber NHS Foundation Trust	Chief Executive		✓
Kevin Smith	Public Health England	Deputy Director of Public Health	✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group (CCG) / NHS Sheffield CCG	Accountable Officer	✓	
John Somers	Sheffield Children's NHS Foundation Trust	Chief Executive	✓	
Helen Stevens	South Yorkshire and Bassetlaw Integrated Care System	Associate Director of Communications and Engagement	✓	
Richard Stubbs	Yorkshire and the Humber Academic Health and Science Network	Chief Executive		✓
Kevan Taylor	South Yorkshire and Bassetlaw Integrated Care System	Director of Workforce	✓	
Hayley Tingle	NHS Doncaster Clinical Commissioning Group (CCG)	Chief Finance Officer	✓	
<u>In attendance</u>				
Mags McDadd	South Yorkshire and Bassetlaw Integrated Care System	Corporate Committee Clerk		
Nicola Jay (agenda item 11)	Sheffield Children's Hospital Care of the Acutely Ill Child Clinical Workstream	Consultant Paediatrician Clinical Lead		
Ben Gildersleve (agenda item 9)	South Yorkshire and Bassetlaw Integrated Care System	Digital Programme Director		

1. Apologies for absence and welcome

The Chair welcomed members and attendees to the meeting and apologies were noted as above.

The Chair informed the meeting that the finance items would be discussed in a closed meeting with Chief Executives and Accountable Offices during the last hour of the meeting.

2. Declarations of interest

There were no declarations of interest noted.

3. Minutes of the Health Executive Group (HEG) meeting held on 8 October 2019

The minutes of the meeting were accepted as a true record of the meeting with an amendment to the Integrated Assurance Report and attendance list.

4. Review of Action Log

The Chair noted that all actions have been resolved or included on the agenda.

5. National and SYB ICS update:

The HEG noted the contents of the report based on the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) November activity. Members were asked to share the report with their Boards, Governing Bodies and Committees.

National update
The STP/ICS Leaders Development event chaired by Sir Andrew Cash took place on 7 November and included a variety of breakout sessions, featuring emerging best practice in integrated care and opportunities for networking with system leaders from across the country. Speakers included Simon Stevens, CEO; Amanda Pritchard, Chief Operating Officer, and Prerana Issar, Chief People Officer, all from NHS England and NHS Improvement and Professor Don Berwick, King's Fund International Visiting Fellow.

AJC added that the expectation is for nationwide established ICSs by April 2021 as part of the NHS Long Term Plan, subject to election outcomes, noting the main issue being the 'change of the default position', the switch from organisation/regulation to system/regulation and the timeframe for this fundamental switch in the operating model in NHS England / Improvement, equating to closer working relationships with ICSs and NHS England / Improvement.

Under this new reform careful consideration and planning would be required namely the planning and co-ordination of system transformation; management of system performance including health outcomes, quality of care, operational and financial performance and the adoption of a collective form of leadership with statutory rights and accountability.

The Group noted that the expectations as described were not a formal communication but from a discussion. The Chair encouraged preliminary discussions on the expectations in private Board and Governing Body meetings.

AJC added that the next steps in commissioning reform, governance arrangements, Primary Care Networks development and provider relationships are progressing within the timeframe of April 2020.

The group discussed the need to work together on a collective model of responsibility, building a shared consensus and proposed a timeout / development session at a future date.

General Election
The Chair opened the discussion on the possible impact of Purdah and pre-election period of sensitivity which could be extended depending on the outcome of the election. No concerns were raised. The group also noted the pre-election period in April/May 2020.

Winter Planning
The HEG discussed the letter received from NHS England / Improvement on winter readiness on the delivery for patients.

It was agreed that the system agreements would be developed at Place with the input of primary care, social care and all partners. RJ agreed to lead on pulling this together for providers with Chief Executives as the Accountable Officer lead.

AK noted that the Chief Operating Officers / Directors of Commissioning workshop on 20 / 21 November would also focus on how the system should work over the winter period.

The HEG raised concern around staff pension tax and the impact to workforce capacity and the need for a sensible central solution.

It was agreed to arrange a call with AJC, RP and Paul Wallace, Director of Employment Relations and Reward, NHS Employers to discuss concerns.

6. Hot Topics

The HEG noted that Simon Stevens, NHS England Chief Executive is visiting Sheffield Children's Hospital on 14th November 2019. The visit will include various showcase events and a question and answering session.

HT provided an update on the flooding rescue and recovery plans in Doncaster. It was noted that the system is responding well with support from a variety of services providers. The main concerns are patients access to medicines, in particular residential areas only accessible by the emergency services and that some residents are resistant to leaving their homes. There also remains a threat to further flooding later this week, in particular the areas of Fishlake and Retford.

IG provided an update on areas affected in Workshop, mostly business premises rather than residential. A positive response from providers was reported, noting it would take a long period of time for communities to recover from the impact.

7. Integrated Assurance Report

AK presented the current position against the Integrated Care System (ICS) Operational Plan and exception reports in relation to delivery, finance and transformation.

The Group noted that the ICS year-on-year performance remains positive, holding its position on national standards.

The Group noted the exception reports and agreed the level of assurance in relation to each issue as follows:

- Referral to Treatment - Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is significantly behind trajectory (85.7% actual versus 90.6% plan) and has now confirmed that it will not meet 92% until the end of March 2020 – amber.
- Emergency and Care – delivery of 4-hour standard at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) overall A&E performance with specific focus on Type 1 performance on the Northern General Hospital site - amber.

The Group noted that following agreement at the HEG meeting in October, work was undertaken to strengthen the management of patients at risk of breaching 12 hours at the Rotherham Hospital Foundation Trust, this included escalating the management of 12 hours from arrival.

AK added that the ICS elective care performance has improved at 90.9% and continues to outperform the national and regional position noting pressures in theatre and anaesthetic capacity at Sheffield Children's Hospital continues to impact on their performance. The key issue remains the position at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust as noted in the exception report. It was noted there were two 52 week breaches at Sheffield Children's Hospital and that new processes have been agreed and are in place to remove the risk of future beaches.

The HEG noted that following commitment from Chief Executives in January 2019, the ICS cancer waiting time performance has improved, meeting three out of the four national standards; 2-week wait, 2-week wait for breast pathway and 31-day standard. The challenge for the ICS on 62 days continues to be shared pathways and new reporting arrangements have been introduced through the Alliance Operational Management Group.

The group noted the need for streamlined reporting of root cause analysis to Boards and the Cancer Alliance.

8. ICS Transformation Workstream Highlight Report

The group discussed the key points and risks of the highlight report highlighting in particular the Children's Surgery and Anaesthesia programme and the out of area placements for LD which continue to be off plan, this risk is being addressed through the MH / LD transformation programme board.

The HEG received and noted the contents of the report.

9. Finance Month 6 Report

The report was discussed at the closed meeting with Chief Executive Officers and Accountable Officers.

10. Capital Allocation

CE informed the Group that an Estates Panel has been established to manage the delivery of the proposed bids within the given timescales and stress testing to the value of £57.5 million. The group comprises of specialist estates advisors, NHS England / Improvement and an ICS finance representative. They assessed the schemes against deliverability, fit with primary care estates strategies and appropriateness for the Wave 4B funding process. A full schedule business case would be presented to the HEG in December for consideration and approval. CE added that all CCGs and Places are represented within the working groups.

11. Developing South Yorkshire and Bassetlaw 5 Year Strategy for 2019-2024

WCG informed the Group that the near final draft circulated to members would be submitted on 15th November to NHSEI national and regional teams. The HEG noted the constructive feedback on the draft plan submitted on 27th September received from regional and national teams, stakeholders, local authorities and councillors, staff, patients and the public, has been collated and incorporated where appropriate into the revised plan. All feedback is available on

NHS Futures Platform. WCG added that since the 27th September submission, activity plans between local plans in each Place have been updated giving a broadly aligned position for activity over the next 4 years. There is a financial plan across SYB and a way forward to bridge this is currently being discussed with Chief Executives and Accountable Officers ahead of final submission on the 15th November.

In line with election guidelines, members were asked to share the revised draft plan in private meetings only. It was noted that the 27th September draft was shared on the ICS website prior to the election announcement.

A number of implementation documents are currently being produced on the main priority areas in support of the plan and will be shared at the December HEG meeting.

The Group asked for the following amendments to the plan in advance of submission on 15th November:

- Reflect the working on primary care to incorporate levels/scale of primary care
- More specific details on workforce shortages (not just nursing issues)

The HEG agreed to submit the draft report on 15th November on behalf of the ICS with the above amendments, noting that the financial trajectories will be worked through prior to the 15th November deadline.

The final (draft) version of the LTP plan will be presented to the December HEG meeting and the HOB on the same day. A full suite of documents to support the plan which be published alongside it when Purdah is lifted following the general election in December. It is anticipated that this will be early in the New Year.

12. Financial Trajectories 2020/21

This item was discussed at the closed meeting with Chief Executive Officers and Accountable Officers.

13. Digital Health and Wellbeing Charter for Yorkshire and Humber and Yorkshire and Humber Care Record Value Case

DB introduced the report, informing the Group that the report has two elements:

- Digital Health and Wellbeing Charter for Yorkshire and Humber Charter for review and endorsement.
- Yorkshire and Humber Case Record (YHCR) Value Case for review and feedback in advance of wider testing with South Yorkshire and Bassetlaw (SYB) Directors of Finance and an updated proposal to the HEG in December.

BG presented details on:

- Why shared records are a critical enabler for a transformed health and care system in (SYB) and out of area (Yorkshire and Humber)
- The current provision in SYB and the latest plans
- Specifics of the Yorkshire Humber Case Record and how it supports the SYB ambitions

The HEG noted that no funding has been allocated for the ongoing provision of the YHCR, with Jeremy Cook to share the YHCR Value Case with SYB ICS Directors of Finance for review and comment. It was agreed that SYB ICS Digital Place Leads should be engaged and formally endorse the YHCR Value Case to ensure compliancy with SYB ICS and Place strategic plans.

It was agreed that an updated YHCR Value Case would be presented to the December 2019 HEG for consideration.

Discussion ensued on the endorsement of the Digital Health and Wellbeing Charter. The HEG endorsed the Charter, noting that business cases to meet any Charter commitments will come to SYB ICS HEG for review and endorsement if there are specific implications for SYB, including funding requirements.

14. South Yorkshire and Bassetlaw Healthier Together Website Proposal

DB introduced the report, welcoming Nicola Jay, Consultant Paediatrician Sheffield Children's Hospital, Clinical Lead for the Acutely Ill Child Clinical workstream and RCPCH Officer.

DB added that the Care of Acutely Ill Child Clinical workstream and the South Yorkshire and Bassetlaw (SYB) Local Maternity System (LMS) seek financial approval for the development of a SYB shared system digital resource to provide clinical resource for health professionals and consistent health information and advice for families, children, young people and pregnant women across SYB. It was noted the resource is part of a programme of work to support the necessary transformational change aimed at addressing the key challenges facing paediatric services across SYB. The proposal is based on the successful Healthier Together 0-18 Hampshire Website. The HEG noted that the shared system resource provided a central place for information in addition to required patient information that has proven, alongside a patient education programme to contribute to significant reductions in A&E attendances and GP appointments. The system is user friendly and widely supported across the system.

DB added that the total cost of the website, two years of development and implementation costs is £120,000. The LMS can fund £40,000 so the cost left to the system over two years is £80,000 (£40,000 per year). Due to the expected annual increase of 11,000 A&E paediatric attendances each year, the average costs to the SYB system is estimated at £1,430,000 putting additional stain on the service and already stretched workforce.

The HEG discussed the proposal at length, noting the benefits both clinically and financially to the system but was unable to agree funding at this point in time. It was agreed that further work is needed on SYB ICS funding and the spend of transformation funds. It was agreed to consider the proposal in the closed finance meeting following this meeting. DB and NJ to be informed of the outcome.

The Chair thanked Nicola for her contribution to the work on the Acutely Ill Child Clinical workstream and her input to the report.

15. Northern Pathology Imaging Co-operative Bid for Digital Histopathology Capital Funding

RP presented the report informing the HEG on the implications for South Yorkshire and Bassetlaw (SYB) and North Derbyshire on the benefits and risks associated with the proposed joint SYB/Northern Pathology Imaging Co-operative (NPIC) bid, providing details on Digital Pathology, NPIC and funding opportunities. The Group was asked to note the content of the report and recommendations as set out within the report as follow:

- The Pathology Delivery Team and SYB Trusts to continue to work with NPIC to prepare a joint bid for funding and future partnership working.

- The Pathology Delivery Team to continue to seek information from NPIC to better understand the model they propose for SYB and the terms of agreement; in particular any tie in/exit clauses and the risk that these may pose to SYB.
- The Pathology Delivery Team to continue to seek information from Roche, (and from other suppliers, services and stakeholders), in a very proactive manner, to better understand the specification of the uPath PACS, the current and proposed Roche scanners, and Roche's approach to integration with other scanners and systems.
- The Pathology Delivery Team to continue to explore if there are any other opportunities for funding.
- The Pathology Delivery Team to provide key information to Pathology Executive Steering Board members and Acute Provider Chief Executives as it becomes available so that the benefits and risks of proceeding with the bid can be re-assessed at each point.

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No additional comments were noted.

16. Utilisation of Primary Care Network Organisation Development funding in South Yorkshire and Bassetlaw

In the absence of JP, DB introduced the report, asking members to note the request from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) Primary Care Programme Steering Board for the utilisation of funding received for the delivering of Organisation Development (OD) programme for its Primary Care Networks (PCN). Full funding for 2019/20 was received part way through the year with the requirement to fully utilise by March 2020.

The Group noted and agreed the following recommendations:

- The ICS Primary Care Programme Steering Board to top slice £200k for OD programmes (including for PCN Clinical Directors) that can be delivered across SYB at scale.
- SYB Clinical Commissioning Groups (CCG) Primary Care Leads and Finance Leads allocate the balance of this funding (£956k) to CCGs to deliver local OD support in response to their PCN development plans.
- Note the governance arrangements applicable to the detailed within the report.

The HEG asked that future reports include details of Dr Nick Balac, Primary Care Clinical Lead.

No additional comments were noted.

17. Yorkshire and Humber Academic Health Science Networks (YHAHSN) update

TJ presented an update to the HEG on the uptake of YHAHSN supported programmes, noting comparative progress for the region and at Place. It was noted that YHAHSN supports programmes that are nationally funded. National funding (but not AHSN support) ends in March 2020. SYB leads in a few areas (SIM, Precept, FIT Test and Faecal Calprotectin) but overall is not realising the full opportunity from AHSN innovations.

TJ added that all Places have seen some adoption, with Barnsley being the most active. There are opportunities for all Places to realise savings and benefit patients through encouraging greater uptake.

Discussion ensued and it was noted the need to mainstream schemes and plan for 2020/21 to be agreed collectively to take forward and include within SYB ICS Implementation Plans.

It was agreed that YHAHSN would return to the HEG at a future meeting to present the top priority areas to be collectively agreed for implementation in 2020/21.

18. ICS System Leadership Development

LS asked the HEG to note the contents of the report and in particular the Chief Executives whom were not present at the last HEG meeting, to consider two consecutive dates in May / June to attend the Mindsetting Strategies for Leaders Programme. Proposed dates would be circulated at a later date.

An update was provided on the ICS Shadow Board Programme, the first meeting is scheduled on 21st November followed by two other teaching modules and three consecutive Shadow Boards from December to February 2020, Chaired by LS, who will report back to the HEG during the four months programme and will be leading the discussion and agreement about future deployment of the ICS senior talent poll across the system.

19. SYB ICS Communication and Engagement update

HS asked the HEG to note the update on the ICS communication news planner, used to showcase the work of the ICS and the subsequent coverage that has been achieved across broadcast, print and social media during October 2019.

HS added that there has been an increase in activity generally, with increasing requests for the ICS Bulletin. A Linkedin page is proving successful in recruitment and job opportunities within SYB ICS.

HS requested the HEG to forward to her any future areas of work that should be publicised.

20. A.O.B.

There was no other business recorded.

21. Date of next meeting

10th December 2019, 09.00 – 12.30, The Source Skills Academy, Sheffield

South Yorkshire and Bassetlaw Integrated Care System

SYB ICS Health Executive Group Meeting Action Log – 12 November 2019

	Meeting Date	Action	Responsible Manager	Due Date	Status
1	12.11.19	**Winter Planning** That AJC, RP to contact Paul Wallace, Director of Employment Relations and Reward, NHS Employers to discuss concern around the staff pension tax and the impact to workforce capacity.	PMO office	20.11.19	Complete
2	12.11.19	**Capital Allocation** That a full schedule business case to be presented to the HEG in December for consideration and approval	CE	10.12.19	December HEG meeting
3	12.11.19	**Digital Health and Wellbeing Charter for Yorkshire and Humber and Yorkshire and Humber Care Record Value Case** That an update on the Yorkshire and Humber Care Value Case would be presented to the December HEG.	DB / BG	10.12.19	December HEG meeting
4	12.11.19	**Yorkshire and Humber Academic Health Science Networks (YHAHSN) update** That YHAHSN would return to the HEG at a future meeting to present the top priority areas to be agreement and implementation in 2020/21.	RS	Ongoing	Present at a future HEG meeting
5	12.11.19	**Developing South Yorkshire and Bassetlaw 5 Year Strategy for 2019-2024** That the final version of the plan to be presented to the December HEG meeting and the HOB on the same day. A full suite of documents to support the plan to be published alongside it when Purdah is lifted and a new government is in place. It was anticipated that this would be early in the New Year.	WCG	10.12.19 January 2020	December HEG meeting / January 2020

South Yorkshire and Bassetlaw Integrated Care System

South Yorkshire and Bassetlaw Integrated Care System CEO Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM
HEALTH EXECUTIVE GROUP

10 December 2019

Author(s)	**Andrew Cash, Chief Executive, South Yorkshire and Bassetlaw Integrated Care System**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☑ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do**		

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the South Yorkshire and Bassetlaw Chief Executive provides a summary update on the work of the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) for the month of December 2019.

Recommendations

The SYB Collaborative Partnership Board (CPB) and SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.

South Yorkshire and Bassetlaw Integrated Care System CEO Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

10 December 2019

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System Chief Executive provides an update on the work of the South Yorkshire and Bassetlaw Integrated Care System for the month of November 2019.

2. Summary update for activity during November 2019

2.1 National ICS Leaders Update

The STP/ICS Leaders Development event on 7th November was a very helpful session and covered key discussions on the support ICSs will want to give to Primary Care Networks and how we can address quality improvement in Systems. In addition, there were opportunities to feed into discussions on tackling race inequalities in the workforce, quality engagement and communications to support system working, local government and the NHS working together as 'anchor institutions', population health approaches and system-wide metrics.

A meeting is also scheduled for 4th December and I will update colleagues on the session at the HEG.

2.2 NHS Leaders Event

Leaders from across the North attended an event in York on November 20th. The session looked at current issues and priorities including inequalities and the prevention of ill health, the 'left shift' and outpatients transformation, digitally enabled care, transforming the workforce, system working, priority programmes and improving performance. There was also a panel discussion on developing ICPs and ICSs and colleagues from North East and Yorkshire ICSs/STPs shared their learning on important issues: remote and rural hospitals, improving mental health services to avoid CAMHS admissions, integrating care for neighbourhoods, and reconfiguration and capital schemes.

2.3 Performance Scorecard

The attached scorecards show our collective position at November 2019 (using predominantly September and October 2019 data) as compared with other areas in the North of England and also with the other nine advanced ICSs in the country.

We continue to be green in six of the ten constitutional standards: six week diagnostics, two week cancer waits, two week cancer breast waits and 31 day cancer waits, Early Intervention in Psychosis (EIP), IAPT access and IAPT recovery. Our overall performance as a System, while still below the constitutional standard in four areas, remains one of the best in the country. We outperform other ICS in the North and also those that are First Wave.

The pressures on our System will of course increase as winter begins. However, our collaborative approach to improving the cancer standards has proven that we have the right methodology and tactics and we must continue to do all we can at Neighbourhood, Place and System to ensure we maintain and improve our position.

At month 7 three provider organisations have reported positions that are adverse to plan. All other organisations are forecasting to achieve plan. Assurances on achieving forecast outturn are being sought alongside routine monitoring and managing of risks, with escalation procedures in place if needed.

2.4 Place Updates

2.4.1 Bassetlaw

Below are some of the main achievements delivered through Bassetlaw's Integrated Care Partnership (ICP) over the past three months:

- Some recent highlights from the Bassetlaw Integrated Care Partnership (ICP) include the 'Worksop Works Inclusive Employment Event' on 18th October. Work is important for health and a priority in the 'Better in Bassetlaw Place Plan'. 62 delegates from Worksop employers such as Cerealto Siro, Premier Foods, Greencore, Wilkinson's, Laing O'Rourke, Samworth Brothers and smaller local organisations attended the event, run by the NHS, Department for Work and Pensions, Bassetlaw District Council and D2N2 partners, and linking employers with sources of support locally.

- A transport summit in September brought together transport providers, community representatives, third sector, NHS and local government to identify how communities could be better connected. Actions included linking Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust with Stagecoach and transport planners in the Council to enable improved cross site transportation of patients and staff. The report is available at www.betterinbassetlaw.co.uk.

- The Integrated Discharge Team are prototyping the digital information prescription app 'recap' to give patients access to timely, accurate online about their care and treatment.

2.4.2 Barnsley

Below are some of the main achievements delivered through Barnsley's Integrated Care Partnership (ICP) over the past three months:

- Health partners are in the process of mobilising the new Neighbourhood Team specification which will support Barnsley Primary Care Network (PCN) to work with community health services to deliver more integrated care for the people of Barnsley and in each of the six Neighbourhood Networks.

- Partners are working on shared leadership structures across primary and community healthcare, aligning clockspeeds and also implementing one Single Point of Access. Mobilisation of phase 1 will be complete by April 2020.

- Through the Integrated Care Partnership, partners across health and care have been working successfully together to deliver improvements via the frailty, stroke, integrated wellbeing teams and population health workstreams. The ICP is currently in the process of determining new place based priorities for 2020/21.

2.4.3 Doncaster

Below are some of the main achievements delivered through Doncaster's Integrated Care Partnership (ICP) over the past three months:

- The refreshed Doncaster Partnership Place Plan 2019 – 2021 was launched in October with executive and lay representation from all partner organisations in October http://nww.connect.doncasterccg.nhs.uk/news/doncaster-place-plan-refresh-more-joined-

up-care-closer-to-home/ The plan updates on original partnership areas of opportunity and builds in the jointly agreed model of delivery.

- New areas for partnership working in 2019 – 2021 include Children living with long term conditions, Mental Health Wellbeing and substance misuse and "Healthier Doncaster."

- Doncaster CCG and Doncaster Council continue to implement joint delivery plans steered through the Joint Commissioning Management Board. These remain on track and further joint posts are to be appointed across the life stage commissioning approach. Further ambitions for integrated commissioning will be demonstrated through the refresh of the legal agreement of the Doncaster Commissioning Agreement in 2020. This will include ambitions to commissioning more targeted outcomes on a neighbourhood basis

- Providers across Doncaster continue to collaborate on redesign models of care across a range of areas. These include partnership delivery of Intermediate Care, Wound Care, Complex Lives and the first 1001 days of a person Life. Partners are also piloted integrated neighbourhood delivery across Frailty and Children and Young People in two of the Doncaster communities. Learning from will be used to spread and implement other areas of redesign across Doncaster in 2020/21.

- The Place partnership continues to work on enabling strategies for delivery. In Quarter 3 this included the appointment of a Digital Director to continue work such as the Integrated Doncaster Care Record, and a commitment to a joint Workforce Lead to develop further work on targeting the joint workforce pressures across Doncaster.

2.4.4 Rotherham

Below are some of the main achievements delivered through Rotherham's Integrated Care Partnership (ICP) over the past three months:

- The third Integrated Health and Social Care Place Plan is currently in draft and due to be approved at the February Place Board meeting. Implementation of the Plan continues to be monitored by the Place Board through the quarterly Performance Report, which is also received at Health and Wellbeing Board. There continues to be positive progress against the milestones and key performance indicators.

- The Mental Health Schools Team Trailblazer Pilot is progressing well towards full implementation with a soft launch with the identified schools planned for December.

- ***'Be The One'*** is a new campaign aimed at bringing down suicide rates in Rotherham. The campaign aims at encouraging people to talk, listen and care and was launched on World Suicide Prevention Day. Since its launch in September it has gathered more than 200,000 website hits and over one million social media impressions, as well as messages from people touched by suicide. (https://www.be-the-one.co.uk/)

- The Rotherham ICP Digital Strategy was approved in November 2019, it sets out a three year roadmap for digital services. The implementation programme for wider use of the Rotherham Health Record is underway and the system is being used to support delivery of the revised Intermediate Care and Reablement transformation programme.

- The Rotherham Health App uptake continues to grow, as at November 9,387 people have signed up to App and 25,902 people have had their medication reviewed via the App. Further functionality for use of the App beyond general practice is being scoped for implementation during 2019/20.

2.4.5 Sheffield

Below are some of the main achievements delivered through Sheffield's Accountable Care Partnership (ACP) over the past three months:

- The approval of a city-wide workforce strategy, which includes building upon some excellent systems leadership development provision already taking place. This strategy is inclusive of unpaid carers and the voluntary sector and incorporates a strong emphasis on Sheffield becoming a person-centred city.

- Sustained and concerted efforts across the ACP have contributed to a significant reduction in delayed transfers of care.

- The launch of a community integrated hub in the south east of Sheffield (known as 'Shortbrook') is transforming communications and working relationships across organisations.

- Seed funding has been agreed for the voluntary sector as part of the agenda to develop the strategic relationship with the voluntary sector.

- A strategic outline case has been agreed for the development of a shared care record, and work is now progressing towards agreeing an outline business case.

- Sheffield is one of two sites taking part in some national National Institute for Health Research (NIHR) research to develop a systems map of children's health and wellbeing

2.5 Primary Care Networks

Since the September Primary Care Network (PCN) Clinical Directors meeting, development plans have been received from each of our Networks and allocation of resources at ICS and Place have been agreed to deliver a range of organisational developement/support programmes that respond to the needs identified in those plans. Some of this support will be delivered via Federations, giving the opportunity to either build on existing arrangements with PCNs or to think about their role as providers at scale, in supporting PCNs to succeed.

PCNs are not just about General Practice or Federations and we are now looking at the pharmacy contractual framework and identifying a lead community pharmacy for each PCN and considering how best to engage with these providers in a meaningful way.

A further event in January will see our 36 Clinical Directors coming together, joined by colleagues from across the ICS and CCGs and focusing on new workforce roles being developed across PCNs and how these will help deliver priorities at PCN, Place and System level.

2.6 Mental Health Alliance

A draft Memorandum of Understanding (MOU) has been developed for discussion amongst the Chief Executives of the five mental health NHS Foundation Trusts. This is following some shared work and learning from West Yorkshire where providers have been working in this way for a while.

All Foundation Trusts continue to be represented at the Mental Health and Learning Disabilities Programme Board to strengthen joint working across the ICS programme priorities. Work has commenced with good progress being made on pathway-specific provider collaboratives: Eating Disorder, CAMHS tier 4 and Low – Medium Secure inpatient services.

2.7 Acute Federation

The Acute Federation, the successor to Working Together, is currently working to define and clarify its work programme and develop its ways of working. The executive teams of all the South Yorkshire and Bassetlaw acute NHS Foundation Trusts, plus Chesterfield NHS Foundation Trust,

met for a first executive timeout in September, and a second is planned for 13th December. The timeouts are looking at how the FTs work together on operational issues; the work programme and capital strategy for the acute sector; and how the Acute Federation should support and engage more effectively in the wider ICS.

2.8 Key appointments

The following organisations within the South Yorkshire and Bassetlaw ICS have made the following key appointments:

- Following a recruitment process, I am delighted to let you know that Jan Ditheridge will be joining Sheffield Health and Care NHS Foundation Trust as the new Chief Executive.

  Jan is an experienced strategic leader with a background encompassing a broad variety of clinical, operational and leadership roles across health, social care and the private sector. She also has a wealth of expertise in the areas of cultural change, transformation, delivery, clinical quality and effective performance management.

  She is currently the Chief Executive of Shropshire Community Health NHS Trust, a post she has held since 2013. During that time she has overseen a period of sustained improvement, culminating in the Trust being rated as Good by the CQC across all its services earlier this year. Jan will take up her post in 2020 and until then Clive Clarke will continue as Interim Chief Executive.

- Ruth Brown has been appointed as the new Deputy Chief Executive at Sheffield Children's. Ruth has been Executive Director of Strategy and Operations at the Trust since 2017 and will continue this role alongside her new role, which started on 2 December.

  Ruth brings a wealth of knowledge from her 30 years of experience in the NHS and is committed to furthering the Trust's improvement work, performance and strengthening its partnerships across the region. Ruth is already an active participant in the region's Integrated Care System and Sheffield's Accountable Care Partnership, helping to provide more seamless, professional care services across the organisational and geographical boundaries. Within the Trust, Ruth is responsible for the operational delivery and performance of services as well as the development of the Trust's strategic direction.

Andrew Cash
Chief Executive, South Yorkshire and Bassetlaw Integrated Care System

Date 4 December 2019

How are we doing? An overview

Key performance report: November 2019 (using predominantly Oct/Sept data)

South Yorkshire and Bassetlaw Integrated Care System

At month 7 three provider organisations have reported positions that are adverse to plan. All other organisations are forecasting to achieve plan. Assurances on achieving forecast outturn are being sought alongside routine monitoring and managing of risks, with escalation procedures in place if needed.

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South Yorkshire and Bassetlaw Integrated Care System

South Yorkshire and Bassetlaw Integrated Care System

Enclosure C

Delivery Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM
HEALTH EXECUTIVE GROUP

10 December 2019

Author(s)	**Alison Knowles**
Sponsor	**Alison Knowles**

Is your report for Approval / Consideration / Noting

For consideration

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☑ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do this**		

Are there any resource implications (including Financial, Staffing etc)?

Resources are contained within each organisation's agreed operational plan for 2019/20

Recommendations

The Health Executive Group is asked to:

1. discuss the current position against the ICS operational plan and note the actions being taken to improve delivery; and
2. agree the approach to cancer 62-day improvement proposed by the Cancer Alliance Board.

Delivery Report
Update to the Health Executive Group

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

10 December 2019

1. Purpose

The report provides an update to the Health Executive Group on the ICS progress against its operational plan for 2019/20.

2. Key issues

2.1 Delivery

At month 5, the overall ICS performance against national standards remains challenging but in most areas the ICS continues to out-perform performance in the North East & Yorkshire and across the rest of England. We failed to deliver on 5 national standards:

Standard	SYB ICS	NEY Region	England
UEC 4-hour (95%)	89%	85.3%	83.6%
RTT (92%)	91.1%	86.2%	84.8%
52-week wait (0)	6 (CCG) / 5 (provider)	106	1305
62-day CWT (85%)	80.3%	77.5%	76.9%
IAPT Access (5.13%)	4.4%	4.57%	4.73%

2.2 Urgent & Emergency Care

The ICS continues to fail to deliver the 4-hour standard but over the last six weeks has outperformed other systems in the region. Sheffield and Rotherham remain the highest risk systems for urgent and emergency care, however, performance at Doncaster & Bassetlaw remains below plan.

ED attendances continue at 1.2% above plan (6.3% year on year growth) but this is not translating into growth in admissions where overall the ICS remains below plan. Within this overall admission figure, zero length of stay admissions are growing faster than > 1-day admissions, reflecting the shift to same day emergency care.

There have been zero 12-hour waits from decision to admit.

From unvalidated sitrep data, there is evidence of growing pressure in the system at the end of November and into December. Respiratory admissions have increased, and influenza is circulating in Yorkshire & the Humber. For week ending 28 November, the influenza-like illness (ILI) consultation rate in Yorkshire and Humber (5.1 per 100,000) was higher than the previous week (3.8). At week ending 27 November:

w/e 27 Nov	Barnsley			Doncaster & Bassetlaw			Sheffield Children's			Sheffield Teaching			Rotherham		
	week	6-week	% change	week	6-week	% change	week	6-week	% change	week	6-week	% change	week	6-week	% change
4-hour	75.08	88.69	-13.6%	85.56	88.2	-2.64%	94.02	95.29	-1.27%	83.16	82.23	0.93%	-	-	
Total attend	2291	2047	11.9%	4100	3685	11.3%	1572	1358	15.8%	4774	4589	4.0%	2186	1969	11.0%
Beds occupied	416	396	5.1%	693	685	1.2%	123	111	10.8%	1322	1298	1.8%	423	413	2.4%
Escalation beds	41	29	41.4%	42	34	23.5%	0	0		22	19	15.8%	31	24	29.2%

The focus of improvement work in November has been on improving resilience. Key points to note:

(i) TRFT have recruited to staff the additional 62 beds in its winter plan through a successful "arrive and allocate" campaign. This approach is now being adopted by other acute providers in SYB.

(ii) TRFT have recruited to vacant consultant posts in stroke, paediatrics and cardiology to improve medical capacity over the winter and going forward. A risk remains around recruitment to acute physician posts.

(iii) STH and the Sheffield system have continued to deliver on their improvement plan, as detailed in previous reports. The SDEC pathways at the Northern General commence from 1 December, following successful pilot work over the summer, and a new Clinical Director has been appointed.

(iv) STH continue to work on their new model of medical staffing (single assessment and changes to the middle-grade rota). The full roll out and benefits from this are expected to accrue through the winter period.

(v) All Trusts continue to focus on managing inpatient capacity as we go into the peak winter period. Each place is achieving the standard for delayed transfers of care. On long length of stay (> 21 days) SYB is 20 patients above its planned trajectory for the year to date. Within this, Barnsley have already achieved their year end position, DBHFT is 2 patients above plan, and STH and TRFT are 18 and 12 patients above plan, respectively.

(vi) The Chief Operating Officers and Directors of Commissioning have reviewed winter plans and the streaming model in ED to identify areas of good practice for implementation within this year.

2.3 Elective Care

In elective care, the ICS performance has improved slightly at 91.1% and continues to outperform the regional and national position.

Pressure in theatre and anaesthetic capacity at Sheffield Children's Hospital continues to impact on their performance but the key issue for the ICS remains the position in Doncaster & Bassetlaw.

DBHFT performance continued to improve from 85.7% to 86.4% in October with actions underway to validate the waiting list, deliver additional activity within the Trust and to outsource activity to NHS and IS providers.

SCH performance in October has dropped further to 88.2%. The Trust has commenced working with NECS to validate its waiting list and is in discussion with the specialised commissioning team

about alternate capacity in Yorkshire and the Humber for some surgical cases. The Chief Operating Officers and Directors of Commissioning are reviewing the SCH waiting list to consider whether suitable alternate capacity can be identified in SYB providers.

On 52-week breaches, there have been 6 breaches for CCGs and five for providers in SYB. On the provider breaches, the four at Barnsley relate to validation of the waiting list. Improvement actions are in place at both Barnsley and Sheffield Children's based on the learning from the root cause analyses.

At the ICS Focus Meeting in October, Richard Barker (Regional Director) emphasised the importance of reducing the total number of patients waiting back to the March 2018 position. Currently, SYB's total waiting list is 10.3% above the March 2018 position. For providers:

	Baseline	Change from baseline									
Trust	**Mar-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Sheffield Children's NHS Foundation Trust	7,998	-336	-137	-301	+304	+439	+577	+1,065	+1,144	+1,045	+986	+1,033
Barnsley Hospital NHS Foundation Trust	12,068	-325	-397	-399	-40	-4	+529	+698	+859	+744	+1,539	+1,507
The Rotherham NHS Foundation Trust	13,558	+998	+1,198	+943	+687	+1,125	+2,234	+1,900	+1,352	+846	+1,130	+1,172
Sheffield Teaching Hospitals NHS Foundation Trust	43,521	+1,903	+715	+280	+910	+1,488	+1,018	+2,287	+2,669	+2,939	+3,813	+4,597
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	31,421	+1,760	+827	+167	+577	-222	-155	+304	+811	+1,098	+1,388	+938
Spamedica (Sheffiled)	0	+459	+369	+506	+524	+557	+493	+527	+532	+516	+482	+468
Newmedica Community Ophthalmology - Bassetlaw - Retford Primary Care Centre	76	0	+4	+4	-21	-27	-29	-20	-9	-15	-32	-22
Pioneer Healthcare Limited	119	+143	+155	+157	+187	+199	+188	+200	+202	+156	+208	+207
Aspen - Claremont Hospital	812	+116	+176	+195	+267	+235	+281	+224	+284	+361	+445	+485
Park Hill Hospital	160	-131	-117	-111	-113	-63	-24	+33	+5	-30	+27	+80
Bmi - Thornbury Hospital	263	-44	-42	-51	-68	-44	-32	-19	-32	+9	+15	-6
The One Health Group Ltd	2,003	+432	+358	+337	+413	+367	+395	+332	+224	+202	+180	+284
South Yorkshire And Bassetlaw STP	**111,999**	**+4,975**	**+3,109**	**+1,727**	**+3,627**	**+4,050**	**+5,475**	**+7,531**	**+8,041**	**+7,871**	**+10,201**	**+10,770**

For the independent sector, Sheffield CCG are leading work with Spamedica, Claremont and One Health Group on behalf of all SYB CCGs to validate and reduce the waiting list in these providers. The growth in the waiting list at Pioneer Healthcare relates to the transfer of specialised spinal activity from Leeds Teaching Hospitals.

The Chief Operating Officers and Directors of Commissioning have agreed to produce improvement plans by the end of December to reduce the total numbers of patients waiting in 2019/20.

At their improvement workshop in November, the Chief Operating Officers and Directors of Commissioning agreed to start work on "fragile" specialties' across SYB to develop and implement system level actions. The first of these services is neurology.

2.4 Cancer

The monthly performance in September has been maintained with the ICS meeting three out of the four national standards – 2-week wait, 2-week wait for breast pathway, and 31-day standard. For the fourth standard, 62-days, the overall performance at month 5, improved slightly to 80.3%

In line with the commitment by CEOs in January 2019, all providers are achieving 85% against the 62-day standard for local (wholly-owned) pathways. Four out of five patients are treated on local pathways and the overall performance for these patients is 86.1% year to date.

The performance on shared pathways has improved in September (most recent available data) in Barnsley, DBHFT and Rotherham.

Data completeness has, however, deteriorated and will be a focus in coming months to ensure that 100% of transfer dates are captured, as when these records are included, IPT drops to 46%.

Inter Provider Transfer	< 38 day	> 38 day	Unknown Date	Total	% < 38 day*
Aug-19					
Barnsley	7	8	5	20	46.6%
Doncaster & Bassetlaw	8	10	6	24	44.4%
Sheffield Teaching		1		1	0.0%
Rotherham	10	10	3	23	50.0%
Total	**25**	**29**	**14**	**68**	
Overall Percentage	36.8%	42.6%	20.6%		
Sep-19					
Barnsley	13	2	2	17	86.7%
Doncaster & Bassetlaw	12	1	5	18	92.3%
Sheffield Teaching	1			1	100.0%
Rotherham	8	4	10	22	66.7%
Total	**34**	**7**	**17**	**58**	
Overall Percentage	58.6%	10.3%	25.0%		

*performance is calculated excluding records where IPT date is unknown.

The Cancer Alliance Board discussed the improvement plan for 62-days at its meeting on 1 November and agreed the following approach for the remainder of this year:

i. Continued roll-out of straight to test pathways and achievement of 7-day polling range to improve delivery of two-week wait pathways;
ii. Focus on the Faster Diagnostic Standard with 80% achievement of the 28-day standard. The learning from the CRS pilot in DBHFT and CRHFT will be shared.
iii. Delivery of the national timed pathways in each tumour group with a focus on lower GI, upper GI and lung. This follows on from the improvements that have been seen in Head and Neck through the introduction of a timed pathway;
iv. Strengthening of operational procedures, reporting and breach analysis for 38-days IPT and the overall 62-day target

Progress against these ambitions and actions will be reported to the Cancer Alliance Board on a bi-monthly basis and tracked through the Operational Management Group. The data and root cause analyses will be made available to individual Boards and Governing Bodies through their local Cancer Boards.

In addition to the actions agreed at the Cancer Alliance Board, the improvement workshop for the Chief Operating Officers and Directors of Commissioning resulted in a commitment to:

- A second round of deep dive meetings with each provider to review their administrative approach to cancer management;
- A review of access policies across providers to embed best practice and ensure a consistent approach; and
- The re-introduction of clinical peer review for individual tumour pathways.

2.5 Improving Access to Psychological Therapies

The ICS is failing to deliver the expected level of access of 5.13% in 2019/20, across four places. Only Bassetlaw is achieving the required level of access.

At the Performance and Delivery Group, each place agreed to ensure that it is reporting performance in line with the national definitions and to develop improvement actions to secure the access target in quarter 4.

3. Recommendation

The Health Executive Group is asked to:

(i) discuss the current position against the ICS operational plan and note the actions being taken to improve delivery; and
(ii) agree the approach to cancer 62-day improvement proposed by the Cancer Alliance Board.

Alison Knowles
Locality Director

South Yorkshire and Bassetlaw Integrated Care System

Delivery Report December 2019

Report presented to: ICS Health Executive Group
December 2019

South Yorkshire & Bassetlaw Integrated Care System
Delivery Report
0. Contents

1. Delivery of National Standards and Operating Plan

South Yorkshire & Bassetlaw Integrated Care System
1a. Performance against National Standards – ICS grouped by place

Achieving constitutional standard
Not achieving constitutional standard

National

SYB ICS Delivery	Standard	Period	SYB ICS	Barn CCG	BHFT	SWYPFT	Blaw	Notts HC	RDASH	Donc CCG	DBHFT	Roth CCG	TRFT	RDASH	Sheff CCG	SCH	STH	SHSC
A&E - Maximum 4-hour wait	95%	Oct-19											Pilot					
12 hour trolley waits	0	Oct-19																
DTOC	3.5%	Sep-19						-								-		
Cancelled Urgent Operations	0	Sep-19																
RTT - 18 week wait	92%	Sep-19																
RTT - 52 ww	0	Sep-19																
Diagnostics	1%	Sep-19																
Primary Care - Extended GP Access	100%	Feb-19																
Primary Care - Satisfaction	82.9%	2019																
Cancer 2 week wait	93%	Sep-19					Pilot			Pilot	Pilot							
Cancer 2 week wait breast	93%	Sep-19					Pilot			Pilot	Pilot							
Cancer 31 day	96%	Sep-19																
Cancer 28 Days FDS	80%	Sep-19																
Cancer 38 days																		
Cancer - 62-day treatment	85%	Sep-19																
Mental Health - IAPT access	5.13%	Aug-19																
Mental Health - IAPT recovery*	50.00%	Aug-19																
Mental Health - 6 week*	75.00%	Aug-19																
Mental Health - 18 week*	95.00%	Aug-19																
Mental Health - EIP	56%	Sep-19																

Quality

Statutory measures	Standard	Period	SYB ICS	Barn CCG	BHFT	SWYPFT	Blaw	Notts HC	RDASH	Donc CCG	DBHFT	Roth CCG	TRFT	RDASH	Sheff CCG	SCH	STH	SHSC
CCG IAF Assessment QOL	RAG	Q4 18-19		G*			G*			G*		G*			A			
CCG IAF Assessment - Finance	RAG	Q4 18-19		G			G			G		G			G			
Organisations in Special Measures	NO	2018-19		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
CQC Inspection rating - under new approach	0	Oct-19			GOOD	GOOD		REQ IMP	GOOD		REQ IM		REQ IM	GOOD		GOOD	GOOD	REQ IMP
NHSI - Single Oversight Framework Segmentation	0	Oct-19			2	2		2	1		2		3	1		2	2	2

Protecting from avoidable harm	Standard	Period	SYB ICS	Barn CCG	BHFT	SWYPFT	Blaw	Notts HC	RDASH	Donc CCG	DBHFT	Roth CCG	TRFT	RDASH	Sheff CCG	SCH	STH	SHSC
Cdiff	0	Sep-19																
MRSA	0	Sep-19																
MSA breaches	0	Sep-19																
MSSA - No of cases	Lower is Better	Sep-19	39	4	2		3			14	6	7	1		11	0	3	
E-Coli - No of cases	Lower is Better	Sep-19	126	13	1		9			25	4	21	3		58	0	15	
Never events declared - number	0	Sep-19																

South Yorkshire & Bassetlaw Integrated Care System
1b. Performance against National Standards – grouped by place

Better Is...	
H (High)	Better performance the higher the vaue
L (Low)	Better performance the lower the value
	Not achieving standard

National

SYB Commissioner Statutory Bodies	Standard / Eng Value	Period	Better is...	SYB ICS	Barnsley CCG	BHNFT	SWYPFT	Bassetlaw CCG	Notts HC	RDASH	Doncaster CCG	DBHFT	Rotherham CCG	TRFT	RDASH	Sheffield CCG	SCH	STH	SHSC
A&E - Maximum 4-hour wait	95%	Oct-19	H	89.0%		95.2%						90.3%		Pilot			97.8%	82.9%	
12 hour trolley waits	0	Oct-19	L	0		0						0		0			0	0	
DTOC	3.5%	Sep-19	L	2.8%		1.1%	1.3%		-	9.6%		1.9%		2.7%	9.6%		-	2.6%	0.9%
Cancelled Urgent Operations	0	Sep-19	L	18		0						0		0			4	14	
RTT - 18 week wait	92.0%	Sep-19	H	91.1%	93.6%	93.8%		87.8%			87.0%	86.4%	92.2%	92.2%		92.8%	88.2%	92.8%	
RTT - Waiting List	Against March 18 position	Sep-19		104242	18140	13575		8498			23833	32359	18071	14730		35700	9031	48118	
RTT - 52 ww	0	Sep-19	L	6	4	4		0			1	0	1	0		0	1	0	
Diagnostics	1.0%	Sep-19	L	0.4%	0.2%	0.1%		0.8%			0.7%	0.7%	0.1%	0.0%		0.4%	1.6%	0.3%	
Primary Care - Extended GP Access	100%	Feb-19	H	100%	100%			100%			100%		100%			100%			
Primary Care - % overall experience	82.9%	2019	H	82.9%	80.6%			86.0%			81.0%		83.4%			84.1%			
Mental Health - IAPT access	5.13%	Aug-19	H	4.49%	3.58%			5.73%			4.24%		4.47%			4.79%			
Mental Health - IAPT recovery**	50.0%	Aug-19	H	52.9%	50.7%		50.0%	54.8%	49.8%	52.4%	56.9%		56.3%		52.4%	48.5%			47.1%
Mental Health - 6 week**	75.0%	Aug-19	H	90.5%	90.5%		69.8%	100.0%	69.9%	89.3%	94.1%		88.0%		89.3%	86.8%			87.2%
Mental Health - 18 week**	95.0%	Aug-19	H	98.3%	95.2%		90.7%	100.0%	98.8%	98.7%	100.0%		98.0%		98.7%	97.8%			99.1%
Mental Health - EIP	56.0%	Sep-19	H	83.3%	66.7%		84.0%	100.0%	77.9%	75.8%	83.3%		60.0%		75.8%	100.0%			86.5%
Cancer 2 week wait	93.0%	Sep-19	H	94.9%	93.6%	93.7%		Pilot			Pilot	Pilot	92.1%	91.2%		95.5%	100.0%	95.9%	
Cancer 2 week wait breast	93.0%	Sep-19	H	97.6%	98.1%	98.1%		Pilot			Pilot	Pilot	92.2%	91.8%		98.1%	-	97.7%	
Cancer 31 day	96.0%	Sep-19	H	97.2%	98.6%	100.0%		100.0%			95.9%	100.0%	94.2%	96.6%		98.6%	100.0%	94.2%	
Cancer -28 Days FDS*	80.0%	Sep-19	H	74.0%		73.7%						76.8%		77.1%			74.0%	69.3%	
Cancer - 38 Days***		Sep-19	H			86.7%						92.3%		66.7%					
Cancer - 62-day treatment	85%	Sep-19	H	80.3%	85.2%	93.5%		90.9%			88.7%	95.0%	68.7%	74.8%		78.6%	-	67.9%	

Quality

Organisations in Special Measures	NO	2018-19	-	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
CCG IAF Assessment	RAG	2018-19	H	-	Outstanding			Outstanding			Outstanding		Outstanding			Good			
CCG IAF Assessment - QOL	RAG	Q4 18-19	H	-	G*			G*			G*		G*			A			
CCG IAF Assessment - Finance	RAG	Q4 18-19	H	-	G			G			G		G			G			
CQC Inspection rating - new approach		Oct-19		0		GOOD	GOOD		REQ IMP	GOOD		REQ IM		REQ IM	GOOD		GOOD	GOOD	REQ IMP
NHSI - Single Oversight Fwk Segmentation		Oct-19		-		2	2		2	1		2		3	1		2	2	2

Protecting from avoidable harm	Standard	Period	Better is...	SYB ICS	Barn CCG	BHFT	SWYPFT	Blaw	Notts HC	RDASH	Donc CCG	DBHFT	Roth CCG	TRFT	RDASH	Sheff CCG	SCH	STH	SHSC
Cdiff	0	Sep-19	L	39	5	3		2			3	3	5	3		24	1	16	
MRSA	0	Sep-19	L	2	0	0		1			1	1	0	0		0	0	0	
MSA breaches	0	Sep-19	L	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA - No of cases	Lower is Better	Sep-19	L	39	4	2		3			14	6	7	1		11	0	3	
E-Coli - No of cases	Lower is Better	Sep-19	L	126	13	1		9			25	4	21	3		58	0	15	
Never events declared - number	0	Sep-19	L	2		0	0		No data	0		0		0	0		0	2	0

* SYB Cancer Alliance Posistion included in SYB ICS column
** Mental Health Provider data is reporting one month behind the commissioners
*** Data is a snapshot and is unvalidated data. Data will change when trusts update IPT fields.

South Yorkshire & Bassetlaw Integrated Care System

1c. Performance against Operational Plan – ICS system against Operational Plan

Below Provider Plan
Above CCG Plan

Elective Care	Period	ICS (Comm) Plan	ICS (Comm) Actual	ICS (Comm) Period Var from plan (%)	ICS (Prov) Plan	ICS (Prov) Actual	ICS (Prov) Period Var from plan (%)
RTT - 18 week wait	Sep-19	91.7%	91.1%	-0.6%	92.2%	90.7%	-1.5%
RTT - 52 ww	Sep-19	0	6	600%	0	5	500%
RTT - Waiting List (CCG)	Sep-19	92,500	104,242	12.7%	109,732	117,813	7.4%
RTT - Waiting List (CCG Against March 18 position)	Sep-19	94,543	104,242	10.3%	108,443	117,813	8.6%
Diagnostics	Sep-19	0.9%	0.4%	-0.5%	0.9%	0.4%	-0.5%
Cancer 2 week wait	Sep-19	93.5%	94.9%	1.5%	94.1%	95.0%	0.9%
Cancer 2 week wait breast	Sep-19	93.7%	97.6%	4.2%	93.3%	97.8%	4.8%
Cancer 31 day 1st Treatment	Sep-19	96.3%	97.2%	0.9%	95.3%	96.1%	0.9%
Cancer 31 day - Surgery	Sep-19	95.4%	93.9%	-1.6%	90.8%	93.8%	3.3%
Cancer 31 day Drug	Sep-19	98.8%	99.6%	0.8%	99.6%	99.7%	0.1%
Cancer 31 day Radiotherapy	Sep-19	95.4%	91.1%	-4.5%	94.1%	90.2%	-4.1%
Cancer - 62-day Urgent	Sep-19	85.6%	80.3%	-6.1%	84.0%	77.7%	-7.5%
Cancer 62 Day - Screening	Sep-19	94.0%	87.5%	-6.9%	87.4%	86.0%	-1.6%
Cancer 62 Day - Consultant Upgrade	Sep-19	88.9%	81.2%	-8.6%	88.2%	83.4%	-5.4%

Urgent Care	Period	ICS (Comm) Plan	ICS (Comm) Actual	ICS (Comm) Period Var from plan (%)	ICS (Prov) Plan	ICS (Prov) Actual	ICS (Prov) Period Var from plan (%)
A&E - Maximum 4-hour wait	Oct-19				91.8%	89.0%	-3.1%
12 hour trolley waits	Oct-19				0	0	0
DTOC	Sep-19					2.8%	2.8%

Activity	Period	ICS (Comm) Plan	ICS (Comm) Actual	ICS (Comm) Period Var from plan (%)	ICS (Comm) Year on year 12 month growth	ICS (Prov) Plan	ICS (Prov) Actual	ICS (Prov) Period Var from plan (%)	ICS (Prov) Year on year 12 month growth
GP referrals (YTD)	Sep-19	174,483	179,830	3.1%	0.0%	188,984	197,805	4.7%	-0.1%
Other referrals (YTD)	Sep-19	115,927	120,576	4.0%	5.2%	138,759	142,978	3.0%	5.2%
Total referrals (YTD)	Sep-19	290,410	300,406	3.4%	2.0%	327,743	340,783	4.0%	2.0%
1st Outpatients (YTD)	Sep-19	269,296	300,329	11.5%	4.2%	361,698	370,364	2.4%	4.5%
Follow-up outpatients (YTD)	Sep-19	531,627	564,739	6.2%	2.6%	718,303	755,778	5.2%	2.8%
Total Elective Admissions (YTD)	Sep-19	115,210	119,496	3.7%	2.4%	148,084	149,425	0.9%	2.2%
AE attendances (YTD)	Sep-19	301,343	307,506	2.0%	5.9%	302,281	306,135	1.3%	6.3%
A&E Type 1 (YTD)	Sep-19	266,403	270,209	1.4%	6.2%	270,141	276,426	2.3%	6.7%
Non elective activity (YTD)	Sep-19	87,505	86,784	-0.8%	2.8%	96,028	95,257	-0.8%	2.7%
Zero LoS Non elective spells (YTD)	Sep-19	23,829	23,729	-0.4%	214 4.8%	25,126	25,538	1.6%	5.0%
1+ LoS Non elective spells (YTD)	Sep-19	63,676	63,055	-1.0%	2.0%	70,902	69,719	-1.7%	1.9%

South Yorkshire & Bassetlaw Integrated Care System
1d. Performance against Operational Plan – Organisations grouped in place

Below Provider Plan
Above CCG Plan

		ICS Comm		ICS Provider		Barnsley CCG		BHFT		Bassetlaw CCG		Doncaster CCG		DBHFT		Rotherham CCG		TRFT		Sheffield CCG		SCHFT		STHFT	
Elective Care	**Period**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
RTT - 18 week wait	Sep-19	91.7%	91.1%	92.2%	90.7%	92.0%	93.6%	95.1%	93.8%	91.5%	87.8%	91.3%	87.0%	91.3%	85.4%	92.0%	92.2%	92.0%	92.2%	92.0%	92.8%	92.0%	88.2%	92.0%	92.8%
RTT - 52 ww	Sep-19	0	6	0	5	0	4	0	4	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0
RTT - Waiting List	Sep-19	92,500	104,242	109,732	117,813	15,383	18,140	12,480	13,575	7,697	8,498	23,450	23,833	29,898	27,953	15,937	18,071	13,912	14,730	31,438	35,700	8,988	9,031	44,454	48,118
RTT - Waiting List (Against March 18 position)	Sep-19	94,543	104,242	108,443	117,813	15,756	18,140	12,068	13,575	7,825	8,498	24,026	23,833	31,074	27,953	15,945	18,071	13,782	14,730	30,991	35,700	7,998	9,031	43,521	48,118
Diagnostics	Sep-19	0.9%	0.4%	0.9%	0.4%	0.9%	0.2%	0.5%	0.1%	1.0%	0.0%	1.0%	0.0%	0.8%	0.7%	0.4%	0.1%	0.9%	0.0%	1.0%	0.4%	0.9%	1.6%	1.0%	0.3%
Cancer 2 week wait	Sep-19	93.5%	94.9%	94.1%	95.0%	95.9%	93.6%	95.6%	93.7%	93.3%	Pilot	93.0%	Pilot	93.4%	Pilot	93.2%	92.1%	93.4%	91.2%	93.0%	95.5%	100.0%	100.0%	94.3%	95.9%
Cancer 2 week wait breast	Sep-19	93.7%	97.6%	93.3%	97.8%	93.2%	98.1%	93.6%	98.1%	96.4%	Pilot	93.5%	Pilot	93.2%	Pilot	94.1%	94.1%	93.7%	91.8%	93.1%	98.1%	-	-	93.5%	97.7%
Cancer 31 day 1st Treatment	Sep-19	96.3%	97.2%	95.3%	96.1%	96.3%	98.6%	97.0%	100.0%	96.2%	100.0%	96.2%	95.9%	98.0%	100.0%	96.5%	94.2%	96.9%	96.6%	96.3%	98.6%	100.0%	100.0%	93.6%	94.2%
Cancer 31 day - Surgery	Sep-19	95.4%	93.9%	90.8%	93.8%	92.6%	95.2%	100.0%	100.0%	100.0%	100.0%	96.2%	94.7%	100.0%	100.0%	96.4%	93.1%	94.1%	94.1%	95.7%	92.2%	0.0%	100.0%	87.9%	92.3%
Cancer 31 day Drug	Sep-19	98.8%	99.6%	99.6%	99.7%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%	100.0%	94.1%	100.0%	98.9%	99.1%	100.0%	100.0%	100.0%	99.6%
Cancer 31 day Radiotherapy	Sep-19	95.4%	91.1%	94.1%	90.2%	96.8%	100.0%	-	-	94.7%	80.0%	95.1%	90.5%	0.0%	-	95.6%	90.9%	94.1%	-	95.0%	91.5%	-	-	94.1%	90.2%
Cancer - 62-day Urgent	Sep-19	85.6%	80.3%	84.0%	77.7%	85.5%	85.2%	86.0%	93.5%	87.5%	90.9%	85.7%	88.7%	86.0%	95.0%	85.7%	68.7%	85.3%	74.8%	85.1%	78.6%	-	-	81.5%	67.9%
Cancer 62 Day - Screening	Sep-19	94.0%	87.5%	87.4%	86.0%	92.9%	100.0%	92.3%	100.0%	100.0%	71.4%	87.5%	78.6%	90.5%	77.3%	100.0%	100.0%	85.7%	100.0%	93.3%	90.9%	0.0%	-	88.2%	86.2%
Cancer 62 Day - Consultant Upgrade	Sep-19	88.9%	81.2%	88.2%	83.4%	92.3%	78.6%	92.3%	82.6%	66.7%	80.0%	85.7%	40.0%	87.5%	82.4%	90.2%	85.0%	89.8%	85.5%	87.5%	100.0%	-	-	83.0%	81.7%
Urgent Care	**Period**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
A&E - Maximum 4-hour wait	Oct-19			91.8%	89.0%			95.0%	95.2%					92.3%	90.3%			89.0%	Pilot			95.0%	97.8%	90.0%	82.9%
12 hour trolley waits	Oct-19			0	0			0	0					0	0			0	0			0	0	0	0
DTOC (19/20 BCF Plan TBC)	Sep-19			TBC	2.8%			TBC	1.1%					TBC	1.9%			TBC	2.7%			TBC	-	TBC	2.6%
Activity	**Period**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
GP referrals (YTD)	Sep-19	174,483	176,830	188,984	197,805	27,677	31,581	25,987	28,903	14,827	14,680	38,219	38,128	55,074	56,296	28,212	27,808	24,527	23,472	65,548	67,611	7,607	9,752	75,789	79,342
Other referrals (YTD)	Sep-19	115,927	120,576	138,759	142,978	21,199	22,732	16,213	17,212	8,680	9,508	23,296	22,672	30,111	28,670	21,103	20,903	16,837	16,015	41,649	44,761	11,580	15,031	64,018	66,050
Total referrals (YTD)	Sep-19	290,410	300,406	327,743	340,783	48,876	54,313	42,200	46,115	23,507	24,188	61,515	60,800	85,185	84,966	49,315	48,711	41,364	39,487	107,197	112,394	19,187	24,923	139,807	145,392
1st Outpatients (YTD)	Sep-19	269,296	300,329	361,698	370,364	45,594	48,646	40,614	44,756	17,860	19,025	50,886	53,206	73,683	74,702	33,907	40,235	30,341	35,516	121,049	139,217	26,825	26,502	190,235	188,888
Follow-up outpatients (YTD)	Sep-19	531,627	564,758	718,303	755,778	119,244	125,942	101,882	112,693	33,199	34,905	80,236	90,703	123,867	121,309	78,221	97,372	61,614	86,032	220,727	215,817	45,545	44,762	385,395	390,982
Total Elective Admissions (YTD)	Sep-19	115,210	119,496	148,084	149,425	20,341	22,189	15,424	16,426	8,670	8,883	25,308	26,075	29,866	30,134	18,836	19,407	15,448	15,496	42,055	42,942	10,021	9,383	77,325	77,986
AE attendances (YTD)	Sep-19	301,343	307,506	302,281	306,135	55,983	56,084	49,879	52,104	22,192	23,477	64,005	65,526	92,665	93,813	52,749	54,225	51,610	51,750	106,414	106,104	27,288	28,550	80,839	79,918
A&E Type 1	Sep-19	266,403	270,209	270,141	276,426	51,886	52,347	49,879	52,104	20,812	22,037	55,745	57,138	78,998	83,688	49,488	50,469	51,610	51,750	88,472	88,218	26,779	28,550	62,875	60,334
Non elective activity (YTD)	Sep-19	87,505	86,784	96,028	95,257	18,810	19,444	17,397	18,799	7,017	7,113	19,352	18,371	26,944	26,250	13,971	13,556	12,954	12,404	28,355	28,300	3,217	3,000	35,516	34,804
Zero LoS Non elective spells (YTD)	Sep-19	23,829	23,729	25,126	25,538	5,090	5,496	4,604	5,385	2,468	2,517	6,773	6,260	9,354	9,133	2,526	2,518	2,058	2,053	6,972	6,938	566	594	8,544	8,373
1+ LoS Non elective spells (YTD)	Sep-19	63,676	63,055	70,902	69,719	13,720	13,948	12,793	13,414	4,549	4,596	12,579	12,111	17,590	17,117	11,445	11,038	10,896	10,351	21,383	21,362	2,651	2,406	26,972	26,431

		ICS Comm		ICS Prov		Barnsley CCG		BHNFT		Bassetlaw CCG		Doncaster CCG		DBHFT		Rotherham CCG		TRFT		Sheffield CCG		SCHFT		STHFT	
Activity	**Period**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**TRFT YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**	**YTD var from plan (%)**	**Year on Year 12mth growth**
GP referrals (YTD)	Sep-19	3.1%	0.0%	4.7%	-0.1%	14.1%	6.1%	11.2%	11.6%	-1.0%	1.1%	-0.2%	4.1%	2.2%	1.9%	-1.4%	0.1%	-4.3%	-1.1%	3.2%	-4.7%	28.7%	10.8%	4.7%	-5.7%
Other referrals (YTD)	Sep-19	4.0%	5.2%	3.0%	5.2%	7.2%	8.8%	6.2%	11.5%	9.5%	13.1%	-2.7%	0.4%	-4.8%	1.7%	-0.9%	0.1%	-4.9%	-1.3%	7.5%	6.9%	29.8%	13.0%	3.2%	5.4%
Total referrals (YTD)	Sep-19	3.4%	2.0%	4.0%	2.0%	11.1%	7.2%	9.3%	11.5%	2.9%	5.5%	-1.2%	2.7%	-0.3%	1.8%	-1.2%	0.1%	-4.5%	-1.2%	4.8%	-0.4%	29.4%	12.1%	4.0%	-1.0%
1st Outpatients (YTD)	Sep-19	11.5%	4.2%	2.4%	4.5%	6.7%	4.7%	10.2%	8.5%	6.5%	4.7%	4.6%	4.9%	1.4%	3.8%	18.7%	2.9%	17.1%	1.0%	15.0%	4.0%	-1.2%	12.8%	-0.7%	3.6%
Follow-up outpatients (YTD)	Sep-19	6.2%	2.6%	5.2%	2.8%	5.6%	5.1%	10.6%	10.2%	5.1%	0.4%	13.0%	2.7%	-2.1%	-3.9%	24.5%	-0.3%	39.6%	-0.1%	-2.2%	3.0%	-1.7%	8.2%	1.4%	3.1%
Total Elective Admissions (YTD)	Sep-19	3.7%	2.4%	0.9%	2.2%	9.1%	3.0%	6.5%	3.7%	2.5%	2.1%	3.0%	3.1%	0.9%	0.5%	3.0%	-0.1%	0.3%	-3.4%	2.1%	2.8%	-6.4%	2.2%	0.9%	3.8%
AE attendances (YTD)	Sep-19	2.0%	5.9%	1.3%	6.3%	0.2%	9.3%	4.5%	12.1%	5.8%	10.0%	2.4%	5.0%	1.2%	5.8%	2.8%	5.9%	0.3%	5.2%	1.7%	4.0%	4.6%	5.3%	-1.1%	4.5%
A&E type 1	Sep-19	1.4%	6.2%	2.3%	6.7%	0.9%	10.1%	4.5%	12.1%	5.9%	10.4%	2.5%	6.3%	5.9%	7.7%	2.0%	6.1%	0.3%	5.2%	-0.3%	3.2%	6.6%	5.3%	-4.0%	3.0%
Non elective activity (YTD)	Sep-19	-0.8%	2.8%	-0.8%	2.7%	3.4%	10.3%	8.1%	12.6%	1.4%	9.0%	-5.1%	-2.4%	-2.6%	-0.3%	-3.0%	1.9%	-4.2%	2.1%	-0.2%	0.6%	-6.7%	0.1%	-2.0%	0.7%
Zero LoS Non elective spells (YTD)	Sep-19	-0.4%	4.8%	1.6%	5.0%	8.0%	16.7%	17.0%	19.6%	2.0%	11.4%	-7.6%	-3.7%	-2.4%	-0.8%	-0.3%	12.9%	-0.2%	16.9%	-0.5%	0.3%	4.9%	-2.0%	-2.0%	1.6%
1+ LoS Non elective spells (YTD)	Sep-19	-0.98%	2.03%	-1.7%	1.9%	1.7%	8.08%	4.9%	10.1%	1.0%	7.70%	-3.7%	-1.78%	-2.7%	-0.1%	-3.6%	-0.30%	-5.0%	-0.3%	-0.1%	0.72%	-9.2%	0.5%	-2.0%	0.4%

South Yorkshire and Bassetlaw Integrated Care System

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Progress Update Developing the SYB Long Term Plan

Health Executive Group

10th December 2019

Author(s)	**Lisa Kell, SYB ICS Director of Commissioning** **Marianna Hargreaves, ICS Transformation Delivery Lead**
Sponsor	**Will Cleary-Gray SYB ICS Chief Operating Officer SYB ICS**

Is your report for Approval / Consideration / Noting

For noting

Links to the ICS (please tick)

☐ **Reduce inequalities**	☑ **Join up health and care**	☐ **Invest and grow primary and community care**	☐ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do this**		

Are there any resource implications (including Financial, Staffing etc)?

Not at this stage.

Summary of key issues

The purpose of this paper is to summarise progress, submission to NHS England and NHS Improvement and sharing with local Boards and Governing Bodies of the final draft of the SYB ICS Long Term Plan response. It culminates the work coordinated by the cross-system task and finish group, the outstanding issues to work through and the steps and timeframe to operationalise the Plan across SYB.

Recommendations

Members of the HEG are asked to

1. Note the final draft submission shared with NHS England and NHS Improvement, local Boards, Governing Bodies and Councils
2. Note plans underway to prepare to publish the plan in the New Year and following a period of Purdah currently 8th January 2020.
3. Note the outstanding key issues of financial gaps against 4 NHS Foundation rust trajectories
4. Consider the next steps and initial thinking on next steps to enable us to begin to implement and operationalise the plan and contribute to its development through discussion between now and end March 2020.

Developing the LTP System Implementation Framework

Briefing for the Health Executive Group

10 December 2019

1. Purpose

1.1 The aim of this paper is to provide an update for members of the Health Executive Group on the national submission of the South Yorkshire and Bassetlaw Long Term Plan response and share initial thinking on next steps in order to enable discussion with all partners to contribute to the development of our SYB LTP implementation framework and inform how we operational the plan together.

2. LTP Final draft submission and key issues remaining

2.1 Final submission for the three parts of the LTP encompassing the final draft strategic narrative, strategic planning tools for activity, finance and workforce and LTP metric trajectories was made at noon on Friday 15th November 2019. Feedback through the regional assurance process continues to be good.

2.2 The LTP metrics were refined following feedback from the submission on the 1st and the 15th November. They have now been agreed and will continue to be refined as we move into operationalising the plan.

2.3 Good progress has been made between commissioners and providers on activity plans which have good alignment across the five places. However there continues to be a financial gap over the four-year period as a result of a gap against 4 of our local NHS Foundation Trusts trajectories. Discussions with Chief Officers and Chief Executives have taken place and steps have been agreed to work this through with a **commitment as a system** to achieve a balanced plan for SYB for 2021 and beyond.

2.4 HEG members at their last meeting requested that the final draft plan be brought to the December HEG for completeness. The **final Plan** with covering letter is appended in **annex, A,** and will be shared with the Health Oversight Board later today. It is currently with all Boards and Governing Bodies for consideration in private with a request to approve in public in the New Year and post the period of Purdah, honouring the guidance given by NHS England and Improvement and with a view to publication on the **8th January.** There will be a range of supporting material including and easy read version of the plan and summary materials to help partners with communicating the plan.

3. Headlines and priorities from the SYB plan

3.1 In summary the LTP strategic narrative sets out our overarching vision and ambition for SYB to:

- Develop a **population health system**, through understanding population health in SYB, the **wider determinants** of health, and developing a **prevention led NHS** to tackle **health inequalities** and reduce **unwarranted variation**. This includes recognising the **life stages** of our population including ensuring children in SYB get the best start in life and action is taken to improve population health outcomes from major health conditions, including mental health, cancer and other long term conditions. We also recognise some changes that need to continue to take place to commissioning to enable this focussing on population health outcomes and integration.
- Strengthen our foundations, through our continued engagement with **patients**

and the public, empowering our **workforce** and making SYB the best place to work for our people, **digitally enabling** our system and maximising the potential for **innovation and improvement.**

- Build a **sustainable health and care system**, through delivering **new service models** at **neighbourhood, place** and **system**. Transforming care with **primary care working in networks** with wrapped around **community care** and the delivery of out of hospital care enabled through **place partnerships**. Transforming emergency care and planned and how we support high quality and **sustainable service across SYB** with Trusts and NHS Foundation Trusts working together in new and innovative ways building on new models and care including hospitals and mental health and community trusts **working in networks.**
- Broaden and strengthen our partnerships to increase our opportunities, including maximising the role of **NHS organisations as anchor institutes** and **working with Local Authorities**, **Sheffield City Region**, academic and research partners and the **voluntary sector** to connect the important synergy of the **wider economic agenda**, wider determinants and the role that the public sector has both in terms of employer and jobs and improving health and well-being.

3.2 The priority areas for action outlined in our LTP strategic narrative (including the LTP foundational commitments) include the areas below and more detailed implementation plans are currently being worked up for us to build on:

- Workforce (NHS People Plan)
- Digital and innovation
- Population health and prevention
- Urgent and emergency care
- Mental health and learning disabilities and autism
- Primary Care and Primary Care working in networks with wrapped around community services (and more broadly out of hospital)
- Cancer
- Children and maternity
- CVD, Stroke, Respiratory
- Planned Care (including outpatients)

3.3 In our LTP strategic narrative we also specifically identified **five areas** that we need to particularly focus on over the next five years to make **marked improvements** in population health and reduce inequalities: **best start in life, reducing harm from smoking, alcohol and obesity, improving cardio-respiratory health, improving mental health and wellbeing and earlier diagnosis and increase survival from cancer** We will need to ensure we are confident that the right priorities have the right balance of focus at neighbourhood, place and system to enable them to deliver on these improvements. A summary of specific commitments **to improving population health and reducing inequalities** are as follows:

- **Smoking in pregnancy:** reduce the % of pregnant women in SYB who are smoking at time of delivery to 6% by March 24.
- **Smoking in adults:** Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness.

- **Early death from cardiovascular disease:** Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation and closing the relative gap between SYB and England to 10% or less by 2024-26.
- **Life expectancy:** Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population.
- **Suicide rates:** Reduce suicide rates across SYB of 5% year on year up to 2024 (NB rebase in 2017/19).
- **Cancer survival:** Improve 1 year cancer survival rates to 79% by March 24.
- **Cancer early diagnosis:** Increase the % people with cancer who are diagnosed at stage 1 and 2 to 58% by March 24.

4. Next Steps – implementing and operationalising the Plan

4.1 The SYB cross-system LTP task and finish group has had a pivotal role in facilitating the co-production of the LTP strategic narrative. As we move into the implementation phase it is acknowledged that the next steps require both focuses and at the same time broader discussion to inform how we operationalise the plan. The last meeting of the LTP task and finish group will take place on 12th December.

4.2 The SYB Plan is a system plan and is **dependent on all part for successful delivery**; organisation, neighbourhood, place and across SYB. Our framework for implementation and operationalising the plan will need to recognise the important role that all parts of the system has and in the context of **care delivery is local** and our detailed planning for care delivery will need to reflect this.

4.3 **Programme implementation plans** are currently being developed building on the draft implementation plans which have been shared together with places. Recognising that the majority of delivery for the national and local transformation programmes including cancer, mental health and LD, primary care, children's and prevention will be done at place and organisation and are locally owned. These plans will start to unpack the strategic narrative with the level of detail needed to assure our system and NHSEI of our capability to achieve the LTP requirements.

4.4 In addition the SYB system will support coordination of the development of a number of implementation plans necessary to enable focussed delivery of the LTP including: taking forward the **People Plan and Workforce**, **Digital and innovation**, **System efficiency, role local partnerships** in each of the five places, the **future role of commissioning** and the **role of provider partnerships** across SYB.

4.5 We will start to have more detailed discussion about implementing and operationalising the plan further on **14th January 2020** with a final implementation plan being ready in time for the HOB at its meeting at **the end of March**. We will have operational guidance which will need to be taken into account as we work through these.

5. Recommendations

5.1 Members of the Health Executive Group are recommended to :

a) Note the final draft submission shared with NHS England and NHS Improvement and local Boards, Governing Bodies and Councils
b) Note the outstanding key issues of financial gaps against 4 NHS Foundation Trust trajectories.
c) Note plans underway to prepare to publish the plan on 8th January 2020 in following the period of Purdah.
d) Note and comment of the summary of next steps to begin to operationalise the Plan in time for April 2021

Appendix, A

SYB Final Draft Plan

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South Yorkshire and Bassetlaw Integrated Care System

South Yorkshire & Bassetlaw Integrated Care System
722 Prince of Wales Road
Sheffield
S9 4EU
Programme Office: 0114 3051905

25 November 2019

Letter to:

SYB CEOs & AOs

Dear Colleague

Re: South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Five Year Strategic Plan 2019 - 2024

Thank you for the significant support you have given to shaping the SYB ICS Five Year Strategic Plan.

We submitted this Plan to NHS England and Improvement on 15 November 2019 following extensive conversations with the public, staff, partners and stakeholders about their hopes and vision for health and care services in South Yorkshire and Bassetlaw. A Task and Finish Group, made up of representatives from all parts of our system, has been the driving force behind shaping the Plan and we would like to thank you for supporting this approach by enabling leaders from your team to contribute. The feedback from many months of conversations informed their thinking and shaped the draft Plan which we subsequently tested with our Guiding Coalition, ICS partners, wider stakeholders and national NHS teams. The result is a refreshed Plan, which has been clinically led, builds on our work to date and has been guided by the NHS Long Term Plan and shaped by our local constituents.

Our submission marks the continuation of our journey, which started three years ago when we published the South Yorkshire and Bassetlaw Sustainability and Transformation Plan. Since then we have made significant progress in delivering our ambitions and we are starting to make real and lasting positive changes to people's lives across the region. If you haven't already read the ICS Three Year Review, please do visit our website to download a copy.

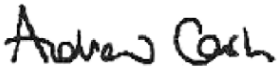
Our 2019 Plan recommits our ambition for everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to be healthy and live longer while aiming to be the best delivery and transformation system in the country. Please find the attached the Plan which was supported by all SYB CEOs and AOs at the meeting in November of our Health Executive Group.

As we are now in Purdah, the pre-election period, we will not be publishing the Plan until after the General Election and we await guidance on exactly when this should be. We therefore propose that the Plan is considered in your private Board or Governing Body meetings during November/December and in advance of consideration in public Boards for formal sign off in the New Year.

South Yorkshire and Bassetlaw Integrated Care System

In the coming weeks and months we expect our focus will be on developing detailed delivery plans and we will all be working together on this next important stage. If you have any questions about this letter or the submissions please do not hesitate to get in touch with Will Cleary-Gray.

Yours sincerely,



Sir Andrew Cash
System Leader
South Yorkshire & Bassetlaw Integrated Care System

South Yorkshire and Bassetlaw Integrated Care System

Final draft

Not for Publication
Due to Purdah, this Plan should not be published in the public domain until further guidance from NHS England and Improvement. Boards and Governing Bodies should discuss in private meetings.

Strategic Plan 2019-2024

November 15 2019

Contents

Foreword

By Sir Andrew Cash
Chief Executive
System Lead

"We are starting to make real and lasting positive changes to people's lives across the region."

It is three years since we published the South Yorkshire and Bassetlaw Sustainability and Transformation Plan. In that time we have made significant progress in delivering our ambitions and we are starting to make real and lasting positive changes to people's lives across the region.

We have extended GP access at evenings and weekends, supported more than 3,000 people with long term physical and mental health conditions to find and stay in work as part of the Working Win programme led by the Sheffield City Region, invested more than £1 million into maternity services and care, introduced new nursing roles and freed up GP appointments with the introduction of 825 care navigators.

This snapshot of achievements is down to us working together in even better ways than we have before and we are rightly proud of our achievements. We have documented our work so far in a three-year ICS Review.

We have started to break down organisational barriers so that we can wrap support, care and services around people as individuals and improve people's lives. Each of our NHS partners has strengthened the way they work with other NHS organisations and with wider partners, such as local authorities and the voluntary sector.

As a System, we have joined forces where it makes sense to do so and where it makes a real difference to patients, staff and the public.

All this has put us in a strong position as we prepare to build on our successes and take forward our ambitions in our refreshed strategy for the next four years.

We have continued to talk with the public, our staff and our stakeholders about their hopes and vision for health and care services in South Yorkshire and Bassetlaw. Those conversations, which built on the ones we had in 2017, focused on the aims and aspirations set out in the NHS Long Term Plan, published in January 2019.

The feedback from many months of conversations has informed our thinking which we have since tested with our Guiding Coalition and partners within the System.

The result is our refreshed Plan, which has been clinically led, builds on our work to date, is guided by the NHS Long Term Plan and shaped by our local constituents.

Foreword ...

Our pledges in 2016 were to give people more options for care while joining it up for them in their neighbourhood, help them to stay healthy, tackle health inequalities, improve quality, access and outcomes of care, ameliorate workforce pressures and introduce new technologies. We paid particular attention to cancer, mental health and primary care, and the two key enablers for change; workforce and digital technology.

> "Our refreshed Plan has been clinically led, guided by the NHS Long Term Plan and shaped by our local constituents."

Our 2019 Plan builds on these but it also focuses on children's health, cardiovascular and respiratory conditions, diabetes, learning disabilities and autism. It also takes forward the work to strengthen primary and community based care and as a result of the review of hospital services across South Yorkshire and Bassetlaw, the development of Hospital Hosted Networks.

People have told us how proud they are of their local health and care services but they also shared their concerns about funding, staffing and the increasing inequalities from a growing and ageing population.

Our Plan tackles these issues as it sets out how we will make funding go as far as possible, alleviate the pressures faced by staff and redesign care and services so that we continue to offer and deliver some of the best health care services in the world.

By working as an ICS over the three years to March 2019 we secured £51m of transformation funding and £78m of capital funding; a total of £129m which has enabled us to progress many schemes. Our refreshed strategy for the next five years includes an indicative £129m of further transformation funding which means we can accelerate the progress in our priority areas while working with the new financial rules to drive efficiencies and deliver for taxpayers.

South Yorkshire and Bassetlaw Integrated Care System

Through our partnership working with Local Authorities and the Sheffield City Region we want to continue to influence and contribute to the development and implementation of a wide range of local 'Place' based strategies that are tackling the wider determinants of health, such as inclusive growth plans, housing, transport, employment and thriving communities. At the same time, we want to ensure that all our local communities have equitable access to a full range of health and care services.

Our 2019 Plan recommits our ambition for everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to be healthy and live longer while aiming to be the best delivery and transformation System in the country.

We have a very strong track record and our renewed drive puts us in an excellent position to deliver on our promises. I look forward to working with you on them to provide the best health and care for all our population.

Andrew Cash

Sir Andrew Cash
Chief Executive
South Yorkshire and Bassetlaw
Integrated Care System

Executive Summary

Our journey to becoming one of the first and most advanced Integrated Care Systems (ICS) in the country has been one of steady progress, solid performance and strong delivery. We have built on our excellent foundation of working together and are now delivering tangible improvements for our population.

We have been working as a partnership for three years and throughout this time, our vision has remained the same:

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

We are in a transition year in 2019/20 as we start to have more responsibilities for our health system, including strategic planning and increasing collective accountability for health performance and finance. We will continue to evolve our governance in line with developments and you can read more about our approach on page 67.

We published our first strategic plan in 2016 and have spent much of 2019 engaging with the public, patients, staff and partners on what they want to see happen next. We used the NHS Long Term Plan, published in January 2019, as the backdrop for our conversations but we are not starting from scratch. Feedback from our conversations in 2017, on the back of our first plan, has also informed our thinking, approach and priorities.

We intend for our approach to be innovative and bold, working with system and regional partners, such as universities, industry and the Yorkshire and Humber Academic Health Sciences Network (YHAHSN) to seek new and more cost effective ways of delivering on our objectives.

Our 2019 Plan builds on our work to date and focuses around four key ambitions:

1. Developing a population health system

Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average. We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol. Much of this burden of illness can be prevented or delayed. We will consider the wider determinants of health and tackle health inequalities with a whole population approach that is person-centred. Our focus will be a best start in life, reducing harm from smoking, alcohol and obesity, improving cardio-respiratory health, improving mental health and wellbeing and early diagnosis and increased survival from cancer.

We have started to make in-roads to improve the quality of care and outcomes in cancer, children's and maternity services and mental health and learning disabilities and we have launched the new South Yorkshire and Bassetlaw Hyper Acute Stroke Service (HASU) and associated Hospital Network. We are also working with Yorkshire and the Humber Academic Health Science Network (YHAHSN) on a project to improve the self-management of Cardiovascular Disease (CVD) focusing on developing local innovations in primary care which could be scaled up and delivered at scale. We will continue our work in these areas at the same time as widening our focus to include diabetes and respiratory conditions.

Bolstered by national transformation funding for some of our work areas, such as cancer, mental health and primary care, we have been able to accelerate progress for patients in these areas. As we take on more responsibilities for our health system for finance, we will increasingly become the route through which system funds flow. We will deliver for tax payers, taking forward our efficiency plans while we work with new payment systems and incentives across our NHS organisations to achieve financial balance.

Executive Summary …

2. Strengthening our foundations

Since 2016, we have had thousands of conversations with the public, staff and our stakeholders – all of which have shaped not just this Plan but our ongoing work in the ICS. We will build on this strong platform with support from our Guiding Coalition and Citizens' Panel to develop an online membership model and better understand how we can positively use the rich sources of patient experience data across the System.

Workforce issues are a key driver for much of the work of the ICS. Our staff provide services 24 hours a day, 365 days a year, and we must continue to support them to do the best possible job they can do.

Our Plan aims to tackle nursing shortages and secure current and future supply, make the NHS in South Yorkshire and Bassetlaw the best place to work and improve our leadership culture while introducing new roles, rostering and programmes that enable flexibility for staff.

In 2016 we set out an ambitious journey to deliver digitally enabled care. Some of our partners have made positive progress in delivering digital capabilities to integrate health and care teams around the person, such as the Rotherham Health App - but we need to do more.

We will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals. We are benefitting from £57.5m capital funding for primary and community care which will bring new and expanded provision in Neighbourhoods and we will seek extra funding to support capital development in line with clinical need.

We also want to strengthen our approach to innovation and have partnered with the Yorkshire and Humber Academic Health Science Network to establish an Innovation Hub which will become the vehicle for system-wide innovation.

3. Building a sustainable health and care system

There are now 30 Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw, all preparing to extend the range of convenient local services and create integrated teams of GPs, community health and social care staff. Already they have met as a Network of Clinical Directors, supported by the ICS, to discuss how they will start to shape the delivery of local services and provide fast support to people in their own homes.

Since our 2016 plan, two of our 'Places' have launched urgent treatment centres to help people get the care they need fast and to relieve pressure on A&Es. We are also trialling new pathways for urgent care and associated standards but we need to do more. We will increasingly start to treat people as 'same day emergency care' as we focus on out of hospital and in hospital emergency care.

We will build on the work we have started to give patients more options, control, better support and joined up care at the right time in the best care setting. In the next five years we will accelerate the recently formed Hospital Hosted Networks to ensure everyone has the same high quality standards, choice and equal access.

By redesigning hospital support, we will give patients the right to alternative modes of appointment such as online, telephone or video consultations. We will also carry out more planned operations and join up care better by increasing access to shared medical records. We will work with innovation partners including the YHAHSN to ensure we are sighted on new ways of delivering and new technologies that might support this aim.

4. Broadening and strengthening our partnerships to increase our opportunity

Our strategic plan takes account of the majority of the work across the ICS taking place locally, in neighbourhoods or in Places and the partnerships we have and continue to develop are built around these strong local relationships serving local populations.

In addition to strengthening the connections we have in Neighbourhoods and in Place with our local authorities and the voluntary sector, we want to build on the role we play in the local and regional economy. Serving the same population, we share a number of ambitions with the Sheffield City Region and we have agreed some key priority areas that will be developed across health and care with both the SCR and our local authorities.

We are extremely grateful to the public, staff and stakeholders who have taken the time to share their views on the future of health and care services in our region. In doing so they have helped to shape the thinking and contributed to the aims and objectives in this Plan.

Plan on a page

1 vision

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

This is the **second** stage of our strategy

3 Life Stages

- Starting well
- Living well
- Ageing well

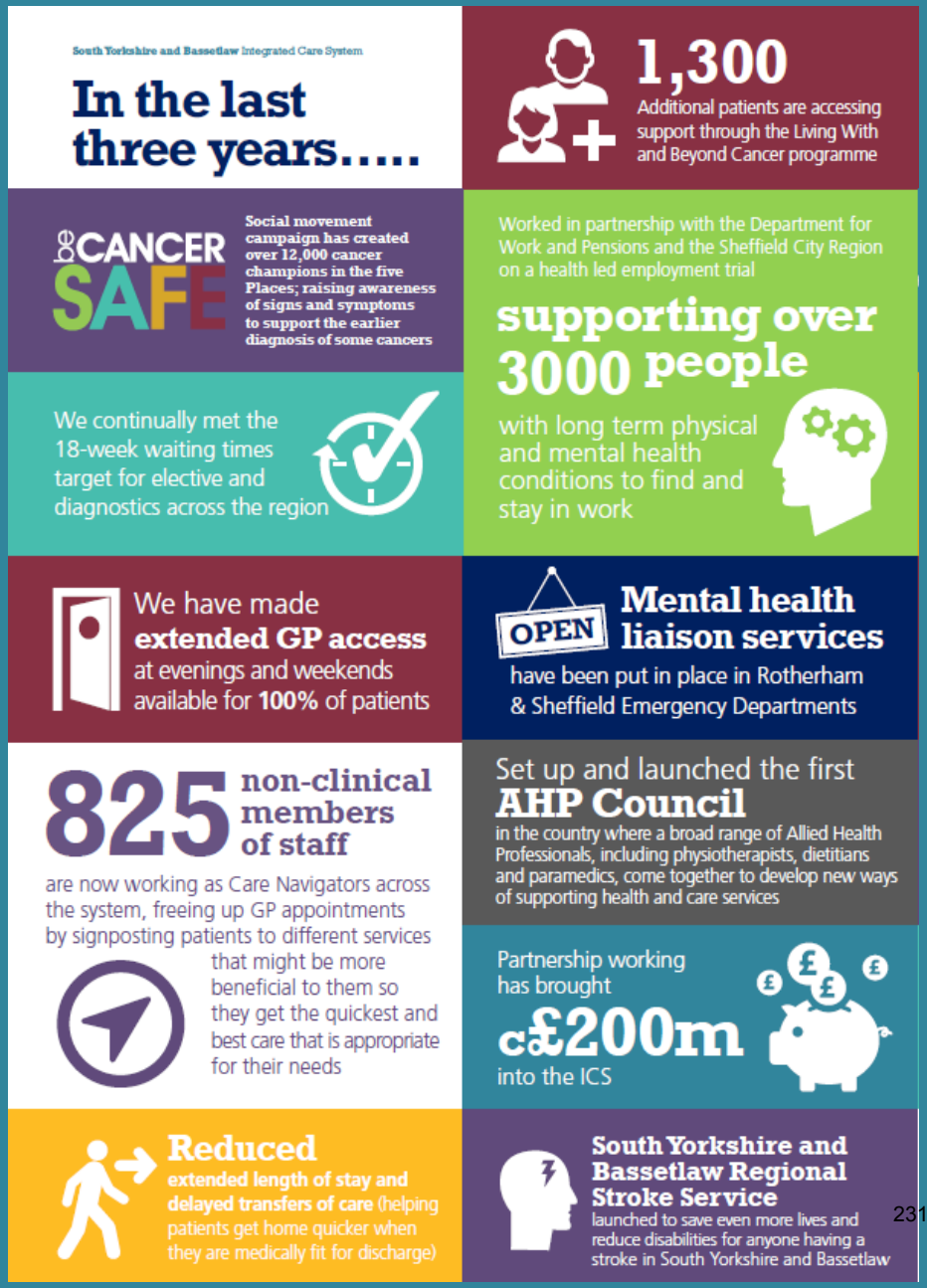
Four THEMES

1. Developing a population health system
2. Strengthening our foundations
3. Building a sustainable health and care system
4. Broadening and strengthening our partnerships to increase our opportunity

5 Focus Areas

- Best start in life
- Reduce harm from smoking, alcohol and obesity
- Improve cardio-respiratory health
- Improve mental health and wellbeing
- Early diagnosis and increased survival from cancer

Achievements and progress



231

Although we officially launched in October 2018 as an ICS, we have been working collaboratively as a System since January 2016. Throughout this time we have built on our excellent foundations of working together and started to deliver real and tangible improvements for our population.

We have much to celebrate and the work we have undertaken over the last three years is transforming the way we do things at a system level.

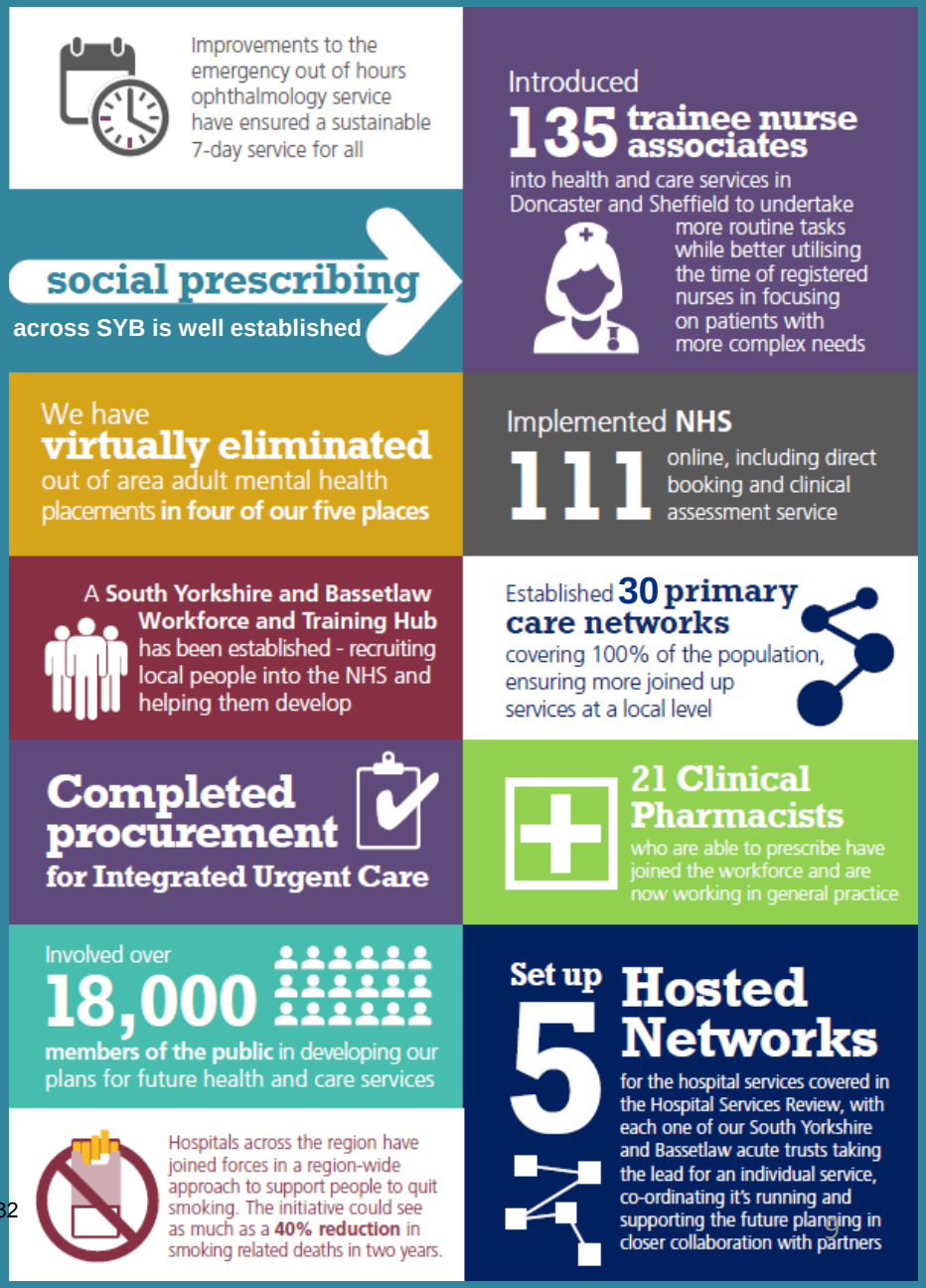
With support from staff, the public and stakeholders, we are making real inroads into transforming our approaches so that people continue to receive high quality services but in ways that are more convenient and with better outcomes.

Just some of our successes include:

- The launch of a new perinatal mental health service across Doncaster, Rotherham and Sheffield, adding to services already in place in Barnsley and Bassetlaw
- New pathways for lower GI, prostate and lung cancers – helping to diagnose and treat people earlier and improve overall outcomes
- Investing more than £1 million into our Local Maternity System to improve care for all mothers and babies. 85% of women now have a Personalised Care Plan
- Providing extended access GP appointments, at evening and weekends, for 100% of our population

Achievements and progress

- Over the last three years more than fifty per cent of practices have benefitted from funding to support them to become more sustainable and resilient, better placed to tackle the challenges they face and to secure continuing high quality care for patients
- We have developed a Primary Care Workforce and Training Hub
- We have put in place the South Yorkshire and Bassetlaw Regional Hyper Acute Stroke Service
- Made improvements in waiting times for diagnostic investigations
- Established the South Yorkshire and Bassetlaw Radiography Academy
- 1,300 extra patients are accessing support services through the Living With and Beyond Cancer programme
- Working in partnership with the Department for Work and Pensions and Sheffield City Region we have supported people with long term physical or mental ill health into the Working Win health led employment trial
- Set up five Hospital Hosted Networks for the services covered in the Hospital Services Review (which was commissioned to tackle sustainability of services following our 2016 Plan)
- Secured £200,000 from Health Education England to work with the Yorkshire and Humber Academic Health Science Network to support transformation in the mental health workforce



Our System

The South Yorkshire and Bassetlaw Integrated Care System formally launched as an 'ICS' in October 2018.

We have been working as a partnership for three years, first as a Sustainability and Transformation Partnership, then as a first wave Accountable Care System and now, as one of the leading ICS' in the country.

Throughout this time, our goal has remained the same:

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives. Our aim is to break down organisational barriers so that we can wrap support, care and services around people as individuals..

We agree to take shared responsibility (in ways that are consistent with individual legal obligations) for how we can use our collective resources to improve quality of care and health outcomes. As a first wave ICS, we are making faster progress than other health systems in transforming the way care is delivered, to the benefit of the population that we serve and we do this by being innovative and bold in our approach, identifying new ways of delivering services and working with innovation partners to deliver them.

We are a system with a population of 1.5 million with five local Places with populations between 130,000 and 576,000

At a glance, we have:

- £3.9 billion total health and social care budget
- 1.5 million population
- 72,000 members of staff
- 208 GP practices
- 30 Primary Care Networks
- 36 neighbourhoods
- 6 acute hospital and community trusts
- 6 local authorities
- 5 clinical commissioning groups
- 4 care/mental health trusts

Our System

5

Place partnerships

There are five Place Partnerships, covering populations between 130,000 and 576,000 . The Partnerships plan and deliver integrated health and care across the Place, and include:

- Primary Care Networks
- GP Federations
- Clinical Commissioning Groups
- Voluntary, community and social enterprise sector
- Local Authorities
- Healthwatches
- Acute hospital trusts
- Mental health hospital trusts

The **System** agrees shared objectives and outcomes and oversight

Hospitals are increasingly working in **Hosted Networks**

Partnerships plan and deliver integrated health and care across **Place**

Neighbourhoods integrate teams to deliver care where people live

5

Hospital Hosted Networks

There are five developing Hospital Hosted Networks covering gastroenterology, maternity, paediatrics, stroke and urgent and emergency care services. The Networks standardise clinical standards and reduce unwarranted variation.

36

Neighbourhoods

There are 36 neighbourhoods, served by 30 Primary Care Networks.
The Networks are GP practices working together to deliver as much care as possible close to where people live. Our Networks cover populations of 19,000 to 50,000, and include:

- GPs and general practice
- Community Pharmacy , Opticians and Dental providers.
- Allied Healthcare Professionals, such as podiatrists and physiotherapists
- Community Geriatricians
- Dementia Workers
- Teams from social care
- Community Wellbeing Teams
- Teams from the voluntary sector
- District Nurses

1

System

There is one System, covering a population of 1.5 million. The System plans and makes improvements for the NHS for the benefit of everyone across South Yorkshire and Bassetlaw. It also has an overview of System NHS finance and performance. It is a Partnership of NHS organisations working with others, such as Local Authorities and the voluntary sector.

Section 1: Developing a population health system

- Understanding health in SYB
- Developing a prevention driven NHS
- Taking a person centred approach
- Getting the best start in life
- Priority areas for improving outcomes from major health conditions
- Reshaping and rethinking resources and delivery to better meet need

Understanding health in

South Yorkshire and Bassetlaw

1.52 million population

Doncaster: 37
Barnsley: 38
Rotherham: 44
Sheffield: 57
Bassetlaw: 106

England Local Authority deprivation ranking of average age score (of 326, 1 most deprived), 2019 *

8.9% population of Black and Minority Ethnic heritage and many people of Eastern European origin

57% increase in the 75s and overs by 2028

People's health is determined by a complex combination of genetics, behaviour, the health care that we receive and the physical, social and economic environment that we live in.

We know that we have a number of health issues that are not as good as they should be when comparing ourselves to similar regions and the national average. We also know that people's health varies a lot within South Yorkshire and Bassetlaw.

In line with the national picture, life expectancy in South Yorkshire and Bassetlaw is no longer increasing. The greatest contributors to our gap in life expectancy in SYB are cancer, cardiovascular disease (CVD) and respiratory disease.

9.6 years life expectancy difference for women between the most deprived and least deprived areas in SYB

12.4 years life expectancy difference for men between the most deprived and least deprived areas in SYB

* Data taken from the Ministry of Housing Communities and Local Government's English Indices of Deprivation 2019

In men, we have too many deaths in early adulthood from suicide, drug related death and violence.

While there has been an overall decrease in premature deaths from CVD and cancer over the last 15 years, this has not been seen for respiratory deaths and the mortality rate from liver disease is increasing.

Alzheimer's disease is now the commonest individual disease causing death in women and fourth commonest in men.

Not only do people in South Yorkshire and Bassetlaw die younger, but they also live fewer years in good health.

More people in SYB reported having a long term disability than the national average in the 2011 Census.

Many people are living with multiple long term conditions. People living in the most deprived areas experience onset of multi-morbidity 10 – 15 years earlier that those in the most affluent areas. The more physical illnesses you have the more likely you are to also have a mental health disorder.

The commonest conditions that lead to a disability are musculoskeletal disorders, mental ill health, neurological disorders and chronic respiratory disease.

Much of this burden of illness can be prevented or delayed. We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol.

Many people are socially isolated and more people report have a mental illness in SYB than nationally. People with severe mental illness in SYB are 3.5 to 4 times more likely to die under the age of 75 than the general population.

People with a learning disability have worse physical and mental health. Women with a learning disability die on average 18 years younger and men 14 years younger.

Healthy Life Expectancy at Birth, 2015/17		
	Male	Female
England	63.4	63.8
Rotherham	59.3	57.4
Barnsley	59.7	61
Doncaster	61.8	61.1
Sheffield	62.5	60.1
Nottinghamshire	65.2	62.7

Developing a population health system

Many people in South Yorkshire and Bassetlaw are living fewer years in good health compared to those living in similar regions or the English average.

The NHS has traditionally tended to focus mainly on treating people when they are unwell. However, we know that people's health is determined by a complex combination of genetics, behaviour and wider determinants of health – the physical, social and economic environments that people live in – as well as the health care they receive.

Many of the issues and illnesses leading to poor health and well being can be prevented. If we are to improve health and reduce health inequalities in South Yorkshire and Bassetlaw we need to broaden our approach.

Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw.

Our ambition is to help people early on and prevent future problems developing.

Our 2016 Plan focused on shifting our system to one that is focused on maintaining wellness and slowing or stopping the progression of disease by impacting on all the wider determinants of health. In our 2019 Plan, we set out our next stage ambitions to address health inequalities and improve our population's health over the next five years.

We have identified five areas that we will need to particularly focus on over the next five years to improve population health and reduce inequalities

- **Best start in life**
- **Reduce harm from smoking, alcohol and obesity**
- **Improve cardio-respiratory health**
- **Improve mental health and wellbeing**
- **Early diagnosis and increased survival from cancer**

We will

- Reduce the % of pregnant women in SYB who are smoking at time of delivery to 6% by March 24
- Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness
- Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation and closing the relative gap between SYB and England to 10% or less by 2024-26.
- Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population
- Improve 1 year cancer survival rates to 79% by March 24
- Increase the % people with cancer who are diagnosed at stage 1 and 2 to 58% by March 24
- Reduce suicide rates across SYB of 5% year on year up to 2024 (NB rebase in 2017/19)

237

Tackling health inequalities

We will take a three-pronged approach to tackle health inequalities, underpinned with strengthened partnerships and leadership in Place.

Civic

As partners in our five Health and Well Being Boards, Integrated Care Partnerships and Sheffield City Region we will support and advocate for public policies and strategies that improve the social determinants of health.

As anchor institutions we will maximise the impact that we can have on the wider social determinants of health in the way we run our organisations and support our staff. We will enhance social value in our commissioning, contracting and procurement processes. We will offer more apprenticeship and volunteering opportunities and be leaders in environmental sustainability.

Community

Recognising that most change happens in local communities we will continue to develop local neighbourhood partnerships and local community assets, help people to support each other and take control of their health.

We will:

- Involve local communities in priority setting, service design and evaluation.
- Strengthen local communities and social networks, including through investment in the voluntary, community and social enterprise sector.
- Build capacity for local people to be involved as volunteers, carers, community champions and peer support workers.
- Make sure there is good access to local activities and support for people and groups at risk of poor health.
- Prioritise support for people affected by inequalities in health; people living with learning disabilities, serious mental illness, our veteran population, and those in contact with the justice system, ethnic minority groups and people living complex lives and homeless.

Health services

Through our core health services we will support people to manage their own health, support population health through the provision of high quality equitable primary care services and develop population health management capabilities and capacity to identify and address unwarranted variations in care. We will provide personalised care, focusing on what matters most to the person.

We will design services to meet the needs of communities with the greatest needs and prioritise services which have the biggest potential to decrease inequalities such as those for children and cardiac, diabetes, respiratory and cancer services . We will take measures to prevent or delay the onset of multi-morbidities and ensure good quality physical and mental health care for people with mental health conditions, learning disabilities and autism.

We will change the culture of the NHS to recognise prevention as a core responsibility of staff and services. We will ensure that prevention measures are commissioned, resourced and delivered at sufficient scale and in a sustainable way, ensuring those that are most disadvantaged benefit the most. We will undertake a range of actions, within the NHS's direct power to do, to support an improvement in the social determinants of health.

Wider determinants of health

Through our partnership working with the local authorities and Sheffield City Region we will influence and contribute to the development and implementation of a wide range of Place based strategies tackling wider determinants of health. There is also a range of practical actions that the NHS will undertake. In addition to this we will work with national programmes to support health and the justice system and veterans.

Education
School readiness is similar to the national average. Fewer children in SYB achieve attainment 8 score. About 6% of 16-17 year olds are not in education, employment or training.

Employment
Fewer people in Barnsley and Sheffield aged 16-64 are in employment than the national average. Unemployment rates are higher in those with long term conditions.

Deprivation and income
SYB has high levels of deprivation. All Places, except Bassetlaw, have higher than average rates of children living in low income families.

Built and natural environment
Areas of poor private sector housing.
30% of adults who use mental health services and 20% of adults with learning disabilities do not live in stable or appropriate accommodation.
Air pollution is estimated to cause between 4.4% and 4.9% of all deaths in SYB.

Social capital and community safety
People using outdoor space for exercise is increasing but still only ranges from 14-19%.
The percentage of those who have as much social contact as they would like is 40-49% for adult social care users and 28-43% for adult carers. Violent crime rates are higher than the national average, except in Sheffield.

Education
We will support children to be ready for school and maximise their potential with improved provision of services such as perinatal mental health, early diagnosis and support for people with learning disabilities and autism and personalised health care for those with long term conditions and disabilities. Identification of children and families who need extra support early and provide a tailored response.

Employment
As major employers in our local communities we will expand our work with local schools, colleges and universities to promote the wide range of NHS career opportunities, offer apprenticeship schemes, provide work experience and improve our staff welfare offer. We will also build on our Working Win pilot with the Sheffield City Region, set up Individual Placement and Support services for people with severe mental illness and enhance access to physiotherapists through Primary Care Networks for people with musculoskeletal problems and continue to improve mental health services.

Deprivation and income
Through social prescribing and working with local welfare advice services we will support people to access advice and support to claim welfare benefits and debt advice. We will be active partners in Sheffield City Region Inclusive Growth Plans.

Built and natural environment
We will collaborate with local authorities on planning for housing developments; engage with communities, public transport providers, Sheffield City Region and local authorities to improve links and walking and cycling routes and further develop active transport plans for hospitals; better integrate health services into local support for people who are or at risk of homelessness including providing specialist mental health services for rough sleepers.

Social capital and community safety
We will expand the provision of social prescribing; continue to invest in the voluntary sector; develop NHS volunteering opportunities for local residents and support our staff to volunteer; work with local communities to ensure NHS services are accessible and responding to local need. Health organisations will play their part in addressing the root causes of violence.

Developing a prevention led NHS

Cut smoking	Reduce obesity	Reduce alcohol related admissions	Lower air pollution	Tackle anti-microbial resistance

We will: Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness.

Healthy Hospital Programme established. QUIT programme embedding the Systematic Treatment of Tobacco Dependency starting in all Acute and Mental Health Trusts early 2020

Wide range of activities across SYB working with LAs in tobacco control, obesity, increasing physical activity, minimising harm from alcohol & improving air quality. High referral rates to Diabetes Prevention Program

Developing system level joint work with SYB LAs:
- Enhancing social connectedness
- Increasing physical activity

- Integrated approach to support people locked in a cycle of rough sleeping, addiction, poor physical health, mental health, and offending behaviour (Complex Lives)

We will work across the System to:

- Implement partnership Place based plans for tobacco, alcohol, obesity (child and adult), physical activity and air quality.
- Increase the provision of very brief advice within clinical practice. Provide SYB commissioned brief advice and behaviour change training for all new post holders in Primary Care Networks.
- Maximise the prevention opportunities afforded by the new National Primary Care and Pharmacy Contracts.
- Develop the scope of the SYB Healthy Hospitals Programme.
- Increase NHS health and wellbeing offer for staff.
- Implement the national antimicrobial resistance strategy.
- Working with the NHSE/I embedded Public Health England (PHE) Screening and Immunisation Teams, identify areas of low coverage, reduce inequalities in access and increase uptake of, screening and immunisations of all immunisation programmes including MMR.
- Improve childhood oral health

Tobacco harm reduction:

- Roll out the QUIT programme so that from early 2020 all patients (except day case and maternity) admitted to acute and mental health trusts will be asked their smoking status and offered treatment for tobacco dependency if a smoker.
- Further develop and implement plans to decrease smoking in pregnancy, supporting mother and family to quit.

Reducing obesity

- Work with Local Authorities and Sheffield City Region to promote physical activity. Embed physical activity as a treatment intervention in clinical care. Implement NHS healthy food standards.
- Increase referrals to the Diabetes Prevention Programme, seek to be a pilot site for enhanced weight management support for people with a BMI of over 30 with Type 2 diabetes or hypertension.
- Review provision of tier three obesity services.
- Support implementation of Place based childhood obesity plans, including an increase in the uptake of breast feeding

Reducing harm from alcohol

- Ensure all SYB acute Trusts have an alcohol care team, with a standard SYB service specification in line with national guidance, commencing in 20/21. Work with LAs to ensure linkage with community services and support Place based alcohol reduction plans.

Improving air quality

- Complete clean air consultations in Sheffield and Rotherham and put recommendations in Place
- Develop alternatives to face to face NHS appointments
- Encourage staff to travel sustainably and actively
- Install more electric charging points on NHS sites, green the NHS fleet and review energy use and supply.

Developing a prevention led NHS

Prevention Place Based Plans

In addition to implementing the national priorities within the Long Term Plan, Places are all actively implementing Place based Health and Wellbeing Strategies and prevention action plans.

Barnsley

- Collaborative work with the Local Authority to implement the 2018-2021 Public Health Strategy focussed on food, alcohol, emotional resilience, oral health of children, creating a smoke free generation and physical activity.
- Work to extend Smoke Free Barnsley, building on the smoke free Town Hall square , smoke free schools and play grounds.
- Implementation of suicide prevention plan
- Implementation of alcohol action plan

Sheffield

- Implement Sheffield Tobacco Control strategy
- Support partners to develop healthy food and drink policies
- Support achievement of the six Move More Strategy Outcomes.
- Healthy weight pathways group in maternity & early years aimed at reducing maternal obesity
- Whole school & setting approach to nutrition
- Low sugar Sheffield social marketing campaign to raise awareness & reduce the amount of sugar that we consume
- Development of Adverse Childhood Events (ACEs) Strategy for the city and of a trauma informed workforce
- Hidden Harm group work in supporting the children of adults using substances, who are more likely to go onto develop substance misuse issues themselves, and at greater severity, than the general population.
- Volunteering strategy in Sheffield with significant cross organisational support about supporting volunteers & how we support our staff to volunteer

Rotherham

- 'Five Ways to Wellbeing' in all strategic plans.
- Loneliness action plan developed with a pilot testing out Make Every Contact Count (MECC)
- Local Authority (LA) Declaration on Weight to be adopted & the 'Healthy Weight For All ' plan implemented.
- Rotherham Activity Partnership to involve all health & social care partners to make good levels of physical activity the norm.
- Rotherham Cultural strategy launched encouraging get active and outdoors.
- CLeaR (Challenge services, Leadership, and Results assessment for alcohol is being undertaken
- Better Mental Health for All Strategy will drive work to improve mental wellbeing of population.

Doncaster

- Testing community based solutions to improve access to early help services for children and families in Denaby and Hexthorpe.
- Testing new frailty model in Thorne
- Revising the Doncaster tobacco control strategy.
- Developing a 'good food' Doncaster approach including adopting the healthy weight declaration.
- Launching an alcohol alliance to reduce the harmful effects of alcohol
- Continuing to deliver Get Doncaster Moving to reduce physical inactivity in those most inactive
- Delivering the mental health prevention concordat and increasing awareness around suicided through the 'another way' campaign.

Bassetlaw

- Target physical activity initiatives at priority groups at high risk of CVD, hypertension & dementia, with a focus on mental health though 'Miles in May'
- Local Childhood Obesity Commission to be established to tackle determinants of obesity including food environment, parenting, schools, access to physical activity, & individual motivation.
- New 'Integrated Wellbeing Service' from 2020, with evidence based interventions delivered as part of a holistic lifestyle change service.
- Focus smoking cessation & weight management services in the most at need communities
- Deliver social prescribing for all adults at risk of social isolation, or to improve mental wellbeing.

Population health management

- We will take a broad approach to population health so that we create the conditions for good health through our role as NHS anchor institutions, using our assets and developing approaches that help build on the strengths of local communities and increase social value.
- We will develop integrated and compassionate care offers in response to population health and care needs across our local neighbourhoods. We will reduce variation across population groups ensuring we improve health fastest in those with the greatest need. We will look at the whole population needs and not just those accessing services.
- We will improve the population health management capability across SYB using digital technology that will help to better understand the needs of the population. SYB is part of the Yorkshire and Humber shared care record programme which when will enable patient information to be shared across hospitals, primary and community care and social care enabling seamless integrated care regardless of where people are treated.

We will focus on:

Outcomes
Health and wellbeing outcomes are often measured as averages, which can hide large variations in outcomes between population groups. We will delve deeper to identify the differences using population segmentation techniques and set realistic expectations for improvement at Neighbourhood, Place and System.

Expectations
Expectations will be underpinned by a set of interventions and service or practice models that may need to be different from those that improve the health of all population groups.

Urgency
We will approach this with a new level of urgency, curiosity and vigour.

Ownership
We will have collective system ownership of the challenges, both within the NHS and with our Local Authority and wider partners, and address them through mutually reinforcing actions.

Empowering people
We will empower local people and communities with support and tools to help improve health and wellbeing across SYB.

Interventions
The approach will inform the redesign of services to ensure they meet the needs of those with the most to gain. We will use evidence based risk stratification and segmentation tools to understand and meet our populations needs. We will use Patient Activation Measures (PAMs) to personalise wellbeing support and digital technology to support people to make healthy lifestyle choices.

Place progress: Sheffield has whole population linked data analytics capability and population health management intelligence dashboard. A pseudonymised linked data warehouse covers the entire GP population and can link all care services datasets at person level, including social care and modelled predictive risk values. Bassetlaw's Primary Care Networks are pioneering PHM approaches, working to undertake root cause analysis for key population segments

Reducing unwarranted variation

Our priorities

SYB has areas of unwarranted variation in access, quality, health outcomes and cost of health care services in primary care, secondary and tertiary care. We also have variations in provision of preventative care and support.

Differences between the quality of care and the clinical practice followed mean that, in some instances, patients across SYB receive different standards of care and potentially have different clinical and health outcomes. These variations can have significant financial implications.

We know from NHS RightCare that we have more people being admitted to hospital as emergencies with respiratory and cardiovascular disease and that we have marked inequalities in health.

We also know from NHS Getting it Right First Time (GIRFT); which is a national clinically led programme established to improve the quality of care within the NHS through the standardisation of practice and reducing unwarranted clinical variations in care, that we have variations in the way services are provided and in the clinical outcomes achieved.

We have made good progress in recent years, including the consolidation of provision of Hyper Acute Stroke services, standardising commissioning across SYB for some procedures, supporting quality improvement in primary care, standardising a number of secondary care planned pathways and using RightCare and GIRFT data to inform planning, service reviews and Quality Innovation and Prevention Programmes.

Our challenge is to reduce unwarranted variations in care whilst improving care and outcomes overall and making cost efficiencies that can be reinvested in improving health across SYB

We will work across the System to:

- Work with the combined improvement offer from NHS England and Improvement e.g. RightCare, GIRFT
- Carry out an annual review of variation against peers on all our main programmes
- Strengthen our population health management analytical capabilities and review the support needed for Primary Care Networks
- Support Primary Care Networks to use the Network RightCare packs, national audits and other tools that support a reduction in variation
- Offer targeted support to primary care providers
- Support PCNs, community pharmacists and clinicians to identify and address unwarranted variation and waste in prescribing of medicines
- Systematically embed NICE and other national guidelines and standards
- Standardise clinical standards and reduce unwarranted variation with the Hospital Hosted Networks
- Continue work on the standardisation of outpatient pathways for first and follow up appointments
- Focus on cardiovascular, respiratory and mental health to reduce unwarranted clinical variation and improve outcomes
- Ensure that early supported discharge is routinely commissioned as an integrated part of community stroke services
- Increase focus on prevention, with particular focus on reducing harm from tobacco, alcohol and obesity and secondary prevention of long term conditions
- Put in place actions that will help to deliver consistent high quality care and access to care for vulnerable communities, such as physical health checks for people with severe mental illness (SMI) or learning disabilities and continuity of care during pregnancy

Taking a person centred approach

Personalised care means people have a say in how their care is planned and delivered, based on 'what matters' to them, their individual needs and preferences

Our progress

- All five Places in SYB are providing personalised care approaches using the national personalised care comprehensive model to offer choice that matters to people in their care
- It is a key element of Primary Care Network development and supports out of hospital care and the Long Term Plan deliverables - prevention and early intervention, integrated community care and social prescribing
- SYB is one of 20 ICS' nationally to have committed through an MOU with NHSE to fully implement Personalised Care collaboratively across the system footprint by 2024
- Sheffield CCG is a exemplar site for Personalised Care supporting other systems nationally to develop a person centred approach
- Each Place is already supporting many people to self manage their health and wellbeing by offering a personal health budget which allows people to make decisions to control their own care, improve their health experiences and better value for money by independently managing their care support package through services of their choice
- We are also growing our highly valued voluntary sector provision to help people needing support through our social prescribing link worker service in each Place and can signpost to other agencies such as housing support

We will offer personalised care through:

Choice; Shared decision making; social prescribing and community based support; Patient Activation Measurement and support for self-management, personalised care and support planning, personal health budgets

Place progress: South Yorkshire and Bassetlaw are national leaders for Social Prescribing, with well established services in all five Places

We will work across the System to:

- Systematically implement the Comprehensive Model for Personalised Care by 2023/24, working with primary care networks, wider NHS services, people with lived experience and partners in local government and the voluntary and community sector.
- Enable people to take more control of their health and care, providing more options, coordinated support and care at the right time and right place
- Make the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences
- Supporting people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well. Also taking whole-population approaches to supporting people to manage their physical and mental health and wellbeing
- Develop our relationships with, and commissioning of, the local voluntary and community sector and further expansion of link workers in Primary Care Networks
- Develop our Workforce, Learning and Development strategies to support health and care professionals to further develop their skills and competencies in promoting personalised approaches, choice and shared decision making.
- Support people and their carers with long term physical and mental health conditions to take control, including developing the use carers passports
- Ensure personalised care approaches are embedded in service redesign

Getting the best start in life

Children's services

Our progress

- We have established innovative out of hospital approaches and are looking to translate these across SYB.
- We have strong, mature networks for children's surgery and anaesthesia and care of the acutely unwell child, through which we have developed new models and standardised pathways for common and urgent conditions.
- The Hospital Services Review recommended accelerating shared transformation for children's services

Our challenges

- Prevention and wider determinants of health are key areas of focus in each Place.
- 4/5 Places exceed the England average for the rate of children in low income families
- High neonatal/infant and child mortality
- High child obesity
- Insufficient uptake of some immunisations in some communities
- High under 18 conception rate
- Specialist workforce challenges with particular shortfalls in hospital children's services.
- Agency and locum use is high
- Integrated out of hospital care models exist but application is inconsistent
- Inconsistency in waiting times for some specialist services, like ADHD, ASD & SEND

We are developing a Children's Hospital Hosted Network

We will:
Reach 95% of children having had 2 doses of MMR by age 5 by March 2022

We are learning from **great examples of integrated care in our Places**, such as the Rotherham team bridging acute and community paediatrics; Recruiting paediatric endocrine, respiratory and tissue viability nurse specialists in Bassetlaw; Integrated service for children with long-term conditions and disabilities in Doncaster and the integrated community, early intervention and prevention models Healthy Minds and Sleep Project in Sheffield.

In mental health services, we are learning from Rotherham's approach to CAMHS/ASD/ADHD; Barnsley's eating disorder pathway and Bassetlaw's innovative partnership with the voluntary sector.

245

We will work across the System to:

- Leverage the power of the ICS, combining a prevention and public health approach and integrated service models, with pathways across primary, community and acute healthcare. We've already done this in our Places and will work to apply this learning consistently and equitably.
- The Yorkshire and Humber regional MMR delivery plan is under development and will include great focus on health equity audit, maximising MECC and looking at more flexible commissioning and delivery to improve access.
- Create a Children's Hospital Hosted Network, bringing together existing networks, with shared aims and senior ownership. Two of our Trusts (Sheffield Children's and Doncaster and Bassetlaw) will explore closer working
- Ensure that best practice in safeguarding is high on our agenda and applied equitably across SYB, reducing variation
- Continue the work of our networks, including embedding the children's surgery and anaesthesia model.
- Ensure a focus on workforce. The networks, along with our Deanery, Health Education England and academia will deliver an initial series of strategic options for an integrated, sustainable workforce.
- Take a systemic view of mental health services for children and young people to understand gaps in service/capacity across SYB
- Implement the Long Term Plan ambitions. We await and will participate fully in the children and young people transformation programme. Given the opportunity, because of our Royal College links, our mature networks, our specialist Trust and established ICS, we intend to apply to be one of the 5-10 systems chosen to develop an evidence-based approach to integrated care models.
- We will build in work on transitions, taking a 0-25 approach. This is already being evidenced by Sheffield's all-age mental health pathway and work in Doncaster for ADHD.

Getting the best start in life

Maternity services

Our progress

- Our Local Maternity System (LMS) has strong clinical leadership
- We have public health and prevention and perinatal mental health work streams
- The Hospital Services Review recommended accelerating shared transformation as the next step for maternity services
- Established Local Maternity Place based plans.

We will:

Reduce the % of women in SYB who are smoking at time of delivery to 6% by March 24

We exceeded the Continuity of Care standard as at March 2019 – 22.3% vs 20% target

Our challenges

- High rates of teenage mothers and mothers over 35
- High rates of low birth weight and neonatal and post neonatal deaths
- High obesity and smoking rates during pregnancy and substantial numbers of mothers are classed as intermediate or high risk
- Workforce challenges with shortfalls in maternity and difficulty recruiting midwives and middle grade doctors. This has led to substantial spend on locums.
- Increasing continuity carer will be challenging with existing workforce pressure.

4/5 Places have very low breastfeeding rates at 6-8 weeks

We will work across the System to:

- Develop a comprehensive strategic approach from pre-conception to transition into children's services
- Create a Maternity Hosted Network (MHN) to work in parallel with our Local Maternity System (LMS) with shared aims and senior ownership
- Undertake a comprehensive review of smoking in pregnancy and implement a range of measures to reduce the percentage of women who are smoking at time of delivery and postnatally
- The MHN will focus first on workforce and reducing clinical variance
- The MHN and LMS will continue Better Births implementation, ensuring all local Place plans are fully integrated with wider system plans, such as children's and neonates (see annexe re details)
- Develop shared approaches to delivering increased Continuity of Care standards and improvements in breast feeding rates
- Ensure that the needs of disadvantaged and vulnerable communities are embedded within our plans to reduce inequalities
- Build on good practice in our Places such as Sheffield's plans to support people in high risk groups (eg diabetes and maternal obesity) to access services
- Develop plans to deliver strong and equitable midwifery led, community and home birth choices in each of our Places. We will build on the good practice in Rotherham where three community midwifery hubs have been introduced
- Work across all our providers to develop a consistent midwifery led approach

In Place:

- We are investing transformation funding to deliver *Better Births*
- We have specialist perinatal mental health services in some of our Places
- Each of our Places has a developing and maturing Maternity Voice Partnership

We are developing a Maternity Hospital Hosted Network

Major health conditions

Mental health

We Will: Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population

We will: Reduce suicide rates across SYB of 5% year on year up to 2024

Our progress

- On track to deliver majority of Five Year Forward View ambitions
- Funding secured for 2018/19 and 2019/20 with plans in place to deliver an enhanced suicide prevention programme
- SYB wide Individual Placement Support (IPS) employment service commissioned for people with severe mental illness
- Enhanced perinatal mental health service launched in Doncaster, Rotherham and Sheffield
- 24/7 liaison mental health services established in Sheffield and Rotherham and funding secured for Barnsley and Doncaster
- Approval gained to establish New Care Models for three specialised services through NHS-led provider collaboratives
- Dementia diagnosis rates remain high across the ICS
- All CAMHS LTPs received fully assured status from NHSE and successful Green Paper Trailblazers in Doncaster, Rotherham and Sheffield and waiting list initiatives in Barnsley and Sheffield
- Workforce transformation project targeting high risk areas

Our challenges

- Increasing demand on mental health services and addressing existing inequalities in health outcomes and life expectancy.
- Maintaining stable and resilient services whilst transforming to meet the Mental Health Investment Standard, Five Year Forward View for Mental Health and LTP commitments
- Enabling more children and young people to access community mental health services and expanding core community teams for adults and older adults through NHS led provider collaboratives for those with severe mental health illnesses (SMI).
- Growing the mental health workforce to deliver quality timely care
- Variation in access and uptake of physical health checks
- Working across boundaries that reside in other ICS footprints
- Suicide rate has reduced, but remains high for some groups.

An integrated approach to support those with complex lives in Doncaster is already demonstrating improvements in outcomes.

We will work across the System to:

- Work with partners to develop an all age service and investment strategy, digitally enable care and support and develop the mental health workforce.

Children and Young People Mental Health

- Continue to deliver on our commitment to invest in and expand access to mental health services for children and young people, expanding community provision
- Continue to develop specialist community perinatal mental health provision
- Continue to prioritise eating disorders with collaborative commissioning
- Expand timely age appropriate crisis services (24/7) including implementation of Intensive Home Treatment services
- Implement mental health support teams in schools to enable early intervention and offer ongoing support
- Develop a strategic approach to service provision 0-25, including those 18-25 to support transition into adulthood as part of an all age strategy
- Continued improvement and development with partners through Local Transformation Plans specifically taking account of full spectrum of need, vulnerabilities, Learning Disabilities, Autism, SEND and health and justice.

Adult Mental Health

- Deliver the suicide prevention programme including further development of real time surveillance and bereavement support
- Adult Common Mental Illness – Continue to expand IAPT for adults/older adults, those with long term conditions and improve access times
- Severe Mental Health Problems – trial new and integrated models of primary and community mental health care to support adults/older adults with severe mental illness. Work to increase uptake of physical health checks. Improve physical health with a particular focus on eating disorders, reducing harm from tobacco, obesity and improving cardiorespiratory health.
- Monitor and improve employment support for people with SMI
- Achieve early intervention psychosis service standards in each area
- Emergency Mental Health Support – Expand services for people experiencing a mental health crisis to include 24/7 age appropriate access to crisis resolution, home treatments and alternative provision. Work with the ambulance service to improve crisis response, including staff training, response vehicles, use of 111.
- Therapeutic Mental Health Inpatient – Provide therapeutic environments and work to reduce longer lengths of stay and reduce out of areas placements.
- Problem gambling – Understand the problem in SYB and collaborate regionally for development of specialist clinics.
- Rough sleeping mental health support – Further understand the problem and work with Local Authorities to develop approaches to improve outcomes.

Major health conditions

Learning disabilities and autism

Our progress

- Highest reduction of inpatients nationally, significant reduction of admissions and reduced length of stay in line with learning disabilities (LD) senate guidelines.
- Implemented intensive support teams – now running extended hours, demonstrable success with preventing admissions
- Implemented forensic outreach liaison services and a forensic step up/step down service on transforming care footprint
- Developed key partnerships with experts by experience who are involved in all aspects of the transforming care programme in line with the ladder of participation methodology
- Proactively rolling out LD/Autism awareness training to GPs acute trusts and other mainstream services, delivered by experts by experience
- Developed an exemplar Dynamic Support Protocol for children and young people which is being rolled out in other areas
- Led on the development and implementation of the Yorkshire and Humber enhanced community framework, leading the way with referrals and new ways of working to improve the community offer.
- Embedded learning disabilities and autism into the ICS mental health and learning disabilities programme, to ensure alignment with all age mental health

Our challenges

- Reducing health inequalities for people with learning disabilities due to low uptake of screening and variations in numbers and quality of annual health checks
- Waiting times vary for children and young people and adults for diagnosis of autistic spectrum disorders (ASD)
- Addressing gaps in provision of post-diagnostic support for autistic children and young people, autistic adults and their families
- Ensuring services work in an integrated way and pathways are seamless across all ages regardless of geography.
- Workforce, both lack of workforce and workforce with the right skills
- Housing, lack of appropriate housing for people with learning disabilities and autism including general and specialist

We will work across the System to:

- Ensure people who are still living in hospitals are discharged in a timely manner, supporting the local markets and systems to facilitate discharge
- Further invest in intensive community support provision including children and young people, increasing extended hours and crisis response to meet the needs locally and to focus on preventing admission into hospital
- Promote health and wellbeing through My Health Day events targeting people and families with LD and/or autism, raising awareness of annual health checks, STOMP/STAMP, Hospital Passports, Screening programmes
- Continue to roll out the coproduced and co-delivered LD/Autism awareness training until the mandatory training is in place
- Roll out a programme of training around the LeDeR learning priorities utilising the ECHO platform to embed the learning across the system
- Increase the number people receiving AHC's, by working as a system to ensure the right support and reasonable adjustments are in place to deliver the 75% target
- Increase number of children receiving Care, Education and Treatment Reviews (CETR) prior to hospital admission by looking at developing a CETR hub to provide additional capacity to meet the increasing demand and provide a sustainable system for delivery and assurance
- Work with families and people with lived experience to improve pathways and experiences for ASC/ADHD, utilising transformation monies to fund pre and post diagnostic support working with the voluntary sector
- Bring to life the Autism Friendly Charter (under development)
- Work to secure funding to develop a strategic housing needs assessment for people with learning disabilities and autism
- Develop a joint workforce delivery plan to identify gaps and review new roles and new ways of working to address some of the gaps
- Develop the concept of providing neuro disability services on a 'holistic whole family – life span' approach
- Support vulnerable groups from becoming involved in crime
- Work with digital work stream to ensure digital flagging of patients with learning disabilities and autism and ensure QOF registers are up to date and information about AHCs logged appropriately and self-management apps

248

Major health conditions

Cancer

Our progress

- Our Cancer Alliance is driving the radical upgrade in prevention. The Alliance is a key partner in the QUIT programme to reduce preventable deaths from tobacco use
- Established a clearer understanding of our health inequalities and the communities more likely to be diagnosed later
- Developed over 16,000 champions as part of our Be Cancer SAFE social movement
- Promoted earlier diagnosis by implementing new tests and care pathways in primary care
- Commissioned reviews to understand diagnostic demand and capacity
- Supported providers to deliver RAPID pathways to enable a faster diagnosis
- Our specialist cancer centre, Weston Park, have improved their facilities, are implementing innovations in radiotherapy and are testing new models to provide chemotherapy closer to home
- 1,000s more people are accessing information and support in their local communities through meaningful conversations and people affected by cancer tell us that when they have a conversation they know they can focus on things that really matter to them and that support is there when they need it.

5 year survival remains significantly worse than the England average

1 in 2 people are currently diagnosed at a late stage, with many through the emergency route

1 year survival is improving and narrowing the gap from the England average

The Cancer Alliance will work across the System to:

- Drive prevention priorities around alcohol, obesity and physical activity in addition to smoking.
- Utilise Primary Care Networks and Screening and Immunisation Teams to further engage communities to reach optimal uptake of HPV vaccination and cancer screening with the biggest increase in those living in most deprived areas
- Introduce lung health checks and rapid diagnostic centres to enable earlier and faster diagnosis
- Embrace innovation and research to bridge the gap on early diagnosis with the SYB Innovation Hub delivered in partnership with the Yorkshire and Humber Academic Health Science Network.
- Build and network diagnostics to enable our workforce to operate as a single cancer service to meet demand and deliver national operational standards.
- Support capital investment plans to promote excellent specialised cancer services for all our communities including innovations in radiotherapy, systemic anti-cancer treatments and genomics
- Ensure equitable access to optimal and personalised treatment including access to national and international clinical trials
- Continue to adopt personalised care and support encompassing physical and mental health through a 'What Matters To Me' approach,
- Build a sustainable workforce and promote digital solutions to enable system models of care

Our challenges

- The number of people being treated for cancer is expected to rise from 14,000 to more than 18,000 by 2030. Over 5000 cancers could be prevented through lifestyle changes.
- This burden on demand is creating additional pressure on diagnostic and treatment capacity and ability to deliver national operational standards. This also requires us to be able to rapidly grow the workforce to enable the delivery of quality, and timely care
- SYB has a significant gap from the national ambition to have three in four people diagnosed at stage one or two.
- Variation in access, care pathways and outcomes.
- Working across boundaries that reside in other ICS footprints

45,000 people living with and beyond cancer expected to rise to as many as 78,000 by 2030

Place progress: Doncaster is leading our participation in the national lung health checks programme

Major health conditions

Stroke care

Our progress

- Following consultation, hyper acute stroke services are now centralised in Doncaster, Sheffield and Wakefield to enable equitable access to high quality care, improve outcomes and provide sustainable provision.
- Sheffield Teaching Hospitals are delivering mechanical thrombectomy with plans to expand access over more hours per week.
- Direct to scan pathways have been implemented in Doncaster and access routes redesigned in Sheffield.
- All SYB stroke units contributed to the Hospital Services Review and work to review the wider pathway
- Work has been initiated to develop a Stroke Hosted Network. A YHAHSN programme is supporting GP practices to detect and treat Atrial Fibrillation patients which has the opportunity to prevent around 151 strokes.

We are embedding our changes to hyper acute stroke services to realise the benefits for patients

We are developing a Stroke Hosted Network

Our challenges

- Stroke can be prevented and a leading cause of death and disability. Mortality has decreased, but survivors with a disability has increased
- Most SYB stroke units are improving their performance on the Sentinel Stroke National Audit Programme (SSNAP) but there is still significant variation in care
- SYB thrombolysis rates are below the national average.
- Specialist workforce challenges and shortfalls
- There is significant variation in the commissioning and care delivery of the post HASU pathway, particularly for stroke rehabilitation

Place progress: There are existing models of good practice in our Places – eg In patient rehabilitation in Sheffield and early supported discharge in Rotherham

We will work across the System to:

- Develop a Stroke Hospital Hosted Network (HN), with clinical and managerial leadership hosted by Sheffield Teaching Hospitals, and bring together all partners across the stroke pathway, including ambulance services and the Stroke Association to act as the SYB Integrated Stroke Delivery Network
- Work through the Network to reduce stroke incidence by making links with CVD prevention work, increase public awareness of TIA symptoms, need for urgent care and tackle variation in delivery.
- Develop networked provision to deliver the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke.
- Embed the centralised hyper acute service and realise the benefits, including equitable access to high quality specialist care and increased access to thrombolysis for eligible patients.
- Through the Hosted Network establish a strategic collaborative approach to workforce planning for stroke facilitated by Stroke Workforce Lead. Work with Health Education England to modernise the stroke workforce, including cross speciality and cross profession accreditation. Explore new roles and ways of working, eg Advance Care Practitioners .
- Enable more consistent access and delivery of stroke rehabilitation and 6 month reviews. Focus on integrated out of hospital higher intensity rehabilitation models working with the voluntary sector, consider both physical and mental health and making reasonable adjustments.
- Ensure that early supported discharge (ESD) is routinely commissioned as an integrated part of community stroke services
- Work with Sheffield Teaching Hospitals to increase availability and equitable access to mechanical thrombectomy, by supporting workforce planning, collaborative working with other neuroscience centres and the use of technology.

Major health conditions

Diabetes

There are **137,000** people at high risk of developing Type 2 Diabetes in SYB

Our progress

- Expanded provision of nationally accredited structured education programmes and set up a digital pilot in Barnsley.
- Targeted upskilling of primary care to improve achievement of treatment targets and prevent complications.
- Achieved full coverage of the NHS Diabetes Prevention Programme hosted by Bassetlaw in September 2017 and over 9600 referrals to the programme have been made.
- Implemented a 7 day diabetes nursing service at Doncaster and Bassetlaw Teaching Hospitals.

Our challenges.

The estimated prevalence of diabetes (16+) is **8.6%** of SYB population, similar to the England average

- Type 1 diabetes cannot be prevented and is not linked to lifestyle, but Type 2 diabetes is largely preventable through lifestyle changes.
- The cost of diabetes to the NHS is high and the majority of this is currently on treating complications.
- One in every six people in hospital has diabetes. Although diabetes is often not the reason for admission, they often have a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher. More than 500 people with diabetes die prematurely every week.
- There is significant variation in the management of diabetes across SYB and variable achievement of the NICE treatment targets.

Place progress: Sheffield has reduced the average length of stay for people with diabetes and achieved a measurable reduction in severe foot ulcerations.

We will work across the System to:

- Establish a Diabetes Programme Steering Group (DPG), that will oversee the implementation and delivery of the national diabetes programme and all the diabetes LTP commitments in SYB.
- Expand access to the 'Healthier You' NHS Diabetes Prevention Programme to deliver the required (6044) places by 2023.
- Work to ensure that the recently expanded structured education, multi-disciplinary foot care team and diabetes specialist nursing capacity is sustained.
- Work with Primary Care Networks to support them to develop personalised diabetes support to make a targeted effort to reduce health inequalities and the decline in treatment of diabetes.
- Lead the implementation of the national online education platform for Type 2 diabetes in line with national timeframes.
- Pilot and evaluate 'low calorie diet' programmes aimed at achieving remission for obese people with Type 2 diabetes.
- Ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020.
- Work with the relevant clinical network to improve the quality of care for children living with diabetes and improve transition to adult services.
- Work with clinical services to ensure equity of access to high quality services for all, including making reasonable adjustments for people with learning disabilities and severe mental illness.
- Evaluate and share learning from the digital pilots. We are working with the YHAHSN trialling and evaluating the Diabetes Hypo toolkit in GP practices in Sheffield, with the aim of improving patients ability to self care and manage hypoglycaemia to improve quality of life, increase medicines adherence and improve glycaemic control, reducing the health burden of deteriorating diabetes

Major health conditions

Respiratory

Our progress

- Supported the development of the SYB QUIT Tobacco dependency Programme.
- Completed a baseline assessment in each SYB Place against the North Respiratory Programme for 2018/19 and developed plans to improve respiratory care pathways
- Our Places have over the last 3 years prioritised respiratory disease as a key focus to support and treat more people in the community
- Initiated a review through our ICS Urgent and Emergency Care workstream to reduce respiratory related admissions to hospital

Our challenges

- Respiratory disease is a leading cause of death, Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease.
- We know from NHS data and intelligence there is unwarranted variation in respiratory outcomes and care in SYB such as detection rates of COPD, provision of spirometry, uptake of pulmonary rehabilitation and the prescribing and use of medicine.
- Emergency admissions for respiratory place significant pressure on the urgent and emergency care system, particularly during the winter period.
- High smoking rates

We will:

Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness

Respiratory disease is a leading cause of death in SYB

Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease

We will work across the System to:

- Establish a clinically led respiratory network to reduce variation, accelerate improvements through the sharing of best practice and standardise respiratory care pathways to improve quality and outcomes
- Participate in the North STP Leaders Programme to ensure that the SYB ICS benefits from collaborative working across the North of England.
- Work with our primary care networks to provide more care closer to home including improving the diagnosis and management of respiratory disease, supporting clinicians and professionals to use systematic tools to identify those at risk.
- We will utilise new roles and approaches in case management in a way that benefits those with respiratory conditions, including clinical pharmacists to optimise medicine use, physician associates and more specialist nurse roles in the community.
- Improve uptake of pulmonary rehabilitation, working with partners such as the British Heart Foundation, British Lung Foundation and Universities to improve access to and completion of rehabilitation.
- We will work with patients and families to develop new personalised care models of pulmonary rehabilitation that are more tailored to peoples needs for rehab and personal health budget support
- Link with the Mental Health and Learning Disability work to ensure a focus on respiratory within severe mental illness and learning disability Health Checks
- Improve the response for people with pneumonia by reviewing existing pathways and working with public health to maximise the uptake of flu and pneumococcal vaccination for those aged 65 and over, in at risk groups and health care staff.

Place progress: Rotherham has developed a new breathing space facility for outpatients which is delivering excellent results

Major health conditions

Cardiovascular Disease

Our progress

- Member of North ICS CVD group and SYB CVD Prevention Task Group and Clinical Lead in place
- SYB is close to the national ambitions for Atrial Fibrillation detection and anticoagulation
- Primary care development schemes are supporting quality improvement
- Sheffield is piloting a community pharmacy and GP hypertension shared care arrangement
- All Places have BNP pathway. Consistent referral guidelines in place for secondary care echo referrals
- Barnsley is redesigning its heart failure pathways

We will:
Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation and closing the relative gap between SYB and England to 10% or less by 2024-26.

Our challenges

- CVD is a major contributor to our health inequalities. Deaths from CVD are the second biggest contributor to the gap in life expectancy between SYB and England
- Although premature mortality from CVD has decreased in SYB over the last two decades, all Places in SYB (except Bassetlaw) still have significantly higher under 75 mortality rates than the English average
- High rates of the key risk factors for CVD.
- Barnsley has next to highest non-elective spend on CVD in the country and Doncaster and Sheffield have higher non-elective spends than their RightCare peer group average
- Significant unwarranted variations between GP practices in diagnosis/management of patients with or at risk of CVD and uptake of cardiac rehab is low
- Suboptimal proportion of patients post NSTEMI are receiving their angiography +/- percutaneous coronary intervention within NICE recommended timelines.

More than 1,000 people under 75 die every year from CVD in SYB

Under 75 CVD mortality rates are 4 times higher in the most deprived areas of SYB, compared to the least deprived

We will work across the System to:

- Prevent CVD – see the section on developing a prevention driven NHS
- Detect early and improve treatment of CVD and its risk factors. **We will**:
  - Move towards the national ambitions for Atrial Fibrillation, blood pressure and CVD risk
  - Decrease unwarranted variations by providing targeted support to GP practices; support use of CVD Prevent audit; develop quality improvement and population health management capacity and support for primary care
  - Maximise the opportunities of the additional roles in Primary Care Networks and the new community pharmacy contract. SYB CVD training course to be commissioned. Learn from national Atrial Fibrillation pilots
  - Expand the Sheffield community pharmacy shared care hypertension pathway across SYB, if pilot evaluation positive
  - Identify patients who may have Familial Hypercholesterolaemia
  - Link with the Mental Health and Learning Disability work to ensure a focus on CVD within severe mental illness and learning disability Health Checks
  - Continue to work with Local Authorities, to support the delivery of Health Checks
  - Work with Yorkshire Ambulance Service (YAS) and our community and voluntary sector partners to develop CVD prevention champions
  - Support the public with opportunities to check on their health
  - Support practices to enhance their support for patients with or at risk of CVD to self manage eg develop peer educators and provide personalised care
- Develop agreed messages for the public, patients and professionals to ensure consistent approach on CVD prevention
- Work with YAS on their restart a heart campaign and support schools in SYB implement CPR training
- Work with partners (British Heart Foundation, British Lung Foundation, universities) and patients to redesign cardiac rehabilitation (including digital options) to increase uptake
- Review GP direct access to echo across SYB & share learning from Barnsley on Heart Failure pathways
- Through the Specialised Cardiac Improvement Programme (SCIP) improve acute care and decrease variations in access to angiography

How we flex resources

System finance

As a high performing ICS, we have had access to offsets and used this effectively in delivering the 18/19 financial position.

The System delivered strong financial performance despite significant local and national challenges. Each of our Places delivered a performance better than that planned at the start of the year and only one organisation did not meet its individual control total and was supported by the System to ensure that they received their full share of PSF.

The ICS financial performance at the end of the year was better than planned at £19.6m (excluding PSF). This was a very positive performance and forms a foundation for continued investment in services or infrastructure for the coming years.

The strength of the financial performance is a testament to our collaborative approach. However, much of the surplus has been generated through non-recurrent measures. Next year remains a challenging financial year and requires the continued robust management of finances.

Transformation funding

We have had access to transformation funding over the last three years and been able to invest significantly in primary care (including access funding, digital funding and cancer), secondary care (including mental health, urgent and emergency care, pathology and maternity) and prevention (including suicide prevention, care homes and social prescribing)

Indicative additional transformation funding of £129 million the next five years will enable us to deliver our plan.

Commissioning development

Across South Yorkshire and Bassetlaw, commissioning has already started to evolve and adapt to meet the needs of people and patients. This is in line with the NHS Long Term Plan and ensures a stronger focus on population health, the impact on the wider determinants of health and reducing health inequalities. This builds on the work of the Joint Committee of Clinical Commissioning Groups.

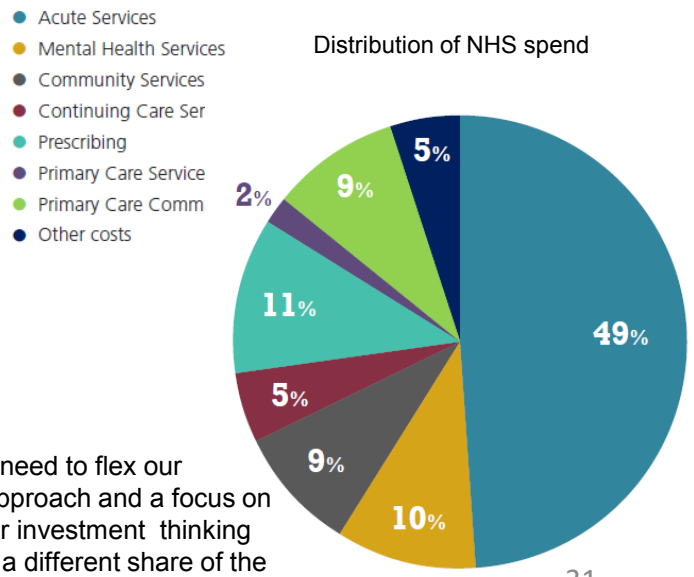
In each of our Places, NHS commissioners and Local Authority commissioners continue to develop closer working relationships enabling joint working, risk sharing, more joint teams and more support to enhance the development of neighbourhood working, integrated primary and community care and the development of Primary Care Networks.

Across the System, health commissioners are working jointly with providers to agree joint ambitions and outcomes for the health of their shared population together and will continue to plan together where it makes sense to do so – especially where we can reduce variation in standards, quality or access to services.

We are committed to building on this work and strengthening our ability to deliver our ambitions by having further developed arrangements in place for April 2021.

NHS and social care spend within South Yorkshire and Bassetlaw

The expenditure of the five clinical commissioning groups totals £2.5bn in 19/20 and the spend is as shown. In addition, there is further £0.5bn on specialised commissioning and the Local Authorities spend £1.4 billion on social care.



To deliver our ambitions, we will need to flex our resources. A population health approach and a focus on prevention will mean a shift in our investment thinking and planning, which will result in a different share of the overall spend.

Reshaping and rethinking

Estates

We will move from a functional approach to Estate Management …

Hospitals

- £1bn of hospital assets
- 44 separate acute and mental health sites
- £160m of backlog maintenance categorised as critical and high

Primary Care

- 316 separate GP, third party, NHSPS and CHP assets
- £44m of estate running costs

Disposals

- 17 different Disposal sites identified
- £28m opportunity
- (£24m fair share disposal target from Naylor Review)

Finances

- £20m of Wave 1 and Wave 2 schemes (Yorkshire Ambulance Service, Barnsley Hospital, Doncaster and Bassetlaw Teaching Hospitals, Sheffield Teaching Hospitals)
- £118m planned investment in 19/20 (incl £7m information management and technology and £19m equipment)
- Over £400m planned investment through to 2023/24
- £60m annual depreciation
- £150m working capital balances

… to a System approach

Acute and mental health	Primary care	Digital and IT
High quality and fit for purpose, sustainable estate which reflects modern patient needs and experience	New facilities reflecting new models of care	Full connectivity
Improved resilience through reduced backlog maintenance	Support a left-shift in provision	Systems which support data sharing and collaboration
New facilities reflecting service developments	Reconfigured existing estate to enable changes in ways of working	Modern IT infrastructure
No redundant estate	No redundant estate	
	Asset Optimisation	
	£57.5m Wave 4 capital	

Section 1: case studies

Cancer

Doncaster is one of ten areas nationally in a drive to save lives by detecting lung cancer early. A number of initiatives proposed will check those most at risk, inviting people for an MOT of their lungs and a chest scan if needed. The project in Doncaster runs from December 2019 to March 2021. A second phase of the project will also take place to allow for scans and follow up appointments, taking the total project to four years.

The targeted Lung Health Check (LHC) could help detect lung conditions earlier and improve lung cancer survival rates in Doncaster. A recent study showed that low dose CT can pick up lung changes earlier and reduce lung cancer deaths by 26% in men and between 39% and 61% in women.

Population health

In Barnsley, the Integrated Care Partnership is developing an outcomes framework that could describe the ambition for joint working that would then determine the priorities and programmes.

The project began by reviewing existing performance and population health frameworks used by different partners, identifying best practice in other areas and also gaps in our information and intelligence.

The Integrated Care Outcomes Framework has now been adopted by the Barnsley Health and Wellbeing Board, forms the basis of the joint strategic needs assessment and neighbourhood needs assessment and has helped to inform the priorities for service development.

Personalised care and community maternity hubs

In Rotherham, Personalised Care Plans being are being offered to 100% of women. In addition, an established Continuity of Carer pathway is being rolled out through a continuity of carer team based model and community maternity hubs are being established in three geographical areas of the Borough. The latest data for the number of women smoking at the time of birth shows a decrease from 20.2% to 16.4% between Quarter 1 and Quarter 2 2019/20, which means that Rotherham is now below the target of 18%

Transition from Children and Adult Health Services

Bassetlaw CCG has mapped out the Transition from children and Adult Health Services creating a work-plan to take this agenda forward. This has resulted in quarterly multi-disciplinary team meetings to plan transitions for individual children and the development of a transition strategy. This enables a clear health plan for each child requiring transitions and seamless approach when moving into adult services.

Integrated community mental health support

Mental health services are being embedded into Sheffield neighbourhood closer to where people live and more aligned to their GP practice. The scheme is a game changer for people with complex mental health issues in Sheffield. It will ensure that people with mental health problems are seen more quickly, in familiar surroundings of either their GP surgery or another place in the community. The mental health workers will work in close contact with GPs, nurses and the voluntary sector to make sure that patients get everything from access to local clubs and activities, to the right medication and psychological support, to help with finding a job.

Hyper acute stroke services

After significant work, clinical input and public consultation people living in SYB who have a stroke are now taken to one of three hyper acute stroke units in our region.

The next stage is to develop a Stroke Hospital Hosted Network, hosted by Sheffield Teaching Hospitals, with clinical and managerial leadership to bring together all partners across the stroke pathway. The Network will reduce stroke incidence by making links with CVD prevention work, increase public awareness of TIA symptoms, need for urgent care and tackle variation in delivery. It will also develop networked provision to deliver the seven-day standards for stroke care and national clinical guidelines.

Section 2: Strengthening

our foundations

- Working with patients and the public
- Empowering our workforce
- Digitally enabling our System
- Innovation and improvement

Working with patients and the public

Our progress

- We have built on the strong communication and engagement networks in SYB enabling us to deliver consistent messages through trusted sources
- Strengthened our relationship with the SYB Healthwatches and organisations that work with seldom heard communities which have undertaken engagement on our behalf
- Undertaken extensive involvement work with public and patients to inform the work of the Hospital Services Review
- Worked with community, patient and voluntary groups as well as staff to inform work across a range of areas, including NHS 111 procurement, over the counter medicines, hip and knee pathways, ophthalmology services, autism, emergency admissions from care homes and stoma care
- Carried out comprehensive involvement with staff, patients, public and stakeholders on the NHS Long Term Plan to inform our Five Year Plan
- Established the SYB ICS Guiding Coalition – a strategic advisory forum which includes voices from primary and secondary care clinicians, local authorities, voluntary sector and the public
- Established the SYB ICS Citizens' Panel, bringing together people from across the region to provide an independent view on matters relating to work at System level
- Established a Transport and Travel Panel with patients and the public, also from across the region, to look at the potential impact changes to services would have
- Developed a System involvement duty assurance process

Our challenges

- Shifting people's view from organisation to neighbourhood, Place and System
- Articulating the benefits of working across a System to patients, communities and staff
- Working in a matrix style across partners' communications and engagement functions

We will work across the System to:

- Meet as a Guiding Coalition twice a year to discuss and agree our strategic direction and hold two public events before each to gather views that will feed in to the sessions.
- Strengthen our links across partner communications and engagement teams to carry out System involvement and meet duties
- Build on our work with the Citizens' Panel and develop an online membership model to support our involvement work on transformation
- Explore how we can triangulate patient experience data from all partner sources to develop a System profile approach to involvement

Long Term Plan involvement

With funding from NHSE, we worked with the SYB Healthwatches and together connected with over 1500 people who shared their views through completing the survey online and face-to-face. We also connected with staff and the public through our partner organisations, our ICS Staff Side Forum, other forums and at events. We also asked our MPs and Health and Wellbeing Boards what they thought. Both the Healthwatch report and two independent reports highlighting the key themes from the work have been shared to inform the development of our Plan. What people said and how the report takes account of the feedback, along with the reports are in this link.

Key themes from the involvement:

- Seamless pathway of care / true patient-centred care
- Focus on prevention
- Integrated working across teams and organisations
- Integration and improvement of IT systems/digital technology
- Equality within the System
- Improved staffing conditions
- More care provided in homes/in communities
- Social care reform
- Better leadership/senior management

Our involvement work routinely connects with patients, families and carers and also with people from seldom heard communities such as asylum seekers, the deaf community, prisoners, young people, people with visual impairment, older people, black and minority ethnic communities, pregnant women and new mothers, Chinese community, people with mental health issues, people with drug and alcohol issues, carers and veterans. We also connect with the 'working well' through our links with South Yorkshire and Bassetlaw employers

Enabling our workforce

We employ over 48,000 members of NHS staff - 72,000 if we include all health and care workers - who work to meet the needs of 1.5 million people across South Yorkshire and Bassetlaw

Our progress

- Established an ICS Workforce Hub to support co-ordination of activities across Place and System level
- Commenced core programmes, including: Primary Care Workforce Training Hub, South Yorkshire Regional Excellence Centre and Faculty for Advanced Clinical Practice
- The Barnsley Partnership is delivering a Workforce Transformation plan for out of hospital workforce based on population health. This is supported by a Barnsley wide OD plan, workforce strategy and talent management strategy
- Workforce strategies agreed across other Places including Sheffield and Bassetlaw
- Initiated an ambitious schools engagement programme as part of a wider plan to promote careers across health and care.
- Launched collaborative staff banks and implemented agency procurement
- Increased portability of staff between organisations
- Supported increase in Advanced Clinical Practitioners across primary, community and mental health care
- Supported partners to work collaboratively on national initiatives including NHSI Retention Programme
- Delivered eRostering “Masterclass” Programme
- Developed an Allied Health Professions Council. Includes looking to identify vacancy hotspots and collaborative solutions.

SYB trusts report more than 800 nursing and midwifery vacancies

Our challenges

- Tackling vacancy gaps in supply and demand impacting our workforce, particularly across nursing
- Aligning workforce planning with service, activity and finance.
- Strengthening the primary and community care workforce to enable care closer to home
- Developing the mental health workforce
- Making the NHS the best place to work, improving retention and engagement
- Working with our schools to promote the NHS and social care to promote health and social care as a career of choice
- Making prevention a core element of every staff member role.
- Equipping existing and future senior leaders to operate successfully System wide in our evolving ICS
- Developing a co-ordinated approach to talent management, with focus on diversity and inclusion

Strengthening primary care workforce is a priority for the ICS

To support sustainable services and enable care closer to home, we have introduced a Primary Care Workforce Hub supporting:

- Development of Primary Care Network Additional Roles such as 1sk Contact MSK practitioners
- Delivery of a Primary Care Nurse Vocational Training Scheme
- Coordination of Undergraduate Nurse Placements Across SYB
- Delivery of targeted apprenticeship scheme for healthcare assistants
- Recruitment of GP Fellows to support transformation projects
- Delivery of a SYB wide Practice Manager Conference
- The roll out of a data collection/workforce tool
- The introduction of physician’s associate role across general practice
- The ICS will also support NHSE/I to increase the number of GPs

259

Enabling our workforce

We will work across the System to:

Make the NHS the best place to work

- Attract and retain our workforce by making SYB the best place to work including a new national core offer for staff.
- Build on our participation in national programmes(NHSI/NHSE) to improve retention, including more flexible working opportunities.
- Increase staff engagement focusing upon outcomes of NHS Staff Survey
- Work with our Places to align systems around a national Health and Wellbeing Framework to support physical and mental health.
- Improve our health and wellbeing offer to staff.
- Increase visibility of retention, sickness, wellbeing, diversity and incidents of violence, bullying and harassment and target support linking to regional and national programmes.

Improve leadership culture

- Promote an agreed systems leadership framework, and support Partner organisations to achieve "Well Led status" underpinned by compassionate, inclusive and positive leadership values and behaviours.
- Develop plans to increase diversity and inclusion at all levels including leadership and wider workforce, monitoring and addressing black and minority representation and other gaps where required, and the new Workforce Disability Equality Standard and Equality Delivery System.
- Address the cultural barriers between organisations and build trust.
- Develop a system wide approach to retain and fully use our talent.
- Build HR and workforce transformation capacity and capability.

Tackle urgent nursing shortages and securing current and future supply

- Facilitate Chief Nurses across SYB Trusts to complete System level plan to tackle shortages.
- Monitor wider vacancy rates working closely with Places on targeted plans.
- Accelerate new roles across key professional groups such as Nurse Associates and Advanced Clinical Practitioners.
- Support growth of international recruitment.
- Increase and improve clinical placements.
- Implement a Future Workforce strategy including ambitious schools engagement programme and employability including "Working Win".
- Scale up apprenticeships and access to training to upskill our workforce, optimising the apprenticeship levy.
- Develop the voluntary sector as a partner within the System, with VCS staff, volunteers and unpaid carers provided with access to support.

Deliver 21st century care workforce redesign:

- Lead strategic workforce planning processes on behalf of System, working closely with Places and aligning with service transformation programmes.
- Focus on enabling Out of Hospital workforce including growth in number of GPs and Primary Care Network new roles, reducing demand on acute services.
- Develop Healthy Hospitals Programme to maximise prevention.
- Enable flexible/streamlined movement of staff between trusts.
- Enable flexible working, return to work and streamlined career pathways.
- Regional Excellence Centre and Faculty of Advanced Clinical Practice developing integrated health and care roles, apprenticeships, advanced clinical practice.
- Embed System level approach to increase number of new roles including Trainee Nurse Associates, Advanced Care Practitioners, Physician Associates.
- Engage with AHSN on workforce innovation such as agile working.
- Enable a digital ready workforce to optimise tech including genomics.
- Build workforce transformation capability adopting tools eg HEE STAR.

Develop a new operating model for workforce

- Partner with Places in development of sustainable health and social care workforce strategies.
- Build visibility of workforce issues including national metrics.
- Ensure workforce plans are realistic and aligned to activity and finance.
- Integrate services beyond NHS across social care and voluntary sector.
- Implement improved governance including a Strategic Workforce Group
- Support hosted clinical network development and co-ordination of professional groups and councils including nurses, AHPs, healthcare scientists and pharmacists.
- Further develop our partnerships across unions, education and local authorities.

Other: Release time for care / Analysis, insight and affordability

- Deliver e-workforce strategy to improve productivity including delivery of national levels of attainment for eRostering and eJob Planning.
- Build upon our collaborative staff bank systems and agency management.
- Work collaboratively to develop effective intelligence systems.

Enabling our workforce

Leadership and organisational development

Our core mission is to harness the potential of SYB System leaders to:

- Lead in a whole System that spans our SYB geography , beyond organisational boundaries
- To lead and act in a way that supports the interests of patients and citizens across SYB as a whole, ensuring equity and reducing variation across each of our 5 Places
- Harness the greater impact of collective action whilst being mindful of both Place and System and the complexity of organisational and statutory accountabilities and System and collaborative working.

Our progress:

- Clinical: Positive engagement via multi-professional stakeholder events, identified clinical leads including clinical pathway redesign.
- Clinical leads in multiple specific topic areas – eg. QUIT, procurement, workforce, digital, pathology transformation, population health, prevention, Oral and Maxillofacial Surgery (OMFS), maternity, paediatrics, primary care, lung health checks.
- Organisation development for System leaders: ICS Shadow Board from November 2019 for aspiring executive directors. Recent ICS led development workshop for 35 clinical directors and implementing Virtual Leadership Academy for Primary Care Networks for individual, team and network development
- Joint scoping of Leading a High Performance Culture Programme (LHPC) tailored to 5 Clinical Hosted Networks – 100 staff (strategic and operational)
- Established Professional Councils and clinical reference groups (CRG). i.e. Allied Health Professionals and Healthcare Scientists Councils, acute provider CRG, CRG's for five acute hospital services within the Hospital Services Review
- ICS leaders are taking part in cross ICS Leadership workshops supported by the Yorkshire and Humber Academic Health Science Network.

We will work together to:

- Instigate formal Clinical Forums at both Place and ICS level
- Establish clinical leads and reference groups for the Hosted Networks within five acute hospital services (stroke, gastroenterology, maternity, paediatrics, urgent care).
- Delivery of five LHPC programmes between November and March
- Complete delivery of the one year ICS System leadership plan including ICS CEOs specific programme
- Embed our SYB 'virtual leadership academy' with a suite of offers for clinical and non-clinical leaders.
- Engage senior nursing leaders to proactively support the delivery of two cohorts of the 'Stepping Up' national programme: one for Bands 7, the other for Bands 5-6 to be delivered post April within the ICS
- Successful bid to HEE and Yale University for 'Using Education to prepare the NHS and Social Care Workforce to deliver the Digital Future'

Digitally enabling our System

Our context

Digital remains a key enabler for SYB and there is significant ambition to deliver digitally enabled care.

There is a mixed economy across SYB that needs to be resolved through implementing the basic digital capabilities for integrated care, whilst providing a framework to allow for innovation and for more mature Places to go further faster in an aligned manner.

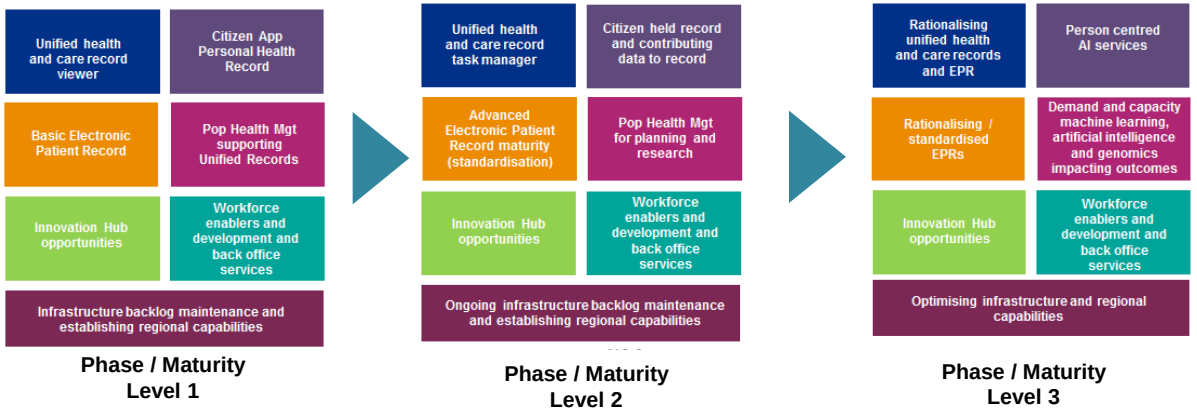
Technical standards are critical to enable integration and standardisation in the delivery of digital services (includes online and offline standards e.g. phone), which SYB needs to adopt in line with published national standards.

Digital themes

A set of digital themes have been developed based on the needs, priorities and objectives of our transformation workstreams, such as prevention, as well as the relevant digital delivery challenges and capability/category types.

Draft priorities, roadmap, framework

The digital themes and phases/ maturity levels have been merged to create a draft roadmap/ framework.



Phases/Maturity levels have been developed to structure and prioritise the delivery of digital enablers. They support aligned delivery, which can be done in a more agile and incremental approach, where organisations and Places can learn from, support and collaborate with one another.

Phase/Level 1 - Establishing the basic digital capabilities for integrated health and care

Phase/Level 2 - Greater use of information and advancing capabilities to improve health and care delivery

Phase/Level 3 - Digitally enabled citizens, professionals and System

Impacts and Implications

There are many implications of this proposed strategy, which include 1) significant increase in funding required, 2) additional capacity within clinical/service leads, operational teams to take on the business change and digital delivery, 3) increased risk appetite, 4) more 'digital/agile' delivery culture to prototype changes, deliver incrementally, 5) greater focus on system requirements from organisations, e.g. consider use of existing systems, consider system requirements within procurements.

262

Digitally enabling our System

Across the System we will:

- Deliver stable, performant, secure (including cyber security) and cost effective infrastructure across SYB, resolving backlog IT maintenance that is a corporate risk
- Achieve 100% compliance with mandated cyber security standards across all NHS organisations by summer 2021
- Deliver unified/integrated health and care records across SYB for professionals and citizens which integrate with the Yorkshire and Humber Care Record
- Provide all citizens with an online/digital service to manage their health and care needs, with provision for those digitally excluded
- Develop basic capabilities to fully digitise Primary Care and Primary Care Networks delivered by 2022, including shared record, citizen access, a Population Health Management capability and support infrastructure services
- Ensure all secondary care providers – acute, community and mental health are fully digitised by 2024
- Deliver a Population Health Management capability across SYB, which integrates with the Yorkshire and Humber Care Record PHM capability
- Establish a consistent maturity of Electronic Patient Record services in NHS Providers and Social Care [GP / Primary Care has this already]
- Establish a hub for digital innovation across SYB, which integrates with the Yorkshire and Humber Academic Health Science Network
- Establish a set of Digital Principles and Standards, which all organisations and Places will commit to and will support more effective system working to deliver digital enablers
- Ensure all service/clinical transformation is underpinned by user centred service design approaches to ensure digital enablers support whole person pathways and wider transformation activity

Digital Principles and Standards (How we do things)

In line with the standards set by NHS X, NHS Digital and the Local Digital Declaration as Digital, Data and Technology Leaders in Yorkshire and Humber:

1. We will work collaboratively and transparently across Yorkshire and Humber, as well as with other regional and national partners (where appropriate), supporting each other to deliver / meet user's needs and objectives of our citizens and professional users, ensuring we design for inclusion.
2. We will collectively develop, iterate and own the digital/technology priorities and delivery roadmap across Yorkshire and Humber, including region, place and any critical organisational priorities.
3. We will seek to achieve consistent maturity across Yorkshire and Humber but allow regions, Places and organisations to go 'further, faster' through pursuing innovation opportunities.
4. We will collectively own and maintain a Standards roadmap (technical and clinical) for Yorkshire and Humber, where we will seek to iterate and/or adopt (as far as possible) published digital, data and technology (including clinical information standards) from Yorkshire and Humber Care Record, professional standards bodies and national bodies such as NHS X and NHS Digital.
5. We will retain delivery responsibility at organisation or Place level, unless otherwise agreed to deliver once across our System.
6. We will seek to re-use and extend existing services where they are meeting shared user needs across Yorkshire and Humber rather than procure new, seeking to converge onto a set of strategic partnerships and Systems across Yorkshire and Humber (note this does not mean onto single Systems) to leverage the value of Yorkshire, Humber and Bassetlaw, manage cost-demand pressures appropriately, ensure better integration and interoperability
7. We will define and use standardised approaches to ensure all Yorkshire and Humber partners can benefit from any digital procurement / sourcing activity within the region, ensuring legally compliant means to extend services across Yorkshire and Humber.

Innovation and improvement

Our progress

- The SYB ICS has partnered with the Yorkshire and Humber Academic Health Science Network (AHSN) to work jointly in taking forward innovation, we will do this through an Innovation Hub which will become the vehicle for system-wide innovation and improvement across SYB
- The Innovation Hub commenced June 2019 to and is developing a number of Innovation exemplar projects with a system population health focus that targets unmet needs.
- More broadly all partners are undertaking continuous quality improvement work to improve services, quality and outcomes for patients.

Our challenges

- Knowledge and awareness of innovations that can help improve practice and address unmet needs is patchy across the sector
- Uptake of innovative technologies, service delivery models and policies has traditionally been slow in the health service
- The process of sharing knowledge and innovative practices from one part of the health service to another is disjointed
- Collaborative efforts to test out new models of working need improvement
- Despite examples of healthcare innovations incubated in the NHS, a culture of innovative thinking does not pervade across all of the services and staff

Led by the AHSN through initiatives such as the Local Health and Care Record Exemplar (LHCRE) programme, the AHSN's Innovation Exchange and the Accelerated Access Collaborative, we will continue the system wide adoption of nationally and locally identified innovation that fit with our priorities.

Our patients can fully benefit from breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery

The Innovation Hub will enable the SYB ICS to:

Match innovation to unmet need

- Establishing and managing a unified approach to capturing, validating and prioritising the unmet needs (problems) of SYB ICS
- Matching and supporting the identification and validation of market ready innovations to help drive improved health outcomes, operational and clinical processes, and patient experience across the ICS health economy

Target single point of contact

- The Hub will act as a single point of contact for all ICS System wide innovation enquiries and requests for guidance, advice and support
- The Hub will lead on the liaison between key stakeholders across the region including the NIHR Clinical Research Network and Healthcare Technology Cooperatives, academia, the AHSN and others

Signpost

- Signposting and connecting internal organisations (NHS providers / Commissioners etc.) and those external to the System (Industry partners) This will be aided by partners including the AHSN and others such as the Health and Care Partnership, Devices for Dignity and Academic institutions

Build a culture of innovation

- Developing a programme of activities and a platform that will support and encourage staff across the System to continually identify unmet needs and consider better ways of addressing them

In creating a managed and prioritised repository of 'problems' that can be solved through innovation, the Innovation Hub will ensure the ICS is at the cutting edge of identifying, evaluating and embedding innovative and transformational approaches. This will be achieved through effective interactions with the YHAHSN innovation exchange, academia, industry, research funders and providers of health and care.

We are also working with YHAHSN on a project to improve the self-management of Cardiovascular Disease (CVD). This project focuses on developing local innovations in primary care which could be scaled up and delivered at scale. We will continue our work in these areas at the same time as widening our focus to include diabetes and respiratory conditions.

Section 2: case studies

Working with patients and the public

Listening to people about the NHS Long Term Plan in South Yorkshire and Bassetlaw saw Healthwatch Doncaster recognised as the winner in the Outstanding Achievement category at the annual Healthwatch Network Awards.

Working with local Healthwatch partners (Sheffield, Rotherham and Barnsley with Doncaster co-ordinating the response) under the South Yorkshire and Bassetlaw Integrated Care System (ICS), the 'What Would You Do?' campaign saw more than 1,300 responses from people across the region, resulting in service user feedback focusing on self-care, mental health investment and joined-up care. The 38-page report was presented at the regional ICS in July to a fantastic response, with updates delivered to local stakeholders and partners in Doncaster alongside publication on our website.

Digitally enabling our System

In Rotherham, residents are benefitting from digital advances. The Health Record and Health App work together to provide both citizens and health and care staff with information at their fingertips round the clock.

The Rotherham Health App is a brand new service providing online access to manage healthcare 24 hours a day. It is available 24/7, on desktop, tablet, or mobile devices. Patients are able to book appointments, manage their medication, view test results, and access their medical record. All Rotherham GP practices are technically enabled for the App and from 1 July practices started offer 25% of their appointments online.

The Rotherham Health Record is an electronic system for sharing patient health information in a secure way with health and care staff that provide care directly. This gives them access to the most up-to-date information so that they can provide better and quicker care. Health and care professionals, including doctors and nurses, who are directly providing care, see a summary of a patient's existing records - such as those held by their GP, hospital or social care provider - to allow them to make the right decisions with the patient and for the patient. Patients only have to tell their story once.

Care homes support

In Barnsley, everyday technology is being used to bring the advice and support from registered nurses, directly into care homes. This is being done through the simple use of face-to-face video calls on hand held devices.

Sat behind the video calls is the award winning RightCare Barnsley team. This is a team of experienced nurses who, through a video call to and from the care home staff, can assess the situation, ask the right questions and physically see how the person is doing.

The RightCare team also does proactive calls to the care homes each morning to see how people are doing. This is where the majority of the referrals are identified and means people can be assessed and monitored from much earlier on in the day.

The devices have been rolled out to 17 care homes across the borough, which is around 900 residents, with the remainder due in 2020.

Workforce

In Barnsley, work is underway to model the out-of-hospital workforce using population health management principles.

Barnsley hospital is one of the leading acute trusts for developing the physician associate role, Barnsley CCG has recruited a strong team of clinical pharmacists supporting GPs in new and innovative ways and the community trust is currently mobilising multi-disciplinary neighbourhood teams as part of the new specification for community services.

Section 3: Building a sustainable health and care System

- Delivering a new service model – Neighbourhood, Place, System
- Transforming care with new service models
- Making the best use of resources

Delivering a new service model

In our 2016 Plan we said we needed to rethink how we invest in, plan for and deliver our services and how we ourselves are arranged and set up to do so.

We have made significant progress in better organising and thinking about how we work and have strengthened our approach so that our entire population has access to high quality local services while addressing health inequalities.

We now work in Neighbourhoods, Places and at a System level. Complementing these are Hospital Hosted Networks for some of our most challenged services and a joint commissioning approach for services and areas of work that apply across the region.

Each of our partner organisations continue to exist as they always have, but their thinking and approaches are now based on collaborations around their local populations; whether those populations are Neighbourhoods, Places or the System.

Of course, the majority of work takes place locally in Neighbourhoods. We have 36 Neighbourhoods with populations of 30-50,000.

Barnsley brings together its six Primary Care Networks into one 'super-Primary Care Network', bringing our total of Primary Care Networks to 30. Primary care is strengthened by working together in Networks and neighbourhood teams and supported by GP federations to enable us to deliver responsive integrated care where people live.

In our five Places, health and care works together more closely at town or city level. Each of our Places has a plan which sets out what the partners want to achieve together to improve health and wellbeing and other factors that affect health, such as employment, housing and education.

At the System level, our health system is joining up to ensure we are delivering health services across our population where it makes sense to do so.

As we mature even further and begin to focus on our new ways of working, we will agree an ICS strategic commissioning function, thinking carefully about how this complements the commissioning operations in each Place and current commissioning for community pharmacy, dental and eye care provision.

We will also expand and develop our collaborations across both acute and mental health providers where appropriate.

The **System** agrees shared objectives and outcomes and oversight

Hospitals are increasingly working in **Hosted Networks**

Partnerships plan and deliver integrated health and care across **Place**

Neighbourhoods integrate teams to deliver care where people live

Transforming care

Primary Care, working in Networks

Our vision

To transform Primary Care through the establishment of 'at scale' primary care organisations capable of taking on population health responsibilities, which provide high quality integrated care services accessible seven days a week through collaborative working in neighbourhoods at Place.

Our guiding principles

- Promote the continuous improvement of primary care and excellent access to services
- Maintain the right balance between operating in a consistent fashion and maintaining appropriate local flexibility
- Demonstrate clear alignment between Primary Care Networks, CCG and ICS strategies and delivery plans
- Deliver the funding guarantee for Primary and Community Care
- Where appropriate 'do once' across SYB

Our Primary Care Networks

Barnsley

Established a **single** Primary Care Network, with clinical leadership and six sub networks. Integrated neighbourhood teams are aligned to Local Authority area councils. Local PCN development programme to be implemented. Neighbourhoods to agree local health and wellbeing priorities and engaging local communities

Sheffield

Established **fifteen** Primary Care Networks with clinical leadership. Neighbourhood transformation programme (1st phase) established across 6 PCNs - integrated care and support targeting needs of specific populations, with plans to roll out across the city.

Rotherham

Established **six** Primary Care Networks with clinical leadership in place. Strengthening the primary care workforce through provision of primary care nurse preceptorships, health care assistant apprenticeships and nurse development roles.

Doncaster

Established **five** Primary Care Networks, with clinical leadership. Neighbourhood project coordinators in place linked to GP practices with social care, community nursing, local authority community and wellbeing teams. Early intervention, local solutions and joined up teams working with common operating models.

Bassetlaw

Established **three** Primary Care Networks, with clinical leadership and co located integrated neighbourhood teams. Agreed link workers to be employed by the voluntary sector.
Extended access to primary care is available through PCN hubs as well as through individual practices. Increased support for practice pharmacists to undertake clinical reviews. New arrangements developed for PCNs with care homes.

Transforming care

Primary Care, working in Networks

Our progress

- Historical arrangements of practices working together supported by GP federations and other primary care providers has helped to facilitate the development of PCNs
- Full SYB population coverage with 30 PCNs established across SYB each with a Clinical Director
- The Clinical Directors have formed a 'guiding coalition' of clinical leadership across the developing PCNs
- Agreements between CCGs and practices to target and focus on variation and data analysis used by PCNs to improve Population health i.e. risk stratification and segmentation
- Emphasis on developing primary and community based care and support, including support for self care and prevention through further development of the role of community pharmacies within Networks.
- Local OD approaches to support sectors (including community pharmacy and eye care) to work together and engage with communities
- SYB workforce training and development hub well established and delivering schemes to promote new roles and recruitment into primary care
- PCNs appointing paramedics and clinical pharmacists to their multi disciplinary teams and working closely with Community Pharmacies.
- Neighbourhood teams within PCNs delivering joined up care supporting people to remain or recover at home.
- Integrated neighbourhood teams aligned to Local Authority areas and PCNs. Some co-location achieved with community clinical and social care services. Wider representation from voluntary sector and schools.
- Testing service redesign within community based new care models eg Neighbourhood project coordinators and link workers supporting practices to engage with partner services (social care, community nursing, LA community and wellbeing teams; housing, welfare and employment).

We have full population coverage with 30 Primary Care Networks. The Network approach enables a focus on population health, prevention, early intervention, and anticipatory care to reduce inequalities.

Our Challenges

- Addressing variation while also valuing the differences between practices and Primary Care Networks (PCNs)
- Mobilising the resource and support to develop PCN models at scale
- Culture and behaviour change
- Improving access to and consistency of general practice
- Providing information and intelligence to support Population Health Management
- Facilitating PCNs working differently to reach seldom heard groups.
- Collaboration with acute sector to develop new models of care/delivery out of hospital.
- PCN maturity enabling them to represent primary care in the ICS
- Meeting the funding guarantee for primary and community care

We will work across the System to:

- Enable PCN progression against maturity matrix, support development plans, including new models of integrated community services as part of PCNs phased over next three years.
- Where we have GP Federations and providers of scale they are supporting PCN development through lead employer/other arrangements
- Support the development of community pharmacy to build and strengthen its role in the delivery of services within PCNs
- Extend access to General Practice via PCN hubs.
- We await and will prepare for the patient reported access measure.
- Offer an ICS Support Offer to Clinical Directors to promote System wide leadership and PCNs incorporating national framework & compliment CCG arrangements.
- Recruit into Social Prescribing and Clinical Pharmacy positions during 2019/20 under the GP Contract DES 'new roles' scheme. In some cases voluntary sector recruitment.
- Support practice manager development
- Support practices to increase telephone consultations.
- Invest in Local Enhanced Services, delivering care closer to home and improving management of patients to avoid admission.
- Develop new PCN led arrangements with Care Homes

Transforming care

Out of Hospital Care

Our progress

Each Place has established an out of hospital care approach through its Integrated Care Partnerships and delivered through Primary Care Networks working collaboratively with health and care partners to integrate care pathways and provide care closer to home

Barnsley

- Partnership of Barnsley MBC, Barnsley CCG, Barnsley Hospital, South West Yorkshire Partnership Foundation Trust, Barnsley Healthcare Federation, Barnsley Hospice, Healthwatch Barnsley and Barnsley Community and Voluntary Services developing the out of Hospital strategy
- One Primary Care Network and six Neighbourhood Networks with 'one team , no boundaries' philosophy to integrate services providing care closer to home
- Integrated model for intermediate care including rapid response Intermediate Care Services
- Integrated community respiratory and pulmonary rehabilitation pathways
- Improved nurse led support to care homes including introduction of digital technology to enable video link up to Rightcare Barnsley to reduce care home hospital attendances

Bassetlaw

- Introduced community pathways for ophthalmology, audiology and pain management services and extended the scope of dermatology services
- Call for Care rapid response providing two hour urgent community response
- Well established Integrated Neighbourhood Teams (INTs) in all three PCNs, with community clinical and social care services co-located with primary care
- PCNs have developed workforce models with paramedics and pharmacists in their INTs, a Memorandum of Understanding was put in place for GP led review of care homes

Rotherham

- Aligned community services to work around GP practices in the PCN networks
- Integrated rapid response service, therapies and care co-ordination centre now co-located to support integrated working
- GP practices aligned to care homes, for care continuity
- Rotherham Health Record live across all services enabling services to have the same information for patient care
- Improved hospital discharge, leading to some of the lowest lengths of stay and delayed transfers in the country

Doncaster

- Integrated intermediate care service introduced with rapid response provided within two hours
- Complex lives service providing proactive care and support to people rough sleeping reducing the risk of admission through better support for addiction, mental health and wellbeing needs
- PCNs established and developing integrated care approaches across health and social care
- Improving care for people with delirium and dementia in the community

Sheffield

- Mature neighbourhood working established over last four years with a development programme to support leadership across PCNs
- Significant investment to support neighbourhood collaboration across schools, mental health, voluntary and community sector, social care, community nurses and police, including a keeping people well programme
- Enhanced care homes support programme well established
- Joint re-ablement services and provision of care home beds to facilitate assessments and care needs outside of hospital, reducing length of stay markedly over the last 12 month period

Out of Hospital Care

Our plans

We will work across the System to expand out of hospital care for our local populations to help them care for themselves where they can and receive the right treatment, in the right place, when they need It.

System architecture

- One Primary Care Network with six neighbourhood networks in Barnsley with a shared care record to be deployed in 2020/21
- Established the Barnsley Population Health Management Unit (PHMU),
- Community based hubs in Sheffield to be developed offering access to health, social and voluntary services
- Development of a model in the community to escalate and de-escalate patient needs, which will include consideration of the improved crisis response within two hours and re-ablement care in two days.
- Ongoing development of current population health need tools for PCNs such as risk stratification and population segmentation that profiles cohorts people in terms of health and care needs supporting future planning of service needs

Pathway change

- New intermediate care service with flexible beds usage and more home based care with a dedicated geriatric nurse led frailty service across Bassetlaw
- Improve care pathways in respiratory, dementia, CVD, diabetes and gastrointestinal across SYB
- Continue to work across primary care and community nursing to improve the interface between the two services and integrated models of care
- Mental health services will be enhanced to ensure timely high quality access for people in crisis.
- Improve flow through the hospital and enhance step up provision to facilitate quicker discharge
- Continued implementation of Enhanced Health Care In Care Homes across SYB
- The development of introduced community pathways for ophthalmology, audiology and pain management services and extended the scope of dermatology services

Service Transformation

- New care home support to reduce avoidable hospital attendances across all SYB Places
- Community health services led by neighbourhood teams of nurses and allied health professionals offering care to keep people at home, supporting timely discharge from hospital and ongoing case management for people with complex needs and at end of life in Barnsley
- Re-configuring intermediate care and re-ablement in Rotherham, reducing the bed base and providing improved care in the community
- Home care provision re-procured in Rotherham to improve quality and support individuals to stay within their preferred place of care
- Continued development of PCNs across Sheffield incorporating risk stratification, multi-disciplinary working, enhanced case management and person centred care planning
- Active support and recovery programme across Sheffield PCNs will build capability and capacity in the community to support people to live well in their own homes and will promote independence.
- Implementing a single point of access (SPA) covering the full range of services available outside of hospital
- Developing a Barnsley proactive care model in primary and community care

Transforming care

Out of Hospital Care

As part of their out of hospital approach, each Place is developing and implementing plans to support people to age well

Supporting people to age well:

- People are increasingly more likely to live with multiple long term conditions, or live into old age with frailty or dementia.
- It is recognised in SYB that extending independence as we age requires a targeted and personalised approach
- Work is well underway in each Place as part of their out of hospital approach and development of primary care networks to support people to age well. This includes:
  - GPs using the frailty index to routinely identify people with severe frailty
  - Proactive population health management approaches focused on the moderately frail
  - Integrated primary and community teams continuing to gather pace to work together to support people to maintain their independence and age well
  - Established falls prevention schemes
- Home based and wearable technology has been tested to support different cohorts of people across SYB
- The pivotal role undertaken by carers is recognised across the system and in each Place. There are strategies and action plans to ensure we identify carers of all ages (including young carers), offer appropriate information and support, including contingency planning for emergency situations
- Dementia diagnosis rates remain high across the ICS and there is ongoing work in each Place to provide better support in the community for those living with dementia as we practically translate the NHS comprehensive model of personalised care.

We will work as a System to:

- Continue to develop and implement plans in each Place to support those living with multiple long term conditions or living into old age with frailty or dementia
- Work with Primary Care Networks and integrated primary and community teams to maximise the use of a population health management approaches to inform a targeted and personalised approach and enable delivery of integrated care pathways.
- Support the deployment of home based and bed based elements of the community response model, community teams and enhanced health in care homes
- Consider the use of home based and wearable technology in our planning and digitally enable community services in preparation for future advances in these care models
- Continue to implement action plans in each to improve how we identify unpaid carers and strengthen support for them to address their individual health needs
- Ensure out of hospital approaches continue to consider the needs of those living with dementia and their carers so we can strengthen community support

Sheffield: Active support and recovery programme in Sheffield is supporting people to live and age well in their own homes
Bassetlaw: The home first model in Bassetlaw includes community based rapid response in two hours

Partnerships in Place

Integrated care partnerships at Place

Over the last three years all five Places in SYB have established mature integrated care partnerships (ICPs) with their local authorities and other Place partners. These partnerships have become the bedrock of SYB Place development and relationships in each ICP continue to evolve and flourish through ambitious joint strategic plans to integrate health and care locally.

ICPs have implemented a range of joint working arrangements and mechanisms to drive forward joint working with local authorities and providers including the following:

Joint Commissioning:
Joint strategies with local authorities in Place, based on life course; Starting Well, Living Well and Ageing Well. Delivery in some Places is supported and facilitated through shared commissioning posts in areas such as children's services, mental health and learning disability. Joint arrangements will continue to develop in line with each ICP's strategic direction, priorities and the requirements of the LTP to integrate care and improve population health outcomes for local people.

Provider alliances and provision:
ICPs have developed approaches with local providers to align, integrate and incentivise care to improve, quality and access and population health outcomes - for example in services such as mental health liaison, social prescribing, acute services, urgent care and intermediate care.

Population health management :
Development of strategic partnership work on the wider determinants of health, such as housing, employment, education, homelessness, transport and population health initiatives that incorporate lifestyle change support aligned to PCNs.

"Our ICP vision for integrated care is to develop a local system where the people don't see organisational boundaries. Instead, they experience continuity of care; regardless of where they are seen, be that in hospital, in the community or at home. Patients and their families are supported and empowered by 'one team'.

"Our goal is to dismantle boundaries at the point of delivery of care to create a simpler, integrated health and care system that supports a shift in focus on treating patients with health problems to supporting the community to remain healthy."

Barnsley Integrated Care Partnership

Digitally enabled care:
Shared health and care records have been implemented across most of SYB to enable NHS and social care clinicians and professionals to access patient information to enable seamless care. These databases of information are also being used in the ongoing development of population health management tools for PCNs

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Transforming care

Reforming emergency care

Our progress

- Procured and mobilised a new model of Integrated Urgent Care, with a regional and local Clinical Advice Service (CAS) Supported by full population coverage of NHS 111 online
- Introduced an Urgent Treatment Centre (UTC) in Doncaster
- Engaged patients and public through the ICS Citizen Panel and Transport Group on plans to reduce avoidable ambulance conveyance
- Rotherham Hospital is a field test site for the new national clinical emergency and urgent care access standard
- Embedded clinical primary care streaming in all SYB A&E departments
- Reviewed and improved system intelligence by piloting an escalation management system for urgent care data and implemented the care home bed capacity tracker
- Strengthened relationships with Yorkshire Ambulance Service and piloted HALO+ to support system escalation pressures
- Mapping to explore digital opportunities to support patient pathways
- Local progress to commission rapid community response services.
- Frailty services in Place across SYB

Our challenges

- Growth in A&E attendances and emergency admissions, exceeding planned activity levels
- Increasing complexity and acuity of patients
- Workforce capacity and resource limitations
- Public expectations, culture and behaviour
- Some Places have challenges with delayed transfers of care

We will work across the System to:

Work collaboratively to continue to improve performance

Pre hospital urgent care

- Simplify patient/public access by further developing a fully integrated urgent care model, developing the virtual clinical advisory service through improved clinical pathways accessible via 111 or 999 and other service access points to reduce demand on acute hospital services
- Further designation of Urgent Treatment Centres (UTCs) to simplify access for patients where this model fits locally commissioned services in Doncaster and Sheffield
- Continue to work with ambulance services including the Northern Ambulance Alliance to improve services, including elimination of handover delays, develop improved clinical pathways to avoid conveyance to hospital via 999 services, initially in respiratory and mental health, increasing hear and treat or hear, see and treat rates
- Strengthened alignment and work with Primary Care Networks
- Ensure patient flow and demand is clinically managed and supported through transparent comprehensive system intelligence
- Further develop high intensity user programme in each Place
- Support care homes to deliver improved patient care by providing better access to clinical advice, access to services and direct support from the ambulance service
- Expansion of NHS 111 direct booking via roll out of GP Connect, initially expanding direct booking into GP services, urgent treatment centres, GP out of hours services and considering further expansion and developments into other community based services

Reform hospital emergency care – Same Day Emergency Care

- Ensure Same Day Emergency Care is in place to complement type 1 A&E departments
- As part of the NHS Clinical Standards Review develop new ways to look after patients with the most serious illness and injury

Reduce delays in patients being able to go home

- Improve system intelligence to support patient flow and demand
- Each Place to continue to improve performance to support people home, reduce delayed discharges and length of stay in line with trajectories

274

Insight from conversations led by the partners in Doncaster to better understand the use of A&E by 18-30 year olds has shaped plans for a streaming model at the 'front door'

Transforming planned care

Our progress

We have developed a range of new care models including:

- A single South Yorkshire and Bassetlaw hip and knee follow up pathway
- The use of virtual appointment in a range of specialties eg fracture clinic, dermatology, ophthalmology and 'good news calls' to reduce delays in receiving results unnecessarily
- Musculoskeletal First Contact Practitioner pilots have been trialled in readiness for roll out across the System in readiness to deliver full coverage of FCPs through Primary Care Networks by 2023/24
- Tele dermatology has been rolled out to primary care in some areas evidencing a reduction in referral levels to secondary care
- Community services in a range of specialties including; heart failure, dermatology, integrated sexual health and gynaecology, ophthalmology, audiology and pain management
- The introduction of outpatient follow up protocols which will be developed and standardised across the region
- South Yorkshire and Bassetlaw Commissioning for Outcomes policy
- South Yorkshire and Bassetlaw has also been identified as a pilot site for offering managed choice at 26 weeks.

Our challenges

- Across the System there is increased demand in both elective and diagnostic care across clinical pathways
- A need to maintain and reduce referral to treatment times by growing the amount of planned surgery year on year, to reduce long waits and cut the waiting list
- Redesign services so that patients can avoid up to a third of face to face outpatient visits by reducing unnecessary follow up and offering alternative modes of appointment eg virtual, telephone or video consultations
- Enable increased access to shared medical records for patients and healthcare professionals to support new service delivery models and more joined up co-ordinated care planning.

We will work as a System to:

- Design and implement a digitally enabled outpatient transformation programme to include:
  - Roll out of clinically agreed outpatient follow up pathways
  - Increased uptake of advice and guidance
  - Increased use of technology and virtual appointments to reduce face to face outpatient appointments by 30% over the next 5 years as per the Long Term Plan commitment
  - Development of community services/alternative planned provision
  - Patient initiated follow up appointments
  - Increase the rollout of first contact practitioners for MSK (or equivalent) to deliver full coverage of FCPs through Primary Care Networks by 2023/24
  - Ongoing quality improvement work
- Deliver shorter waits for elective care through more effective use of capacity across the region and offering a managed choice at 26 weeks to support the elimination of patients waiting beyond 52 weeks
- Implement *Urolift* as part of the range of treatment options for benign prostatic hyperplasia
- Specialty level reviews to agree and implement recommended pathways of care using Rightcare, GIRFT, elective handbooks and other best practice
- To implement technological solutions to support patient information sharing
- Development of the shared care record through the Digital Programme including the ability to move relevant clinical information across the region to access specialist opinions

Partners in Sheffield are supporting primary and secondary care to help make sure patients get the right treatment at the right time in the right place with a new elective care model

275

Transforming care

NHS Foundation Trusts working together

Our progress

Our NHS Foundation Trusts in SYB have a long history of shared working. Our mental health trusts have formed an Alliance, which has identified lead trusts for three priority pathways and is looking to establish three Collaboratives. They are putting into place the governance to support this, with a draft partnership agreement now being developed.

Since 2014, our acute trusts have been working closely together, starting first as the Working Together Vanguard. Their ever developing shared work is formally overseen by a Committees in Common model, supported by an Acute Federation within the ICS.

Our challenges

Shared working is bringing clear benefits for patients and staff. As this way of working matures, we are looking at transformation programmes at the most appropriate level within the System.

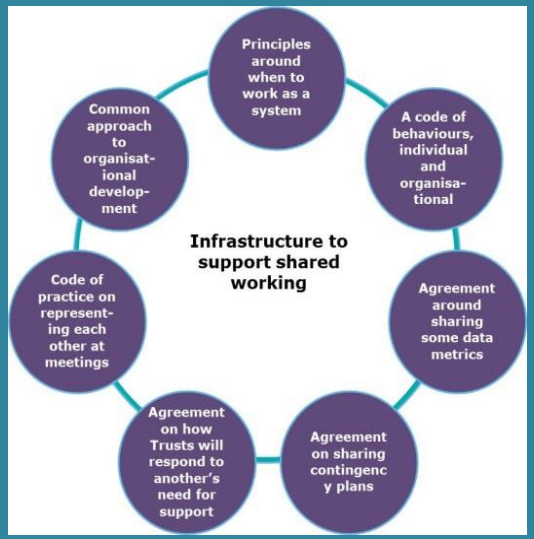
We have prioritised shared working, giving it the right focus, and looking at how we can establish the right governance. In our next phase both the acute and mental health trusts will further strengthen their collaborations to enable shared working to enter the next phase.

This will mean greater focus on the 'spine' of supporting services, i.e. the underpinning infrastructure of digital and workforce, rather than expanding the Hospital Services Review to cover additional services.

The acute hospital NHS Foundation Trusts will strengthen their ability to work together:

Our acute NHS Foundation Trusts are working together to develop an infrastructure of agreements to support shared working to become more streamlined and effective:

- Building the underlying infrastructure: shared action, with ICS partners, on digital and workforce
- Greater transparency about risks and challenges, so that trusts are better placed to support each other and prioritise areas for shared work
- Agreements around how the trusts will work together.



The mental health NHS Foundation Trusts will strengthen their ability to work together:

Phase 1

- Develop Collaborative arrangements for low/medium secure inpatient services, Eating disorders and CAMHS Tier 4 service
- Form and mature the Collaborative Alliance Board
- Agree Partnership Agreement which sets out ways of working
- Agree membership for Alliance governance
- Strategic discussions and establish priorities for NCM and other mental health services
- Establish governance and delivery arrangements;
  - Alliance Operational Delivery Group and NCM Delivery infrastructure – joint with independent sector and commissioners
  - Align with ICS MH Transformation Programme

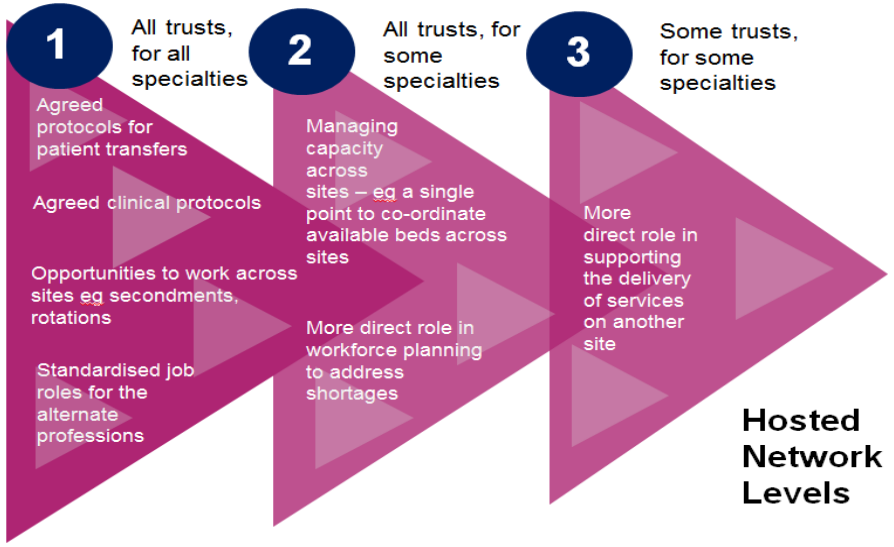
Phase 2

- Embed Collaborative ways of working in three priority pathways
- Establish formal governance - Committees in Common
- Agree areas for formal delegated decisions making
- Agree additional New Care Model priorities

Hospitals, working in Networks

Using shared working to improve care

- The shared working that the acute NHS Foundation Trusts are developing has the aim of improving outcomes for patients. The programmes of work which trusts are taking forward aims to improve clinical standards; make better use of our workforce and make the SYB acute trusts a great place to work; reduce inequalities; and make efficiencies.
- The guiding principle is that by working together, patients can access the best care. The majority of hospital care will be provided in the patient's local hospital with trusts working together to give access to more specialist services.
- The SYB NHS Foundation Trusts already work in networks: e.g. the Regional Hyper-Acute Stroke Service, the head and neck Cancer multi-disciplinary team which has representation from every trust, with major surgery centralised at Sheffield Teaching Hospitals and clinics and diagnostics at every District General Hospital and bilateral arrangements such as Doncaster providing nephrostomy interventional radiology at Rotherham, or Barnsley and Rotherham recruiting joint gastroenterologist posts.
- Trusts have also developed shared strategic and efficiency work: Shared working on procurement and back office functions, which has saved £5.5m so far;
  - A review of Hospital Services, focused on five challenged services, (urgent and emergency care, maternity, paediatrics, stroke and gastroenterology) which looked at the configuration of services and how trusts could work together better. This resulted in the setting up of Hosted Networks which are a structured approach to strengthening shared working.
  - The System is aiming to avoid reconfiguration unless there is believed to be no other way to make services safe and sustainable.



We will work as a System to:

- **Develop a new approach to shared working**, called Hosted Networks. We are setting up level 1 Hosted Networks in five specialties. These put a stronger governance framework and support around collaboration to develop workforce planning, clinical standardisation, and innovation across the Trusts, while retaining equal status of all partners;
- **Make the best use of specialist clinical expertise** to support other trusts: developing a level 3 Hosted Network between Sheffield Children's Hospital and Doncaster and Bassetlaw Teaching Hospitals:
- **Develop shared infrastructure** through building our shared capacity e.g. through creating SYB Pathology and networking imaging and diagnostics
- **Deliver the national standards for all of our patients**: the acute trusts will work together to deliver the targets in the NHS Constitution. For example, for elective care we will work as a System to match capacity to demand, so that we make better use of the beds and workforce we have, so that we can reduce waiting times for patients.

Making the best use of resources

System efficiency

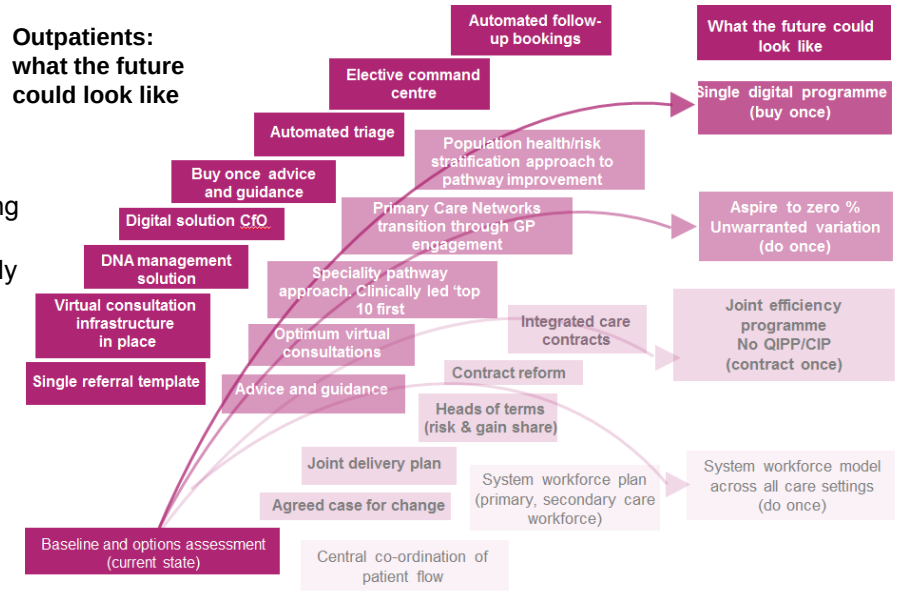
Our System Efficiency Board was set up to:

- Prioritise a small number of efficiency opportunities and ensure the pipeline is developed for creating future efficiencies
- Recommend the schemes that can be best done at scale by building on existing ICS and Place schemes avoiding duplication
- Make faster progress on transformation as an ICS than can be done individually

Our progress:

- As part of a rigorous process with partners, we mapped a range of 17 possible projects against value for money, deliverability and quality and strategic fit benefits.
- Four priorities emerged which the System has adopted

Outpatients: what the future could look like



E-rostering

Aim: to reduce the £92m spend on temporary staffing.
Scale of opportunity: £9m-£18m

Suggestions being explored: Centralised and coordinated frontline training, implementing medical rostering (non consultant, System level job planning, System level nurse erostering policy, System level eroster contract 2021 renegotiated by the Allocate Regional User Group on behalf of the ICS, Hub and Spoke model – centralised eroster helpdesk with satellite local helpdesk officers.

Outpatients

Aim: to redesign outpatients and reduce unwarranted variation - 2.2 million attendances in 2018/19 – with estimated spend of £330-£340m
Scale of opportunity: £9m - £10m

Suggestions being explored: Reduction in unwarranted pathway variation (specialty basis), rolling out advice and guidance – roll out, virtual consultations, DNA management solutions, joint efficiency programme and delivery framework, single referral template, automated triage and a System workforce plan.

Theatres

Aim: to increase theatre utilization from 82% currently
Scale of opportunity: £4m-£7m

Suggestions being explored: Standardisation of scheduling process so demand and capacity can be managed across the patch, System wide demand and capacity to maximize use of NHS, standardised protocols and processes to enable movement across sites, ECCU – to support demand and capacity review, theatres performance dashboard and maximizing the use of NHS theatres (less activity flowing to IS for additional capacity).

Independent Sector

Aim: to reduce spend which is currently for additional capacity (not patient choice). IS Spend £46m.
Scale of opportunity: <£1m

Suggestions being explored: IS framework for managing the market for contracting capacity, ICS standardized contract with KPIs, contracting best practice pathways NHS and IS to free up capacity, ICS Elective Care Coordination Unit (ECCU) to coordinate capacity and demand, System based approach to contract all elective activity (NHS and IS), lead NHS provider model for high volume pathways

Making the best use of resources

System efficiency

In order to eliminate the gap between the plans and the trajectories, as well as the four priorities already agreed we are also looking at additional efficiencies.

- The long list of seventeen projects will be revisited to supplement the four business cases already developed through the System Efficiency Board. There is a range of opportunity in each.
- These schemes will be developed at a System level or through the NHS Foundation Trusts working together

Area	Short description	
Function / Pathways		
Outpatients	In line with the Long Term Plan, an opportunity has been identified in relation to reshaping the way outpatient services are delivered	£10-20m
Theatres	Analysis of capacity utilisation analysis across the system has identified both an income and cost out opportunity	£6-12m
Admission optimisation	Benchmarking of variation, has highlighted five key specialties where Bed day opportunities appear	£7-10m
Diagnostics	Initial demand and capacity analysis in Imaging and CT has highlighted an opportunity based on unwarranted variation	£5-8m
Non-elective respiratory	Analysis of variation has identified opportunities in relation to admission avoidance and community care utilisation	£4-5m
Mental health, out of area Placements	What if analysis identifying how much could be saved through a reduction in Out of Area Placements	£5-7m
Single musculoskeletal triage	What if analysis undertaken to try understand the potential efficiency opportunity by either standardising practices or creating a single Triage Service for SYB	£2-3m

Area	Short description	
Workforce focussed		
Corporate services	Analysis of the full portfolio of corporate services has been undertaken. Considering 18/19, the residual opportunity is presented	£12-24m
E-Roster	Work is underway with NHSI to utilise E-Roster more efficiently in managing our workforce	£10-20m
Temporary Pay	Work is underway to rationalise and standardise the supply and cost of temporary pay	£4-8m
Skill/Mix	Benchmarking analysis has highlighted potential opportunities across the workforce groups	£15-59m
New integrated models	High Level "What if" analysis has been undertaken, considering the Long term Plan ambitions for integration, to assess the indicative efficiencies that could be achieved in SYB	£5-10m
Continuing Health Care	High level assessment of key areas of work that could potentially benefit from being done at scale, such as pooling budgets	£4-5.5m
Transactional in nature		
Independent services	An opportunity has been highlighted to more effectively use NHS capacity.	£0-45m
Estates	Work is underway to establish efficiency opportunities	*tbc*
Digital	Focus on ' Buy-once" where appropriate as a system (Hardware and Software)	£2-13m
Wholly owned subsidiary	Partnership approach to enable system economies of scale	£7-12m

Making best use of resources

Improving Productivity

Improving clinical productivity to release more time for patient care	**Deliver efficiencies in administration costs**	**Reducing growth in demand through integration and prevention**
Maximising the buying power of the NHS	**Make better use of capital investment and System assets**	**Reducing unjustified variation**
Supporting the development of pathology networks and of diagnostic imaging networks	**Utilising the Evidence Based Interventions Programme**	**Making better use of capital investments and existing assets**
Support pharmacy staff to take on patient facing clinical roles and optimise medicine usage	**Utilising the national Patient Safety Strategy**	**Delivering System wide efficiency**

We will work across the System to:

- Optimise System level collaboration to improve clinical productivity and release more time for patient care. We will take a network approach to develop more efficient rosters and deliver opportunities to manage support contracts
- Maximise the buying power of the NHS through benchmarking and comparing our spend and review opportunities for individual and collaborative savings
- Leverage economies of scale through partnership across SYB and with neighbours
- Continue to work with clinical specialties and the Get It Right First Time programme to adopt recommendations around unwarranted variation and standardisation
- Identify opportunities for efficiencies in our corporate services to reduce administrative running costs
- Enable the development of an SYB pathology network to enable efficient use of our workforce and capacity to meet demand
- Progress the development of a diagnostic imaging network to improve capacity planning. Continue to develop the imaging academy and workforce plan/strategy
- Optimise medicines management in care homes through clinical pharmacists and pharmacy technicians as part of NHSE Enhanced Health in Care Homes framework
- Redesign pathways to improve medicines management including stoma, continence and wound care as well as nutritional products.
- Optimise medicines management in care homes through clinical pharmacists and pharmacy technicians as part of NHSE Medicines Optimisation in Care Homes pilot and the Enhanced Health in Care Homes framework
- Review medicine related resources to ensure they are optimised and identify areas suitable for guidance including the use of gluten free products and over the counter medicines
- Generate direct savings linked specifically to medicine costs through standardisation of rebates and branded medications.
- Optimising estate and investment through a System wide strategy

Making the best use of resources

System Planning 19/20

- The financial planning approach has been to agree a framework and timetable across the Systems and allow Places to work together to agree fully aligned finance and activity plans
- Key planning assumptions have been agreed including:
  - Systems should develop and agree realistic assumptions based on local trends. This should take account of:
    - How funding growth will deal with improving the volume of elective procedures, cut long waits and reduce the size of waiting lists
    - How outpatients will be reformed to remove a third of face to face outpatient visits
- All organisations are required to return to recurrent financial balance over the life of the five year plan or earlier
- For emergency care assumptions for demand growth need to be agreed between providers and commissioners to ensure they reflect recent local trends adjusted for agreed demand management initiatives and national priorities including improving performance in cancer and A&E NHS Constitutional Standards
- Commitments for increased spend in mental health and primary medical and community services
- Regional teams agreeing a realistic and stretching bottom line each year where providers in balance requiring to deliver 1.1% cash releasing productivity growth and those in deficit delivering at least an additional 0.5% of cash releasing productivity growth

281

Place	Planned £m	Variance £m	Actual £m
Sheffield System	(20.9)	9.4	(11.5)
Doncaster & Bassetlaw System	(18.1)	0.3	(17.8)
Barnsley System	(15.7)	0.2	(15.5)
Rotherham System	(18.3)	0.2	(18.1)
Sub-total	**(73.0)**	**10.1**	**(62.9)**
Technical Adjustments (including in-year adjustments & CCG drawdown)	(9.5)	9.5	-
Total	**(82.5)**	**19.6**	**(62.9)**

Capital

- We will prioritise capital plans to inform how the funds will be deployed once we know what System capital is available
- We have agreed a process to evaluate and score business cases
- In anticipation of Wave 4 capital, the ICS identified £445m of capital investment requirements covering all aspects of primary, acute and mental health services
- This included material investment in the digital agenda, clinical strategy, removal of critical infrastructure risk and joined-up System wide investment in cancer services
- Business as usual capital is focussed on maintaining current estate; particularly noting the high and increasing value of critical infrastructure risk backlog maintenance
- The ICS investment requirements are currently being updated in the context of national constraints of capital availability, as well as dealing with critical investment in the intervening period

Making best use of resources

STP Planning Tool – Financial Analysis
Key issues

High levels of engagement:

- The ICS has made significant progress in a short space of time to produce the strategic financial plan.
- Organisational Boards and Governing Bodies have been actively engaged in the process to iterate further submissions of the financial plans reflecting updated intelligence

Risk management:

- The 19/20 System Control Total is routinely managed through system governance reflecting the emergent and ongoing risks including demand and performance pressures. Plans have been based on current forecasts

Ambition:

- The SYB ambition to manage resources within the system trajectories from 2021/22 to 2023/24 has not yet been realised. Further work is required to address the gaps.

Financial framework:

- The system has used the national trajectory calculations to inform the trajectories from 2020/21 to 2023/24 for each provider organisation.

Cash and support:

- Cash management will be important during the period of the plan and include reliance on FRF for organisations that are not in recurrent balance.

Efficiency:

- The pace of improvement is different amongst providers and a process of peer review will enable a full and transparent system-wide understanding of the pressures and efficiencies included in plans to deliver a consistent system approach to supporting transformation

Drawdown:

- CCGs have significant levels of banked drawdown which they are looking to drawdown and invest in local transformation across the planning period. These are reflected in the final plans.

Wave 4 capital:

- Commissioners have reflected the Wave 4+ capital for primary and community care in their draft plans. The timely release of resources will provide much needed investment in the sector

Transformation of capital:

- Constraints on capital nationally provides a potential barrier to transformation.
- Providers have sought to cover immediate capital needed through internal sources but major investment in required in the system to deliver service change and resilience to manage critical infrastructure risk. The strategic approach to capital investment will be linked to the ICS Estates Plan

Alignment:

- Financial plan alignment is strong across SYB partners and activity between commissioner and providers is fully aligned.

Making best use of resources

Draft STP Planning Tool - Indicative Financial Analysis
High level outputs

	19/20	20/21	21/22	22/23	23/24
Annual System Deficit	(£49.7m)	(£57.9m)	£(45.4m)	(£36.3m)	(£27.4m)
Variance to trajectory	£0.0m	(£25.5m)	(£21.7m)	(£18.5m)	(£16.0m)
Avg Efficiency – Provider Trust	2.62%	1.88%	1.81%	1.94%	2.05%
Avg Efficiency – Commissioner	2.12%	2.31%	1.97%	1.78%	1.75%
Total averasge efficiency	2.36%	2.10%	1.89%	1.86%	1.89%
Total Efficiency – Value	£116.3m	£106.2m	£97.7m	£99.1m	£103.8m
Total Capital Investment	£100.1m	£168.1m	£129.8m	£293.1m	£642.8m
Financial Alignment	0.4%	0.5%	0.5%	0.5%	0.5%
Activity		Fully aligned	Fully aligned	Fully aligned	Fully aligned

Making best use of resources

STP Planning Tool - Financial Analysis - Next steps

Item	Issue	Action
1	The system has got a gap against its trajectories as follows: 20/21 £25.5m, 21/22 £20.7m, 22/23 £18.5m and 23/24 £16m. This relates to four provider organisations	In order to close the gap against trajectories additional efficiency and transformation needs to be delivered over and above that reflected in the current plan. In addition organisations will require to update their assumptions as their plans mature as part of the 2020/21 operational planning round. The additional efficiency will need to come from four sources 1. At provider level 2. At commissioner level 3. At system level 4. At providers working together level. This will also include development in innovation which will have clinical and financial benefits. This will be supported by the Yorkshire and Humber Academic Health Science Network. The plan will include an implementation plan for the four business cases that have been developed through the System Efficiency Board - 1. Outpatients 2. Theatres 3. E- rorstering and 4. Independent Sector. In addition the long list of seventeen schemes that were considered by the System Efficiency Board will be revisited to provide scope for further savings.
2	Further work is required to develop a more detailed workforce plan that has a number of actions that will deliver a suitably trained workforce to implement the ambitions in the Long Term Plan	It is recognised that nursing and midwifery offers the greatest challenge in terms of workforce shortages (both existing and planned). A plan is underway with Chief Nurses to develop costed expansion plans by January 2019 which will be reviewed by the System. Further to the strategic plan setting out finance, activity and workforce projections, a wider detailed plan will be developed that aligns with ICS clinical programmes and the NHS People Plan due for publication in early 2019. We will work closely with NHSE/I and HEE in the development of this.

Making the best use of resources

Our progress

- Effective use of ICS flexibilities (offsets) to secure organisation positions and maximise inward investment
- Strong financial performance in a time of ongoing challenges of activity increases and pressure in the System
- Transparent approach to the utilisation of transformation resources for System investment
- Development of a System Efficiency Board to identify where the System can add value by working differently together to provide more effective implementation or faster progress than can be done individually
- Deliver on a capital and estates investment strategy including £57.5m of capital to improve primary and community facilities
- Take forward the benefits of the efficiency opportunities identified through the System Efficiency Board

Our challenges

- Maintaining strong financial performance linked to strong operational performance in a time of increasing activity and workforce challenges
- Need to find resources to support an increased focus on prevention , reduction of health inequalities and move of services out of hospitals
- Inflationary pressures on providers and continued recurrent delivery of stretching cost improvement programmes and challenging control totals
- Upward pressure in all aspects of CCG investment both inside and outside the acute sector
- The complexity of the financial framework (including tariffs) providing uncertainty for the future
- Lack of a strategic capital framework nationally acting as barrier to transformation
- High levels of backlog maintenance across the System requiring urgent injections of capital to ensure resilience

The NHS financial settlement

- In September 2019, the Chancellor announced an NHS spending increase of 3.1% in real terms (£6bn) including investment in increased training places (HEE), investment in public health, capital investment (of which SYB received £57.5m for primary and community schemes) and investment in artificial intelligence. This was alongside an additional £1bn for social care and a process to review the social care precept
- This built on the budget announcement (October 2018), providing real terms growth of 3.4% (£20.5bn) by 2023/24 taking the overall NHS budget to £148bn
- There is also the commitment to ensure mental health investment grows at the same rate as the overall NHS budget for five years
- The budget announcement reflected the Prime Ministers spending announcement in June 2018 promising real terms growth of £20.5bn (nominal £33bn and £1.25bn pension funding)

This financial settlement is part of the Long Term Plan which includes five key financial tests for delivery

Test 1
How organisations will return to or maintain financial balance through providers in balance delivering cash releasing productivity growth of 1.1% per annum

Test 2
Providers in deficit will require delivering additional cash releasing productivity benefits of at least 0.5% per annum. Regional teams will agree a realistic and stretching bottom line position in each year

Test 3
Plans to incorporate System actions to maximise efficiencies and support appropriate reductions in demand for care through better integration and prevention

Test 4
Reduce variation across the health System

Test 5
Better use of capital investment and existing assets to drive transformation

Section 3: case studies

Community pharmacists

Sheffield CCG is piloting a 2 year scheme to benefit patients living with hypertension.

The new pilot will see community pharmacists providing care to patients identified as requiring management of hypertension by their GP. Patients will be offered the choice to see the community pharmacist who will support the patient to manage their hypertension through; optimising medication, performing health checks and providing support and advice on lifestyle changes.

With an aging population and increasing pressures on GPs, this new service will utilise the wealth of skills of pharmacists, reduce pressure on practices and make the service more accessible to patients within their community.

Early supported discharge from hospital

Rotherham's health and social care discharge teams have been brought together under a single integrated leadership role. 27 discharge destinations have been streamlined into 3 pathways. Discharges home for over 65s have increased by 7% for over 65s and 5.2% for over 65s.

It is estimated that around £0.5M of acute bed days have been saved and that the introduction of a new single electronic referral process saves around 30 minutes per patient, time which can now be spent on care. Decision Support Tools are now all carried out outside of the acute setting. A weekly acute and community multi-disciplinary team hospital wide review of longer lengths of stay has been introduced based on the Emergency Care Intensive Support Team (ECIST) model of good practice.

Rotherham's dedicated, multi-partnership-approach to health and social care means that delays are being minimised and getting patients fit, well and home, with the support they need, is a top priority.

Integrated Wellbeing Team

In the Dearne a neighbourhood integrated care project is bringing together different frontline staff to test new ways of working together and provide better services for the local population. They began with a big workshop and asked for volunteers to form a local working group.

The integrated wellbeing team meets each month. The attendance varies but there is always core group including the matron, GP lead and area council manager. They discuss action plan updates, hot topics in the area and one or more case studies to improve services and how they work together. The meetings have helped build relationships and trust.

Outside of these meetings it means better signposting, peer support, more informal requests for involvement between colleagues that can avoid referrals and hand-offs and learning together and from each other.

Call for Care

Call for Care is a model of urgent care which was launch during July 2019: access and navigation which was commissioned by Bassetlaw CCG in 2019 in line with the requirements of the NHS Long Term Plan which requires health systems to provide a 2 hour crisis response service as part of the national drive to increase out of hospital urgent care and reduce unplanned acute activity.

In one telephone call, health and social care referrers are able handover patient care needs to Call for Care clinicians. The team then mobilise responding clinicians based within the district to assess the patient within two hours of the referral. The urgent responder will complete a holistic assessment of the person's physical, psychological and social care needs in order to implement a care plan to meet these needs in the immediate and short term.

Section 4: Broadening and strengthening our partnerships

- Partnership with the City Region
- Anchor institutions and contributions to the wider economy, science, research and innovation
- Partnership with the voluntary sector
- Our commitment to work together
- Governance and ways of working

Partnership with the City Region

The Sheffield City Region (SCR) works across the Region and brings together public and private sector leaders to make decisions that drive economic growth and create new jobs.

Our Plan recognises that economic prosperity and health and wellbeing are interdependent. A healthy population means less people out of work or retiring early due to ill health, but equally it means that having a good job supports and protects health.

Our progress

We have been working with the SCR on the Health-led Employment Trial, Working Win. The Trial has been testing individualised employment support delivered by healthcare professionals. It has received over 6,000 referrals demonstrating the demand for labour market interventions delivered with the health sector.

We are committed to exploring further opportunities to work collaboratively to locally design and commission programmes.

Sheffield City Region

- We are committed to strengthening the anchor institution role of our NHS organisations. We recognise that the health and care sector is the biggest employer in the City Region and that NHS organisations have huge economic power both as an employer and through commissioning and procurement processes. We will explore the potential of the Public Services Social Value Act across SYB ICS so that we can have a significant impact on health and health inequalities, and also support the local economy
- We will team up with the SCR to explore the significant research strengths and technologies that are being developed locally that could futureproof health services and transform the way care is delivered. We will explore the research strengths in health and wellbeing innovation and technology, children's health, digital, and orthopaedic products and medicines and translate them into health interventions and efficiencies
- As part of our ongoing work and through the SYB Innovation Hub, we will work collaboratively with locally based research and technology, as well as invest in institutions like the Advanced Wellbeing Research Centre and the Olympic Legacy Park
- Our support to the local authority led work on active travel connects directly with the SCR programme of activity to promote healthy and active lifestyles. Through both routes, we will back Active Travel within the region to improve the commute of residents and drive improvements in the health and wellbeing of our population
- A commitment to move to sustainable transportation across the SYB ICS, including enabling active travel for staff, visitors and even for some patients, would have wide reaching benefits for health whilst also helping to reduce air pollution and meet carbon targets
- Through our partnership work to tackle health inequalities, we will also lend our support to prevent ill health amongst the most vulnerable people as part of the Mayor's campaign to end Excess Winter Deaths

Anchor institutions and

wider contributions

An anchor institution is one that in addition to its main function, plays a key role in making a strategic contribution to the health and wellbeing of the local population and the local economy.

This includes non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is linked to the wellbeing of the local population.

The NHS has significant influence over population health and is able to enhance its impact by choosing to invest in and work responsibly with other anchor institutes and local communities to collectively harness resources.

Alongside being a system partner there are a number of key areas where the NHS can contribute further as an anchor institute:

The NHS as an employer - Given that employment is important for good health increasing the amount of recruitment an NHS organisation does locally is an opportunity to increase the impact that it has on the wellbeing of the local community.

The NHS as a purchaser and commissioner for social value - As major procurers and purchasers of services, NHS organisations have an indirect impact on the conditions of workers more widely not formally NHS employed.

The NHS as a land and capital asset holder – As a significant land and asset holder the NHS has the potential to manage and develop its land and estates to support broader social, economic and environmental aims.

The NHS as a leader for environmental sustainability – Given the significant environmental impact and large carbon footprint the NHS is well placed to take action to support responsible consumption and reduce waste that can have a positive impact on the environment.

We will work as a System to:

- Maximise the potential role of all anchor institutes in SYB to harness their collective influence on the health and wellbeing of our population
- Maximise the benefits of the NHS and other anchor institutes as employers in SYB to promote local recruitment and widen access to quality work
- As a purchaser promote spend in communities to support local businesses, employ local people and stimulate local economic development
- Promote the consideration of social value into purchasing decisions
- Manage and develop land and estates in a way that benefits local communities
- Take action to support responsible consumption to reduce waste and our environmental impact

SCC has made a public commitment to ethical commissioning and procurement, including the use of local suppliers wherever possible and this is now well embedded across the council's supply chains.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust provides staff with a comprehensive Health and Wellbeing offer which includes support in the following areas; physical health, mental health, financial health, weight management & healthy lifestyle promotion. In January 2019 the offer was recognised by Nottinghamshire County Council and accredited their Platinum Wellbeing @ Work Award."

289

Partnership with the voluntary sector

Our progress

- SYB is home to a large and diverse voluntary, community and social enterprise (VCSE) sector that undertakes wide ranging activities and services that impact positively on the health of our residents
- VCSE representatives sit on the ICS Collaborative Partnership Board, Health and Wellbeing Boards and Integrated Care Partnerships
- VCSE/ICP Chair in Bassetlaw positively impacting on 'parity of esteem' with the public sector
- VCSE organisations influencing ICS workstream priorities
- Expansion of social prescribing an existing ICS priority, building on our well established and highly regarded VCSE led social prescribing services in all five Places
- Examples of NHS funded micro commissioning of VCSE via our VCSE infrastructure organisations
- Examples of Primary Care Networks forging relationships with VCSE partners
- Range of VCSE organisations commissioned to provide services wrapping around primary care in Bassetlaw
- Sheffield Accountable Care Partnership investing in additional VCSE infrastructure to strengthen linkage between health services and the VCSE

Our challenges

- Fragile VCSE but increasing national and local expectations of the VCSE eg due to expansion of social prescribing
- Increasing need of the types of support that the sector can offer people who have complex social, psychological and physical needs, compounded by deprivation
- New approach to commissioning and funding the VCSE needed
- Capacity, on both sides, to engage with such a broad and diverse sector of over 10,000 organisations

We will work across the System to:

- Develop a strong vision for embedding VCSE participation at every level of the ICS as an equal partner in strategy and delivery
- Co-design a new framework for engagement and development of relationships between the ICS and VCSE, strengthening existing relationships and developing new ones
- Support VCSE organisations and the NHS to better understand each others values and expertise
- Invest in the VCSE sector and infrastructure support, developing new models of funding and commissioning, enabling greater sustainability
- Harness local VCSE expertise and knowledge of local communities to support identification of need and co-design of services to enhance population health
- Embed within care pathway development consideration of the potential role of VCSE services
- Support the development of community assets and services for vulnerable and at risk groups, in collaboration with the VCSE and wider partners
- Further expand social prescribing
- Develop peer support and health champions to support prevention awareness and LTC personalised care
- Maximise the potential benefits for our communities from further developing volunteering opportunities within NHS organisations and the broader health and wellbeing system
- Further develop the potential role of VCSE within secondary care
- Explore the linkages between Trusts as anchor institutions and the VCSE
- Consider VCSE colleagues as core part of multidisciplinary teams

Our commitment to work together

There is a range of groups where partners come together to collaborate at a System level. It gives both space and focus for NHS partnership working and NHS partnership working with Local Authority colleague and key stakeholders. Our governance works alongside the governance of our statutory organisations.

Shared Principles

We operate within an agreed set of guiding principles which cover the ICS groups and ways of working and shape how we work together:

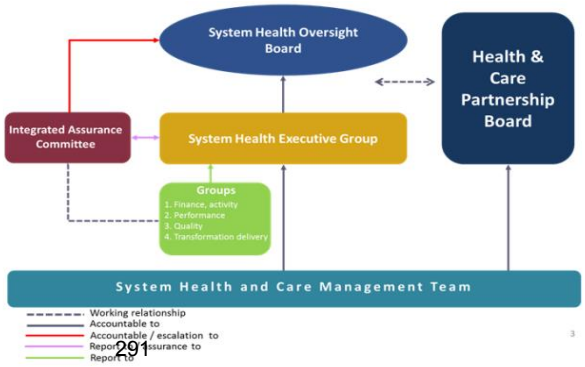
- We are ambitious for the people and patients we serve and the staff we employ
- We will build constructive relationships with partner organisations, groups and communities to tackle the wise range of issues which have an impact on people's health and wellbeing
- We will do the work once and avoid duplication of systems and processes; ensuring we make the best use of our available resources
- We will apply a subsidiarity principle in all that we do with work and action taking place at the most appropriate level for our System and as local as possible
- In pursuing our key objectives we do not increase inequalities or worsen health outcomes for any local populations

We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives.

Clinical leaders, chief executives, chief officers and very senior and experienced leaders from NHS Trusts and CCGs support the work of the ICS alongside a team of people seconded or aligned from organisations across the region. It is led by Sir Andrew Cash, the ICS Chief Executive.

System Health Oversight Board - provides a joint forum between health providers, health commissioner, NHS England, NHS Improvement and other national arms' length bodies, to respond to the national policy direction for health and implementation of the NHS Long Term Plan.

It builds on the SYB partnership working on strategic health priorities requiring closer working across systems. It facilitates a maturing of relationships and System working, building on collaborative working locally in Places and across SYB collaborative health groups of Joint Committee of CCGs (JCCCG), Committees in Common (CsiC), Mental Health Alliance (MHA) and Primary Care Federations.



Interim governance arrangements 2019/20

System Health Executive Group - facilitates a maturing of relationships and integrated working between health partners, building on the work locally in each Place and collaborative health groups across the system, including: JCCCG, Committees in Common, Mental Health Alliance and Primary Care Federations.

Health and Care Partnership Board - we continue to work with our Local Authority partners to inform and shape how our system health and care partnership works.

Integrated Assurance Committee - provides assurance to the partners and to regulators on the performance, quality and financial delivery of health and care services within the five Places and across the system in South Yorkshire and Bassetlaw.

Section 4: case studies

Voluntary Sector

Sheffield is supporting local voluntary, community and social enterprise (VCSE) infrastructure and delivering on its social responsibility by investing in small, local grass roots initiatives where the monies used could have a genuine impact on capacity building and learning for those organisations.

By utilising the skills and networks of local VCSE organisations, and encouraging neighbourhood based peer to peer conversations, they hear from people who don't traditionally engage.

In Bassetlaw, the Community and Voluntary Services are the lead organisation

Anchor institutions

Sheffield City Council has made a public commitment to ethical commissioning and procurement, including the use of local suppliers wherever possible. This is now well embedded across the Council's supply chains. The Council has also had a consistent approach to the insourcing of service delivery over recent years. It is committed to using its influence wherever possible to maintain and share the commitment.

Transport

Bassetlaw is predominantly rural and travel and transport is an acknowledged challenge. In a multi-agency engagement exercise with the community of Tuxford, it emerged that a lack of access to the primary care centre via public transport was resulting in more patients requiring home visits.

NHS partners are now working with the Council and transport providers has enabled hourly bus services to and from the practice, and better access for Tuxford people.

Multi agency approach to people with complex lives

Rough sleeping in Doncaster town centre dropped by 70% thanks to a concentrated action plan by key public and third sector partners .The intensive action plan to support people living on the street has resulted in some of the most entrenched rough sleepers in the town now living in accommodation and receiving rehabilitation for physical and mental health issues.

Named The Complex Lives Alliance teams of professionals from Doncaster Council, South Yorkshire Police, St Leger Homes, Community and Acute NHS Trusts, Rotherham Doncaster and South Humber NHS Foundation Trust, which includes Aspire, the drug and alcohol service, Primary Care Doncaster, NHS Doncaster Clinical Commissioning Group (CCG) Criminal Justice, Department for Work and Pensions (DWP) and community, voluntary and faith organisations all work together to identify and support people off the streets and into the help they need to improve their lives.

Annex

SUPPORTING VIDEOS:

- Developing our LTP Response: first guiding coalition event 9th July : https://youtu.be/7Owr_5xpomg https://youtu.be/pWNGvLVIvUA
- Our second LTP guiding coalition event 8th Oct : https://youtu.be/8bqc5Qx6itw
- Primary Care Network event: https://www.youtube.com/watch?v=lCzhc0ydjYY

SUPPORTING INFORMATION:

- Engagement:
  All ICS reports – Patients/Public analysis, Staff and Stakeholders analysis and 'You said, we will…how comments shaped the Plan - https://www.healthandcaretogethersyb.co.uk/get-involved/using-your-feedback
  Healthwatch report - https://www.healthwatchdoncaster.org.uk/wp-content/uploads/2019/06/00-Healthwatch-NHS-Long-Term-Plan-survey-SYB-ICS-March-2019.pdf
- Understanding the SYB Population our Challenges and Inequalities: https://www.healthandcaretogethersyb.co.uk/what-we-do/working-together-to-be-healthy/understanding-population-south-yorkshire-and-bassetlaw

Enclosure I

South Yorkshire and Bassetlaw Integrated Care System

Closing the gap with financial trajectories
Health Executive Group

December 11 2019

Contents

1. System commitment
    1. Plan alignment

2. Summary of current position on trajectories
    1. SYB position
    2. -SYB position in context of NEY&H

3. The ICS approach to supporting closing of the gap
    - National expectations
    - Steps agreed following CEO and AO session 5 November
    - System efficiency opportunities
    - NHS FTs working together opportunities

4. Next Steps and timelines

1. The System commitment

- Commitment by all organisations and Places to deliver a plan that meets the trajectories in 20/21 to 23/24
- As activity is aligned, the gap against trajectory is an efficiency gap
- Activity volume changes are as follows:

	GP Referrals	Other Referrals	Total Referrals	First OP	Follow up OP	Total OP	Daycase	Ordinary	Total Elective	Zero LoS Non-elective	1+ LoS Non-elective	Total Non-elective	Type 1&2 ED	Other ED	Total ED
2020/21	331,067	238,535	569,602	537,403	1,043,544	1,580,947	182,933	33,470	216,403	45,451	124,949	170,400	535,676	37,458	573,134
2021/22	335,038	242,265	577,303	544,062	1,055,051	1,599,113	183,732	33,682	217,414	46,517	127,471	173,988	554,777	38,711	593,488
2022/23	338,854	245,436	584,290	550,951	1,067,066	1,618,017	185,720	34,007	219,727	47,633	130,195	177,828	574,478	40,008	614,486
2023/24	342,613	248,381	590,994	558,011	1,079,273	1,637,284	186,768	34,240	221,008	48,785	133,007	181,792	595,158	41,352	636,510

Activity Growth year on year

Current Year on Year	2.0%	3.0%	2.4%	2.8%	5.9%
2021/22	1.3%	1.1%	0.5%	2.1%	3.4%
2022/23	1.2%	1.2%	1.1%	2.2%	3.4%
2023/24	1.1%	1.2%	0.6%	2.2%	3.5%

2. Current position

Summary for South Yorkshire and Bassetlaw

	VARIANCE TO TRAJECTORIES				
	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m
Providers					
Barnsley FT	0.0	0.0	0.0	0.0	0.0
DBTH	0.0	-7.5	-1.0	0.0	0.0
RDASH	0.0	0.0	0.0	0.0	0.0
SCH	0.0	-3.7	-2.8	-0.5	1.9
SHSC	0.0	0.0	0.0	0.0	0.0
STH	0.0	-11.9	-15.2	-15.2	-15.2
Rotherham FT	0.0	-2.4	-2.7	-2.8	-2.7
	0.0	-25.5	-21.7	-18.5	-16.0
Commissioners					
Barnsley CCG	0.0	0.0	0.0	0.0	0.0
Bassetlaw CCG	0.0	0.0	0.0	0.0	0.0
Doncaster CCG	0.0	0.0	0.0	0.0	0.0
Rotherham CCG	0.0	0.0	0.0	0.0	0.0
Sheffield CCG	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**-25.5**	**-21.7**	**-18.5**	**-16.0**

Summary of North East and Yorkshire and the Humber

Variance to trajectory 20/21	£m
SY&B	25.5
NE&C	15.0
HC&V	5.0
WY&H	5.0
Region	50.5

3. The ICS approach

- National expectation is for incremental improvement in reducing the variance with trajectories

- Meeting with the Directors of Finance of the four providers whose plan does not meet the trajectories for 20/21
- Providers whose plan does not meet trajectory to continue to work on the three steps outlined in the e mail from Jeremy Cook of 7 November
  - Step 1 – To review and refine assumptions used in the long term plan
  - Step 2 - To identify additional or stretch efficiency opportunities that would improve or eliminate the deficit against trajectory
  - Step 3 – To consider efficiency opportunities available at system level and through collaboration of providers working together
  - Escalation to NHSE/I as required

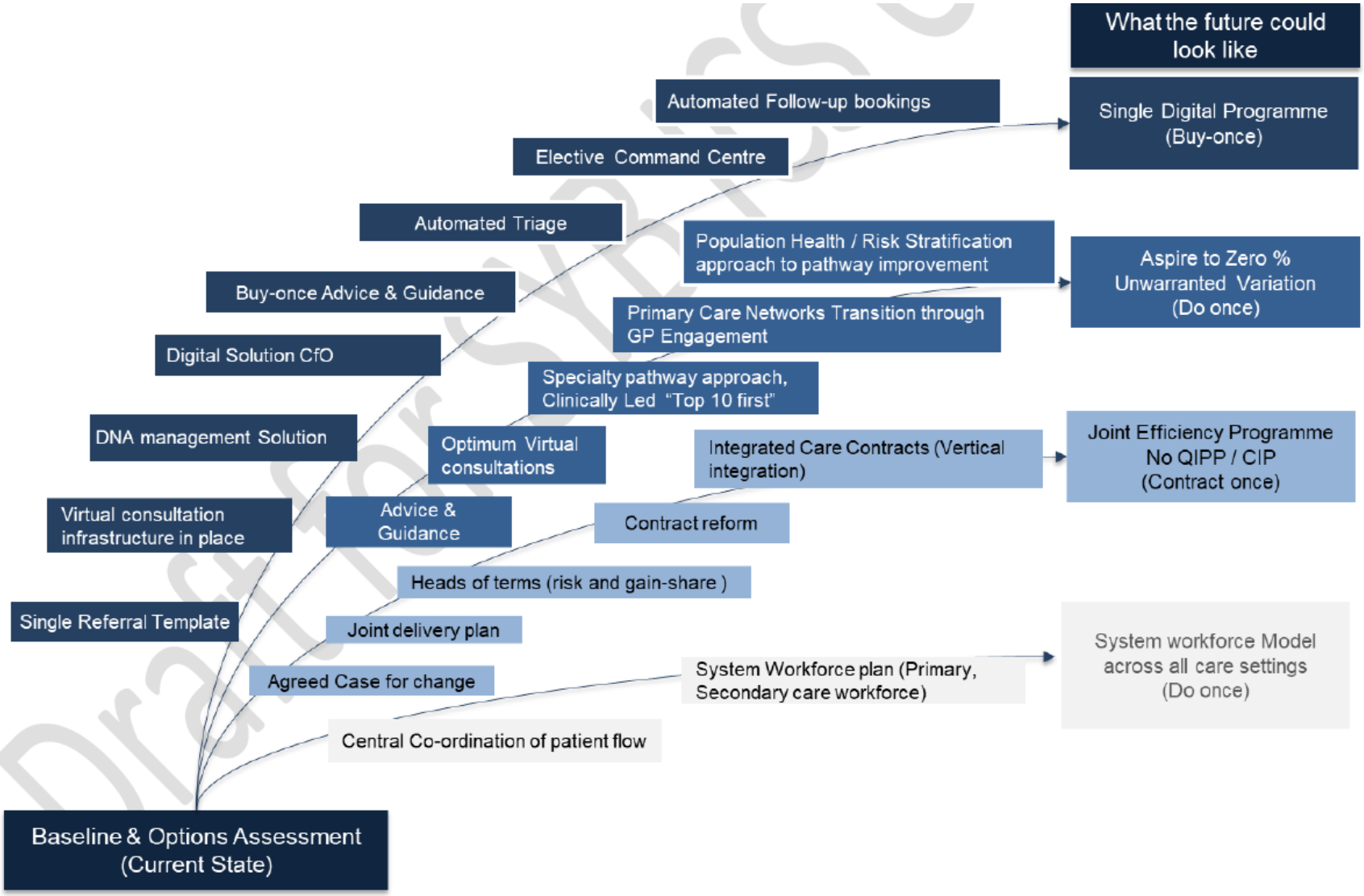
Potential efficiency opportunities

The following are efficiency opportunities which have been worked up by the system efficiency board which offer opportunities to close the gap:

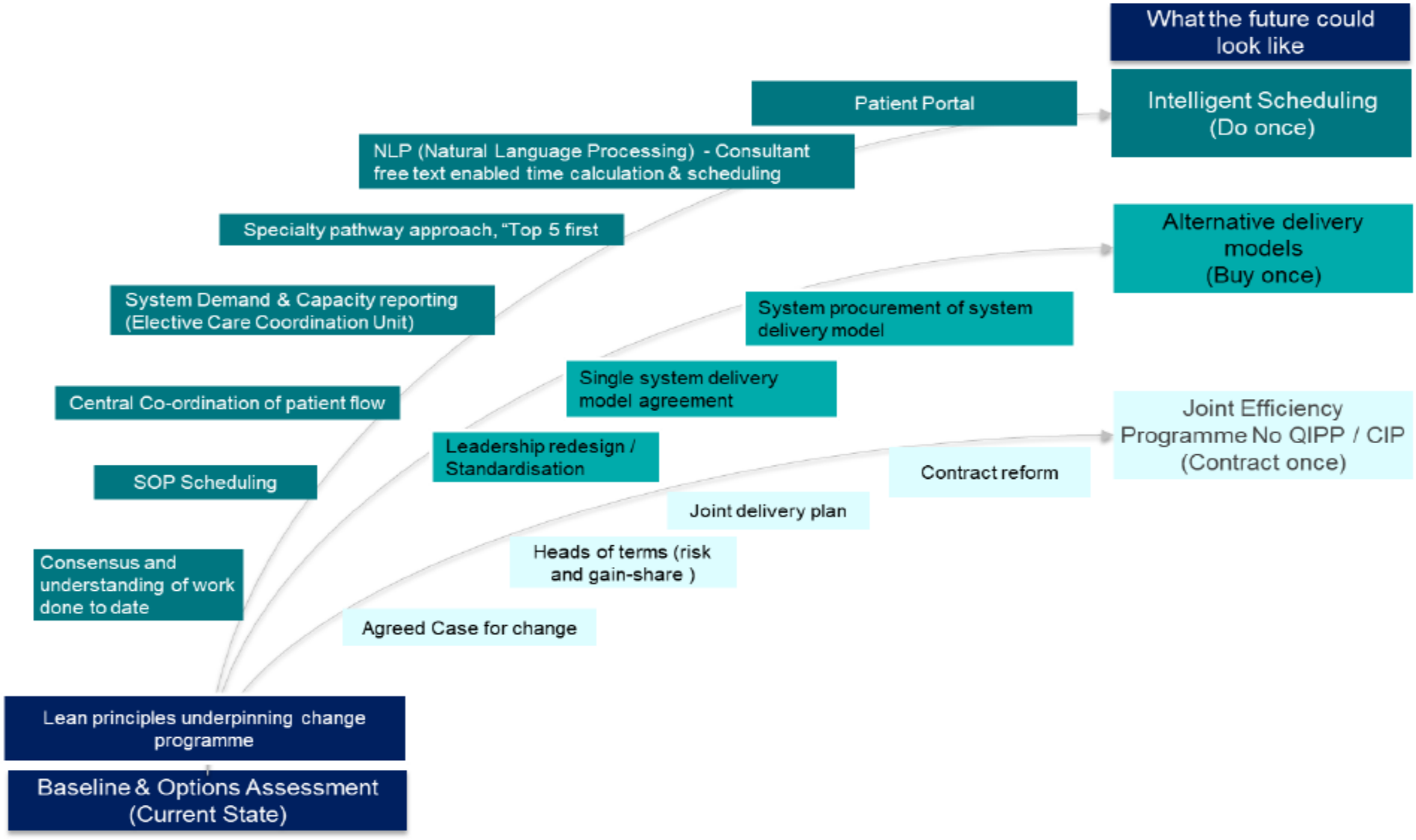
1. Outpatients
2. Theatres
3. Independent sector
4. e- Workforce

Total potential opportunity - provider analysis £16.4 – £28.5 million

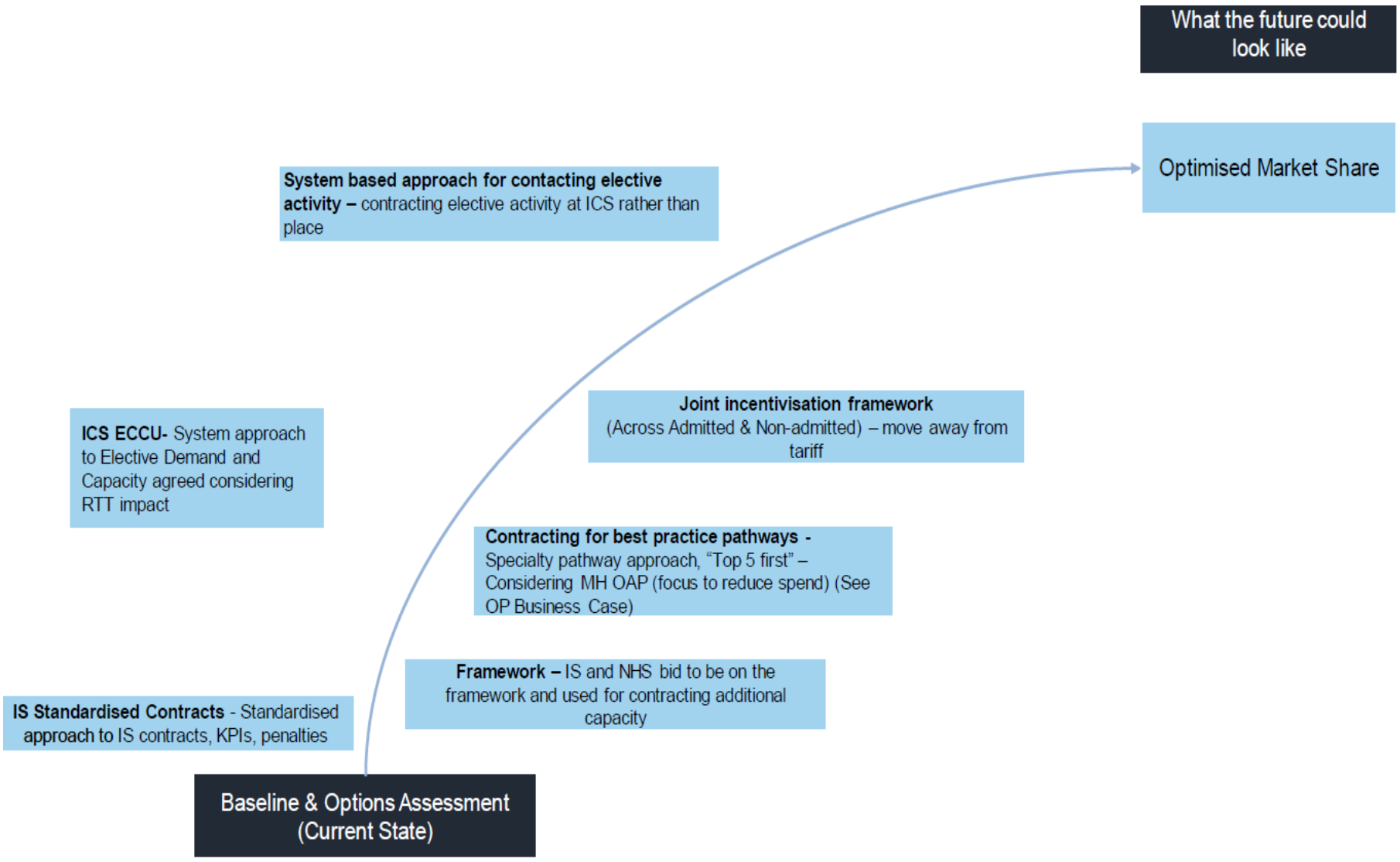
Outpatients



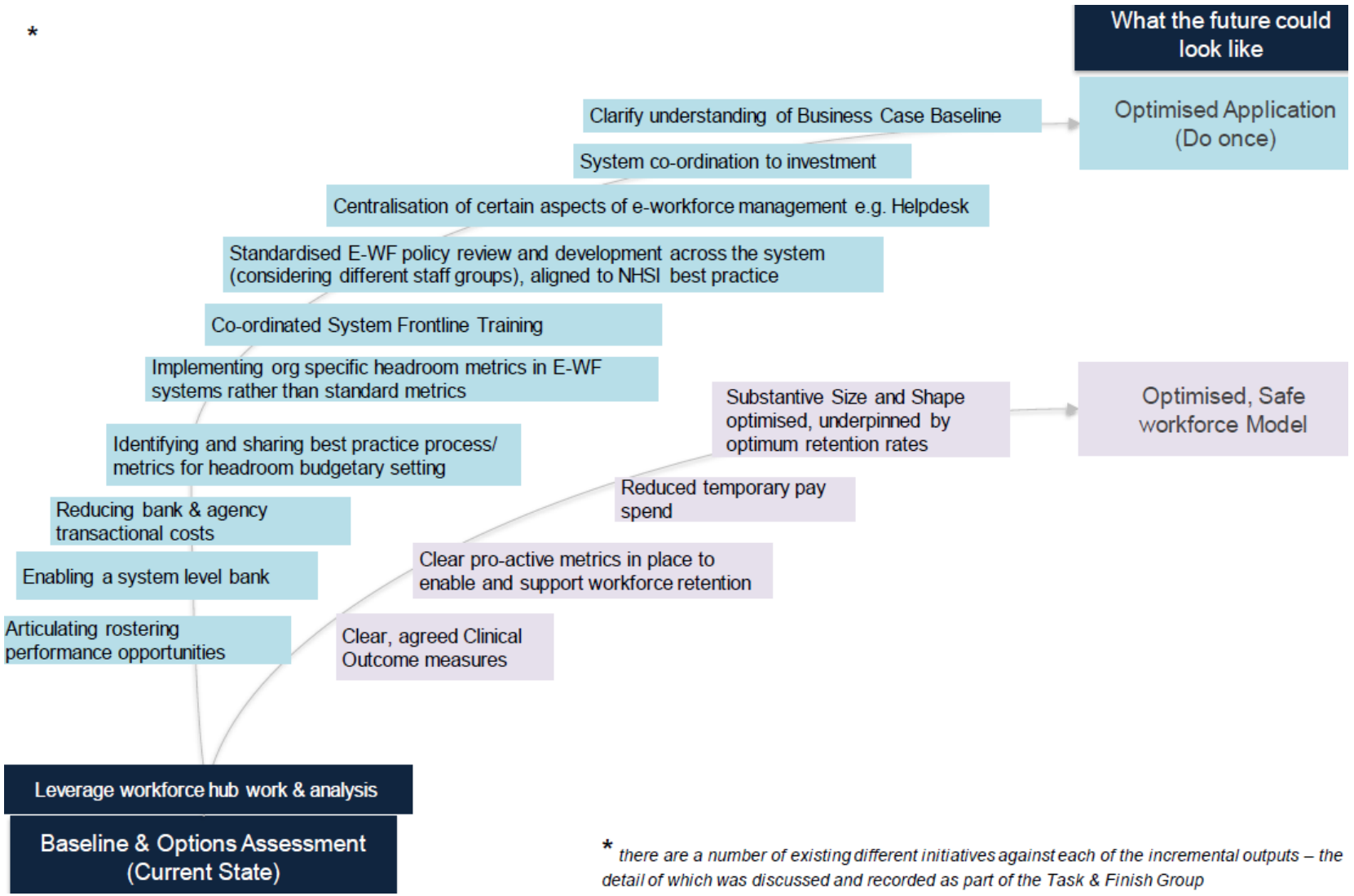
Theatres


What the future could look like
Patient Portal
Intelligent Scheduling (Do once)
NLP (Natural Language Processing) - Consultant free text enabled time calculation & scheduling
Specialty pathway approach, "Top 5 first
Alternative delivery models (Buy once)
System Demand & Capacity reporting (Elective Care Coordination Unit)
System procurement of system delivery model
Single system delivery model agreement
Central Co-ordination of patient flow
Joint Efficiency Programme No QIPP / CIP (Contract once)
Leadership redesign / Standardisation
SOP Scheduling
Contract reform
Joint delivery plan
Consensus and understanding of work done to date
Heads of terms (risk and gain-share)
Agreed Case for change
Lean principles underpinning change programme
Baseline & Options Assessment (Current State)

Independent sector



Workforce



* *there are a number of existing different initiatives against each of the incremental outputs – the detail of which was discussed and recorded as part of the Task & Finish Group*

System schemes

revisit the long list

Area	Short description	Opp Range*
Function / Pathways		
Outpatients	In line with the Long Term Plan, an opportunity has been identified in relation to reshaping the way Outpatient services are delivered	£10-20m
Theatres	Analysis of Capacity utilisation analysis across the system has identified both an income and cost out opportunity	£6-12m
Admission optimisation	Benchmarking of variation, has highlighted 5 key specialties where Bed day opportunities appear	£7-10m
Diagnostics (Imaging & E)	Initial Demand and Capacity analysis in Imaging and CT has highlighted an opportunity based on unwarranted variation	£5-8m
NEL Respiratory	Analysis of variation has identified opportunities in relation to admission avoidance and community care utilisation	£4-5m
Mental Health, Out of area Placements	What if analysis identifying how much could be saved through a reduction in Out of Area Placements	£5-7m
Single MSK Triage	What if analysis undertaken to try understand the potential efficiency opportunity by either standardising practices or creating a single Triage Service for SYB	£2-3m

Area	Short description	Opp Range*
Workforce focussed		
Corporate Services	Analysis of the full portfolio of corporate services has been undertaken. Considering 18/19, the residual opportunity is presented	£12-24m
E-Roster	Work is underway with NHSI to utilise E-Roster more efficiently in managing our workforce	£10-20m
Temp Pay	Work is underway to rationalise and standardise the supply and cost of temporary pay	£4-8m
Skill/Mix	Benchmarking analysis has highlighted potential opportunities across the workforce groups	£15-59m
New Integrated Models	High Level "What if analysis has been undertaken, considering the Long term plan ambitions for integration, to assess the indicative efficiencies that could be achieved in SYB	£5-10m
CHC	High level assessment of key areas of work that could potentially benefit from being done at scale, such as pooling budgets	£4-5.5m
Transactional in nature		
Independent Services	An opportunity has been highlighted to more effectively use NHS capacity.	£0-45m
Estates	Work-underway to establish efficiency opportunities	*tbc*
Digital	Focus on ' Buy-once" where appropriate as a system (Hardware and Software)	£2-13m
WoS	Partnership approach to enable system economies of scale	£7-12m

Working together schemes

- Pathology
- Radiology
- Procurement
- Hosted Networks
- Reducing A and E attendances
- Streamlining workforce
- Back office

Next steps and timeline

- Meetings with the finance directors of the four NHS FTs that are not on trajectory **(25 to 29 November)**
- Meeting between Andrew Cash, Richard Barker to agree next steps **(w/c 2 December)**
- Revisions to provider plans that are not meeting the trajectory required **(24 December)**
- Agreement of NHS FTs working together priorities and system priorities together with infrastructure to support implementation and governance arrangements **(HEG 14 January)**
- Further escalation if still gaps with trajectories **(during February)**

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body meeting in public
Held on
5th December 2019

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Chair
Dr Penny Blackwell	PB	Governing Body GP
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCh	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Buk Dhadda	BD	Governing Body GP
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Sandy Hogg	SH	Executive Turnaround Director
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Andrew Middleton	AM	Lay Member for Finance
Laura Moore	LM	Deputy Chief Nurse (for Brigid Stacey)
Gill Orwin	GO	Lay Member for Patient and Public Involvement
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Dr Greg Strachan	GS	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies

Brigid Stacey	BS	Chief Nursing Officer
Dr Merryl Watkins	MWa	Governing Body GP
Dean Wallace	DW	Director of Public Health, Derbyshire County Council
Dr Cate Edwynn	CE	Director of Public Health – Derby City Council

In attendance:

Leni Robson	LR	Office Manager/ Minute Taker
Suzanne Pickering	SP	Head of Governance

Item No.	Item	Action
GBP/1920/ 161	**Welcome, Apologies & Quoracy** Apologies were received from Brigid Stacey, Dr Meryl Watkins and Dean Wallace. Laura Moore was welcomed in Brigid Stacey's absence. Dr Avi Bhatia welcomed those round the table and introductions were made for the benefit of the public. Quoracy was confirmed.	

GBP/ 1920/162	**Declarations of Interest** AB reminded committee members of their obligation to declare any interests they may have on any issues arising from committee meetings which might conflict with the business of the governing bodies. Any declarations made by the members of the governing bodies are listed in the individual CCG's Register of Interests. There were no changes requested to the Register of Interest and no further declarations of interest were reported.	
GBP/ 1920/163	**Questions from members of the public** No questions were received from the public for this meeting.	
GBP/ 1920/164	**Chair's Report** AB presented the report of the Chair. He took the opportunity to update the Governing Body on the progress being made through the Place Board. AB provided an update on a second meeting that had taken place between himself, Dr Chris Clayton (CC), the Clinical Leads and the Primary Care Network (PCN) Medical Directors. There is an ongoing dialogue to develop a two-way conversation between the Clinical Commissioning Group (CCG) and the PCN. Both meetings had been positive with a robust discussion, and the intent and progression for the PCNs was clear. This dialogue will continue at the GP Leadership meetings on a monthly basis. AB and CC have both said they will meet with the PCNs at their behest as and when needed. **The Governing Body RECEIVED and NOTED the report of the Chair.**	
GBP/ 1920/165	**Chief Executive Officer's Report** CC presented the report of the Chief Executive. He took the opportunity to remind the Governing Body of the strict rules of Purdah that are in place at this time. CC drew the Governing Body's attention to section 2 which listed the meetings attended by the Chief Executive over the last few months. There has been a shift in direction for the organisation in terms of the work it is currently involved in. A different approach has been taken this year. An example of this is that CC is now formally invited to the EMAS Trust Board. This is an important shift since the new contract negotiation. Winter and Urgent Care plans are escalating, including conversations with national leaders regarding Derbyshire and this area of work remains a priority for the Executive team. The list of meetings also shows the move towards the working with wider partners and increasing connections with these. Work is ongoing to develop the Integrated Care Partnerships and CC concurred with the report of the Chair that this is gaining momentum. CC has also been working with Staffordshire, gathering information with regards to the Staffordshire way of working.	

	Values and Behaviours have been launched with staff and CC reiterated the importance of this. CC offered congratulations to University Hospitals of Derby and Burton who had achieved an outstanding CQC report. Formal congratulations will be sent to them. Dr Greg Strachan (GS) queried what the Derby Renaissance Board was. CC explained that it was an important forum around wealth regeneration in terms of the city and focused on building alliances across the public and private sector. GS asked if there was a Chesterfield equivalent and CC confirmed that the equivalent was the Chesterfield Conference. Andrew Middleton (AM) queried the remarks in section 3 around single use plastics and whether any focus has been given to this. CC informed the Governing Body that there was a working group within the CCG who are working on how the organisation could become greener and the plastic reduction scheme has been launched. He agreed this was an important issue and the Derbyshire Chief Executives Forum, have engaged the climate change agenda. Links are being formed with local authorities and partners about what the approach to Carbon reduction is. There will be the CCGs' challenges, what can be influenced through commissioning and what can be done by the NHS. AM queried whether more meetings could take place via teleconference to reduce driving as the footprint becomes larger and CC agreed that this is an option to take forward. **The Governing Body RECEIVED and NOTED the report of the Chief Executive Officer**	
GBP/ 1920/166	**Strategic Objectives Development** HD presented the paper for decision by the Governing Body. The paper is a continuation on the discussion that has been ongoing at Governing Body meetings over the last year. The Governing Body agreed the organisation's strategic objectives and associated risks in June. During the summer months 360 Assurance took an initial view as to how this was developing and how the document was being utilised to assist the organisation. There were two parts to the review: 1. Process around Risk Management. 2. How the Governing Body Assurance Framework (GBAF) was being used and the description around the strategic objectives. A report was brought to Governing Body in November with regards to embedding the work in response to the review. 360 Assurance recommended amendments to the language used in the objectives, namely the explicit articulation of measurement. Two areas were recommended for amendment, with the word measurably being included in both: 1. To reduce our health inequalities and **measurably** improve the physical health, mental health and wellbeing of our population 2. To **measurably** reduce unwarranted variation in the quality of healthcare delivered across Derbyshire	

	It was believed that the other objectives were implicit. **HD asked the Governing Body for feedback and approval on these amendments.** Professor Ian Shaw (IS) stated that the placement of the word 'measurably' in objective 1 was reconsidered as there is a difficulty in achieving a reduction in health inequalities and improving physical health. You can improve physical health and increase inequalities depending on how different social groups engage. Placing 'measurably' in front of 'improve physical health' puts the emphasis on this. IS suggested that the word 'measurably' was placed in front of 'reduce' so the objective read ***'****To* ***measurably*** *reduce our health inequalities and improve the physical health, mental health and wellbeing of our population'.* Jill Dentith (JD) broadly supported the proposal. She queried whether the risks needed amending in-year and the process involved in this. She acknowledged that the strategic risk associated to a strategic objective could change. If there is a recommendation to change a risk description it would be for the relevant committee to agree the change and then bring through to the Governing Body to approve. When the GBAF is reported in Quarter 3 all changes will be brought to Governing Body for formal approval and this will include any risk description changes. Martin Whittle (MW) supported proposals going forward. He queried strategic objective 3. Which reads *"To plan and commission quality healthcare that meets the needs of our population and improve its outomes*". At the Engagement Committee concerns had been raised that the targets set may be too high. He asked if this feedback had been considered. HD proposed the addition of the word reasonably so the objective reads: *"To plan and commission quality healthcare that* ***reasonably*** *meets the needs of our population and improve its outcomes*" In terms of next steps, if Governing Body approves the changes at this meeting, then the Committees and lead directors will be asked for the measures. Some may be obvious, and there is a plethora of data already in place, but there may be others that need to be targeted. Not all objectives will be achieved immediately and the measures need to reflect this. AM queried strategic objective 5. "*Work in partnership with stakeholders and population"* as it appeared incomplete and suggested adding '*in order to measurably improve outcomes for patients'* to it to clarify the purpose. Dr Bruce Braithwaite suggested "*Work in partnership with stakeholders and population to achieve the above four objectives"* as this is the 'how'. Richard Chapman (RCh) requested that points 1 and 2 could read "*Measurably to reduce"* as this was better grammar. The following amendments were agreed:	**ALL**

	1. Measurably to reduce our health inequalities and improve the physical health, mental health and wellbeing of our population. 2. Measurably to reduce unwarranted variation in the quality of healthcare delivered across Derbyshire. 3. To plan and commission quality healthcare that reasonably meets the needs of our population and improve its outcomes. 5. Work in partnership with stakeholders and population to achieve the above four objectives. **The Governing Body APPROVED the amendments to the Strategic Objectives.**	
GBP/1920/167	**Future in Mind Plan** Zara Jones (ZJ) presented the paper with regards to Future in Mind Plan. The paper was taken as read with ZJ drawing the Governing Body's attention to particular highlights. The plan has been published on the websites of Derby and Derbyshire CCG, Derby City Council and Derbyshire County Council. It is the 5th year of the national initiative for children and young people. The summary report covers the plethora of service initiatives including what is being done to improve the mental health of children and young people. The detail of the plan has been discussed at the Clinical and Lay Commissioning Committee (CLCC), as have the aspirations for the future. There have been improvements but there is still a long way to go. One of the key points is that there is a specific target of 34% to be reached in 20/21 regarding access. Discussion has taken place at CLCC as to what the aspirations should be and what it would take to achieve more than the national standard. Whilst clearly there is a debate about access, there is also a significant focus on prevention so that less access is required and work is ongoing to achieve this, in particular around digital access and around schools and education. Trailblazer funding has been achieved for support in schools which is showing a positive response. Governance is also covered in the plan and the importance of this has been agreed, therefore progress will be reported to the SEND Board and through the Joined Up Care Children's workstream to ensure visibility of progress being made. A financial commitment has been made annually and this has been met each year. Next year there is a plan for £4.3m of spend and a £400k uplift which comes as part of the investment standard. AM agreed that this was a positive paper and urged everything to be done in partnership with the education system. He drew attention to the sentence that read *'Our ambition is that by 2024 over half those who need a service will be able to access one',* and queried whether it should be 100%. ZJ stated that this builds on the conversation that took place at CLCC about the level of ambition. The report mirrors the national requirements and this needs to be explored further. Dr Ruth Cooper (RC) reinforced the statement made by ZJ regarding the discussion at CLCC. There had been a robust challenge to the 39% and that this figure should not be the ambition.	

	Gill Orwin (GO) queried whether there is an area within the country who are achieving above and beyond with regards to mental health and if so can a visit be arranged to review the methods used. GO also asked for more information on Kooth as to whether this was just online or could the service users speak to somebody. ZJ was only aware that it was a messaging service but would confirm. Dr Penny Blackwell (PB) echoed the aspirations already voiced around the table and informed the Governing body that Kooth and Qwell had been utilised by her practice as a resource. Qwell is for caregivers and Kooth is for children and young people. She confirmed they could speak to someone if required but in many instances the digital access is preferred. The children and young people who have engaged with Kooth and Qwell have been asked to complete short questionnaires to measure the impact. It has been very successful. Dr Emma Pizzey (EP) had missed the discussion at CLCC but acknowledged that there was good work being completed, however the information on the services was not circulated and schools are not always aware. The message needs to be communicated. ZJ confirmed that there had been communications but more will be actioned to ensure that all relevant partners are aware of the available services. RC confirmed that she was not aware of the services until she read the paper and reiterated the need to circulate the message as soon as possible and that the communications should be measured to ensure effectiveness. CC asked ZJ for the top 3 outcomes required. ZJ stated that in terms of access there had been an improvement but more is still required. Equally the pool of people requiring access has to be smaller and so there must be an outcome about prevention and earlier intervention, which will lead to less people requiring access to statutory services. With regards to Tier 4, again numbers have reduced, however work still needs to be done to eliminate the Tier 4 level. CC clarified that access has improved, and there has been a reduction in Tier 4, and reducing the number of patients requiring the service. IS asked to highlight in terms of the healthcare system the importance of going upstream, not just for Mental Health but for organisational sustainability within Primary Care. IS stated that statistics show an issue for Primary Care as 40% of people within GP surgeries are there for Mental Health issues, which increases to approximately 75% coming for subsequent appointments about the same condition. If GPs are spending a vast majority of their time on Mental Health issues there will be an ongoing impact and if this is approached from upstream resources can be released in Primary Care. PB queried whether the Future in Mind programme is defined nationally. Most teachers can identify a child at a young age who may have issues. Whilst prevention is important, so is early recognition. There was a targeted one-off initiative in Derby City which targeted preventing escalation. ZJ stated that now that the plan is in the 5th year it is wrapped up in the Mental Health implementation plan which is part of the NHS Long Term Plan. There are national targets to meet but there are	

	opportunities to look at early recognition going forward. AB will include the details regarding Kooth and Qwell in his newsletter to GPs **ACTION: ZJ to ensure suitable communications around the services available. AB will include in the Chair's newsletter to GPs.**	**ZJ AB**
GBP/1920/ 168	**Finance and Savings Report – Month 7** RCh presented the Finance and Savings report. The position at the end of month 7 is that the CCG is reporting that it is currently on plan year to date forecast position and are on plan to achieve the £29m planned deficit before the Commissioner Sustainability Fund (CSF) is applied to the position. The cash limit remains on plan from month 6. £552k of the £8.1m mandated contingency has been applied to the forecast outturn position. This reflects an adjustment to the overseas visitors' allocation which is due. The overall adjustment is about £1.5m, a reserve was in place of £1m so £0.5m has been met with the contingency in agreement with the Chief Executive. The savings forecast outturn is now a £20m adverse variance against a 69.5m target. Forecast is to achieve £49m savings in the current financial year. The underlying position is £49.4m exit rate against a £46.4m target. The £20m savings under delivery forecast at the end of the year is a net position. Therefore, it is forecast that of the plans set in place these will under deliver by £29m. Some plans will over achieve and there are some new plans that will deliver and this will achieve approximately £9m. The two positions net off the £20m that is forecast The Finance Committee received a financial risk paper which was fully appraised and gave assurance that there is a high level of confidence the control total will be achieved. Ian Gibbard (IG) queried the current position with the acute Trusts with regards to quality of data and to what extent is that seen as part of risk profile in relation to this paper. RCh confirmed that in terms of the risk management profile he is in discussion with all four providers in terms of the year-end position. They are close to agreeing the position with Derbyshire Community Health Services (DCHS). Acute Trusts are more complicated as there is potential for agreement of the financial value with United Hospitals Derby Burton (UHDB) around the existing patterns and then for urgent care to escalate in winter. ZJ confirmed that the data quality issues have improved at UHDB. An update had been provided to the Finance Committee with regards to a breach notice which had been issued in respect of the data issues. This	

	had been closed as these had been resolved. There were other issues and the CCG is working closely with UHDB to resolve these. As part of the close down position, work is ongoing to ensure clarity around the outstanding issues to ensure that next year there is not the same level of problems. ZJ acknowledges the issues of merging two data systems and assured the Governing Body that UHDB were aware of the impact on the wider system. **The Governing Body RECEIVED and NOTED the Month 7 Finance and Savings report.**	
GBP/1920/ 169	**Finance Committee Assurance Report – 28 November 2019** AM talked through the Assurance report. The Finance Committee was assured that mitigations had been put in place to ensure that the control total would be met this year. AM provided an update on the second System Financial Oversight Group meeting. All had agreed that there was a need to work together to meet the challenges ahead across the system. There were concerns over engaging the clinicians who could action the savings which were noted. IS queried whether there is a need to have a 'sense check' to ensure that by having a smaller Executive/Management team it is not having a detrimental effect given there is an underspend on Organisational costs of 1m and if so when will that check take place. HD confirmed that additional savings had been saved through the organisational efficiency programme and these savings had been made predominantly across two areas; firstly, in estates and secondly related to staff in terms of additional savings, predominantly related to recruitment and the pacing that staff were recruited. Throughout November pay budgets and structures have been revisited for further testing and review. RCh stated that there will be a reduction in running cost budget which the CCG must be prepared for so work is ongoing to be prepared for this. He agreed that further work is required on how the systems resource is applied and every organisation in the system will go through this. IS referred to the statement over the reduction in running costs. The CCG was now the size of a Primary Care Trust (PCT). PCTs took a 40% cut in running costs to convert to CCGs and CCGs are now taking a 20% running cost reduction. HD clarified that the CCG is not taking 20% out of the base line; the reduction has already been made by merging the 4 CCGs. BB referred to AM's comment with regards to clinicians. Dr Andrew Goddard, Chair of the Royal College of Physicians and Dr John Abercrombie, a senior member of the Royal College of Surgeons are both based in the East Midlands and suggested that meeting with them would have more traction then meeting with Medical Directors as they could have an influence on all members of their respective Colleges.	

	ACTION: AB will pick up with BB to take forward and facilitate a meeting Dr Steve Lloyd (SL) agreed that this was a good approach to take and flagged to Governing Body the approach being taken through the systems space along with Dr Mangus Harrison, Medical Director at UHDB. They had embarked on system reviews. This does not undermine Clinicians but guides them in new ways of working in the community. He assured the Governing Body that the challenge from the Clinical Workforce is recognised and work is being done to shape the approach so it becomes a clinical pathway. Sandy Hogg (SH) stated that she was unsure as to whether now was a good time to revisit the CCG's structure. A number of the Executive team are having conversations on how to pool system resource to create system function. There is a risk that the right design could be in place but there would still be an issue to deliver as the architecture would not be in place. JD noted the fantastic work that has been done, accepting the issue of recurrent versus non-recurrent. She stated that it would be beneficial for Governing Body to acknowledge the progress and the hard work of staff. This will assist in staff to think positively about moving forwards. AM endorsed SH's point and stated that it would be acceptable amongst the CFOs and that there must be economy where teams are duplicating work. He supported SH to work up proposals to put before CC to see what may be put forward as a concrete proposal. CC assured the Governing Body that these were conversations that were ongoing with regards to the system and how staff are moved across. Examples have been seen today on how year-end will be closed more quickly to allow staff to focus on managing the risk as opposed to proportioning the risk. **The Governing Body RECEIVED and NOTED the report of the Finance Committee.**	**AB**
GBP/1920/ 170	**Quality and Performance Committee Assurance Report – 28 November 2019** Dr Buk Dhadda (BD) talked through the report. At the last meeting, Maria Riley from Chesterfield Royal Hospital presented improving cancer targets assuring the Committee members that work is ongoing in collaboration with UHDB, to implement the 29 learning points from the visit to Frimley Park. BD highlighted the CQC report into Cygnet Acer Clinic; the report has been published and is in the public domain. The Clinic has been inspected three times since 2015 and was rated good. The last inspection was October 2018. The CCG Quality team have been actively working with the provider in the last few months and have done good work in terms of providing a good service, CQC was asked to come and carry out a further inspection. The Unit was still rated inadequate and put	

	into special measures. Work with the CCG Quality Team has continued and CQC recognised that a significant amount of improvement had been made. However, given the rating measures have been taken; the Unit has been closed to new admissions. The CCG Quality Team is visiting on a weekly basis and working very closely with CQC to ensure that the action plans are being implemented. Transforming Care Partnership (TCP). BD will bring back the Q2 update to the Governing Body as a singular item on the agenda so this can be discussed fully. There are multiple areas to be looked at and BD stressed the importance of the Governing Body understanding what is involved and what work is being done to take this forward. There are a number of statutory and national guidance awaited. This is a result of two Parliamentary committee meetings which both had similar findings around the detention of young people with learning difficulties and autism. In terms of current guidance already in place, by the end of December 2019 in line with the NHS England and Improvement (NHSEI) oversight arrangements regarding Out of Area (OOA) placements, there must be a minimum of 6 weekly visits to children and young people in Tier 4 beds and 8 visits to adults in Tier 4 OOA beds. The team have commenced work and there are 14 adults in Tier 4 beds OOA and 4 children and young people in Tier 4 beds. There are 18 adults in secure beds. And independent clinician has been appointed to complete these visits and BD assured the Governing Body that the requirements will be met. Another strand of the update was around the performance of Children and Young People in Tier 4 beds which is below trajectory. However there are other measurables that are being looked at, including adults in tier 4 beds and the long stay cohort. A number of which are in CCG beds. It was confirmed that this is on the risk register. This is an STP level piece of work and NHSEI have requested a review. An action plan has been put in place as Issues remain around workforce. **ACTION: Future Agenda item - TCP** BD highlighted the positive points, including the NHSEI for Antimicrobial Prescribing reduction. Derbyshire are below the national trajectory for meeting this target. There is one new risk to highlight which places a financial challenge. This is a new risk, Risk 39 in relation to Section 117 Aftercare costs. The Quality and Performance Committee will review this in more depth at the next meeting. CC stated that the paper does not align with the key messages. Laura Moore (LM) reported that this is due to timing as the Quality and Performance Committee takes place the day before the papers are due and this will be rectified when organising dates for next year, however she will ensure that the papers are more aligned. **ACTION: Align meetings so that papers are available and relevant to the Governing Body to enable them to have prior sight.**	**HD/BD** **HD**

	The Governing Body RECEIVED and NOTED the report.	
GBP/1920/171	**Engagement Committee Assurance Report – 4 December 2019** MW highlighted three points from the Engagement Committee: 1. Presentation on the ongoing Urgent Care work. The Committee was able to provide input and comment into this work. 2. Presentation - Repeat prescribing and Medicines Order Line was reviewed and the Committee were assured. There was an open invite to visit the Medicines Order Line (MOL) which several Committee members did. 3. The timings of this Committee are not aligned with the Governing Body so it was agreed that the Terms of Reference will be reviewed and from February there will be a paper that is better synchronised with the Governing Body. **The Governing Body RECEIVED and NOTED the report.**	
GBP/1920/172	**Governance Committee Assurance Report - 4 December 2019** JD highlighted the following three points from the Committee. 1. <u>Emergency Planning Resilience and Response (EPPR)</u> The Committee was assured by reports not only in terms of the CCG's position, but also in terms of the Derbyshire Providers' position. The Committee are looking at how planning is put into action. Assurances and positive feedback were received from both the recent issues with the flooding in Derbyshire and following the Whaley Bridge Dam incident. 2. <u>HR Policies</u> The Governing Body noted that the Governance Committee approved the following policies: • Disclosure and Barring Policy; • Secondment Guidance and Procedure; and • Working Time Directive Policy. 3. <u>Internal Audit Report Governance and Risk Management</u> The Committee reviewed the Internal Audit Report for the CCG's Governance and Risk Management. The report gave a significant assurance opinion for Risk Management; however the report detailed two recommendations which were rated medium, which resulted in a limited assurance opinion for Governance. This was raised at Audit Committee and challenge was given to Internal Audit colleagues. It was noted that the audit was completed at a time when the organisation was a newly merged CCG and that at that time the GBAF was being strengthened. The GBAF has been strengthened further to include the measurement of the CCG strategic objectives and being is developed within the constraints allowed. CC recognised that the report may have been at a point in time, however asked for confirmation that further independent analysis should be undertaken to ensure that the issues raised had been addressed.	

	JD and HD confirmed that the Governance Committee had been disappointed with the report, and believed that there had been some process irregularities in how the review was conducted. There was recognition that the review was completed too early in the year in terms of having measures of the strategic objectives in place. 360 Assurance will be asked to review the work completed. HD expressed confidence that the work is progressing. AM reiterated challenges discussed at Audit Committee. IG agreed that there are some indicators within the report that it was completed early. He supported CC's suggestion that a further review with the Internal Auditors should take place and that they have made a commitment to complete a further review to ensure that this is followed through. JD confirmed that the report had been reviewed by the Audit Committee and they stated that there would be a further review, which would be brought back to Audit Committee in January. This information is needed so that there can be confidence in the Head of Internal Audit Opinion at the end of the financial year. AB stated that there needs to be triangulation so whilst there is every confidence that all is correct, this must be confirmed by a third party. He requested a timeline as to actions being taken and this will be reported in the Audit Committee Assurance Report. **The Governing Body RECEIVED and NOTED the report.**	
GBP/1920/ 173	**Audit Committee Assurance Report – 21 November 2019** IG asked the Governing Body to formally note the Internal Audit Report and their findings. Risk Management provided significant assurance which is an improvement on from the limited assurance provided when the CCGs were 4 separate entities. There was also an audit report on Contract Management which provided a limited assurance, which again could be due to the timing of the report. An improved audit report was expected. A positive report had been received from KPMG, external auditors which had been conducted on the 18/19 financial year and was incredibly useful. **The Governing Body RECEIVED and NOTED the report.**	
GBP/1920/ 174	**Primary Care Commissioning Committee Assurance Report – 27 November 2019** IS highlighted one area from the report which was the cost pressure on Category M drugs. It appears that this is going to end the year going over in terms of both cost and prescribing. Overall however, the PCCC is set to come in within budget.	

	The Governing Body RECEIVED and NOTED the report.	
GBP/1920/175	**Risk Register Report – November 2019** HD presented the risk report for November. Two new risks have been identified since the last meeting. Both are rated as high with a score of 12: • Risk 39 with regards to Section 117 Aftercare Costs which was discussed in the Quality and Performance Committee. • Risk 40 has been assigned to Finance Committee and relates to data quality issues in UHDB. Two risks have been closed under section 4.4 as recommended through the committee reports. GS asked when the data issue would be resolved. ZJ confirmed that work is ongoing with regards to residual data issues There have been ongoing issues with merging data. She would expect these to be resolved within the financial year. CC clarified where the data is discussed. Finance Committee hold the risk but the data issues are discussed at Quality and Performance Committee and therefore he queried whether the risk should be that Committee's responsibility. ZJ confirmed that the financial risk and contractual obligations are discussed in Finance Committee and the activity position is discussed at the Quality and Performance Committee. The technical issues which are driving the incorrect data or poor data quality is also discussed. At Quality and Performance Committee whilst not looking at the technical detail, the activity profile in year is discussed where the data issues may drive a different trend to what the reality is. CC requested that BD and AM work it through and decide whether the recommendation to Governing Body is correct and the risk is under the correct Committee. GS stated that the issue around having an in-depth conversation at Quality and Performance Committee is that they are not assured that the data is correct. BD fully took on board the challenge. Quality and Performance Committee have questioned the data due to the difference in figures from UHDB and Chesterfield Royal, but there is a need to have a clear line of sight in Governance to ensure that this is being properly reviewed. JD asked for clarification around why, in a high-level risk report, i.e. anything rated 15 or above, the report also gives information on issues which are rated high.	

	HD stated this was to ensure full sight reporting specifically on very high risks but will pick up outside the meeting with JD. **Action: HD to discuss the risk report with JD** CC stated that the recommendation to approve the new risk 40, could not be agreed at this stage as there needs to be clarity over which committee is responsible for the management of the risk. AB challenged CC as to whether the issue around Data is being picked up within the system and CC stated that he did not believe it was seen as a system problem. He will work with colleagues within the system to ensure that this is picked up and taken forward. **The Governing Body NOTED the report but did not agree with the risk reduction at this time.**	**HD**
GBP/1920/176	**Ratified Minutes of Corporate Committees:** • Primary Care Commissioning Committee – 23 October 2019 • Quality and Performance Committee – 31 October 2019 **The Governing Body RECEIVED and NOTED the minutes of the Corporate Committees**	
GBP/1920/177	**Minutes of Health and Wellbeing Board Meetings** Derby City Council – 12 September 2019 **The Governing Body RECEIVED and NOTED the minutes of the Health and Wellbeing Board Meetings**	
GBP/ 1920/178	**Minutes of the Governing Body meeting held on 7 November 2019** BD is listed as attending and as having given apologies. He will be removed from the attending list for this meeting. With this amendment the minutes of 7th November 2019 were agreed as a true and accurate record	
GBP/ 1920/179	**Matters Arising / Action Log** The action log will be updated and amended accordingly.	
GBP/ 1920/180	**Forward Planner** The forward planner was accepted and agreed.	
GBP/ 1920/181	**Any Other Business** There was no other business.	

DATE AND TIME OF NEXT MEETING

Thursday 9 January 2020 – 9.15am – Conference Room, Toll Bar House, Ilkeston, DE7 5FH

Signed by: …… (Chair) Dated: ……

NHS
Derby and Derbyshire
Clinical Commissioning Group

GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – December 2019 meeting in public

Item / Minute No.	Action Proposed	Lead	Action Required	Action still to be taken	Due Date
2019/20 Actions					
GBP/1920/168	Future in Mind Plan	Zara Jones/Avi Bhatia	Concerns were raised over the communications of beneficial programmes to GPs. ZJ will ensure suitable communication around the services available and AB will include details within the Chairs newsletter		January 2020
GBP/1920/169	Finance Committee Assurance Report	Dr Avi Bhatia/Dr Bruce Braithwaite	AB will pick up with BB to take forward and facilitate a meeting the Chair of the Royal College of Physicians.		February 2020
GBP/1920/170	Quality and Performance Committee Assurance Report	Dr Buk Dhadda/ Helen Dillistone	The Transforming Care Partnership Update will be brought back to the Governing Body as a singular item.		March 2020
GBP/1920/170	Quality and Performance Committee Assurance Report	Laura Moore/ Helen Dillistone	Align Quality and performance Committee meetings so that papers are available and relevant to the GB to enable them to have prior sight.		February 2020
GBP/1920/170	Risk Register Report	Helen Dillistone	HD to discuss the Risk Report with JD	Risk register report amended and reflected in the GB papers	January 2020

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Forward Planner 2019/20

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM/ ISSUE												
WELCOME/ APOLOGIES												
Welcome/ Apologies and Quoracy	X	X	X	X	X	X	X	X	X	X	X	X
Questions from the Public	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest Register of Interest Summary register of interest declared during the meeting Glossary	X	X	X	X	X	X	X	X	X	X	X	X
CHAIR AND CHIEF OFFICERS REPORT												
Chair's Report	X	X	X	X	X	X	X	X	X	X	X	X
Chief Executive Officers Report	X	X	X	X	X	X	X	X	X	X	X	X
FOR DECISION												
Affirmation of Corporate Governance Responsibilities								X				
Constitution and Committee Terms of References	X											
DCHS Investment Case								X				
EPRR Framework and EPRR Standards											X	
Discharge pathways at Erewash												X
PLACE Phase 2 Investment Case							X					
Lighthouse Consultation Update											X	
FOR DISCUSSION												
360 Stakeholder Survey												X
Derby SEND Written Statement of Action											✓	
CORPORATE ASSURANCE												
Finance and QIPP Report	X	X	X	X	X	X	X	X	X	X	X	X
Finance Committee Assurance report	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM/ ISSUE												
• Quality & Performance Report • Serious Incidents • Never Events												
Governance Committee Assurance Report • Business Continuity and EPRR • Complaints • Conflicts of Interest • Freedom of Information • Health & Safety • Human Resources • Information Governance • Procurement	X		X		X		X		X		X	
Audit Committee Assurance Report	X	X	X				X		X		X	
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report		X		X		X		X	X		X	
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X			X				X		X		X
Strategic Risks and Strategic Objectives												
Workforce Report Quarter 1 & Quarter 2								X				
Annual Report and Accounts and AGM			X			X						
Audit Committee Annual Report				X								
FOR INFORMATION												
Director of Public Health Annual Report						X						
Minutes of Corporate Committees												
Audit Committee	X	X				X		X		X		X
Clinical & Lay Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM/ ISSUE												
Engagement Committee	X	X	X	X	X	X	X	X		X	X	X
Finance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee		X		X		X					X	
Primary Care Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of Health and Wellbeing Board Derby City+	X		X		X		X		X		X	
Minutes of Health and Wellbeing Board Derbyshire County*							X (Jul)			X (Oct)	X	
Minutes of STP Joined Up Care Board	X	X	X	X	X	X	X	X		X	X	X
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETNGS												
Minutes of the Governing Body	X	X	X	X	X	X	X	X	X	X	X	X
Matters arising and Action log	X	X	X	X	X	X	X	X	X	X	X	X
ANY OTHER BUSINESS												

+Meetings are on 14 Nov 19, 16 Jan 20, 19 Mar 20 and 14 May 20

https://cmis.derby.gov.uk/cmis5/Committees/tabid/101/ctl/ViewCMIS_CommitteeDetails/mid/550/id/1931/Default.aspx

***Meetings are on 3 Oct 19, 30 Jan 20 and 2 Apr 20**

https://democracy.derbyshire.gov.uk/ieListMeetings.aspx?CId=175&Year=0