Joined Up Care Derbyshire

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5 Year Strategy Delivery Plan:

2019/20 to 2023/24

FINAL

15 November 2019

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Executive Summary

This plan sets out our response to the NHS Long Term Plan published in January 2019. To better enable delivery of the ambitions set out the Derbyshire system has agreed to ensure a broader population health and wellbeing approach in our plan. Fundamentally, this five year plan sets out:

- Our response to implementing the commitments set out in the to the NHS Long Term Plan to 2023/24, with 2019/20 as the transitional year
- Our plan to become and Integrated Care System (ICS); including how we will bring together local organisations to redesign care and improve population health, creating shared leadership and action
- An outcomes driven approach so that the people of Derbyshire **'have the best start in life, stay well, age well and die well'**. These are the three population level outcomes which the Derbyshire system has agreed and are consistent with the NHS LTP ambition to ensure that we give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people to age well
- Our approach to growing and transforming our workforce in line with the NHS Interim People Plan
- Our approach to developing stronger links and improvements in the wider determinants of health, leading to improved outcomes for people in Derbyshire which include housing, education and air pollution management, which is considered particularly important given the link between health and each of these areas
- Our approach to using our resources wisely and living within our financial allocation as a system
- A stronger focus on addressing inequalities through population health management, embedding the personalised care model as an enabler to improve outcomes through segmentation approaches
- Our engagement and involvement approach to ensure strong collaboration and coproduction with our public and stakeholders

Importantly, we recognise the cultural shift required to enable wellbeing rather than solely fixing ill health, throughout our plan and our approach going forward will focus on people not just patients.

"The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should where possible be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home'. NHS Long Term Plan, January 2019.

The health and care case for change is strong; we know that:

- By 2033 it is forecast that a quarter of the population will be over 65 years old
- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving
- People die earlier than they should in some parts of Derby and Derbyshire from respiratory, mental health, falls, CVD and MSK related conditions compared to national averages

Demand on services has been increasing, but much of that extra demand is for treatment of conditions which are preventable. At its heart, the NHS remains a treatment service for people when they become ill. Our ambition is to develop a system in Derbyshire which shifts the focus from treating ill-health to enabling wellness; to improve the health of local people, reduce health inequalities and stem the rising demand for health and care services. If we are serious about improving population health, health inequalities and stem the demand for services, we need to take action across the four domains:

Vision	**A Vision for Population Health in Derbyshire –** that people in Derbyshire have the best start, stay well, age well and die well Delivered through improving population health and reducing inequalities			
Outcomes (what)	1. Have the best start in life	2. Stay well	3. Age well and die well	
4 pillars (how)	**Wider determinants of health**	**Health Behaviours & lifestyles**	**Integrated health and care system**	**Our Communities**
	e.g. Income, housing, environment, transport, education, work	e.g. Diet, smoking, physical activity, alcohol and drug use	e.g. Integrate care around need, ability to manage multi-morbidity, services effective and efficient	e.g. Planning, licensing, relationships, community networks, asset-focussed.

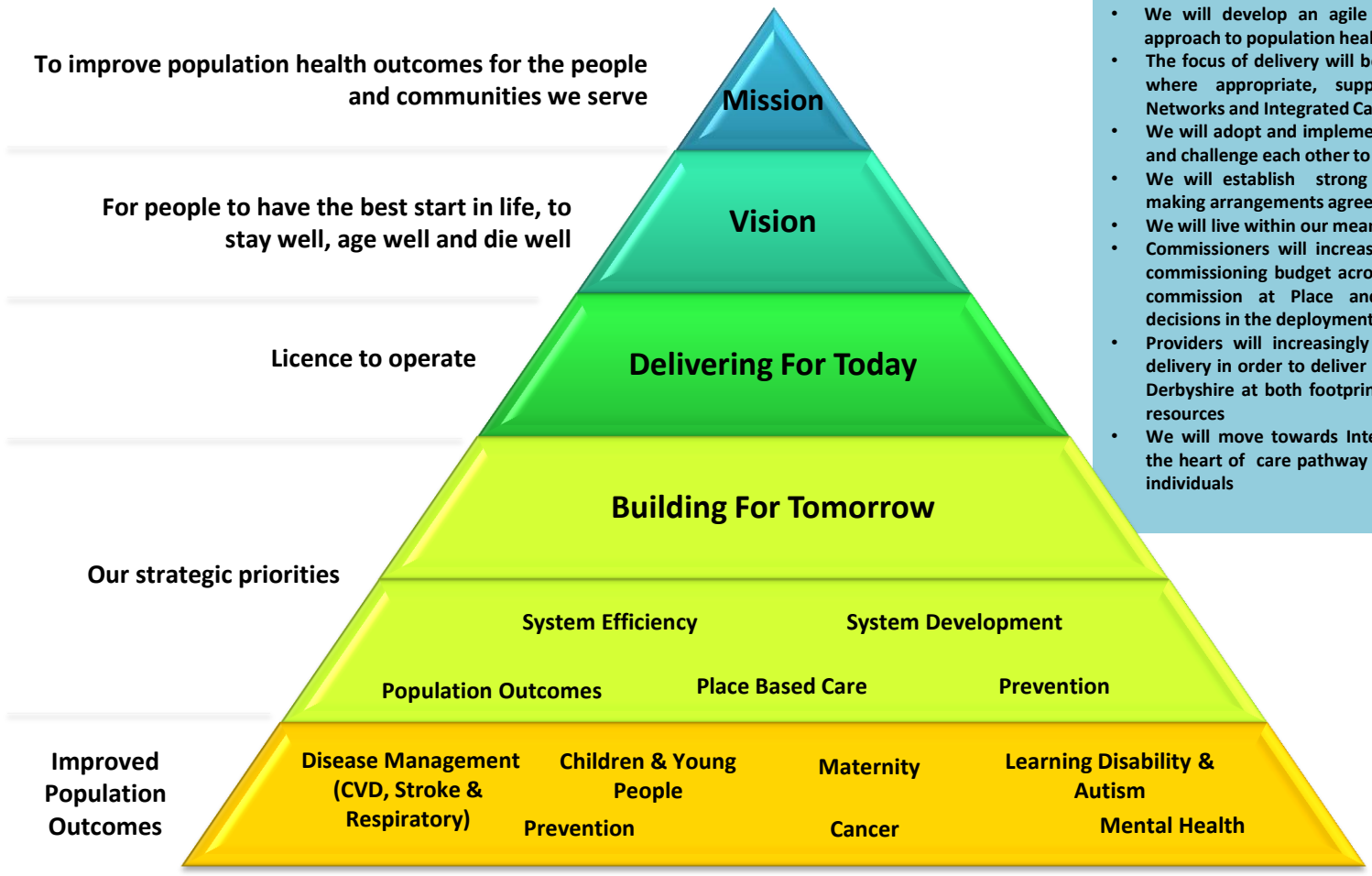
The Derbyshire ambition to deliver the **Quadruple Aim - Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience and resilience, Reducing the per capita cost of healthcare**; will remain at the forefront in our approach and will be underpinned by our five strategic priorities: **Place based care, prevention and self management, population outcomes, system efficiency and system development**. In addressing the quadruple aim and delivering the ambitions set out in our plan, Derbyshire will be a great place to grow up in, work and live.

Our plan will continue to evolve and there will be opportunities for Derbyshire people to share their views to help make services the best they can be. For more information, and to find out in coming months about how to get involved please visit https://www.joinedupcarederbyshire.co.uk/

Any changes proposed to current services would involve local engagement and, if appropriate, consultation. Any consultation would follow legal guidance, and involve as many local people as possible.

What is Joined Up Care Derbyshire?

Our partnership is made up of providers (NHS, Local Authority and Voluntary Sector) and commissioners; Joined up Care Derbyshire (JUCD) is the identity by which we work together in this partnership.



What Will Be Different

- Our system will jointly plan for the health and social care needs of the population; moving from fixing illness to enabling wellness
- We will develop an agile workforce to meet the changing approach to population health and system working
- The focus of delivery will be PLACES rather than organisations where appropriate, supported by strong Primary Care Networks and Integrated Care providers
- We will adopt and implement core principles for how we work and challenge each other to upholding them
- We will establish strong system governance with decision making arrangements agreed
- We will live within our means
- Commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at Place and make strategic commissioning decisions in the deployment of that budget
- Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources
- We will move towards Integrated Care Partnerships being at the heart of care pathway delivery to meet the local needs of individuals

Our Guiding Principles: We will…

Be driven by the interests of the people and communities we serve

Support each other to address barriers to system transformation

Ensure services are provided as close as possible to the places people live

Design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them

Joined Up Care Derbyshire – 'plan on a page'

The summary below provides a high level overview of the five year Joined Up Care Derbyshire Strategy Delivery Plan

(1) The Quadruple Aim: Challenges

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the County:

- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist; the are areas of significant rurality which create access challenges
- We have made significant progress with beginning to 'join up care'; however, there remain many opportunities to integrate care more effectively and consistently
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap if we do nothing for the Derbyshire health system is anticipated to be £332m by 2023/24
- In addition the anticipated cost pressures for Derbyshire County Council is circa £113m. We are working with Derby City Council to determine the cost pressures from that perspective. Both Local Authority and General Practice elements will be considered as part of the system view as we develop a better understanding
- To tackle the gaps requires transformational changes to the way in which care is provided

To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole.

(2) Our priorities

Five priorities form the core of our 5 Year Joined Up Care Derbyshire Strategy Delivery Plan:

- **Place-based care:** We will accelerate the pace and scale of the work we have started to 'join up' care to transform out of hospital care and fully integrate community place based care by operating as a single team to wrap care around a person and their family; tailoring services to different community requirements across our 8 Places, underpinned by Primary Care Networks
- **Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing
- **Population Outcomes:** We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes
- **System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers
- **System Development**: We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Partnerships (ICPs) and our Strategic Commissioning function through aligned leadership and governance

(3) Impact & Implications

Delivering our plan will help us to:

- Meet our aims to keep people: (i) **safe & healthy** – free from crisis and exacerbation; (ii) **at home – out of social and health care beds**; and (iii) **independent – managing with minimum support**. We will begin to address lifestyle issues related to poor health and will improve access to urgent and routine care
- Achieve a financially sustainable system: the combined impact of the priorities described will enable us to achieve a financially balanced health system by 2023/24

We will significantly change the 'shape' of the system:

- With more care delivered through Place based care, we will work to reduce care delivered in specialist settings where appropriate
- Major changes to the workforce – more staff delivering place-based care
- Changes to the physical configuration of place-based services
- Greater integration and streamlined commissioning across health and local authority driven by a population health management approach
- Increased integrated provision of services wrapped around people and their communities

(4) Next steps

Delivering the STP:

- The work over the next five years to deliver our plan is part of and consistent with our ongoing journey to deliver our model of care which will transform 'out of hospital care' through fully integrated place based care ; reducing reliance on institutional care
- We will accelerate the pace and scale of these changes to have the necessary transformational impact. We will build upon progress made to date to establish our Place Alliances and develop these further in light of new models which include Primary Care Networks (PCNs) and Integrated Care Partnerships (ICPs)
- Our approach will be facilitated by the development of our Integrated Care System by April 2021, to now begin the transition from planning into delivery
- During the next 6 months we will:
  - Align system capacity and capability to enable even greater focus on delivery
  - Progress delivery of a number of high impact transformation schemes to support future sustainability
  - Continue our localised engagement programme focussing on staff, stakeholders and our local population

What (Outcomes) & How (Workstreams and Provision)

Best Start in Life:

A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support

- Fewer women smoking at time of delivery (6% or less by the end of 2022)
- Reduce stillbirths, neonatal deaths, maternal death and brain injury by 20% by 2020/21 and serious neonatal brain injuries by 50% by 2025
- Increase in women on continuity of carer pathway
- Community Wellness approach developed where individuals and families can receive the improved support for their physical and emotional health and wellbeing
- Provision of 24/7 services for Children and Young People with mental/emotional behavioural needs, requiring urgent care response; accessible via NHS111 by 2023/24
- Reduction in child excess weight; Derbyshire Childhood Obesity Strategy with improved coordination of treatment across health, local authority, public health

Stay Healthy:

Helped to live a healthy life, make healthy choices and protected from threat. Able to maintain quality of life and recover from ill health or injury

- 30% of non-elective attendances treated as same day emergency care, including same day urgent care services in primary care and treating people within community-based Urgent Treatment Centres (UTCs)
- At least 75% of people with a learning disability and/or autism aged >14yrs will receive an annual health check
- Reduced reliance on inpatient care so no more than 28 people with LD require inpatient care (secure and acute) by 2020/21
- Reduce the length of time people spend in hospital and end the need for all out of area adult acute mental health placements by 2020/21; for those requiring Psychiatric Intensive Care we plan to develop a local PICU unit by 2023/24
- Implementation of a service for High Intensity Users (HIU) with chaotic lifestyles which enables targeted proactive care management
- Better cancer screening uptake for Breast (80%), Cervical and Bowel (75%) leading to 62% of all cancers to be diagnosed at an earlier stage by 2020
- Transform the way outpatient services are delivered, reducing the need for face to face outpatient appointments by a third by 2023/24; using digital technology to support prevention and self-management

Age Well, Die Well:

Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable and supported end of life

- More people with dementia and delirium being supported in their own home or in a place they call home
- Older people will receive proactive, person centred and integrated care. We will embed the frailty model of care for Derbyshire to manage frailty as a long term condition in its own right, rather than as a label
- People living in care homes will receive more support, ensuring that their needs are assessed and met; reducing the need for unnecessary and avoidable hospital admissions
- Embed the ageing well programme so that integrated care teams enable more effective care closer to home; contributing a 4.5% reduction in non-elective admissions
- People approaching the end of their life will have fair access to personalised end of life care and support and to die in their preferred place of care. We will promote honest and open conversations about death across communities; with those caring for the dying person are involved and supported

Provision

Integrated Care Partnerships

Places/ Primary Care Networks

NHS Providers

Primary Care

Local Authorities

Voluntary and Independent Sectors

Work Streams: CYP Maternity Urgent & Emergency Care Planned Care Mental Health Learning Disabilities & Autism Cancer EoL Disease Management Improving Flow Place/ PCNs

Enabler Workstreams: Comms. & Engagement Workforce Digital Estates Prevention Population Health Management

Partners involved in Joined Up Care Derbyshire

Primary Care Networks Place Alliances

Derbyshire Health United

Derbyshire Healthcare Foundation Trust EMAS

Chesterfield Royal Hospital General Practice

Derbyshire Community Health Services

Derby and Derbyshire CCG GP Provider Alliance

Derbyshire District and Borough Councils

Derby City Council Derbyshire County Council

University Hospitals of Derby and Burton LMC

Voluntary Sector NHS England Direct Commissioning

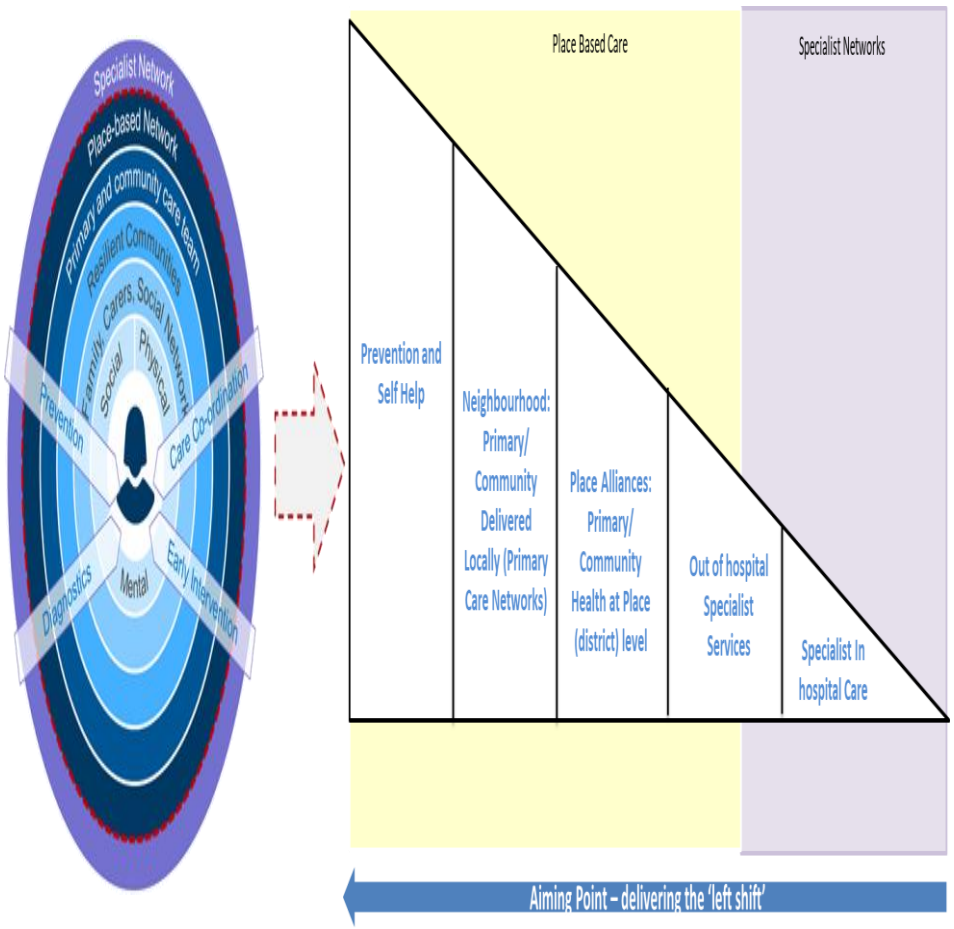
We are in this together…..

Journey So Far (1)

Health and social care organisations across England have been working together more closely than ever as Sustainability and Transformation Partnerships (STPs), to look at improving care and services for people, making them as effective and efficient as possible. In Derbyshire, organisations came together in 2016, as the Derbyshire STP and developed **Joined Up Care Derbyshire (JUCD)** as our identity. Since this time we have been working hard to break down traditional organisational boundaries to develop greater integrated care for the population we serve. Together, we have made some progress but there is significantly more to be done.

Within our partnership, JUCD is committed to corporate citizenship to ensure that we meet our legal, ethical and economic responsibilities in our environmental, social and governance practices.

The Derbyshire Model of Care



The 2016 plan provided the foundations for the next iteration and development of our five year Strategy Delivery Plan in response to the NHS Long Term Plan (LTP) published in January 2019. **The agreed Derbyshire model of care remains valid; providing the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes, as set out in this refreshed five year plan.** We are therefore refreshing rather than re-writing our plan.

Our model of care defines a placed based system which is effectively joined up with specialist services and managed as a whole. So that, fundamentally, the Derbyshire system would aim to keep people:

- **Safe & healthy** – free from crisis and exacerbation.
- **At home** – out of social and healthcare beds.
- **Independent** – managing with minimum support.

... founded on building strong, vibrant communities.

Working together to deliver our model of care

Our plan is underpinned by a system wide Clinical Care Strategy developed through our Clinical and Professional Reference Group (CPRG). This is based on a set of agreed care principles and standards, which fully support the model of care. The role of CPRG is to provide clinical and professional leadership to support development and implementation of service changes required to deliver the system objectives.

Both Local Authorities are members of the JUCD Board and have been fully engaged in the STP to date, in addition have leadership roles at Place level and are SROs for specific workstreams. We expect these relationships to mature further as we continue on our journey towards an Integrated Care System.

We are actively engaging with broader representatives in relation to our plan. We intend to develop our approach in relation to the wider determinants of health and have progressed collaborative working with partners in areas such as housing, air pollution, fire services etc. We will also continue to discuss the plan with both Health and Wellbeing Boards and Health Scrutiny.

Our eight Places and Primary Care Networks will increasingly take a leadership role and will be integral in delivering our model of care.

Healthcare research is a core part of the NHS; JUCD recognises that in order to achieve the highest standards of excellence and professionalism, it is essential to promote, conduct and use research findings to improve health for both the current and future populations. We are actively involved in promoting research and innovation within our individuals organisations and will continue to spread the approach across boundaries as we move forward.

In addition we are working closely with partners beyond our footprint, including Public Health, Health & Justice, and Specialised commissioning and tertiary services to consider population health improvements at a local level for example Nottinghamshire ICS in relation to the development of the National Rehabilitation Centre.

Journey So Far (2)

Whilst we recognise there is a lot more to be done; since the publication of our STP Plan in October 2016 we have made significant progress which provides a solid foundation going forward…

We set out some bold ambitions in our 2016 plan including that we would:

- *Achieve a financially sustainable system*
- *Significantly change the 'shape' of the system:*
  - More care delivered through Place (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings
  - Major changes to the workforce – 2,500 more staff delivering place-based care (c.10% of our current workforce)
  - Reduction of bed-based care – 535 fewer beds
  - And, changes to the physical configuration of place-based services

In response we have:

- Remodelled our bed requirements and recognised that our position has now changed, confirming that a reduction of 535 beds is no longer feasible
- Delivered a major transformation programme; Better Care Closer to Home in the North which has resulted in a reduction in Pathway 3 beds and resources converted into providing additional Pathway 1 and Pathway 2 capacity and additional staff for both Pathways 3 and 2 to provide equitable staffing across the pathways
- Established " Joined Up Careers" a collaborative system approach to recruitment, retention and development
- Established a specialist inpatient OPMH Centre of Excellence (Walton Hospital)
- Established Community Dementia Rapid Response Teams to work across each of the eight communities; supporting Place based care for older people with mental ill health rather than traditional inpatient bedded care
- Lung cancer diagnostics (molecular testing) have reduced from a 22 day test result turnaround down to 6 days
- Derbyshire wide Faecal Immunochemical Testing (FIT) for colorectal cancer to speed up early diagnosis implemented
- Place based integrated care teams including general practice, community, fire and voluntary services, housing and social care established to support people in their own communities
- Intensive Home Support service for children and young people in mental health crisis has led to a reduction in use of in-patient beds
- More efficient use of our emergency departments with GP streaming, and an enhanced emergency department 'pit stop' at Chesterfield Royal Hospital
- More than 3,700 online holistic wellbeing assessments have been completed in Derbyshire, helping to prevent ill-health
- 100% coverage across Derbyshire for extended access to GP practices, leading to 108,264 additional GP appointments available a year
- A reduction in the stillbirth rate, exceeding the local target of 4.79 stillbirths per 1,000 birth set for 2019
- Access and recovery rates for Improving Access to Psychological Therapies (IAPT) are above national average
- 1,422 members of the health, social care and voluntary sector have completed online delirium awareness training
- We have established a Derbyshire-wide aging well programme which was previously referred to as our Frailty Model. Implementation of this model of care has been recognised nationally as an example of best practice
- A Clinical Assessment Triage Service for MSK has been implemented across Derbyshire
- 6 sites have been sold c£20m disposal value

By working more closely together over the past 3 years, we have developed a better understanding of the services offered already, where gaps might be, and what changes should be considered to offer everyone the best care, now and in future; using all available resources to maximum effect. This understanding balanced alongside the LTP commitments have enabled us to challenge our assumptions and recognise that some of our original ambitions need to change as we move forward. Joined Up Care Derbyshire is therefore in a strong position to accelerate plans and implementation to achieve the desired outcomes for our population.

Challenges and lessons learnt

Whilst we have delivered real change, there have been challenges along the way and it is important that as a system we learn from these challenges as it will affect the way in which we succeed in delivery of our plan going forward. The following table demonstrates some of the key lessons learnt. This is based on feedback received directly from within the system, from individuals implementing transformational change and also recognising the change in the environment in which we are now operating.

Lessons Learnt
Capacity and Resourcing: • Delivering the scale and pace required for transformation programmes requires capacity to deliver • Dedicated Clinical Leadership is required to ensure clinical credibility in our plans
Communication and Wider Relationships: • Stronger system wide communication and engagement, so everyone is moving in the same direction • Effective system working - needs to be based on solid, open communication across all levels.
Finance and Contracting: • There is a need to establish a single system control total. • We must continue to move away from a focus on short-term, organisational level transactional savings plans and adopt behaviours which enable larger/ longer term transformation and system savings • We need to consider alternative contracting mechanisms which better support the model of care which we are trying to achieve
Workforce: • We need radical change to our workforce; to build resilience and to enable greater flexible working practices

These lessons learned have informed our approach to the refresh of our plan and more importantly the way we organise ourselves as we move towards becoming an Integrated Care System (ICS).

Case for Change: Overview of the Joined Up Care Derbyshire Footprint

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the county…

Demography and Diversity

- As at April 2019, our registered population was 1.05 million people
- By 2033, a quarter of the population will be 65+ years (275,000 people)
- Over the next 5 years, the number of people aged 75+ years is expected to increase by around 23% to more than 116,000
- High deprivation in Derby and the North East contrasts with affluence in the Dales and South West
- Dense urban communities in Derby and North East; rural comparatively isolated communities in the North and West; smaller urban centres a mix of more affluent market towns and more deprived ex-mining areas
- Rich cultural mix across Derby City; 97.5% White British in the County

Our plan must be flexible to meet diverse needs – in relation to both geography and population. To achieve consistent quality we must not take a 'one size fits all' approach.

Derbyshire STP with Places, showing Acute and Community Hospitals and DCC P2 Establishments

A wide range of health and care commissioners & providers

The statutory organisations within Derbyshire are:

- NHS Derby and Derbyshire Clinical Commissioning Group (CCG), two local authorities (Derby City, Derbyshire County, Borough and District Councils), Regional NHS England and Improvement
- Two acute Foundation Trusts in Derby (University Hospitals Derby and Burton) and in Chesterfield (Chesterfield Royal Hospital)
- One community Foundation Trust (Derbyshire Community Health)
- One mental health and wellbeing Foundation Trust (Derbyshire Healthcare)
- 115 GP practices (reg. pop. ranges (2-25k) forming 15 Primary Care Networks, plus one Out of Hours provider
- Residential and care home providers
- Ambulance Trust – East Midlands-wide
- Multiple voluntary and independent sector organisations

Our plan must provide a common framework – and, importantly, aligned incentives - for us to work together.

Health of our population

- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving. The national average is 79.5 years and 83.1 years for men and women; in Derbyshire this is 79 years and 82.8 years respectively.
- The gap in healthy life expectancy between the most and least deprived areas is approximately 19 years and 14 years in City and County respectively
- The rate of infant mortality is gradually worsening; in Derby it is significantly higher than the national average. Premature mortality rates, for example, from cardiovascular disease, liver disease and respiratory disease in Derby and parts of Derbyshire are significantly worse than the national average
- Around two thirds of our adult population are estimated to be overweight or obese, significantly higher than the national average (Derbyshire County: 63.8%, Derby City: 65.1%, England: 61.3%)
- 15.7% of mothers are recorded as smoking at time of delivery, significantly higher than the national average of 10.8% and more than double the national ambition of 6% or less
- Around 40% of people diagnosed with Type 2 diabetes did not receive all 8 care treatment processes in 2017/18

Our plan must be both realistic about the challenges we face, and ambitious in tackling them – particularly in addressing the causes of ill health to slow future increases in demand.

'Out of county' healthcare provision

- Significant patient flows to acute hospitals in Sheffield, Nottingham, Mansfield, Burton and Stockport
- Specialist/tertiary care is provided from Sheffield and Nottingham

Our plan must be sensitive to reflect the current flows between Derbyshire and neighbouring footprints.

Health and care spending

We have used agreed growth rates for all services across the system to provide estimates of the costs of NHS treatment and care for 2020/21 to 2023/24.

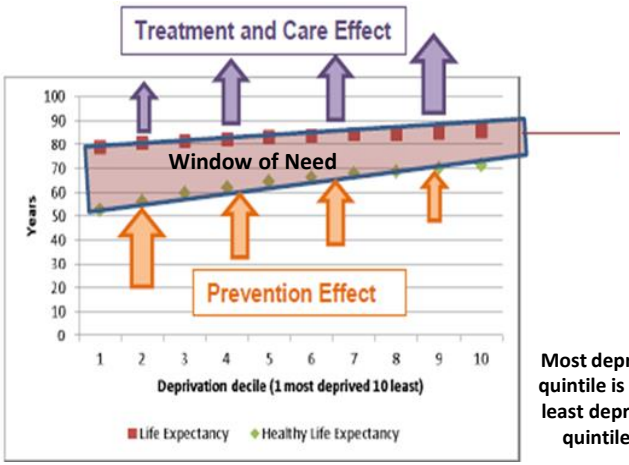
These estimates generate a need for NHS savings of £127m, £81m, £68m and £55m between 2020/21 to 2023/24. This assumes delivery of the 2019/20 Derbyshire system control total and does not model any potential shortfall in social care provision and commensurate need for savings.

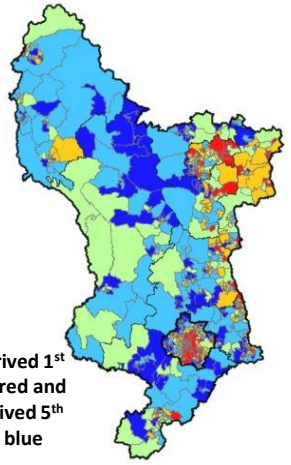
We will further develop the mitigations within this plan and their impact inside and outside of our footprint, where those providers cross a number of STP/ ICS boundaries.
Our plan must tackle and address the forecast growth in health and care service demand.

Case for Change: Improving the health of the population

Fundamentally we know that across Derbyshire people are living longer in ill health and significant inequalities exist…

More people in Derbyshire are living longer in poor health due to a combination of increasing life expectancy and decreasing healthy life expectancy and persisting inequalities. The period in people's lives when they require health and social care support, the 'Window of Need', is steadily rising. We also know there are marked inequalities in healthy life expectancy. People who live in the more deprived communities in the footprint or are part of certain groups such as those with severe and enduring mental health or learning disabilities spend more of their lives in ill health.





Most deprived 1st quintile is red and least deprived 5th quintile blue

We are in the worst quartile of STP areas for key indicators of preventing disease (e.g. the number of mothers smoking at time of delivery) and reducing the impact of established disease (e.g. the number of diabetes patients to achieve all three NICE recommended treatment targets). Lifestyle risk factors such as smoking, physical inactivity and poor diet is more prevalent in our deprived communities. There are currently 49,500 unidentified cases of hypertension across the Derbyshire footprint.

26% and 45% cases of hypertension are due to obesity in men and women respectively

There is increasing evidence of the importance of emotional health and wellbeing in early years. Having the best start in life has a major impact on health and life chances, as children and adults, so early intervention and prevention can significantly improve population health and reduce inequalities. Deprived communities have greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. These wider determinants of health underpin lifestyle risk factors such as smoking, physical inactivity and poor diet, which are most prevalent in these communities.

The table below shows the variation in lifestyle and behaviour between our most and least deprived areas. Almost all are notably higher in the deprived communities.

Averages of MSOA rates	10% most deprived	STP average	10% least deprived	England average
Binge drinking adults (%)	18.9	20.8	19.6	20.0
Healthy eating adults (%)	23.2	28.2	36.0	28.7
Obese adults (%)	26.5	24.9	20.7	24.1
Obese Children (Reception) (%)	10.4	8.4	5.8	9.3
Obese Children (Year 6) (%)	23.9	18.0	13.6	19.3
Regular smoker (Age 15) (%)	10.0	9.5	7.3	8.9
Deliveries to teenage mothers (%)*	2.2	1.0	0.0	1.1
Teenage Conceptions (rate per 1,000)*	41.7	24.4	15.4	20.0

*affected by suppressed values

It is known that a small proportion of the population accounts for a high proportion of use of health and social care resources as people are living longer with ongoing needs and increased risk of developing one or more chronic conditions. Lifestyle factors are also contributing to a rise in long-term conditions among younger people.

Men and women living in deprived areas are 4.5 and 3.9 times more likely to die from an avoidable cause compared with those living in the least deprived areas respectively

Case for Change: Improving the health of the population: Derbyshire Places

Bolsover and North East Derbyshire

Bolsover: Population ↑ 2.3% next 5 years, 75+ years ↑ to 8.5K. High deprivation, significantly lower average weekly earnings, significantly higher premature mortality and significantly lower overall life expectancy. However, the self-rated happiness score is highest in the county.

NE Derbyshire: Population ↑ 1.4% next 5 years, 75+ years ↑ to 14K. Largely rural and prosperous area but pockets of deprivation in and around Clay Cross and Grassmoor. 6.6% ESA claimants. Highest adult excess weight in county. Significantly higher rates of hospital admissions for self harm and alcohol.

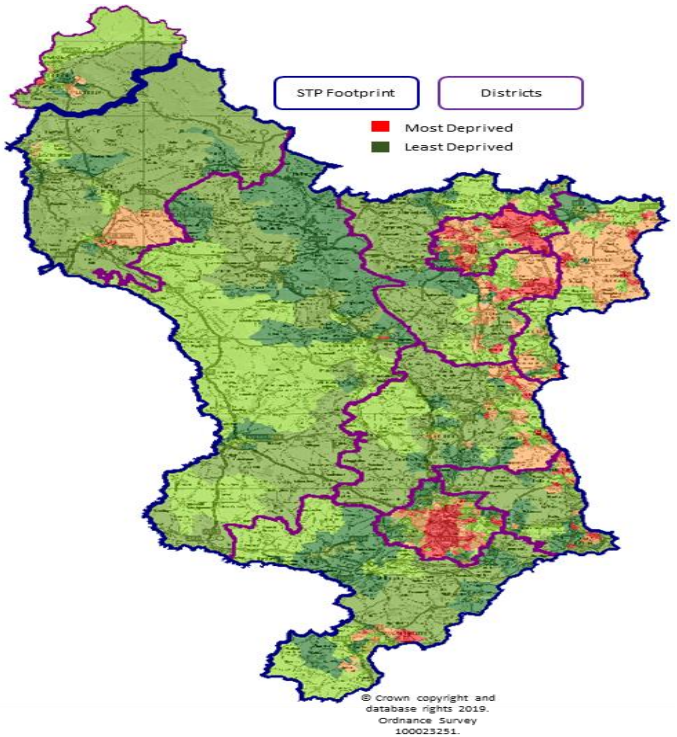
High Peak Population ↑ 0.9% next 5 years, 75+ years ↑ to 10.5K. Sparsely populated areas reflected in above average travel times to key services. Generally better than or similar to England, but alcohol specific hospital admissions remain significantly higher than average. The gap in employment for people with a long-term condition is in the highest 20% in England.

A more detailed breakdown across each of our areas can be found at Appendix 1

South Derbyshire Population ↑ 4.3% next 5 years, Two thirds of the population are working age, but the number 65+ will increase by 12% to 21.6K. Relative job density is low and it is the only county district with a significantly higher rate of homelessness. Female life expectancy is significantly below average.

'Double jeopardy'; we know that far shorter lives are spent in far poorer health in the most deprived areas . Much of the increasing demand for health and care services is for treatment of preventable conditions.

Men and women living in deprived areas are 4.5 and 3.9 times more likely to die from an avoidable cause compared with those living in the least deprived areas respectively



The life expectancy of someone living in Derbyshire Dales is three to four years longer than someone living in Bolsover.

There is up to a 10-year gap in life expectancy in different parts of Derby (between Allestree and Arboretum).

Chesterfield Population ↑ 0.9% next 5 years, 75+ years ↑ to 12K. Clear areas of high deprivation throughout the district. 8% of people claiming employment support benefits and 20% of children in low income families. Average life expectancy significantly lower for men and women. Premature mortality from CVD highest in the county.

Derbyshire Dales Population ↑ 0.6% in 5 years, 75+ increase to 11K, around 15% of total population. Though a largely prosperous area, the older population, rurality, inaccessibility to key services and hidden pockets of deprivation present their own challenges.

Amber Valley Population ↑ 1.9% next 5 years, 75+ years ↑ to 15.5K. Deprivation in and around Alfreton, Somercotes, Ripley and Heanor reflected in stark inequalities in average life expectancy. Gap in life expectancy for females is in the highest 20% nationally. Smoking significantly higher in both R&M occupations and pregnant women.

Derby City Population 26% 16-34 years. Population ↑ 2% next 5 years, 75+ years ↑ to 23K. Around a quarter of the population from BME groups. Significant areas of deprivation in and around the city centre and higher proportions of children in lower income families and ESA claimants. Significantly lower life expectancy and higher premature mortality from CVD and respiratory disease. Smoking prevalence, alcohol and self-harm admissions all worse than average.

Erewash Population ↑ 2.4% next 5 years, 75+ years ↑ to 13K. Deprivation exists around the 2 towns of Ilkeston and Long Eaton. Job density is relatively low for an area with a younger population. 18% of women are smoking at time of delivery, and a quarter of 4-5 year olds are overweight/obese. Self harm admissions are significantly higher.

Case for Change: Improving experience of care (quality & satisfaction)

80% of a persons good health is influenced by social, behavioural and environmental factors as set out previously; 20% of health outcomes are determined by level of access and quality of care received. We have made significant progress in 'joining up care'; however, many opportunities remain to integrate care more effectively and consistently…

Why do we need to change?

The lack of joined up care results in…

Services which are not integrated effectively:

- Fundamentally, our health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care). These services are often characterised by organisation and role boundaries, not a system that is centred on people and communities.
- Individuals and teams do not yet work in a fully integrated way and are often conflicted and constrained by organisational priorities.
- Our services are struggling to meet the increasing demand for ongoing complex care (social, physical and mental) the way they are currently delivered.
- People with such needs often experience care that:
  (i) does not support their independence and control;
  (ii) is fragmented and difficult to navigate;
  (iii) results in a poor quality of life for both the patients and their carers.

Care is not proactive:

- We do not routinely and systematically identify and support people with complex ongoing needs.
- Mechanisms for information sharing, care planning and care coordination are generally ineffective.
- There are occasions where harm could be prevented for vulnerable people (e.g. pressure ulcer and falls)

Frail elderly patients decompensate:

- Elderly patients sometimes spend too long in bed-based care (acute and community) causing physical, psychological, cognitive and social deconditioning resulting in lost independence.

Our system being overly reliant on bed-based care…

Patients are not supported to be independent:

- Derbyshire is an outlier for numbers of people admitted to care homes, key drivers are long-term stays and overprescribing of care home use on discharge from hospital.
- We have made improvements with Better Care Closer to Home in North Derbyshire but too many people with dementia continue to be hospitalised particularly in the south of the county which can have negative impacts on both physical and mental health, making a return home difficult.
- Reported 'Delayed Transfers of Care' performance is in line with the standard and the Derbyshire System remains in the top quartile nationally. However, local experience highlights flow and discharge issues.

We don't always provide care in the right settings or give people alternative ways to access information about care…

- Patients being admitted to hospital when they could be cared for in alternative, more appropriate ways if the necessary services were available. This includes care for our frail elderly patients but also ambulatory care for acute conditions (in particular UTIs and pneumonia) and chronic conditions (in particular CVD and Respiratory).
- Poor access to services which would prevent crisis and exacerbation
- Within Derbyshire, 45% of all deaths occurred in hospital (PHE, Fingertips 2017 data) a significant proportion of these will be individuals on our palliative/supportive care registers
- There is no single record of an individual's health and care that is accessible to the person and care professionals in the system.
- Use of telehealth and telecare to support people, particularly those with long- term conditions, is still embryonic.
- Individuals are often provided prescriptions and interventions with limited health education and implementation support. Lack of follow-through on provider recommendations is a key contributor to negative health outcomes

What does this mean for our services and our people?

We are not consistently providing the right services, in the right place at the right time…

Urgent & Emergency Care

- An inconsistent integrated urgent care offer 7 days a week In Derbyshire's most rural areas MIUs are not fully utilised; there are uncoordinated points of delivery, inequitable access and limited integration which results in confusion with A&E departments remaining the default.
- System 4 hour wait A&E performance as at July 2019 is 84.1% , with A&E attendances at CRH increasing by 9% and UHDB 7% year on year
- Reliance on acute and community (health and social care) beds placing patient safety at risk as alternatives are not clear, easy to access or responsive and integrated.

Cancer

- Inconsistent delivery of Cancer waiting times standards
- Around 79% of deaths from lung cancer and COPD can be attributed to smoking; estimated that 43% of people with a mental illness smoke

Mental Health

- Overreliance on bed based care; the Length of Stay in Derbyshire acute beds is around 45 days compared to a national average of 32, which is above the 85% threshold
- There is a high reliance on admission for older adults due to lack of crisis intervention services.
- Adults requiring acute, Psychiatric Intensive Care Units (PICU) and rehabilitation services continue to be treated out of Derbyshire
- Mental health hospital admission rates per 100,000 are higher than the England average; as are emergency hospital admission for self–harm.
- Disjointed community pathways for individuals with severe functional presentations often outside of 'Place' still exist and there is inequity in provision across the county.

Planned Care

- Meeting RTTs in some specialties for example urology, lung and Gynae
- Contacts with secondary care are not always valuable.
- Elective services largely delivered within acute hospital.
- Over 25% of surgical interventions are considered unnecessary due to a lack of end-to-end integration.

Learning Disabilities & Autism

- People with a learning disability and/or autism in Derbyshire are more likely than the national average to be receiving care in inpatient settings.
- More likely to also suffer with physical health problems such as epilepsy, hypothyroidism, diabetes, heart failure, chronic kidney disease or stroke.
- Less likely to receive cancer screening.
- Are more likely to be obese between the age of 18-35 and more likely to be underweight once they are over 64.

Children & Young People

- Services focus heavily on provision rather than on enabling children, young people and families to respond to their own needs.
- High-cost placements for vulnerable groups create pressure on provision.
- Inconsistent support for children with SEND

Condition Specific:

- Lack of preventative interventions which avoid late diagnosis and sub-optimal management

Primary Care:

- Variation in screening, early diagnosis and chronic disease management , means impact on quality of life, independence and life expectancy.
- Quick access to see GPs varies

Workforce

- We have an aging general practice workforce
- Our workforce is not as adaptable and resilient as needed to cope with increasing demand, expectations and increasing clinical needs

Case for Change: Reducing the per capita cost of healthcare

The Derbyshire system is collectively spending greater resources compared to our allocations year on year. We recognise there are significant material financial challenges which will continue into future years. If we are to meet the increasing demand identified in our case for change we will need to continue working together collectively to address these challenges…

System Efficiency Target

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
NHS Derby and Derbyshire CCG	69,500	55,855	63,319	48,105	34,936	25,380
Chesterfield Royal Hospital NHS FT	9,831	9,831	2,937	2,977	3,507	3,540
Derbyshire Community Healthcare Trust	6,082	6,130	5,565	2,880	3,986	3,925
Derbyshire Healthcare NHS FT	4,599	4,595	6,770	1,614	1,847	1,893
East Midlands Ambulance Service	4,647	4,647	5,560	5,020	5,410	4,610
University Hospitals of Derby and Burton NHS FT	56,300	31,000	43,230	20,614	18,385	16,117
	150,959	**112,058**	**127,381**	**81,211**	**68,071**	**55,465**

Capital Expenditure Plans

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
NHS Derby and Derbyshire CCG	2,158	2,158	1,873	1,880	2,179	1,894
Chesterfield Royal Hospital NHS FT	14,608	14,608	23,673	12,586	8,338	5,000
Derbyshire Community Healthcare Trust	9,312	8,393	14,365	19,234	12,537	5,669
Derbyshire Healthcare NHS FT	5,564	5,564	18,500	5,800	4,500	4,500
East Midlands Ambulance Service	8,331	8,331	9,739	10,694	11,690	11,188
University Hospitals of Derby and Burton NHS FT	61,566	48,590	83,818	125,527	83,090	50,493
	101,539	**87,644**	**151,968**	**175,721**	**122,334**	**78,744**

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
CCG Recurrent Allocation	1,622,446	1,621,048	1,678,594	1,722,139	1,785,079	1,846,908

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Recurrent	132,193	96,076	68,226	49,526	49,555	46,505
Non Recurrent	18,766	15,982	59,155	31,685	18,516	8,960
Total Efficiency Target	**150,959**	**112,058**	**127,381**	**81,211**	**68,071**	**55,465**
% of CCG Allocation	**9.3%**	**6.9%**	**7.6%**	**4.7%**	**3.8%**	**3.0%**

The financial modelling for the long term plan, starts with an assumption around the delivery of the 2019/20 Derbyshire system control total. This is a key risk and sensitivity to the model. If we are unable to deliver £151m in 2019/20, 2020/21 and beyond will be more challenging by the shortfall.

Activity growth rates have been modelled and agreed with all the NHS statutory bodies, including mental health, community services and ambulance services; these create the unmitigated overall savings challenge for 2020/21 to 2023/24 - £127m, £81m, £68m and £55m . We have used commissioner spend as a proxy for system marginal costs which looks broadly reasonable on review. This has generated a broadly triangulated, activity, workforce and financial model, pre the required transformational changes.

We have made significant progress in modelling the impact of the transformation deliverables described in this plan, to generate a mitigated, agreed and triangulated position; the greatest impact of which has been identified in relation to changes to planned care, urgent & emergency care and Place. We have assumed that the growth rates in the unmitigated model can be fully addressed through the transformation associated with plan deliverables, which is also a key sensitivity and risk in our model.

The agreed position includes demonstration of our commitment to allocating the additional LTP investment funding in relation to specified key deliverables. We are continuing to work towards developing a firmer view on the 2019/20 savings sensitivity. These savings are modelled in the table above and in the strategic planning workbook. In terms of the status of the mitigation the system believes it can consume the provider CIP requirement listed above, via the delivery of reduced unit costs for the existing models of care, but this is again challenging and a key risk.

Case for Change: Improving staff experience and resilience

To genuinely deliver 21st century integrated care, will require growth in our workforce, transformation in the roles and ways of working. We need to make the health and care system a better place to work to be able to recruit and retain the staff we need…

Recruitment and attraction

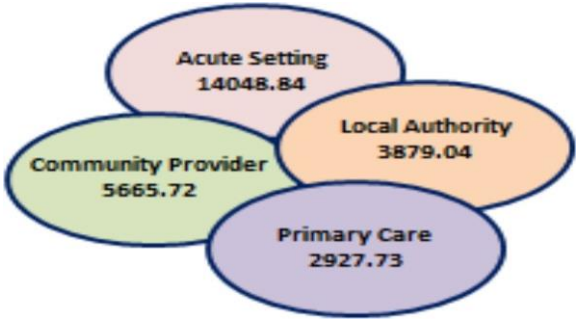
In health and care, we operate in multiple labour markets for different types of staff. In Derbyshire, employment is at 79%, compared to 76% nationally with the number of vacancies steadily increasing across all sectors, so we have to rethink how we can attract people into health and care, to develop and support our people and make the health and care system a great place to work. For those roles where we operate in regional and national labour markets, we need to develop a strong brand awareness to present Derbyshire as a great place to live and work to keep students who train here and attract from elsewhere. There are particular national shortages in doctors in psychiatry and learning disabilities which impact on our area.

The Long term Plan envisages 20,000 more staff working in Primary Care Networks, 6,500 more staff in children and young peoples mental health services, 25,000 more staff in mental health services, 4000 more staff to support faster diagnosis and treatment and 10,000 more community staff to support the ageing population. We need to identify what our contribution towards these targets is and to ensure we can recruit and retain those staff.

Transforming the way in which staff work

'There is a shortage of key clinical roles and increasing demand for NHS services. Care is increasingly delivered in the community, and our staff are treating a wider range of clinical conditions and in ever more complex environments.'
DCHS Clinical Strategy 2019

Out of a current total health and care workforce of 19,625 (contracted available FTE), 14, 048 work in an acute setting. As the expected growth in workforce is predominantly expected to be in community and non bedded care settings, this presents a big challenge in terms of shifting staff into different settings, and working alongside a more diverse team from health, care and the voluntary sector. We can also expect significant developments in technology which will mean many tasks become automated, significantly changing the content of established jobs.



Changing the skill mix and introducing new roles

Many of our services are run on a traditional medical model, particularly in General Practice and Mental Health and LD and some acute specialties. Shortages in GP's and consultants due to changes in training numbers mean that we need to develop new roles to operate in holistic, multi disciplinary teams. Roles such as Advanced Practitioners take a number of years to train, and require similar levels of supervision and assessment to medics which is currently not funded. Other roles such as Physicians Associates are not currently trained in Derby, so we do not have a supply pipeline, and they also require significant post qualification training which is not currently funded.

We need to maintain our supply of nurses through a number of routes, a key one will be Trainee Nursing Associates, but we are constrained by the number of clinical placements in the system, particularly in the Private, Voluntary and Independent (PVI) sector and General Practice

Even in the best-performing health care organisations, staff burnout has a direct negative effect on the experience of care for the patient. There's also a correlation between high levels of staff engagement and high level of patient engagement. Staff are much more likely to be enthusiastic and positive about securing the best outcomes for patients when they feel supported, empowered, and respected.' Institute for Healthcare Improvement.

Making the NHS a great place to work

Our levels of employee satisfaction and indicators such as absence and turnover are similar in comparison with other health and care employers e.g.

	Range in Derbyshire NHS Trusts	Comparator
Sickness absence	4.27% - 5.9%	NHS East Midlands 4.40%
Turnover	9.42% - 10.52%	NHS Midlands & East 13%

There is more we can do to improve the staff experience by supporting and developing our staff. In particular we need to focus on the health and wellbeing of our staff and make it easier for staff to progress their careers by reaching their full potential along less linear professional and organisational boundaries, we need to modernise our offer for the future workforce including more flexible working patterns to appeal to generation X and Y , and we need to promote greater diversity and inclusion by ensuring all our organisations have a positive, person centred leadership culture. We are developing a system workforce dashboard to enable us to identify risks and opportunities across the whole health and care workforce and measure the impact of changes we introduce.

Our Strategic Priorities

*To deliver our vision for people to have **the best start in life, to stay well, age well and die well**, and address the challenges identified in our case for change (quadruple aim), requires major changes to the way care is provided and the way in which we are organised…*

As set out earlier in this document the agreed Derbyshire model of care remains valid and will provide the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes. Enabling the 'left shift', to deliver a new service model for the 21st century, will be underpinned by five interdependent strategic priorities:

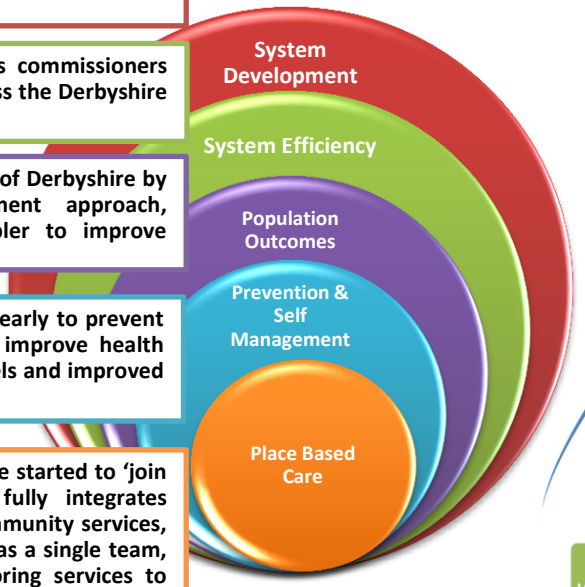
We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

We will ensure ongoing efficiency improvements across commissioners and providers are a key component of ensuring we address the Derbyshire financial challenge

We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes

By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand

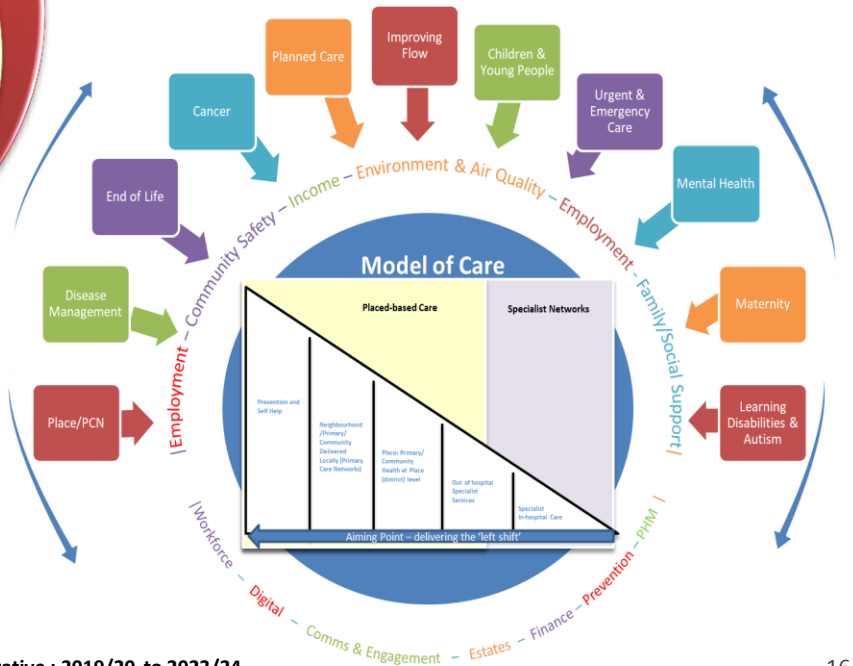
We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. So that services operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 places and 15 Primary Care Networks



Our strategic priorities enable delivery of the commitments set out in the NHS LTP. For the purpose of this five year Strategy Delivery Plan , some of the core elements, set out as 'foundational commitments' in the NHS LTP are described within our strategic priorities; namely our approach to place based care, prevention and self-management and system development. Whilst these are delivered as a whole they are also embedded within more specific programmes of work, described later in this document. Furthermore, our model of care is based on delivering more personalised care which is also embedded within our programmes of work.

We are organised into key programme areas alongside enabler programmes designed to deliver our priorities, as set out in the diagram below. The workstreams are fully aligned to the LTP commitments and framed around delivering the agreed model of care for Derbyshire. This five year plan therefore describes our approach based on these key programme areas and is structured to demonstrate the commitments in the LTP and interdependencies between programmes of work.

Joined Up Care Derbyshire Programme Areas



Strategic Priority: Delivering transformed out of hospital care through fully integrated place based care

We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 Places and 15 Primary Care Networks…

To meet the changing needs of our population (growing demand for ongoing complex care – social, physical and mental) and make our system sustainable, we will continue with our approach to make a transformational shift from fragmented care based around institutions and beds, to coordinated community based care wrapped around people and communities; ensuring our hospitals and specialist providers deliver the specialist care only they can.

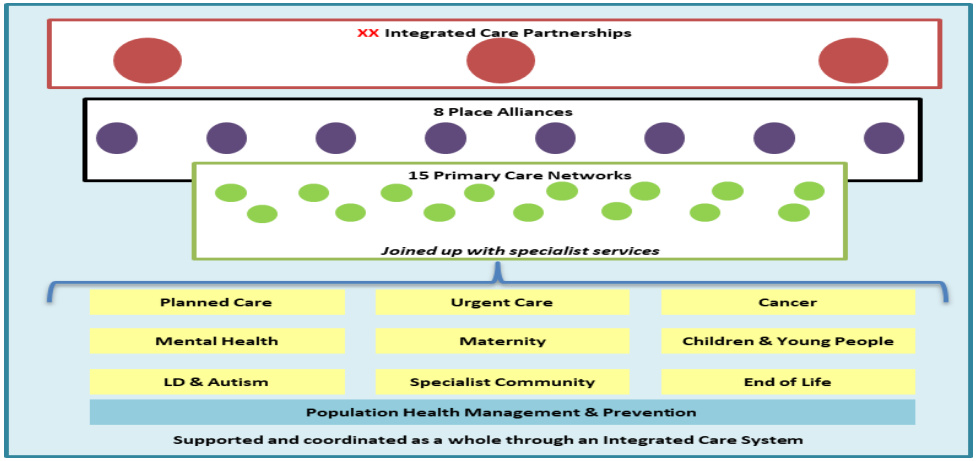
The Derbyshire Model of Care is essentially designed to deliver more localised place based care, whereby we will keep people:

- ***Safe & healthy*** *– free from crisis and exacerbation.*
- ***At home*** *– out of social and healthcare beds.*
- ***Independent*** *– managing with minimum support.*

…which will be founded on building strong, vibrant communities.

We have already established 8 Places across Derbyshire which have been focused on developing care closer to home and integrating services in the community, through multidisciplinary teams/ approaches to anticipatory care, which include housing and the fire service for example.

This is a journey which will evolve as our system architecture develops. Fundamentally our model of care will underpin our approach across each of our strategic priorities and enable delivery of the commitments for each of our programmes of work, as described below.



Personalised Care

To achieve the 'step change' in preventing ill health and supporting people to live healthier lives; delivery of our model of care will enable a cultural shift for health and care professionals, to promote 'wellness' in the public and patients in developing the confidence to self-manage and take a lead role in decisions about their health. This will be at the heart of delivery within our Places/ Primary Care Networks, with personalised care in the broader sense embedded throughout. Our approach is described further in the prevention strategic priority section which follows.

By 2023/24 we are committed to the implementation of The NHS Comprehensive Model for Personalised Care's 6 principles; namely shared decision making, personalised care and support planning, enabling choice, social prescribing, supported self-management, personal health budgets and integrated personal budgets across the NHS and the wider health and care system. Specifically:

Principle	Commitment
Personal Health Budgets	• Derbyshire has a commitment to achieve 3,240 PHB's by 2023/24. • PHB as default in Continuing Healthcare (Domiciliary), continuing care (children) and Wheelchair budgets are already implemented in Derbyshire. • There will be an NHSE accelerated roll out of 'legal right to have' e.g. for people with entitlement to Section 117 aftercare (mental health).
Social Prescribing (SP)	• Derbyshire has a commitment to achieve 16,419 referrals to SP by 2023/24 and provide SP link workers to meet this need via PCNs • SPs will be embedded within Derbyshire PCNs through the Network Contract Direct Enhanced Service (DES)
Personalised Care and Support Planning (PCSP)	• Derbyshire has a commitment to achieve 18,086 PCSP by 2023/24 • PCSP and its 5 essential criteria will be embedded in 100% of service specifications and care pathways, especially where people have long term conditions or complexity of care. A local CQUIN could support changes in healthcare culture required to meet commitment.
Shared decision making (SDM)	• To become business as usual for healthcare and therefore will be embedded in 30 of Derbyshire's clinical situation service specifications and care pathways.
Enabling choice	• Expansion of choice will include Maternity and End of Life Services therefore this will be embedded in Derbyshire's Maternity Transformation Programme and the End of Life Services Strategic Vision.
Supported self-management	• Derbyshire have a target of 15,393 usage of the NHSE provided Patient Activation Measure (PAM) to identify improved knowledge and skills in people with long term conditions (LTC) via PCN's and LTC care pathways.

We believe that to deliver personalised care effectively will require a universal whole system approach. We will build our approach based on a review undertaken of the key components of personalised care which feature strongly within our programmes of work including examples such as health coaching, peer support and education programmes that support personalised support planning. A summary of how these approaches are embedded within our programmes of work can be found at Appendix 2.

Strategic Priority: Delivering transformed out of hospital care through fully integrated place based care

We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 places and 15 Primary Care Networks..

Primary Care Networks (PCNs)

Central to achieving transformed out of hospital care is primary care. The establishment of our 15 PCNs will be key enablers in delivering our model of place based care. The role of our PCNs is described in our system development strategic priority later in this document; underpinned by the Derbyshire Primary Care strategy (July 2019).

Our PCNs were established in July 2019; each have appointed Clinical Directors to take forward the PCNs and will be equal partners in the ICS development going forward. We will continue to support our PCNs to grow from an embryonic state to mature integrated community care providers and funding has been committed to enable this. PCNs will benefit from the Additional Roles Reimbursement Scheme, which was announced in the 2019 GP Contract Framework. Under this scheme, additional funding will be made available to PCNs for the following five roles:

- 2019/20 Clinical Pharmacist and Social Prescriber
- 2020/21 Physician Associates and First Contact Physiotherapists
- 2021/22 First Contact Community Paramedics

This builds on our positive progress towards our GP Forward View (GPFV) workforce trajectories. Currently, Derbyshire is above target in achieving its GP workforce trajectories, as follows:

	Actual	Actual	Actual	Actual	Forecast Outturn	Plan	Plan	Plan	Plan
Staff Working in General Practice	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
GPs and GP registrars - Total	587	616	581	675	661	661	661	661	661
Registered nursing staff - Total	338	353	353	357	361	361	361	361	361
Direct Patient Care - Total	188	212	206	211	206	206	206	206	206
Admin & Clerical	1287	1279	1282	1312	1,337	1,337	1,337	1,337	1,337

PCNs as part of the Derbyshire Place are now receiving data packs to assist in assessment of local populations at risk and are working with community services to develop approaches for targeted support.

Against the minimum requirements for 'out of hospital care' JUCD is committed to:

Meet the new funding guarantees for primary medical and community health services

- Committed to the continuation of funding currently available non-recurrently to support Extended Access and GP Forward View funding streams, (e.g. practice resilience programme). Additional funding is also included to support the development of Primary Care Networks
- Identified Rapid Diagnostic Centres funding in 2019/20; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams

Support the development of PCNs

- Fully meet the requirements for PCNs and their development

Improve the responsiveness of community health crisis response services to deliver the services within two hours of referral, and reablement care within two days of referral

- Within the Derbyshire STP there are interdependencies with the Urgent Care and Mental Health workstreams. The PCNs have identified key personnel who work directly with these areas to ensure effective development of rapid response teams

Create a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking account of the national phasing of the new five-year GP contract.

- Plans in-place for roll-out of digital services to increase patient access and improve productivity. We are progressing the implementation of online consultations by April 2021, which is a key deliverable in our digital strategy
- In addition to the service requirements, changes in 2020/21 will include the introduction of the Network Dashboard and the Impact and Investment Fund which will complement service requirements. The service specifications will set minimum requirements within the Direct Enhanced Service (DES). The dashboard will include measures of success to allow PCNs to benchmark their performance and monitor their delivery of the five service specifications
- We are committed to investing the Impact and Investment Fund (IIF) to provide additional funding to PCNs and deliver the national service specifications once developed; incentivising PCNs to reduce unwarranted demand on NHS services, including overprescribing and inappropriate A&E attendances. The IIF is expected to commence in April 2020, and will develop over the subsequent four years. Once access measures are confirmed these will be implemented to ensure target is met
- Development of new service models to improve rapid response and greater community offering

Our Places/ PCNs will be central to the delivery of our comprehensive frailty pathway focusing on the Ageing Well programme to support an efficient, high quality, multi-disciplinary response to people who have an urgent need that is best provided in their own home (even if that's a care home).

Enhanced Health in Care Homes (EHCH)

Work is underway to develop the approach in 2019/20 which will be aligned to the national Ageing Well programme and the publication of a maturity matrix for full delivery of the EHCH model . We will commission PCNs to work together to develop, at scale, models of pro-active, integrated care to support care homes residents by:

- Developing models which are integrated into community services
- Ensuring that care is based on a CGA style of care planning that is MDT based, holistic and includes residents wishes / preferences
- Developing and monitoring a set of outcomes consistently across Derbyshire Ensuring that PCNs are well prepared to adopt the new NHS England specification from April 2020

Strategic Priority: Prevention and Self-management

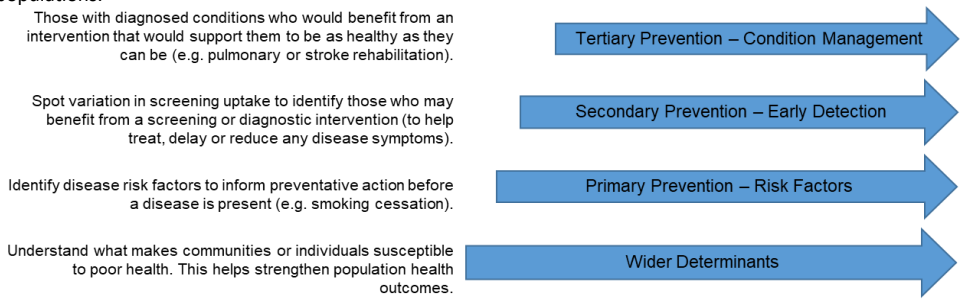
By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand…

Why is this a priority for Joined Up Care Derbyshire?

Our public health challenges are significant, and the widening 'window of need' described in our case for change, means that many people across the county are living longer in ill health, with significant inequalities in life expectancy and Healthy Life Expectancy (HLE) within and between areas in Derby and Derbyshire. We must act now to address these inequalities and move from a system which is focused on solely fixing ill health to a proactive one which enables wellness and reduced dependency.

Our Approach

To address the challenges, our ambition is to embed prevention across all programmes of work and for all organisations to champion the priority by working together to create healthy, resilient communities and populations.



We will continue with our collective commitment (Health and LAs) to develop a systematic approach to prevention at pace and scale by enacting our agreed system wide prevention strategy and delivering the four priority areas:

- Enable people in Derbyshire to live healthy lives
- Build mental health, wellbeing and resilience across the life course
- Empower the Derbyshire population to make healthy lifestyle choices
- Building strong and resilient communities where people are supported to maintain & improve their own wellbeing

In doing so we will:

- Further embed prevention across all workstreams and organisations within JUCD; led by the Prevention Board.
- Ensure additional investment specifically directed for prevention initiatives will be provided to achieve the step-change required, recognising that many benefits (including financial benefits) may take time to realise. These commitments are necessary to ensure a sustainable health and care system into the future.
- Work together to enable a 'whole-pathway' approach to prevention, particularly recognising the role and impact of wider determinants on morbidity, premature mortality, health inequalities and service utilisation. We will embed a comprehensive approach to prevention (primary, secondary, tertiary where appropriate) across all areas of care deliver; for example through promotion of physical exercise and access to green spaces
- Support primary, community and secondary care in the development of pathways that include referral to healthy lifestyle services and community initiatives; so they are applied systematically and delivered at scale to have a level of impact that will reduce the gaps in life expectancy and healthy life expectancy and reduce the demand for health and care services. We will also develop place-based initiatives where appropriate and feasible.
- Work as a system and in conjunction with Public Health England to maximise the opportunities of national and local campaigns aimed to improve health and wellbeing and promote healthy lifestyles through a range of media on a national scale.

Specific interventions include (note many of our approaches are also aligned to our programmes of work):

- Access to wellness services: creation of a network of community venues where local residents can receive information and advice to 'wellness services'
- Falls prevention: (i) Systematic promotion of and signposting to physical activity opportunities across JUCD partners to increase the number of people being active as they approach older age, (ii) referral & signposting to falls prevention services and (iii) implementation of the Derbyshire falls pathway
- Cardiovascular Disease (CVD) Prevention: Determine current prevalence and associated mortality of a range of CVD conditions, and evidence for effective and efficient services
- • Primary care to maximise CVD prevention opportunities across the CVD prevention pathway e.g. AF detection
- Suicide Prevention & Mental health awareness : Embed self-harm and suicide awareness as an organisational priority by recognising key campaigns, sharing information and messages, training all staff and supporting people in more vulnerable groups e.g. people diagnosed with a long-term condition, those with substance misuse issues. Help to build the mental health literacy of the wider workforce and the public challenging stigma and discrimination and promoting positive mental wellbeing
- Healthy Workplaces: Support to employers to develop a positive proactive and responsive approach to mental health and wellbeing in the workplace

Prevention and Place based care

We have a history of delivering preventative activities, however our efforts to prevent ill health have been small scale; we are now in a position to develop a more systematic approach to preventative services. This will be supported by better coordination of preventive efforts through full alignment and integration in our approach to Place based care; described earlier.

Public Health, within Local Authorities, ensure services are in place to support healthy lifestyles. These include a wide range of locality-based services and activities run by the public sector, voluntary and grant aided organisations – all of which have a role in primary and secondary prevention of ill health and support either physical or mental wellbeing. We will build on this through the application of an effective Population Health Management, approach as set out later in this document; so that primary prevention and early intervention is fully embedded in place based care delivery to ensure targeted efforts are developed within our 'wellness system'.

All professionals that come into contact with patients and the wider public will play a critical role in the promotion of healthy choices, healthy environments and resilient communities. We will support staff to feel confident and have the skills and knowledge to have 'quality conversations' with individuals and communities about their opportunities to improve their health and wellbeing .

Furthermore, prevention and proactive identification of patients, combined with risk stratification, and effective care planning will continue to provide the best approach to supporting patients and carers with the most complex needs; enabling them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services.

Strategic Priority: Prevention and Self-management

Derbyshire's public health challenges are significant, and the widening 'window of need' means that many people across the county are living longer in ill health – with the greatest impact in our most deprived communities…

Delivering national priorities - The NHS Long Term Plan provides a renewed focus on prevention, highlighting the need to reduce inequalities and enabling people to stay healthier for longer; setting out the following risk factors as priorities for the prevention agenda; screening and immunisation, smoking, obesity, alcohol, air pollution, anti-microbial resistance (resistance to some anti-biotics). There are also national NHS initiatives that support prevention including Cancer Screening, National Diabetes Prevention programme and NHS Health Checks.

Our strategic approach to the key deliverables set out in the LTP are descried below, with more specific prevention deliverables described later and embedded within our respective programmes of work. Or Prevention Strategy (2018) sets out the vision for 'Derbyshire that champions prevention across all organisations and works together to create healthy, resilient communities and populations'. We aim to eliminate unwarranted variation by working with our partners to identify any health inequalities in our patient population. Together we will develop a detailed and measurable delivery plan with milestones and trajectories for how we will contribute to narrowing the health inequalities gap over the next 5 to 10 years.

Embedding preventative approaches in everything we do, has the potential to make the greatest impact to the overall health and welling of our population, reduce inequalities (geographical and for high risk/use groups) and wider determinants which affect use of our systems finite resources. Staff training will include an awareness of the importance of personalised care and self-management.

Key indicators which will demonstrate our progress can be found in **our Population Outcomes,** which include life expectancy, healthy life expectancy, Emergency admissions due to falls, smoking at time of delivery, population vaccination and screening.

Smoking

We will enable staff, patients and visitors to become smoke-free through:

- Implementing smoke free sites polices, normalising smoke-free
- Provision of pharmacotherapy for inpatients
- Systematic promotion, signposting and referral to stop smoking services will continue and will be built upon to deliver more targeted smoking cessation services in selected sites and smoking cessation services for all inpatients who smoke, pregnant women and users of high risk outpatient services from 2020/21. These will be confirmed in our final submission.

Obesity

We will develop a greater focus on obesity by 'upscaling' support to people who are overweight or obese within a 'whole systems' approach, for example, planning, licencing, access to green space, active travel and policy. JUCD system organisations will be a leader in enabling staff, patients and visitors to be active and eat healthy through:

- Ensuring organisational policies and infrastructure create an environment that enables healthy eating and active travel
- Ensuring weight management services are promoted and signposting/referring into services is systematic, including links to other programme area deliverables such as the diabetes weight management which includes a targeted plan, delivered by a 'Prevention Facilitator' and agreed referral trajectories which contribute to the national Diabetes Prevention Programme to support 525 people through the programme by 2019/20.
- Utilising nationally developed resources such as fitter, better sooner/stop before any surgical interventions.
- Develop a Derbyshire wide Childhood Obesity Strategy, to include treatment service pathways which is coordinated through public health, local authority and health

Alcohol

Alcohol admissions are significant issue for the City and to some degree the County; we have prioritised this in our prevention strategy to enable healthier choices which result in:

- Increased numbers of adults in Derbyshire drinking within the recommended limits
- Decreased rates of alcohol related admissions
- Increased rates of dependent drinkers accessing services

The targeted investment for Alcohol Care Teams (ACTs) from 2020/21 to 2023/24 will also be explored as an option for further development; subject to further national information and requirements to access the funding. We will work closely with the Mental Health Programme to ensure an integrated approach.

Substance Misuse Services across the City and County are currently provided by a partnership led by DHcFT and there are potential opportunities for greater integration into the new models of Adult Community SMI services after April 2021.

Air Pollution

Air pollution is the biggest environmental health risk, contributing to an estimated 530 deaths and 5400 life years lost in Derbyshire County and City. Our vision is to reduce the health impact of poor air quality for the people of Derbyshire. As partners we will use our individual and collective influence as employers, providers and commissioners, to reduce our own contribution to local air pollution, facilitate change, influence others and protect health. We plan to engage through our Air Quality Working Group, to focus on protection from pollution and prevention, specifically for people with long term conditions to raise awareness of triggers. Our key areas of focus being taken forward by the Health and Wellbeing Board include:

- Travel behaviours with partners facilitating sustainable and healthy travel options through healthy eating and active travel policies
- Reducing sources of air pollution
- Proportion of people living in a smoke control zone
- Mitigating the health impacts of air pollution

The Derbyshire Air Quality Working group will be responsible for implementation of the Derbyshire County and Derby City Air Quality Strategy (2020-2030).

Antimicrobial resistance (AMR)

We recognise the threat that AMR has on the effective prevention and treatment of an ever-increasing range of infections. We will establish a system wide AMR steering group, and determine a baseline position from each provider to build upon work undertaken to tackle AMR and related Gram Negative Blood Stream Infection (GNBSI). We will use this forum to fully implement the Governments national action plan 'Tackling Antimicrobial Resistance' to reduce overall antibiotic use, health care associated GNBSI and drug resistant infections.

We will target approaches for high risk populations and areas of high variation, key priorities include:

- Further reducing antimicrobial use in the community, tackling unwarranted clinical variation and outlier prescribers
- Enhancing the role of pharmacists in primary care to review antimicrobial prescriptions working with prescribers to review those that are inappropriate through evidence-based, system-wide interventions.
- Raising public awareness to encourage self-care

Strategic Priority: Population Outcomes

We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach…

Effective Population Health Management (PHM) to improve population outcomes

We recognise that a focus solely on healthcare provision will not solve the significant challenges we face given the relative contribution of other factors to our health. We will therefore further develop our PHM approach to maximise data and intelligence to strengthen our communities so that we:

- Better co-ordinate system wide action to create healthy places
- Improve population health and wellbeing and tackle health inequalities.
- Effectively allocate resources and support service redesign
- Evaluate the impact of interventions and identify system savings
- Understand the population and sub-population need
- Understand the use of, and demand for, services across the health and care system; including where there is variation (warranted and unwarranted)
- Identify best practice, effective interventions and promote innovation

Our Approach

Whilst we have many important elements of a PHM approach already in place, we recognise that we are early in the journey to develop a comprehensive local cross-system PHM function to deliver the appropriate intelligence which effectively supports local planning and decision-making. To achieve this we will prioritise development of the following:

Culture and leadership

- Engaging and supporting change in the system to embed effective PHM.
- Better use of clinical leadership to drive transformation.
- An approach rooted in an understanding of equality and inclusion

Workforce

- Understand and building on, the capacity and capability of the knowledge and intelligence workforce.
- Understand and develop the capability of the wider workforce to effectively engage with and use intelligence and data tools.

Technical & infrastructure

- Relevant data sources and flows and system requirements are required (understanding what we have now and how to get to where we need to).
- Understand the 'products'/ end user(s) needs to enable accessible and meaningful knowledge and intelligence to support effective decisions.

By applying an effective PHM approach, we will develop a broad set of indicators that measure local conditions for wellbeing and whether those conditions are being delivered fairly and sustainably and build on our outcomes based accountability approach described below.

Outcomes Based Accountability (Whole System Outcomes)

The Derbyshire system has agreed to apply an outcomes based accountability approach to ensure everything we do is outcomes led, with multiple accountability across partners as appropriate.

We will continue to develop this approach to ensure shared accountability for delivery of the LTP commitments and our broader approach to improving the health of our population. This approach which will be further enhanced through the development of PHM in Derbyshire to ensure our approach is fully aligned and agreed across all parts of the system, including our local Health & Wellbeing Boards and Local Authority (for instance in relation to Housing, Education, Air Quality).

We have agreed a set out outcome indicators across our existing programmes which are aligned to improvements in our three overarching population outcomes for people to have the best start in life, stay healthy, age well and die well. These indicators are also consistent with the LTP metrics. Our framework is set out on the following pages. By delivering the collective transformation programmes as set out in our plan, we will make real improvements in the health outcomes for the people of Derbyshire.

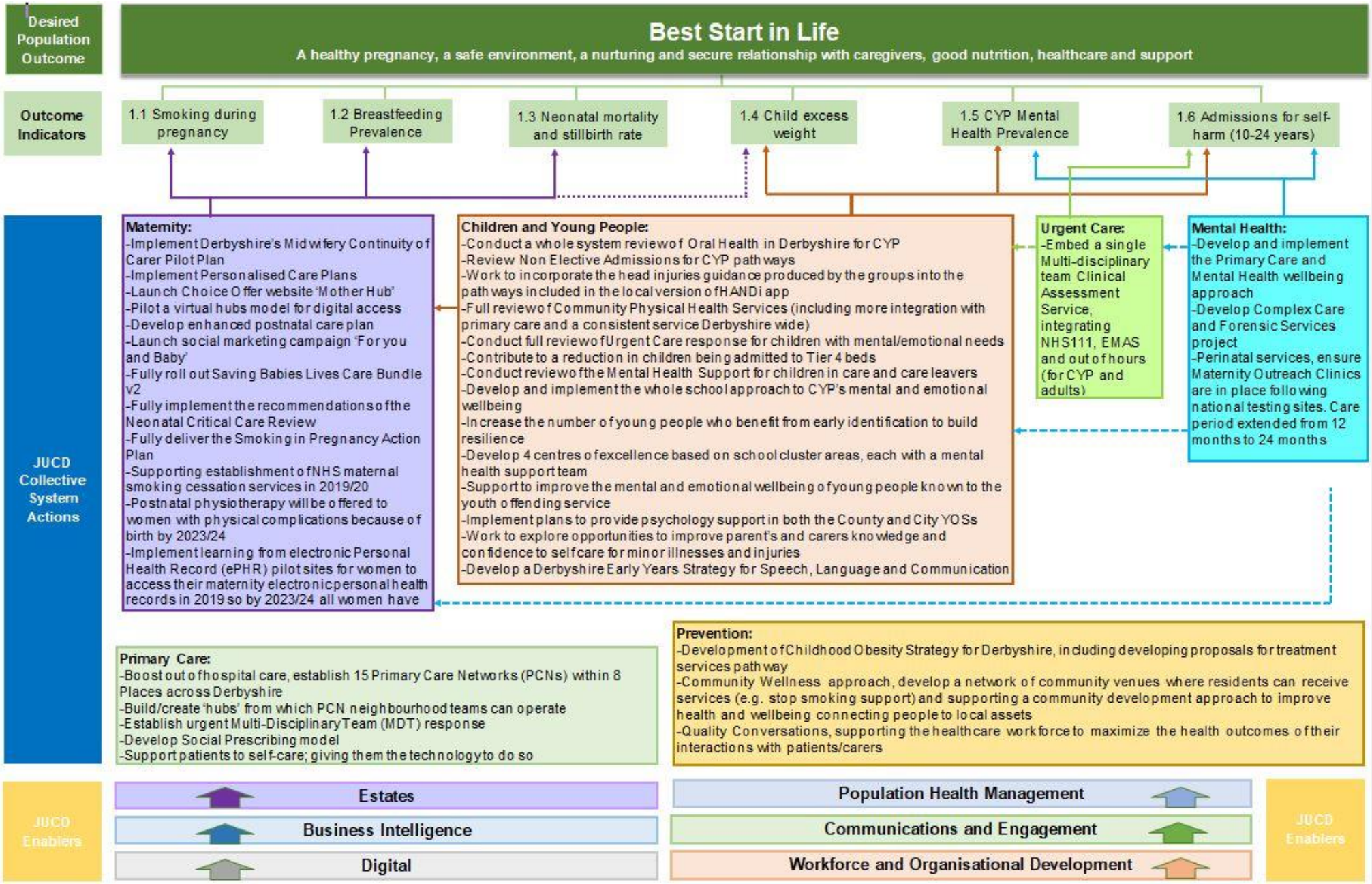
Derbyshire Wide Quality impact Assessment (QIA) tool

We have developed a system wide QIA approach which sets out how interdependencies and impacts across all component parts of our plan will be managed. This process enables quality and equality implications to be considered more effectively; where potentially negative quality impacts are identified either at organisational or cross system level, robust mitigations will be developed collaboratively across system partners.

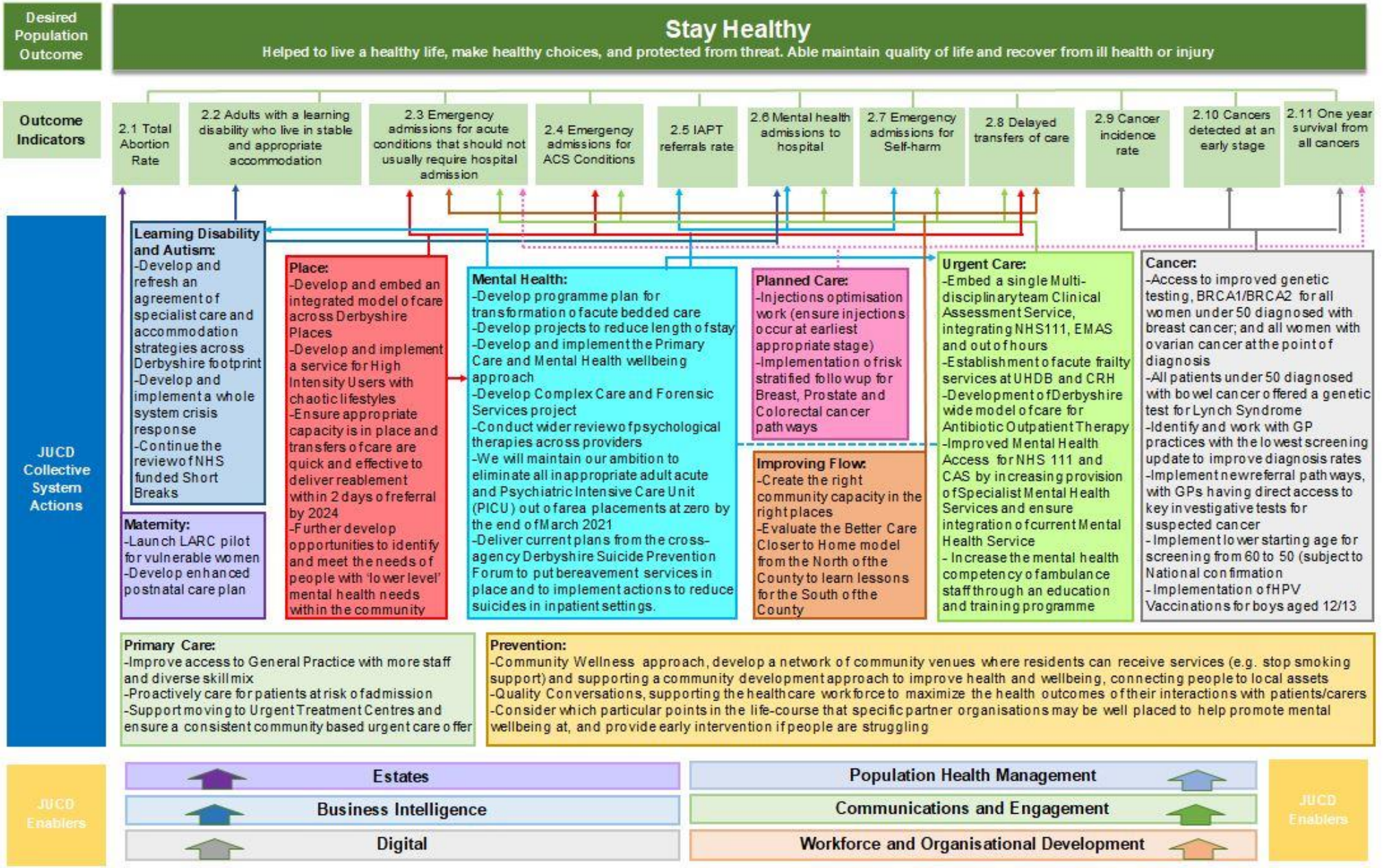
We have identified three quality components which underpin the QIA process:

- Patient Safety – there will be no avoidable harm to patients from the healthcare they receive. This means ensuring that the environment is clean and safe at all time and the harmful events never happen.
- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit.
- Patient Experience – the patient's experience will be at the centre of the organisation's approach to quality.

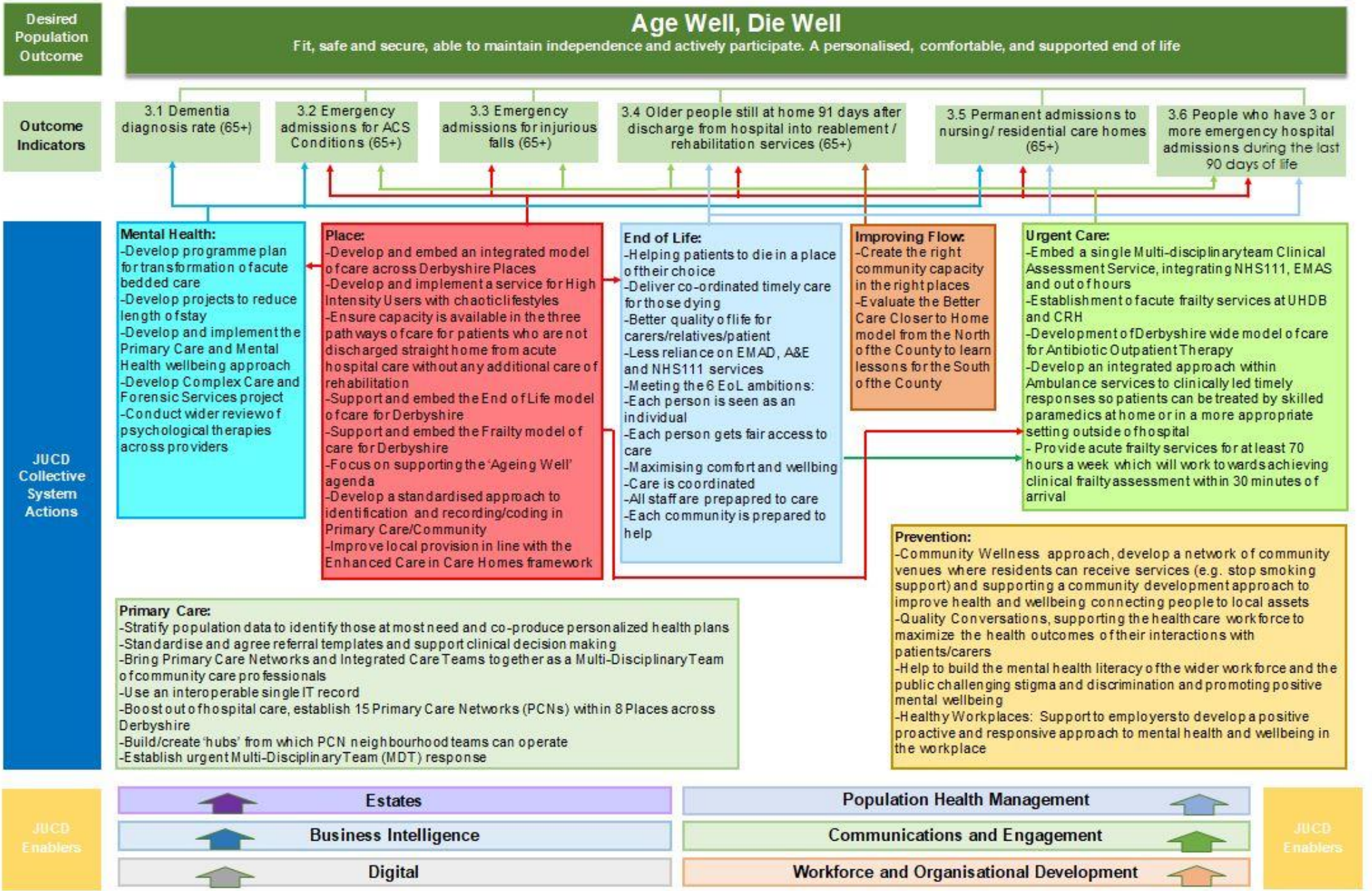
Improving Population Outcomes: Outcomes Based Accountability – Best Start in Life



Improving Population Outcomes: Outcomes Based Accountability – Stay Healthy



Improving Population Outcomes: Outcomes Based Accountability - – Age Well and Die Well



Strategic Priority: System Efficiency

We know our health system is inefficient in a number of ways, and therefore improved efficiency must be a key part of our plan…

The financial gap if we do nothing across the Derbyshire healthcare system is forecast to be £332m by 2023/24. We know our health system is inefficient in a number of ways, and therefore system efficiency is embedded throughout our plan and can be evidenced in the specific sections, for example we will:

- Streamline care pathways to reduce duplication and hand-offs; with aligned clinical governance processes
- Align and optimise 'back-office' services (HR, PMO, Business Intelligence) to enable a coordinated approach and single version of the truth
- Optimise integrated care provision including the alignment of clinical support services with a specific focus on diagnostics
- Further optimise the use of medicines: Cost effective choices, reducing waste and harms, transfer of care, disease prevention and symptom control, systems efficiency and procurement. Further information in relation to our overarching approach to Pharmacy & Medicines Optimisation can be found at Appendix 3.
- Streamline organisational governance process and shared decision making
- Develop our place based/PCN networks to improve anticipatory care
- Reduce reliance on agency/locum staffing
- Reduce in waste across the system to which will improve our carbon footprint
- Rationalise and optimise estate
- Make better use of digital technology

Furthermore as a system we have agreed to develop our approaches to improve ways of working to ensure we are more sustainable and affordable, including:

- A commitment to improving operational ways of working, underpinned by the People Plan
- Aligned organisational HR process which will include 'staff passports' to facilitate moving between jobs more easily
- Developing a single system PMO function
- Streamlined organisational contracting, performance management and planning to enable a single system approach

As well as being demonstrated throughout our plan the table below identifies key efficiency opportunities.

Efficiency Initiatives	Supporting Deliverables
Care Pathways	• Integrated Care across County and interface with Urgent Care Clinical Pathways including ambulatory care • Same Day Emergency Care • Theatre efficiencies • Efficiency and cost reduction through digitalisation and modernisation of outpatient appointments • Reduction in Length of Stay for Occupied Bed Days
Optimised use of clinical workforce	• Workforce & team efficiency • Align to demand (rotas, job plans) • Skill mix / working to top of license • Sickness levels and turnover
Estates and facilities management	• Community hospital/facility rationalisation • Acute hospital (incl. PFI) optimisation • Technology to support agile working
Agency Costs	• Better control of staffing through e-rostering systems • Improved workforce planning to ensure substantive staff are recruited and trained • Cost control through agency caps
Digital Technology	• Reduction in wasteful duplication by integrating clinical systems and making clinical time more effective
Reduction in local health inequalities and unwarranted variation	• Applying Rightcare data to make improvements including MSK, Respiratory and CVD pathways • Improved cancer wellbeing with Derby County Community Trust working on the 'Wellbeing for All' project targeting seldom heard groups • Moving towards greater place based care

Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance…

Why is this a priority for Derbyshire?

Many of the initiatives within the NHS LTP are not new to Derbyshire as we have been working on these since developing our last STP plan. However, so far they have not yet been fully implemented to deliver the necessary transformational impact – in either care quality or financial improvement terms. And, we believe that this is significantly due to our existing system infrastructure, which drive competing organisational priorities and an inability to divert funding and investment from historical patterns of provision that do not meet the changing needs of the population.

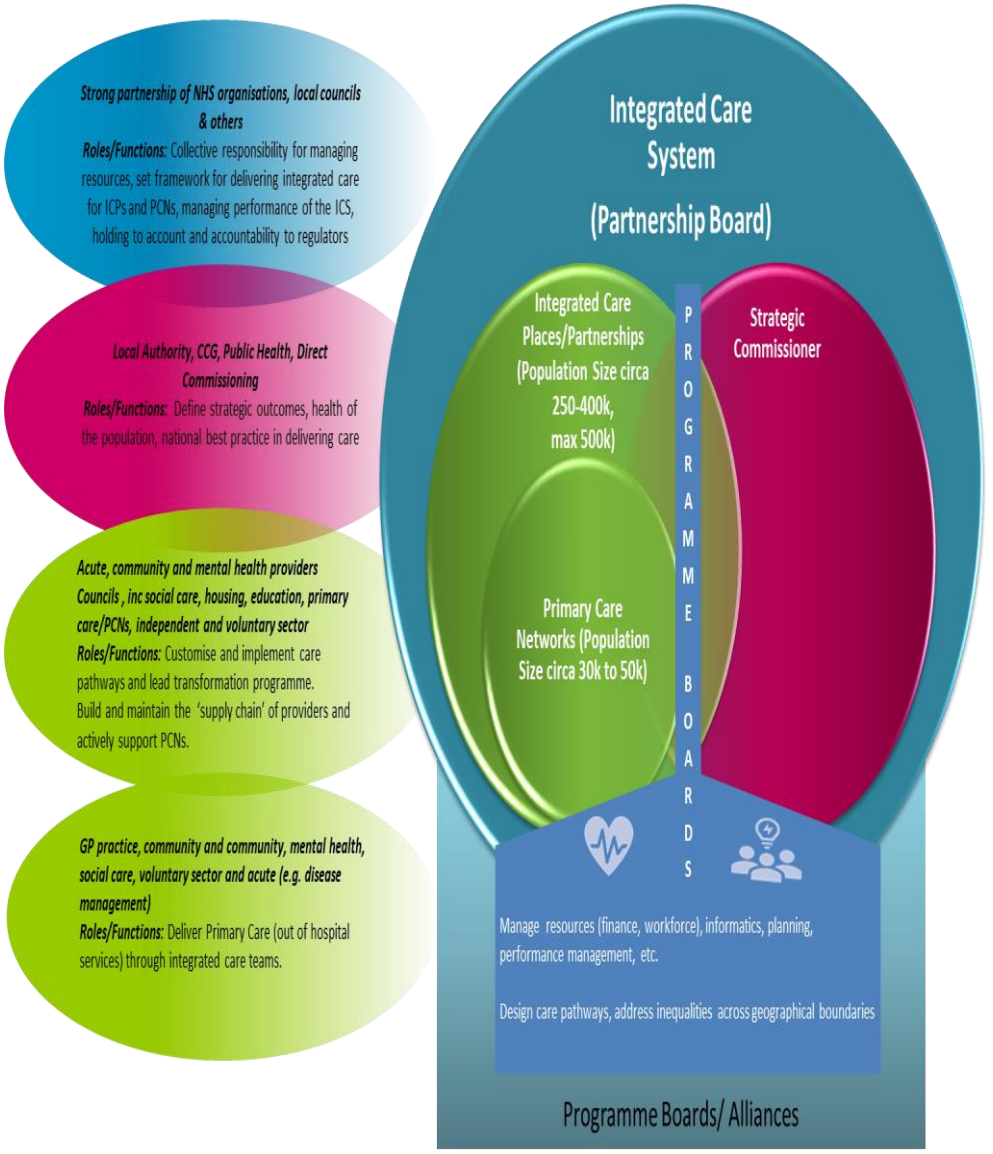
So, we need to ensure that this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and patient-centred perspectives.

Transforming how we work together across organisations to manage the system is therefore a priority for our STP. We must make system-level working the default option - 'business as usual' - as an approach for managing all of the care we commission and provide. We will do this by developing as an Integrated Care System by April 2021.

The NHS LTP provides us with the catalyst required for this system change to create a strong underpinning infrastructure which supports transformation and improvements for our population without the historic barriers we have faced.

To facilitate our transition towards an ICS, we have agreed the Derbyshire ICS framework and constituent job cards.

Integrated Care System (ICS): Job Cards



Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance…

Our Approach

Place based care will remain at the heart of our approach to meet the local needs of individuals; developing our Neighbourhoods through Primary Care Networks (PCNs) within our Integrated Care Partnerships (ICPs) and the wider Integrated Care System (ICS).

Our ICS Development Plan: Headlines

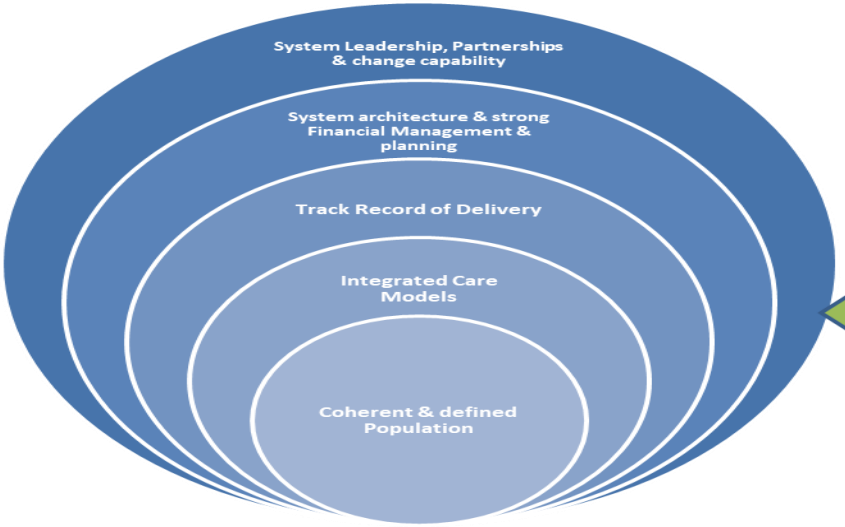
- We have successfully completed the ICS Development Programme and Commissioning Capability Programme
- General Practice leadership are increasingly engaged in system decision making
- Our ICP configuration is being progressed through the ICP Development Group, and is described further on the following page
- We have launched a System OD programme, including transformation workstreams, Executives, and NEDs/Lay members events
- We have strengthened our governance which now includes a finance sub-committee, Quality and Performance Group and Chairs group
- We intend to be operating as a shadow ICS from 1 April 2020

Furthermore, we have identified the following key milestones in the next quarter:

- Agree our system clinical strategy (December 2019 STP Board)
- Continue to build resilience and services provided at Place level
- Approve STP OD strategy and roll out system wide OD programme to help partners increasingly work in the system space (November 2019 LWAB/STP Board)
- Develop a single system financial savings plan for 2020/21
- Review of STP Board governance and ways of working
- Streamlining of ways of working: HR processes, procurement

Our aim is to be an Integrated Care System which is built around care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

Characteristics of an Integrated Care System



Key Deliverables to enable Derbyshire to become an ICS

Transformation Workstreams

- Planned Care
- Improving Flow
- Urgent & Emergency Care
- Place/ Primary Care Networks
- Children & Young People
- Maternity
- Mental Health
- Learning Disabilities & Autism
- Cancer
- End of Life
- Disease Management

Enablers

- Prevention & Population Health Management
- Workforce
- Digital
- Communications & Engagement
- Estates
- Finance

Enabling development programmes

- ICS Development Programme ✓
- Commissioning Capability Programme ✓
- Population Health Management Programme
- System wide OD Programme

Enabling work

- System Savings Approach ✓
- Outcomes Based Accountability ✓
- Business Intelligence/PHM
- Development of Place Alliances and Primary Care Networks ✓
- Derbyshire Clinical Care Strategy
- Shared finance plan and risk share agreement ✓
- Integrated Care Partnership development
- Profiling system wide demand, capacity and workforce

Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance…

We will develop our partnership to become an ICS by April 2021 which is central to the delivery of the LTP; our future arrangements will include the following components.

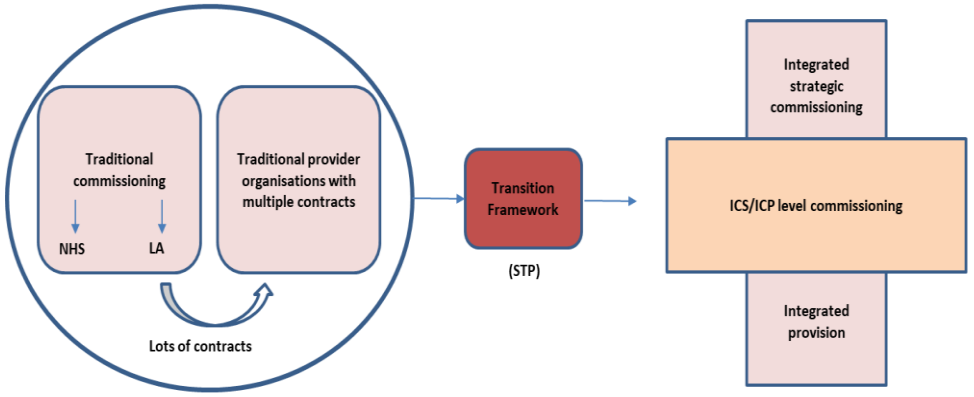
Streamlined Strategic Commissioning

- We have already streamlined our commissioning arrangements with the merger of four Clinical Commissioning Groups (CCG) into one. Derby and Derbyshire CCG formally came into existence on 1 April 2019. These arrangements enable a single set of commissioning decisions at system level.
- Commissioners will make shared decisions with providers on how to use resources, design services and improve population health. We will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget.
- We will further develop our joint commissioning arrangements with Local Authorities.

Strategic commissioning architecture in Derbyshire

How strategic commissioning will look for Derbyshire

Strategic commissioning will be a departure from the current state for both the NHS and LA. There will no longer be a focus on **detailed contract specification**, **negotiation and monitoring** or the **routine use of tendering**. Rather, the emphasis will shift to **defining and measuring outcomes, putting in place capitated budgets, assigning appropriate incentives for providers** and **using longer term contracts** extending over five to ten year timelines.



Current state – many contracts, many specifications, fragmented, inconsistent, multiple dispute points and unwarranted variation

Future state - simplified, fewer contracts, fewer procurements, less unwarranted variation, reduced transaction costs, increased focus on delivery and transformation maintained.

Streamlined Provision: Integrated Care Providers (ICPs)

Providers will 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 within allocated resources – known as Integrated Care Partnerships (ICPs). All PCNs will be integral to ICPs; which will be designed to deliver localised place based care.

Our ICPs will provide a fundamental shift in the way care provision is designed and organised with all partners playing an equal role. This inclusive approach will not only drive our approach to longer term care redesign but has also provided the basis by which we have agreed our ICP configuration .

Through this inclusive approach, we agreed the case for change and confirmed 4 geographical ICPs for Derbyshire; these are:

- Chesterfield, North East Derbyshire and Bolsover
- Derby City
- South Derbyshire, Amber Valley and Erewash
- Derbyshire Dales and High Peak

Key factors which influenced this decision are:

- Local Authority boundaries taking primacy, to enable a focus on population health, prevention and relevance to local people and communities to maintain localism
- The value of existing Place Alliances remaining important both in terms of progress and development and alignment with council boundaries
- Cognisance of cross boundary working which will need to be managed; some PCNs are already working in this way across Place boundaries and it is being managed, the ICP role will be to ensure this continues. It is recognised that the South Derbyshire in particular would require mitigations and close monitoring as the ICPs evolve

During quarter 4 of 2019/20 we will develop the ICP Operating Model ready for shadow running from 1 April 2020. This approach is underway and will build upon the key things we want our ICPs to address/deliver for our population:

- Understand our population and their health and social care needs (link to Population Health Management)
- Use place alliance intelligence
- Focus on care models not clinical pathways in isolation
- Recognise that there needs to be a service redesign
- Shared workforce, planning and assets
- Need to consider what is done at different levels within/across the system
- Don't lose gains developed over the years
- Need staff and public engagement
- Engage professional and clinical leadership
- Develop the Place/ PCN and ICP interface

We will continue to engage with partners including primary care in developing our approach. We also recognise the importance of District and Borough Council involvement in this development and the approach is being aligned to ensure factors which may impact from that perspective are also reflected in our developments.

Delivering further progress on fully integrated Place Based Care

As described in our strategic priorities, we will deliver transformed out of hospital care; through place based care, underpinned by our model of care with a focus on supporting the national 'Ageing Well' programme…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Urgent Community Response - Assess and improve capacity and quality of key community crisis response and reablement services, developing our integrated community rapid response provision to support the 2 hour response standards where clinically appropriate by 2024					✓
Ensure appropriate capacity is in place and transfers of care are timely and effective in order to implement the urgent community response standards for reablement within 2 days of referral by 2024					✓
Progress towards the ambition of an integrated service model available 24/7 as appropriate					✓
Co-design our urgent community response with all of our stakeholders. The aim being to develop a set of standards, outcomes and a governance framework which will allow our system to commission a community urgent care response from Primary Care Networks in a way that allows local delivery to an STP framework, with a target to implement across Derbyshire by April 2021.	✓	✓			
Work with PCNs to develop multi-disciplinary, cross sector teams of community care professionals and review options for greater integration within the emerging ICP structure		✓			
Consistent proactive identification and management of people at risk of unwarranted health outcomes through risk stratification, assessment and care planning in line with the anticipatory care element of 'Ageing Well'	✓	✓			
Improve local provision in line with the Enhanced Care in Care Homes framework and publication of a maturity matrix for full delivery of the EHCH model as part of the national Ageing Well Programme		✓			
Expression of Interest submission to the Community Heath and the Ageing Well programme Urgent Community Response Accelerator Site Proposal for 2020/21. Key elements include: A single number within the system for patients and professionals to access a same day response, a GP led clinical assessment/triage, locally based integrated rapid response teams that, where clinically appropriate, will provide care in people's homes.	✓	✓			
Implement and review targeted case management approach to the most severe 'high intensity users'. Expand if successful	✓	✓			
Ensure community assets are understood and widen the support available for social prescribing link workers to access in each Place.					
Utilise Population Health Management embedding the personalised care model as an enabler to improve outcomes through segmentation approaches to understand the use of, and demand for services across the health and care system to inform planning and prioritisation / development of provision for out of hospital care.	✓	✓			
Further develop opportunities to identify and meet the needs of people with 'lower level' mental health needs within the community			✓		
Maximise the benefits of access to the single health care record by integrated community teams and ambulance staff				✓	
Consider the opportunities, and maximise the benefits, of digitally enabled care in the community promoting early adoption		✓			
Contribute to continued reductions in the number / proportion of delayed transfers of care to achieve Derbyshire share of the national target through ensuring appropriate range and capacity of provision to support people leaving hospital	✓	✓			
Leaders will feel equipped to deliver in a collaborative and transformative way agnostic of organisation, with a focus on people and communities	✓	✓			
Ensure continuation of the well-developed wider partnership role in place based working that has been built in Derbyshire to ensure we draw on the widest range of community assets in developing and delivering improvements in care and outcomes adopting the Ageing Well best practice tools and supporting service guidance for urgent community response, reablement care and community multidisciplinary teams	✓	✓			
Support and manage Places in the transition to a new governance structure in the emerging system architecture, ensuring that the structures and frameworks of ICS/ICP enable true integration of planning and delivery of local services.	✓	✓			
Identify where increased resource in community could deliver impact on system; costs, outcomes and experience and agree mechanisms to plan and manage that shift, incentivising preventative and proactive care.	✓	✓			

Reducing pressure on emergency hospital services

Delivering our vison for urgent & emergency care through the combined deliverables below will improve care and create a more coordinated response for our citizens…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
• A Clinical Assessment Service (CAS), accessible via 111 for Derbyshire is in place with people able to speak directly to a clinician; supporting navigation to the optimal service 'channel' so that only those with more serious or life threatening physical or mental health needs present at A&E with the majority of people accessing suitable alternatives within the community and self-care options. • The CAS clinician will seek to complete the call there and then without the need to transfer the patient elsewhere, ensuring 50% plus of calls receive a clinical assessment of this nature and more than 40% of appointments booked direct (extension of Direct booking in GP in-hours primary care and extended access). • Where face to face contact is deemed necessary the CAS will advise on the most appropriate services including UCTCs, GP both in and out of hours, community care, pharmacy, emergency dental and will directly book more than 40% of those requiring urgent appointments in services alternative to A&E. NHS111/CAS will also be able to directly book into the acute SDEC assessment function where appropriate. • By 2023, our CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care. This will include all adults, children and young people experiencing mental health crisis, with access to mental health triage and crisis care available 24 hours a day, seven days a week by calling 111.	✓	✓	✓	✓	
• A 24/7 Clinical Assessment, Advice and Treatment Hub (including dental, pharmacy, paramedics) that supports 111, 999 and out-of-hours calls from the public and all healthcare professionals will be in place; including support for people with known and/or long-term conditions or additional vulnerabilities (such as learning disability and mental health) will be offered enhanced planning and support to avoid acute presentations. • Increasing capacity to deliver hear and treat and increase see and treat services with the support of the clinical advice hub.					✓
• Delivering the optimal level of on day urgent primary care appointments and home visits to patients (at local/PCN level) to meet the anticipated demand, including the provision of extended access at weekends and evenings. • Strengthen our Primary and Community offer so that a broader range of integrated services (GP Access Hubs/UCTCs, mental health crisis clinics etc.) are all in one location for patients within their communities, supporting both physical and mental health urgent needs by when. • All Derbyshire localities will have a consistent offer for out-of-hospital same day urgent care. ***NB this deliverable is linked to developments in place based** care*					✓

• Delayed Transfers Of Care (DTOC) are further reduced, in partnership with local authorities by:
  • Reducing hospital care and resourcing integrated community services capacity within each Place, to meet demand closer to home and support patients to be discharged to a new long term place of care with minimal transfers; improving patient and carer experience, and increasing capacity and flow out of acute hospital settings. The focus will be on the south of the county, building on the Better Care Closer to Home transformation in the north.
  • Mapping resources and capacity across community and intermediate care to better identify and access capacity as part of the Improving Flow work to therefore effectively utilise services better in the community by March 2020
	✓				

• We will further develop a comprehensive model of Same Day Emergency Care (SDEC) for medical and surgical pathways, in both our acute hospitals so that there is 100% provision of SDEC services least 12 hours a day, 7 days a week and work towards agreed trajectories for the percentage of non-elective activity treated as SDEC which is subject to technical guidance being released. • This will ensure effective flow through the system from acute bedded facilities and integrated discharge pathways into the community. The SDEC model will provide people who access acute services with new diagnostic and treatment practices, allowing patients to spend just hours in hospital rather than being admitted to a ward; increasing the proportion of acute admissions discharged on the day of attendance from a fifth to a third so that the there is a 40% reduction in the long length of stays compared to those our patients experienced in 2018, by March 2020. • Complete the expansion and redesign of our Emergency Departments and acute front door services which will facilitate the delivery of comprehensive patient assessments and on-going quality urgent health care. This will include on-going development of a co-located Primary Care Streaming Service, improved frailty assessment, pharmacy and mental health, plus greater integration between the Emergency Department and wider emergency provision in the hospital, specifically ambulatory care services, Acute Frailty Service providing assessment within 30 minutes of arrival and Paediatrics. • The redesign of our front door services will support us to ensure that patients who arrive at A&E via ambulance have their care transferred from paramedics to A&E staff within 15 minutes of arrival. • This comprehensive model for medical and surgical pathways will relieve pressure elsewhere in our hospitals and free up beds for patients who need quick admission either for emergency care, or for a planned operation.	✓	✓			
• Fully implementing Urgent Treatment Centres (UTC), operating to the national specification by autumn 2020 as part of our integrated community urgent care offer; designation based on comprehensive urgent care review.	✓	✓			
• Efficient A&E departments which are appropriately resourced and are fully meeting the emergency and urgent care standards arising from the national Clinical Standards Review	✓				
• Introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls, and increase the mental health competency of ambulance staff through an education and training programme. As a result people with a mental health crisis, will be able to consistently access alternative services to A&E, reducing the need for conveyance to A&E.					✓
• Introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E.					✓

Better Care for Major Health Conditions: Improving Cancer Outcomes

Working across multi-professional partners, we will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer & Beyond. We will work in partnership with the East Midlands Cancer Alliance to deliver the National Ten Year Cancer Plan; utilising the additional LTP investment to ensure trajectories for one year survivorship and Early Diagnosis at stages 1 and 2 are achieved…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
HPV will be a primary screen in the cervical screening programme with the implementation of HPV screening as a more sensitive and reliable test for Cervical Cancer, HPV Vaccinations for girls (complete and in place) and for boys aged 12/13 (Sept 19)	✓				
We will improve bowel, breast and cervical screening uptake by working with GP practices with the lowest cancer screening uptake from national programmes to optimise the uptake of cancer screening programmes to increase the number of cancers diagnosed at an early stage so that 62% of cancers are diagnosed at Stages 1 and 2 by 2020, increasing to 75% by 2028; enabled by increase uptake so that by 2021 there will be 80% uptake of Breast and Cervical Screening and 75% Bowel Screening uptake. This will include continuation of a programme of support to GP practices, particularly within hard to reach communities, facilitated by CRUK and Public Health (City & County)	✓	✓			
Identify opportunities within screening and two week wait pathways to support staff to provide lifestyle advice so by March 2021 all staff are routinely providing lifestyle advice	✓	✓			
Gather data and develop population characteristics for Breast Cancer screening to develop information for professionals to engage key target groups so by March 2022 more tailored information will be in place to enable targeted interventions for key groups			✓		
Hard to reach communities, specifically BAME will have access to the 'Wellbeing for All' programme facilitated by Derbyshire Community Trust so that by March 2022 seldom heard communities will be encouraged to lead healthy lifestyles and early presentation to health services			✓		
We will work to improve GP referral practice and GP direct access to key investigative tests for suspected cancer					
Continue to develop and deliver GP cancer education / learning programmes with dedicated sessions across the footprint	✓	✓	✓	✓	✓
Work with the Digital Workstream to support the implementation of two week wait forms in the GP Referral Support System in Primary Care	✓				
We will roll out implementation of Faecal Immuno-chemical Testing (FIT) testing for symptomatic and non-symptomatic populations in line with national policy so patients have access to non-invasive, hygienic test, with only one sample required. Starting with all patients with bowel cancer symptoms and (complete and in place) extended to Bowel Cancer Screening	✓				
Implement lower starting age for screening from 60 to 50 and increase sensitivity level (Timescales subject to national confirmation)					
We will implement optimal and best practice pathways to facilitate early diagnosis and better outcomes, with patients surviving longer after diagnosis by implementing pathways to enable faster investigation, diagnosis and treatment.	✓	✓			
Direct access MRI Brain Pathway	✓				
Implementation of RAPID Prostate Pathway; implemented at UHDB (Derby) and work has commenced to implement consistently in Burton; straight to Test at CRH implemented	✓	✓			
National Optimal Lung Pathway: Year 1 of two year programme completed. Work progressing to deliver Year 2, embedding efficient and effective lung cancer pathway	✓				
Upper GI Pathway: Pathways to be reviewed and refined		✓			
Direct access to Vague Symptoms Pathway, supporting regional development. Programmes in place; to be clinically evaluated (Sept/ Oct 19)	✓				
Improve access to Genetic Testing (BRCA1/BRCA2) for all women diagnosed with breast cancer who meet the Mainstreaming Criteria and all women with ovarian cancer. Work through ECAG (Expert Clinical Advisory Group) to establish protocol and commission services so that By April 2020 any familial risk of cancer in this group of patients will be identified through this improved Genetic Testing		✓			
Work with Cancer Alliances to provide Lynch Syndrome testing for all patients under 50 diagnosed with bowel cancer		✓			
We will work with the EMCA so that by 2020 one RDC will be implemented in each Cancer Alliance with further rollout by 2023/24. Development of clinical and delivery models for Rapid Diagnostic Centres (RDC); pilot sites will be agreed within the EMCA region to deliver national implementation plans across the footprint, together with any additional cohorts based on local need, capability and capacity; Pilot sites within the East Midlands Cancer Alliance region to be agreed, with at least one RDC to start accepting patients by January 2020 and National evaluation of pilot sites to support further rollout thereafter	✓	✓	✓	✓	✓
We will improve access to high quality treatments, including through rollout of Radiotherapy Networks, strengthening of Children and Young People's Cancer Networks, and reform of Multi Disciplinary Team meetings. Continue to work with Specialised Commissioning to ensure patients have access to high quality personalised treatment/therapies for radiotherapy, chemotherapy and immunotherapy.	✓	✓	✓	✓	✓
Support develop and effective functioning of EMCA Radiotherapy networks	✓	✓	✓	✓	✓
We will implement the National Specification for Early Diagnosis from the GP Contract Reform in line with NICE guidance, for children, young people and adults at risk of cancer by working with Primary Care Networks (PCNs) to review and implement DES and seek a cancer champion in each PCN group to encourage and support implementation at a local level.	✓	✓			
We will deliver the updated Service Specification for children and young people's cancer services subject to national specification timescales					
We will work through the Cancer Workforce Action Group, facilitated by the EMCA to address unwarranted variation, improve patient experience which is supported by an appropriate workforce and will support implementation of National Cancer Workforce Plan and changes as they evolve.	✓	✓	✓	✓	✓

Better Care for Major Health Conditions: Improving Cancer Outcomes

Working across multi-professional partners, we will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer & Beyond. We will work in partnership with the East Midlands Cancer Alliance to deliver the National Ten Year Cancer Plan; utilising the additional LTP investment to ensure trajectories for one year survivorship and Early Diagnosis at stages 1 and 2 are achieved…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Maintain, deliver and improve the position against National Cancer Patient Experience Survey and develop ongoing programmes to incorporate focus groups, questionnaires and engagement events; to demonstrate a year on year improvement (national average currently 8.8). Build on stakeholder events such as focus groups, patient involvement events and react to national and local surveys. There are currently four Health & Wellbeing events planned which will involve patients, carers, clinical stakeholders and third party providers (by Dec 19). Feedback obtained from these events will inform where gaps exist, with focus groups implemented to progress work to fill these gaps. Active Recovery and 'Wellbeing for All' programmes will also support improvements in patient experience and satisfaction.	✓	✓	✓	✓	✓
Ensure all those diagnosed with cancer have the opportunity to undertake a Holistic Needs Assessment (HNA) and Care Plan throughout their diagnosis, treatment and follow up; with 75% of all new cases being offered a HNA.		✓			
Ensure all patients are given the opportunity to join a Physical Activity Programme facilitated by Community Trusts; all patients provided with information on this service. Work towards developing a service for the north of the county		✓			
Ensure all cancer patients are offered access to health and wellbeing support appropriate to their needs at the time. Events publicised through the hospital and primary care. Four events to be held throughout the year (2 Burton/2 Derby) with programme expanded across the footprint	✓	✓			
Develop and implement a pathway to ensure all patients receive a Treatment and End of Treatment (EoT) Summary (EoT only at CRH)		✓			
GP practices to undertake Cancer Care Reviews for all patients within six months of a Cancer Diagnosis. Improved support for patients in the community through joined up care between secondary and primary care	✓				
Improve engagement with Carers and develop plans for ongoing support so that by September 2020 focus groups for carers of children, young people and adults with cancer to support further development	✓	✓			
Undertake Bowel Health Equity Audit; identify recommendations and implement action plan so that by March 2022 actions have been fully implemented	✓	✓	✓		
Ensure patients have access to enhanced supportive care with links to End of Life (subject to links with newly established EoL workstream)					✓
We commit to delivery of the cancer performance standards including 14, 31 and 62 day standards and, from 2020/21, compliance with the 28 day Faster Diagnosis Standard. Ongoing - To achieve required national targets of 93% (2ww), 96% (31 day), 85% (62 day target - recovery action plan in place). Ensure actions are taken to meet current constitutional targets for Cancer Waiting Times (CWT) and implement any revised CWT targets in 2020/21.	✓	✓	✓	✓	
Implement recording of the 28 day Faster Diagnosis Standard with shadow monitoring of data in 2019/20 and full implementation from 2020/21.	✓	✓			
Work with stakeholders to produce a Derbyshire-wide report looking at predictive modelling for cancer referrals for next 5-10 years, in order to support commissioning of activity and workforce development	✓				
We will ensure that from April 2020 two thirds of patients who finish treatment for breast cancer will be on a supported self-management follow-up pathway. Also, all trusts will have in place protocols for personalising/stratifying the follow-up of prostate and colorectal patients and systems for remote monitoring for patients on supported self-management. Develop and implement personalised follow-up pathways of care for people with cancer so that by April 2020, 75% Breast patients will be on a personalised self-management follow-up pathway tailored to their needs and by April 2021 Prostate and Colorectal patients will be on a personalised self-management follow-up pathway tailored to their needs. By April 2024, all those diagnosed with cancer will be on a personalised self management follow-up pathway tailored to their needs		✓	✓	✓	
Implementation of Supported Self-Management with Remote Monitoring across remaining tumour sites starting with Breast and Urology and all remaining tumour sites implemented by 2021/22		✓			
New Quality of Life (QoL) Metric in use locally for all Providers to submit QoL data from April 2020		✓			
Working with the EMCA to deliver the National programme (national guidance is awaited) to ensure Genome Sequencing will be offered to all children diagnosed with cancer from April 2020		✓	✓	✓	
By 2023 the first phase of the Targeted Lung Health Checks Programme will be completed, with plan for wider rollout (depending on evaluation)					✓
EMCA will implement one of the ten projects involved in the first phase of delivering targeted lung health checks. Extended lung health check model in place (subject to EMCA plans). Interim evaluation of first phase of projects, Implementation plan/approach for further rollout 22/23 and final evaluation of first phase 23/24			✓	✓	✓
Fully Integrated Cancer Care supported by our Integrated Care Partnerships will be delivered across the system					✓

Better Care for Major Health Conditions: Improving Mental Health Services

Delivery of our plan will be supported by our continued commitment to the Mental Health Investment Standard (MHIS); Information in relation to how this will be allocated can be found at Appendix 4. We will deliver the foundational commitment in relation to Mental Health across the system; achieving access standards as defined nationally. We will continue development of the Derbyshire Mental Health Alliance to include all statutory and voluntary sector providers and commissioners of mental health services across health and care will participate in the emerging regional collaborative around Forensic, CAMHS, Eating Disorder services and future waves, to include Perinatal and Learning Disabilities services…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Perinatal Mental Health: Derbyshire will be lead provider across the region for Tier 4 services once phase 2 of NCMs opens. We will increase access to specialist community perinatal mental health services with performance meeting 5% target of birth rate coverage and Psychological therapy input into the team by the end of 2019/20. Community Perinatal coverage already across the County and performance close to national ambition. Maternity Outreach Clinics will be in place following national testing sites with the care period extended from 12 months to 24 months by the end of 2023/24.	✓				✓
Adult SMI Community Care: We will bolster adult Severe Mental Illnesses (SMI) integrated models of primary and community mental health care with investment in specialist Personality Disorder (PD) support teams in place in Community Mental Health Teams (CMHTs) from 2019/20 onwards. We will link closely with Lincolnshire and other pilot sites to be ready to start implementation of the new models from April 2021 and fully established by the end of 23/24. We will maintain national performance standards and sustain fidelity of the model for the Early Intervention Psychosis (EIP) service and Individual Placement and Support (IPS). An IPS wave 2 service is being established in line with national model in 19/20. Pilots in digital contacts testing model will take place in 2019/20, enabling EIP Level 3 compliance, with roll out of digital contacts subject to evaluation by 2020/21.	✓	✓			✓
Mental Health Primary Care and Physical Healthcare: IAPT services continuing to meet all national targets, with IAPT therapists into integrated PCN teams, Long Term Conditions (LTC) service in place and IAPT accessed by more older people and people in care homes. National access ambitions met in full by end of 23/24. SMI Physical Health checks at 60% from April 20/21 onwards. Wellbeing approaches (Tower Hamlets and GM models) prototyped in two PCN areas 2019/20 and rolled out across the County in 2020/21, engaging fully with communities and the voluntary sector. This will provide individualised opportunities for people to live full and well lives in their communities without recourse to statutory services. Link CMHT staff with GP practices to provide advice and guidance. Close relationship and interaction between this work and the work to implement new models of Adult SMI Community Care.	✓	✓			✓
OPMH, Dementia and Delirium: Integrated Care Homes training package in place, including Frailty, EoL and OPMH. Training package in place across all providers by 2020/21 to support care staff in identification of delirium and dementia. Consistent and equitable crisis response services (Dementia Rapid Response Teams and Functional Rapid Response Teams) for Older People using CRHTT Transformational monies in 19/20 and 20/21 (see below). Implementation of Day Services changes to deliver single countywide model across the County in 2019/20. Furthermore, we will agree system wide Derbyshire Well Pathway for Dementia as a whole systems approach to Frailty, OPMH and End of Life and sustain transformation of MAS service and continue to meet diagnosis targets.	✓	✓			
Mental Health Urgent Care: By March 2021 we will have eliminated the placement of Derbyshire patients in out of county adults acute mental health beds. There is currently no PICU facility within the Derbyshire footprint, as such we will continue to need to utilise 1,825 occupied bed days (approximately 5 patients at any one time) out of the county until a local facility can be developed as part of the medium to longer term approach. The DHcFT Estates strategy due for sign off in December, will propose the development of a PICU as part of a redesigned acute inpatient facility to eliminate dormitories. Due to the small number of patients any unit will be considered as part of the wider improvements to ensure viability. There is system agreement to ensure inclusion of the Derbyshire Healthcare plans in to the next refresh of the Derbyshire STP Local Estates Strategy. Crisis Teams across the county in fidelity with the model across all age groups and alternatives to A&E attendances in place, with 1 alternative to A&E in 2019/20 increasing to two by 2020/21. 100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams (CRHTTs) operating in line with best practice by 2020/21 and maintaining coverage to 2023/24. These will be accessed via a single point of entry for crisis response via 111 by 2023 and supported by Core 24 Mental Health Liaison Services at CRH and DRH sites and PD specialist resource in place in CMHTs from 2019/20. For people with Personality Disorder, only those with exceptional circumstances will require admission to hospital settings. We will also develop innovative digital alternatives to physical observations (Oxehealth) across all seclusion rooms.	✓	✓			✓
Suicide Reduction and Bereavement Support: We will deliver current plans from the cross-agency Derbyshire Suicide Prevention Forum to put bereavement services in place and to implement actions to reduce suicides in inpatient settings. Trailblazer funding used to establish RTS service with Derbyshire Police and BPT resulting in bereavement support provided within 72 hours in 2019/20 with new services sustained and learning shared with NHSE/I in 2020/21.	✓	✓			
Problem Gambling and Rough Sleeping: Should Derbyshire be identified as one of the 15 problem gambling sites or one of the 20 areas for increased rough sleeping provision, then the JUCD MH Programme will be ready to respond with proposals to address either or both areas, building on our existing links and strong relationships with the voluntary sector in both areas of work.					✓

Better Care for Major Health Conditions: Shorter Waits for Planned Care

Our Planned Care Programme of work is designed to enable significant transformation in end to end pathways so that we fundamentally modernise outpatient care (including through digital options) and ensure shorter waits for planned care when required. Through delivery of our Planned Care programme of work, we will ensure that no patient waits more than 52 weeks from referral to treatment and offer choice where patients reach a 26 week wait…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
We will redesign and transform 'end to end' MSK clinical pathways to reduce variation, improve self-management and shared decision making, and reduce avoidable clinical interventions by: 2019/20: Further developing our Clinical Assessment and Triage Services(CATS), maintaining First Contact Practitioner (FCP) Pilot, reviewing and enhancing adherence with clinical policies and optimising use of injections 2020/21: Implementing 'end to end' MSK pathways by working with PCNs and review current physiotherapy to deliver FCP ambitions, aligned to CATS 2021/22: Implementing a hub delivery model incorporating MSK Triage, Assessment and Treatment utilising FCP, CATs and Physiotherapy models to complement PCN and Place Based Care; including implementation and monitoring of injections policy within primary care 2022/23: Monitoring effectiveness of the hub delivery model and refine / enhance with additional services to include podiatry, orthotics and paediatric MSK and incorporate International Consortium for Health Outcomes Measurement models for delivery within MSK pathways 2023/24: Monitoring progress and developing the contracting model to support outcomes based pathways, further developing services for alignment with outcomes based pathways and monitor progress of hub model at PCN/Place to review and inform future delivery	✓	✓	✓	✓	✓
Design and deliver sustainable solutions to close the gap in capacity vs demand for ophthalmology services by annually reviewing the plan to address the imbalance in capacity vs demand by 2025 and: 2019/20: Completing a capacity and demand review and establish strategic and responsive plan to address the gap, reviewing and redesign ophthalmology pathways, launching a pilot for Minor Eye Conditions service, extending tele ophthalmology pilot (evaluating and establish sustainable service solution) and developing digital solutions to support virtual management of patients 2020/21: Standardising and optimising pathways across the system, evaluating Minor Eye Conditions pilot and establish plan to sustain, implementing virtual appointments for agreed pathways and evaluating digital pilots and establish JUCD specification and strategy for digital solutions 2021/22: Scale up and optimise use of virtual appointments, modernise workforce models in line with pathway redesign, work with optometrists and primary care to support 'left shift' of services and procedures, implement JUCD strategy to standardise and optimise digital solutions 2022 – 2024 : Scale up and optimise use of virtual appointments, modernise workforce models in line with pathway redesign, work with optometrists and primary care to support 'left shift' of services and procedures, explore opportunities to further maximise effective utilisation of resources across the system	✓	✓	✓	✓	✓
Subject to confirmation of specific national metrics; we will modernise, digitally enable and redesign services to deliver the NHS Long Term Plan ambition of avoiding a third of face to face outpatient visits in a secondary care setting by 2025 by: 2019/20: Review and redesign four 'end to end' clinical pathways, Pilot digital solutions to support modernisation and redesign of secondary care, Pilot NHS Attend Anywhere to support alternative virtual model for secondary care attendances, Design and implement a digital solution to support referral management in primary care, Develop and implement enhanced advice and guidance services, Scope opportunities to design new co-morbidity clinics 2020/21: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan, Implement virtual appointments for agreed pathways, Implement risk stratified and patient initiated follow up for agreed pathways, evaluate digital pilots and establish JUCD specification and strategy for digital solutions, establish plan to develop co-morbidity clinics 2021/22: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan ambition, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Implement JUCD strategy to standardise and optimise digital solutions, modernise workforce models in line with pathway redesign, pilot new co-morbidity clinics 2022/23: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan ambition, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Modernise workforce models in line with pathway redesign, Work with primary care and place to support 'left shift' of services and procedures, Extend co-morbidity clinics 2023/24: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Modernise workforce models in line with pathway redesign, Work with primary care and place to support 'left shift' of services and procedures, Scale up and optimise use of co-morbidity clinics	✓	✓	✓	✓	✓
Maximise effective and efficient use of theatre capacity across the system so as to deliver the NHS Long Term Plan ambition for improved patient access to Planned Care by: 2019/20: Agree and enact Derbyshire Theatres Strategy, Optimise utilisation of theatre resources at each provider Deliver strategic shift of services from DCHS to UHDB, Agree strategy on fit for surgery and shared decision making, Review and agree strategic approach on national policy for faster treatment offer 2020/21: Agree and deliver annual plan to scale up pooling of theatre resources across the system, Review and standardise pre operative assessment processes across the system, Implement national policy on faster treatment offer, develop and implement best practice principles across Derbyshire 2021/22: Agree and deliver annual plan to scale up pooling of theatre resources across the system, Explore opportunities for redesign and modernisation of theatre workforce across the system, Optimise use of virtual pre assessment processes across the system 2022 – 2024: Agree and deliver annual plan to optimise utilisation of theatre resources across the system, Work with primary care and place to support 'left shift' of services and procedures, Explore opportunities to further optimise theatre efficiency via digital or workforce solutions	✓	✓	✓	✓	✓

Delivering Further Progress on Care Quality and Outcomes: Maternity and Neonatal Services

The Derbyshire Local Maternity and Neonatal System (LMNS) is responding to the recommendations of Better Births (2016), the Planning Guidance key deliverables and the new LTP commitments 2020-2024. Work is delivered through 21 individual workstreams coordinated by a structure of groups which are held to account by Programme Board which reports into STP governance structures, with parallel alignment to commissioning quality governance…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Safety and the 'Halve it' ambition: A single SI process is now in place across the footprint and an established Maternity Quality Review group provides a forum for system wide learning and sharing. The implementation of PROMPT (PRactical Obstetric Multi Professional Training) enables those who work together to learn together and implementation of the Saving Babies Lives Care Bundle v1 is complete. Stillbirths at our two maternity providers have reduced to 2.5 per 1,000 births (2018/19), and neonatal deaths; however, SATOD figures remain static (14% Q2 19/20). We will implement the Saving Babies Lives Care Bundle v2 (March 2020), expand the offer of NHS maternal smoking cessation services (2019/20)/implement an improved local smoking in pregnancy pathway and play a role in the development of Maternal Medicine Networks (fully operational by 2023/24) to maintain our commitment to a reduction in stillbirth, neonatal death, maternal death and brain injury during birth by 20% by the end of 2020/21, and a 50% reduction by 2025; a 50% reduction in serious neonatal brain injuries by 2025.	✓	✓			✓
Neonates: We will work with Operational Delivery Networks to implement fully the recommendations of the Neonatal Critical Care Review in 2019/20, including delivery of the ATAIN programme to reduce avoidable admissions of term babies to neonatal unit to no more than 5% by 2019/20 (current performance 3%).	✓				
Community Hubs and SPoA: We have begun by scoping 'virtual' community hubs which foster closer working between staff groups in a particular locality and supporting our emerging Continuity of Carer teams, to set the foundation for a physical community hubs network offering a 'one stop shop' facility. Our aim is that services are coordinated by a single point of access and initially we will investigate how women may self refer for midwifery care and how contact with their midwife during pregnancy can be streamlined. We will develop the model based on the availability of digital infrastructure, estate (including our role in the OPE initiative) and the feasibility to coordinate care across our LMS and our borders, so that 50% of care is coordinated through a hubs and SPoA network by 2020/21.	✓	✓	✓		
Choice and Personalised Care Plans (PCP): All women can currently make choices about their maternity care, during pregnancy, birth and postnatally and utilise a variety of providers (ahead of national milestone for 100% of women by 2021), with the Mother Hub Derbyshire website providing trusted, unbiased information on the choices available since April 2019. We aim to empower women to take control of their birth choices and encourage more women to give birth in midwifery settings (at home and in midwifery units); 19% by 2020/21 increasing to 20% in 2021/22. At Q1 2019/20, 14% of women had been issued with a paper-based personalised maternity care plan (PCP), the design of which has been coproduced by service users. We will further develop the PCP in response to feedback from women and midwives and ensure that 100% are offered one by 2020. We will also consider how to digitise the PCP, alongside the development of ePHR (see below).		✓	✓		
Continuity of Carer (CofC): At March 2019, Derbyshire reported 14% women booked onto a CofC pathway, which is set to increase to 17% in March 2020. We have calculated a 5yr trajectory for expanding the offer of CofC to ensure more women can benefit, although we recognise tour ambition falls outside of national milestones. We will implement locality based model of team continuity and further address inequalities and support some of the most deprived families, including targeted funding which will be applied to ensure 75% from vulnerable and BAME Groups benefit from CofC by 2023/24.	✓	✓	✓	✓	✓
Postnatal care: In response to guidance, we will develop a postnatal care improvement plan agreed by commissioners and providers by February 2020, to include postnatal physiotherapy offered to women with physical complications because of birth by 2023/24. All Derbyshire maternity services are accredited under the UNICEF Baby Friendly initiative. Maternity outreach clinics are in place in the south of the county for women experiencing mental health difficulties arising from or related to, the pregnancy or birth experience and by November 2019 will have been rolled out to all women in the footprint.	✓				✓
Digital: Currently, <10% of women benefit from access to an Electronic Personal Health Record (ePHR). We will learn from our pilot site and consider expanding the offer at each of our units, so by 2023/24 all women have to access ePHR which includes a digitised version of their personalised care plan (PCP) – see above.					✓

Delivering Further Progress on Care Quality and Outcomes: Children & Young People

We will continue to develop age-appropriate integrated care, integrating physical and mental health services, enabling joint working between primary, community and acute services, and supporting transition to adult service. This will be achieved through a clinically led, holistic approach to improve outcomes for children and young people; delivered through four workstreams (SEND, Emotional Health & Wellbeing, Community Provision for physical health and Urgent Care)…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Supporting the expansion of Children and Young People's mental health services - We will review community provision to inform development of a transformed model that meets the needs of children consistently across Derbyshire with greater integration between primary, community and specialist care; including local council provision.	✓				
We will engage with clinical networks as they are rolled out to support the work being led through the condition specific workstreams, to improve the quality of care for children with long term conditions such as asthma, epilepsy and diabetes. In doing so we will improve care for children with diabetes and complex needs, reviewing the pathway and services for treating and managing childhood obesity by 2022/23. This will be supported by a clearly defined childhood obesity strategy at all levels of need, implemented across the system. We will also work across the children's and condition specific workstream for Respiratory conditions to review pathways for children/ young adults with Respiratory Conditions.	✓	✓		✓	
We will develop a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults by 2023/24. This will be developed with SEND strategic boards so that the mental offer is also responsive to 0-25 year olds that also have SEND needs. This will mean both SEND and mental offers will be aligned and integrated where appropriate with clear pathways that are effective, responsive to need and maximise resource.	✓	✓	✓	✓	✓
We will review and establish a clear understanding of need of the Mental Health Support for Children in Care and care leavers who are placed in care out of area. We will work with our locally commissioned Emotional Health and Wellbeing Service to ensure each child place d out of area has a good quality effective and appropriate service that will be able to address assessed mental and emotional needs with a view to improving placement stability and reducing out of area placements from the baseline.	✓				
We will undertake an Eating Disorder service review to improve access and wait times, actively promoting the THRIVE model to deliver early interventions, with a new service by Sept 2019 to achieve the 95% standard in 2020/21 which will be maintained thereafter.	✓	✓			
Implementation of the system wide long term plan will be delivered and monitored through the STP and fully aligned with the Future in Mind local transformation plan. It will be refreshed annually.	✓	✓	✓		
Linking with the urgent care workstream and the estates enabler workstream, we will ensure the estates redesign across emergency departments and in the Paediatric wards align to the STP strategy.	✓	✓	✓	✓	✓
CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice [from 2022/23]. We will improve the mental and emotional well-being of young people known to the Youth Offending Service, ensuring support is in place in both CAMH Services and training in place across the JUCD system and review arrangements for children in care and care leavers who are in care out of area. During 2019/20 we will reduce waiting times by ensuring adequate access to community based early effective intervention services, ensuring an understanding of roles and responsibilities and clear timed process for completing Education Health & Care Plans; consistent service specifications and processes will be developed across the footprint as well as a review of core CAMH services.	✓			✓	
We will develop keyworkers for children and young people with the most complex needs and their carers/families from 2020/21 by developing robust multi-agency community provision that wraps around the child to effectively address their mental health needs and keep them safe. There will be 24/7 mental health crisis provision for children and young people accessible via NHS 111 by 2023/24, that combines crisis assessment, brief response and intensive home treatment functions. So that by 2028 we move towards a service model for young people that offers person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.	✓		✓		✓
We will develop a robust multi-agency community provision that wraps around the child to effectively address their mental health needs and keep them safe by developing our whole school approach to CYP's mental and emotional wellbeing. This will be done by implementing 4 x Mental Health Support Teams (MHSTs) The MHST's will be implemented within education settings across Derby & Derbyshire by January 2020 with full mobilisation from April 2020.	✓	✓			
We will work with Public Health commissioning colleagues to increase uptake, coverage for childhood vaccinations; diphtheria, tetanus, poliomyelitis, pertussis, HiB, hepatitis B, rotavirus, MenB, MenC, pneumococcal, MMR by 2020/21	✓	✓			

Delivering Further Progress on Care Quality and Outcomes: Learning Disabilities & Autism

We will reduce the causes of morbidity and preventable deaths and transform care for people with learning disabilities & / or autistic spectrum conditions who display behaviour that challenges including a mental health condition…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
We will ensure that at least 75% of people per year with a Learning Disability and/or Autism aged over 14 years receive an annual health check, carried out to a consistently high standard, and make sure that people with a learning disability get timely access to the healthcare they need in the right place, at the right time by : Improving access to annual health checks and diagnostic services, monitoring contracts held with primary care practices to ensure achievement of 75% uptake rate. Review of performance to identify best practice in increasing uptake for health checks for those with a learning disability and identification of areas of poor uptake to provide additional support to PCNs by 2020/21. We will also implement national guidance regarding eye, hearing and dental checks for young people in residential schools by 2021/22	✓	✓	✓		
We will ensure that we continue to learn from the deaths of people with Learning Disabilities; ensuring all deaths are reviewed within 6 months by 2019/20 which will be supported by the recruitment of a dedicated Learning Disabilities mortality review (LeDeR) reviewer and support	✓				
We will work collaboratively to reduce reliance on inpatient services so that by 2020/21 no more than 28 (currently 48) people are receiving inpatient care within both secure and acute hospital facilities, as they will be better supported in the community; leading to the eventual closure of hospital facilities from 2021/22. We will achieve this by: - Completing a Specialist LD inpatient Assessment and Treatment service review and agreeing a delivery plan for improvement in specialist LD inpatient services in 2019/20 We will continue to work as a system to reduce restrictive practices including the use of seclusion and long term segregation, ensuring all providers are using the 12 point discharge planning guidance. Put procedures in place to audit compliance with PBS training requirement in 2019/20 and develop plans based on outcome of audit by 2020/21. Further development of intensive support teams (crisis and forensic) to support greater levels of independent living in the community by: - Full implementation of new service model across counselling and psychology services - Standard multi-disciplinary intensive support service offer in place across both providers to provide intensive assessment and treatment for individuals within their own home and respond to urgent care needs to avoid admissions wherever appropriate. - Undertaking LD short breaks service user reviews and assessments to develop options regarding LD Short Breaks services in 2020/21	✓	✓			
We will further develop intensive support teams (crisis and forensic) to support greater levels of independent living in the community by 2020/21 by: - Undertaking a review of system wide crisis response (including feedback from individuals and carers) to develop the model for the integrated wrap round offer in 2019/20; ensuring mental health services offer crisis support for people with autism without a learning disability, LD & ASD forensic service in place with clearer links into mental health forensic services - Development of an Integrated earlier intervention model for crisis, further development of care provider market to increase personalised community care provision	✓	✓			
We will further develop our approach to personalised care and support planning by embedding the use of PHB's to deliver interventions as identified in individuals care and support plans, alongside CHC and S117 entitlements by 2020/21. This will be supported by comms plan to support roll out of key tools to support development of Personalised care and support / stay well plans and work with key providers to embed use of PCSP for all individuals on DSR, confirming the system approach to CPA and review of current use of PHB's to support people with LD &/or ASD outside of CHC.	✓	✓			
We will monitor and reduce the over prescribing of anti-psychotic medication (STOMP / STAMP) by establishing a baseline in 2019/20 and re-audit in 2020/21. A stakeholder group has been established, including PCN Clinical Directors to progress the areas identified in the national STOMP audit 2018/19	✓	✓			
We will ensure local systems are updated to meet national requirements of digital flag to identify patients who require reasonable adjustments by raising awareness and skills to establish a system wide action plan to enable use of digital flags by 2020/21, by developing a system wide workforce action plan and undertaking a skills audit across statutory health and social care services to identify areas for further training re LD & ASD in 2019/20 and developing a system wide training plan by 2020/21 to support.	✓	✓			
We will ensure all LD quality standards are met by undertaking a system wide audit/collation of performance against LD quality standards in 2019/20 to inform development of short and medium term action plans to deliver standards by 2020/21. This will include the digital flag to identify patients who require reasonable adjustments	✓	✓			
We will develop a system wide engagement strategy to support improvements and support quality monitoring and improvements by 2020/21	✓	✓			
We will continue to ensure Care and Treatment Reviews/Care Education and Treatment Review's (CTR/CETR) are undertaken when considering admission and in community settings so that 75% of adults and CAMHS patients have an inpatient CTR/CETR within agreed timeframes and 75% of adults and 90% of CAMHS patients having a pre or post admission CTR/CETR.	✓	✓			
Implementation of Key Worker role for all C&YP with complex needs by developing of business case and delivery plans based on national guidance to ensure rollout by 2023/24		✓		✓	
We will continue to ensure dynamic risk stratification and registers are in place throughout 2019/20 and maintained thereafter	✓	✓			

Delivering Further Progress on Care Quality and Outcomes: CVD and Stroke

Over the next five years, we will support people to manage their own health and train staff to have the conversations which help patients make the decisions that are right for them. As a system, we will improve the prevention, early detection and treatment of cardiovascular disease (CVD)…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Improving prevention and early detection of Cardiovascular disease (CVD): During 2019/20 we will strengthen links to be part of the Local ISDN development and redesign our current Cardiac Rehab Model, supporting improvements in Heart Failure pathways, implementation of community BP screening and a Familial Hypercholesterolemia Genetics Diagnostics Service. We also plan to implement a programme of workforce upskilling in relation to hypertension diagnosis and management, promoting increased AF detection in primary care.	✓	✓			
Our digital technology offer will be expanded from 2020/21 to further support prevention, self-management and early diagnosis through systematic case finding and risk stratification of people with hypertension, Blood Pressure Screening in community settings / pharmacies. We will expand our work with stakeholders to support readily accessible tests of high risk conditions with particular focus on people from deprived and disadvantages groups.					
We will improve treatment of CVD and increase the number of people with CVD who are treated for the cardiac high-risk conditions; Atrial Fibrillation, high blood pressure and high cholesterol by reviewing and redesigning our CVD services for people with SMI and developing our workforce upskilling plans aligned to CVD interventions during 2020/21. We will work with the national stroke team to develop and roll out a digital approach to improving stroke pre-hospital pathways and communication, and work alongside the national CVD and Respiratory programme to implement the CVDprevent audit, delivering improved outcomes for CVD . We also plan to work with voluntary sector partners to launch a campaign to increase number of volunteer responders to help improve outcomes of out-of-hospital cardiac arrests. During 2021/22 we will develop the Derbyshire CVD Risk Stratification Strategy, review and scope to increase Defibrillator usage across Derbyshire, working with PCNs on Digital Apps expansion to increase referral and uptake of cardiac rehabilitation. We will further develop the House of Care model across Derbyshire to support all LTCs, including CVD.		✓	✓	✓	✓
From 2022/23 we will work with providers to support the training of hospital consultants to offer mechanical thrombectomy, improving and configuring stroke services, to ensure that all patients who need it, receive mechanical thrombectomy and thrombolysis. We will further improve and align services to the GP Contract and allocate fair shares funding allocation (from 2019/20 to 2023/24) to support workforce development. We will review and identify further opportunities for Enhanced Services aligned to improved end to end pathways including the EoL CVD pathway. This will ensure that by 2023/24 our plans will be built on the increased availability of technology that will assist the expansion of life-changing treatments to more patients.					
As a system, we have developed robust plans, and effective local clinical and system leadership to develop and improve stroke services, centred around delivering Integrated Stroke Delivery Networks (ISDNs) and built upon the NHS Rightcare Stroke resource pack to identify further opportunities. We will continue to work with national stroke team during 2019/20 to implement revised payment structures for stroke services and the development of the CQUIN for post-stroke reviews and Thrombectomy staffing. We plan to facilitate Early Supported Discharge (ESD) for all patients for whom it is appropriate, during 2020/21, developing plans to integrate ESD and community services through revising and redesigning our post-hospital stroke rehabilitation models and further developing our community placed base services. During 2022/23, we will review and identify further opportunities for Enhanced Services aligned to improved end to end pathways.	✓	✓	✓	✓	✓
From 2023/24, we will commission to support an increase in the proportion of patients who receive a thrombectomy after a stroke so that year on year more people will be independent after their stroke, promoting the best performance in Europe for delivering thrombolysis to all patients who could benefit. We will develop and implement higher intensity care models for stroke rehabilitation, building on increased availability of technology that will assist the expansion of life-changing treatments to more patients.					

Delivering Further Progress on Care Quality and Outcomes: Diabetes

We will improve early identification, services and support for people with Type 1 and 2 diabetes, in line with the Long Term Plan commitments…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
We have set out local referral trajectories that will contribute to the national Diabetes Prevention Programme (DPP) to support 525 people through the programme by 2019/20. In order to achieve our trajectories, we will implement a targeted plan to increase uptake, which will be delivered by a 'Prevention Facilitator'. During the year we will recruit a second Prevention facilitator to provide greater impact with delivery of the targeted plan. We have established a communication plan to launch the updated Derbyshire wide prevention pathway and will complete the Phase 3 local procurement against the 2019 NDPP framework, which includes both a face to face and a digital offer. From 2020/21 Phase 3 NDPP roll out will commence and continue to deliver the targeted plan in primary care, improving quality of referrals to NDPP and increasing course take up as per our trajectories and in line with the national plan.	✓	✓	✓	✓	✓
Support for more people living with diabetes to achieve the three recommended treatment targets (3TTs); We plan to support improvement in achievement of the 3TTs during 2019/20, based on a review of the impact and learning from our north quality scheme, which supports practices to undertake more patient reviews. We will also review the impact and learning from the proof of concept in the south in which practices are delivering innovative 12 month Place level schemes to improve 3TTs. We will continue to up skill and support Primary and Community care staff to enable up to 20% of people living with Type 1 diabetes who are eligible under the clinical criteria for that funding, to access flash glucose monitoring devices and to better enable people with diabetes to self-manage their condition. Working alongside the maternity work stream, from April 2020 we will ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring , where clinically appropriate, establishing baseline data. During 2020/21 we will take learning from the 2019-20 primary care schemes to develop our PCN approach, continuing to support more people living with diabetes to achieve the 3TTs. Alongside this, we will continue to deliver the upskilling workforce training programme and monitor to ensure that all pregnant women with type 1 diabetes are being offered continuous glucose monitoring, reviewing the pathway for type 1 pre-gestational women in conjunction with maternity work stream to identify any areas of variation. We will review our pathway and services for treating and managing childhood obesity during 2021/22 in order to improve care for children with diabetes and complex needs; we will continue to monitor to ensure that all pregnant women with type 1 diabetes are being offered continuous glucose monitoring and develop our pathway for type 1 pre-gestational women in line with outcome of review completed in 2020/21.	✓	✓	✓	✓	✓
We will improve access to Diabetes Structured Education by expanding the provision of digital and face-to-face structured education and self-management support tools for people with Type 1 and Type 2 diabetes; providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20. We will utilise transformation funding to increase course capacity and reduce waiting lists for type 1 DAFNE courses, engaging with stakeholders to develop a strategy for delivering a range of type 1 structured education courses including DAFNE and digital, and a range of type 2 structured education courses including face to face and digital. In order to develop our sustainability plan to increase capacity for structured education across a variety of options, from 2019/20 we will support the roll out of clinical networks to ensure we improve the quality of care for children with diabetes. Our sustainability plan will be implemented in 2020/21 and will focus on increasing the uptake and completion of type 1 structured education courses by offering a range of course formats and making them more accessible and rolling out the National HeLP - Healthy Living for People with Type 2 Diabetes online self-management support programme and accompanying structured education pathway, Commencing in 2021/22, we plan to review our structured education options for children, parents, women with pre-gestational diabetes and women with diabetes planning pregnancy further increasing the update of structured education. From 2022 we plan to continue to use Tapered Diabetes Transformation funding to support increased capacity of type 1 and type 2 structured education	✓	✓	✓	✓	✓

Delivering Further Progress on Care Quality and Outcomes: Diabetes

We will improve early identification, services and support for people with Type 1 and 2 diabetes, in line with the Long Term Plan commitments…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Our plans for 2019 onwards include targeting variation in the achievement of diabetes management, treatment and care processes and addressing health inequalities through the commissioning and provision of services. We will continue to provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+, which will be adjusted appropriately for ethnicity and will have a significant impact on improving health, reducing health inequalities and reducing costs.	✓	✓	✓	✓	✓
We will reduce existing health inequalities by introducing a standardised care approach within GP systems, catering for multiple languages, and providing options for patients without digital skills. We also aim to engage more young people with type 1 and type 2 diabetes to improve self-management, attend clinic appointments and improve use of medication through a dedicated Transition worker.					
We will continue to make improvements to the foot care pathway across Derbyshire with the aim of reducing episodes of foot disease by ensuring universal coverage of multidisciplinary footcare teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care. We plan to work with Diabetes UK to complete a review of our current (four) foot care pathways in 2019/20 in order to understand where there is variation in service delivery and outcomes and to articulate one Derbyshire diabetes foot care pathway. Based on our review, we will develop a programme of consistent foot care training for primary and community care staff, enabling staff to complete good quality foot assessments and provide consistent self-management advice. We plan to transfer our outpatient activity to community podiatry and will develop a sustainability plan to be proposed for delivery in 2020 when the current licence expires. Following this, we will review the impact of the expanded north community interdisciplinary foot care team and develop a further sustainability plan proposal.	✓	✓	✓	✓	✓
From 2020, we plan to identify efficiency opportunities within the pathway and improve integration between providers. This will enable us to communicate a clear accessible Derbyshire foot care pathway to people with diabetes and healthcare professionals, which will raise awareness about diabetic foot risks. Diabetes Inpatient Specialist Nurse (DISN) pathways will be developed from 2019/20 with EMAS which will enable ambulance staff to speak directly to DISN from the persons home with aim to prevent conveyance, the aim is to prevent admission for people who can be managed from a rapid access clinic. We will continue to develop our plans to maintain increased capacity DISN within the acute hospitals, improving support for long term condition management for those with diabetes.					

Delivering Further Progress on Care Quality and Outcomes: Respiratory

***We** will support local identification of respiratory disease and increase associated referrals to pulmonary rehabilitation services for those who will benefit, supporting people to manage their own health, particularly for the most socio-economically disadvantaged people who are disproportionately represented in this patient cohort…*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
By ensuring 76% of patients seen in HOT clinic are discharged home the same day, we aim to see a reduction in respiratory related non-elective spend from 2019. Following a review of the National Network Service Specification for Medication, we will adapt and develop the implementation strategy to localise it for Derbyshire during 2020/21. This will lead to a review of the Derbyshire Breathlessness pathway, and plans to utilise more digital technology, increasing the use of appointments and telehealth. During 2021/22, we plan to expand our pulmonary rehabilitation services and test new models of care for breathlessness management in patients with either cardiac or respiratory disease, working with the national Respiratory Team to test A1 technologies to interpret lung function test and support diagnosis. We will also complete a review of national programmes for respiratory diseases with testing in order to improve services in Derbyshire. We plan to commence a review of children/young adults with respiratory conditions during 2022/23, enabling us to complete a service benefit review of the existing respiratory model for Derbyshire, and working closely with providers we will ensure our models of care and pathways are efficient and effective. This will enable us to implement a 'new' respiratory service model for Derbyshire during 2023/24, based upon RightCare data, Model Hospital data packs and increased availability of technology which will assist us in providing life changing treatments to more patients.	✓	✓	✓	✓	✓
Our respiratory priorities for 2019/20 are focused on adopting a 'whole person' approach to respiratory care whereby those at risk of lung disease, or those with confirmed disease, are proactively supported earlier in their pathway to prevent health deterioration and unnecessary admissions. We will ensure that all people admitted to hospital who smoke are offered NHS-funded tobacco treatment services via provision of an inpatient smoking cessation service (currently at UHDB). We will continue to improve support for patients, carers and volunteers to enhance 'self-management' and increase systematic signposting to lifestyle services to support people to access stop smoking services, with the aim of improving upstream prevention of avoidable illness and its exacerbations through smoking cessation. It is our aim that 40% of patients who start inpatient smoking cessation successfully quit at 4 weeks. Our plans will be developed during 2021/22 in partnership with Public Health to increase uptake of flu vaccinations to meet and exceed PHE immunisation targets and also to support expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments implemented.	✓	✓	✓		
Alongside the above, we will continue to support implementation and delivery of the government's five-year action plan on Antimicrobial Resistance developing local plans to tackle Antimicrobial Resistance and reduce overall antibiotic use and drug-resistant infections.	✓	✓	✓	✓	✓

Delivering Further Progress on Care Quality and Outcomes: End Of Life Care (EoL)

Our EoL programme of work incorporates the six ambitions set out within the National Framework for EoL. Our ambition is to provide truly collaborative, co-ordinated care, standardised County wide but offering personalised care and support for individuals; allowing people to die in their preferred place of care with support, care and maximising symptom control…

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Based on the foundations that support the ambitions for Palliative and EoL care, we will ensure that everybody approaching the end of their life is seen as an individual and offered the chance to create a personalised care plan based on their needs, preferences and wishes. We will ensure that opportunities for informed discussion and planning are universal and ongoing with options regularly reviewed. To ensure the plan guides a person centred approach we will ensure it is available to the person and, with their consent, can be shared with all those who may be involved in their care. We will utilise our IT infrastructure to share care plans and reduce unwarranted, unnecessary, expensive hospital admissions and so giving better quality of life to the person and their family. We have developed an electronic ReSPECT form which is ready and planned for County wide distribution in 2019/20. This will ensure a focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney and 'living wills'. The use of technology and other mechanisms will continue to be a priority to ensure those wishes are known and adhered to wherever an individual enters the health and care system.	✓	✓	✓	✓	✓
We recognise that there is currently a wide variation on the services available for EoL across the county and also by condition. Cancer EoL services are, in most cases, more available than those for Long Term Conditions for example. Therefore we will review services county wide to ensure we are consistently meeting the standards to provide the care that patients and their carers need to die comfortably, in the setting of their choice and with dignity.	✓	✓	✓	✓	✓
We plan to review and accelerate the roll out of Personal Health Budgets to give people greater choice and control over how care is planned and delivered. This will include expanding the offer for people receiving specialist end of life care, maximising comfort and wellbeing. We recognise that timely CHC input reduces inappropriate admissions, carer crisis, stress and distress. Therefore, we have developed an electronic Fast Track form which decreases the time needed to complete and process the form and will implement its use across the county during 2019/20. Further, we will develop a county wide policy of filling syringes based on the service established in the South of the County to ensure geographical consistency.	✓	✓	✓	✓	✓
The Derbyshire STP EoL Strategy will be signed off during 2019/20 with the aim of delivering consistent care across the county by 2020/21 and delivery of strategic intentions across the system by 2021/22. We will continue to build on the strategy which emphasises local leadership, service delivery and accountability. We recognise that Palliative and EoL care requires collaboration and cooperation to create the improvements we all want. Therefore, cross-organisational collaboration is vital to design new ways of working that will enable each community to achieve better EoL care. We will consistently enable this through the STP EoL group which facilitates joint working by being a focal point for delivery.	✓	✓	✓		
In Derbyshire we will ensure 'All staff are prepared to care' by completing a review of education requirements for the system, subsequently we will continue to roll out training to help staff identify and support relevant patients, and continue to promote proactive and personalised care planning for everyone identified as being in their last year of life. From 2021 we will develop a County education plan which will support and train staff to have personalised care conversations, helping them to identify and care for patients in their last year of life with personalised, proactive care planning.	✓	✓	✓		
We will continue to develop a county wide approach that supports open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care. This will ensure that each community is prepared and that opportunities for informed discussion and planning are universal. Our plans are focused around the individual and those important to them, so they will be locally led and delivered, supported by us all across all communities. We will continue to develop a county wide approach that supports open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care.	✓	✓	✓	✓	✓

Giving our staff the backing they need

The value we place on our collective workforce is of significant importance to Joined Up Care Derbyshire and is reflected in our ambition to deliver the quadruple aim…

The Derbyshire system has come together to develop our strategic approach in relation to workforce which is overseen by the Local Workforce Action Board (LWAB). We have made significant improvements since our original STP plan in 2016, although we recognise that there is a considerable shift required to truly implement the broader workforce changes required to deliver the LTP ambitions and continue to ensure we improve overall staff experience and resilience.

We intend to make our health and social care system the best place to work, which is consistent with the ambitions set out in the NHS Interim People Plan. Our workforce plan will be structured to enable the system to:

- Improve our leadership culture at all levels
- Tackle the nursing challenge
- Deliver 21st century care
- Develop a new operating model for workforce

Our Strategic Approach

We have agreed a set of system workforce objectives which move us towards a new operating model for workforce; these include:

- Streamlined recruitment and employment processes so that we 'recruit once for Derbyshire' wherever possible, enhanced mobility around the system and eliminating non value adding processes and duplication
- One set of employment policies and contract documentation for all organisations (starting with the Disciplinary policy).
- A single workforce dashboard which identifies a set of key system workforce metrics which will evidence workforce transformation and progress against shared objectives
- A whole system approach to developing new roles, specifically ACPs and advanced practice, Trainee Nursing Associates, including recruitment, training and deployment
- A whole system approach to the delivery of mandatory training
- A system well being offer for staff in Derbyshire including general practice
- Our aim is to reduce agency spending by 2023/24 through improved recruitment and retention, introduction of new roles and ways of working in the context of more proactive and preventative approaches in the community to reduce the need for secondary care services. Whilst we develop these plans we will maintain compliance with the agency spending cap.

Transforming the way in which our staff work

We recognise that we have challenges in certain areas such as recruitment and retention; specifically medical staff in ED, qualified nurses, Ophthalmology, Urology, LD and Psychiatry. The local labour market in Derbyshire has high employment levels (79%, compared to 76% nationally) with the number of vacancies steadily increasing across all sectors, making recruitment of care staff increasingly difficult.

Building leadership across all levels

The Derbyshire offer for our future workforce will include more flexible working patterns to appeal to generation X and Y, and we will ensure all our organisations have a positive, inclusive, person centred leadership culture at all levels. To enable this, we are developing a longer term system Organisation Development Plan which will complement existing OD and leadership plans within Trusts; building on the significant work undertaken to date within the system to develop the capability within the system to enable transformation. The system plan will be going to the STP Board in November 2019.

A collaborative approach to attraction and retention under the banner *'Joined Up Careers Derbyshire'*, with an initial focus on apprenticeships and promoting careers in health and care to school leavers, piloting an integrated health and care apprenticeship

Improving mental and physical health and enabling flexible working

We have commissioned Sheffield Hallam University to support Derbyshire in developing a system wide approach to wellbeing. Through this approach we will:

- Develop a better understanding of how the organisations support workforce wellbeing; the current offer
- Derive data to determine need, improve monitoring and evaluation of impact
- Align approach to examples of best practice (within organisations/other NHS organisations/research)
- Identify gaps between current service provision and best practice (Overall wellbeing and OH)
- By the end of 2019/20 the Derbyshire system will have proposals and recommendations with regards to the next steps for workplace wellbeing.

Giving our staff the backing they need

The value we place on our collective workforce is of significant importance to Joined Up Care Derbyshire and is reflected in our ambition to deliver the quadruple aim…

Enabling transformation and delivering our Model of Care

We have identified a number of actions earlier in this section to demonstrate our strategic approach to workforce which will enable transformational improvements, deliver our model of care along with the ambitions of the NHS LTP. In addition we will:

- Further develop our system approach to retention and wellbeing in general practice in collaboration with the LMC overseen by the GP Workforce Steering Group (e.g. first 5 years support, practice manager development programme)
- Explore the opportunity to develop a lead employer model to support increased training and deployment of Advanced Clinical Practitioners in collaboration with Nottinghamshire ICS to strengthen our capability and resilience
- Build on the Physician Associate training programmes in the north of the county and raise awareness of the potential of the role in all care settings
- Build postgraduate assessment and supervision into job plans
- Develop new approaches to expand capacity for trainee nursing associate placements in the private, voluntary and independent sector
- We will introduction of new roles e.g. Psychology led services
- Develop a skilled and relevant pharmacist and pharmacy technician workforce both as part of PCNs and integrated care working within and across systems including specialisms

Changing the Skill Mix and Introducing New Roles

Out of a current total health and care workforce of 19,625 (contracted available FTE), circa 14.5k work in an acute setting. As the expected growth in workforce is predominantly expected to be in community and non bedded care settings, this presents a challenge in terms of shifting staff into different settings, and working alongside a more diverse team from health, care and the voluntary sector.

We will continue to work closely with the Programme Leads for each of our programme areas to ensure the workforce implications in relation to the key deliverables set out in this plan are genuinely supported; we will identify how they envisage growing and transforming the workforce in line with the LTP ambitions, which will be triangulated with the organisational numerical forecasts. Appendix 5 summarises the key workforce implications identified from the delivery plans. From the strategic planning work we have done to date, we envisage a greater increase at advanced and foundation level roles than in core and extended level practitioners.

We have plans to further extend the Public Health and wellbeing agenda over the next two years by equipping 1400 Derbyshire health care, Derbyshire social care and primary care practitioner partners with skills in having 'Quality Conversations'. This will support person-centred interactions underpinned by a broader awareness of the wider social determinants of health and of asset and strength-based approaches to communication.

Furthermore, we will support the transformation programmes and our workforce through digital technology and innovation, through a digital skills training bid for European Social Fund funding, integrated health and care apprentice pilot, system wide Return to Practice scheme and system wide consistent training on service improvement and transformation.

Local metrics

We are in the process of further developing our local metrics which will be reflected in our overarching workforce dashboard and will be aligned to national measures as and when these are confirmed. This will include measures in relation to staff well-being.

The following table summarises the current position for our 4 Foundation Trusts against some high level indicators:

Measure	Current position *	Planned actions
Staff retention rate	88% retention rate	We will further examine the figures by job type to identify any significant variances and address these
Workforce who identify as BAME	No specific targets currently although collectively there is a 11.5% average	We are developing our approach to enable agreed targets to be in place by 2021/22; including both leadership and overall workforce.
Vacancy rates and specifically nurse vacancy rates	Overall average 7% Nursing average 7.12%	We will identify specific hot spots e.g. LD and MH and refine current plans to address the gaps
Turnover rate	Average 9.65% compared with average for NHS Midlands & East of 13%	As above
Sickness absence/ attendance	95.01%	We will identity areas of concerns and agree a sensible local target
Well Led Ratings	1 Outstanding, 2 Good, 1 requires Improvement	Programme of leadership development at system and organisational levels

In addition the Derbyshire system:

- Has low staff turnover rate compared to other Midlands systems
- Is on plan or ahead of plan for GP recruitment (3% improvement on plan), Physician Associates (0% variance from plan)
- Has recruited 2 Social Prescribers and 2 clinical pharmacists under the PCN additional role reimbursement scheme with a further 2 social prescribers to be in post by the end of November 2019.
- Respond to the requirements of the new Workforce Disability Equality Standard: All trusts will implement the requirements of the Standard and this will be incorporated into our work on EDS3 including diversity metrics.

Using our estates to maximum effect to support a 21st Century model of care

Working through our Local Estates Forum (LEF) we will continue to adopt our whole system approach in relation to our estates, ensuring opportunities to support integration are maximised…

In response to our 2016 STP plan, Derbyshire established a Local Estates Forum (LEF) consistent of all system partners. Our LEF includes strong relationships with our local One Public Estates (OPE) as key strategic partners in our approach and we have strengthened this link through a jointly funded programme manager to support the entire STP and OPE work programme and ensure the link is maintained in everything we do.

The core purpose of the LEF is:

- Reshaping the estate to support wider system service redesign
- Improving effective utilisation of the estate
- Rationalising estate

We were required to develop a Local Estates Strategy (LES) in July 2018, which set out our current position and provided a stronger foundation to support and enable delivery of individual organisation, STP and the wider NHS and Government key priorities. The LES was rated as **good** by regulators and therefore provides us with a solid foundation. In response to the national requirement for all areas to update local LES' to reflect feedback received, the LES was further refreshed in July 2019. These updates included:

- Development of a Primary Care Strategy
- Articulation of the wider STP clinical strategy
- Progress on Disposals/improved use of the estate
- Revised governance arrangements
- Reflection of closer working with the One Public Estate

The Derbyshire Estate

Acute and Community Care:

- 352 premises occupied
- 87 Ha known premises footprint
- 613,892 m2 gross internal floor area
- c£136m estate costs
- 30-33% non clinical space
- C£11m backlog maintenance

Primary Care:

- 160+ premises occupied
- C£2m backlog maintenance

Disposals opportunities: 11 Sites have been declared/identified for disposal which translates to 20 Ha total land area, c£19m estimated disposal value, 670 housing Units, and c£4.5m reduced running costs.

During 2017/18 and 2018/19 we have delivered:

- 6 sites have been sold c£20m disposal value
- Circa 600 housing units
- Circa £250k reduced running costs
- Achieved the national Naylor fair share allocation
- Secured funding for bids in each of the first 4 waves of STP funding (total capital funding circa £60M)

Our 2019/20 LES Implementation Plan contains the following key workstreams which will guarantee best use of the NHS estate and ensure the estate is a key driver in ensuring the STP/ICS clinical need is met:

- Improving estate efficiencies
- The realisation of disposals to directly improve patient care and further investment
- Capital pipeline and funding, including accessing further S106 monies
- Development of a Capital Financing Strategy encompassing BAU, equipping, BLM, capital developments etc across all sectors
- Further partnering with Local Government colleagues via OPE and LEPs

Specific areas of LEF focus within the Implementation Plan include:

- Reduction in non clinical space
- Reduction in unoccupied floor space
- Space utilisation review of South Derbyshire LIFT Co premises
- A better understanding of current and emerging Clinic Service Strategies
- Improved support and oversight of the LEF and One Public Estate
- Support of a part time Programme Manager – STP/OPE
- OPE Grant Funding for feasibility studies – Health and Social Care Hubs
- Better relationships and knowledge sharing
- Commissioning of a Primary Care Estates Strategy
- Working towards a more cohesive approach to s106 applications
- ETTF secured to make improvements in GP Estate

The LEF continues to support Trusts in the delivery of existing capital developments:

- Acute Front Door redesign – UHDB
- Urgent Care Village – UHDB
- Outwoods Development – UHDB (within Staffordshire STP)
- Improved Urgent Care Pathways – CRH
- Belper Community Hub – DCHS
- Additional bed capacity/Recommissioning of Endoscopy Services - UHDB
- Bakewell Community Hub – DCHS/EMAS

Early pipeline proposals have been identified in relation to a local PICU unit and the replacement of dormitory facilities across the Derbyshire mental health estate; these will be reflected in any future system estates plans.

Delivering Digitally Enabled Care

We will further develop our comprehensive approach to joined up digital care acting as a true enabler for transformation…

Our Vision and Priorities

- Digital services are at the heart of the JUCD shift from Managing Illness to Supporting Wellness – A clear Clinical Digital Vision underpins the Digital strategy, demonstrating how the 'quadruple aim' will be delivered;
- A Clear Digital Strategy has identified 5 themes – Citizens, Professionals, Foundations, Innovation and Analytics – that together build a robust approach to delivery of vital new services and technologies;
- The Derbyshire Digital family – Commissioners, providers and local government working together at every level to ensure seamless integration of products and services for end-users throughout Derbyshire, delivering fully integrated care records
- Flexibility to changing digital circumstances – through a principle of 'converge and connect' – implementing common shared systems wherever possible, and providing excellent interoperability products where necessary
- Value for money – Ambitious investment plans for Digital services are balanced with careful financial stewardship of existing resources;
- We are committed to supplying NHS mail accounts to all Derbyshire care homes that wish to use the service. So far, 46 (out of an estimated 310) care homes have been issued with accounts

Leadership and Governance

- Strong System Governance – A JUCD Digital Board, chaired by a provider Chief Executive, and with senior representation from all partners;
- The Digital board has a clear mandate (with TORs) a set attendance with Agenda / Minutes. All System organisations are represented and the board receives timely and accurate updates on Transformation programmes, finances, risks, issues, workforce, clinical priority changes etc.
- Clinical Leadership – Through a JUCD Chief Clinical Information Officer (CCIO) group, chaired by the CCG Medical Director;
- Technical leadership through the Derbyshire Heads of IT (HoIT) group;
- There is JUCD board visibility of digital programmes and initiatives across the system and the associated detailed plans are regularly discussed and monitored.
- There is appropriate Digital Board representation from Academic Health Science Networks (AHSNs) and strong evidence of close liaison between system organisations, digital leaders and AHSNs. There is a clear ambition on partnership working with research and industry partners.

Risks, Issues and Constraints

- Citizen Engagement – continue the development a digital awareness amongst citizens, building on the strong achievements made to date
- Staff Engagement – At a time of significant change, the digital strategy recognises the need to support colleagues through the complex changes;
- Specialist Digital Skills – Maximising the use of scarce human resources;
- Resourcing – demonstrating clear value for money is essential if the ambitious funding needs of the system are to be met;

2019/20 Operational risks

Delays in the release of national capital (HSLI – Health System Led Investment in Provider Informatics, ETTF – Estates and Technology Transformation Fund, BAU – GP Business as usual) may delay delivery of respective programmes of work;

- Emergency Care Data Set (ECDS) – delivery of ECDS for University Hospitals of Derby and Burton is delayed, with a current projected delivery date of M6/19

Next Steps

- Apply to participate in the Global Digital Exemplar (GDE) programme;
- Work towards integrating Digital services across JUCD, providing seamless services to health professionals throughout the county;
- Delivery of an ambitious work programme of activities based around the following work programmes:
  - Convergence at scale of out of hospital care records, through standardisation on a single platform throughout community, mental health and (where appropriate) primary care settings;
  - Increasing the digital maturity of Secondary care acute providers in the Derbyshire footprint, moving to a true 'paper free' status by ;
  - Delivery of a comprehensive package of interoperability tools, including fully supporting social care integration;
  - Support for ambulance service integration with local providers;
- Active participation in the Local Health Care Record Exchange programme, supporting care for Derbyshire patients in out of County locations;
- Continuing to strengthen system resilience and security to achieve 100% compliance by summer 2021;

Delivering Digitally Enabled Care

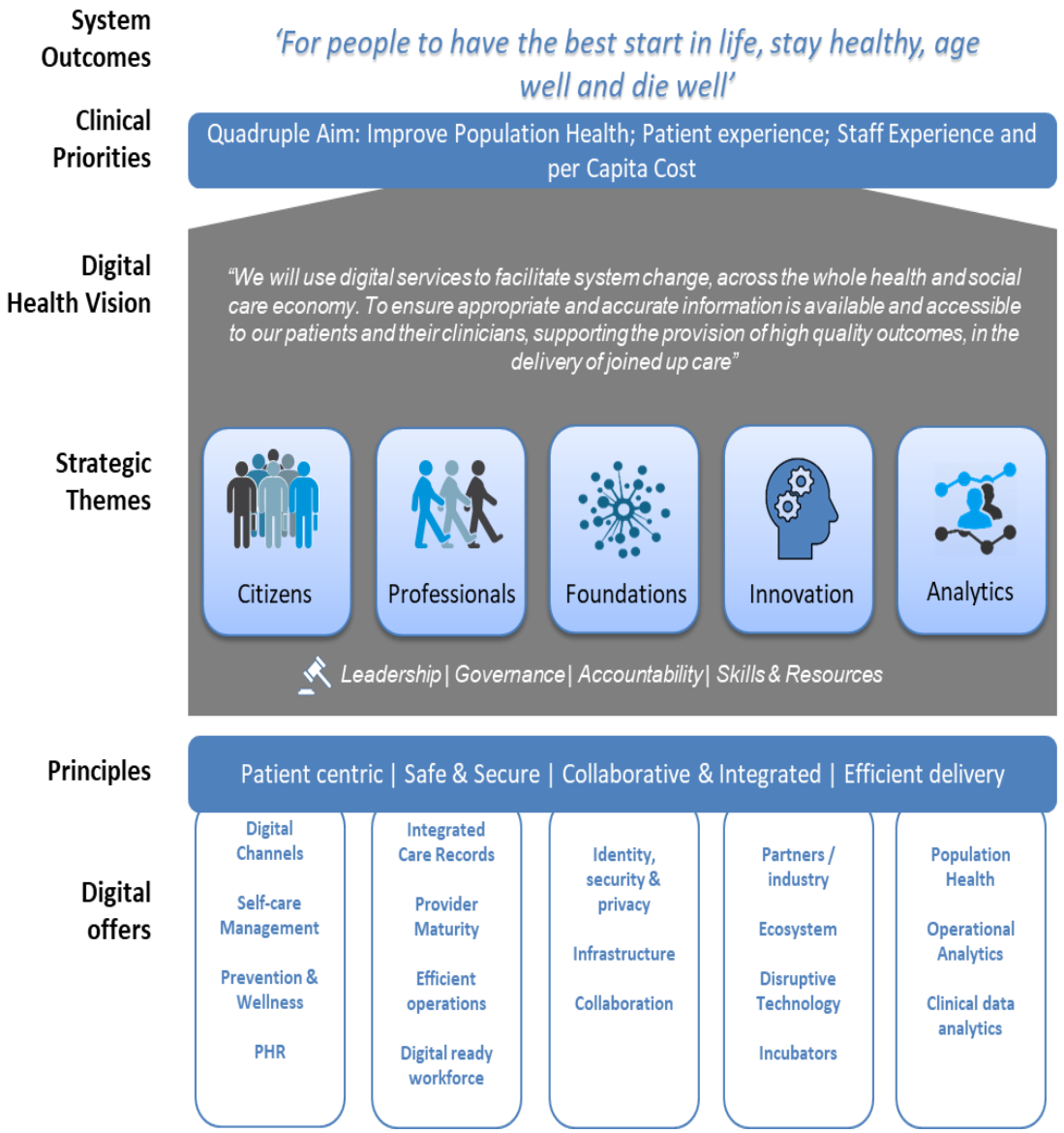
We have made significant progress to date and will further accelerate our approach through our refreshed digital strategy…

Our Achievements – the journey so far

- *Clear Digital Leadership and Governance*
- *28% of patients have electronic access to GP systems, via POLAR project;*
- *100% of GP practices are enabled to have access to NHS app;*
- *100% of GP practices have patient Wi-Fi available;*
- *100% of GP practices offering extended hours appointments;*
- *35% of patients already have access to online consultation, with plans to reach 100% by 31/01/20;*
- *20% of GP practices are enabled to receive appointment from 111 services, with plans to reach 100% by 31/01/20;*
- *Preparations in hand for implementing GP futures and Digital first;*
- *HSCN data networks in deployment;*
- *Delivery of the MIG Interoperability system;*
- *Delivery of windows 10 upgrade programme is on track to meet national deadlines Q4 2019/20;*
- *Strengthening cyber security capabilities;*
- *Delivery of year 1 HSLI projects;*
- *Commitment to supply NHS mail accounts to all Derbyshire care homes that wish to use the service. So far, 46 (out of an estimated 310) care homes have been issued with accounts.'*
- *Agreed an ambitious new digital strategy, which has significant resource implications. System-wide discussions are taking place to review options for prioritising current digital spend across all partner organisations, to enable local resources to be released to support key deliverables*

Detailed information in relation to workstream alignment and our digital strategy can be found in Appendix 6.

Moving forward enabled by the Joined Up Care Derbyshire Digital Strategy

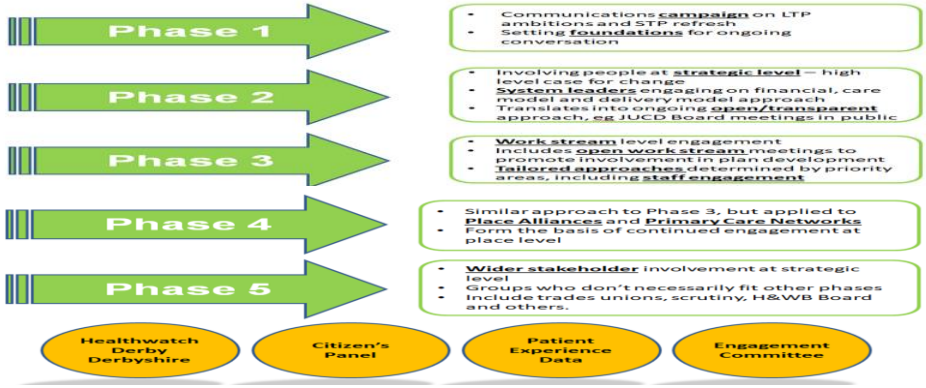


Communication and Engagement Approach

We have undertaken a comprehensive engagement approach in developing our 5 year plan and will continue to build upon this going forward. The themes which resulted have shaped and informed the plan, or have influenced on-going planning work for the STP are identified in Appendix 7.

Our approach

- Took place between April and September 2019.
- Ensured that a wide range of stakeholders, including staff, patients, their carer's and members of the public had the opportunity to help shape the plan.
- Underpinned by 5 phases, inviting engagement at a variety of different levels.
- Included the development of the Joined Up Care Derbyshire (JUCD) Citizens' Panel, which now has in excess of 1,600 members
- Supplemented by engagement conducted by Healthwatch Derby and Derbyshire, which included workshops aimed at seldom heard and marginalised groups.
- Will form the basis of continuous engagement in the work of JUCD going forward.



What engagement took place?

- All work streams utilised either established engagement mechanisms, open meetings and/or confirm and challenge sessions with their stakeholders to test out thinking and priorities during July and August
- Five Place Alliances held events during July 2019 to discuss the model of care, the NHS long Term Plan and wider determinants of health. Two other places used existing engagement forums and south Derbyshire will hold their event shortly. 35 - 60 people attended per event.
- 80 stakeholders from broad range of backgrounds (politicians, voluntary sector, NHS staff, patient groups) attended discussion session with JUCD Board in September 2019 to comment on strategic aims of the plan
- Healthwatch received input from more than 500 people through surveys and focus groups. Key questions included:
    - What services can do to provide better support (particularly for specific conditions, such as cancer, mental health, dementia, heart and lung conditions, learning disabilities, and autism)
    - How the NHS can make it easier for us to take control of our health and wellbeing
    - How they people be supported to live healthier lives from birth to old age
- 40 members of Citizen's Panel attended confirm and challenge sessions, hearing the details of urgent care, children, Learning Disability and disease management plans
- First Citizen's Panel issued in August on 'online access to health services'.

Governance

- The JUCD Board received monthly updates on the communications and engagement approach.
- The joint DDCCG and JUCD Engagement Committee had oversight and sought assurance on the process.
- The operational implementation of the approach was overseen by the JUCD Communications and Engagement Group, which acts as a coordinating body for all system-relevant communications and engagement activity.

Key stakeholders

A wider range of stakeholders have been involved in the 5 phases of our approach, including MP's, Local Councillors, campaigners with an active interest in health and care services, Foundation Trust Governors, CCG lay members, Local Authority partners, clinicians, VCS, Healthwatch, Patient Participation Group members, clergy, carers and the general public. The plan has also been considered through the local Health & Wellbeing Boards and Health Overview and Scrutiny Committees; in addition we have discussed the plan with the Derbyshire District Council Chief Executives .

A media release and stakeholder briefing were issued in June promoting to a wide external audience the aims of the refresh and the opportunities to get involved.

There was also a drive via the partner communications and engagement teams to use all existing channels and opportunities to promote the STP refresh to system staff and encourage them to get involved in the opportunities available, or feedback via staff discussions and online.

Beginners Guide to JUCD

We have developed a 'Beginners Guide to JUCD' to send out to Citizens Panel members, give out during workshops and display at events, to give people an understanding of our work and what we are aiming to achieve in terms of improvements in services for people in Derbyshire.

It covers the case for change, the need to consider the wider determinants of health, our priorities, our journey to becoming and Integrated Care System (ICS) and an overview of the work taking place in JUCD work-streams.
It will be available on our website
https://www.joinedupcarederbyshire.co.uk/application/files/3415/6750/5838/Introduction_to_JUCD_leaflet_Sep_2019.pdf

Newsletters

JUCD has a quarterly newsletter which is distributed to a wide range of stakeholders and the latest edition can be found on the website here
https://www.joinedupcarederbyshire.co.uk/news/newsletters

The impact of our plan: Activity and Finance

We have worked in collaboration to develop this plan and will continue to do so to ensure a jointly owned approach is embedded to enable delivery of our plan….

Our Approach

The system has worked collectively to ensure we have a clear understanding of our in-year financial position and forecast deficit position to 2023/24 assuming an unchanged state which has provided us with a clear baseline position. We have further developed the future years forecast position by assuming at a high level the valuation of the transformation programmes of work and broader redesign initiatives for 2020/21 and beyond.

Recognising that activity/demand pressures are a key driver to the financial and operational pressures facing the system, the model has been developed to clearly articulate the "do nothing" and " do something" plan.

The modelling work has been overseen through the system Directors of Finance aligned to each of the transformation programmes to work through as a bottom up approach as far as possible.

Assumptions

Our approach is based on the following key planning assumptions which drive the financial model:

- Forecast outturn (FOT) based on month 6
- Forward projections were based on three year rolling averages, adjusted for non-recurrent impacts and known changes
- Review of planning policy changes and assessment of required activity levels to deliver the planning requirements
- All 2019/20 QIPP is delivered in the position
- £5m set aside for investment (in addition to LTP Investments)
- 0.5% contingency per annum
- Mental Health Investment Standard (MHIS) is met
- Assumed growth:
  - Acute growth based on 3 year average (avg 3.73%)
  - Ambulance 1.68%
  - Prescribing 5%
  - Continuing HealthCare (CHC)4.5% to 5.8%
  - Community 1.1%
  - Running costs 3%
- This plan is predicated on achievement of the system control total by 2023/24, recognising that there are system and organisational risks associated with achievement of that position which will be to be further understood and worked through.

Impact

The workstream mitigating actions, identified at this stage will contribute £12.9m towards achieving a financially balanced position by 2023/24.

This impact on activity is reflected in the table below.

	Growth	Mitigations	Net position
Commissioner Expenditure area			
Secondary care	3.73%	(2.52%)	1.21%
Non Electives	3.27%	(3.27%)	(0.00%)
Elective Spells	4.13%	(4.77%)	(0.64%)
Outpatients	2.41%	(3.14%)	(0.74%)
A&E	5.63%	(5.61%)	0.01%
Other	4.18%		4.18%
Associates	3.51%	(3.60%)	(0.09%)

Impact on capacity (including beds)

The 535 beds reduction calculation originally submitted in the 2016 Derbyshire STP is no longer feasible. The local landscape has changed since then, with reduced length of stays in hospital beds and improvement to pathways that impact on the way beds are used. In addition, the merger of burton and derby hospitals has required additional acute beds to support redesigned clinical pathways. As a result we have done further modelling on growth of admissions which shows that if we do nothing and activity grows by 4.2% then we will need 2546 beds* in the Derbyshire system in five years' time compared with 2345 today, an increase of 286 beds.

We know that our main pressure on beds is happening in acute trusts, and this is where the anticipated growth will take place as greater numbers of poorly people require admission to an acute hospital bed. Our proactive and preventative work, and linking into the wider determinants of health are crucial parts of the plan to ensure that we are not 'doing nothing' and are actively tackling the growth in admissions.

In addition, our model of care in the community remains that care is better provided closer to home. We are therefore introducing more Pathway 1 (Home) and Pathway 2 (Care Home) care to ensure that patients can be discharged to the most appropriate care setting. This results in a net reduction of community hospital beds.

The two issues – acute beds and community beds – are clearly inter-related but we can reduce the number community beds at the same time as needing more acute beds as they provide different types of care. Retaining community hospital beds does not solve the acute hospital bed issue and it is our work in other programmes – disease management, prevention and planned care - which will help to solve the acute bed issue. The above provides a baseline position from which we will model our assumed growth rates for 2020/21 and beyond to better understand the anticipated bed capacity requirements for Derbyshire.

The 2546 figures quoted are total beds across the system, including community, mental health and acute beds.

The impact of our plan: Activity and Finance

The summary below provides a high level overview of the financial plan for the Derbyshire STP.

Investments

We will commit the additional LTP investments as identified in the table below to support delivery of specific LTP commitments. Where appropriate further targeted investment opportunities will also be explored.

	2019/20	2020/21	2021/22	2022/23	2023/24
	LTP allocation	LTP allocation	LTP allocation	LTP allocation	LTP allocation
	£000	£000	£000	£000	£000
Joined Up Care Derbyshire STP	10,709	10,901	15,059	22,104	31,915
1. Mental Health	1,107	1,196	3,785	7,590	10,175
(a) CYP community and crisis		58	1,161	1,792	2,948
(b) Adult Crisis		1,138	540	722	941
(c) New integrated models of Community and Primary care for SMI			2,084	5,076	6,286
2. Primary Medical and Community Services	6,456	7,205	8,284	10,822	13,180
(a) Primary Care	6,456	6,677	7,051	7,225	7,125
(b) Ageing Well		528	1,233	3,597	6,055
3. Cancer	2,383	1,701	1,331	1,277	1,280
4. Other	763	799	1,659	2,415	7,280

Financial Plan

- The STP plans to return to a surplus position of £14.9m by 2023/24.
- 2019/20 will be the baseline period which will form future year projections based on forecast out-turn
- The baseline will be uplifted for growth (based on activity assumption identified earlier) and inflation
- Commissioners and providers will also deliver technical efficiencies
- The future financial plan will be underpinned by agreed risk share and risk management arrangements; managed through the system governance
- The STP will use the financial plan as the basis for agreeing contracts with providers to ensure the sustainability of the system but there will need to be a critical refresh associated with the systems actual recurrent outturn position and the bottom up calculation of the availability of efficiencies in year 1.
- Work is continuing to further map the impact of the transformational changes to mitigate the challenges identified in our case for change including financial, workforce and activity

Outstanding Issues and Next Steps

Whilst we have made significant strides in our collective approach, we will continue to work collaboratively to effective manage demand and resource which will be reflected in our future operational plans. We will do this by:

- Develop our transformation planning on an efficiency basis
- Develop a better understanding in relation to the impact of the Staffordshire plans on the Derbyshire system, given one of our main acute providers sits across both footprints
- Further development of the mitigations within the STP plan and their impact inside and outside the STP where those providers cross a number of STP boundaries.
- Firm up our underlying recurrent position going into 2020/21
- Further enhance system mitigations to ensure full reflection of transformation deliverables
- Continue working from the bottom up
- Develop a single system transformation plan for 2020/21 and beyond
- Further assessment of risk associated with plan delivery and development of mitigations
- Assess options to reduce the level of premium cost activity
- Identify additional step cost reduction opportunities particularly in relation to estates

System In Year Underspend/(Deficit)

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
NHS Derby and Derbyshire CCG	(29,000)	(29,000)	(10,780)	(610)	4,320	6,480
Chesterfield Royal Hospital NHS FT	6,858	6,858	7,515	1,287	1,327	1,367
Derbyshire Community Healthcare Trust	1,832	1,832	2,200	1,032	1,062	1,092
Derbyshire Healthcare NHS FT	615	615	1,192	635	645	655
East Midlands Ambulance Service	(5,069)	(5,069)	(4,068)	(2,348)	(238)	1,072
University Hospitals of Derby and Burton NHS FT	(12,146)	(15,261)	(4,251)	1,469	4,269	4,269
Underspend / (Deficit) - (Excl.. CSF,PSF,FRF Incl. MRET)	**(36,910)**	**(40,025)**	**(8,192)**	**1,465**	**11,384**	**14,935**

Note: The CCG 2019/20 FOT position is based on confirmed quarter 1 Commissioner Sustainability Funding

Information in relation to system capital expenditure can be found in Appendix 8.

The impact of our plan: Improving Population Outcomes

Delivering our Joined Up Care mission to improve population health outcomes for the people and communities we serve will enable us to ensure that the people in Derbyshire have the best start in life, stay well, age well and die well. Working together, and with strong and vibrant communities through our Places, we will keep people safe and healthy – free from crisis and exacerbation, at home – out of social and healthcare beds and independent – managing with minimum support. To do this we will ensure all our services are well run, integrated and make the best use of the available resources…

So what is our plan saying?

Population Level Outcome	For the people of Derbyshire this means that…..
Best Start in Life **A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support**	Expectant mothers will be better supported through personalised care planning, continuity of the person caring for them , access to digital health records and enhanced postnatal support .
	Children and young people will receive improved mental and emotional wellbeing support, with improved access to urgent care and psychological support when they need it, including 24/7 mental health crisis provision
	A Community Wellness approach will be developed where individuals and families can receive the support they need to improve their physical and emotional health and wellbeing;
Stay Healthy **Helped to live a healthy life, make healthy choices and protected from threat. Able to maintain quality of life and recover from ill health or injury**	Care for people with learning disabilities and autism will be transformed. Intensive support teams will be developed to support independent living in the community
	Mental Health services will receive increased investment . We will reduce the length of time people spend in hospital and end the need for out of area placements. More people will be supported through a Primary Care and Mental Health wellbeing approach, including increasing access to psychological therapies
	People have access to care at the right time and in the right place. With more staff, and through a diverse skill mix , we will improve access to General Practice including same day urgent care services in primary care and in our community-based Urgent Care Treatment centres.
	Where people do need hospital care , access to urgent and routine care will be improved and services will be tailored to their needs. This way we will enable people to recover from ill health or injury quickly and to return home at the earliest opportunity. We will transform the way outpatient services are delivered, reducing the need for face to face outpatient appointments by a third and using digital technology to support prevention and self-management
	Primary Care Networks will develop and deliver multidisciplinary care and services that meet the needs of the patients and communities and operate as a single team to wrap care around a person and their family. Care and treatment will be provided closer to home, such as treating minor eye conditions and support to patients' wellbeing through social prescribing.
	Cancer outcomes will be improved. We will improve the early diagnosis of cancer by increasing the uptake of screening programmes and extending access to diagnostic tests. We will ensure that people living with cancer have improved access to high quality treatment and care, including psychological support.
Age Well, Die Well **Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable and supported end of life**	People with dementia will be supported through the Derbyshire Well Pathway for Dementia ; providing the best care possible for people living with dementia, their carers and those important to them.
	Older people will receive proactive, person centred and integrated care. We will embed the frailty model of care for Derbyshire to manage frailty as a long term condition in its own right, rather than treating it as a label
	People living in care homes will receive more NHS support ,ensuring their needs assessed and met and reducing the need for unnecessary and avoidable hospital admissions
	People approaching the end of their life will have fair access to personalised end of life care and support and to die in their preferred place of care. We will promote honest and open conversations about death across communities. and that those caring for the dying person are involved and supported .

Timetable for STP plan approvals

The draft plan has been shared and considered by all partner organisations as part of ongoing engagement and involvement into the development of the final plan. The plan will be agreed by system leaders ahead of the 15 November submission. The JUCD Board agreed at the meeting on 18 October that the System Executive: CEOs group would have 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 collectively managed with appropriate risk mitigations where necessary.

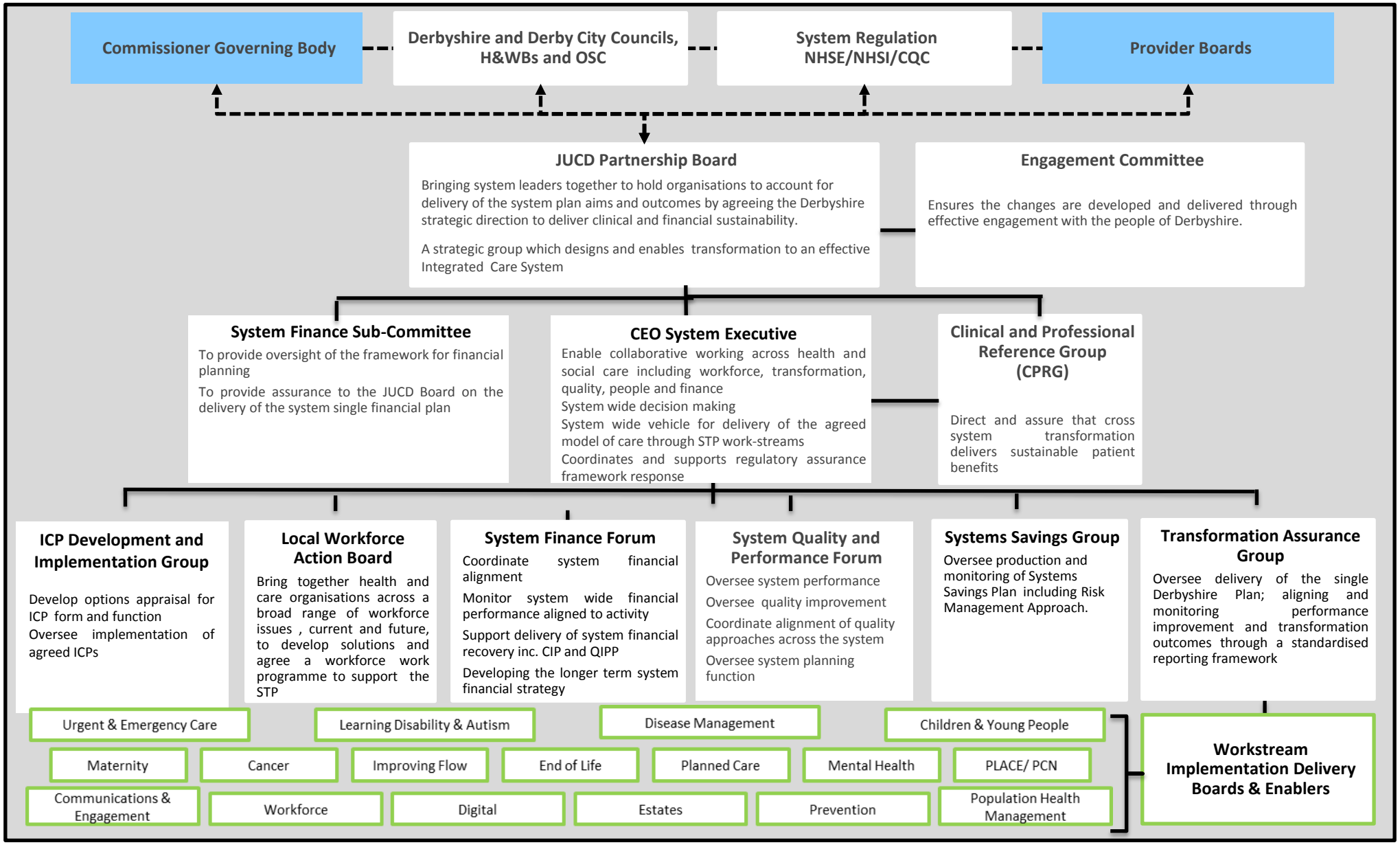
Action	Deadline
Submission to JUCD Board	13 September
Derbyshire County Council Adults Health Improvement and Scrutiny Committee ***(1)***	16 September
JUCD Board sign off (draft plan)	20 September
Derby City Council Adults Health Improvement and Scrutiny Committee ***(1)***	24 September
Submission to NHSE/I (draft plan)	27 September
Submission to JUCD Board for approval	11 October
JUCD Board ***(2)***	18 October
Trust Boards, Governing Body, Local Authorities and Health & Wellbeing Boards approval ***(3)***	
Derbyshire County Health & Wellbeing Board	3 October
DCHS	31 October
Submission to NHSE/I (draft plan)	1 November
DHcFT	5 November
CRH	6 November
DHU	6 November
CCG	7 November
CEO Plan Triangulation Review	11 November
UHDB	12 November
Derby City Health & Wellbeing Board	14 November
Plan finalised and submitted to regulators for approval (also see note 5)	13 November
Submission of Final Plan to JUCD Board ***(4)***	14 November
Final submission ***(5)***	15 November
Final JUCD Board ***(6)***	21 November
EMAS ***(7)***	3 December
Publication of Plan – Date to be confirmed dependent on outcome of the General Election	

Notes:

1. Both Scrutiny Committees do not sit again ahead of final submission (the next county meeting is on 25 November and City do not meet again until February 2020). However the draft plan has been taken to both committees in September and further updates will also be taken to future meetings
2. The JUCD Board received and approved further amendments to the plan to confirm version being taken through organisational governance processes
3. Due to the scheduling; particularly with regards to feedback from region, it may be necessary for Boards/ Governing Body to receive the final plan which is subject to further amendments (depending on the nature of the feedback). The principles in terms of the narrative have been supported by the JUCD Board with delegated authority to the System Executive to approve the financial modelling and triangulation (impact of the plan) as these areas develop prior to 15 November. A CEO review meeting has been scheduled for 11 November.
4. Papers will be submitted to the Board one day before final submission to NHSE/I but the Board meeting itself will take place after. The JUCD Board have agreed that the System Executive: CEO group will have delegated authority for final sign off of the plan ahead of the submission.
5. **Although this is the final submission to NHSE&I discussions will need to take place before this date to ensure plans are agreed with system leads and the regional team**
6. The JUCD Board will receive the final plan; including any final feedback from region
7. The EMAS Board date falls after the plan submission and therefore consideration/ agreement is required in relation to interim approach ahead of the plan being published to ensure fit with timescales

Monitoring Delivery of Our Plan

Our existing governance structure will be the mechanism by which we hold each other (the system) to account for delivery of our plan. This will be underpinned by a system PMO, regular workstream risk reporting and an escalation route to the JUCD Board. The JUCD Board are responsible for monitoring and managing the strategic risks across the system. A summary can be found at Appendix 9.



APPENDICES

APPENDIX 1

Profile of Environmental, Behavioural and Socio-economic Determinants of Health and Wellbeing Outcomes at Place Level

Structural Socio-Economic Factors	England	Derby City	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
Working age adults with HND, Degree and Higher Degree level qualifications	39.0	34.6	31.8	28.7	28.7	48.2	34.1	42.5	34.1	34.7
Working age adults with no formal qualifications	7.6	9.1	5.9	6.7	8.4	4.0	3.8	4.9	4.7	5.7
Employment rate (aged 16+)	75.4	74.2	83.5	77.7	72.0	84.0	78.3	75.2	78.0	82.4
Unemployment rate (aged 16+)	4.1	4.6	3.6	4.4	5.2	2.8	5.0	3.9	4.0	3.3
Workless Households (Unemployed/Inactive)	14.0	16.5	11.5	11.1	22.1	10.8	14.4	14.0	11.6	10.7
Job Density	0.87	0.89	0.75	0.65	0.87	1.03	0.62	0.65	0.54	0.55
Gap in the employment rate between those with a long-term health condition	11.5	9.0	13.3	16.5	10.6	15.0	16.6	17.8	15.5	11.6
Average weekly earnings	£440	£444	£417	£355	£388	£438	£423	£429	£395	£466
Gender pay gap	19.1	38.3	31.5	17.7	12.1	17.2	29.5	21.6	16.1	25.6
Children in low income families	17.0	21.0	15.1	19.8	19.6	9.4	17.2	11.9	15.3	11.9
Income Deprivation Affecting Older People	16.2	18.6	13.8	17.0	17.6	9.1	14.4	12.7	13.6	11.6
Employment and Support Allowance Claimants	5.4	7.2	6.0	8.0	8.4	4.0	5.3	5.4	6.6	4.4
Health Behaviours										
Smoking prevalence in adults	14.4	19.2	15.4	18.2	17.3	9.5	11.0	15.5	9.3	14.4
Smoking prevalence in adults - Routine and Manual Occupations	25.4	33.2	31.0	25.1	34.2	22.2	13.5	30.3	9.6	16.8
Smoking in pregnancy	10.8	16.2	16.2	18.6	11.7	13.5	18.1	13.1	15.6	16.2
Excess weight in children (4-5 year olds)	22.4	22.4	21.2	25.3	25.5	23.4	24.9	24.9	23.1	23.5
Excess weight in children (10-11 year olds)	34.3	36.8	31.1	39.5	34.1	26.5	33.9	31.3	33.6	33.2
Excess weight in adults	62.0	65.5	62.8	69.7	71.1	54.2	65.8	57.3	70.8	66.9
Physically inactivity, 18+ years	22.2	65.1	21.3	25.3	19.8	19.0	22.6	21.6	21.2	23.7
Alcohol specific hospital admissions - Under 18 years	32.9	33.8	27.9	53.1	46.7	31.5	30.3	61.7	50.8	27.7
Alcohol specific hospital admissions	569.9	780.4	491.9	577.3	938.2	471.0	553.8	644.0	551.6	430.1
Chlamydia detection rate (15-24 years)	19.7	22.3	19.7	16.6	22.7	13.1	22.1	9.4	17.6	18.8
Self-harm - emergency admissions	185.5	259.2	179.7	288.5	444.5	166.5	226.0	183.4	229.0	172.7
Suicides	9.6	7.3	8.7	8.9	10.8	8.5	7.8	7.1	9.2	9.0
Natural, Built and Living Environment										
Mortality attributable to air pollution	5.1	5.7	4.8	4.6	4.0	3.8	5.6	3.5	4.1	5.1
Average particulate matter	9.3	11.3	9.7	9.3	8.5	7.9	11.1	7.4	8.7	10.3
Density of fast food outlets	88.2	104.2	78.3	86.8	117.9	67.3	87.7	98.5	68.4	59.0
Average minimum travel time in minutes by public transport or walking to reach key services	17.7	16.5	19.0	20.0	16.2	25.6	18.9	19.8	19.3	21.6
Housing affordability ratio	7.9	5.1	5.3	5.3	5.5	7.9	5.4	6.1	6.6	6.3
Owner occupied tenure	62.9	60.2	76.5	63.1	61.1	75.7	64.9	69.1	68.7	78.3
Older people living alone - Estimated Households (65+ years)	45.1	47.2	41.7	44.9	45.7	42.7	43.9	44.6	41.2	39.1
Emergency admissions due to falls, 65+ years	2170.0	2306	2071	2343	2678	2118	2242	2327	2172	2390
Statutory homelessness	2.4	4.5	1.4	0.8	0.5	1.4	0.3	0.8	0.3	2.9
Housing in non-decent condition - proportion of LA owned housing stock	4.4	0.0	0.0	7.2	0.0	0.0	0.0	16.3	10.3	0.0
Fuel poverty	11.1	13.2	12.4	11.7	11.9	10.9	12.3	10.6	11.4	10.5
Crime Severity Score	3.8	16.7	9.5	9.9	10.7	6.9	10.3	8.1	7.3	9.2

Health Outcomes - Length and Quality of Life	England	Derby City	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
Life Expectancy at birth - Females	83.1	82.7	82.6	81.5	82.1	84.2	83.4	83.3	82.9	82.5
Life Expectancy at birth - Males	79.6	78.5	79.6	77.9	77.9	80.8	79.5	79.9	79.7	79.3
Difference in average life expectancy years between most and least deprived - Females	7.4	8.5	8.5	4.5	8.1	3.0	4.6	7.5	7.6	7.7
Difference in average life expectancy years between most and least deprived - Males	9.4	10.0	10.0	6.2	9.9	3.5	9.6	9.1	8.2	6.9
Neonatal Mortality and Stillbirths	7.1	8.2	7.3	7.1	5.4	2.1	7.2	7.6	4.3	9.1
Premature Mortality - CVD	72.5	83.5	69.6	68.2	89.7	48.1	73.6	62.3	61.2	58.6
Premature Mortality - Respiratory	34.3	42.9	34.6	44.2	49.4	20.9	26.9	34.2	29.2	32.3
Premature Mortality - Cancer	134.6	142.2	127.5	169.3	155.7	121.6	138.4	130.3	129.6	142.6

Sources: Public Health Profiles, Available at: https://fingertips.phe.org.uk and NOMIS Local Authority Profiles, Available at https://www.nomisweb.co.uk/ , Accessed September 2019

Personalised Care

APPENDIX 2

The Derbyshire Model of Care is built upon delivering more personalised care approaches and this is embedded throughout our programmes of work and our focus on prevention. The table below provides a snapshot of personalised care LTP commitments and alignment to the JUCD programmes of work.

	A Snapshot Summary of JUCD programmes of work in relation to the 6 principles of personalised care.
Personal Health Budgets	▪ PHB as default in Continuing Healthcare (Domiciliary care) and Wheelchair budgets are already implemented in Derbyshire. Children & Young People with Continuing Care eligibility are also offered a PHB. ▪ LD/ Autism – Where possible people will be enabled to have a personal health budget, with plans to review current use of PHB's to support people with LD &/or ASD outside of CHC, identify gaps (19/20) and develop implementation plan (20/21). ▪ Mental Health – People entitled to Section 117 aftercare have been identified as the next cohort of people who will have a legal right to have PHBs; implementation plan is in development.
Social prescribing	▪ Primary Care Networks - formation and the roll out of employing Social Prescribing link workers ▪ Place - identify the action to understand the existing Social Prescribing offer and identify potential improvements to support Frailty. ▪ Social Prescribing and Health Coaching is included in Future Service Model for Long Term Conditions (Disease) Management.
Personalised Support and Care Planning (PSCP) and Enabling choice	Approaches are identified in many care pathways via JUCD workstream Outline Business cases – examples of which are: ▪ Maternity - Continuity of Carer model and Derbyshire Personalised Maternity Care Plan. ▪ CVD - upskilling and building confidence for front line staff in early identification and personalised support of people with CVD conditions. ▪ MSK Individual Placement and Support (IPS) in regard to peoples goals about work. ▪ Learning Disability/Autism People with learning disabilities and/or autism must feel that they own their (co-produced) plans so we all know how best to look after them. ▪ EoL Care Planning and Respect: Ensure a focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney, 'living wills' and Respect Forms ▪ PHB SEC 117 aftercare PSCP is integral to all PHB offers
Shared Decision Making	▪ We will work with RightCare colleagues to identify the most impactful situation to develop Shared decision Making in Derbyshire in order to reduce clinical variation. ▪ This will be based on completion of the SDM checklist and self assessment to support the Derbyshire System in establishing a baseline and next steps.
Supported self - management	Health coaching, peer support, education programmes: ▪ Public Health - Staff trained in coaching approaches. This allows service users and service providers to work together to work out what matters most to them. These conversations take place in a wider context of health messaging, conversation tools and promotion of NHS digital resources. ▪ Living well with autism self-management programme in place for all recently diagnosed adults ▪ LD/ Autism - Develop a greater focus on person centred care across the system. including digital flag to identify patients who require reasonable adjustments. ▪ Self-management, Education, Social Prescribing and Health Coaching etc. included in Future Service Model for Long Term Conditions Management ▪ CRHFT Transition worker to engage young people with type 1 and type 2 diabetes to improve self-management attend clinic appointments and improve use of medication. ▪ Staff to complete good quality foot assessments and provide consistent self-management advice and Health Coaching (diabetes). ▪ Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20; ▪ Maternity - Information & involvement – Personalised care planning; every woman and her partner feels they were listened to and involved in their care ▪ CYP - Advice and prevention – Parents and practitioners will be able to obtain advice within the community to give them the confidence to support the child appropriately. If they are still not confident in addressing the need they will know when, where and how to seek early intervention. ▪ MSK - Improved self-management by patients and reduced necessity to access services and clinically avoidable interventions ▪ Mental Health - Plans for the delivery and required investment for digitally enabled transformation across mental health pathways will be developed in 2019/20:: - Pathways identified to test digitally enabled care - Every person will be able to access their care plans - Digitally enabled models of therapy being rolled out in specific mental health pathways. - Digital processes to support clinical monitoring - A range of management apps/ digital consultations - Digital clinical decision making tools ▪ Cancer - Patients are supported to live well for longer in the community through the offer of a health and wellbeing programme - Active Recovery and 'Wellbeing for All' programmes will also support the patient experience and satisfaction ▪ Respiratory - Expanded provision of access to digital and face-to-face structured education and self-management support tools. ▪ Dementia extend Dementia Connect programme

Personalised Care

APPENDIX 2

The table below sets out the sequential planning of the Personalised Care trajectories for the Derbyshire system; as we develop our approach the governance processes for managing the programmes of work and how they will feed into system priorities and reporting structures will also be confirmed.

5 year ambition – Personalised Care and Support Planning	19/20	20/21	21/22	22/23	23/24
Personal Health Budgets	Target 1,080 to be met by: ▪ Confirming priority cohorts and trajectories ▪ Developing s.117 PHB offer ▪ Reviewing current use of PHBs to support people with LD &/or ASD outside of CHC, identify gaps and developing plan.	Target 1,620 to be met by: ▪ Development of implementation plan based on gaps identified within review of current use of PHBs outside of CHC. ▪ Commencing s.117 PHB offer implementation. ▪ Identifying new s.117 cohort. ▪ Embedding PHB's to deliver interventions as identified in individuals care and support plans, alongside CHC and S117 entitlements.	Target 2,160 to be met by: ▪ Rolling out s.117 PBH's ▪ New cohort in place, further priority cohort identified.	Target 2,700 to be met by: ▪ s.117 fully in place ▪ Two cohorts fully in place, final priority cohort identified.	Target 3,240 to be met by: ▪ s.117 fully in place ▪ All additional cohorts in place.
Social prescribing (SP)	▪ Complete recruitment of SP link workers ▪ SP advisory group and agreed plan developed. ▪ Recruit to Mental Health SP roles in Hubs. ▪ Plans identified for targeting 1,026 referrals through SP link workers. ▪ Scope 'community connector' programmes across system via Integrated Volunteering Approaches Programme.	▪ Plans identified for targeting 4,105 referrals through SP link workers and MH link workers in MH Hubs. ▪ Replicate and develop best practice, by exploring current programmes such as 'community connectors', and adding value to social prescribing services and outcomes.	▪ Plans identified for targeting 8,209 referrals including SP link workers, community connectors and MH link workers. ▪ Scope the next LTC pathway to target for PCSP development ▪ Develop at scale implementation plan for community connectors	▪ Plans identified for targeting 12,314 referrals through current and new routes.	▪ Plans identified for targeting 16,419 referrals through current and new routes.
Personalised Support and Care Planning (PSCP) and Enabling choice	PCSP Trajectory: 2996 ▪ Work with the national team to develop planned cohorts for interventions. ▪ SEND - Review the graduated approach to ensure the right support is available at the earliest opportunity and ensure access to therapy services is available, personalised, in the right place and at the right time to help C&YP access education. ▪ Confirm our approach to ensuring everybody approaching the end of their life is offered opportunity to create a personalised care plan. ▪ LD/ Autism - Development of comms plan to support roll out of key tools to support development of Personalised care and support / stay well plans. ▪ Cancer - Patients will have a follow-up pathway in the right setting for them.	PCSP Trajectory:4,404 ▪ Community provision for Physical Health Services - Review of top 5 'high needs ' C&YP and their combined packages to establish pathways specific to them. ▪ Disease management - support upskilling and building confidence for front line staff in early identification and personalised support ▪ LD/ Autism - Further development care provider market to increase personalised community care provision ▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at throughout the pathway. ▪ All pregnant women have a personalised care plan. ▪ Confirm system approach to supporting patients with cancer to undertake a holistic needs assessment and care plan based on examples of good practice.	PCSP Trajectory: 8,307 ▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway. ▪ All pregnant women have a personalised care plan.	PCSP Trajectory: 13,342 ▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway. ▪ All pregnant women have a personalised care plan.	PCSP Trajectory: 18,068 ▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway. ▪ All pregnant women have a personalised care plan
Shared Decision Making	▪ Liaise with Rightcare colleagues to establish areas of unwarranted clinical variation, checking alignment with the national 30 'high value' clinical situations. ▪ Engage with national team to source Shared Decision Making checklist and self assessment	▪ Develop action plan based on SDM checklist and self assessment.	▪ Implement action plan	▪ TBC	▪ TBC
Supported self - management	PAMS target - 2,052 to be met by: ▪ Engaging with national team for support on PAMs. ▪ Identify priority area for implementation – potentially this would be the Long term Conditions pathway ▪ Reviewing work completed in other areas with cancer survivors including peer support and social prescribing to inform a Derbyshire approach. ▪ Cancer - patients will be offered enhanced supportive care at the earliest opportunity and will be supported to self-manage their condition following treatment.	PAMS target - 4,105 to be met by: ▪ Development of plan for PAMS training implementation in priority area. ▪ Identify additional priority area. ▪ Share success of PAMs impact to build system wide support. ▪ Cancer -Breast patients will receive personalised care, tailored to their needs.	PAMS target - 7,183 to be met by: ▪ Development of implementation plan for second priority area ▪ Identify additional priority area and PAMs administrators ▪ Cancer - Prostate and Colorectal patients will receive personalised care, tailored to their needs.	PAMS target - 11,288 to be met by: ▪ Development of a plan to for PAMs implementation in third priority area ▪ Identify additional priority area and administrators	PAMS target - 15,393 to be met by: ▪ Development of a plan to for PAMs implementation in fourth priority area ▪ Identify additional priority area and administrators

Pharmacy & Medicines Optimisation: Enabling the best health outcomes through the optimal use of medicines

APPENDIX 3

Improving experience of care : High quality and safe use of medicines

- System partnerships working to develop a STP/ICS/ICP vision and strategy for Pharmacy & medicines optimisation
- Work with system counterparts, pharmacy/GP/nursing/AHPs to deliver the strategy
- Maintain and develop the STP wide medicines safety network, including responding to serious incidents and learning plus systems to avoid harm from errors and sub optimal medicines use
- Integrated working to support the Antimicrobial Resistance Strategy
- System strategies to avoid risks due to transfer of care including digital solutions
- Ensure strategies support urgent care focusing on self care to manage minor conditions and to prevent avoidable medicines harm
- Promote medicines safety through the use of clinical systems, including decision support tools, clinical audit and risk stratification, repeat prescribing, patient Apps

Improving the health of the population: Delivering effective interventions

- Strategic and professional leadership to ensure medicines decisions are evidence & outcome based, safe and cost-effective
- System partnership working to ensure medicines are prescribed, supplied and manged safely providing maximum health benefits through enabling and delivering medicines optimisation
- Set and maintain a collaborative style of working across the STP to ensure best outcomes, avoiding waste and duplication, and identifying care gaps
- Ensure system strategies are in place to involve public consultation on commissioned services where relevant for medicines
- Support strategies for patient shared decision making and concordant use of medicines promoting high quality medication reviews addressing polypharmacy and de-prescribing in line with the national agenda
- Promote and act as an enabler to support wider prevention strategy including self care, health optimisation policy, proactive use of medicines and health tech in care pathways

Reducing the per capita cost of healthcare: Value use of medicines

- Oversight of the Provider Trust CIPs and CCG medicines QIPP (value programme) – ensure cross sector collaboration with all providers including PCNs/GPs and community pharmacy to maximise opportunity
- Utilise system wide business intelligence to identify clinical variation and prioritise opportunity for reducing unwarranted variation e.g. RightCare
- Provide professional leadership on the development of transformational medicines optimisation initiatives across the system to drive future value
- Ensure robust strategic level clinical decision which both informs and enables cost effective local use of medicines, clinical interventions and technologies
- Scope future prescribing financial models to establish benefits of ICS/ICP system control totals and drug expenditure incentives

Improving staff experience and resilience: Skilled and agile Pharmacy workforce

- Develop and implement a pharmacy workforce plan across the STP
- Work with PCNs to support the development of GP practice clinical pharmacists and technicians as per the LTP
- Enhance and develop integrated care pharmacist and technician specialists working for both primary and secondary care
- Offer professional clinical leadership, education support and strategies to improve competencies for the use of medicines for prescribers across an integrated care system
- Work with system providers, NHSE, AHSN to develop a Derbyshire career pathway for the pharmacy workforce to include trainee to senior management levels. Enabling opportunities for cross sector workforce experience and development to aid and improve transition between sectors

Mental Health Investment Standard

Mental Health Investment Standard

	2019/20	2020/21	2021/22	2022/23	2023/24	LTP Investment Ambitions	Total Investments	Total Investment %
Children & Young People's Mental Health (excluding LD)	10,843	12,892	13,441	14,490	15,667	3,422	4,823	141%
Children & Young People's Eating Disorders	835	1,033	1,046	1,055	1,065	230	230	100%
Perinatal Mental Health (Community)	1,338	2,501	3,113	3,907	4,021	2,683	2,683	100%
Improved access to psychological therapies (adult and older adult)	10,970	12,048	13,393	14,748	17,170	5,579	6,200	111%
A and E and Ward Liaison mental health services (adult and older adult)	3,271	3,768	3,768	3,768	3,768			
Early intervention in psychosis 'EIP' team (14 - 65)	3,750	3,750	3,750	3,750	3,750			
Adult Community Crisis (adult and older adult)		39,921	40,636	40,666	40,695	1,945	2,996	154%
Ambulance response services		435	661	897	1,270	1,270	1,270	100%
Community mental health, including new integrated models (adult and older adult, excluding dementia)		44,171	44,433	45,282	48,822	7,583	7,863	104%
Crisis resolution home treatment team (adult)	5,783							
Community Mental Health	40,959							
Mental Health Act	1,500	1,500	1,500	1,500	1,500			
SMI Physical Health	350							
Suicide Prevention	0	0						
Acute inpatient services (adult and older adult)		141	234	473	839	839	839	100%
Other adult and older adult - inpatient mental health (excluding dementia)	53,729	56,623	59,863	62,194	60,771			
Other adult and older adult mental health - non-inpatient (excluding dementia)	31,916							
Mental health prescribing	10,807	7,628	7,628	7,628	7,628			
Mental health in continuing care	0		0	0	0			
Sub-total - MH Services (exc LD & Dementia)	**176,050**	**186,410**	**193,466**	**200,357**	**206,965**			
Growth in CCG allocations	5.4%	3.9%	3.8%	3.6%	3.3%			
Required growth above allocations	0.7%	1.7%	0.0%	0.0%	0.0%			
Total required growth in MH spend	0.7%	5.6%	3.8%	3.6%	3.3%			
Required MH spend to meet MHIS	176,050	186,410	193,466	200,357	206,965			
MHIS achieved (Planned spend is equal to or greater than Required MH spend)		OK	OK	OK	OK			

The MHIS investments contained within the LTP submission have been realigned into the LTP categories and assessed against the Mental Health ambitions tool. Most of the categories should align with the additional investment contains within the ambitions tool kit and to clarify investment in other community based crisis and acute adult mental health services have been included in the Adult Community Crisis category. However there are some services where investments are over and above the ambitions tool kit however this is due to a higher forecast outturn for 2019/20 which has continued into future years due to the commitments already made. For example CYPMH investment through the life of the plan is higher than required investment in the ambitions tool kit but this is due to the recurrent investments made in 2019/20 which are higher than the original plan for 2019/20.

Workforce Implications of transformation delivery plans

APPENDIX 5

Workforce Development Leads from across the system are working with Transformation Workstreams to identify and implement the implications of the transformation plans on our people, and to ensure that our workforce and OD support offer is aligned to their needs.

The following table summarises the key workforce themes from the delivery plans set out previously in this document and gives examples under each which will be addressed through our workforce and OD plans:

Introducing New Roles	Establishing New Teams	Changes in care setting	Training and Development
We have run a pilot for a Health and Care Worker apprentice who we envisage working in our integrated Place based teams	LD and autism - development of intensive support teams (crisis and forensic)	Mental Health focused Maternity Outreach Clinics	New cancer screening pathways, increasing uptake of screening and self management particularly among BME communities
Implementation of Key Worker role for all C&YP with LD and autism complex needs	increase access to specialist community perinatal mental health services	Left shift of ophthalmology and MSK services	Changes in the models of care for CVD and stroke and respiratory
Develop keyworkers for children and young people with the most complex needs and their carers/families	Bring IAPT therapists into integrated PCN teams,	County wide approach to theatre utilisation	Recognising and addressing cognitive impairment as part of the Aging Well Programme
Consider increase in midwife sonographers	Establish MH Urgent Care Crisis Teams across the county	Urgent Care Treatment Centres as part of integrated urgent care community offer	Introduce 'All staff are prepared to care' education programme to promote proactive and personalised care planning for everyone identified as being in their last year of life.
Diabetes Inpatient Specialist Nurse (DISN) pathways will be developed from 2019/20 with EMAS which will enable ambulance staff to speak directly to DISN from the persons home with aim to prevent conveyance	4 x Mental Health Support Teams (MHSTs) The MHST's will be implemented within education settings	Introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls	Support the optimisation of digital solutions across all care settings specifically in CVD, stroke, planned care, cancer, LTC's, Diabetes
Trial a Medical Assistant role as part of the General Practice team	Clinical Assessment Service accessible via 111	Enhanced provision in Care Homes	System training plan for midwifery staff to support Continuity of Care

Mental Health and LD and Autism: The ambitions for improvements in mental health and LD and Autism services will require a specific focus on workforce.
We aspire to train and develop our workforce and offer a career development pathway to support staff. We have plans in place to develop the skills of our existing workforce to enable them to adapt to the changing service model. Continuing professional development funds will be maximised to ensure our staff have the skills and competencies to respond to changes in how and where we deliver care, reflecting the changes in acuity and dependency of our patients. We are developing new roles including the Nursing Associate and Advanced Clinical Practitioner, and extending our offer for apprenticeships. The detail of the Mental health workforce is now analysed and being worked through as the financial envelope is confirmed. Further work will explore opportunities to join up services working with our system partners including the private and voluntary sector
To ensure we have the workforce required to meet service development we are developing a range of initiatives including:-
Develop and support new roles and inter-disciplinary credentialing programmes enabling increased workforce flexibility across an individual's NHS career and between individual staff groups.
Further develop the "grow our own" initiative such as apprenticeships, work experience and volunteer schemes.
Increasing the number of Clinical Placements, we provide for students by 25% in year 1, with the expectation this will increase further in the next 3 years. Currently we provide 171 students with placements and this will increase by 54 this year.
Increasing our flexible contracts to meet the needs of a multi-generational workforce.
Currently we have a small but valued pool of active volunteers who have roles where they are directly enhancing the experience of the service receivers, supporting our inpatient and community teams. Their roles enable our staff to improve service provision and we are exploring options to increase this workforce.

Delivering digitally enabled care

APPENDIX 6

Our digital strategy themes have been aligned to key deliverables set out in this plan, which is demonstrated in the table below; the funding streams where relevant are also highlighted.

Key:

Funding Sources: 111 booking resources ✓ On-line consultation funding ✓ ETTF ✓ GPFV ✓ GP Business as Usual ✓ TBA ✓ HSLI ✓ Local Resources ✓ STP Resources ✓

Links to Strategy Themes: Citizens ▲ Professionals ▲ Foundations ▲ Analytics ▲ Innovation ▲

	Key Deliverables	Year 1	Year 2	Year 3	Year 4	Year 5
		2019/20	2020/21	2021/22	2022/23	2023/22
Primary Care Priorities	NHS app ▲	100% of practices engaged with NHS app 1% of patients using NHS app	5% of patients using NHS app NHS app used for all Online consultation products	20% of patients using NHS app	50% of patients using NHS app No excluded patients	NHS app used for all routine non face to face contacts
	111 Direct Booking ✓ ▲ ▲	100% of GP practices receiving direct booking from 111 service	111 service booking all relevant patient contacts into GP practices	Business As Usual	Business as Usual	Business as Usual
	Online Consultation ✓✓✓ ▲ ▲ ▲	100% of practices engaged with online booking programme 70% of Derbyshire population with access to Online consultations All GP extended access hubs engaged with Online consultations	100% of Derbyshire patients with access to online consultations, either directly with the practice or through the extended access hubs	Business as Usual	Business as Usual	Business as Usual
	GP connect ✓ ▲ ▲	GP Connect deployed in EMIS GP Practice sites	GP connect deployed in all practices	Business as Usual	Business as Usual	Business as Usual
	GP systems ✓ ▲ ▲	TPP S1 75%; EMIS 25%	GP Futures contract implemented	Business as Usual	Business as Usual	Business as Usual
	Referral Support ✓ ▲	Local Referral support system 'Pathfinder' deployed in pilot practices	Pathfinder used throughout Derbyshire	National products phasing in	National products	National products
	Lloyd George Record Scanning ✓ ▲	Evaluation of local scope	Pilot project(s) implemented	100% LG records scanned	Fully electronic records	N/A
Common Applications (Cross-workstream support)	Single Health Record ✓ ▲ ▲ ▲	Consolidation of non-acute patient records on TPP S1 platform Acute secondary care systems interfacing across UHDB (South Derbyshire) Review GDE FF bid options	Implement GDE FF bid recommendations Develop LHCRE response including review of MIG (Medical Interoperability Gateway) future development/replacement	Procure/early adopter single patient record system	Single health record in place across all key services/sites	Completion of Single health record deployment and move to Business as Usual
	Patient access ✓✓ ▲	NHS app deployed in primary care (see above) Patient direct access to maternity systems (North Derbyshire) Patient access to UHDB letters via PKB	Expansion of secondary care patient access systems via PKB and other systems	Combined primary care/secondary care access projects	National applications available (working assumption)	National applications adopted
	Specialist Analytics ✓ ▲	Local models based on RAIDR and other supplementary systems	Pan-Derbyshire data model Procurement of joint system early adoption of national products (working assumption)	Pan-Derbyshire data service supplemented by implementation of national 'data lake' applications	Full adoption of national models	Business as Usual
	Telehealth ✓✓ ▲ ▲	Pilot projects, based on individual workstream needs Early adopter GP practices	Roll-out of telehealth through primary care & secondary care settings	Integrated options available for patients participating in MDT consultations	Business as Usual	Business as Usual

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Links to Strategy Themes: Citizens ▲ Professionals ▲ Foundations ▲ Analytics ▲ Innovation ▲

	Key Deliverables	Year 1 2019/20	Year 2 2020/21	Year 3 2021/22	Year 4 2022/23	Year 5 2023/22
Non-Core Functionality (specific to individual Workstreams)	Cancer ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps	Deploy apps at scale	Business as Usual	Business as Usual	Business as Usual
	Children's ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps Develop 'patient story' specification	Deploy apps at scale procure and implement 'patient story' functionality	Business as Usual	Business as Usual	Business as Usual
	CVD ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps	Deploy apps at scale Develop a business case for 'intelligent devices'	Deploy 'intelligent devices'	Business as Usual	Business as Usual
	Diabetes ✓ ▲ ▲	Specify telehealth options Develop 'patient story' specification	Procure and implement 'patient story' functionality Telehealth functionality in place	Patients routinely communicate blood results electronically	Business as Usual	Business as Usual
	End of Life ✓ ▲ ▲	Implement cross organisational EoL functionality	All partners have online access to patient care preferences Review assisted technology options	Implement assisted technology to patients	Business as Usual	Business as Usual
	Improving Flow ✓ ▲	Full specification of 'Improving flow' requirements	Implementation of 'Improving flow' recommendations Review assisted technology options	Implement assisted technology to patients	Business as Usual	Business as Usual
	LD and Autism ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps Ensure patient 'reasonable adjustment' flag is provided	LD and Autism patient records fully integrated (with appropriate security) within overall patient record Deploy apps at scale. Implement data set for flag to indicate where patients have needs for 'reasonable adjustment'	Business as Usual	Business as Usual	Business as Usual
	Maternity ✓ ▲ ▲	Three separate maternity systems in place) Complete deployment of electronic access to patients in North of the County	Review options for single Pan-Derbyshire maternity system (either fully integrated within mainstream patient record, or as interfaced offer) Expand patient access to UHDB patients	Implement combined maternity digital offer	Business as Usual	Business as Usual
	Mental Health ✓ ▲	Consolidation of mental health systems on TPP S1Review future of 'locked estate' systems	Define requirements for patient appsProcure pilot apps	Business as Usual	Business as Usual	Business as Usual
	Place ✓ ▲ ▲ ▲	Strengthen 'Place-based' Digital option through consolidation on TPP S1 platform and MIG (Medical Interoperability Gateway)	Single 'Place' platform throughout Derbyshire MIG (Medical Interoperability Gateway) phased-out except in exceptional circumstances	Review unified 'Place' system requirement, potentially moving to procurement of new system	Implement review implementations	Business as Usual
	Planned Care ✓ ▲ ▲	Define planned care-specific options for integrated patient record Specify 'tactical' PBC apps with aim of supporting specific patient channel offers	Utilise 'pathfinder' referral support systems, together with cross-setting joint working solutions to develop strategic planned care systems Integrate planned care systems with intelligence-based analytic systems	Implement strategic planned care system	Business as Usual	Business as Usual
	Respiratory ✓ ▲	Specify telehealth options Develop 'patient story' specification	Implementation of 'Improving flow' recommendations Review assisted technology options	Patients routinely communicate respiratory results electronically	Business as Usual	Business as Usual
	Urgent Care ✓ ✓ ▲ ▲ ▲	Define Urgent care-specific options for integrated patient record Specify 'tactical' UEC (Urgent and Emergency Care) apps with aim of supporting specific patient channel offers	Utilise 999 and 111 system integration with local systems, supported by online patient access offer to develop strategic urgent care systems Integrate UEC (Urgent and Emergency Care) systems with intelligence-based analytic systems	Implement strategic urgent care system	Business as Usual	Business as Usual
Other	Support for Social Care achieving DSPTK ✓ ▲	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas

Themes arising from engagement in the plan

APPENDIX 7

Our plan was underpinned by a comprehensive programme of engagement activities see page 48, which resulted in the themes below being highlighted.
These themes have shaped and informed our STP plan submission, and influenced on-going planning work for JUCD, the full details can be found in the 'News Section' of our website.

	Theme
1	PRIORITIES • People generally welcomed all the priorities in the plan but wanted more assurances that the programmes of work would be 'joined up', and not working in silos. • It was felt that it would be a good idea to identify extra-ordinary priorities requiring extra-ordinary effort, as it is unlikely that we can focus on all the priorities at once. • The 'how' was important to people, i.e. how would the priorities be implemented.
2	COMMUNICATION AND ENGAGEMENT • People welcomed the opportunity to comment on the plans, but wanted more ongoing communication and the opportunity to get involved, so they could influence decision making. • It was felt that more engagement was needed to change mind-sets, behaviours, and promote self-care amongst the general population. • People want to be engaged in a timely manner about potential cuts, and changes to services. They want to be informed about the benefits to them of the changes. Where they have been asked about their experience or opinion, they would like to have feedback.
3	PERSONALISATION • The plan needs more emphasis on personalised care. • People felt that throughout transformation choice is important and maintaining it. • It was felt that patients and professionals should make joint decisions on any health or care treatment • It needs to be clear that patient is at the centre of all decisions in JUCD, not felt that this is emphasised enough currently, e.g. not in executive summary. • It should be acknowledged that the patient is often the expert in their own condition. Important for people to be empowered to take control of their condition. • It was highlighted how important it is for people to receive sufficient information to be able to make choices about their health and care treatment. Information should be forthcoming and in a way that patients and carers can understand. People preferred this information to come from their GP. People feel confident with good information. • Health information needs to be shared widely in as many settings and via as many mediums as possible in order for these plans to work
4	NHS FOCUSED/WIDER DETERMINANTS OF HEALTH/INTEGRATED CARE • People felt the plan was still very NHS focused, and needed more reference to integration, acknowledging the different layers of the local authority, e.g. district councils. • People welcomed the move to focusing on the wider determinants of health, but felt that the priorities still reflected improvements in services, rather than wealth, education, and prevention. • The link between the wider determinants of health and the STP's Quadruple Aim needs to be made more explicit. • Voluntary Sector key to addressing Wider Determinants of Health • People wanted to emphasise the importance of ensuring different services communicate with one another. • People felt seeking help for more than one condition was much harder.
5	IT, DATA INTELLIGENCE AND SHARING INFORMATION • Better collection, sharing, and use of data was seen as key. • Choice around use of online services.
6	CULTURAL CHANGE - • People felt the plan needed more emphasis on the cultural change need to ensure joined up working and an acknowledgement of the enormity of this task.
7	VOLUNTARY AND COMMUNITY SECTOR (VCS) • There is a need to see the VCS as partners, and engage with them as a provider of services. • Recent cuts have caused concern to Social Prescribing Offer.

Themes arising from engagement in the plan

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8	**FINANCE** • **The finance is confusing, and this is impacting on the trust people have in the plans.**
9	WORKFORCE • Workforce is seen as a huge challenge, but also a big opportunity to join up, if we stop working in silos. • There was concern around how the changes taking place were impacting on staff causing uncertainty and instability.
10	PLACE BASED WORKING • The term Place was not felt to be widely understood, or whether indeed people would identify with Place. • There was concern over the tension/confusion between Primary Care Networks and Place. • Links to other Governance structures should as Health and Wellbeing Boards wasn't clear.
11	PREVENTION • There were concerns over the commitment to prevention. • Importance of education to be more healthy. • Prevention considered fundamental but funding needs to follow.
12	URGENT CARE • People were concerned over capacity of 111 to be the single point of action for all urgent care. • One size fits all approach doesn't take into account needs of rural areas. • People felt there needed to be more information about where to go if they get ill or injured. • Quick and easy access to the relevant help and treatment was seen to be vital.
13	IMPROVING FLOW • Concerns over Pathway 2 capacity. • Concerns over closer of beds at community hospitals. • People want to be able to stay in their own home for as long as possible with the right support • What evaluation has been done/evidence this is the right model
14	END OF LIFE • People want to feel well supported at the end of life.
15	CARERS • Want to feel listened to, and included in early conversations (where appropriate), about their loved ones health. • Carers need their own health and wellbeing needs supported. • Need to stop having to repeat the same information over and over.
16	ACCESS • To be able to access timely help and treatment when needed, e.g. access to a GP, or support groups. • Access to support following diagnosis e.g. specialist nurses and support groups • Reasonable adjustments for people with LD to support access
17	JOINING UP ACROSS BORDERS • People wanted assurances that JUCD works with other STP's and ICS's to join up pathways across borders.
18	FRAILTY • Identification, assessment, and management of frailty should be a priority for JUCD. • It was suggested that we might want to change terminology from elderly to older or frail throughout the plan.
19	MENTAL HEALTH • Needs to be a priority. • Seen as the poor relation to physical health/Need to join up Mental and Physical Health services • Better urgent and emergency provision.

System Capital Expenditure

APPENDIX 8

·CDEL Calculation

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Property, Land and Buildings	61,756	53,200	106,923	113,356	81,268	40,877
Plant and Equipment	29,753	19,831	23,377	22,553	22,092	21,187
IT	10,075	9,732	14,829	32,811	11,513	9,337
Other	4,056	8,245	6,400	6,400	6,400	6,400
Gross Capital Expenditure	**105,640**	**91,008**	**151,529**	**175,120**	**121,273**	**77,801**
Disposals / other deductions	(1,300)	(2,419)	0	0	0	0
Charge after additions/deductions	**104,340**	**88,589**	**151,529**	**175,120**	**121,273**	**77,801**
Less Donations and Grants Received	(4,538)	(2,682)	(1,100)	(1,100)	(1,100)	(1,100)
Less PFI Capital (IFRIC12)	(5,300)	(5,300)	(5,300)	(5,300)	(5,300)	(5,300)
Plus PFI Residual Interest	4,879	4,879	4,966	5,121	5,282	5,449
Purchase/Sale of Financial Assets/Prior Period Adjustments	0	0	0	0	0	0
Total CDEL	**99,381**	**85,486**	**150,095**	**173,841**	**120,155**	**76,850**

Funding Sources of CDEL

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Self Financed - Depreciation	41,478	40,818	46,256	45,796	45,629	44,199
Self Financed - other internal capital cash	57,433	16,480	26,217	10,393	8,480	1,559
Less Capital loan repayments, PFI capital repayments and Finance Lease payment	(16,632)	(16,626)	(18,548)	(18,514)	(18,361)	(16,804)
Interim Support Capital Investment Loans - To be Approved	0	13,528	58,384	101,595	64,602	42,447
Interim Support Capital Investment Loans - Approved	0	11,000	0	0	0	0
Other Loans inc Salix	0	0	1,500	2,000	0	0
STP Wave 1 - 4 PDC - Approved	5,344	6,352	19,983	22,514	11,485	0
Efficiency programme PDC - Approved	0	220	0	0	0	0
Other Central Programme PDC - Approved	220	0	0	0	0	0
Other PDC (incl Major Schemes) - To be Approved	6,659	8,319	11,337	4,936	3,338	0
Other PDC (incl Major Schemes) - Approved	0	556	0	0	0	0
Residual Interest	4,879	4,879	4,966	5,121	5,282	5,449
Purchase/Sale of Financial Assets/Prior Period Adjustments	0	0	0	0	0	0
Net CDEL	**99,381**	**85,526**	**150,095**	**173,841**	**120,455**	**76,850**

Summary of strategic risks to delivery

APPENDIX 9

Date	Theme	Risk Description	High Level Mitigation Plans
01/03/2017	Strategy	Risk that STP Programmes of work will not deliver the agreed model of care and system wide transformational change.	STP plan refresh to strengthen alignment of transformation programmes with delivery of the model of care and financial recovery, with associated Outcomes Based Accountability (OBA) approach to clearly identify outcome indicators and performance measures. Workstream confirm and challenge meetings scheduled to take place before the end of December 2019 to support development of workstream maturity.
22/08/2019	Strategy	Efforts need to be focused on ensuring that pathway and activity changes result in removal of cost across the system not simply a shift in cost.	The action required to ensure cost out across the whole system will be established on an individual pathway and specialty basis as the opportunities are validated
22/08/2019	Strategy	Assumptions in relation to activity and finances are at a high level, the actual benefits from the initiatives described can only be accurately worked up at a specialty or procedure level as the work progresses	The activity and financial impact will be established on an individual pathway and specialty basis as the opportunities are validated.
01/03/2017	Delivery	There is a risk that insufficient programme resourcing across the system compromises delivery and implementation at the pace and scale required	All workstreams submitted their capacity requirements which have been reviewed by the CEO/FDs Group. Agreed to consider what organisations need to stop doing or do differently to release this capacity. Gaps continue to be reviewed and addressed through the CEOs group to ensure workstreams are properly resourced.
09/09/2018	Delivery	Constitutional standards and key performance indicators will not be met	Workstream plans for 2019/20 developed which incorporate OBA indicators some of which are also constitutional standards. Improved monitoring and reporting of delivery through the Transformation Assurance Group to support earlier identification of remedial actions required. Quality & Performance Group established with responsibility for ongoing monitoring and reporting of system level constitutional standards.
14/12/2018	Delivery	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 increased focus on the prevention agenda will be driven through the Prevention strategy which was approved through JUCD Board and continues to be embedded locally with all organisations taking this through internal governance arrangements. The System Opportunities Programme identified the need to focus on the prevention agenda given the priority areas identified; this provides the opportunity to develop pathways end to end to include primary and secondary prevention. Through the Prevention Board greater alignment to workstreams taking place with named public health colleagues working with programme leads to ensure delivery plans include prevention and make stronger links to the strategy.
19/08/2019	Delivery	That the plans in neighbouring LMS will not fit well with those in Derbyshire, jeopardising what JUCD wishes to achieve and creating inequity in the offer to women who choose to access care over the Derbyshire borders.	Liaison with neighbouring LMS PMOs and sight of transformation plans. Detailed discussions over shared opportunities and risk and issues, regarding border flows. Stronger relationship and exploration of shared opportunities with Pan-Staffordshire LMS in particular.
16/09/2019	Delivery	Continued increase in demand for Mental Health (MH) inpatient service means that LoS reduction outweighed by admissions resulting in inability to reduce out of area placements	Crisis and Home treatment service investments during the course of 19/20 and 20/21.
12/09/2019	Delivery	Risk to patient safety & system reputation due to the potential cessation of inpatient MH and LD services by independent providers as a result of the national transformational care partnership work.	Attendance at national & regional NHS E contracting meetings to gather intelligence Development of system wide contingency plan
06/08/2019	Delivery	Changes to models of care, activity growth, and/or commissioning adversely impacts upon the future efficiency, capacity and suitability of the project design.	Close working with users and commissioners to understand the direction of healthcare service provision, along with a flexible design solution. Monitoring of actual activity growth compared to forecasts used in modelling.
01/03/2017	Engagement	Lack of 'buy-in' to STP due to inadequate engagement with stakeholders	Engagement Committee established as part of revised STP governance. Communications and engagement (C&E) strategy refreshed. Significant engagement undertaken to support the STP Plan refresh, including the using members of the citizens panel (1500 members) to hold confirm and challenge sessions, wider stakeholder events including members of the public, MPs, voluntary sector. C&E alignment to transformation programmes strengthened with offer developed for all workstreams to utilise as part of their ongoing approach. Improved GP representation throughout STP governance
22/02/2018	Digital Technology	Service delivery and transformational change programmes are compromised due to inadequate digital technology strategy and operationalization	Strengthened governance in place and workstream now gathering momentum and making stronger links to workstreams. Digital strategy developed with alignment of digital technology plans to workstream transformation priorities and plans; decreasing the risk that products and services will not meet the evolving needs of the system. Pathway transformation is being designed in alignment with the Digital programme of work and the development of a digital solution to support delivery.
25/07/2019	Analytics	Access to data and the ability to use this to provide intelligence will prevent effective planning and monitoring of delivery	Considerations taking place through the CEO/FDs meetings to review capacity available across the system and how it is being utilised, taking into account various strands of work in train. Meeting arranged to review and align approaches; with a proposal to be taken back to CEOs.
09/08/2018	Workforce	Increasing trend for GPs to retire early/work significantly less than full time hours impacting on primary care capacity within the system	GPFV workforce plan focused on retention of GPs in the latter part of their career Programme of work commissioned through the LMC to implement targeted interventions for that cohort.
16/05/2019	Workforce	Insufficient emphasis and consideration of workforce challenges across the system will result in integrated care delivery being compromised	Given the increasing focus on workforce in response to the NHS People Plan, a focused workforce discussion took place at the July JUCD Board. Through the STP refresh greater alignment and understanding of workstream plans undertaken to support development of workforce plans in response . Ensure a suitable programme of staff engagement, training, recruitment and retention is implemented