NHS England

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NHS Improvement

Cambridgeshire & Peterborough

Sustainability & Transformation Partnership

Cambridgeshire County Council Health Committee

7 September 2017

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

NHS Cambridgeshire and Peterborough NHS Foundation Trust

NHS Cambridgeshire Community Services NHS Trust

NHS Cambridge University Hospitals NHS Foundation Trust

NHS North West Anglia NHS Foundation Trust

NHS Papworth Hospital NHS Foundation Trust

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

East of England Ambulance Service NHS Trust

Context

This Health Committee, at the July 2017 meeting, requested that future reporting by the Sustainability & Transformation Partnership (STP) should focus on the following areas:

1. STP operational performance;
2. STP programme delivery; and
3. Risk management approach and STP strategic risks

The purpose of this presentation, to be delivered at the 7th September Committee meeting, is to provide the Committee with information relating to the above areas in order to stimulate discussion and seek agreement regarding the range and depth of reporting to be routinely provided, as well as to clarify a schedule of areas for focus at future meetings.

In addition to the above, the STP is briefing the Committee in relation to a further item:

4. Review of STP leadership

STP Operational Performance

STP Operational Performance

Overview

The following four slides set out current Cambridgeshire & Peterborough system operational performance against key standards in:

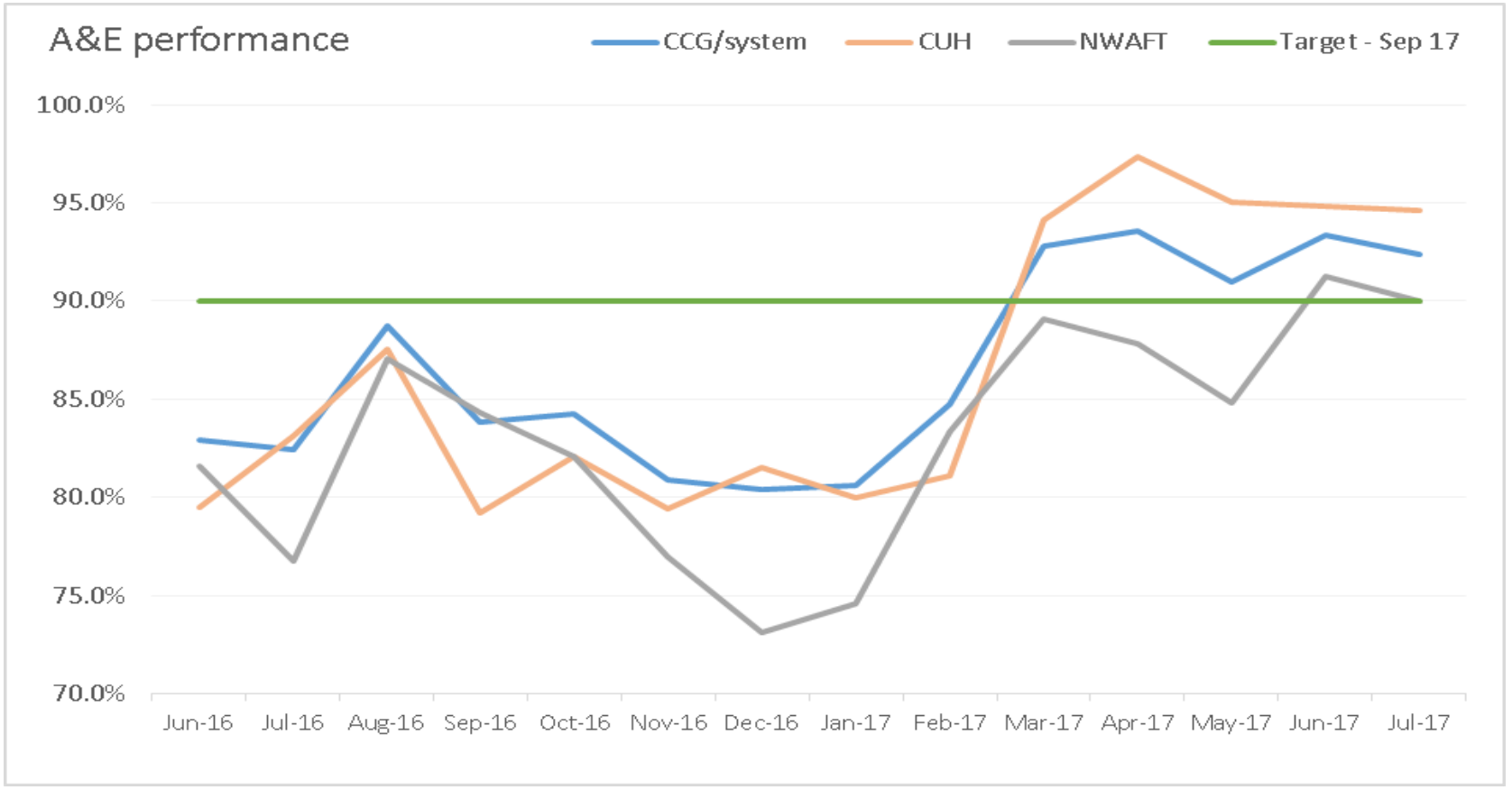
- Accident & Emergency Performance;
- Delayed Transfers of Care (DToC) i.e. delays in discharging patients from hospital who are ready and safe to leave;
- Referral to Treatment (RTT) i.e. the time from when a GP refers a patient to treatment commencing; and
- Cancer – 62 day first definitive treatment.

Accident & Emergency Performance

The national target is that 95% of patients must be seen within four hours and Cambridgeshire & Peterborough has a system target set by national bodies of achieving and maintaining 90% by September 2017.

Over the last four months, this target has already been met for Cambridgeshire & Peterborough.

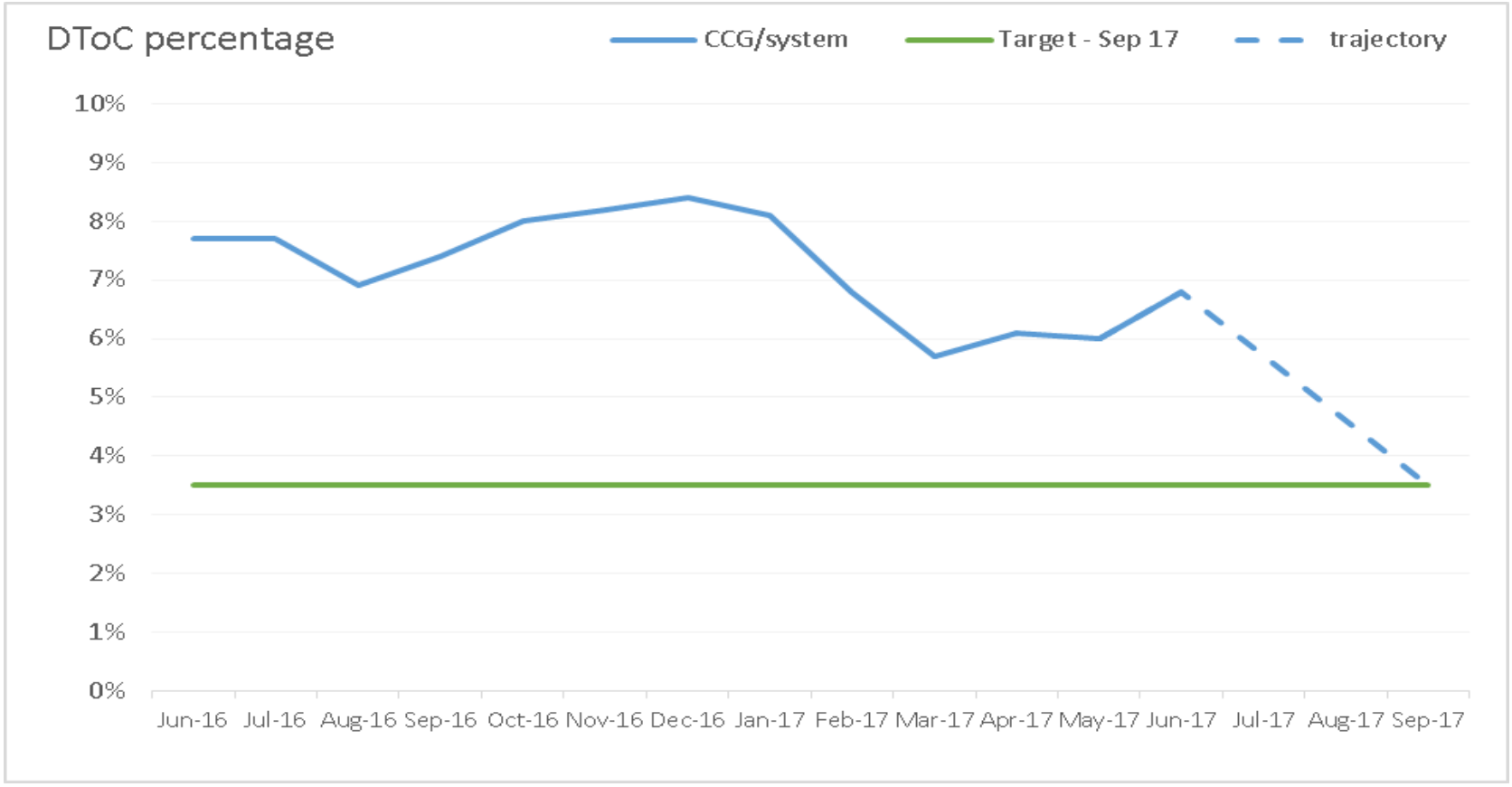
In that time period, Cambridge University Hospitals Foundation NHS Trust (CUHFT) has also met the target and North West Anglia Foundation Trust (NWAFT) crossed the 90% threshold in June and has stayed above it.



Delayed Transfers of Care (DToC) Performance

DToC percentage had stabilised since March 2017, but there has been an increased in June to 6.8%.

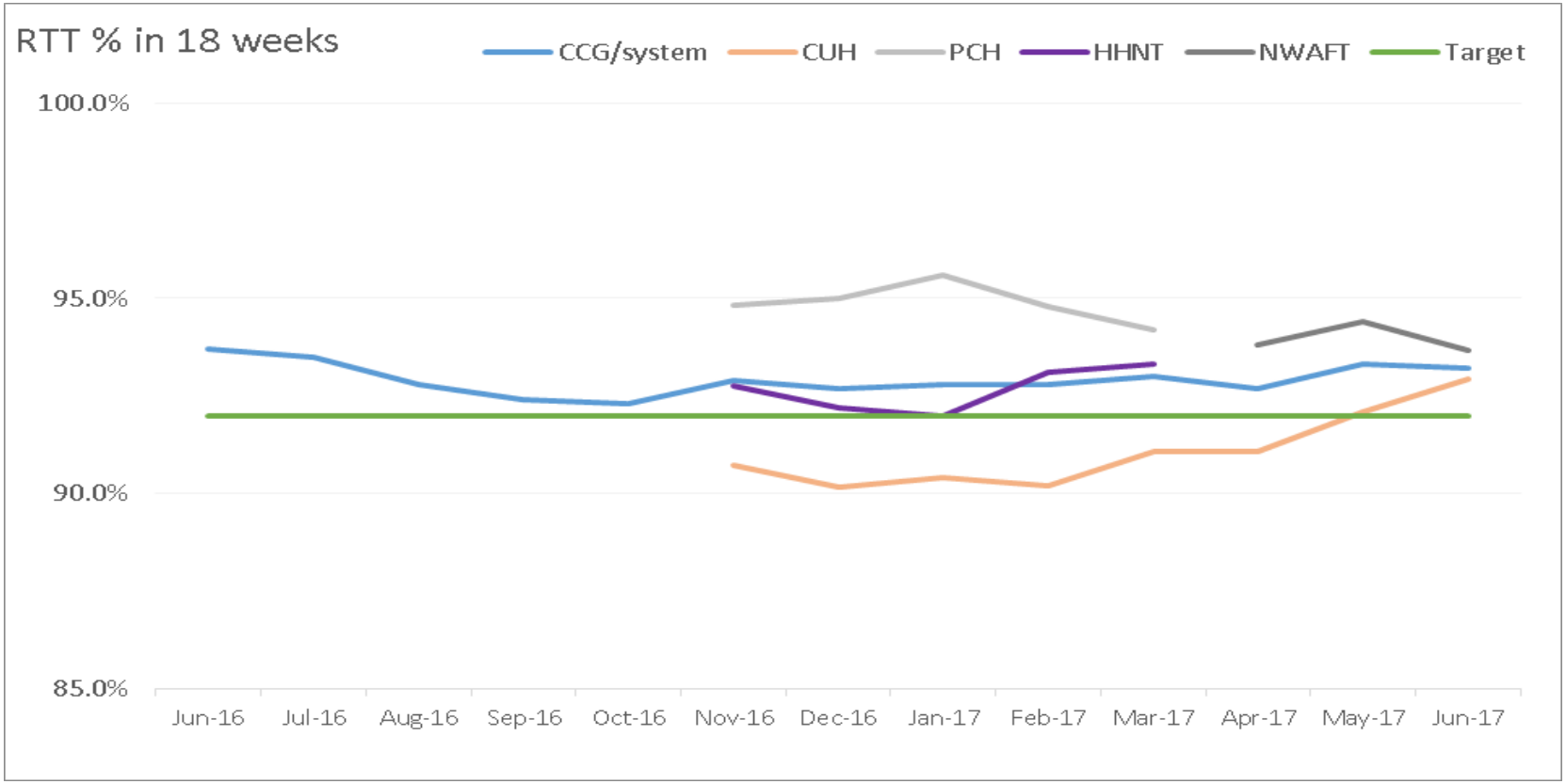
In order to meet the national target of 3.5% by September 2017, DToC percentage would need to decrease by about 1.1% per month.



Referral to Treatment (RTT) Performance

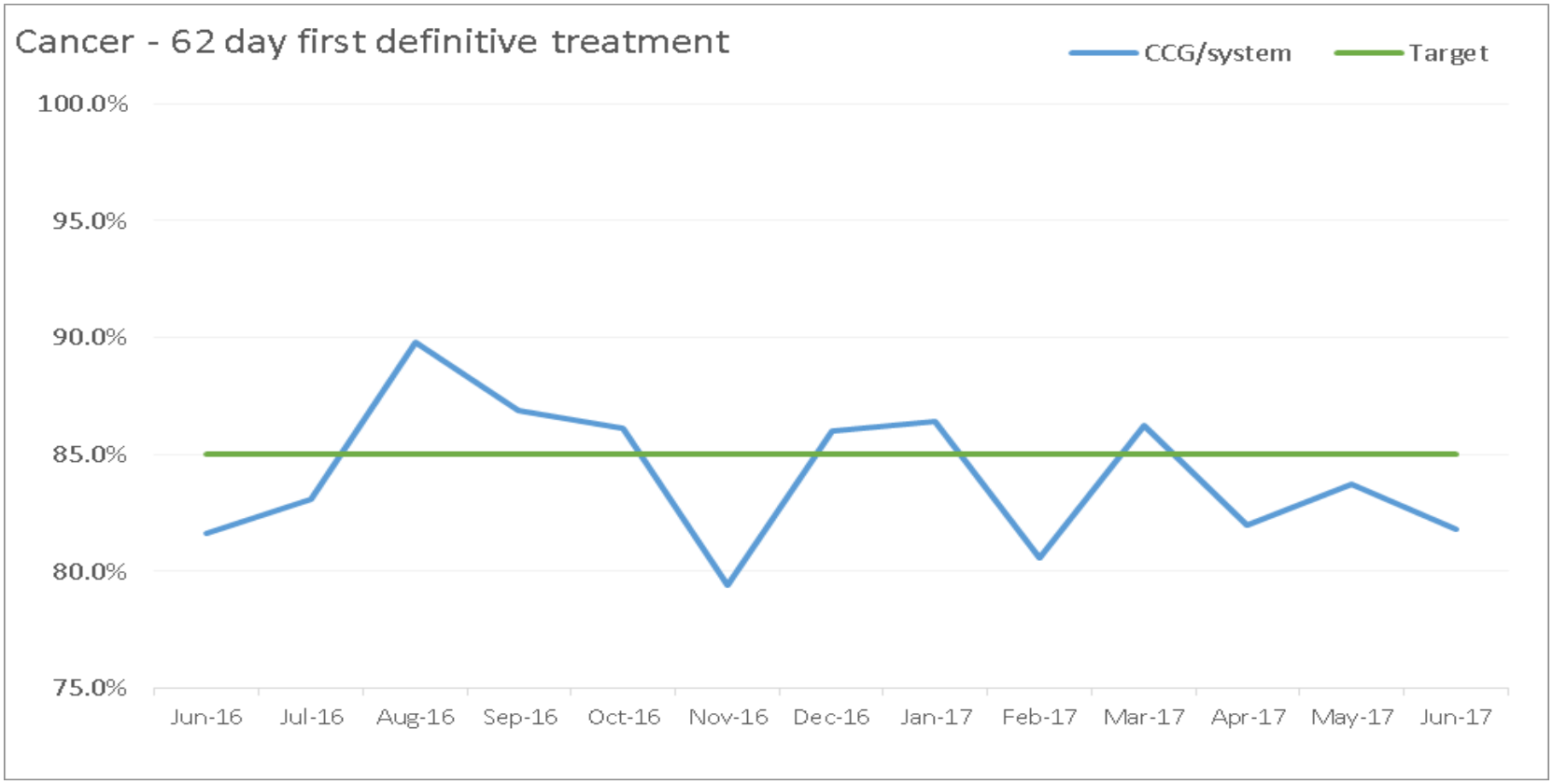
In the last year, the system's RTT% in 18 weeks was above the national target of 92%.

CUHFT has improved its RTT performance and has been above the standard since May 2017.



Cancer Treatment Performance

In June 2017, 81.8% of cancer patients had their first definitive treatment within 62 days, therefore, performance deteriorated from the previous month and the system missed its target of 85%.



STP Operational Performance

Other key indicators

- The indicators within the tables on the following two slides show performance at STP or Clinical Commissioning Group (CCG) level for other key metrics linked to the delivery of STP plans.

- These metrics are a combination of performance metrics e.g. waits in A&E and activity metrics e.g. the number of A&E attendances.

- Each STP Delivery Group has further metrics that focus on specific project outcomes e.g. the Falls Prevention Project will look at the number of admissions related to falls per 1000 population to confirm their project is reducing the number of falls.

- Shown are recent trend as well as a comparison with the same month last year and a Year-To-Date comparison. Green items are areas where performance has improved or activity has reduced, amber shows a stable position, red is a deterioration or increased activity.

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STP Operational Performance

	Indicator	Provider	Target / Threshold	Previous 6 months: Earliest					Latest	Latest month	c/w same month last year	Same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:	Trend
Urgent & Emergency Care	A&E Attendances	STP	n/a	27464	25615	29724	28888	30681	30416	30741		30897	116978		118430	Jul-17	
	A&E Performance	STP	95%	80.6%	84.8%	92.8%	93.6%	91.0%	93.9%	93.6%		82.4%	93.1%		83.8%	Jul-17	
	Emergency Admissions	CCG	n/a	6819	6895	6479	7503	6869	7424	7270		6739	21563		20281	Jun-17	
	Emergency admissions crude monthly rate per 1000 registered population	CCG	n/a	6.7	6.9	6.9	6.2	7.7	7.0	7.5		7.1	14.5		13.8	May-17	
	Total bed day crude monthly rate per 1000 registered population	CCG	n/a	36.8	36.7	39.3	35.3	40.9	34.8	37.5		38.6	72.3		76.5	May-17	
	DToC Average Daily Bed Days per 100,000 population 18+	CCG	n/a	18.9	19.5	18.2	15.6	13.7	14.5	13.5		17.2	14.0		17.1	May-17	
	DToC Percentage (DToC bed days/occupied bed days)	CCG	3.5%	8.2%	8.4%	8.1%	6.8%	5.7%	6.1%	6.0%		7.2%	6.0%		7.1%	May-17	
	Cat A < 8 minutes - Red 1	EEAST (CCG)	75%	71.7%	65.2%	64.6%	70.3%	70.2%	70.4%	66.1%		58.8%	68.9%		57.8%	Jun-17	
	Cat A < 8 minutes - Red 2	EEAST (CCG)	75%	60.0%	58.9%	61.3%	63.2%	62.7%	58.8%	55.1%		54.0%	58.8%		54.2%	Jun-17	
	Cat A < 19 minutes	EEAST (CCG)	95%	89.2%	89.7%	90.5%	92.9%	92.5%	89.6%	88.4%		85.5%	90.1%		86.9%	Jun-17	
	111 - number of calls triaged per day	HUC	n/a	605.0	570.0	548.0	507.0	592.0	523.0	502.0		476.0	1617.0		502.7	Jun-17	
Planned Care	Referrals	CCG	n/a	24127	27407	26082	28049	25278	29697	30633		26473	85608		79370	Jun-17	
	First Outpatient Attendances	CCG	n/a	25399	27762	26036	29670	24567	29347	29111		27630	83025		83532	Jun-17	
	Follow Up Outpatient Attendances	CCG	n/a	31151	35321	31468	36173	30354	35784	34845		36959	100983		116989	Jun-17	
	Elective Admissions	CCG	n/a	1517	1440	1475	1642	1441	1572	1464		1687	4477		5305	Jun-17	
	Daycase Admissions	CCG	n/a	6047	6564	6229	7342	6792	7478	7341		6220	21611		19177	Jun-17	
	RTT % in 18 weeks	CCG	92%	92.7%	92.8%	92.8%	92.9%	92.7%	93.3%	93.2%		93.7%	93.1%		93.4%	Jun-17	
	Diagnostics - < 6 weeks	CCG	99%	97.7%	97.7%	99.3%	99.4%	99.0%	99.0%	99.3%		96.4%	99.1%		97.3%	Jun-17	
	Cancer - 2 week wait	CCG	93%	95.3%	91.1%	93.5%	95.5%	95.0%	95.7%	95.8%		96.2%	95.5%		94.8%	Jun-17	
	Cancer - 2 week wait breast	CCG	93%	95.3%	96.1%	95.7%	95.8%	93.9%	90.6%	96.2%		92.7%	93.5%		93.7%	Jun-17	
	Cancer - 31 day first definitive treatment	CCG	96%	98.6%	96.6%	98.9%	98.3%	97.5%	97.5%	98.3%		97.9%	97.8%		98.4%	Jun-17	
	Cancer - 31 day subsequent surgery	CCG	94%	100.0%	94.1%	95.8%	96.6%	95.2%	96.6%	97.4%		100.0%	96.7%		98.4%	Jun-17	
	Cancer - 31 day subsequent drug	CCG	98%	100.0%	100.0%	100.0%	100.0%	98.4%	96.7%	100.0%		100.0%	98.4%		99.5%	Jun-17	
	Cancer - 31 day subsequent radiotherapy	CCG	94%	96.1%	98.1%	96.9%	96.8%	94.2%	98.5%	97.7%		96.1%	96.9%		97.6%	Jun-17	
	Cancer - 62 day first definitive treatment	CCG	85%	86.0%	86.4%	80.6%	86.2%	82.0%	83.8%	81.8%		81.6%	82.6%		84.6%	Jun-17	
	Cancer - 62 day screening	CCG	90%	89.5%	100.0%	96.3%	87.0%	100.0%	92.9%	90.0%		96.4%	93.1%		90.8%	Jun-17	

STP Operational Performance

	Indicator	Provider	Target / Threshold	Previous 6 months: Earliest					Latest	Latest month	c/w same month last year	Same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:	Trend
Quality and Safety	Number of unit/Labour suite closures (no target set)	STP	n/a	1	3	0	7	1	3	4		3	4		7	May-17	
	Safety - Incidence of MRSA (CCG/Trust Assigned)	STP	0	0	0	1	0	0	0	0		0	2		0	May-17	
	Safety - Incidence of C difficile (Sanctioned Cases)	STP	94	6	2	3	4	3	2	3		2	10		2	May-17	
	Safety - Never events	STP	0	1	0	1	0	1	0	2		0	1		1	Jun-17	
Mental Health	MH - completed therapy and are moving to recovery	CCG	50%	46.9%	51.5%	52.9%	53.8%	50.8%	50.0%	51.8%		47.7%	50.7%		45.5%	Jun-17	
	MH - early intervention in psychosis (EIP) starting treatment within 2 weeks of referral - rolling 3 months	CCG	n/a	87.5%	75.0%	85.7%	73.7%	62.5%	57.1%	73.1%		78.6%	57.1%		64.3%	May-17	
	Out of area placements for acute mental health inpatient care transformation - self assessed level of compliance	CCG	n/a							Full		Partial	Full		Partial	Mar-17	

STP Operational Performance

Conclusion

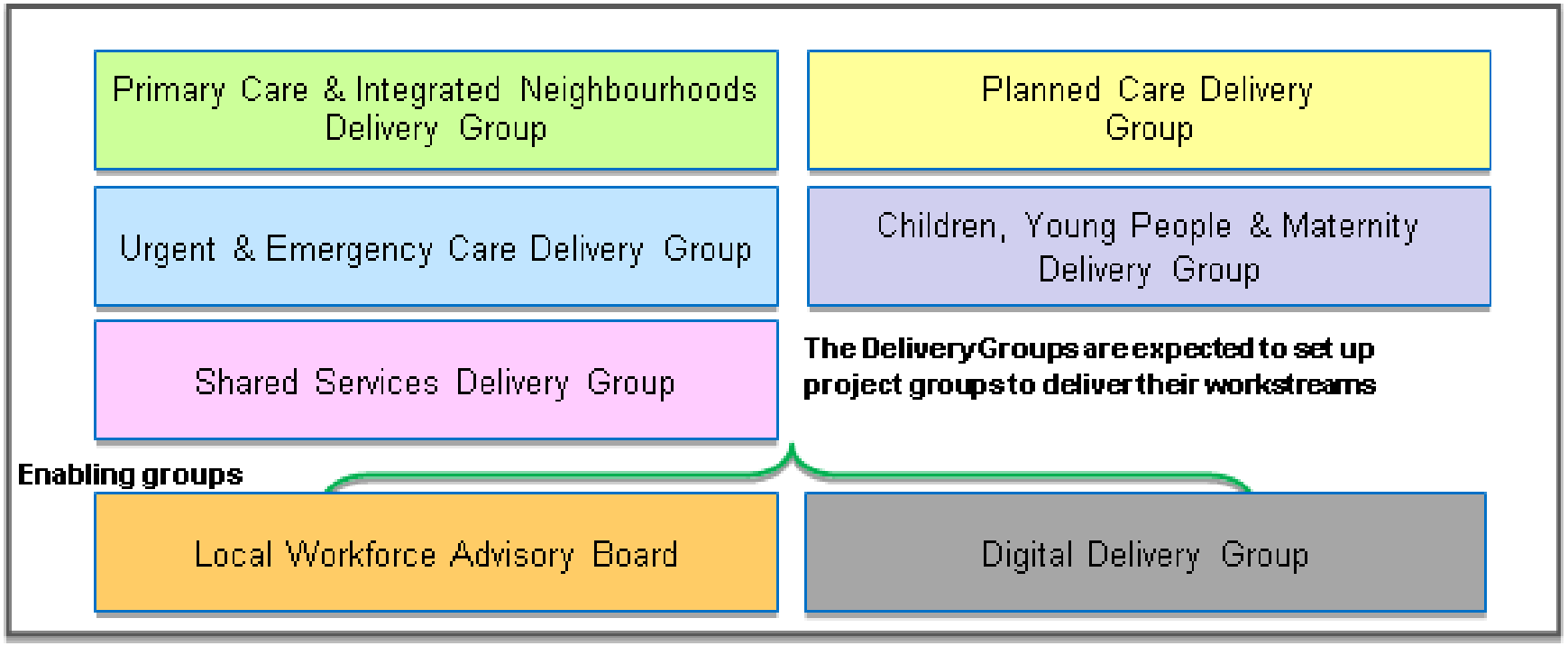
- The performance metrics in the preceding slides can routinely be made available to Committee members.

- Members are asked to confirm if and how they wish to receive this operational performance information

STP Programme Delivery

STP Programme Delivery

The STP programme has, at its core, seven Delivery Groups, each one responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system, as set out below.

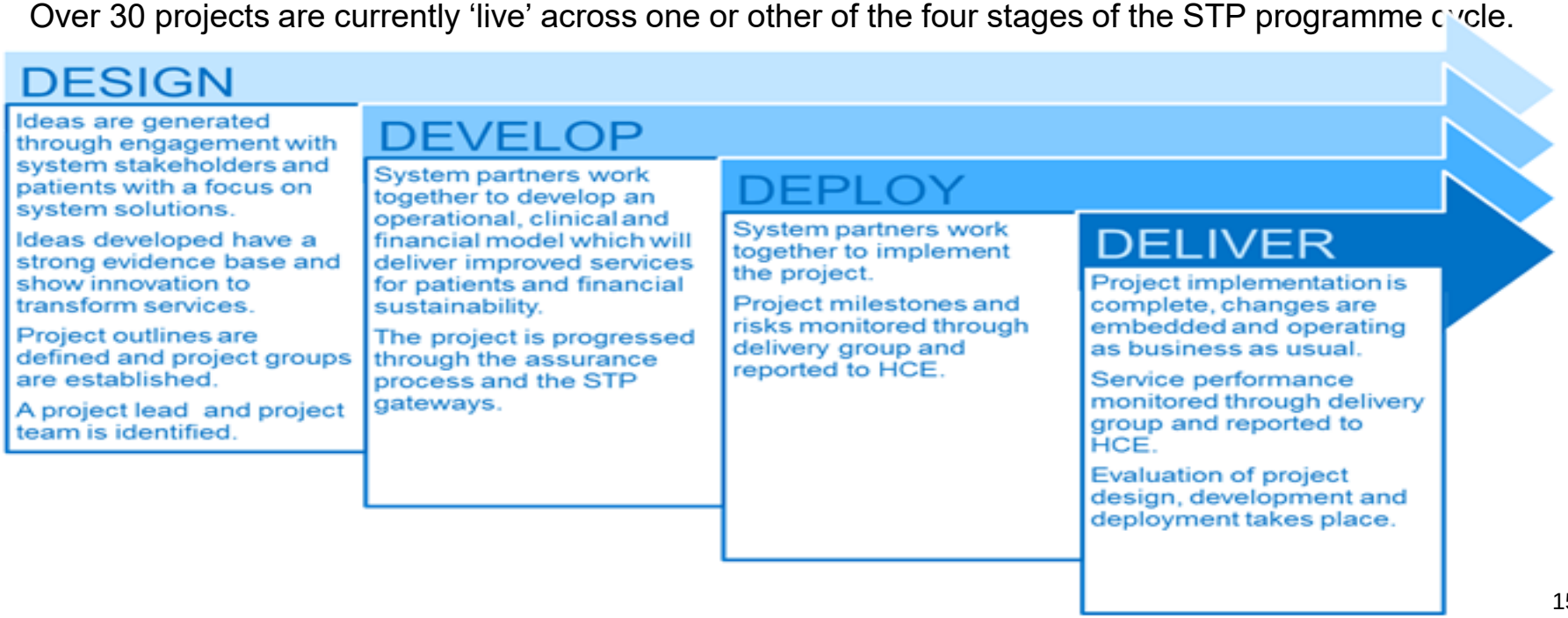


STP Programme Delivery

- The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do..

- Improvement Project Groups have been established within each Delivery Group to take forward specific aspects of work and, again, these groups include/will include clinical membership and patient and public representation.

- We have established a clear and consistent structure to frame the various processes across the STP to ensure appropriate accountability across the 'lifecycle' of each STP Improvement Project, as set out below.
- Over 30 projects are currently 'live' across one or other of the four stages of the STP programme cycle.



STP Programme Delivery

Urgent & Emergency Care (UEC)

- This presentation focusses on UEC delivery in order to demonstrate progress and illustrate the type and level of information available to share with the Committee.

- Members are asked to note that the format and content of any routine reporting to the Committee would need to be consistent with that currently utilised for internal STP delivery, in order to ensure consistency and minimise duplication of effort.

- Committee members can request to schedule specific Delivery Groups for a ‘deep dive’ focus at future meetings.

- Committee members are asked to note that STP officers attending this meeting are not UEC subject experts and that there will be a need to schedule attendance of appropriate clinical and managerial colleagues to support detailed discussion of specific Delivery Group progress at future meetings.

- The following slide provides a summary of progress for the UEC Delivery Group and includes information on:
  - Key Performance Indicators (KPIs);
  - Key risks; and
  - Savings Plan.

- The subsequent slides provide a one page summary of progress for each of the two UEC Improvement Projects currently in the ‘deployment’ stage.

Urgent & Emergency Care

JULY

4yr Target	£ 28.02m	17/18 Target	£ 10.5m	18/19 Target	£ 7.37m

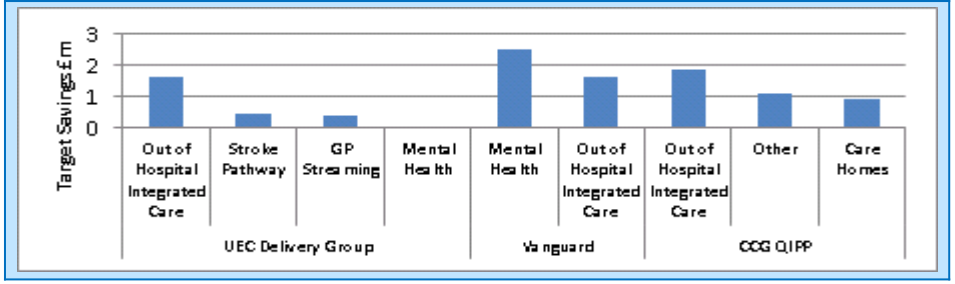
Accountable Officer	Roland Sinker	HR Lead	David Wherrett	Comms Lead	Dail Maudsley-Noble	Finance Lead	Jonathan Rowell

Improvement Area Summary

System Owner	Improvement Area	Project	SRO	Project Lead	Point in Cycle	Gross 17-18 savings (£m)			
						Invest-ment	Target savings	Identified savings	Variance
UEC Delivery Group	GP Streaming	GP Streaming	Ruth Derrett	Ian Weller	Design		0.40		
	Mental Health	Psych Liaison	Cathy Walsh	Katerina Lagoudaki	Develop	TBC	TBC		
	Out of Hospital Integrated Care	Extendend JET	Ruth Derrett	Katie Morrish	Deploy	1.87	1.61		
		Intermediate Care Tier	Ruth Derrett	Sara Rodriguez-Jimenez	Develop	TBC	TBC		
	Stroke Pathway	ESD	Debbie Morgan	Katie Morrish	Deploy	0.47	0.47		
		Rehab	Debbie Morgan	TBC	Design	TBC	TBC		
		Thrombectomy	Debbie Morgan	TBC	Design	TBC	TBC		
UEC Delivery Group Total						2.34	2.48		
CCG QIPP	Care Homes	Care Homes	Ruth Derrett	Ian Weller			0.65		
		Frailty	Ruth Derrett	Simon Pitts			0.28		
	Out of Hospital Integrated Care	IUC Contractual QIPP associated with Yr 2&3 of the contract	Ruth Derrett	Gareth Cairns			0.35		
		Ambulatory Care Sensitive Conditions	Ruth Derrett	Liz Phillips			0.00		
		Ambulatory Care	Ruth Derrett	Mark Evans			0.91		
		EEAST - Hear & Treat and See & Treat	Ruth Derrett				0.62		
	Other						1.09		
CCG QIPP Total						0.00	3.90		
Vanguard	Mental Health	Mental Health	Ruth Derrett	Simon Pitts		3.00	2.49		
	Out of Hospital Integrated Care	NHS 111 / IUC	Ruth Derrett	Ian Weller			0.41		
		Frequent Attends	Ruth Derrett	Simon Pitts			0.00		
		JET	Ruth Derrett	Katie Morrish			1.21		
Vanguard Total						3.00	4.11		
TOTAL					0	5.34	10.49	0	0

Note: Vanguard Mental Health Funding is via MRET

Savings Plan



KPIs

Indicator	Provider	Target / Threshold	Latest month	c/w same month last year	Same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:	Trend
A&E Attendances	STP	n/a	30416		28957	86237		87533	Jun-17	
A&E Performance	STP	95%	93.9%		82.9%	92.9%		84.2%	Jun-17	
Emergency Admissions	CCG	n/a	7362		6995	6770		6547	May-17	
Emergency admissions crude monthly rate per 1000 registered population	CCG	n/a	7.5		7.1	14.5		13.8	May-17	
Total bed day crude monthly rate per 1000 registered population	CCG	n/a	37.5		38.6	72.3		76.5	May-17	
DToC Average Daily Bed Days per 100,000 population 18+	CCG	n/a	13.5		17.2	14.0		17.1	May-17	
DToC Percentage (DToC bed days/occupied bed days)	CCG	3.5%	6.0%		7.2%	6.0%		7.1%	May-17	
Cat A < 8 minutes - Red 1	EEAST (CCG)	75%	66.1%		58.8%	68.9%		57.3%	Jun-17	
Cat A < 8 minutes - Red 2	EEAST (CCG)	75%	55.1%		54.0%	58.8%		54.4%	Jun-17	
Cat A < 19 minutes	EEAST (CCG)	95%	88.4%		85.5%	90.1%		87.6%	Jun-17	
111 - number of calls triaged per day	HUC	n/a	502.0		476.0	1115.0		516.0	Jun-17	

Top 3 Achievements

1. JET posts out to advert and 13 posts recruited
2. Clear recruitment plan in place for JET and ESD
3. Agreement and approval of Discharge to Assess

Areas of focus

- Mobilisation of Discharge to Assess project team and creation of project plan
- Integrated Care Worker (ICW) recruitment fair 05/08/17
- Psychiatric Liaison Business Case to Care Advisory Group (CAG) and FPPG
- Development of Outline Business Case for Thrombectomy service
- Identify project lead and project team for Inpatient rehabilitation

Key Risks

- Current poor utilisation of JET service particularly in Cambridge
- Failure to recruitment sufficient ICW's, JET practitioners and Allied Health Professionals (AHP)
- System resource to support projects (for example, Discharge to Assess, regional stroke rehab unit)

Extended JET Update

DEPLOY

17/18 Target Savings	£1.40m	17/18 Forecast Savings	£1.40m	17/18 Variance	£0m

SRO	Ruth Derrett	Project Lead	Katie Morrish	Clinical Lead	Ben Underwood	HR Lead	Cathy Mayes	Comms Lead	Mark Cole	Finance Lead	Tracey Shepherd

Financial Benefits and Expenditure Profile

	April	May	June	July	August	September	October	November	December	January	February	March	12 months
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Investment	0	0	£9,983	£9,983	£47,920	£151,786	£235,665	£262,278	£263,673	£270,648	£270,648	£270,648	£1,793,231
Forecast Savings	0	0	-£20,386	-£40,772	-£61,158	-£81,544	-£119,710	-£151,721	-£183,732	-£215,743	-£247,754	-£273,610	-£1,396,131

Milestones

Milestone ID	Milestone	Owner	Start Date	Due Date	Status
Extended JET	SRO: Ruth Derrett	Implementation Lead: Katie Morrish			Go live date: 01/06/2017
Extended JET M1	Identify options for bases for extended JET service	Alison Manton	20/03/2017	27/03/2017	C
Extended JET M2	CFPT sign off preferred model for ICW	John Martin	27/03/2017	12/04/2017	C
Extended JET M3	Communications plan developed to relaunch JET offer	Mark Cole	08/05/2017	26/05/2017	C
Extended JET M4	Sign off ED to JET referral pathway and referral criteria	JET Board	15/06/2017	08/08/2017	G
Extended JET M5	sign off revised JET service specification	JET Board	01/08/2017	01/09/2017	G
Extended JET M6	Recruitment of vacant posts completed and in post	John Martin	01/06/2017	01/09/2017	G
Extended JET M7	Go live with additional posts in Cambridge	John Martin	01/06/2017	01/09/2017	G
Extended JET M8	Go live with additional posts in Ely	John Martin	01/06/2017	01/10/2017	G
Extended JET M9	Go live with additional posts in Hunts	John Martin	01/06/2017	*TBC*	not started
Extended JET M10	Go live with additional posts in Peterborough	John Martin	01/06/2017	*TBC*	not started

Key Meetings/ Next Steps	31-Jul	07-Aug	14-Aug	21-Aug
JET Delivery Board (monthly)		X		
CPFT JET task and finish group (fortnightly)	X		X	
CPFT STP transformation meeting (monthly)				X

Top 3 Achievements

1. Triage Lead and JET dispatcher roles out to advert
2. Senior Manager appointed and commences 31 July
3. Recruitment of 13 ICWs

Areas of focus

- Ongoing recruitment plan for all JET posts
- CPFT ICW recruitment fair on 5th August in Huntington
- IT changes to SystmOne templates for triage and assessment
- Communications on agreed pilot with ED regarding admission avoidance for patients from care homes
- Review of KPIs including Patient Outcome measures

Key Risks

- Current poor utilisation of existing JET, particularly Cambridge area, although utilisation is improving
- High use of agency staff in triaging & existing vacancies across JET service
- Recruitment to ICWs in context of current and forthcoming recruitment to other services – reducing risk – good level of applicants so far.
- Shortcomings in GP engagement linked to service utilisation

Stroke ESD Update

DEPLOY

17/18 Target Savings	£0.124m	17/18 Forecast Savings	£0.124m	17/18 Variance	£0m

SRO	Debbie Morgan	Project Lead	Katie Morrish	Clinical Lead	Charlie Dorer	HR Lead	Cathy Mayes	Comms Lead	Mark Cole	Finance Lead	Tracey Shepherd

Financial Benefits and Expenditure Profile

	April	May	June	July	August	September	October	November	December	January	February	March	12 months
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Investment	0	0								TBC	TBC	TBC	TBC
Forecast Savings	**0**	**0**								**-£41,333**	**-£41,333**	**-£41,333**	**-£124,000**

Milestones

Milestone ID	Milestone	Owner	Start Date	Due Date	Status
Stroke ESD	SRO: Debbie Morgan	Implementation Lead: Charlie Dorer			Go live date: 08/01/2018
Stroke ESD M1	Clinical workshop with CPFT and all acute stakeholders to map pathways	Stroke Network	27/03/2017	01/09/2017	G
Stroke ESD M2	Agree clinical pathways	Stroke Network	27/03/2017	01/10/2017	G
Stroke ESD M3	Sign off final ESD service specification	Stroke Network	01/05/2017	01/10/2017	G
Stroke ESD M4	Implement wider communications plan	Sue Last	18/04/2017	15/12/2017	G
Stroke ESD M5	Induction capable of go live for ICWs and other clinical posts	John Martin	01/05/2017	01/09/2017	G
Stroke ESD M6	Go Live Cambridge	John Martin	01/06/2017	08/01/2018	G
Stroke ESD M7	Go Live Hunts	John Martin	01/06/2017	08/01/2018	G
	Go Live East Cambs and	John			
Stroke ESD M8	Fenlands	Martin	01/06/2017	08/01/2018	G
Stroke ESD M9	Go Live Peterborough		01/06/2017	08/01/2018	G

Key Meetings/ Next Steps

Key Meetings/ Next Steps	31-Jul	07-Aug	14-Aug	21-Aug
Stroke Network Meeting (monthly)	X			
CPFT Stroke ESD task and finish group (ad hoc)			X	
Systemwide Stroke T&F Group	X			

Top 3 Achievements

1. Clinical Lead (Charlie Dorer) is now in post.
2. Undertaken workshop with SALT and Dietetics to further review details of ESD criteria and rotation options
3. Workshop booked for 31st July across footprint to review detail of acute to ESD and acute to Neuro rehab referral and discharge process

Areas of focus

- Ongoing recruitment to new ESD posts.
- Ongoing engagement with acute trusts regarding new service and clinical pathways, options for staffing new posts across ESD
- Meeting with SystmOne team regarding S1 change requirements for new ESD pathways
- Work with D2A delivery team to ensure alignment of ICW model across projects
- Work with staff involved with working up stroke skilled care into 5 beds Camb. & P'boro

Key Risks

- Interdependency with future model for IP Stroke Rehab
- Recruitment to Allied Health Professionals roles
- Recruitment to Integrated Care Workers in context of current and forthcoming recruitment to other services
- No agreement to date from Acute providers in rotation of AHP staff
- Provision of sufficient community bed capacity

STP Programme Delivery

Conclusion

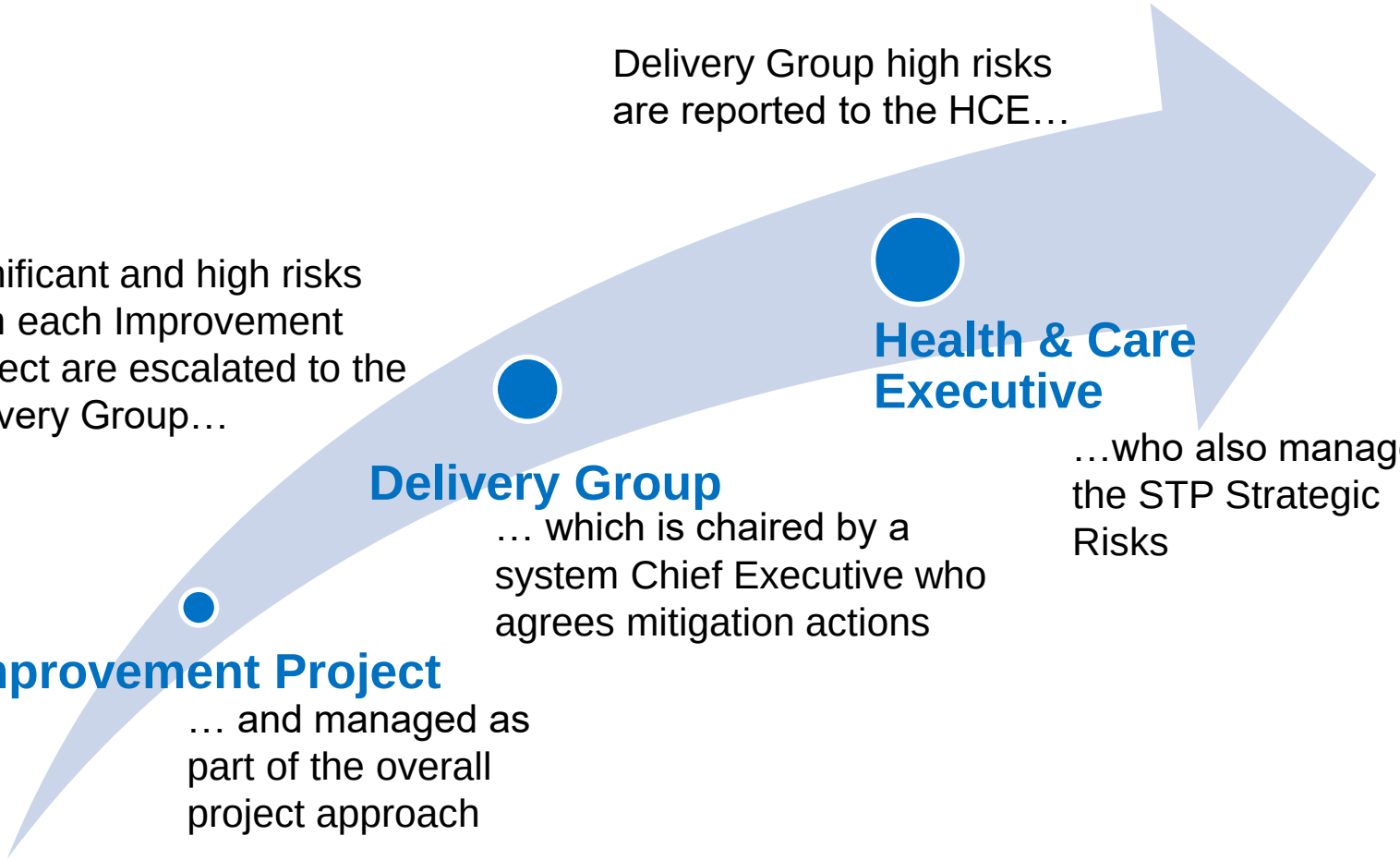
- The preceding slides illustrate the type and level of information available to share with the Committee in order to support discussion on progress with STP delivery.

- The Committee is asked to consider and agree to detailed briefings on specific Delivery Group progress at future meetings.

- The Committee is asked to consider and agree any routine STP Programme Delivery summary information it wants to receive, subject to the format and content being consistent with that currently utilised for internal STP delivery, in order to ensure consistency and minimise duplication of effort.

Risk Management Approach and STP Strategic Risks

Risk Management Approach



Risk Assessment

Risk Scoring

The STP uses the NHS National Patient Safety Agency's Model Risk Matrix to evaluate and score its programme risks. In short this involves identifying and scoring the potential consequence(s) of a risk and assessing and scoring the likelihood of that risk occurring. For reference an extract of the guidance that is used to calculate these scores is set out below:

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor - GREEN**	**Moderate - YELLOW**	**Major - AMBER**	**Catastrophic - RED**
Impact on the safety of patients, staff or public (physical/psychological harm)	• Minimal injury requiring no/minimal intervention or treatment. • No time off work	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by 1-3 days	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients

	Likelihood score				
Descriptor	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely - GREEN**	**Possible - YELLOW**	**Likely - AMBER**	**Almost certain - RED**
Frequency (How often might it/does it happen)	• This will probably never happen/recur	• Do not expect it to happen/recur but it is possible it may do so	• Might happen or recur occasionally	• Will probably happen/recur but it is not a persisting issue	• Will undoubtedly happen/recur, possibly frequently

Risk Assessment

Risk Scoring – continued

The consequence(s) score and likelihood score are then multiplied to provide an overall risk score.

Likelihood **X** **Consequence**

		Insignificant - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Rare – 1		**1**	**2**	**3**	**4**	**5**
Unlikely – 2		**2**	**4**	**6**	**8**	**10**
Possible – 3		**3**	**6**	**9**	**12**	**15**
Likely – 4		**4**	**8**	**12**	**16**	**20**
Almost Certain – 5		**5**	**10**	**15**	**20**	**25**

STP Strategic Risks

The Health and Care Executive (HCE) has responsibility for managing the STP strategic risks.

The STP strategic risks (summarised on the slides 25 and 26) are reviewed by the HCE monthly by the following exceptions:

1. By the Risk Review Date;
2. Any Risks which have changed; and
3. Following discussion at HCE for inclusion of any new risks

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STP Strategic Risks (1/2)

Ref No.	Risks/Issue Description	Risk Score	Mitigating/resolution/ Actions	Post Risk Score
R-06	There is a risk that deterioration of our core financial position may lead to failure to access additional monies such as sustainability funds.	20	CCG Financial turnaround plan aligned to STP delivery plan. CUHFT and NWAngliaFT financial recovery plans and operational Plan assumptions aligned to STP. Delivery of QIPP and CIP.	16
R-08	There is a risk that, if we do not effectively engage with patients, members of the public and other stakeholders, STP implementation may be compromised due to lack of support.	20	Communication & Engagement Strategy in place and to be routinely refreshed. Training & guidance in how to effectively engagement with stakeholders provided to all STP staff and clinicians. Active patient involvement in STP Delivery Groups and Improvement Areas. Routine stakeholder communication via, for example, STP Website, newsletter, social media and proposed Stakeholder Group.	12
R-15	There is a risk that Clinicians will not engage with STP implementation if they believe that clinical conclusions and agreed care models will not be implemented.	20	Clinical Engagement Strategy that 1) establishes Strategic Clinical Networks to lead clinical planning and proposed care models in areas such as Cardiovascular and Stroke 2) ensures clinical leaders are in place for every significant implementation area 3) puts in place Evaluation Task & Finish Groups and 4) strengthens, in collaboration with communication colleagues, engagement with specific clinical groups e.g. GPs.	12
R-16	There is a risk that proposed solutions are not supported by MPs, councillors and other elected representatives.	25	Engagement with councillors via Health Committee, Health & Wellbeing Board and processes, specific meetings and fora to ensure two-way dialogue that informs elected representatives of the case for change and ensures that there is an opportunity for councillors to influence solutions. Routine meetings with MPs, individually and collectively, to brief on issues.	20
R-17	There is risk that Primary Care as providers are not engaged or included in system wide leadership conversations.	25	Sustainable General Practice strategy group to provide assurance over implementation of GP Forward View. CCG investment in GP time to support GPs to be involved in redesign work. Communications Cell to devise system-wide GP engagement strategy.	20
R-20	There is a risk the system will not have the ability to capture sufficient savings opportunities in 2017/18 due to the lack of dedicated delivery resources.	16	Prioritise where to focus effort and response for 2017/18. CCG have realigned staff to priority projects. Focussed oversight of delivery by SDU.	12
R-25	There is a risk that negotiations with national bodies (Department of Health, Treasury) are un-coordinated among system partners, reducing negotiating leverage and likelihood of getting desired changes (e.g. to Market Forces Factor, for estates / infrastructure investment)	20	Application of MOU behaviours regarding sharing intelligence about strategic intent, via updates to HCE and/or FPPG. CEO commitment to speaking as a system, with one voice when negotiating with national bodies. HCE & CPSB meeting quarterly with shared agenda priorities agreed.	16

STP Strategic Risks (2/2)

Ref No.	Risks/Issue Description	Risk Score	Mitigating/resolution/ Actions	Post Risk Score
R-26	There is a risk that ineffective STP Governance may lead to failure to deliver on agreed actions.	20	Revision of Governance Framework underway and seeks to strengthen accountability and decision making.	16
R-27	There is a risk of delivery of STP wide projects due to capacity of teams and SROs alongside business as usual pressures.	20	Accountable Officer to actively monitor delivery of STP objectives, seek to resolve any delivery issues and escalate unresolved issues to HCE.	12
R-29	There is a risk that competing pressures placed on the CCG and Providers from National Bodies to deliver short term turnaround could be at the detriment of longer turn sustainability and deliverability of the STP.	20	HCE to monitor delivery of programme and to raise concerns honestly and openly in the HCE meetings in the first instance and escalate any unresolved issues to Bi-partite meeting with NHS England and NHS Improvement.	12
R-30	There is a risk that the system will be unable to secure external funding required to support delivery and this will result in the programme failing to achieve its objectives.	25	Deploy appropriate resource to ensure bids for national monies are completed to a high standard to maximise opportunity to be awarded funds. Utilise the virtual task and finish group to support the process. Seek other funding sources. If funding is not granted reassess STP objectives and identify other opportunities to deliver savings and objectives. Engaging with local MPs.	20
R-31	There is a risk that if a number of business cases all rely on recruiting new staff it may be difficult to recruit to all positions and if they are recruited from within the system this may cause problems for existing services	25	Delivery Groups to work closely with their Workforce lead to develop an appropriate recruitment strategy. Workforce leads to liaise to maintain an overview of Workforce requirements to ensure the needs of all business cases do not conflict and to ensure that the impact of large scale recruitment may have on other parts of the system is understood.	20
R-32	There is a risk that current transformation staff within all organisations aren't fully aligned to the STP and could result in the programme failing to achieve its objectives.	25	Accountable Officers to actively monitor delivery of STP objectives, seek to resolve and any unresolved issues to be escalated to HCE. Review engagement and communication strategy within organisations to ensure understanding and awareness of the STP.	20
R-33	The is a risk that as a consequence of being drawn into the Capped Expenditure Process (CEP) the system will be required to focus on short term actions and/or restrict the systems ability to focus on delivery of the STP programme of work.	20	Accountable Officers to continue to engage national bodies to understand and, where possible, influence the CEP.	12

Risk Management Approach and STP Strategic Risks

Conclusion

- The STP Strategic Risks in the preceding slides can routinely be made available to Committee members.

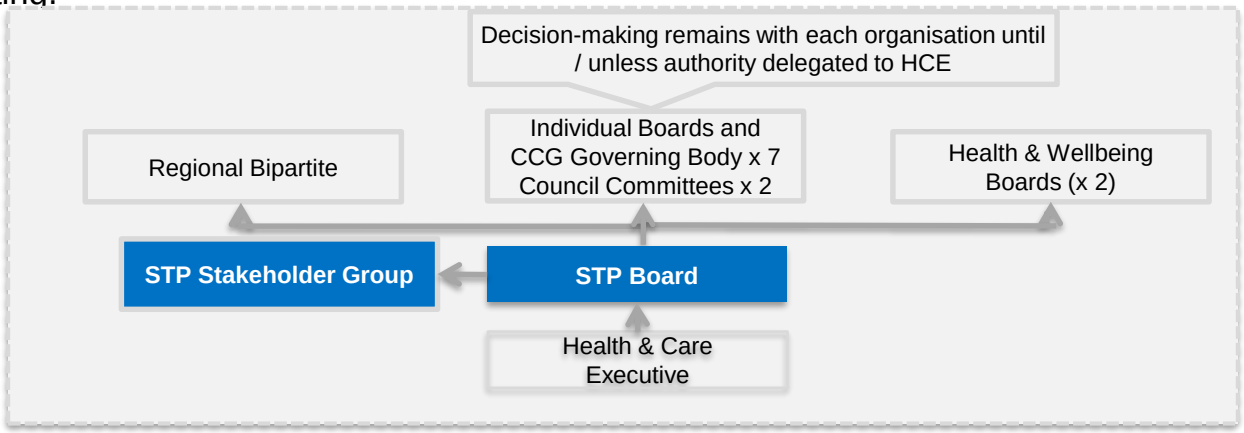
- Members are asked to confirm if and how they wish to receive this information

Review of STP Leadership

Review of STP Leadership

STP Board

- There is universal support from both the NHS partner Chairs and HCE for the formation of an STP Board which will have Non-Executive Director (NED) membership from across the system as well as Local Authority elected representation
- The first meeting will take place on 14 September. Meetings will then take place on a bimonthly basis.
- Key documentation, including the ToRs and the STP Governance Framework, is being revised to clarify the respective responsibilities of the STP Board and the HCE.
- A process is underway to appoint an Independent Chair. The post holder is expected to be in post by the November meeting.



Proposed membership	
• Chair: Independent Chair • CCG: Clinical Chair and Accountable Officer • CPFT: Chair and Chief Exectuive • NWAngliaFT: Chair and Chief Executive • CUHFT: Chair and Chief Executive • CCS: Chair and Chief Executive • Papworth: Chair and Chief Executive	• EEAST Chair and Chief Executive • Local Authority Representative • Executive Programme Director • CAG Chair • FPPG Chair • SDU Secretariat

Review of STP Leadership

STP Board (Continued)

Key documentation, including the ToRs and the STP Governance Framework, is being revised to clarify the respective responsibilities of the STP Board and the HCE. Broadly, the HCE will be operationally focused while the STP Board will be responsible for setting medium and long term STP strategy; as follows:

Area	STP Board
Strategic decision making	• Responsible for **medium and long term STP strategy**, including ensuring the system has in place a process for working towards **Accountable Care**
Operational delivery	• **Holds to account HCE** for delivery of the STP, ensuring accountability and reporting arrangements are in place
Governance	• Ensures adherence to collective **governance** arrangements
Risk management	• Reviews/ addresses **strategic programme risks**
Engagement	• Ensures there is a process in place to understand how the system manages the expectations of **service users and the general public and members of the STP Stakeholder Group**
Accountability	• Receives brief update from the HCE regarding STP delivery. Chair attends Bipartite meetings.

STP Executive Leadership

- Tracy Dowling, the current Accountable Officer for the STP, will continue in the role for the medium term
- Catherine Pollard has been appointed as Executive Programme Director and will replace Scott Haldane who will resume his full-time responsibilities as Finance Director at CPFT

Review of STP Leadership

Conclusion

- The Committee is asked to note:
  - The changes to STP leadership including the establishment of the STP Board; and
  - That Local authority colleagues are currently considering appropriate elected representation to sit on the STP Board