**Item No. 2**

# SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

## Held in Committee Room 1, Sunderland Civic Centre on Friday 30 March 2012

## MINUTES

**Present:**

| | | |
|---|---|---|
| Councillor Paul Watson (Chair) | - | Sunderland City Council |
| Councillor Dave Allan | - | Sunderland City Council |
| Councillor Pat Smith | - | Sunderland City Council |
| Councillor Mel Speding | - | Sunderland City Council |
| Councillor John Wiper | - | Sunderland City Council |
| Ron Odunaiya | - | Executive Director, City Services |
| Keith Moore | - | Executive Director, Children's Services, Sunderland City Council |
| Sue Winfield | - | Chair of Sunderland TPCT |
| Dr Gerry McBride | - | Sunderland Clinical Commissioning Group |

**In Attendance:**

| | | |
|---|---|---|
| Councillor Christine Shattock | - | Sunderland City Council |
| Jean Carter | - | Health, Housing and Adult Services, Sunderland City Council |
| Pam Lee | - | Sunderland TPCT |
| Michal Chantkowski | - | Sunderland Black and Minority Ethnic Forum |
| Nichola Fairless | - | North East Ambulance Service |
| Ralph Price | - | Sunderland LINk |
| Vince Taylor | - | Office of the Chief Executive, Sunderland City Council |
| Stuart Douglass | - | Office of the Chief Executive, Sunderland City Council |
| Karen Graham | - | Office of the Chief Executive, Sunderland City Council |
| Gillian Warnes | - | Governance Services, Sunderland City Council |

### HW37. Apologies

Apologies for absence were received from Dr Ian Pattison, Nonnie Crawford, David Hambleton and Neil Revely.

## HW38. Minutes

The minutes of the meeting held on 3 February 2012 were agreed as a correct record.

## HW39. Health and Wellbeing Strategy and Performance Management Update

Vince Taylor, Head of Strategy, Policy and Performance Management presented a report updating the Board on the process and timetable for the development of the Health and Wellbeing Strategy and asking them to consider the vision and values, operating principles and structure.

The Board had committed to producing the strategy jointly and a large amount of initial analysis work had been carried out against the background of a changing strategic context and environment.

A full programme of engagement and consultation had been developed for the Strategy and was illustrated at Figure 2 in the report. An officer working group had been set up to oversee the drafting and editing of the strategy and the membership was open to any interested parties. As part of this programme, engagement events had been held in January and March and Board members would shortly receive notification about the next event being held on 10 May at the Stadium of Light.

The Board itself had been engaged through its development sessions and the public and practitioners would continue to be consulted regarding the direction of travel of the strategy.

The work already done had been condensed into a vision for the Strategy and the CCG had done work in parallel to establish their vision of 'Better Health for Sunderland'. There had also been discussions on what was meant by reducing health inequalities and about how services could be better integrated across health and social care.

The Board would need to consider from where the values for the strategy would derive and how the strategy might be structured. There were a number of ways this could be done; by assets, by the Marmott principles or by life course. In terms of assets, this would consider the large amount of strong and stable families in the city, the coast, countryside and passion for sport. It was also necessary to define what was meant by wellbeing, not just health, and this took into account of elements such as level of confidence, physical resilience, a conducive environment and aspirations. These elements generate a way of potentially clustering activities and a simple and understandable structure for the Strategy.

The report also referred to the performance management framework and that this would be a whole system view. The Board would receive performance management reports throughout its shadow year.
In conclusion, the Health and Wellbeing Strategy was developing well, it was clear what needed to be covered within the strategy but more thought needed to be given

to how this could be grouped together as coherent blocks which would build up the strategy.

Councillor Smith enquired when outcomes for children would be considered within the strategy development and Vince Taylor advised that this would be done at a local level as there was no national framework in place at the present time. The outcomes would start with the Council's Corporate Plan, the priorities already outlined in the Children and Young People's Plan and action planning from the safeguarding inspection.

Pam Lee advised that since the production of the report, the CCG had added 'Patient-centred' and 'Innovative' to their values and were starting to broaden their views.

Sue Winfield commented that the health and wellbeing engagement events had demonstrated that different people viewed health and well being as very different things and the issue of engaging local residents in the discussion was a large and complex one. The more people that were engaged, the more successful the strategy would be. Officers had to respond to people as they were in reality, not in an ideal world and it was for partners to travel with the city's population, on the route which they wanted to take.

With regard to the CCG values, it was queried if these were all to be taken on by the Health and Wellbeing Strategy. Rather than 'patient' focused, the strategy would be 'customer' or 'people' centred. As time progressed there would be a convergent evolution of the Health and Wellbeing Strategy and the CCG's Clear and Credible Plan. Discussions on this subject would take place outside the meeting to identify which elements of the strategy and plan were the same and where things were necessarily divergent.

Michal Chantkowski from the Sunderland Black and Minority Ethnic Network commented that with regard to the engagement events, people from the Black and Minority Ethnic community were less likely to go along to the sessions than other people and the Chair noted that equality impact assessments needed to be built into all considerations. Karen Graham added that if it was not appropriate for some groups to attend consultation events, then officers would always go out to them and had done so with the Youth Parliament and young people with learning disabilities. This offer remained open for any groups who wished to contact Karen.

Following discussion, it was: -

RESOLVED that: - (i) the Strategy development process be noted;

(ii) the vision and values be agreed;

(iii) the proposed strategy structure be noted; and

(iv) the development process for the performance management framework be noted.

## HW40. Clinical Commissioning Group Update

Dr McBride updated the Board on the latest developments regarding the Clinical Commissioning Group. The group had a large task to come from where it had been to be ready to become a statutory body. There were still a number of things which had to be done, but the Sunderland CCG was at the forefront of developments and was confident in putting itself forward for the first wave of authorisations.

Dr McBride expressed his satisfaction with the progress made and was optimistic about achieving the goal of statutory status. He also thanked the PCT for their support throughout the process.

The Clear and Credible Plan (CCP) was evolving and the Group felt that it was not far short of where it would need to be in a few months time. The CCG was working with colleagues in local authorities to develop the plan and also with the universities on training issues.

Sue Winfield commented that the PCT Board had been preparing for working differently from April and that the CCG would now be driving matters forward and would be responsible for finance and performance issues. The PCT would continue to do its best to support the CCG.

Keith Moore advised that he had made an initial presentation to the CCG on children's priorities and the Children's Services Leadership Team had been invited to give a more detailed presentation to a future meeting.

In response to a query from the Chair, Dr McBride stated that, going forward, the CCG envisaged that the PCT would still have the statutory responsibility but the main thrust of the work would be delegated to the CCG. The difficult process of staff transition would now begin and detailed plans would be developed to outline which services would be bought in and which would be retained in-house.

There was a requirement to have an accountable officer for the functions being carried out by the CCG and until March 2013, this officer would be held to account by the Chief Executive of the PCT. There had to be proper accountability within the delegated structure but this was being held up by lack of guidance. However, the CCG considered it was well placed in terms of finance and matters of governance.

RESOLVED that the Clinical Commissioning Group update be noted.

## HW41. Feedback from Advisory Boards

### Adults Partnership Board

Councillor Speding reported that the main agenda items considered by the Adults Partnership Board at its meeting on 13 March 2012 had been: -

- Terms of reference and work programme
- Development of Local Accounts

- Carers' Strategy update
- Adults Autism Strategy update
- Transition of Public Health
- 50+ Action and Ageing Well

Councillor Speding made particular reference to the item on the terms of reference and that there was to be a rationalisation of the Healthy City groups within the partnership and that the membership had been opened to the housing federation, local medical, dental and pharmaceutical bodies.

With regard to the 50+ action group, there were discussions about how the organisations under the Health and Wellbeing Board would feed in. Good practice in relation to housing and planning was also discussed as part of the work of the action group.

There had been a comment from the Carers' Association about a lack of recognition in the CCP but this was related to the good working between the CCG and the Carers' Association not being emphasised within the plan.

**Children's Trust**

Councillor Smith reported that the Children's Trust had received a presentation on Northumbria Police's newly created Protecting Vulnerable People Unit and had received the early outcome feedback from the safeguarding inspection.

The Trust had then gone on to consider the progress on priorities within the Children and Young People's Plan as part of an ongoing programme of confirm and challenge sessions. The priority outcomes which were considered were: -

- Reduce levels of childhood obesity so that there are fewer overweight or obese children and young people
- Reduce levels of teenage pregnancy so that there are fewer teenage conceptions
- Improve attainment for all children and young people by achieving national average at all key stages
- Improve attainment for all vulnerable and under performing groups of children and young people

Future meetings of the Children's Trust would consider other priorities within the Children and Young People's Plan.

Keith Moore highlighted that the final report of the safeguarding inspection had been confirmed and would be published on 10 April 2012. The report was positive and referred to considerable strengths within the service, but also identified some actions for improvement. He thanked partners who had been involved and contributed to the huge efforts made over the inspection period.
The Chair congratulated those involved in the safeguarding inspection and also praised the Telecare Service who had recently performed to an extremely high standard in their inspection. Ron Odunaiya stated that the service was a joint venture between City Services and Health, Housing and Adult Services but was

supported by the whole Council. He advised that full inspection report would be published in April.

RESOLVED that the information be noted.

**HW42. Community Safety and Health and Wellbeing**

Stuart Douglass, Policy Lead for Community Safety, presented a report giving an overview on the linkages between health and wellbeing and community safety through the work of the Safer Sunderland Partnership.

The Safer Sunderland Partnership had a statutory responsibility to work with responsible authorities and had agreed the following six strategic priorities to focus on in 2012/2013: -

- Alcohol misuse and alcohol-related crime and disorder
- Drug misuse and drug related crime and disorder
- Domestic violence (including other violent crime)
- Anti-social behaviour
- Safety and feelings of safety for high risk victims/vulnerable groups
- Re-offending

Alcohol stood out as a particular challenge and it was noted that there was £6.5 million invested in alcohol and substance misuse treatment which would eventually be transferred to the local authority through the Public Health transition. Stuart highlighted that once the Police and Crime Commissioner for Northumbria was elected, the resource of the Safer Sunderland Partnership would be transferred to them and also a certain amount of the drug treatment funding. It would then be for the Commissioner to determine how that money would be distributed or services commissioned.

The CCG would be very important to the work of the Safer Sunderland Partnership and it was understood that it would take the statutory seat of the PCT on the partnership in due course.

Councillor Allan was pleased to note the positive steps in relation to the feelings of safety for high risk victims and vulnerable groups and highlighted the impacts which the extended family could suffer as well as the vulnerable individual. He raised the issue of disability hate crime, which affected both physical and mental health, but was often unreported and consequently overlooked. He stressed that victims needed to feel confident in reporting ‘low level’ issues, instead of waiting until they escalated to ‘high level’ incidents.

Stuart Douglass reported that the Partnership had responsibility for the ARCH system for reporting racist incidents and this was being rolled out for the reporting of disability crime too. In the light of the Fiona Pilkington case, work had been carried out to look at the potential risks of people with disabilities and how these could be managed. The Telecare service had stepped in to provide support following the reduction in Home Office funding.

Sue Winfield if it was envisaged that the Police commissioning body would have a statutory place on the Safer Sunderland Partnership and Stuart Douglass advised that the Police and Crime Commissioner was at arms length from the locality and would not be considered a responsible authority, but the Safer Sunderland Partnership would have a duty to co-operate with the Police and Crime Commissioner. The Commissioner would be held to account on some aspects of work with limited scrutiny by the police and crime panel established by the constituent local authorities.

Having considered the report and the linkages between community safety and health and wellbeing, it was: -

RESOLVED that:

(i) the Health and Wellbeing Board support the Safer Sunderland Partnership with treatment system redesign and receive progress reports;

(ii) the Safer Sunderland Partnership support the CCG in commissioning appropriate services to meet the needs of drug and alcohol users as well as offenders and vulnerable individuals in primary care;

(iii) the Health and Wellbeing Board and Safer Sunderland Partnership consider developing closer links with the Early Intervention Board to ensure that the needs of young drug and alcohol users are met:

(iv) the Board and Partnership work collectively with the Strengthening Families Board to progress the underlying linked community safety and health and wellbeing elements of the work;

(v) the Board link with the Partnership prior to the election of the Police and Crime Commissioner to produce the business case for the continuation of funding for existing schemes;

(vii) the Board and Partnership support the Licensing Committee in implementing new powers to tackle alcohol related harms associated with the night time economy; and

(viii) the Board and Partnership to work collectively to tackle violence against women and girls, in particular ensuring clear referral and needs assessment arrangements.

**HW43. National Learning Network for Health and Wellbeing Boards**

Jean Carter presented a report providing an update on the work of the National Learning Network for Health and Wellbeing Boards.

The Sunderland Health and Wellbeing Board had made a successful application to be part of the National Learning Network and had been allocated to the set which was considering how health and wellbeing boards could make the best use of collective resources. The aim of the group was to develop the understanding of how the role of health and wellbeing boards could drive the best use of resources across the NHS and local government.

The group had held four video conference meetings and it was intended that the group would produce reference sets an products such as questions to prompt consideration of key issues and a series of 'tips' for boards. There were a range of resources available and examples of good practice would be shared.

A draft of the group's work was to be produced by 29 March and would be circulated to the Board, Children's Trust and Adults Partnership Board for comments and the work of all the learning sets would be submitted to the Department of Health in April to be moulded into a single, final product.

The Health and Wellbeing Board: -

RESOLVED that: - (i) the content of the report be noted;

(ii) the draft product from the 'Making the Best Use if Collective Resources' group be circulated to members of the Board and advisory groups for comment; and

(iii) a report be received following the completion of the work by the National Learning Network.

**HW44. Future Development of the Health Visiting Service**

Dr Gerry McBride presented a paper on the future development of the health visiting service, highlighting that in 2013, the responsibility for commissioning these services would pass to the National Commissioning Board on an interim basis, with the responsibility passing to the local authority in 2015.

There had been some concerns raised by GPs about the way the health visiting was currently provided, including communication and safeguarding issues and also the proposed service specifications. The Clinical Commissioning Group felt that this would be an important opportunity to influence the service specification prior to the responsibility for commissioning being transferred.

It was proposed that the Children's Trust be asked to take forward working on this issue and provide a report back to the Health and Wellbeing Board in due course.

RESOLVED that: - (i) the Children's Trust be tasked to work with stakeholders to investigate the issue of the future development of the health visiting service; and

(ii) a report be brought back to the Health and Wellbeing Board in six months with recommendations to address concerns, mitigate risks and the influence the future development of the service in order to improve outcomes for children.

**HW45. Update on Public Health Transition**

Pam Lee reported that the second iteration of the Public Health Transition Plan had been submitted to the Government that week and following the review by the Strategic Health Authority, more actions had been marked as green. The only elements which remained amber and red were those where there was a lack of guidance.

The plan would go through the relevant Council processes as the local authority was the receiver organisation and the plan had also been considered by the PCT at its most recent Board meeting. A joint PCT/local authority transition board had been established to oversee workstreams looking at transformation, commissioning and procurement, finance, human resources, communications and engagement and information and intelligence. As part of the governance of the transition, risks would be identified for each workstream and a risk log maintained.

RESOLVED that the update be noted.

**HW46. Board Development Session – Integrated Commissioning**

Karen Graham presented a report outlining the scope of the next Board development session.

As the Board had agreed that developing a joint approach to the commissioning of services would be vital to the effective working of the Board, the development session on Monday 23 April 2012 at 10.00am had been set aside to discuss commissioning. The session would be facilitated by Professor Chris Drinkwater and Board Members were encouraged to do their best to attend the session.

RESOLVED that the details of the session be noted.

**HW47. Dates and Times of Future Meetings**

RESOLVED that the schedule of meetings for 2012/2013, as listed below, be noted.

Friday 18 May 2012 at 12.00noon
Friday 27 July 2012 at 12.00noon
Friday 14 September 2012 at 12.00noon
Friday 16 November 2012 at 12.00noon
Friday 25 January 2013 at 12.00noon
Friday 22 March 2013 at 11.00am

(Signed) P WATSON
Chair

**Sunderland Early Implementer Health and Wellbeing Board**
**18th May 2012**
**Feedback from the Adults Partnership Board 1.5.12**

| ITEM | |
|---|---|
| **3 Adults Partnership- Board – forward plan** | A working group was to be convened to discuss<br>- areas of work to be brought to APB by the members of the group – (bearing in mind the advisory role of the Board)<br>- It was noted that with the amendments to the TOR of APB there are additional organisations are now represented at the Board who should suggest their key topics for discussion and feed into HWBB<br>- Topics should be dealt with as a task and finish approach – a group lead by a member of the Board working together with reps of the relevant partners to look at the issues<br>- Membership - that Community Health South of Tyne and Wear be invited to the group and invitations re-issued to the Housing Federation North East, LMC, LDC and Ambulance service |
| **4 Health and Wellbeing Scrutiny Committee – verbal update** | Suggestion was put forward that the APB could assist to develop action plan and its implementation could then be monitored collectively (by APB) |
| **5 Health and Wellbeing Board - Agenda** | CCG Commissioning Plan:<br>- timing of submitting the report was commented on – the Board would have expected to have been involved in the process much earlier, not just prior to the paper being submitted to the HWBB<br>- Age UK noted that they felt that the aspect of the social model seems to be missing in the document (e.g. how prevention could be linked with the social model)<br><br>Transforming Community Resilience through Health and Wellbeing<br>- it was recommended that the proposed development session include APB and Children's Trust representation<br>- this approach is relevant to and should be linked to other work e.g. work around strengthening families, the asset approach and community capital. |

| | |
|---|---|
| | Public Heath Transition<br>- it was acknowledged that the success will depend of the partnership work |
| **6 Older People Mental Health Strategy Group – update** | - the Board requested an on the Memory Protection Service<br>- the question was raised on how widely the Dementia Liaison and Co-ordination Champions could be developed beyond Care Homes.<br>- Potential to include the topic of dementia in the Health Champion Programme |
| **7 Alcohol prevention and treatment - links between APB and Safer Sunderland Partnership** | - Representative of the Safer Sunderland Partnership to be invited to be a member of the group |
| **8 WHO Healthy Cities Network** | - the group were asked to consider whether there is a merit in hosting WHO event (national or international) in the City<br>- it was noted that there should be more WHO work in the mainstream work |
| **9 Personalisation – Update** | item deferred to the future meeting |

**Item No. 4b**

## BRIEFING FOR EARLY IMPLEMENTER HEALTH AND WELL-BEING BOARD

## SUNDERLAND CHILDREN TRUST BOARD – 26 APRIL 2012

**Ofsted Announced Inspection of Safeguarding and Looked After Children's Services**

Meg Boustead, Head of Safeguarding provided a presentation outlining the outcomes from the recent Announced Inspection of Safeguarding and Looked After Children's Services.

The inspection team were on site between 20 February and 2 March, and during this period spoke to a range of stakeholders, including:

- 37 children and young people
- 20 parents and carers receiving services
- Frontline staff and managers
- Senior officers
- Elected Members
- A range of community representatives
- Frontline professionals, managers and senior staff from partner agencies.

Each Council and its partners are scored against 22 judgements (four headline and a further 18 supporting judgements). The outcomes for Sunderland are noted below:

| JUDGEMENT | SCORE |
|---|---|
| **Safeguarding services** | |
| Overall effectiveness | Good |
| Capacity for improvement | Good |
| **Safeguarding outcomes for children and young people** | |
| Children and young people are safe and feel safe | Good |
| Quality of provision | Adequate |
| The contribution of health agencies to keeping children and young people safe | Good |
| | |
| Ambition and prioritisation | Good |
| Leadership and management | Good |
| Performance management and quality assurance | Good |
| Partnership working | Good |
| Equality and diversity | Good |
| **Services for looked after children** | |
| Overall effectiveness | Good |
| Capacity for improvement | Good |
| **How good are outcomes for looked after children and care leavers?** | |
| Being healthy | Good |
| Staying safe | Good |
| Enjoying and achieving | Good |
| Making a positive contribution, including user engagement | Good |
| Economic well-being | Good |
| Quality of provision | Good |
| | |
| Ambition and prioritisation | Good |
| Leadership and management | Good |
| Performance management and quality assurance | Good |
| Equality and diversity | Good |

The one area judged to be 'adequate' was the quality of provision in Safeguarding. The inspectors explained the primary reason being the inconsistent quality of assessments and plans. This had already been highlighted as a priority and considerable work has been undertaken in recent years to have the infrastructure in place to support improvement.

Work is ongoing to identify improvement actions to address the areas for improvement outlined in the Inspection Report.

A draft improvement plan is being presented to EMT and Cabinet for approval.

**Children and Young People's Plan Priorities – Confirm and Challenge**

In order to monitor progress on priorities within the Children and Young People's as part of an ongoing programme of confirm and challenge sessions and agree the Children's Trust priorities for 2013-2016 (the second delivery plan arising from the Children and Young People's Strategy 2010-2025), two priority areas were discussed:

<u>Priority Outcome 14: Increase the proportion of young people who are in Education, Employment and Training (EET)</u>

The indicators specific to increasing the proportion of young people who are in Education, Employment and Training (EET), support the understanding of the population and targeted outcomes:

1. The number and proportion of 17 year olds who are in employment, education or training.
2. The number and proportion of 18 year olds in employment, education or training.
3. The number and proportion of 16-18 year olds from the following backgrounds in education, employment or training:
    - Learners with learning difficulties and/or disabilities
    - In care/care leavers
    - Teenage parents
    - BME learners
4. The number of proportion of young people in learning.
5. The number of young people who have been NEET for a period of 6 months or longer.

The plans in place to improve outcomes are as follows:

- Ensuring all stakeholders are engaged in the development of a robust and deliverable action plan and that they are committed to timely delivery.
- Supporting young people to maintain their engagement and support staff working with them to understand issues and respond effectively.
- Enabling young people to have good information, advice and guidance and support at transition.
- Placing a collective responsibility for ensuring young people are appropriately placed on all partners.
- Ensuring learning providers offer an appropriate curriculum for all young people.
- Increasing the number of supported apprenticeships across partners.
- Improving performance management framework in lreation to Neet.

Priority Outcome 4: Reduce Substance Misuse, including smoking reduction

The indicators specific to reducing substance misuse and smoking reduction support the understanding of the population and targeted outcomes for:

1. Successful treatments completed
2. Offending and re-offending rates
3. Improved behaviour
4. Improved confidence and self esteem
5. Equity of access to services
6. Access to advice and information.
7. Number of adults who smoke
8. Number of young people who smoke
9. Secondhand smoke
10. Smoking at time of delivery

The plans in place to improve outcomes are as follows:

- Reducing the number of young people frequently using illicit drugs, alcohol or volatile substances.
- Ensuring appropriates services for young people in treatment as defined by NTA
- Reducing alcohol related Accident and Emergency admissions
- Reducing alcohol related crime and disorder
- Reducing the number of women smoking at the time of delivery
- Reducing smoking prevalence in young people aged over 16
- Ensuring all secondary schools attain gold smoke free award by September 2009
- Improving access to smoking cessation services across the city for under 18s
- Reducing levels of smoking during pregnancy by 15% by 2010.

In order to ensure that all priorities within the Children and Young People's Delivery Plan (2010-2013) have been through this confirm and challenge process, an additional two sessions have been arranged for 21 May and 25 June, and will inform both the Children and Young People's Plan Annual Report (2011-2012) and the development of the Children and Young People's Delivery Plan (2013-2016).

**Young People's State of the City Debate – Sunderland Youth Parliament**

On 25 November 2012, the Young People's State of the City Debate took place in the Council Chamber.

A group of young people from various schools across the city who are members of the Sunderland Young Parliament attended the Children's Trust Board meeting to provide detailed feedback from the event.

The State of the City Debate brings together young people from a wide range of backgrounds and 16 of the 18 secondary schools were represented, including one special school. The main areas which were highlighted through discussion were:

- Careers
- Health
- Sex education
- Student rights
- Discrimination

And these issues form priorities for Sunderland Youth Parliament in the year ahead. A detailed action plan has been development, which includes the following key actions:

- To forge stronger relationships with the leadership teams and citizenship co-ordinators within schools and colleges.
- To work more prominently with youth groups and within youth centres.
- To begin to develop relationships with minority groups and those with whom Sunderland Youth Parliament is not currently interacting with.
- To begin to develop use of social networking sites and the Sunderland Youth Parliament website.
- To ensure that decision-makers, councillors, public sector workers, charities and Sunderland City Council are aware of the existence of Sunderland Youth Parliament, and to develop contacts and relationships with these individuals.
- To recruit more members to the group.

A copy of the action plan can be made available. It was agreed that the relationship between the Children's Trust and the Youth Parliament be formalised and that termly meetings take place.

*Sunderland Clinical Commissioning Group*

*NHS South of Tyne and Wear*

# Development of CCG Commissioning Plan
# Progress Update for Sunderland Early Implementer Health and Wellbeing Board May 2012

## Purpose of the Report

Following receipt of the initial draft version of the Clinical Commissioning Group Commissioning Plan in January 2012, this report presents the latest version of the plan and provides an overview of improvements incorporating stakeholder feedback following a number of engagement sessions.

The Health and Wellbeing Board is asked to consider the latest version of the plan and provide input and feedback, as part of the plan development process.

## Background

Department of Health guidance on the development of Clinical Commissioning Groups requires them to develop a 5 year strategic plan which sets out their vision; the challenges they face; their strategy for tackling those challenges; and arrangements for delivering the changes.

## Sunderland Clinical Commissioning Group Commissioning Plan 2012- 2017

The Sunderland CCG Pathfinder Committee has worked since October 2011 to articulate their Commissioning plan and at the end of December 2011 produced a first draft / work in progress which was shared with the Health and Wellbeing Board in January 2012.

Following the development of the draft plan, a series of engagement events were undertaken involving the public, patients, carers, providers, GP practices, local authorities and the voluntary sector. The objective of these events was to raise awareness of, and gather feedback on, the Plan with a key focus on the Vision, Values and Plan on a page.

Feedback from these events informed further development of the plan which included the inclusion of additional values and additional initiatives included within the plan on a page. The plan has also been further developed including:

- Further strengthening of how the NHS Constitution requirements will be delivered;
- Identification of high level Commissioning Outcomes;
- Impact of our strategy on the market;

The plan remains very much a work in progress and continues to be refined as further guidance is received by the Department of Health.

**Recommendations:**

The Health and Wellbeing Board are recommended to:

1. Note the revised Clear and Credible plan.
2. Discuss and feedback and comments on the SCCG Clear and Credible Plan.

Author: Lynsey Caizley, Performance & QIPP Delivery Lead, and Debbie Burnicle, Head of Commissioning Development (Sunderland CCG)

Date: 9th May 2012

# Sunderland Clinical Commissioning Group

## Commissioning Plan

## 2012-2017

# Sunderland Commissioning Plan 2012 - 2017

## Contents

# Clinical Commissioning Group Chair Foreword

Since the inception of the NHS and the arrival of its very first patient in 1948 (Sylvia Diggory, aged 13), health and social care has developed and advanced at rapid pace.

During this time, there have been necessary challenges and changes but the NHS has remained central to its core principal that of being free at point of care and available to all.

With the advent on the new health and social care bill, clinicians have been placed at the centre of identifying and commissioning much of the services patients require to ensure good health (defined by the World Health Organisation as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity').

Sunderland has itself since 1948 undergone much change (closure of mines and shipyards always come to mind) and our health needs have also changed over these years and this will continue into our future. Within this document is a plan (not just Sunderland Clinical Commissioning Group`s plan but everyones plan - be you patient, clinician or provider) to address these challenges and meet our needs.

Within this document we have used all possible information to help plan what future challenges will lie ahead - to ensure we achieve **'better health for Sunderland**'. We have addressed national recommendations and used all our local knowledge and expertise to plan for the health challenges ahead.

The role and purpose of the Sunderland Clinical Commissioing Group is to ensure that we use all of our clinical expertise, knowledge of our patients, our relationships with NHS management, local authority, local hospital and other partners to ensure the services we commission for the people of Sunderland provide good health outcomes for you - when and where needed.

We are all aware that currently the country's finances are under pressure and like all public services, the NHS has a responsibility when spending your money to ensure we spend it appropriately and wisely. There will be challenges and difficult decisions but at all times we must remain focused on ensuring we remain central to those founding principals of the NHS – providing free care of excellent quality to all.

This plan maps out the challenges identified now looking forward over the next 5 years. If and when any new challenge or need occurs we will remain adaptable and will listen to your needs and work to ensure they can be addressed.

Dr Ian Patterson
Sunderland Clinical Commissioning Group Chair

## Section 1 - Sunderland Clinical Commmissioning Group (SCCG)

### Who are we?

54 Practices in Sunderland make up the single Clinical Commissioning Group, bringing together the 3 former Practice Based Consortia (PBC). Facilitated by the Local Medical Committee (LMC), the Practices agreed to form one CCG and elected 6 GPs to form the Executive Committee. The Committee then agreed a Chair and Vice Chair and lead roles for each GP member. Since the Group was formed in March 2011, a Practice Manager has been appointed to the Committee and work is underway to appoint a Nurse member.

The move from 3 PBC groups which existed for a number of years, to one CCG represents a major achievement in Sunderland and remains fully supported by all Practices. The Executive has devoted significant time to ensuring continual communication with its member Practices and not long after forming consulted on a locality sub structure which resulted in the development of 5 Localities aligned to Local Authority regeneration areas. Regular meetings with all Practices take place throughout the year, along with a monthly newsletter and monthly locality meetings. Locality practice managers and nurses have been appointed; all designed to ensure ongoing engagement of member Practices.

As a Leadership team, the Executive have dedicated substantial time and energy to developing themselves as a corporate body. Each week has involved at least one full session on executive business meetings, pathfinder committees or development sessions; the latter also include locality representatives. We have embraced learning opportunities, including membership of the Health and Wellbeing Board; engagement with the PCT Commissioning Directors and other CCGs through a fortnightly collaborative team meeting; participation in deep dive performance meetings; quality meetings; PCT Board meetings as well as lead pathfinder priority areas. Our elected Leadership team is also enhanced by the Director of Public Health and the LMC secretary, with support from the PCT including the aligned Director, Director of Commissioning Development and a Non Executive.

Whilst as individuals we are all on a development journey as Commissioners, and each have strengths and areas for development, as a leadership team we benefit from collective synergy and our commitment to acting corporately for the benefit of our members and the public we serve.

## 2.1 Vision

Our vision is to achieve **'better health for Sunderland**' and was agreed by the Executive Committee and all member practices.

Our vision is supported by three high level goals which describe the changes we aim to make in the medium to longer term, which are to:

- **Improve the health and well being of all local people**; to live longer, with a better quality of life and a reduction in health inequalities across the locality;
- **Integrate services better across health and social care**;
- Underpinned by **more effective clinical decision making.**

We will do this by working closely with patients, the public, carers, providers and partners.

## 2.2 What will health, health services and social care look like in Sunderland in five years time ?

The following section describes how we want health, health services and social care to look and feel once the changes set out in this Plan have been implemented.

### 2.2.1 Improve the health and well being of local people

Our aim is for every individual to live longer, with a better quality of life and a reduction in health inequalities across the locality

**The future health of our local people will be characterised by:**

**Addressing inequalities**

- Targeting of resources to address the needs of disadvantaged and vulnerable people in the most deprived communities of Sunderland to reduce health inequalities;
- Increased resilence of individuals and communities to address inequalities in coping strategies;

**Prevention**

- A reduction in lifestyle behaviours which pose major risks to health (including smoking, alcohol abuse and obesity);
- Increased identification of people with risk factors or in the early stages of disease;

**Identification integration and navigation**

- Every contact with a health professional to be a health improvement contact;
- Comprehensive care and treatment for people with identified risks or established illness;

**Engagement**

- Improvements in the wider determinants of health through our participation in the Sunderland Health and Well Being Board and collaborative working with partners;
- Improved engagement with communities of greatest need through locality working;

**Choice and control**

- Individuals having a greater awareness and ownership of their own health and well being and that of their families;
- Individuals feeling empowered and supported to adopt healthier choices and lifestyles.

## 2.2.2 Integrate services better across health and social care

**Our future services will demonstrate:**

**Integration to improve clinical effectiveness**

- Seamless integration across primary, community, secondary and social care resulting in improved health outcomes for patients;
- Optimum treatment pathways with standardised care consistently provided by all GP practices thereby reducing clinical variation;
- A multi disciplinary approach where appropriate (i.e. Long Term Conditions) to enable a holistic approach to care planning;
- Increased synergies resulting from streamlining and integrating pathways;
- Patients receiving the right care in the right place, first time thereby reducing waste and demonstrating value for money in everything that we do;

**Quality**

- Safe, effective care which is consistently delivered and routinely evidenced through commissioning mechanisms;
- A patient-centred approach based on the needs and wishes of patients to ensure excellent patient experience;

**Access and choice to improve patient experience**

- More care available closer to patients' homes; with routine treatment increasingly provided in primary and community settings (e.g. more GPs with a Special Interest) and complex treatments commissioned from specialist centres;
- Greater choice of services for patients, with convenient and timely access at all stages, so that patients can make informed decisions about where and from whom they receive their care.

### 2.2.3 More effective clinical decision making

**By 2017 effective clinical decision making will be evidenced by:**

**Communication**

- Increased collaborative working across organisations (primary, community, secondary care, social care) to enhance knowledge and the sharing of expertise, including timely access to opinions;
- Strong and mature clinical relationships between organisations so that clinical input adds value to the pathway resulting in improved outcomes and patient experience;

**Evidence based care that maximises clinical effectiveness**

- All care based on best clinical evidence available, including compliance with standards;
- Application of best practice and outcome information where available complemented by local evaluation and research reflecting a commitment to continuous learning and development;
- Promoting use of research in an evidence- based approach to decision making;
- Using both nationally agreed and local guidance

**Standardisation of provision**

- Consistent standard application of optimum pathways in primary care resulting in a reduction in clinical variation and reduced waste.

**In summary by 2017, our patients will:**

- Feel empowered and supported to look after themselves and take control over their treatment regime, particularly those patients with long term conditions;
- Have input into the processes for making decisions about their healthcare;
- Be actively engaged in shaping the planning and delivery of services to ensure their needs are met and views taken into account;
- Have confidence in the services we commission.

## 2.3 How will we know when we have got there? Outcomes and Aspirations

We have chosen an initial set of key high level outcomes to measure achievement of our vision and delivery against each one of our strategic objectives.

The outcomes have been chosen form the draft Commissioning Outcomes Framework which will be used by the NHS Commissioning Board to identify the contribution of CCGs to achieving the priorities for health. The following table highlights the indicators chosen for each strategic objective and the domain that each maps to in the Outcome Framework.

| Strategic Objective | Commissioning Outcome Framework indicator | Domain |
|---|---|---|
| Play an active role in the delivery of the **Health and Wellbeing Strategy** | • Life expectancy aged 75 (i males, ii females) | • Preventing people from dying prematurely |
| Every practice to optimise **screening** and **early identification** opportunities | • Potential years of life lost from causes considered amenable to healthcare | • Preventing people from dying prematurely |
| Integrated tiered approach to **Mental Health** across the whole healthcare system | • People with depression referred from psychological therapies receiving it | • Enhancing quality of life for people with long term conditions |
| Integrated **urgent care** response, easily accessible at the appropriate level | • Emergency admissions for acute conditions that should not usually require hospital admission | • Helping people recover from episodes of ill health |
| Improve quality of care for **long term conditions** across the whole system | • Unplanned hospitalisation for chronic ambulatory care sensitive conditions | • Enhancing quality of life for people with long term conditions |
| Provide more **planned care** closer to home | • Under 75 mortality rate from cancer | • Preventing people from dying prematurely |
| Every practice to systematically improve the quality of **prescribing** adhering to evidence based guidelines | • Prescribing cost per Astro-Pu | • Local indicator |
| Every practice operating to agreed **standards** and pathways – working collaboratively with partners | • Practices implementing agreed pathways across Sunderland CCG | • Local indicator |

The next stage is to quantify the level of improvement (our aspiration) we intend to achieve in relation to each indicator. We await publication of the final Commissioning Outcomes Framework, including detailed definitions and the national data set. All our initiatives are based on best evidence of what works. However evidence is not yet available to accurately quantify the impact of each initiative on our chosen outcome. Instead we will use the national benchmark data set to identify our aspiration based on best practice and recognition of our starting point and past trends.

## 2.4 Core Values

We have identified a set of core values which will shape and underpin all of the work we undertake to deliver our vision, including all aspects of decision making and governance, as illustrated on the following chart:

## 2.5 Commissioning for Quality

Commissioning for quality is an integral part of our vision and encompasses the three key components of quality: patient safety, clinical effectiveness and patient experience. We will promote the principles and values of the NHS Constitution and have due regard for people's rights and NHS pledges in our quality improvement work. We will drive continuous improvements in quality through provider management and pathway reform and this is a key development area for the Executive Committee in the short term. We will work within the NHS quality improvement framework using relevant standards and best use of available levers to maximise outcomes for local people.

# Section 3 – The Big Challenges for Sunderland

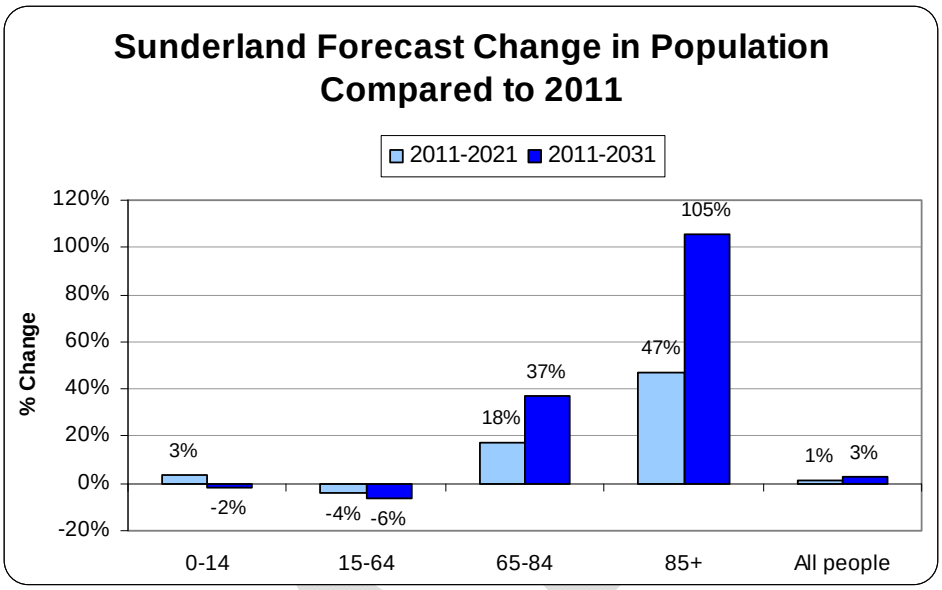
We have used a range of information and analyses to identify the big challenges facing the NHS in Sunderland. The challenges which we need to address through our commissioning and joint work with our practices and partners can be summarised as:

- **Excess deaths, particularly from heart disease, cancer and respiratory;**
- **Health which is generally worse than the rest of England;**
- **A growing population of elderly people with increased care needs and increasing prevalence of disease;**
- **An over-reliance on hospital care;**
- **Services which are fragmented and lack integration.**

This section gives a general overview of the Sunderland population we serve, describing the age structure, general health and income of our people. It then summarises the analyses which we have used to identify the major challenges facing the NHS in Sunderland.

## 3.1 Overview of the Sunderland population

There are approximately 281,500 people in Sunderland, with an increase of 8,100 (3%) forecast over the next 20 years. The age structure of our population is forecast to change significantly, as follows:




*Office for National Statistics, 2008-based Subnational Population Projections, available at [www.statistics.gov.uk](http://www.statistics.gov.uk)*

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five, ten and twenty years. Even if the general levels of health in these age groups continues to improve, the shape and structure of health services will need to change to meet the needs of this growing population, particularly as older people use services more often, have more complex needs and stay longer in hospital. Our modelling shows that in ten years, if we do nothing differently, we will need over 150 extra beds which our hospitals don't have, at a cost of over £18m which we cannot afford.

### 3.1.1 Overview of health in Sunderland

Sunderland has overall levels of deprivation significantly higher than the England average (we are in the 10% of local authority areas with the highest deprivation). Levels of health and underlying risk factors in the area are amongst some of the worst in the country.

The 2011 Community Health Profiles, prepared by the Association of Public Health Observatories compare health in Sunderland to England averages, highlighting in red those measures which are significantly worse and in green those which are significantly better. It is clear that on most health measures, Sunderland is significantly worse than the rest of England.

## Health summary for Sunderland

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The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

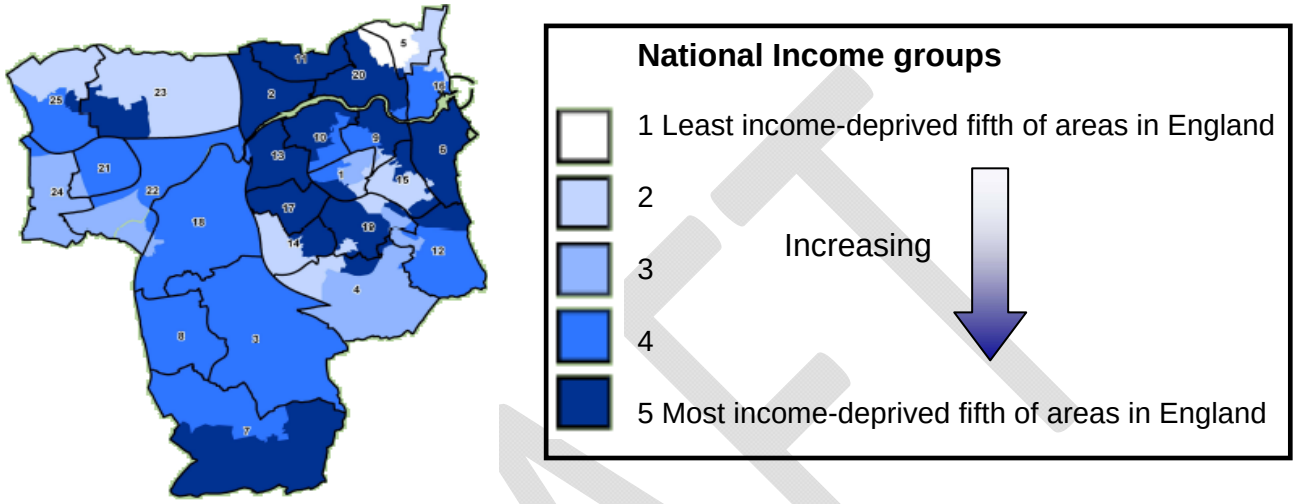

+ In the South East Region this represents the Strategic Health Authority average

| Domain | | Indicator | Local No. Per Year | Local Value | Eng Avg | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|---|---|
| Our communities | 1 | Deprivation | 119430 | 42.5 | 19.9 | 69.2 | | 0.0 |
| | 2 | Proportion of children in poverty | 14760 | 25.0 | 20.9 | 57.0 | | 5.7 |
| | 3 | Statutory homelessness | 166 | 1.37 | 1.86 | 8.28 | | 0.08 |
| | 4 | GCSE achieved (5A*-C inc. Eng & Maths) | 1812 | 52.6 | 55.3 | 38.0 | | 78.6 |
| | 5 | Violent crime | 4027 | 14.3 | 15.8 | 35.9 | | 4.6 |
| | 6 | Long term unemployment | 1408 | 7.6 | 6.2 | 19.6 | | 1.0 |
| Children's and young people's health | 7 | Smoking in pregnancy | 665 | 22.3 | 14.0 | 31.4 | | 4.5 |
| | 8 | Breast feeding initiation | 1476 | 51.1 | 73.6 | 39.9 | | 95.2 |
| | 9 | Physically active children | 20141 | 57.5 | 55.1 | 26.7 | | 80.3 |
| | 10 | Obese children (Year 6) | 556 | 21.1 | 18.7 | 28.6 | | 10.7 |
| | 11 | Children's tooth decay (at age 12) | n/a | 1.1 | 0.7 | 1.6 | | 0.2 |
| | 12 | Teenage pregnancy (under 18) | 302 | 54.9 | 40.2 | 69.4 | | 14.6 |
| Adults' health and lifestyle | 13 | Adults smoking | n/a | 29.8 | 21.2 | 34.7 | | 11.1 |
| | 14 | Increasing and higher risk drinking | n/a | 26.6 | 23.6 | 39.4 | | 11.5 |
| | 15 | Healthy eating adults | n/a | 19.4 | 28.7 | 19.3 | | 47.8 |
| | 16 | Physically active adults | n/a | 12.3 | 11.5 | 5.8 | | 19.5 |
| | 17 | Obese adults | n/a | 28.6 | 24.2 | 30.7 | | 13.9 |
| Disease and poor health | 18 | Incidence of malignant melanoma | 27 | 9.4 | 13.1 | 27.2 | | 3.1 |
| | 19 | Hospital stays for self-harm | 1059 | 382.2 | 198.3 | 497.5 | | 48.0 |
| | 20 | Hospital stays for alcohol related harm | 8310 | 2581 | 1743 | 3114 | | 849 |
| | 21 | Drug misuse | 1444 | 7.7 | 9.4 | 23.8 | | 1.8 |
| | 22 | People diagnosed with diabetes | 12788 | 5.63 | 5.40 | 7.87 | | 3.28 |
| | 23 | New cases of tuberculosis | 20 | 7 | 15 | 120 | | 0 |
| | 24 | Hip fracture in 65s and over | 304 | 517.1 | 457.6 | 631.3 | | 310.9 |
| Life expectancy and causes of death | 25 | Excess winter deaths | 142 | 15.4 | 18.1 | 32.1 | | 5.4 |
| | 26 | Life expectancy - male | n/a | 75.9 | 78.3 | 73.7 | | 84.4 |
| | 27 | Life expectancy - female | n/a | 80.7 | 82.3 | 79.1 | | 89.0 |
| | 28 | Infant deaths | 11 | 3.52 | 4.71 | 10.63 | | 0.68 |
| | 29 | Smoking related deaths | 636 | 308.1 | 216.0 | 361.5 | | 131.9 |
| | 30 | Early deaths: heart disease & stroke | 260 | 81.5 | 70.5 | 122.1 | | 37.9 |
| | 31 | Early deaths: cancer | 459 | 143.9 | 112.1 | 159.1 | | 76.1 |
| | 32 | Road injuries and deaths | 104 | 37.1 | 48.1 | 155.2 | | 13.7 |

*Source: Association of Public Health Observatories*

### 3.1.2. Income inequalities

Income levels are directly related to both life expectancy and health inequalities. The map below shows the variation in income levels across Sunderland compared to the whole of England. There are significant variations in income levels between wards within the area, therefore specific strategies are required to minimise the health gap between the affluent and less affluent members of our population.




## 3.2 Challenges identified in the Joint Strategic Needs Assessment

Joint Strategic Needs Assessment (JSNA) is a continuous process by which the Sunderland Director of Public Health works with partners including the third sector and patient/public groups to identify the health and well-being needs of local people. It sets out key priorities for commissioners and provides a health baseline for the development of this plan.

The Sunderland JSNA is undergoing a major refresh to broaden the coverage of wider determinants of health; takes account of Marmot priorities; updates the analysis of health and well being information; gives greater insight into expressed needs of local people; identifies where effective interventions to address needs are available but not taking place; and includes equality impact assessments as they are developed.

The JSNA refresh has used a structured process with clear criteria, which continues to involve partners and the public. Further prioritisation will be carried out before the JSNA is considered by the Health and Wellbeing Board, because we are in a time of economic uncertainty and major system change which make it crucial that JSNA recommendations are clear regarding priorities based on a one Sunderland strategy; what needs can be met

and how we can mitigate against unintended consequences from changes in funding and organisational arrangements over the next 3-5 years.

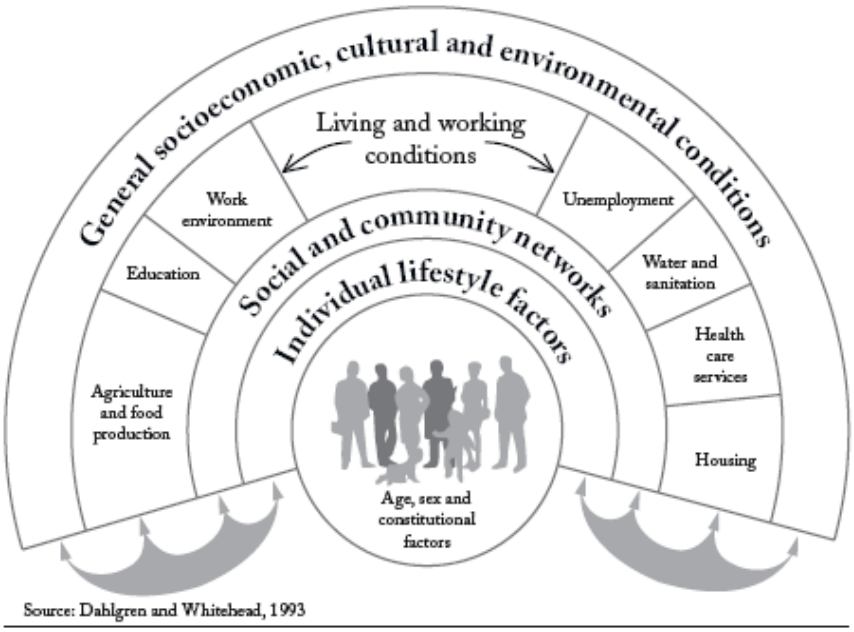
### 3.2.1 Summary of JSNA messages

The refresh of the JSNA recommends that those commissioning services in Sunderland continue to take the following approach:

- Increasing life expectancy and reducing health inequalities;
- A tiered approach to prevention and risk management;
- Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;
- Identifying those who would benefit from services and improving navigation through those services;
- Integration of services, whether NHS, social care or other services which affect health (eg spatial planning, housing, transport, enhancing wellness and wellbeing thorugh libraries, wellness services etc);
- Reducing health inequalities by focussing on the wider determinants of health, including deprivation, employment, education, housing, environment and by identifying neighbourhoods to target;
- Commissioners and providers engaging with individuals, families, neighbourhoods, and communities in order to deliver on all the above.

We have traditionally focused on treating illness but to improve health, we need to move, as represented by the following diagram, out into the concentric circles working with a broader range of partners.

**The main determinants of Health**




In considering this model the top ten priorities to improve health in Sunderland are to:

1. Tackle worklessness;
1. Improve educational attainment;
2. Reduce overall smoking prevalence (all ages) and numbers of young people starting to smoke;
3. Reduce levels of obesity;
4. Reduce overall alcohol consumption and increase treatment services for those with problem drinking;
5. Commission excellent services for cardiovascular disease;
6. Commission excellent services for cancer;
7. Commission excellent services for diabetes;
8. Commission excellent services for mental health problems;
9. Raise the expectation of being healthy for all individuals, families and communities and promote health seeking behaviours.

As a Clinical Commissioning Group, we are directly responsible for commissioning the hospital, community and mental health services associated with these priorities, but we also have a significant role to play in all of these areas, both through our participation in the

Health and Wellbeing Board, but also through the mobilisation of all our member GP practices to play a full part in this agenda.

### 3.2.3 Life expectancy challenge

One of the starkest inequalities highlighted by the JSNA is life expectancy. The local life expectancy gap against England is:

| | England Average Life Expectancy | Sunderland Life Expectancy | Gap (%) * |
|---|---|---|---|
| Males | 77.9 | 75.4 | -3.2% |
| Females | 82.0 | 80.4 | -2.0% |

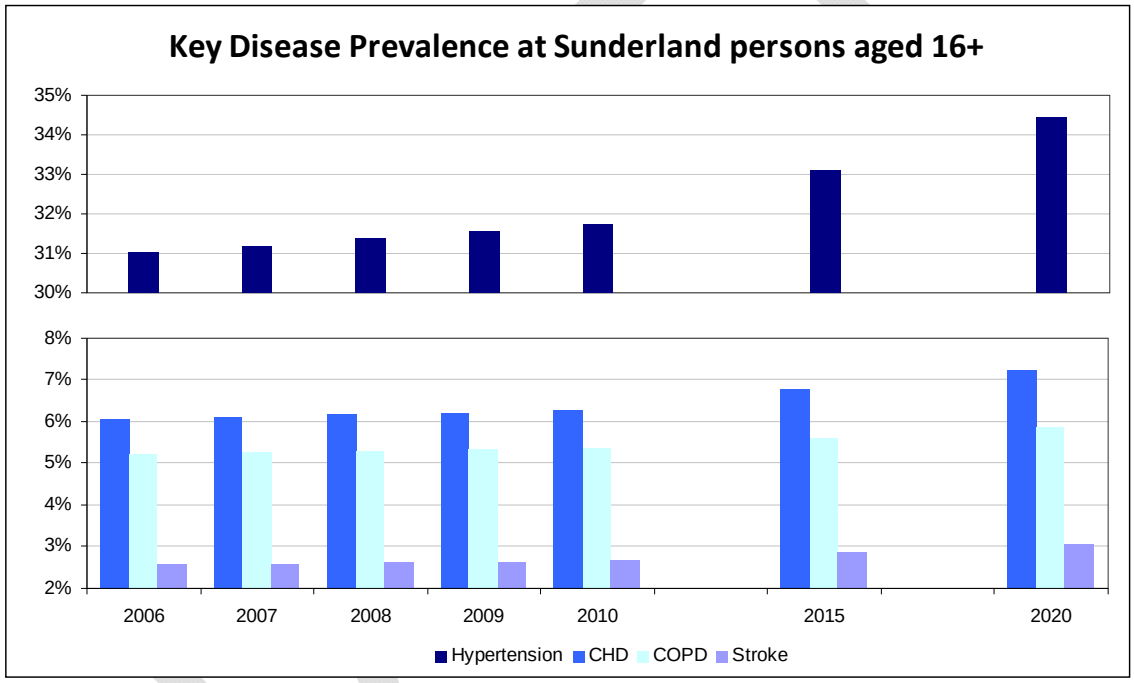
**Life expectancy gap expressed as a percentage of the England life expectancy.*

Over 60% of the gap is caused by CVD, cancer and respiratory diseases and to address this the Health Inequalities National Support Team has identified five supporting strategies (tobacco control, community engagement, measuring impact, maintaining momentum and working with the Local Authority) and 8 "High Impact Interventions" which our commissioning and work with partners and our GPs will contribute to:

- Use of Health Checks to identify asymptomatic hypertensives age 40–74 & start them on treatment;
- Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;
- Systematic cardiac rehabilitation;
- Systematic COPD treatment with appropriate local targets;
- Develop & extend diabetes best practice with appropriate local targets;
- Best practice access to TIA clinics for stroke across South of Tyne and Wear;
- Cancer early awareness and detection;
- Identification and management of Atrial Fibrillation.

## 3.2.4 Expected disease prevalence

Projections of expected disease prevalence have been used to understand what our key disease areas of CHD, COPD, Stroke and hypertension might look like in five, ten and twenty years, if we do not implement effective change. In all four disease areas, Sunderland's prevalence is higher than the England average, and is forecast to increase if no effective action is taken. These disease areas are the major causes of premature death and emergency hospital admissions in Sunderland, so the health and service implications of an ageing population will be further exacerbated by this increasing burden of chronic disease.



## 3.3 Challenges identified by patients, public, clinicians and partners

| | |
|---|---|
| **Patients and the Public** | Sunderland residents generally feel that the local NHS provides them with a good service and helps to improve the health and wellbeing of both themselves and their family.<br>However,<br>▪ Only half feel that the NHS works well together with social services to provide joined up care;<br>▪ Less than half feel that the NHS enables them to influence decisions which affect local services;<br>▪ Only half of residents believe the NHS will continue to improve services over the next few years.<br>*(IPSOS Mori survey 2009)* |
| **Clinicians (including practices)** | Clinicians (including practices) expressed the following views:<br>▪ Concern regarding the fragmentation and lack of integration of current services;<br>▪ Greater focus on clinical effectiveness and the need to address variation in practice;<br>▪ Need for clinicians across the system to work together;<br>▪ Wish to influence the commissioning of a range of services including community nursing and mental health;<br>▪ Play a greater role in the prevention agenda. |
| **Partners and Stakeholder** | Partners and Stakeholders expressed the following views:<br>▪ Need for shared leadership and joint working across health and social care system and for greater probity;<br>▪ Need to ensure CCG vision is aligned with Health and Wellbeing Strategy;<br>▪ Reform of the urgent care system is a key priority given the impact on whole system working. |

### 3.4.1. Current performance challenges

The PCT performance against national priorities is tightly managaged but there are a small number of targets where the PCT will not achieve the year-end targets and standards. These are shown in the table below, split between those for which we will have a direct commissioning responsibility in the future (and some are in our current Pathfinder remit) and those which we will help our partners to deliver through their commissioning:

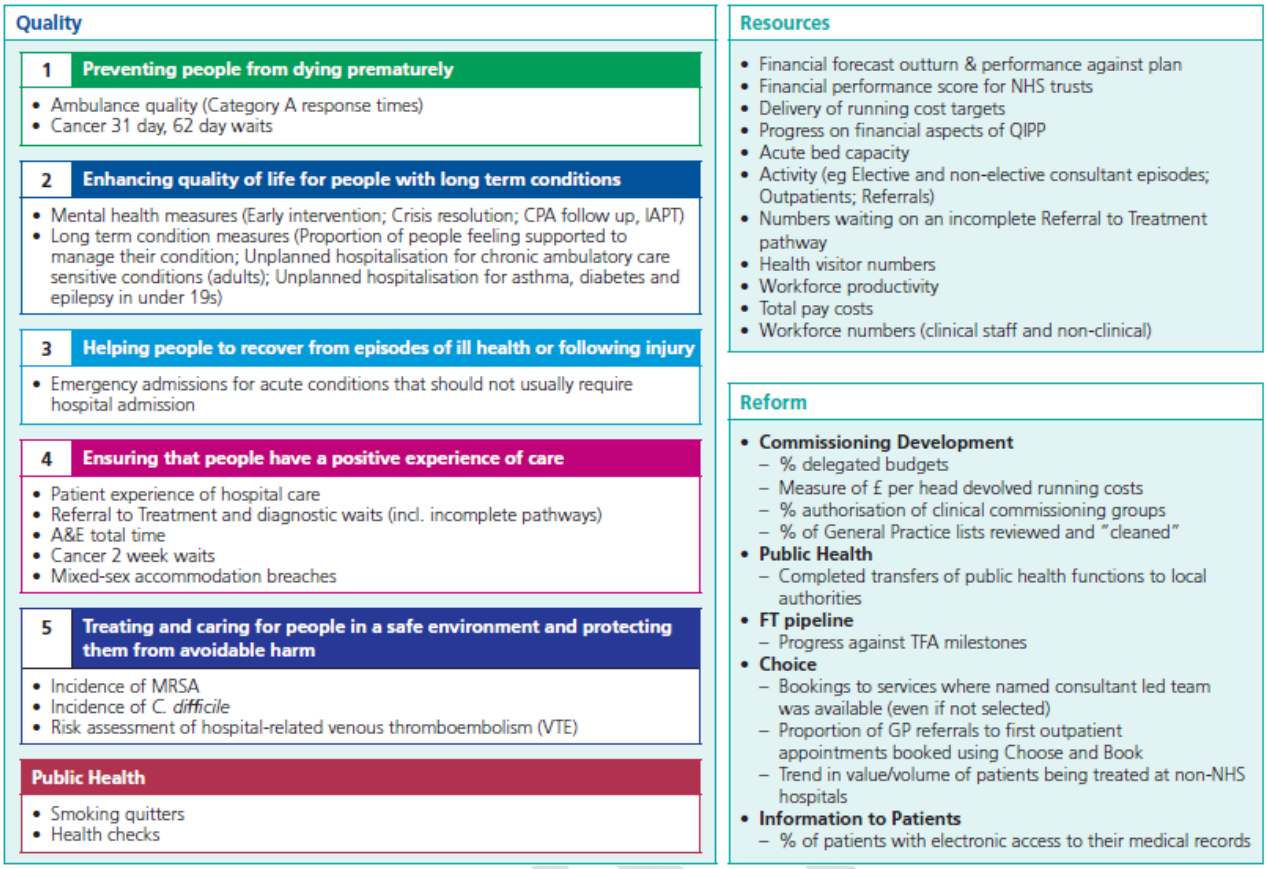
| Indicators at risk of non delivery 2011/12 Clinical Commissioning Group | Indicators at risk of non delivery 2011/12 Public Health |
|---|---|
| Clostridium difficile infections | All age, all cause mortality |
| 6 week diagnostic waits | Year 6 child obesity |
| Outpatient and daycase hospital activity | Chlamydia screening |
| Use of Choose and Book | Smoking in pregnancy |
| Mixed sex accommodation | Teenage pregnancy |
| | Breastfeeding |

### 3.4.2 Additional challenges in the NHS Operating Framework 2012/13

The NHS Operating Framework 2012/13 requires us to continue to meet existing standards and targets, and also details the following areas in which we must make specific improvements in 2012/13.

- Delivery of the QIPP Challenge;
- Dementia and care of older people;
- Carers;
- Military and Veterans' health;
- Health Visitors and Family Nurse Partnerships;
- An outcomes approach;
- Public Health;
- Emergency Preparedness.

The Framework emphasises that the experience of patients, service users and their carers should drive everything the NHS has to do. It sets out the key performance measures which will be used to assessment the performance of CCG's in delivering the national targets and standards.




## 3.5 Challenges posed by existing provider landscape

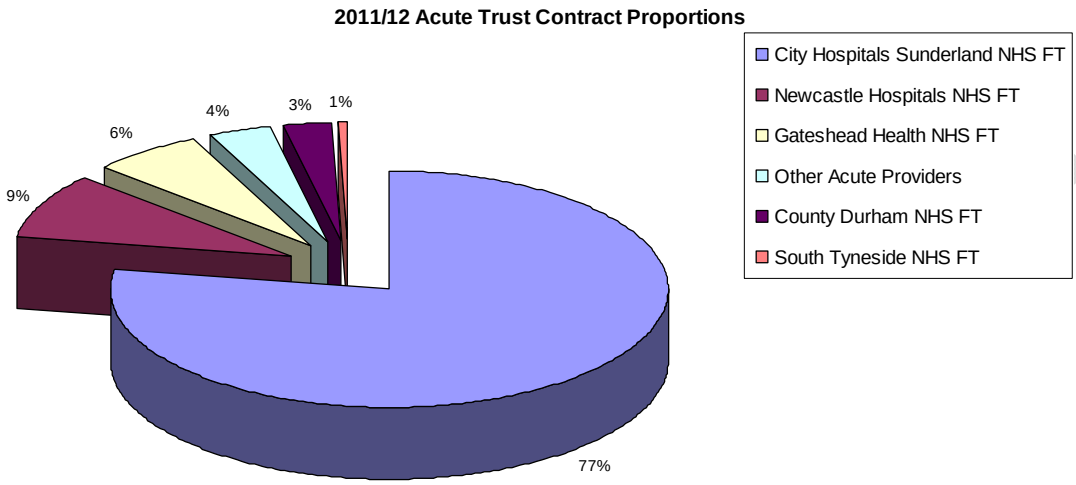
As well as the health and service challenges described in this chapter, the services which we are able to commission are constrained in the short term by the current shape and availability of local services and the major challenges involved in any significant change to this configuration and pattern of service use.

This does not mean that in the longer term we will not be looking for major changes in the shape of local service supply, but it does place limitations on the speed with which change can be achieved and this has been taken into account in the development of detailed initiatives for 2012/13.

### 3.5.1. Current pattern of acute hospital use

The people of Sunderland receive most of their acute hospital care from City Hospitals Sunderland where the annual contract is approximately £169 million. City Hospitals provides Accident and Emergency; surgical and medical specialties; therapy services; maternity and paediatric care; an increasing range of more specialised services; and a substantial range of community based services, particularly family care and therapy services.

Sunderland people also access services at Newcastle Hospitals and Gateshead Health, with annual contract values of £19 million and £14 million respectively.



### 3.5.2. Current pattern of Community Services

There are a range of community services including Community Nursing, Allied Health Professionals and Therapies which are currently commissioned from a number of different providers, including the community services arm of South Tyneside Trust, the voluntary sector and the independent sector (including care home providers). A number of these services are jointly commissioned with Local Authorities.

### 3.5.3 Current pattern of Mental Health Services

The majority of mental health and learning disability services are commissioned from Northumberland, Tyne and Wear Mental Health Foundation Trust which provides a wide range of mental health, learning disability and neuro rehabilitation service. The services are utilized by a population of approximately 1.4 million people, based in over 160 sites covering 2,200 square miles in the North East. Other services include urgent care mental health, planned care services, Specialist care services and Forensic services.

## 3.6 Challenges likely in the future

As well as the challenges we have identified from the analyses and insights into current health status and service provision, we have used a set of predictive models developed by NHS South of Tyne and wear to identify further challenges we will face in the future. The modelling also supports our planning as follows:

1. Contracted hospital and community activity levels reflect our forecasts of demand changes and impacts of planned disinvestment initiatives;
2. The investment and disinvestment plans which underpin our balanced financial position fully reflect the financial consequences of these planned changes in activity levels;
3. We have a shared understanding with our local providers of the likely workforce implications of both our planned changes in activity levels and the impact of tariff and tariff equivalent efficiencies, with a high level view of how these implications will be managed.

### 3.6.1 Hospital Activity Model

The PCT use an established predictive model to predict likely changes in hospital and community activity levels. The annual update of the model continues to confirm that if we do not take effective action**,** the increasing elderly population with their high use of health services, coupled with the inevitable developments in clinical practice, technology and patient expectations would result, in less than ten years, in hospital capacity shortages equivalent to a small general hospital and a financial cost which could not be met.

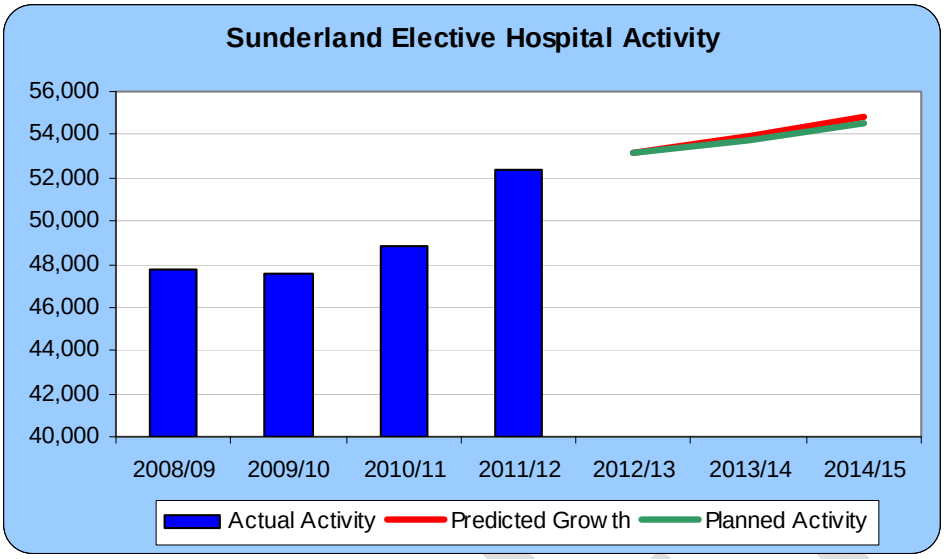
In the shorter term, if we do not change the way in which our services are provided, we would expect to see the following growth in hospital activity levels over the next three years.

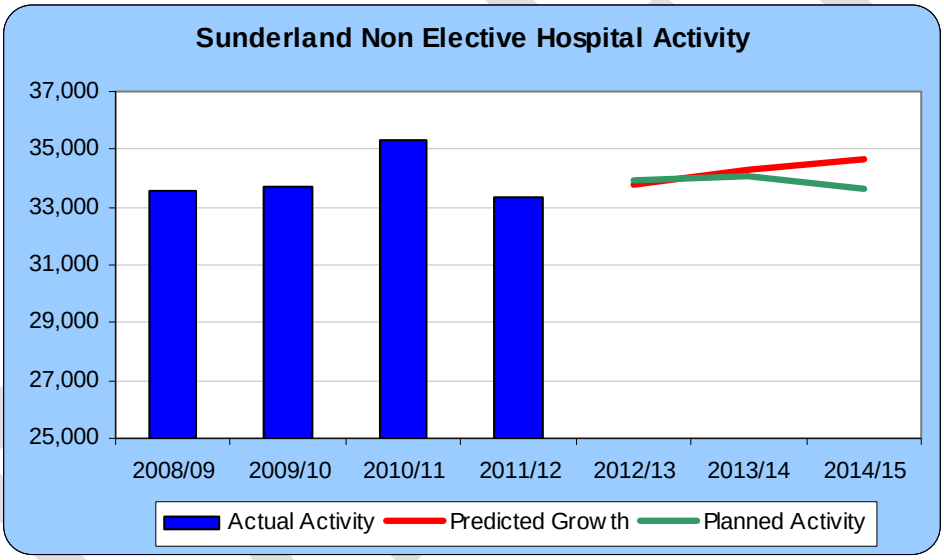
| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Elective Hospital Spells | 1.49% | 1.65% | 1.48% |
| Non Elective Hospital Spells | 1.32% | 1.43% | 1.14% |
| First outpatient attendances | 1.53% | 1.82% | 1.69% |

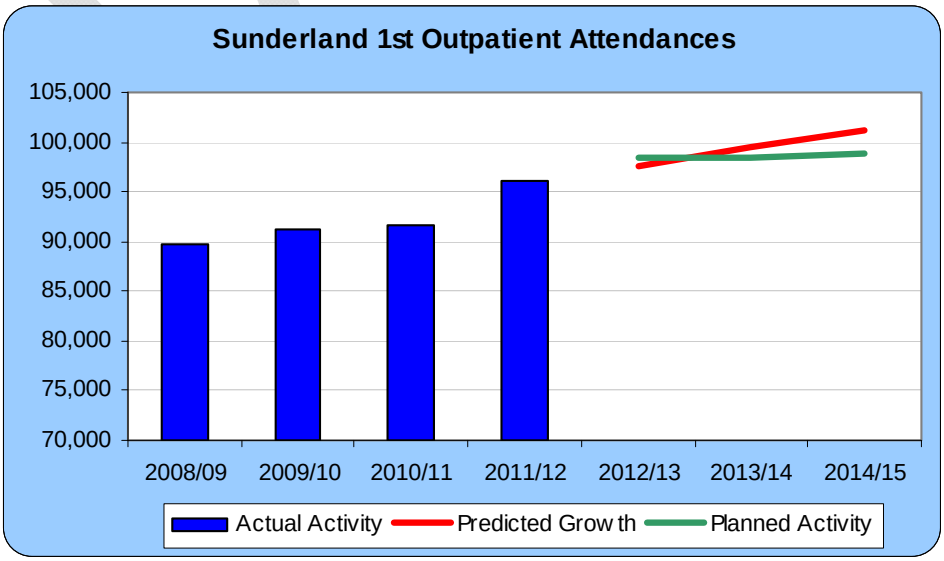
Similar increases in accident and emergency attendances are also expected, if we do not change how these services are provided.

However, as detailed in the strategy part (Section 4) of this plan, we have a range of initiatives in place to reduce hospital activity (elective, non-elective and outpatient) through redesign of services, better care of people with long term conditions and more streamlining of urgent care services.

The following charts illustrate the expected impact of our initaitives. The red lines represent the predicted growth in activity over the next three years, while the green lines show how the plans for activity reductions mitigate this growth.



Hospital activity reductions are planned throughout 2012-15 with particular emphasis on elective and emergency admissions. Achieving the planned reductions in hospital activity will require additional primary and community care contacts; a separate modelling exercise estimates an additional 13,000 primary and / or community contacts.

## 3.7 Financial Plan 2012/13

Nationally CCG's do not currently have financial allocations for 2013/14 and the likelihood is it may be well into the 2012/13 financial year before any further information is received. We are aware that the "mapping of expenditure" exercise undertaken by PCT's during 2011 is to be repeated in the summer of 2012 and this will be used to influence CCG allocations for future years. Given this "gap" in financial planning, the CCG plan has been initially based upon the PCT plans, although all the information has been reviewed and amended where appropriate to reflect the CCG led process. Given the lack of budgets for future years, the finance plan is driven by assumptions agreed by PCT Cluster Directors of Finance and used within the PCT's ISOP. Consequently the remainder of this section is based upon the Sunderland ISOP which we have been actively involved in developing.

The collective NHS South of Tyne and Wear Strategic Plan for 2011/12-2014/15 forecast the additional income expected over five years; the impact of unavoidable increases in demand such as growth in the elderly population; and the investments needed to achieve the vision of better health, excellent patient experience and the wise use of money.

The original 2011/12 plan identified a "Cluster" wide **financial shortfall from 2011/12 – 2014/15 of £193.8 million** and described the improvements planned in Quality, Innovation, Productivity and Prevention (QIPP) which would be implemented over those four years to close that gap. The Sunderland element of this was £85.7m.

PCT savings schemes commenced in 2010/11 and have continued throughout 2011/12 with good progress being made; however for the period 2012/13 to 2014/15 £27.4m (Sunderland £11.9m) of Resource Releasing Initiatives (RRI's) supplemented by technical tariff changes of £111.3m (Sunderland £48.6m) is required to help sustain financial balance – a total cluster savings target of **£138.7m (Sunderland £60.5m)**.

In December 2011, the NHS Operating Framework for 2012/13, PCT allocations for 2012/13 and the 2012/13 rules on tariff were all published. These documents changed:

- The planning assumptions used to determine the size of the financial gap;
- The split of the savings between those required from providers through tariff and those needed to be generated by commissioners through reform.

These documents build upon information published within the national Government Comprehensive Spending Review (CSR) published in October 2010. The CSR gave an insight into the additional funding the NHS is likely to receive in the period through to 2014/15.

Financial plans have been revised to give a refreshed outlook. The following table is a summary of the "headline" numbers.

**Sunderland Teaching Primary Care Trust**
**Summary Source & Application of Funds Statement**

| **SOURCES** | **"12/13 £,000** | **"13/14 £,000** | **"14/15 £,000** |
|---|---|---|---|
| Increased Allocation | 15,985 | 11,613 | 11,857 |
| Tariff Efficiency | 14,785 | 13,874 | 13,942 |
| Presc Efficiency | 2,024 | 2,004 | 1,998 |
| R.R.I.'S | 5,625 | 3,078 | 3,214 |
| **Total Sources** | **38,419** | **30,569** | **31,011** |
| **APPLICATION** | | | |
| Tariff Uplift | 9,240 | 9,910 | 9,958 |
| Presc Uplift | 2,530 | 2,505 | 2,497 |
| CQUIN Payments | 3,925 | 1,962 | 1,962 |
| Investments | 17,453 | 9,499 | 9,391 |
| *Contingency* | *5,271* | *6,693* | *7,203* |
| **Total Application** | **38,419** | **30,569** | **31,011** |

Based upon the PCT financial plans we will be able to:-

- Meet national requirements described in the Operating Framework for 2012/13, the developing outcomes frameworks and other national policies;
- Complete implementation of existing commitments;
- Meet the costs of implementing the QIPP programme initiatives;
- Provide contingency reserves for future uncertainty given the lack of future years planning guidance and the abolition of PCT's from the 1st April 2013.

The detailed actions and costs associated with each of these are described in the programme sheets in *Section 3* of this plan and the costs are summarised in *Appendix 2* which details the **£55.5m recurrent investment plans** for Sunderland.

Planning assumptions used within the PCT plan are detailed in the table below:

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| **PCT uplift** | **2.80%** | **2.10%** | **2.10%** |
| **Tariff** | | | |
| **Uplift** | 2.50% | 2.50% | 2.50% |
| **CQUIN Increase over prev yr** | 1.00% | 0.50% | 0.50% |
| **Efficiency** | -4.00% | -3.50% | -3.50% |
| **Net Adjustment** | **-0.50%** | **-0.50%** | **-0.50%** |
| CQUIN cumulative | 2.50% | 3.00% | 3.50% |
| PCT prescribing Gateshead | 1.00% | 1.00% | 1.00% |
| PCT prescribing Sunderland | 1.00% | 1.00% | 1.00% |
| PCT prescribing South Tyneside | 0.00% | 0.00% | 1.00% |
| GMS | 0 | 0 | 0 |
| Dentistry | 0 | 0 | 0 |

The refreshed three year target of £11.9m from resource releasing initiatives for Sunderland will be delivered through a revised programme of initiatives which are listed in *Appendix 3.* The schedule includes a number of technical savings (some of which have been previously agreed with providers) together with initiatives that continue to support the reform agenda described in the PCT original Strategic Plan including urgent care, long term conditions and children. Each is supported by a detailed integrated plan which describes actions, milestones, risks and key performance indicators and these are summarised in the relevant sheets in Section 3.

Within the PCT plans the allocation of 2% of the overall resources available to each PCT to be spent on Non Recurrent Initiatives are clearly identified. We have generated a number of options for the use of this resource and final approval for submission to the SHA will be made jointly by ourselves and the PCT Board.

We have assumed the return of an element of our “brokered” funds with the SHA to assist in the financing of approved business cases particularly within Sunderland (£5.1m). We are aware that this is subject to the SHA agreeing a satisfactory control total for use of brokerage with the Department of Health.

The commissioning plans for both the CCG and PCT are clearly aligned demonstrating cohesion of strategic objectives and goals. It also demonstrates delivery of our strategic objectives whilst at the same time maintaining recurrent financial balance throughout the life of the plan given the limitations as outlined at the outset of this section regarding the lack of formal CCG allocations.

## 4.1 Our Success so far

Our pathfinder application, which was submitted to the North East Strategic Health Authority on 17th June 2011 and approved on 28th June 2011, set out the following priority areas:

- Urgent Care
- COPD
- Prescribing
- Clinical Effectiveness.

Improvement work in these areas is firmly rooted in the principles of safe, evidence based care that aims to provide positive patient experience but also recognising the importance of using money wisely. The key below has been used to demonstrate how quality and value for money run through our improvement work achieved to date:

**Key:**

| | | | |
|---|---|---|---|
| Clinical Effectiveness | | Patient Experience | |
| Safety | | Productivity | |

| **Urgent Care** | |
|---|---|
| Established strong links between the reform of the Urgent Care system and COPD pathway reform in order to reduce emergency admissions, readmissions and hospital length of stay through the development of a greater preventative integrated approach. | |
| Agreed action plan to address fragmented gaps in service between Primary and Community Teams to ensure seamless care; developing a single point of access to two currently separate teams to order to clarify how to access which team in different circumstances. | |
| Introduced a standard Emergency Assessment Proforma for GPs to use before sending a patient to secondary care for assessment or admission which incorporates an Early Warning Score (EWS) increasing GP awareness of any alternative services which could be used to manage the patient in the community thereby ensuring the patient receives the right care in the right place at the right time. | |
| Introduced proforma pads for GPs to use on home visits for patients in need of assessment or admission to hospital and have electronic versions available within practices which pre-populate key information. | |
| Implemented a community based cellulitis pathway to allow suitable patients who require intravenous (IV) antibiotics to be treated in the community instead of triggering a hospital admission together with a | |

| | |
|---|---|
| protocol using a specific IV antibiotic drug. | |
| Prioritised funding to implement a community based Anticoagulation Initiation and Monitoring Service in 2012/13; rolled out the software tool (GRASP-AF) which identifies patients with Atrial Fibrillation who are suitable for anticoagulation to all practices with appropriate training to ensure patients are identified and treatment commenced for those at risk of stroke. | |
| Appointed a clinical lead to develop a community based pathway for DVT. | |
| Reviewed options for the Houghton Primary Care Centre in terms of most appropriate Urgent Care facilities to best suit the local population as part of developing our short, medium and long term strategy for urgent care in Sunderland. | |

| **COPD** | |
|---|---|
| Established Sunderland COPD Improvement Group to improve the quality of care for people with COPD across the whole health care system. Key actions include:<br>▪ Signed a joint working agreement with the Pharmaceutical Company GSK to support implementation of project plan;<br>▪ All practices are developing individual action plans, with the aim of reducing variation in the quality of care provided;<br>▪ Early progress in increasing the percentage of patients on the COPD register who have disease severity coded, 70% in Quarter 1 2011/12 to 87% in Quarter 3. | |
| Completed a training needs analysis to ensure primary care staff receive appropriate training in the care of COPD patients. | |
| Programme of Spirometry interpretation sessions organised with attendance of GPs and practice nurses from majority of practices. | |
| All practices have reviewed their palliative care registers and completed an audit for these patients; education session delivered to practices focusing on the prognostic indicator guidance and when COPD should be considered for the palliative register. | |
| Developed a standardised patient information pack for distribution to patients attending for annual reviews; agreed a self-management plan which is being used with patients as appropriate. | |

| **Prescribing** | |
|---|---|
| Appointed a Prescribing lead to work with PCT Medicines Management Team to implement a Prescribing Incentive Scheme to support practices in achieving quality improvements and deliver QIPP savings.<br>▪ Set a target of 80% for practices to achieve in relation to patients on all 4 drugs post-MI. Practices have received baseline data and guidance regarding how to review patients. There has been a 3.4% improvement from Quarter 1 2011 to Quarter 3 2011. | |
| Developing educational materials to aid practices to increase repeat prescribing following a Rapid Process Improvement Workshop; initial data indicates a 3.4% increase in repeat prescribing from April 2011 to January 2012. | |
| Enabling pharmacists to undertake medicines reviews within care homes to reduce prescribing errors. | |

| Clinical Effectiveness | |
|---|---|
| Appointed a clinical lead to address clinical effectiveness in primary care; work programme addresses three themes: informing, changing and monitoring. | |
| Key priorities identified including raising awareness of lung cancer among patients attending COPD, CVD and smoking cessation clinics. | |
| Developed detailed guidance in the Local Incentive Scheme and "Be Clear on Cancer" leaflets distributed to all practices. | |
| Held educational event in January 2012 to raise awareness of early diagnosis with practices directed to follow NICE guidance when referring coughs. | |
| Lead role in QOF QP indicators for Emergency Admissions and Outpatient Appointments. Practices participated in an External Peer Review to identify areas for pathway reform; resulted in agreement with practices to follow 6 key pathways in order to reduce over performance in planned care. | |

| Adding clinical value to wider initiatives | |
|---|---|
| Leading the review of the District Nursing service provided by Community Health Services at South Tyneside Foundation Trust. Practices feedback views regarding current service provision; Executive reviewed the service specification to ensure it meets the needs of our patients. | |
| Contributed to the service specification and participated in the procurement of the new Houghton Intermediate Care service. | |
| Contributed to the business case for new build Sunderland hospice. | |
| Reviewed dermatology service recovery plans for service contracted from County Durham Hospitals following staffing changes; lead the review of the model for dermatology services during 2012/13. | |
| Supported a pilot for counselling services as part of a spectrum of support for people with common mental health problems prior to AQP developments. | |
| Influenced the selection of the 3 AQP pathways for 2012/13. | |

## 4.2 Overview of our Strategic Objectives and initiatives

In order to achieve our vision of '**better health for Sunderland**' by 2017, we have identified three key **strategies** for moving from our current position to our desired future state:

- Prevention, empowerment and resilience;
- Seamless integrated pathways;
- Clinical relationships and increased standardisation.

We have identified high level outcome measures from the Commissioning Outcomes Framework as key outcomes to quantify our five year ambitions and will use national and

international benchmarks to identify challenging but achievable aspirations as noted in Section 2.3.

In order to achieve these outcome measures we have identified 8 strategic objectives that will be the focus of our efforts going forward:

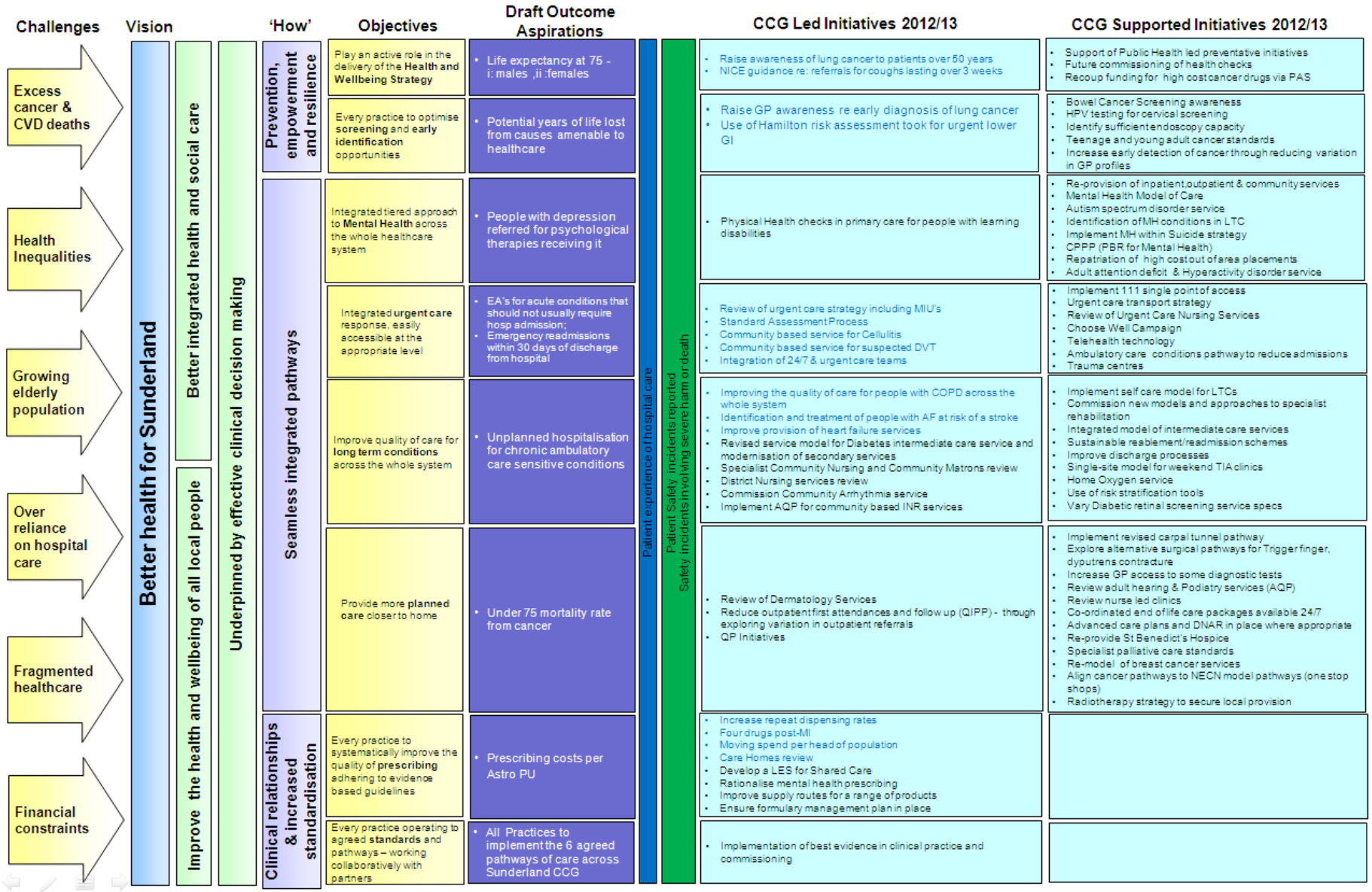
- Play an active role in the delivery of the **Health** and **Wellbeing Strategy;**
- Every practice to optimise **screening** and **early identification** opportunities;
- Integrated tiered approach to **Mental Health** across the whole healthcare system
- Integrated **urgent care** response, easily accessible at the appropriate level;
- Improve quality of care for **long term conditions** across the whole system;
- Provide more **planned care** closer to home;
- Every practice to systematically improve the quality of **prescribing** adhering to evidence based guidelines;
- Every practice operating to agreed **standards** and pathways – working collaboratively with partners.

The following diagram illustrates the stages (an iterative process) we worked through to develop our strategy:

- From challenges (where are we now?);
- Through vision (where do we want to be?);
- 'The How' and Objectives (how will we get there?);
- Outcomes (how will we know when we get there?);
- To initiatives (what actions do we need to take?);
- To delivery (developments and enablers needed to deliver the plan).


The ‘map’ of our strategy known as a ‘plan on a page’ is overleaf and illustrates in visual format our commissioning agenda going forward.

# Future provision of health and social care in Sunderland - 'Plan on a Page' 2012-17



## 4.3 Initiatives to deliver changes

As part of the development of this commissioning five year plan, we played a key role in shaping the detailed changes planned for the NHS in Sunderland in 2012/13 (known as Commissioning Intentions).

These detailed changes were well developed and agreed by the 31st December 2011 in order that they could be included in 2012/13 contracts. This timescale means that our longer term strategy has influenced and shaped the detail for 2012/13 rather than determined it, as will be the case for 2013/14 onwards. The initial changes was generated from the PCT legacy strategy but has been the subject of scrutiny and change from ourselves as our own longer term strategy emerges.

2012/13 is a year of transition, as commissioning transfers from the PCT to the CCG. We have agreed delegated responsibility in 2011/12 for the priorities set out in our pathfinder application. We are extending our lead delivery role to a broad range of priorities in 2012/13, on a path to accountability for the full agenda from April 2013. Taking on increasing responsibilities on a phased basis will both assist with our rapid development as an effective decision making body and provide the evidence of delivery required for authorisation.

A structured process was used to enable us to:

- Become familiar with the full agenda to help in determining our 5 year plan;
- Influence, shape and change the Commissioning Intentions and detailed changes planned for 2012/13;
- Identify which areas we wish to lead in 2012/13, in addition to our pathfinder commitments.

Working with PCT strategic leads and the local authority colleagues, we identified potential changes with each of our strategic objectives which we considered suitable to lead in 2012/13 as noted in *Appendix 1.*

We agreed a set of standard criteria against which potential changes were revewed and used a simple scoring system to score each change. The simplicity of the scoring helped the discussion but also meant some subtleties of impact and do-ability needed to be reflected in addition to the scores and this was reflected in the outcome of the process.

Following the outcome of this process, we agreed that in addition to our Pathfinder priorities we will also lead the following initiatives in 2012/13:

- Reduce outpatient first attendances through 'Exploring variation in outpatient referrals';
- Review role and effectiveness of community matrons and community nursing ;
- District nursing review;
- Develop diabetes intermediate care;
- Health checks for people with learning disabilities;
- Review of dermatology service.

## 4.4 Changes we plan to make

We are currently developing strategic programmes in order to demonstrate clear links from our initiatives to our Strategic Objectives. The following section shows an example of how we will demonstrate the link across our Vision map. It describes for each:

- Why the changes are needed;
- The strategic objectives to be delivered through the changes;
- What we want the future to look like;
- Detailed changes planned with milestone dates and financial implications of each;
- Key performance indicators to measure progress;
- Risks and mitigating actions;
- Implications for estates, workforce, informatics and communications.

# MENTAL HEALTH (ADULT)

**Why is change needed?**

- Major cause of poor health & quality of life in SoTW & increasing mental ill health prevalence
- Ageing population will increase numbers with dementia
- Variable access to adult and children's mental health services

**Objective**

An integrated tiered approach to mental health across the whole healthcare system

**How do we want the future to look and what are the transitional issues?**

- Fully integrated model of mental health care with robust pathways with all partners working in collaboration
- Reprovision of all Sunderland inpatient services
- National dementia strategy implemented

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| Implement the emotional health & wellbeing plan. | | | | | | |
| Implement mental health specific actions within the Suicide strategy. | | | | | | |
| Re-provide Black and Minority Ethnic and Lesbian Gay Bisexual Transgender wellbeing programmes. | | | | | | |
| Re-provide workplace health programme with improved service offer for organisations not pursuing North East Better Health at Work Award. | | | | | | |
| Implement recommendations arising from report on outcomes of physical health improvement programme for people with severe mental illness. | | | | | | |
| Increase input into long-term conditions in terms of identification of mental health problems and treatment. | | | | | 450 | |
| Continue the process of repatriating high cost out of area placements to locally provided services. | | | | | | |
| Develop and agree an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service. | | | | | | |
| Continue work with Northumberland Tyne & Wear to realise efficiencies in resource releasing initiatives and support service development. | | | | | | |
| Work with Northumberland Tyne & Wear to support the implementation of the new facilities at Ryhope & Monkwearmouth. | | | | | | |
| Continue implementation of the Mental Health Model of Care | | | | | | |
| Lead the implementation of Care Pathways & Packages Project (Payment by Result for mental health) in shadow form across contracts | | | | | | |
| Consider existing commissioning arrangements moving to Any Qualified Provider for psychological therapies in Primary Care | | | | | | |
| Ensure that physical health care checks in primary care for people with learning disabilities are implemented. | | | | | | |
| Develop an Autism Spectrum Disorder assessment and diagnostic service across Sunderland. | | | | | | |
| Implementation of robust joint strategic function arrangements with Sunderland Local Authority through the use of Health Act flexibilities. | | | | | | |
| Implement preferred option for CHC (Continuing Health Care), FNC (Free Nursing Care) & s117 (Section 117). | | | | | 300 | |
| Continue to implement the Carers strategy and local action plans in each locality. | | | | | 630 | |
| Enhance governance & quality arrangements with independent sector providers. | | | | | | |
| Work collaboratively to bring together plans for development of physical health, mental health, medicines management and end of life care | | | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- Crisis resolution home treatment
- Early intervention in psychosis (new cases)
- Care programme approach (CPA) 7 day follow up
- Improved access to psychological therapies (IAPT)

**Local Measures**

- Total assertive outreach caseload
- Total Early Intervention Programme caseload
- Development of local comprehensive quality improvement/ outcomes framework

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Capacity to deliver plans at risk due to management cost reductions | Engagement with Primary Care to ensure support to proposed changes |
| High risk - repatriation - demand for out of area placements for people stepping down from forensic placements, therefore demand for high cost specialist services will continue to rise as driven by decision of court | Ensure funding implications of action plans are fully articulated, identify alternative sources of funding |
| Engagement and agreement of Primary care mental health model with primary care clinicians | Robust implementation plans to be developed and supported stakeholders |
| Current economic situation will necessitate increased financial scrutiny of investment proposals | |
| Financial resources available to implement action plans | |
| Competing priorities for funding and pressures on Local Authority's re funding streams especially within the voluntary sector | |
| Concerns re funding for Learning Disabilities health checks for 2013/14 onwards | |
| Concerns from Local Authority's re. reduction of Primary Care Trust funding arrangements at time of financial reductions in public sector | Continue to prompt engagement with senior officers & look for levers and incentives |
| Contracts - capacity and capability of small provider to implement national NHS contracts | A lead contract manager identified to establish good relationship and communication with providers to ensure smooth contract implementation |

### Communications Implications

- Public and staff awareness of health & well being plan and Suicide Strategy (specifically mental health section)
- Communication of reforms
- Bed modelling and ward configuration consultation with staff and service users to determine the reprovision of in patient, out patient & community services at Ryhope & Monkwearmouth
- Social marketing and media campaign to increase awareness and uptake of health checks for people with learning disabilities
- Communication plan to raise awareness of NHS Health Checks services for people with learning disabilities
- Carers strategy
  - Communications in local media to raise awareness of carers services and new investments
  - National campaign by Princess Royal Trust for carers report (NHS SOTW as best

### Estates Implications

- Reprovision of in patient, out patient & community services at Ryhope & Monkwearmouth
- Development of an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service
- Potential use of all Primary Care facilities for the delivery of memory protection service

### Informatics Implications

- Provision of outcome and performance Information
- Gap in contract information systems with third sector providers
- Capture the detail of NHS Health Checks for people with learning disabilities undertaken and the results of the checks
- Data quality and validation of information – information flows well documented for health checks for people with learning disabilities
- Monitoring of the implementation of robust joint commissioning arrangements with Sunderland Local Authority
- Carers strategy – Local Authority, independent and voluntary sector organisations all collect data and report to Primary Care Trust commissioning

### Workforce Implications

- Implementation of model of care for Mental Health, remodelling of liaison services for veterans and development of mental health in primary care
- Development of an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service
- Reduction in beds following the reprovision of in patient, out patient & community services at Ryhope & Monkwearmouth will result in changes to Northumberland Tyne Wear workforce
- Effects following implementation of carers strategy

# CAMHS, Learning Difficulties and Complex Needs

## Why is change needed?

- One in ten children and young people between 5 and 16 years has a mental health problem which significantly impacts on health, education and social outcomes, with half of those with lifetime mental health problems experiencing symptoms by the age of 14
- Fragmented mental health and learning disability service provision for children and young people
- Lack of clarity about pathways and provision for children with complex needs and children and young people with multiple problems

## Objective

Establish integrated models of care that deliver personalised, holistic and outcome focused services to children, young people and their families with mental health, learning difficulties, disabilities and multiple and complex needs.

## How do we want the future to look and what are the transitional issues?

- Improved access to talking therapies (Improving Access to Psychological Therapies) for children and young people as part of the development of Tier 2 Child and Adolescent Mental Health Services
- Improved access to effective Child and Adolescent Mental Health Service and Learning Disabilities for all children and young people including those in special circumstances; with acute mental health needs and with complex behavioural mental health and social care needs through the establishment of specialist community Child and Adolescent Mental Health and Learning Disability
- Reduction in the number of children and young people requiring out of area treatment
- Clearly defined pathways of care for children and young people with neuro-developmental disorders
- Clearly defined pathways and effective provision of service for children and young people requiring individual packages of care including implementation of the continuing care framework
- Improved support for children, young people and their families with disabilities including implementation of Aiming High
- Improved health outcomes for children and young people in special circumstances including Looked After Children and Children and Young People involved in the Youth Justice System

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| Development of Tier 2 Child and Adolescent Mental Health service provision including improved access to talking therapies in line with evidence base. To increase the capacity of universal service providers to promote mental health for children and young people, recognise problems early in their development, intervene and refer as appropriate. Provide direct services to Children, young people and their families with moderate mental health needs, including grouping work and talking therapies. | | | | | | |
| Establishment of new model of specialist community Child and Adolescent Mental Health / Learning Disabilities service provision with a particular focus of integrated pathways of care for children, young people and their families. | | | | | | |
| Re-alignment of resources/ changes in service provision for children and young people with Autistic Spectrum Disorder based on outcomes of the review. | | | | | | |
| In partnership with Local Authority, development of services for Children and Young people with Disabilities. | | | | | | |
| Working in partnership with Local Authority support the review of Special Education Needs assessment and statement framework. | | | | | | |
| Implementation of the review of services for Looked After Children | | | | | | |
| Implementation of result of review of Child protection service specification | | | | | | |
| Implementation of outcomes of review of services for children and young people involved in youth justice system. | | | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Local Measures**

- Improved access to psychological therapies (IAPT)
- Commissioning comprehensive Child & Adolescent Mental Health service

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Differences in configuration of services in different localities; | Alignment with developing health and well being board / children's Local Strategic Partnership arrangements |
| Resources not available to meet requirement to improve access to psychological therapies and reduction of resource available to Local Authorities as a result of Comprehensive spending review and availability of area based grant | Clearly defined level of resource for children and young people to support the development of talking therapies as part of development of Tier 2 Services |
| Transition between current and new service provision; Transfer of Undertakings Regulations implications; transfer of care, transfer of records implications | Ensure involvement of local Child and Adolescent Mental Health Service and Learning Difficulties & Disabilities partnerships, Foundation Trust, community and Child and Adolescent Mental Health Service commissioners in process |
| Lack of clarity in relation to future commissioning arrangements for tier 2 Child & Adolescent Mental Health Service | |
| New service fails to deliver required changes | |

**Communications Implications**

- Engagement and communications plan for the development of Tier 2 Child & Adolescent Mental Health service

**Informatics Implications**

- Information systems – Primary Care Trust and provider system to be developed to support collection of performance information following release of new guidance

**Estates Implications**

- Re-alignment of service provision for children and young people with Autistic Spectrum Disorder (specifically specialist community provision)

**Workforce Implications**

- Employment and workforce remodelling to support re-alignment of service provision

# URGENT CARE

## Why is change needed?

- Higher than average emergency admissions and re-admissions to hospital compared to England
- High rates of hospital emergency admissions for 0 and 1 day length of stay and for emergency admissions for long term conditions

## Objective

Ensure integrated 24/7 **urgent care** systems across all sectors which delivers quality care in appropriate settings

## How do we want the future to look and what are the transitional issues?

- Integrated 24/7 urgent care system across all sectors, which delivers quality care in appropriate settings
- Reduced acute ambulatory care sensitive emergency admissions

## What are we doing about it?

| Project Gantt Chart | 2011/12 Q1 | Q2 | Q3 | Q4 | £k + * | £k - * |
|---|---|---|---|---|---|---|
| North East Ambulance Service contract over performance and funding for Ambulance Hazardous Area Response Team | *NA* | | | | 530 | |
| Implement the 111 single point of access for urgent care to signpost patients with an urgent care requirement to the most appropriate service to meet their needs. | | | ■ | ■ | 550 | |
| Develop an urgent care transport strategy to support the implementation of 111. | | | ■ | ■ | | |
| Annual 'Choose Well' public information campaign to publicise the range of services, points of access, hours of operation and areas of exclusion | | | | ■ | | |
| Standard model of General Practitioners integrated working will be implemented across all Minor Injuries Units. Houghton Minor Injuries Units options to be agreed, the exploration of an urgent care hub in Community Health Service | ■ | ■ | ■ | ■ | 170 | |
| Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted. | ■ | ■ | ■ | ■ | | 710 |
| Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality. | ■ | ■ | ■ | ■ | | |
| Review Urgent Care Nursing Services to understand the impact to develop a future state. | ■ | ■ | ■ | ■ | | |
| Commission activity to reflect the expected impact of the introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units | ■ | ■ | ■ | ■ | | |
| Develop a community based cellulitis model and service. | ■ | | | | | 710 |
| Develop a community based Deep Vein Thrombosis model and service | ■ | ■ | ■ | ■ | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- Ambulance quality - Cat A response times
- Emergency admissions for acute conditions that should not normally require hospital admission
- Accident and Emergency waiting times – total time in the department
- Non elective First Finished Consultant Episodes
- Accident & Emergency attendances
- Ambulance Urgent & Emergency Journeys

**Local Measures**

- Accident & Emergency quality indicators (all other measures)
- Ambulance quality indicators (all other measures)
- Accident & Emergency Quality Indicators (5 measures)
- Emergency Readmissions
- Urgent care metrics
- MRSA (meticillin-resistant staphylococcus aureus) Screening (contractual measure)
- Methicillin-sensitive Staphylococcus Aureus Screening (contractual measure)

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Working with providers for development of services | Urgent care board and locality networks |
| Provider engagement | Performance metrics |
| Financial pressures | Clinical engagement sessions and kaizen workshops, Rapid Process Improvement Workshop |
| Agreement to collaborative model | Close contract monitoring |
| Workforce and infrastructure | Learning from best practice |
| Payment By Results tariff changes (emergency admissions) | |
| Pace of change required to deliver initiatives | |

### Workforce Implications

- Develop Intravenous Therapy therapy provision in the community
- Single point of access & associated transport for all health and social care require additional training in use of new standard clinical protocols
- Staffing in relation to the introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units.
- Training for Telehealth service

### Estates Implications

- Development of an urgent care transport strategy to support the implementation of 111
- Introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units.

### Informatics Implications

- Work towards more integrated IT records so the right information is available at the right time.
- Move to more integrated directories of services on Sunderland Information Network.
- Production of performance data (activity and outcome) from Walk In Centres and Minor Injuries Unit
- Implementation of the single point of access (111)
- Capacity Management System hosted by North East Ambulance Service / Connecting for Health
- Evaluation of 'Choose Well' initiative
- Introduction of Telehealth technology for patients with long term conditions
- Effects of the introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units

# LONG TERM CONDITIONS

## Why is change needed?

- Higher than average emergency admissions and emergency re-admissions to hospital compared to England.
- Significantly higher rates of admissions for long term conditions compared to England.
- More people living with long term conditions.
- An ageing population – if current hospital use continues the system becomes unaffordable in 10 years.

## Objective

Improve the quality of care for Long term Condtions across the whole system

## How do we want the future to look and what are the transitional issues?

- People with Long Term Conditions are confident in managing their condition and are clear about the care they need and when.
- When conditions worsen there are easily accessible services to help and patients feel these are 'joined up'.
- Most interventions are available outside hospital.

## What are we doing about it?

| Project Gantt Chart | 2011/12 Q1 | Q2 | Q3 | Q4 | £k + * | £k - * |
|---|---|---|---|---|---|---|
| **Develop a commissioning model for Long Term Conditions (Self Care) -** review the future commissioning arrangements of self care services & embed self care opportunities into health care core services | ■ | ■ | ■ | ■ | | 55 |
| **Develop a commissioning model for Long Term Conditions (Specialist Rehabilitation)** - Commission new models and approaches to specialist rehab | ■ | ■ | ■ | ■ | | 143 |
| **Develop and commission an integrated model of intermediate care services** (including rehabilitation and reablement) | ■ | ■ | ■ | ■ | | 204 |
| **Review existing rapid access community nursing teams** - intention is to improve access and clarity of role | ■ | ■ | | | | 55 |
| **Review provision, role and effectiveness of Community Matrons -** develop appropriate models of case management | | | ■ | ■ | | 143 |
| **Implement revised service specification of the district nursing service** | ■ | ■ | | | | |
| **Develop sustainable and successful reablement/readmission schemes** | ■ | | | | | 143 |
| **Improve provision of heart failure services across primary community and secondary care** | | ■ | ■ | | | 55 |
| **Review the Chronic Obstructive Pulmonary Disease pathway and identify improvements that could be made to improve patient care.** | ■ | ■ | ■ | ■ | | 55 |
| **Improve discharge processes (including documentation) and opportunities for early supported discharge.** | ■ | ■ | ■ | ■ | | 143 |
| **Implement single-site model for weekend Transient Ischemic Attack clinics.** | ■ | | | | | 55 |
| **Develop a revised service model for the provision of diabetes services across primary community and acute.** | | | ■ | ■ | | |
| **Develop recommendations for future commissioning following the pilot of the community arrhythmia service.** | | ■ | ■ | | | |
| **Implement an Any Qualified Provider procurement for community based INR (international normalisation ratio) services.** | | | ■ | ■ | | 55 |
| **Improve provision of Atrial Fibrillation services across primary, community and secondary care** | ■ | ■ | ■ | ■ | | 55 |
| **Commission a home oxygen assessment service.** | ■ | ■ | ■ | ■ | 125 | |
| **Increase the use of risk stratification tools including across primary community and secondary care** | ■ | ■ | ■ | ■ | | 55 |
| **Diabetic Retinal Screening - Vary service specifications to reflect the new national commissioning pathway** | ■ | ■ | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

### Operating Framework Measures

- People with Long Term Conditions feeling independent and in control of their condition
- NHS Health Checks
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- Unplanned hospitalisation for asthma, diabetes and epilepsy <19s

### Local Measures

- Emergency admissions for Long Term Conditions
- Readmissions within 30 days
- Delayed transfers of care
- Proportion of people spending 90% of their time on a stroke ward
- Proportion of Transient Ischemic Attacks treated within 24 hrs
- Diabetic retinopathy screening
- All-age all cause mortality (Males)
- All-age all cause mortality (Females)
- Proportion of individuals admitted to Care Homes
- People supported to live independently)

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Capacity to deliver and complexity of projects | Identified lead for SoTW. Working collaboratively with Clinical Commissioning Groups Clinical Leads, Local Authority, Public Health and Social Care partners. Work with stakeholders to develop investment plans for 2012/13 |
| Competing agendas | Clinical engagement in prioritisation. |
| Long Term Conditions Model with focus on this rather than individual pathways | Develop Commissioning Model and focus on Workforce strategy |
| Unable to reduce emergency admissions/readmissions | Align strategies. Targeted interventions. Cross cutting reform issues e.g. Long Term Conditions and Urgent Care. |

### Communications Implications

- Develop and implement joined up social marketing approach to support self management of Long Term Conditions across all programme linking into national campaigns.

### Workforce Implications

- Development of Integrated Teams
- Effects of review of Community Nursing
- Implementation of changes to District Nursing services
- Review of specialist inpatient and community neurological rehabilitation services
- Increase capacity and training health professionals to manage range of conditions in primary/community care.
- Up skilling community and primary care staff.
- Training/culture change to encourage and promote self-care.

### Estates Implications

- Group space in all Primary Care Centres and many health centres.
- Community ECHO (echocardiography) facilities within Primary Care Centres.
- Consider community based services for Atrial Fibrillation, Diabetes and Heart Failure within Primary Care Centres.
- Consider opportunity to co-locate community teams and facilitate team working and integration.
- Development of a clinician led integrated intermediate care inpatient service at Houghton Primary Care Centre.

### Informatics Implications

- Standard sets of information/data sets (recurring).
- Real time data – monitoring.
- Introduce a minimum data set and outcome measures and ensure that all eligible patients are included for rehabilitation. This will have an impact on hospital re-admissions.

# PLANNED CARE

## Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home

## How do we want the future to look and what are the transitional issues?

- Streamlined, high quality, patient centred care, close to home.
- Shift of planned activity out of hospital into primary and community settings
- Reduced patient travel, waste and duplication
- Right care, first time, right place

## Objective

- Provide more planned care closer to home

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| Implement the revised pathway for patients with carpal tunnel syndrome | | | | | | 200 |
| Reduce outpatient first and follow up attendances. | | | | | | 416 |
| Explore feasibility of increasing General Practitioner access to diagnostic tests for non obstentric ultrasound and Magnetic Resonance Imaging for dementia | | | | | | |
| Review dermatology services with a view to aligning the service model with services commissioned for Gateshead and South Tyneside | | | | | | |
| Following scoping of nurse led clinics in terms of continued viability and cost, agree clinics to "decommission" or change to ensure added value to patient pathways | | | | | | 265 |
| Review Adult Hearing Services with an aim to improving access, choice and quality of care (Any Qualified Provider) | | | | | | |
| Review podiatry services with an aim to improving access, choice and quality of care (Any Qualified Provider) | | | | | | |
| Specialist commissioning developments | N/A | | | | 1,400 | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- Referral to Treatment Pathways (admitted 90%, non admitted 95%, incomplete 92%)
- Number waiting on incomplete Referral to Treatment pathway
- Patient experience survey
- Venous Thromboembolism risk assessment
- General Practitioner written referrals to hospital
- 6 week diagnostic waiting times (15 key diagnostics)
- Diagnostic Activity – Endoscopy based tests
- Diagnostic Activity – Non endoscopy based tests
- Bed Capacity – General and Acute
- Other referrals for a 1st outpatient appointment
- 1st outpatient attendances following General Practitioner referral
- All 1st outpatient attendances
- Elective First Finished Consultant Episode
- Bookings to services where named consultant led team available
- Proportion of General Practitioner referrals to 1st op appointments booked using Choose & Book
- Trend in value/volume of patients being treated at non NHS hospitals

**Local Measures**

- Length of stay (acute)
- Daycase rate
- Patient Reported Outcome Measures Scores
- Low value procedures

**Contractual Measures**

- Cancelled elective operations for non clinical reasons
- Choose and Book – direct booking
- Choose and Book – slot issues
- MRSA (meticillin-resistant staphylococcus aureus) Screening

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Continued over performance on elective and outpatient activity contracts | Action plan agreed by Clinical Commissioning Group Board |
| Acute sector engagement to increase General Practitioner access to diagnostic tests | Development of pathway with all stakeholders |
| Capacity to manage contracts with large number of new providers for Adult Hearing Services and Podiatry Services | Associated commissioning arrangements for Adult Hearing Services and Podiatry Services. Also addressed through design of Commissioning Support Organisations. |

**Communications Implications**

- Communications implications being led by Vascular network for Varicose Vein procedures
- Stakeholder engagement for the review of Adult Hearing Services and Podiatry Services via Any qualified provider.

**Informatics Implications**

- None

**Estates Implications**

- Explore Primary Care Centre facilities for General Practitioner access to diagnostic tests

**Workforce Implications**

- None identified

# CANCER

## Why is change needed?

- Significantly higher than average early deaths from cancer
- 30% of all deaths across Sunderland are due to cancer
- Evidence shows earlier identification of cancer would have fastest, most significant impact on life expectancy

## Objective

Earlier diagnosis and treatment of cancer to reduce mortality and improve survival.
To improve access to appropriate treatments

## How do we want the future to look and what are the transitional issues?

- Increased uptake of cancer screening
- Earlier diagnosis & treatment of cancer
- Improved survival rates
- Reduced cancer mortality

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| Local Cancer drugs @ £300k per annum and National Cancer Plan | | | | | 1,150 | |
| Continue to implement the Improving Outcomes Strategy for Cancer | | | | | | |
| Remodel Breast Cancer Services across NHS SoTW (excluding screening services) in order to implement a sustainable service model. | | | | | | |
| Ensure cancer pathways for Foundation Trusts are in line with North East Cancer Network model pathways. Awaiting standards for Brain and Sarcoma services | | | | | | |
| Work with Foundation Trusts to ensure processes are in place to recoup funding through Patient Access Schemes for High Cost Cancer Drugs. | | | | | | |
| Increase uptake of Bowel Cancer Screening by raising awareness.. | | | | | | |
| Identify sufficient endoscopy capacity to meet demand | | | | | | |
| Introduction of Human Papilloma Virus testing for Cervical Screening. | | | | | | |
| Increase the early detection and identification of cancer and increase uptake by reducing variation in General Practitioner profiles | | | | | | |
| Implement urgent lower Gastrointestinal investigation by adopting the Hamilton Risk Assessment Tool into 2WW time frame. | | | | | | |
| Enhance engagement and uptake of services following Health Equity Audit of Breast Screening Service. | | | | | | |
| Deliver outcomes of teenager and young adult cancer standards in collaboration with North East Cancer Network | | | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- 2 week wait (aggregate measures for urgent and breast referrals)
- 62 day wait (urgent referral from General Practitioner and consultant)
- 62 day wait (referral from national screening service)
- 2 week wait – urgent referral to 1st appt
- 2 week wait (breast symptoms)
- 62 day – urgent referral to treatment
- 62 day – urgent referral from screening service
- 62 day – urgent referral consultant upgrade
- 31 day – diagnosis to treatment

**Operating Framework Measures…**

- 31 day – diagnosis to treatment (surgery)
- 31 day – diagnosis to treatment (anti cancer drug regime)
- 31 day – diagnosis to treatment (radiotherapy)

**Local Measures**

- Extension of breast screening to 47-49 and 71-73
- Extension of bowel screening to men and women 70-75
- Cervical screening results – 2 week turnaround
- Reduction in cancer mortalities in under 75s

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Failure to implement remodelling of Breast Cancer Services will result in lack of workforce in future. | Hub and spoke model for Breast Cancer Services being developed. |
| Delayed access to diagnosis following changes to the cancer pathways and awaiting publication of standards. | Close working with all providers led through cancer locality group to support alignment of cancer pathways. |
| Risk that patient access schemes may cease nationally i.e.; there will be no schemes which require reimbursement | Link in with North of England Cancer Drug Approval Group to monitor national trends for patient access schemes to ensure that the contract for the risk share element is only viable whilst patient access schemes exist. |
| Fail to secure patient uptake of Bowel Cancer Screening. | Dedicated health promotion specialist working within this field of Bowel Cancer Screening. |
| Develop endoscopy capacity but fail to increase demand through awareness campaign | Work with North East Cancer Network to ensure early knowledge of economic model for endoscopy. |
| Hitting the 14 day turnaround time for HPV testing for Cervical Screening as two tests on same sample will need to be undertaken within the same timescales | All cervical screening services working together to ensure pathway implementation within timescale. Will be closely monitored by Primary Care Trust. |
| Failure to understand and meet demand of early detection and identification of cancer. | Working collaboratively with providers across North East Cancer Network as the agenda develops. |

**Communications Implications**

- Communications strategy for General Practitioners in relation to remodelling of Breast Cancer Services.
- Communications via cancer locality group for alignment of cancer pathways.
- National endoscopy strategy and awareness campaign commencing January 2012
- General Practitioner Cancer Lead working with identified practices for the early detection and identification of cancer.

**Estates Implications**

- May require additional capacity to run endoscopy clinics in the community.

**Informatics Implications**

- Provider responsibility - Data sharing to ensure 14 day turnaround time for HPV testing for Cervical Screening.

**Workforce Implications**

- Require more clinical oncology in local Multi Disciplinary Team's for Radiotherapy Services
- Requirement to grow workforce to meet anticipated demand for endoscopy
- Potential requirement for colposcopist. Awaiting impact of HPV

# END OF LIFE CARE

## Why is change needed?

- Increased number of deaths forecast in next 5-10 years, many occur in hospital
- People say they want choice of place of death
- Inconsistent standards of end of life care in different settings
- Bed days in hospital for people who die after 14 days or more have increased

## Objective

Ensure all people entering the end of life have their needs, priorities and preferences identified and met, with the same standards of care in all settings

## How do we want the future to look and what are the transitional issues?

- All people in Sunderland towards the End of Life will have their needs, priorities and preferences for End of Life Care, including care after death, identified and met, throughout the last phase of life and bereavement
- People can choose their place of death
- 5% reduction in numbers of people dying in hospital

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| To ensure end of life care packages are co-ordinated and available 24/7 | | | | | | |
| To have advanced care plans and DNAR in place for all appropriate patients | | | | | | |
| Development of St Benedict's hospice inc Macmillan and Marie Curie pick up in 2011/12 | | | | | 500 | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- There are no measures identified within the operating framework specifically to measure end of life for 12/13

**Local Measures**

- Proportion of Deaths at Home (Reduce hospital deaths by 5%)
- Total length of stay in last year of life
- Reduction in total admissions
- Number of patients with DNAR in place
- Number of patients on palliative care register

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Failure to secure buy in from non palliative care specialists to ensure end of life care packages are co-ordinated and available 24/7 and have advanced care plans and Do Not Attempt Resuscitation in place. | Communications strategy on Do Not Attempt Resuscitation and integrated model of care. |
| Failure to secure planning permission to re-locate St Benedict's Hospice. | Engagement with all stakeholders re relocation St Benedict's Hospice - Contingency plan will be developed. |

### Communications Implications

- End of life care packages subject to communications strategy
- Communications re advanced care plans and Do Not Attempt Resuscitation are being led through North East Cancer Network with Primary Care Trust support.
- Full communications plan in place re: relocation of St Benedict's

### Informatics Implications

- No additional informatics implications for end of life care packages
- Informatics part of Project Team for relocation of St Benedict's Hospice

### Estates Implications

- Full capital business case, Estates engaged in Project Team for relocation of St Benedict's Hospice

### Workforce Implications

- Educational element to ensure end of life is everyone's business. Assessment of care home training requirements will help inform educational agenda for 12/13.
- Recruitment to Nursing and admin posts in Q4 12/13 in relation to relocation of St Benedict's Hospice.

# PLANNED CARE – ACUTE ACCESS & CHOICE

## Why is change needed?

- Under the NHS Constitution, patients have the right to access services within maximum waiting times
- There is still scope to improve the choice of services for patients, including having more services closer to patients homes
- There is an ongoing need to manage waiting lists in a way which prioritises the clinical need of patients while maximising the use of resources

## How do we want the future to look and what are the transitional issues?

- Patients will, get the right care, first time, in the first place they go to
- Patients will be able to use the Choose and Book system for planned treatments
- Patients will have more information to allow them to make informed choices
- Patients will continue to be seen on the basis of clinical need

## Objective

Ensure that patients have an informed choice of services and appointments when they are referred to hospital for planned care and are seen as quickly as their condition requires, within the maximum waiting times in the NHS Constitution. The choice of services should include an appropriate range of hospital and out-of-hospital care.

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + | - |
| **Activity** | | | | | | |
| Agree contracts with acute hospitals to meet the increased demand seen in 2011/12 and projected demand for 2012/13, then manage those contracts | | | | | 6430 | 320 |
| **Referral to Treatment/ Waiting Times** | | | | | | |
| Joint PCT / hospital "Access and Choice Task and Finish Group' to review waiting lists and times (including planned waiting lists) to identify issues and actions and share good practice. The Group will oversee delivery of the following: | | | | | | |
| ▪ Ensure systems in place to manage waiting lists effectively | | | | | | |
| ▪ Review of waiting lists for all specialties and diagnostic services to ensure that safety and standards of care are not compromised | | | | | | |
| ▪ Ensure 90% of admitted patients and 95% of non admitted patients are seen within 18 weeks for all specialties in all months | | | | | | |
| ▪ Ensure 92% of patients of patients who are still waiting will be seen within 18 weeks | | | | | | |
| ▪ Ensure no patients still waiting has waited over 52 weeks | | | | | | |
| ▪ Ensure systems in place to identify reasons why patients waiting longer than 18 weeks & where this is not due to patient choice or is in the patients clinical best interests a plan is in place to manage the patient | | | | | | |
| ▪ Ensure that patients have the information they need to choose a different provider when they have waited over 18 weeks | | | | | | |
| ▪ Ensure no more than 1% of patients wait more than 6 weeks for a diagnostic test | | | | | | |
| ▪ Maintain 2 week wait for urgent GP referrals for cancer and breast symptoms – refer to cancer sheet; close monitoring via contract review mechanisms | | | | | | |
| **Choice** | | | | | | |
| Patients will be offered the choice of using 'Any Qualified provider' in three services by September 2012, using outcome based specifications | | | | | | |
| Continue to develop the Choose and Book service and increase use:<br>▪ Include the "Any Qualified Provider" services and communicating this<br>▪ Improve engagement with GPs to encourage use of Choose and book<br>▪ Include all community Allied Health Professional services on Choose and Book<br>▪ Work with providers to reduce Slot Issues<br>▪ Work with GP practices towards them making 90% of referrals using Choose and Book<br>▪ Evaluate and roll out pilots under which hospitals offer advice and guidance to GPs to avoid inappropriate referrals | | | | | | |
| Improve the range of choices for patients so there is a choice for most services from 2013/14:<br>▪ Continue to advertise choice of named consultant<br>▪ Work with hospitals to ensure patients have choice when they are referred for a diagnostic test (subject to Department of Health guidance)<br>▪ Establish process for choice of onward referrals following diagnosis, including choice of treatment by GPs and hospitals<br>▪ Ensure choice of treatment and provider are offered for mental health services and include on Choose and Book<br>▪ Ensure patients have choice of services for care of their long term conditions as part of personalised care planning<br>▪ Work with local hospitals to improve their policies on choice of maternity care | | | | | | |
| Ensure all patients referred for an outpatient appointment can choose a named consultant team by requiring hospitals to:<br>▪ Accept patients referred to a named consultant team, as long as the referral is clinically appropriate;<br>▪ List their services on Choose and Book in a way that allows users to book appointments with named consultant led teams | | | | | | |
| Ensure that decisions that restrict patient choice are taken by the Board and published annually | | | | | | |

## What KPIs will we use to monitor progress?

**Operating Framework Measures**

- Referral to Treatment Pathways (admitted 90%, non admitted 95%, incomplete 92%)
- Number waiting on incomplete Referral to Treatment pathway
- Patient experience survey
- Venous Thromboembolism risk assessment
- General Practitioner written referrals to hospital
- 6 week diagnostic waiting times (15 key diagnostics)
- Diagnostic Activity – Endoscopy based tests
- Diagnostic Activity – Non endoscopy based tests
- Bed Capacity – General and Acute
- Other referrals for a 1st outpatient appointment
- 1st outpatient attendances following General Practitioner referral
- All 1st outpatient attendances
- Elective First Finished Consultant Episode
- Bookings to services where named consultant led team available
- Proportion of General Practitioner referrals to 1st op appointments booked using Choose & Book
- Trend in value/volume of patients being treated at non NHS hospitals

**Local Measures**

- Length of stay (acute)
- Daycase rate
- Patient Reported Outcome Measures Scores
- Low value procedures

**Contractual Measures**

- Cancelled elective operations for non clinical reasons
- Choose and Book – direct booking
- Choose and Book – slot issues
- MRSA (methicillin-resistant staphylococcus aureus) Screening

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Continued over performance on elective and outpatient activity contracts | Refer to Planned Care Action plan developed and agreed to manage demand into secondary care<br>Provider management – 12/13 contract negotiations/use of contract and contract review groups to mitigate supplier driven demand |
| AQP:<br>unplanned increases in demand – financial pressures<br>increased numbers of providers & associated demands on contract requirements & capacity | Effective commissioning business processes to ensure AQP used as the most appropriate procurement option; risk analysis & proportionate approach to contract management |
| Choice/Choose & Book:<br>Failure to secure clinical engagement by GPs and Consultants.<br>GP contracts and loss of incentives via enhanced services<br>Ability to engage with providers with the reforms due to internal pressures<br>NHS priorities and organisational change<br>Failure to make sure all services are available on Choose and Book | Choice fully embedded within health provider contracts<br>Strong engagement at all levels<br>Ongoing discussions at Strategic level and Contract level with Acute Trusts. |

### Informatics Implications

- Support for activity management actions/contracting/AQP/Choose & Book

### Estates Implications

- Understand implications of AQP on Estate capacity

### Communications Implications

- Develop Communication Strategy to support Access: RTT/AQP/Choice

### Workforce Implications

- Understand implications of AQP on workforce: providers, e.g. TUPE; commissioners, capacity & skills

# MEDICINES MANAGEMENT

## Why is change needed?

Medicines are associated with significant cost to the NHS in terms of mortality, morbidity and financial impact. Effective management of medicines can improve patient outcomes and yield cost efficiencies through a reduction in expenditure and hospital admissions due to inappropriate prescribing Throughout this period of restructuring the local NHS needs to ensure priority is given to the safe, legal and effective use of medicines and medicines management is actively integrated into new commissioning structures

## Objective

Every practice to systematically improve the quality of prescribing adhering to evidence based guidelines

## How do we want the future to look and what are the transitional issues?

- Ensure statutory obligations with respect to medicines use continue to be met
- Ensure development of appropriate governance infrastructure to effectively manage the medicines agenda
- Ensure prescribing costs are managed within the agreed budgetary envelope and identified cost efficiencies are achieved

## What are we doing about it?

| Project Gantt Chart | 2012/13 Q1 | Q2 | Q3 | Q4 | £k + * | £k - * |
|---|---|---|---|---|---|---|
| To have an action plan in place to improve the quality of prescribing, optimise medicines usage in patients with long term conditions and deliver disinvestment opportunities in Primary care prescribing. | | | | | | 650 |
| To manage prescribing expenditure within prescribing envelop, to move closer to the North East average to release resources to invest in better quality service. (Astro PU) Age, Sex, and Temporary Resident Originated Prescribing Unit | | | | | | |
| Work with secondary, community and primary care to develop a health economy approach to prescribing of medicines across care pathways. | | | | | | |
| Through the contracting process develop plans for a consistent and collaborative approach for the transfer of prescribing responsibility, including improving the effectiveness of communication, provision of shared care medicines and outpatient prescribing | | | | | | |
| Explore options for Shared Care | | | | | | |
| Explore options to develop services to improve medicines management in care homes in order to reduce the number of emergency admissions and reduce medicines wastage. | | | | | | |
| Explore options for collaborative working across primary and secondary care in relation to the provision of oral nutritional products | | | | | | |
| Explore options for collaborative working across primary and secondary care in relation to the provision of stoma and incontinence | | | | | | |
| Explore options for collaborative working across primary care and communality in relation to the provision of wound management products, including encouraging appropriate use of the wound management formulary | | | | | | |
| Improve the systems for high impact / cost drug exclusions to include a consistent approach across the locality / region and effective implementation of the decisions. | | | | | | |
| Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including improving rates of repeat dispensing, new medicines service, targeted use of medicines usage reviews and review of the use of MDS (myelodysplasia, dysmyelopoiesis syndrome) | | | | | | |
| Ensure there are robust local mechanisms for decision making around medicines. | | | | | | |
| Review the contract for provision of medicines management support to individual practices | | | | | | |
| All secondary care and primary care providers to ensure patients post MI benefit from 4 drugs - aspirin, beta-blocker, statin and ACEI (angiotensin-converting enzyme inhibitors) | | | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

**Local Measures**

- Prescribing Cost growth
- Prescribing cost per Astro-Pu (age, sex & temporary resident originated prescribing unit)
- Percentage of prescribed items as repeat dispensing
- All practices to achieve a target of 2 ADQ (average daily quantity) per STAR-PU or reduce prescribing of benzodiazepines by 5%
- 4 Drugs post Myocardial Infarction

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Lack of engagement from General Practitioners and secondary care clinicians | Develop effective communication strategies via the formal groups including the 5 localities |
| Drug tariff fluctuations | Monitor prescribing and prescribing costs |
| New drugs / drugs approved by National Institute for Health & Clinical Excellence / high cost drugs | Engage with London Pain Consortium formally and include them in the consultation process |
| Lack of support / procurement expertise | Utilisation of regional procurement expertise |
| Challenge to new supply models from community pharmacy representatives | Carry out horizon scanning exercise |
| Lack of medicines management resource | Review areas of work and priorities |
| Lack of regional engagement | Heads of Medicines Management to liaise with Chief Pharmacists and those employed within current regional structures. |
| Lag time between initial drug investment (prescribing) and long term therapeutic outcomes | Identify quick wins from prescribing savings to compensate initial investments that will deliver longer term improvements in patient care and release resources |
| Lack of resources within secondary care pharmacy and associated disciplines to support transfer of prescribing responsibilities | Lease with secondary care leads to ensure that priority areas are addressed |
| Lack of engagement of community pharmacy in the NMS (new medicine service) | Appointment of community pharmacy mentor (time limited to support the roll out of the service locally) |
| Lack of engagement of community pharmacy in targeted MURs (medicine use reviews) | Develop medicines management action plans that include the ability to respond to change and to evolve to meet ongoing needs |
| Challenge from community pharmacy representatives relating to provision MDS (minimum data set) | Utilise formal communication channels with secondary care |

**Communications Implications**

- Communication strategy required with all key stakeholders

**Estates Implications**

- Minimal

**Workforce Implications**

- Limited medicines management resource to deliver objectives
- Additional resource required to provide new services

**Informatics Implications**

- Monitoring of action plans

# CARE OF SICK AND INJURED CHILDREN

## Why is change needed?

- Changing nature of childhood illness, fewer children need inpatient stay
- High proportion of zero length of stay
- Underutilisation of paediatric inpatient capacity
- European working time directive will impact on sustainability of medical cover

## Objective

Reform services for **acutely sick & injured children**, moving to integrated, high quality, 24/7 services, with increased emphasis on care outside hospital working with viable inpatient units

## How do we want the future to look and what are the transitional issues?

- Streamlined, integrated 24/7 services for sick & injured children, increased emphasis on care outside hospital
- Reconfigured paediatric services to provide high quality, well utilised inpatient facilities and locally accessible consultant led assessment and short stay facilities; enhanced children's community nursing teams
- Continued good access to high quality tertiary paediatric services

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| Enhance services provided by Children's Community Nursing Teams to include care of acutely sick and injured children and with extended hours (evenings and weekend working). Evaluate the ongoing testing of the revised Children's Community Nursing Team model in Sunderland and use the evaluation to inform future development of services. | | | | | | |
| Subject to public consultation, implement the agreed paediatric emergency pathway; including children's assessment and short stay services. | | | | | | |
| Implement a contract variation to extend the role of Walk-in-centres and Minor Injury Units to include assessment and treatment of children under two years of age. | | | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Headline Measures**

- 

**Supporting Measures**

- 

**Local Measures**

- Hospital admissions for deliberate and unintentional injuries to children, per 100,000 populations

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Working with providers for development of services | Having clear communication with both commissioners and providers regarding appropriate levels of service |
| Provider engagement | Development of comprehensive, accurate and easily accessible information widely available so that public can make informed view. Clinicians will be at forefront of public consultation |
| Financial pressures | |

### Communications Implications

- Ongoing communication with parents and young people accessing services
- Communication in relation to public consultation re paediatric emergency pathway
- Change existing information in relation to Minor Injuries Unit and Walk In Centres offering services to all ages e.g. in Choose Well leaflets
- Effective collaboration with all stakeholders to ensure continued delivery of high quality and safe urgent care services across the three health localities.

### Informatics Implications

- Sharing information re referral pathways to all agencies / health professionals for child health
- Data capture of public consultation re paediatric emergency pathway
- Work towards more integrated IT records so the right information is available at the right time
- Production of performance data (activity and outcome) from Walk In Centre and Minor Injuries Unit
- Evaluation of 'Choose Well' initiative

### Estates Implications

- Potential changes to paediatric emergency pathway; including children's assessment and short stay services
- Minor Injuries Unit and Walk In Centres offering services to all ages

### Workforce Implications

- Training programme in Minor Injuries Unit for additional competencies
- Implications following review of Children's Community Nurses
- Increased skills and training for all front line staff

# CHILDRENS and MATERNITY

## Why is change needed?

- Child health is significant predictor of life expectancy & health in later life
- Higher numbers of unnecessary hospital admission
- The integration agenda requires a review of therapy services – remodelling to meet need

## Objective

Provide high quality integrated **child health and maternity services**

## How do we want the future to look and what are the transitional issues?

- All children to receive regular health checks with appropriate referral to services as required
- Therapy services available to all children who require them
- Process in place for identification & management of high risk women
- Work across Children's services requires development to ensure early identification is effective within the broad range of children's services. This approach is reliant on integrated and coordinated pathways of care for children and families with additional needs
- Integrated and coordinated pathways of care to ensure early support for families with additional needs across midwifery, health visiting, children's centre's and family support

## What are we doing about it?

| Project Gantt Chart | 2012/13 | | | | £k | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | + * | - * |
| **Childrens** | | | | | | |
| Implement the recommendations from the review of Speech, Language and Communications needs. Working in partnership to ensure the model is sustainable. | | | | | | |
| Review Children's Community Nurses (CCNs) and palliative care for children in line with requirements set out in Aiming High for Disabled Children. | | | | | | |
| Review services specifications for community based children services and maternity against existing evidence base. Identify opportunities for innovative practice. | | | | | | |
| Review school nursing services to ensure all key elements of the Healthy Child Programme 5-19 years are delivered and key outcomes are achieved. | | | | | | |
| Ensure compliance with NHS SOTW strategy, policies and procedures for Safeguarding Adults and Children. | | | | | | |
| Implement recommendations from the Care Quality Commission and Ofsted (office for standards in education) joint inspections. | | | | | | |
| Review occupational therapy and physiotherapy services for children and young people and consider future commissioning intentions. | | | | | | |
| Ensure increased focus on short breaks for young carers and parents of children with disabilities. | | | | | | |
| Review the implications for new national tariff for children's diabetes. | | | | | | |
| **Maternity** | | | | | | |
| Review pathways for families with additional needs with a view for develop an integrated pathway with children's services. | | | | | | |
| As part of the programme to develop integrated pathways of care for high risk women; To implement a restricted pilot to measure the impact of an additional home visits from community midwifery team at 16 weeks gestation, to undertake a comprehensive family needs assessment and review the outcome. To consider future commissioning intensions. | | | | | | |
| To explore the options available to deliver a community based rapid response service to reduce the numbers of unplanned admissions during pregnancy. | | | | | | |
| Review newborn screening pathways including assessment of Any Qualified Provider impact on audiology | | | | | | |

* +£k = Investment; -£k = Disinvestment

## What Key Performance Indicators will we use to monitor progress?

**Supporting Measures**

- 12 week maternity appointments
- Prevalence of breastfeeding at 6-8 weeks
- Coverage of breastfeeding at 6-8 weeks

**Local Measures**

- Under 18 conception rates
- Childhood immunisation rates aged 1 (DTaP/IPV/Hib) Diphtheria, Tetanus, Pertussis (whooping cough), polio (with Inactivated Polio Vaccine) and Haemophilus influenzae type b
- Childhood immunisation rates aged 2 (PCV) positive crankcase ventilation, (Hib/MenC) Haemophilus influenzae type b Meningococcal group C meningitis , (MMR) measles, mumps and rubella
- Childhood immunisation rates aged 5 (DTaP/IPV) Diphtheria, Tetanus, Pertussis (whooping cough), polio and Haemophilus influenzae type b, (MMR) measles, mumps and rubella
- Childhood immunisation rates aged 12-13 years (HPV) human papilloma virus
- Childhood immunisation rates ages 13-18 years (DTaP booster) diphtheria, tetanus, and pertussis
- Childhood obesity rates – reception and year 6
- Percentage of children living in poverty (age <16 years) (Local Authority measure)

## Implications, Risks and Mitigating Actions

| Risks | Mitigating Actions |
|---|---|
| Changes to child health service provision across the borough (preventative service) may result in an adverse impact on medium to long term outcomes | Discussions with children's leads x 3 and respective Local Authority to determine the impact of the Comprehensive Spending Review in relation to child health services and identify opportunities for joint commissioning |
| Provider IT system not able to report outcome measures required to demonstrate performance against healthy child programme. | Development of comprehensive, accurate and easily accessible information widely available so that public can make informed view. Clinicians will be at forefront of public consultation |
| Changes to child health service provision across the borough (preventative services) may result in adverse impact on medium to long term outcome | Discussions with children's leads x 3 and respective Local Authority to determine the impact of the Comprehensive Spending Review in relation to child health services and identify opportunities for joint commissioning |
| Provider IT system not able to report outcome measures required to demonstrate performance against healthy child programme. | Development of comprehensive, accurate and easily accessible information widely available so that public can make informed view. Clinicians will be at forefront of public consultation |

### Communications Implications

- No specific implications have been identify

### Informatics Implications

- Monitor compliance with NHS SOTW Safeguarding Adults and Children strategy, policies and procedure
- Define minimum data sets for new community child health contracts
- Sharing information re referral pathways to all agencies / health professionals for child health
- Effects of pathway redesign in relation to high risk behaviours and lifestyle issues

### Estates Implications

- Potential changes to occupational therapy and physiotherapy services for children and young people

### Workforce Implications

- No specific implications have been identify

## 4.5 Impact of our strategy on the market

**Impact of our plan on acute services**

**Why is change needed?**

- Levels of hospital activity exceed current contract levels;
- Financial context (reduced growth in NHS funding) including the national changes in 2012/13 tariff and the local requirement to generate savings to fund health improvement programmes;
- Fragmentation and lack of integration of current services across acute, community and primary care services.

**What will the acute sector look like in the future?**

- Safe, high quality care which is consistently delivered and routinely evidenced through commissioning mechanisms;
- Reduced admissions as more care available closer to patients homes; with routine treatment increasingly provided in primary and community settings;
- Greater internal efficiency achieved through reduction in overheads to cope with changes in tariff, impact of local resource releasing initiatives and better integration and streamlining across care pathways.

**How will we ensure this happens?**

- Services commissioned based on best clinical evidence available; in line with NHS Quality improvement framework using relevant standards and best use of available levers to maximise outcomes for local people;
- Use of incentives implemented via CQUIN and agreed NE wide penalties in contracts;
- Additional reablement funding targeted at preventing admissions and speeding up discharge.

**Impact of our plan on the mental health and learning disabilities sector**

**Why is change needed?**

- Ageing population will increase numbers of people with dementia;
- Variable access to adult and children's mental health services;
- Complicated care pathways restrict appropriate access to relevant, timely interventions.

**What will the acute sector look like in the future?**

- New model of care with integrated pathways across sectors with all partners working in collaboration will deliver personalised holistic care for patients and their carers and drive increased productivity and efficiency through greater integration and streamlining;
- Re-provision of Sunderland inpatient services will provide highly specialist care only;
- Strengthened community teams able to provide breadth of early interventions and services to patients in the community.

**How will we ensure this happens?**

- Building effective partnerships as model of care addresses 'whole-system' in particular interface issues between sectors and organisations;
- Improved information systems and data collection and data sharing across pathways and sectors;
- Joint collaborative commissioning arrangements with partners will ensure new model is implemented to planned timetable;
- Inclusion in contract specifications of meaningful personalised outcome measures for service- users.

**Impact of our plan on primary and community care**

**Why is change needed?**

- Need capacity and capability to respond to increasing elderly population and shift of activity out of hospital;
- Variation in quality, outcomes, patient experience and type of care offered;
- Major health problems and stark health inequalities across Sunderland.

**What will the acute sector look like in the future?**

- Standardisation of provision;
- Increased identification of people with risk factors in early stages of disease;
- Optimum treatment pathways with standardised care consistently provided by all GP Practices.

**How will we ensure this happens?**

- Ensuring a multi disciplinary approach where appropriate to enable a holistic approach to care planning;
- Consistent standard application of optimum pathways in primary care resulting in a reduction in clinical variation;
- Procurement / contracting to drive up quality through CQUIN and incentivising preventative schemes;
- Commission specialist community services to provide urgent and planned care at home or in the community.

# Section 5 – Delivery and Transition

## 5.1 Organisational Development

### 5.1.1 Organisational Development Plan

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people; it is often termed as the "oil that keeps the engine going". We fully embrace this philosophy and concept of continuous improvement and development; the Executive Committee agree that this strategic approach is critical at a time when we, and the wider NHS, are undergoing such extensive and wide ranging change.

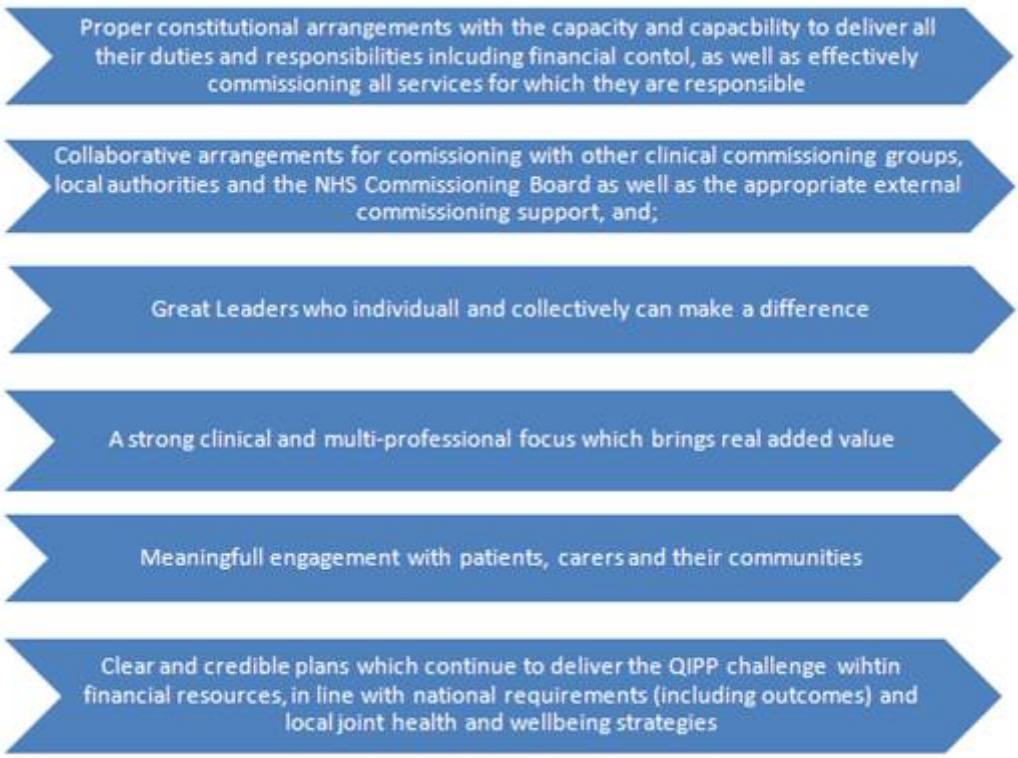
An Organisational Development Plan has been developed in order to:

- Support the delivery of this Commissioning Plan including the delivery of our vision, high level goals and objectives in order to improve health outcomes;
- Enable the Executive Committee to mature and expand its knowledge and expertise on its journey towards authorisation and beyond;
- Achieve authorisation by October 2012;
- Ensure that the actions we take in the shorter term support delivery of our longer term objectives;
- Ensure that the organisational enablers for delivery are in place and being progressed;
- Be refreshed regularly as different needs are identified by the Executive Committee and as national requirements change.

As a clinically led organisation, we will add value and build upon the current NHS South of Tyne and Wear Integrated and Strategic Operational Plan (ISOP). We are working closely with the PCT to ensure effective knowledge transfer prior to and beyond April 2013.

### 5.1.2 Development of the Executive Committee

A key milestone in the development of the Executive Committee is to achieve authorisation by October 2012. The national self assessment diagnostic tool was utilised to initially assess our current baseline position against the six domains noted below for effective clinically led commissioning organisations:




Each member of the Executive Committee completed the Price Waterhouse Cooper diagnostic tool, followed by a Board dialogue to test assumptions, challenge perceptions and agree the current state of our organisational health and the key areas for development. From this, a composite report was produced which the Board agreed was a true picture of the current state.

This baseline position formed the basis of the Organisational Development Plan; twelve high level objectives were identified for development incorporating the areas for improvement in relation to each of the six domains. The objectives were prioritised and milestones with agreed timelines agreed for implementation. As a result a critical path for development was established with nominated Board leads.

The table in *Appendix 4* highlights our twelve development objectives mapped to the six domain areas (each objective supports delivery of at least two domains thereby adding value); the detail actions are identified within the Organisational Development Plan.

### 5.1.3 Primary Care involvement in the CCG

Harnessing the added value of clinical input from primary care is key to delivering our vision in terms of improving quality, stimulating innovation and ensuring value for money. We need to encourage awareness, engagement and ultimately ownership of commissioning decisions and in the delivery of our objectives and initiatives.

To enhance communication between the Executive Committee and constituent practices, five Board Locality Links have been established (reflecting the five regeneration areas in Sunderland). A structured approach to engagement has been agreed via 'Time In Time Out' events and locality meetings: the remit of the Locality Groups is to provide a:

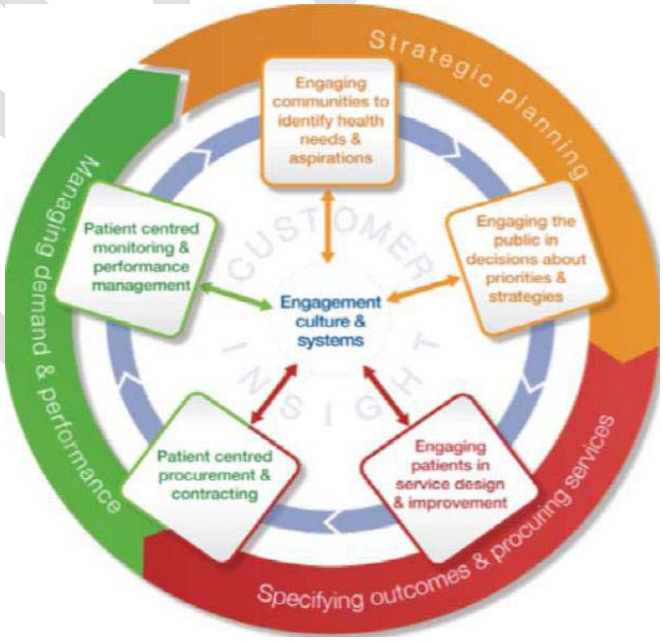
- Two-way communication between practices and the Board;
- Robust mechanism for practice involvement in commissioning;
- Mechanism for the delivery of the Commissioning Plan objectives and initiatives i.e. clinical variation, prescribing;
- Forum to consider local developments e.g. Primary Care Centres;
- Support delivery of the Local Incentive Scheme (LIS) and QoF QP indicators;
- Forum to share good practice and encourage innovation;
- Effective Public and Patient Involvement mechanisms within the localities;
- Educational programme as part of 'Time In Time Out' programme.

## 5.2 Joint working and involvement

### 5.2.1 Patients and public involvement

We are committed to excellent patient care and it is essential that strong communication and relationships are developed with our patient population in order that local people are meaningfully involved in the development and implementation of our vision, values, objectives and initiatives. It is vital that patients are actively engaged in shaping the planning and delivery of local services in order to ensure that their needs and wants are met, and that healthcare is accessible and responsive to their views and experiences. We have a unique position in that we communicate with patients on a daily basis and welcome the opportunity to harness this experience in order to develop strong and effective ties with communities.

The following diagram illustrates how effective community engagement will inform all aspects of our commissioning, from detailed planning (identifying health needs and identifying priorities) to commissioning services (service redesign and identifying outcomes in specification) through to managing performance.




Patient experience information is critical to informing quality improvement initiatives as well as contributing to the monitoring of existing providers. We will be able to demonstrate that we have made improvements as a result of feedback from patients and the public.

To drive this agenda forward, we have appointed two Executive Leads who will actively develop a range of patient and public involvement mechanisms, working closely with a dedicated public involvement officer with experience in developing effective communication methods and also accessing existing partner engagement mechanisms.

Our patient and public involvement draft strategy and engagement strategy sets out the mechanisms we will use to continue to strengthen and co-ordinate this core process including communications, social marketing, community engagement, patient involvement and Local Involvement Networks. The engagement and involvement mechanisms are illustrated in the following diagram:

### 5.2.2 Working with partners and stakeholders

We are proactively engaging with the wide range of local partners including local authorities, business community and voluntary sector, clinicians and patients/carers to ensure our plans reflect local need and that partners play a key role in change for local people. The strength of partnership activity and collaboration is critical to delivery of the transformation we have described in this Plan and is a key strand of our ongoing OD activity.

We recognise that there are many stakeholders and partners with whom we need to engage over time and in a variety of ways. We agreed a draft Communication and Engagement Strategy in November 2011 which set out key objectives to support effective engagement and communication, including reputation management. The first key action progessed in January 2012 was a formal and systemic stakeholder mapping exercise together with a review regarding how best to effectively manage communications with the various stakeholders (acknowledging that we will need to utilise a range of communication mechanisms). This mapping informed our consultation process on this commissioning plan.

Furthermore, a communication programme supported the effective engagement of this Commissioning Plan with partners and stakeholders between January and March 2012. This will complement the engagement plan for the public, patients and practices; activities of which include:

- Executive Committee members meeting key stakeholders to update on the development of the Plan;
- Draft Plan being available on the public and practice websites;
- Opportunity for discussion at Local Engagement Board meetings with the public and also at Local Overview and Scrutiny Committee;
- Accessing LINK and utilising the Voluntary Sector and Local Authority mechanisms to share information with the public;
- Event with key stakeholders attended by the local providers, local authority and the PCT Board.

### 5.2.3 Health and Well Being Boards

The Sunderland Health and Well Being Board was established as an early implementer site in April 2011. We are represented at the Board by our Chair and Governance Leads. We have established clear communications between the Board and the CCG Executive and Pathfinder Committee.

As part of the work programme of the Health and Well Being Board, we have consulted on developments including:

- 2012/13 Sunderland CCG and PCT Commissioning intentions;
- Regular updates regarding the development of the CCG including development of this plan, the CCG authorisation process and alignment with Sunderland regeneration areas.

We also continue to participate in a number of developments including:

- Delivery of the refreshed JSNA which includes a broad range of health determinants (members of the CCG have input into specific aspects of the JSNA including tobacco, alcohol, long term conditions, cancer);
- Development of the Sunderland Health and Wellbeing Strategy;
- A review of all current joint commissioning arrangements (including Alcohol, Drugs, Mental Health, linked health and social care commissioning for adults and children);
- Development of the local HealthWatch.

We acknowledge the importance of joint working with the Health and Well Being Board and recognise the synergies to be gained in enhanced health outcomes through both the alignment and integration of commissioning plans.

## 5.3 Delivery of safe high quality care

### 5.3.1 Ensuring quality and improved outcomes

Our success will be measured by the NHS Commissioning Board against the Commissioning Outcomes Framework which reflects the prioities set out in the NHS Outcomes Framework. The five domains of the outcomes framework are derived from the three part definition of quality, namely effectiveness of care, patient experience and patient safety.

We are committed to delivering quality improvement across the three areas of quality. As an organisation we will ensure truly clinically led commissioning, ensuring quality and outcomes drive everything we do, the following are examples of initiatives we will lead in 2012/13:

**Safety**

- Healthcare aquired infections - Lead an approach with NHS providers to monitor performance against infection control targets including MRSA, C difficle, MSSA and eColi across the health community and to facilitate shared learning and best practice in order to improve outcomes for patients.

- Safeguarding - Work in partnership with the Local Authority and other relevant organisations to ensure that our statutory duties regarding the health and well-being of looked after children are met. We will lead on safeguarding adults and interpret and implement emerging statutory responsibilities across the health economy.

- Safety systems – Maintain systems to manage serious incidents and incidents as appropriate and identify themes and trends to inform quality improvements. We are actively promoting incident reporting in primary care.

**Clinical effectiveness**

- Establish a systematic process to review published guidance and ensure these are used in pathway / service reform and reviews. Analysis of published audits and data will be used to secure assurance identifying and addressing unwarranted clinical variation.

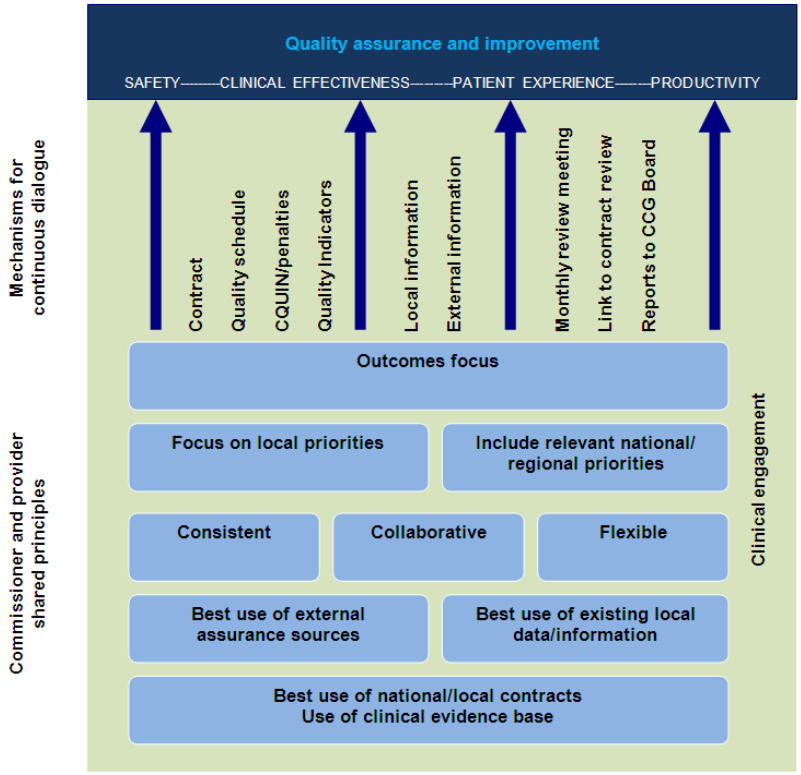
**Patient experience**

- Review published patient experience information and locally collated patient experience information to provide assurance and identify areas for quality improvement. We will feedback to patients and the public how the information has been used and the improvements made as a result.

## 5.3.2 Quality assurance and improvement in commissioned services

The following diagram highlights the range of activities which collectively provide assurance of the quality of commissioned services.

**Commissioning for Quality**




Examples to the range of actions we are taking include:

- Develop and maintain relationships with providers to ensure continuous dialogue on quality;
- Secure and use quality assurance information from a broad range of sources both external and local;
- Identify areas for improvement, respond to areas of concern in relation to quality and monitor accordingly;
- Maximise use of contractual levers to secure quality improvement e.g use of quality indicators and Commissioning for Quality and Innovation (CQUIN) schemes;
- Promote the implementation of national guidance and standards with all providers;
- Work with associate/lead commissioners, including local authority, to maximise quality assurance/improvement in commissioned services;
- Summarise quality assurance reports to CCG Board as the accountable body.

## 5.4 Enablers of delivery

### 5.4.1 Workforce

Developing and remodelling the workforce is critical to the delivery of our Plan to ensure that we have a workforce that is fit for purpose, working flexibly across boundaries in integrated pathways to provide patient centred quality care. As part of the development of the programmes of initiatives, a number of generic workforce requirements have been identified, including the need to:

- Build capacity and capability to provide the skills to improve health and deliver the new types of services required;
- Enable the effective transfer of services from acute to primary / community settings through development of skills to support integrated care delivery within pathways and across organisational boundaries;
- Develop a broader skills base in all sectors of the generic workforce to deliver health improvement messages routinely within care delivery i.e. every contact is health improvement opportunity;
- Develop robust and meaningful workforce productivity and assurance measures (including the 9 national assurance key lines of enquiry) with early emphasis on community services;
- Support recruitment in specific disciplines, including health visitors, through reform of the existing shape of the workforce, given that the current age profile indicates that a proportion of staff will be retiring in the next five years.

The PCT ISOP indicates for the local health economy to achieve financial balance the system needs to demonstrate an increase of 2.5% in productivity. With regards to workforce, local FT's are identying areas where paybill savings can be achieved including:

- Reductions in mean sickness absence rate;
- Reduction in temporary staffing, agency costs and reduction in the use of overtime;
- Reviewing skill mixing and re-profiling vacant posts;
- Reviewing terms and conditions of employment, pay and incremental progression;
- Efficiency savings out of none workforce areas, e.g. estates, day case and medicines costs.

### 5.4.2 Informatics

Informatics will underpin our organisations business strategy, however, we will also need to consider the dimensions of Commissioning and the Local Health Community. The Informatics dimensions for CCG can be described by the following diagram:


Organisation - We will need to put in place appropriate informatics provision in order to operate as an organisation which will depend on variables such as:

- Information flows in and out of the CCG;
- Functions the CCG will perform in house or externally;
- Collaborative working requirements;
- Fixed, mobile and agile workers.

Commissioning – We will ensure consideration of informatics requirements and information flows are built into the design of service specifications so that providers are clear on what they are to deliver and how, and to maximise opportunities to drive forward improvements and efficiencies in patient care through the use of technology.

Services and pathways identified for focus in 2012/13 include:-

- Revised model for the provision of Diabetes Service;
- Re-provision of inpatient, outpatient and community services;
- Review of joint urgent care service provision;
- Health economy approach to the prescribing and management of medicines;
- Review of dermatology service;
- Development of community-based services including cellulitis, deep veined thrombosis, INR and arrhythmia;
- Review of COPD pathway.

Local Health Community - We will initiate, plan and deliver cross organisation informatics programmes with information governance assurance and confirmation that the strategies of partner organisations will meet local informatics requirements. These include:

- Healthlinxx - a common network infrastructure for the Local Health Community (LHC), enabling greater cooperation and collaboration between health professionals for the benefit of patients;
- EMIS Web;
- GP integrated working across Minor Injury Units;
- Electronic discharge communications, – information flows between primary and secondary care;
- Telehealth – utilisation of technology available to support self care for patients with long term conditions, enabling more integrated care pathways across providers and social care, increasing patient confidence in their ability to manage their condition;
- GPs working in A&E department to develop appropriate admission / attendance avoidance pathways.

A data quality framework within primary care will be developed to improve the quality of data held on GP clinical systems as practice data forms the nucleus of clinical records.

We will consider the informatics expertise and knowledge required to deliver the 3 informatics dimensions and oversee the governance responsibilities across the health community by establishing an Informatics Group, chaired by an Executive Committee Member. The Informatics support will be purchased rather than directly provided. This is likely to be from the North East Commissioning Support in the first instance, subject to review.

National standards for information sharing and requirements for data on local service delivery will be understood and incorporated into all points of the commissioning cycle, ensuring the availability of data in a compatible format for business intelligence, analysis and interpretation purposes, building a picture for future commissioning priorities.

Projects relating to the roll out of national informatics priorities such as 111, GP out of hours, Choose & Book, Electronic Prescription Service release 2, GP2GP record transfer, Summary Care Record, NHS Number and GPSOC will be initiated, planned and delivered, with risk escalation and assurance that the strategies of partner organizations will meet national informatics expectations. We will support new ways of working will be supported using the standards defined within the national Interoperability Toolkit.

## 5.5 North East Commissioning Support

The shared operating model noted that Clinical Commissioning Groups should be involved in the development of the commissioning support that will help them to achieve their objectives. Commissioning support will be needed to help CCGs to achieve their objectives, give the CCGs the information and support they need to take effective decisions and make them into a reality. We have considered the issue of 'Do, Buy or Share' and have decided we wish to provide most of the support ourselves, to share some support with other CCG's and to purchase back office / transactional services from the North East Commissioning Support.

As a large CCG, we are able to directly provide key commissioning support and whilst we appreciate the risks (predominately availability of staff), consider the benefits to outweigh the risks. This approach gives the benefit fr enabling the CCG to have direct control of key functions to support delivery of statutory responsibilities; however this will be kept under review as we develop.

We are actively involved in shaping the development of North East Commissioning Support including responding to the initial offer outlined in the Prospectus in January 2012, informing the preparation of its Outline Business Plan in March and Final Business Plan in August 2012.

## 5.6 Proactive Management of Risks

### 5.6.1 Financial Risks

We have identified the very high level financial risks which could destabilise our plans, namely:

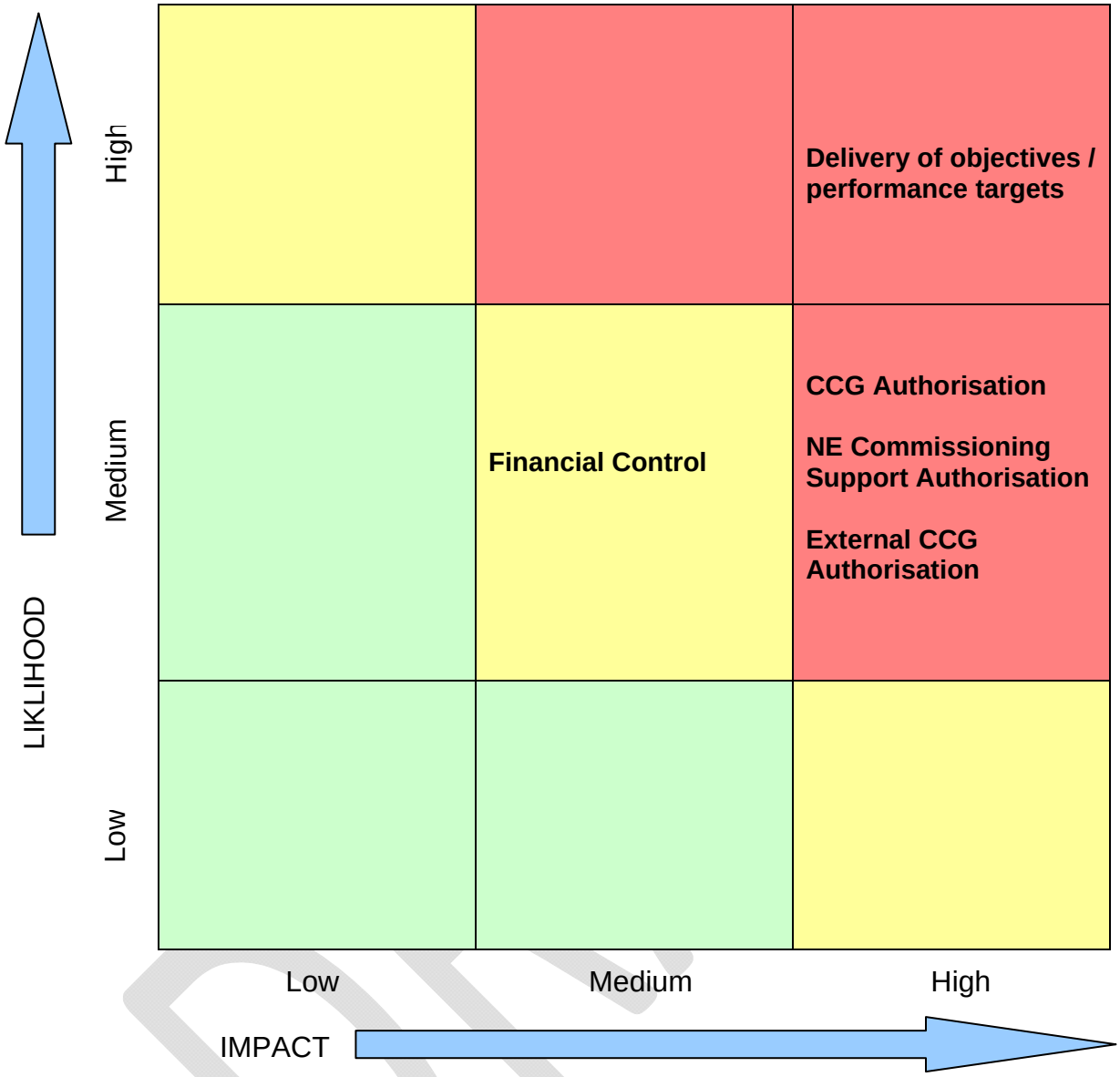
- Underachievement of the savings planned from our resource releasing initiatives;
- Under realisation of the savings expected from the reduced national tariffs if local provider Trusts work to recoup those reductions through technical adjustments to contract charges rather than through true efficiency improvements;
- Increases in hospital activity, over and above those levels set in this Plan;
- Increases in either volume or price of prescribing, over and above what is included in this Plan.

If financial pressures materialise, we would initially make use of the contingencies provided in our financial plan; then we would revisit our balance of investments / disinvestments using our local prioritisation process (assessment of impact and feasibility together with cost).

## 5.6.2 System Risks

The risks to delivery of the Plan have been systematically identified and quantified for all of the investment and disinvestment initiatives as part of the planning process, using an assessment of likelihood and impact. A moderation exercise then reviewed the risks to ensure comparability and validity. This is an ongoing and evolving process which will be regularly reviewed and updated as both sets of initiatives are implemented and evaluated and also as new evidence becomes available.

From the detailed analysis underpinning these high level risks, a number of cross-cutting risks to delivery have been identified, which predominately reflect the impact of undertaking system wide transformational change in the short to medium term. These have been assessed for impact and likelihood and are plotted on the following chart.


LIKLIHOOD
High
Medium
Low
Delivery of objectives / performance targets
Financial Control
CCG Authorisation
NE Commissioning Support Authorisation
External CCG Authorisation
Low
Medium
High
IMPACT

The risk log below outlines mitigating actions to reduce impact and likelihood for each of the cross cutting risks and is ranked by severity.

## RISK LOG

| **Failure to deliver strategic objectives and performance targets**<br>***Impact - HIgh, Likelihood – high*** | |
|---|---|
| **Delivery risk**<br>▪ Underperformance against key targets during 2011/12. High risk - C diff, A&E 4 hour wait at City Hospitals<br>▪ Planned actions do not deliver intended impact<br>▪ Lack of capacity within PCT / CCG to support delivery | **Mitigating action**<br>▪ Integrated plans include assessment of risks and mitigating actions<br>▪ Legally binding contracts include levers / penalties to manage activity and deliver performance targets<br>▪ Menu of actions agreed with practices to manage activity - better identification and management of high risk patients, referral standard and work with nursing home<br>▪ Alignment of staff Phase 2<br>▪ 5 locality practice managers and practice nurses plus a Board nurse appointed |

| **CCG fail to achieve full authorisation by October 2012**<br>***Impact – HIgh, Likelihood – Medium*** | |
|---|---|
| **Delivery risk**<br>▪ Failure to meet pre-application, application, NHS CB assessment<br>▪ ISOP is not signed off by NE SHA – impact on CCG commissioning plan<br>▪ Capacity within the CCG to deliver breadth of agenda<br>▪ Failure by NE Commissioning Support to achieve Authorisation within timescales<br>▪ Failure to resolve the Do;Buy:Share option for commissioning support | **Mitigating action**<br>▪ Developing knowledge and expertise – OD Plan<br>▪ Commissioning Plan – vision, objectives, initiatives, finance etc<br>▪ Governance - scheme of delegation<br>▪ Dedicated support - Interim Accountable Officer, DOF, CDU, PCT support<br>▪ Development of NE Commissioning Support build upon identification of CCG customer requirements with engagement in the production of the business plan<br>▪ Work on Do;Buy; Share model is underway |

| Failure of NE Commissioning Support to achieve authorisation<br>*Impact – High, Likelihood - Medium* | |
|---|---|
| **Delivery risk**<br>▪ Outline Business Plan not approved at Checkpoint 2<br>▪ CCG do not wish to buy full commissioning support – insufficient critical mass<br>▪ Transition of four PCT Clusters into one commissioning support organisation<br>▪ Loss of key staff as a result of uncertainty | **Mitigating action**<br>▪ Dedicated resource - Interim Management Team appointed<br>▪ Detailed project planning<br>▪ Continuing dialogue with CCG including sharing of service line specifications |

| Failure of authorisation of neighbouring CCG's<br>*Impact – High, Likelihood – High* | |
|---|---|
| **Delivery risks**<br>▪ Potential additional commissioning responsibilities<br>▪ Impact on authorization | **Mitigating actions**<br>▪ Relationships with neighbouring CCG Chairs and support from LMC's |

| Failure to meet control total and deliver financial balance and QIPP savings<br>*Impact – Medium, Likelihood –Medium* | |
|---|---|
| **Delivery risks**<br>▪ PCT allocations only 2012/13 - future plans based on CSR assumptions<br>▪ Tight control totals reduce flexibility<br>▪ Ability to manage/control secondary care demand and financial impact<br>▪ RRIs deliver planned level of savings | **Mitigating actions**<br>▪ Detailed financial planning identifies range of risks and contingencies<br>▪ Additional reablement funding to prevent admissions and speed up discharge<br>▪ Extend QIPP initiatives to generate further schemes to release efficiencies<br>▪ Contingency fund |

## 5.7 Governance

We are clearly mindful of the need to have in place effective governance arrangements as set out in the guidance issued by the Department of Health "Towards establishment: Creating responsive and accountable clinical commissioning groups" and the associated documents. A significant amount of work has already been undertaken to ensure that we have effective and robust governance arrangements in place, pending finalisation of the national guidance. These arrangements address our "internal" working arrangements and delegated authority from the PCT Board to the Clinical Commissioning Pathfinder Committee during the transition period, in the lead up to the CCG authorisation as a statutory body in its own right.

Whilst the PCT Board continues to be accountable for ensuring that it discharges its statutory duties for the commissioning of healthcare, governance arrangements have been put in place between the CCG and the PCT which provide for an accountability framework under which the Clinical Commissioning Pathfinder Committee operates as a committee of the PCT Board under delegated authority during the transition period and until such time as the CCG is authorised and becomes a statutory organisation. Specifically, detailed terms of reference are in place governing the CCG's role as a committee of the PCT Board together with a detailed Scheme of Delegation with timescales setting out details of the functions for commissioning of healthcare, for which the CCG is assuming responsibility including 100% of the delegated budget for the CCG.

The Clinical Commissioning Pathfinder Committee meets monthly and consists of elected and appointed members of the Executive Committee, and executive and non-executive representatives of the PCT. The agenda is structured such that a range of strategic, quality, performance and assurance matters are discussed and action is taken in keeping with our delegated authority.

Resulting from the greater delegation of responsibility to the CCG, revisions have also been made to the committee structure of the PCT such that the CCG assumes responsibility for the functions of some of its committees on behalf of the PCT or alternatively attends the respective PCT committee. For example, the Quality, Patient Safety and Clinical Governance Committee has been re-established as a sub-committee of the Clinical Commissioning Pathfinder Committee. In relation to the Audit Committee, it has been

agreed that it continues to meet and report directly to the PCT Board. However, in recognition of the need to demonstrate a detailed understanding of the role of the Audit Committee in terms of its scrutiny of systems of internal control, the CCG Chair or representative have been invited to attend the Audit Committee.

Underpinning all of this work is the our commitment to the Nolan principles of openness, accountability and transparency; with these principles in mind, we have adopted a Conflicts of Interest policy which all Clinical Commissioning Pathfinder Committee members have signed up to. As part of our journey towards authorisation, we are developing, in parallel with our Organisational Development Plan, a Governance Development Plan which takes into account the work of the National Leadership Council and the national Governance Framework for CCGs in supporting them with the development of their governance arrangements. Using this framework, we are developing effective governance and assurance arrangements which will be necessary in the short and longer term to meet our statutory responsibilities. This work has also been supported by an externally facilitated development session for the CCG dealing with governance and risk.

We are in process of producing a Constitution which will be in line with the national template when produced. In addition to setting out the arrangements for the governing body and how it will discharge its functions including arrangements for transparency about its decisions, the Constitution will also regulate the relationship between the Member Practices within the CCG and the elected members. In the interim Member Practice Agreements are in place with each Member Practice who have nominated a lead GP with regard to the Clinical commissioning group.

As well as the role of member practices in development of the Commissioning Plan it is important that we engage with all member practices in development of our plans and priorities on a continuing basis. Dialogue is indeed taking place at locality level with member practices and they have been engaged in development of Commissioning Intentions for the coming year, peer review work as well as engaging their views in areas of reform. In addition to engagement with member practices we have also involved other key stakeholders including the Health and Wellbeing Board in the development of our commissioning plans.

We continue to develop our proposed structure and governance arrangements to be in place for authorisation, and will re-align our interim pathfinder arrangements towards those over the coming period.

# Section 6 – Equality Impact Analysis (Assessment)

In accordance with our equality duties, an Equality Impact Assessment was carried out on the PCT five year Strategic Plan and the supporting integrated plans. As a result of the Equality Act 2010 we have updated this by undertaking an Equality Impact Analysis on this CCG Commissioning plan. There is no evidence to suggest that the plan has an adverse impact in relation to race, disability, gender, age, gender reassignment, marriage and civil partnership, pregnancy and maternity, sexual orientation, religion and belief or infringe individuals' human rights. The plan is accessible to everyone regardless of age, disability, race, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health.

Throughout the development of the plan, we have sought to promote equality, human rights and tackle health inequalities. This has been through carrying out health needs assessments, life-style surveys, publication of the Single Equality Scheme, equality impact assessments and analysis and involving partners, stakeholders and local communities in the design, planning and development of services. In addition to their involvement in agreeing our gradings of the Equality Delivery System and identifying our equality development objectives which will be published by 31 March 2012. Full Equality Impact Analysis scoping will continue to take place on each programme of work to ensure that the needs of all local communities are fully reflected in the design, planning, implementation and evaluation of services.

# Section 7 – Declaration of Approval from Pathfinder Committee

This commissioning plan is to be reviewed by the Pathfinder Committee on 17th April 2012. The plan reflects a point in time and will continue to evolve to reflect the requirements of the authorisation process going forward.

# Appendix 1 – Prioritisation Exercise

| | CRITERIA | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Impact of change | | | | | | Do-ability of change | | | | | £ |
| **LONG LISTED 2012/13 CHANGES** | Improves health | Reduces inequalities | Safer / more effective | Improves access / choice | Improves productivity | **Total Impact Score** | Has local GP support | Has other local support | Infrastructure is in place | CCG clinical lead in place | **Total do-ability score** | Short term £ impact Cost(+) Saves(-) neutral(0) |
| Reduce outpatient first attendances and follow up (QIPP) 'Exploring variation in outpatient referrals' | | | | ✓ | ✓ | **2** | | | | | **0** | **-** |
| Where appropriate, transfer some diagnostic test activity out of secondary care. Consider opening up CT and MRI access to primary care to reduce unnecessary referrals | | ✓ | | ✓ | | **2** | ✓ | ✓ | | | **2** | **+** |
| Review Dermatology Services with a view to aligning the service model with services commissioned for Gateshead and Sunderland (QIPP) | | ✓ | | ✓ | ✓ | **3** | ✓ | | | | **1** | **-** |
| Review nurse led clinics and where appropriate decommission (QIPP) | | | ✓ | | ✓ | **2** | ✓ | | ✓ | | **2** | **-** |
| Review role and effectiveness of Community Nursing and Community Matrons | ✓ | ✓ | ✓ | ✓ | ✓ | **5** | ✓ | | ✓ | ✓ | **3** | **-** |
| Complete the review and implementation of the changes to the District Nursing services whilst retaining the option to procure alternatives depending on the outcomes. | ✓ | ✓ | ✓ | ✓ | ✓ | **5** | ✓ | | ✓ | ✓ | **3** | **-** |
| Further review of Heart failure service | ✓ | ✓ | ✓ | ✓ | ✓ | **5** | | ✓ | ✓ | | **2** | **-** |
| Develop a revised service model for a Diabetes intermediate care service and modernise current secondary services to reduce unnecessary admission and length of stay | ✓ | ✓ | ✓ | ✓ | ✓ | **5** | ✓ | ✓ | | ✓ | **3** | **0** |
| Implement physical Health checks in primary care for people with learning disabilities | ✓ | ✓ | ✓ | ✓ | | **4** | ✓ | ✓ | ✓ | | **3** | **+** |

# Appendix 2 - New Investments

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| ***CHILDREN & YOUNG PEOPLE*** | | | |
| CHILDREN'S HEALTH INC HEALTH VISITORS | 460,000 | 460,000 | 280,000 |
| ***LONG TERM CONDITIONS*** | 2,592,000 | | |
| LONG TERM CONDITIONS / SELF CARE MANAGEMENT | - | 200,000 | 200,000 |
| OXYGEN ASSESSMENT & REVIEW TENDER | 115,000 | 80,000 | - |
| CONTINUING CARE | 300,000 | 300,000 | 300,000 |
| CARERS STRATEGY / RESPITE BREAKS | 630,000 | 630,000 | 630,000 |
| ***MENTAL HEALTH*** | | | |
| OPMH LIAISION SERVICES | - | - | - |
| PRIMARY CARE MH SERVICE FOR THOSE WITH LTC | 450,000 | - | - |
| BALANCE OF INVESTMENT TO DELIVER M.H. STRATEGY | 290,500 | 850,000 | 310,000 |
| MENTAL HEALTH REBASING | - 1,450,880 | - 1,450,880 | - |
| ***PLANNED CARE*** | | | |
| ACUTE ACCESS - OTHER | 7,930,000 | 4,850,000 | 4,850,000 |
| ACUTE ACCESS - SPECIFIC CONTRACT ISSUES | | | |
| STFT CRITICAL CARE OUTREACH TEAM | - | - | - |
| HEP C BUSINESS CASE GHNHST | - | - | - |
| SPECIALIST COMMISSIONING DEVELOPMENTS / ISSUES | 1,620,000 | 1,200,000 | 1,200,000 |
| LOCAL CANCER DRUGS + NATIONAL CANCER PLAN | 1,150,000 | 650,000 | 700,000 |
| END OF LIFE | 500,000 | 500,000 | - |
| ***STAYING HEALTHY*** | | | |
| OTHER PUBLIC HEALTH AND HEALTH INEQUALITIES | 200,000 | 200,000 | 200,000 |
| ***URGENT CARE*** | | | |
| SUNDERLAND MIU | 170,000 | - | - |
| NEAS OVER-PERFORMANCE + HART | 530,000 | 200,000 | 200,000 |
| 111 RECURRENT CONSEQUENCES | 550,000 | 430,000 | 120,000 |
| ***PRIMARY CARE*** | | | |
| GP ACCESS | - | - | - |
| ***SUPPORT FUNCTIONS*** | | | |
| SAFEGUARDING FUNDING CONTRIBUTION | - | - | - |
| LOSS OF ISTC MANAGEMENT FUNDING | 60,000 | - | - |
| IM&T ADD RUNNING COSTS | 100,000 | 100,000 | 100,000 |
| ***COMMUNITY SERVICES*** | | | |
| DISTRICT NURSING REVIEW - TREATMENT ROOMS | 500,000 | - | - |
| ***OPERATING FRAMEWORK*** | | | |
| CONTINGENCY/MOVING CARE OUT OF HOSPITAL | 5,271,129 | 6,692,734 | 7,202,847 |
| MAKING GOOD BUDGETS (INCL. BLAYDON PCC) | - | - | - |
| ***OTHER ASSUMPTIONS*** | | | |
| 2% NR FUNDED IN FULL 10/11 via RESERVES | - 189,000 | 300,000 | 300,000 |
| REABLEMENT | 945,000 | - | - |
| | | | |
| | **22,723,749** | **16,191,854** | **16,592,847** |

# Appendix 3 – Resource releasing initiatives 2012-15

| SUNDERLAND TPCT | | | | | |
|---|---|---|---|---|---|
| Programme Board | RRI | Year on year target savings £k | | | |
| | | 2012/13 | 2013/14 | 2014/15 | Total |
| **Children's** | | | | | |
| | Reform care of sick & injured child | £0 | £0 | £0 | £0 |
| | **Total** | £0 | £0 | £0 | £0 |
| **Long Term Conditions** | | | | | |
| | Reduce emergency admissions (EL Re-admissions) | £147 | £0 | £0 | £147 |
| | Reduce emergency admissions (NEL Re-admissions) | £902 | £0 | £0 | £902 |
| | Reduce emergency admissions | £0 | £338 | £806 | £1,145 |
| | Reduce excess hospital bed days | £442 | £442 | £442 | £1,326 |
| | **Total** | £1,491 | £780 | £1,248 | £3,520 |
| **Urgent Care** | | | | | |
| | Reduce emergency admissions (EL Re-admissions) | £440 | £0 | £0 | £440 |
| | Reduce emergency admissions (NEL Re-admissions) | £1,103 | £0 | £0 | £1,103 |
| | Reduce emergency admissions | £0 | £367 | £874 | £1,240 |
| | **Total** | £1,543 | £367 | £874 | £2,783 |
| **Mental Health** | | | | | |
| | Reduce price paid for Gateshead FT older peoples mental health service | £0 | £0 | £0 | £0 |
| | **Total** | £0 | £0 | £0 | £0 |
| **Planned Care** | | | | | |
| | Reduce outpatient first attendances | £177 | £177 | £177 | £531 |
| | Reduce outpatient review attendances | £239 | £239 | £0 | £478 |
| | Move Carpal tunnel out of hospital | £200 | £200 | £0 | £400 |
| | Reduce nurse led outpatient clinics | £265 | £265 | £265 | £795 |
| | Review ISTC (Spire) contract | £320 | £160 | £0 | £480 |
| | End short term funding to community services for HCAIs | £0 | £0 | £0 | £0 |
| | Research grant funding for cancer drugs, not currently reimbursed | £0 | £0 | £0 | £0 |
| | **Total** | £1,201 | £1,041 | £442 | £2,684 |
| **Primary & Community based services** | | | | | |
| | Reduce Primary Care budgets | £500 | £0 | £0 | £500 |
| | **Total** | £500 | £0 | £0 | £500 |
| **Medicine Management** | | | | | |
| | Reduce prescribing costs to North East average (Astro PU) | £650 | £650 | £650 | £1,950 |
| | **Total** | £650 | £650 | £650 | £1,950 |
| **Support Functions** | | | | | |
| | Reduce PCT management Costs (Including Community Health Services) | £240 | £240 | £0 | £480 |
| | **Total** | £240 | £240 | £0 | £480 |
| **Public Health** | | | | | |
| | Public Health | £0 | £0 | £0 | £0 |
| | **Total** | £0 | £0 | £0 | £0 |
| | **Total** | **£5,625** | **£3,078** | **£3,214** | **£11,917** |

# Appendix 4 – CCG Development Objectives

| Priority | Objective | Delivery will support Domain | Board Lead | Timeframe | Progress RAG rating |
|---|---|---|---|---|---|
| 1. | Complete Vision and values and engage/ share with Practices | Domain 1, 3 & 5<br>*Main Domain 1* | I Pattison<br>G McBride<br>J Gillespie | December 2011 | |
| 2. | To develop the Commissioning Plan utilising the current JSNA and ISOP | Domain 3 | I Pattison | December 2011 | |
| 3. | Develop a strategic approach to engaging patients, public and communities | Domain 4 & 6<br>*Main Domain 4* | G McBride | December 2011<br>Review quarterly | |
| 4. | Review their expected statutory responsibilities and agree the functions to deliver them. Determine the Commissioning Management Team/capacity required (both employed, shared and procured). e.g. finance, contracting, governance and business intelligence . | Domain 2, 3 & 5<br><br>*Main Domain 2* | I Pattison | Review December – conclude March 2012 and then revisit quarterly | |
| 5 | Identify and lead the development of commissioning intentions for 2012/13 | Domain 1 & 6<br>*Main Domain 6* | I Pattison<br>I Gilmour | December 2011 - January 2012 | |
| 6 | Develop a Communication and engagement strategy which should also incorporate the approach to public engagement. This strategy should include as a first priority the completion of a stakeholder mapping; analysis and agreement on the way to manage the various stakeholders | Domain 4, 5 & 6<br>*Main Domain 5* | G McBride | Stakeholder mapping by November 2011 and Strategy by February 2012<br>Review quarterly | |
| 7 | Review the Governance arrangements - conclude the constitution and the revised scheme of delegation with ongoing review of governance arrangements | Domain 2 & 5<br>*Main Domain 5* | G McBride | November 2011 Constitution and Delegation by December 2011<br>- Ongoing | |
| 8 | Agree & appoint Clinical Leads to support the delivery of the objectives. | Domain 1, 3 & 5<br>*Main Domain 1* | H Choi | Fully operational by February 2012 | |
| 9 | Complete and review Locality work – including Practice Manager leads | Domain 1, 3 & 5<br>*Main Domain 1* | H Choi | March 2012 | |
| 10 | Complete Board appointments including appointing Practice Manager and Practice Nurse | Domain 1, 3 & 5<br>*Main Domain 1* | I Pattison<br>I Gilmour | P Manager – December 2011<br>P Nurse – January | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | 2012 | |
| 11 | Ensure effective Clinical Leadership - agree personal development plans and appraisals for all Board members | Domain 1, 2 & 5<br>*Main Domain 5* | I Pattison<br>J Gillespie | Ongoing appraisals by March 2012 with 6 monthly reviews | |
| 12 | Build an effective relationship with the Health and Well Being Board | Domain 1, 4 & 6<br>*Main Domains 1 & 6* | I Pattison<br>B Arnott | Dec – March 2012 - Ongoing | |

**Item No. 8**

**Shadow Health and Wellbeing Board** **18 May 2012**

**Health and Social Care Systems Diagnostic – NHS Institute**

**Report of the Executive Director of Health Housing and Adult Services**

## Background

The NHS Institute for Innovation and Improvement (the NHS Institute) have been tasked nationally with offering support to health and social care systems through a support programme. In the North East, the Strategic Health Authority have provided funding for the Institute to work with all of the Local Authorities and PCT clusters in the region to assist in the change that is required to meet the emerging Health agenda. The particular focus is on ensuring that Health and Wellbeing Boards can grow into their role of leading the strategic development of health and wellbeing policy and commissioning.

Sunderland Health and Wellbeing Board commissioned the NHS Institute to start the diagnostic tool in Sunderland in late 2011 with the subsequent report to be used to inform the development of the Shadow Health and Wellbeing Board.

## Current Situation

The NHS Institute carried out the diagnostic tool during January to March which involved

- A review of key organisational and system documents
- A chief executives listening exercise
- A stratified staff survey

A draft report has been produced and is being circulated to the organisations who took part.

The report relates to the operational environment and relationships that are central to the successful development of the Health and Wellbeing Board and the Health and Social Care system in Sunderland. In this context, in the report Sunderland is described as a coherent area where there is a maturity in relationships that is not common elsewhere. The HWB is described as having the opportunity to really drive improvement and tackle major health inequality issues in the city.

The report contains a series of recommendations to support debate and discussion across the partner organisations aimed at developing further our partnership work. This includes enhancing system leadership to drive improvements through integration and transformation across the Health and Social Care system in the City. The report also considers the links to

neighbouring areas particularly Gateshead and South Tyneside but also across the region more widely.

The report suggests that the next step should be a workshop that brings together all those organisations who contributed to the research to consider the findings, share learning and develop a way forward.

**Recommendations**

The Board is therefore recommended to:

- Use and extend the next programmed Board development session to be focussed on the Health and Social Care System Support findings and agree next steps.
- Invite partners involved in the research to attend the event.

# Transforming Health and Wellbeing: the Role of Resilience
# A Discussion Paper - Summary

## Introduction

The current social and economic climate could result in risks to the health of the population. Equally, however, the changing context alongside the structural changes that are taking place in relation to local government and NHS responsibilities provide a unique opportunity to address the underlying issues of Sunderland's poor health record in a new way.

This paper provides a summary of the journey we have had in the City in relation to improving health together with identifying a new approach which is made possible by a more local approach to leadership. This approach builds on and adds to a number of approaches including complexity theory, building community resilience and an asset-based approach.

## Population health and wellbeing: the journey so far

Since the middle of the nineteenth century there has been sustained involvement of the state in health and wellbeing. This has moved from early concerns with sanitation and the control of communicable disease in emerging towns and cities to the development of vaccination and immunisation and child and maternal health at the beginning of the twentieth century. Until the 1970s the dominant paradigm related to the opportunities of medicine as a science to improve the health of the population leading to the development of the NHS and the movement of the specialist public health workforce in 1974. The increasing dominance of chronic diseases and poor mental wellbeing, however, has highlighted the limitations of the medical model and so more recently there has been a focus on the impact of individuals' circumstances and subsequent choices on their health throughout the life course – often referred to as the wider determinants of health.

## Health and wellbeing as an outcome of a complex system

The dominance of chronic disease (e.g. coronary heart disease, cancer and mental ill health) on the health of the population has meant that many of the old approaches of controlling and treating disease and addressing risk factors in a fragmented way are increasingly ineffective for many in supporting them to achieve best health outcomes. There is a growing body of literature that relates the new science of complexity to health systems. This approach recognises that the multiplicity of factors that affect people's health and the choices that they make cannot be easily predicted and often appears to be irrational. In reality, however, there is a clear rationale for people's choices based on their values and the environment in which the system is operating.

Many of the less formal elements of a complex system, which often tend to have the greatest influence on choices and outcomes, work because of people's underlying values or working principles and the assets available to them. Working with people in a way that takes account of these values allows goals to be achieved in a way that "command-and control" processes can't. There is also an added benefit. By working with individuals, families and communities in this way their resilience is increased. This will lead to improvements in health and a greater capacity to deal with change in a more positive way.

This approach also recognises that the outcomes of a particular intervention cannot always be predicted, even if there is full engagement. It is therefore critical that in addition to engaging with users and communities throughout the process the outcomes are evaluated and interventions either built upon or abandoned, depending on the outcome. In this way assets within the community are grown.

**Opportunities moving forward**

The focus of much of the guidance in relation to the transition of public health to local authorities has been in relation to commissioned services and supporting functions undertaken in partnership to deliver on a range of health programmes. This is entirely sensible as it ensures that during the process of transition, services continue to be delivered safely and the improvements in health that we have seen are maintained. There is, however, the risk that the opportunity for transformation will be lost. Opportunities for transformation based on a community resilience model include: -

- The major changes that are taking place economically and socially which mean that previous ways become "unfixed";
- The new powers of local authorities;
- The ability of the council to use its skills, influence and opportunities for engagement in relation to its place-shaping role, linked to more locally focused governance arrangements (e.g. embedded in the changing Area structures);
- The movement of the specialist public health workforce into the council and the opportunities to exploit the full range of public health competencies as well as recognition of the contribution of other partners;
- The potential for more integrated service delivery based on a community resilience model.

**Next Steps and Recommendation**

The Council has drafted a Community Resilience Plan as its response to urgent pressures in relation to welfare reforms and the current economic climate. At this stage it is a Council document, but it is recognised that building strong and resilient communities in Sunderland will require an integrated and multi-agency approach. The process of engagement and consultation with partners is expected to begin in the upcoming months.

It is recommended that the Health and Wellbeing Board identify a development session in the near future to further consider how this approach can be taken forward.

**Gillian Gibson**
**Consultant in Public Health**
**27 April 2012**

**Item No. 9b**

**SUNDERLAND HEALTH & WELLBEING BOARD** **18 May 2012**

**REPORT OF HEAD OF STRATEGY AND PERFORMANCE**

**EMERGING COMMUNITY RESILIENCE PLAN**

## 1.0 PURPOSE OF THE REPORT

1.1 This report provides an overview of the Council's emerging Community Resilience Plan which sets out the proposed approach to building community resilience in Sunderland. We would like partners' views on how they may wish to be engaged in this agenda to ensure that their wider contributions to building community resilience may be reflected in the Plan. We are also keen to get partners' views on the aims, objectives and priority areas for action.

## 2.0 DEFINING COMMUNITY RESILIENCE

2.1 Community resilience is about securing good outcomes for individuals and the wider community under difficult circumstances. It is about people coping and recovering in the face of adversity ('bouncing back'), but ideally adapting and continuing to fulfil their potential. Resilient communities are able to harness all local resources to mitigate the negative impact of an external shock (e.g. economic downturn or recession, major policy change) on individual residents, families and the wider community as a whole.

## 3.0 CONTEXT

3.1 The current uncertainty over the country's economic prospects and the disproportionate impact of public spending cuts on the North East present key challenges for Sunderland, the impact of which will be felt differently across the city. All residents will be affected in some way, but the cumulative effect of changes to the welfare system, cuts to public spending and the economic climate is likely to have a much more significant impact on some neighbourhoods relative to others. There is growing concern about the potential increase in neighbourhood concentrations of poverty and disadvantage and their effects on individuals, families and the broader community.

3.2 The need for a strategic response was identified in order to galvanise the energies and resources of the Council in the first instance, whist looking more fundamentally in the longer term to work together with partners to respond as a city to the emerging issues. It was also recognised that the changing environment offered an opportunity to review and improve the way the Council works with residents and communities in Sunderland. Faced with diminishing public resources, many current delivery methods are recognised as no longer appropriate. Consideration is now being given to how services can be

delivered in the future to make best use of the resources available to achieve better outcomes. As a city, we need to enable and support communities in Sunderland make the transition to greater strength and independence, with less reliance on the public sector in the longer term. This involves being responsive not only to local needs but also to community strengths. By mobilising and building on the resources and energy of our communities, we can deliver better outcomes whilst encouraging people to take greater ownership over the changes that affect them.

## 4.0 CURRENT POSITION

4.1 A draft Community Resilience Plan has been developed to provide an integrated and focused approach to targeting resources on areas of need. The Plan sets out a potential framework for supporting all communities during this challenging time, with a particular emphasis on vulnerable individuals and communities who are most likely to experience poor outcomes.

4.2 The Plan has initially been developed as a Council document to focus the energies and resources across the Council on those areas that we have an ability to influence that will make the most difference for communities in the short to medium term. However, we recognise that community resilience is something that must be built in partnership – with other organisations in the public, private and voluntary and community sectors, and with residents themselves.

### 4.3 Statement of intent

The following statement of intent has been proposed:

*To build stronger communities where people come together to tackle local challenges, take ownership of change, and help shape the places in which they live.*

### 4.4 Principles

The following principles underpin our proposed approach to building community resilience in Sunderland:

- **Early intervention and prevention** – identifying and addressing issues before they escalate into more problematic and complex needs.

- **Building capacity and reducing dependence** – encouraging and developing community solutions by helping people to help themselves and each other

- **Creating connections** – providing places and opportunities for people to come together to build relationships and access support, strengthening their sense of belonging and sense of community.

- **Community leadership** – Elected Members, residents, officers and partners working together to build stronger communities, leading and supporting local areas through change.

- **Responsive local services** – delivering integrated services to respond to local conditions and priorities

- **Delivering publicly valued outcomes** – focusing on what matters to residents rather than what matters to the organisation

- **An asset based approach** – identifying and building on the specific strengths of each community, so that the abilities and insights of local residents become resources for the challenges ahead of us. An asset based approach does not ignore needs – instead, it distinguishes between those needs that can best be met by families and friends, those best met by communities working in partnership with public services, and those that can only be met by public sector providers.

### 4.5 Aims

The emerging Community Resilience Plan identifies a set of core aims where we believe the Council and partners can make the greatest contribution to resilience in communities. Each of these broad aims is supported by a range of specific objectives defined over the short to medium term (see Appendix 1).

Aim 1 Maximise and stabilise the **disposable income** of households

Aim 2 Ensure people have **a place to live** that meets the needs and entitlements of their household

Aim 3 Increase the ability of residents to **influence and own change** that affects them and the communities they live in

Aim 4 Create a strong and inclusive **sense of community** and local pride

Aim 5 Support people to manage their **health and wellbeing**, and the health and wellbeing of others, including during times of stress

Aim 6 Maintain a community environment where people are, and feel, **safe and secure**

Aim 7 Ensure people have **access to appropriate services** and facilities that enable them to meet their changing needs

Aim 8 Maintain a physical environment that is **clean and attractive**

## 5.0 NEXT STEPS

5.1 The draft Community Resilience Plan has initially been developed as a Council document in that it sets out how we will better align our service delivery offer to address the clear need for resilience in communities. Moving forward, we would like to engage partners and incorporate their views on the aims, objectives and priority areas for action in order to develop the draft plan into a multi-agency document. A workshop session has been arranged through the Sunderland Partnership (Sunderland Innovation and Improvement Group – SIIG) on 13 June 2012. We will be cross-referencing membership of the Health and Wellbeing Board with the SIIG to ensure all partners are invited to the workshop.

**Appendix 1**

## Emerging Aims and Objectives

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| **AIM 1:**<br><br>**Maximise and stabilise the disposable income of households** | 1.1 Increase the number of people gaining or regaining employment |
| | 1.2 Develop employment skills to increase or stabilise income |
| | 1.3 Increase take up of benefits and tax reductions |
| | 1.4 Support households to manage their finances effectively |
| | 1.5 Minimise the number of households who become over-indebted; and assist people who have fallen into debt |
| **AIM 2:**<br><br>**Ensure people have a place to live that meets the needs and entitlements of their household** | 2.1 Support people to remain in their own homes where appropriate |
| | 2.2 Enable access to decent and affordable alternative accommodation for people whose current home has become unaffordable |
| | 2.3 Meet accommodation needs of all vulnerable and 'socially excluded' people |
| **AIM 3:**<br><br>**Increase the ability of residents to influence and own change that affects them and the community they live in** | 3.1 Ensure an integrated approach to engaging communities in identifying, shaping and delivering local priorities |
| | 3.2 Enable all individuals and communities to influence and feel they own the design/redesign of services that directly affect them |
| | 3.3 Create opportunities for community-led solutions, promoting self help and building social capital |
| | 3.4 Ensure communities benefit as far as possible from external funding opportunities |
| **AIM 4:**<br><br>**Create a strong and inclusive sense of community and local pride** | 4.1 Increase the number of people volunteering in their community |
| | 4.2 Increase participation in the local culture, heritage and leisure offer |
| | 4.3 Provide spaces and places for people to come together |
| | 4.4 Support the fostering of good relations within and between communities |
| **AIM 5:**<br><br>**Support people to manage their health and wellbeing, and the health of others, including during times of stress** | 5.1 Make healthy choices easy by providing accessible physical activity opportunities, lifestyle advice and health education within communities |
| | 5.2 Enable individuals to move towards independence, confidence and wellbeing |

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| | 5.3 Ensure that people who are dealing with a mental health issue feel safe, supported and understood |
| **AIM 6:**<br><br>**Create a community environment where people are, and feel, safe and secure** | 6.1 Put systems in place which enable us to anticipate and respond in 'real time' to emerging issues (such as tensions in or between communities) |
| | 6.2 Reduce or prevent an increase in crime; anti-social behaviour; drug and alcohol misuse; domestic violence and other violent crime; and re-offending |
| | 6.3 Challenge discrimination, harassment and victimisation |
| **AIM 7:**<br><br>**Ensure people have access to appropriate services and facilities that enable them to meet their changing needs** | 7.1 Provide a level of local support to people and families who find themselves in severe financial hardship, whose needs are most immediate and acute |
| | 7.2 Increase awareness of the services and support available to people in their community |
| | 7.3 Build the capacity of voluntary and community sector (VCS) organisations to help people help themselves and assist them in delivering services within their communities |
| | 7.4 Adopt a more responsive and locality based approach to service delivery |
| | 7.5 Integrate our approach to strengthening families |
| | 7.6 Improve public transport access to locations of social and economic importance |
| **AIM 8:**<br><br>**Maintain a physical environment that is clean and attractive** | 8.1 Engage residents, VCS organisations and businesses in the upkeep and improvement of their local area |
| | 8.2 Protect and enhance public transport corridors, cycle routes, footpaths, and green infrastructure |
| | 8.3 Improve the condition and use of neglected land and properties that are vacant and/or in a poor state of repair |