All together Sunderland!

NHS
Sunderland
Clinical Commissioning Group

Sunderland Health & Care System

Strategic Plan 2014-2019

Version 1.0

Better health for Sunderland

Contents

Introduction

1.0 Sunderland Health & Care System

Sustainable system wide change requires a system wide approach. This strategic plan outlines the desired state for the Sunderland Health and Care system by 2018/19 and has been developed in Sunderland for Sunderland. The key partners of which, outlined below, are all represented at the Sunderland Transformation Board, chaired by the CCG.

Organisation	Role in the Health and Care System
Sunderland Health & Wellbeing Board	A statutory board where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
NHS Sunderland Clinical Commissioning Group	The statutory body responsible for planning, purchasing and monitoring the delivery and quality of most of the local NHS healthcare and health services for the people of Sunderland.
GP Member Practices	The 53 GP practices across Sunderland are members of Sunderland CCG.
Sunderland City Council	Sunderland City Council secures and influences a wide range of services, either directly through their staff or by commissioning services from outside organisations. They also have responsibility for the economic, social and environmental 'wellbeing' of Sunderland.
City Hospitals Sunderland NHS NHS Foundation Trust	City Hospitals Sunderland is the main acute healthcare provider in Sunderland, operating from Sunderland Royal Hospital, Eye Infirmary and the Children's Centre.

	They have a number of intermediate specialist services and Sunderland Eye Infirmary is a leading regional eye treatment centre.
South Tyneside NHS Foundation Trust	South Tyneside FT are both an acute and community services provider. They are the main provider of community services in Sunderland.
Northumberland, Tyne and Wear NHS Foundation Trust	Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest Mental Health and Disability Trusts in England and the main provider of mental health services in Sunderland.
North East Ambulance Service NHS Foundation Trust	The North East Ambulance Service provides a number of NHS services including 999 response and patient transport services for the people of Sunderland.
healthwatch Sunderland	The aim of Healthwatch Sunderland is to strengthen the collective voice of citizens and communities in influencing local health and social care services to better meet their needs. It also supports people to find the right health and social care services for them by providing appropriate information, advice and signposting.
NHS England	NHS England is an executive non-departmental public body of the Department of Health and oversees the budget, planning, delivery and day-to-day operation of the NHS in England. Also responsible for the commissioning of primary care and specialised services at a local level.

2.0 Our Vision and Strategic Objectives

2.1 Our Vision for 2018/19

Our Vision is to achieve **Better Health for Sunderland**

We will deliver this through:

- **Transforming out of hospital care (through integration and 7 day working)**
- **Transforming in hospital care, specifically urgent and emergency care (including 7 day working)**
- **Enabling Self Care and Sustainability**

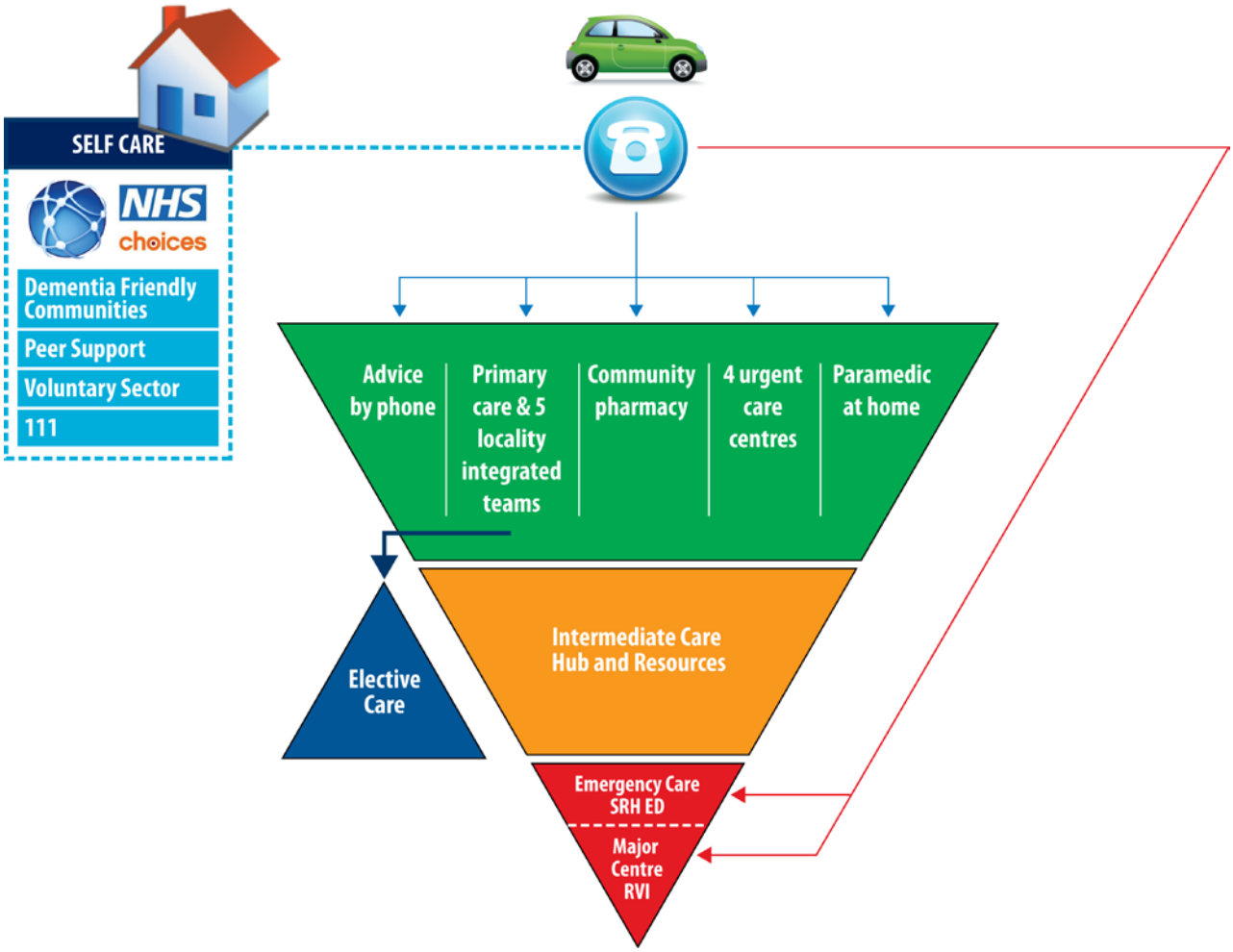
We will do this by having a whole system approach working closely with citizens, patients, carers, providers and partners.

2.2 Our Strategic Objectives

Transforming out of hospital care through integration and 7 day working	Transforming in hospital care, specifically urgent and emergency care and 7 day working	Enabling Self Care and Sustainability
▪ Right Care; Right Place; Right Time ▪ System wide approach with one common vision ▪ Multi-disciplinary teams in localities working together with people, adults and children with long term conditions / complex needs to improve their lives / meet their needs ▪ Improved overall quality of care for the elderly ▪ Reduced variation in primary care ▪ Patient centred ▪ A system which is simple to navigate ▪ Reduced emergency admissions to hospital as people are cared for effectively in the community	▪ Equality of access across the City to urgent care ▪ 24/7 hub ▪ Reduced handoffs in the system ▪ Reduction in emergency admissions	▪ Local people influence and understand the system ▪ A city that actively supports / enables people to be and stay healthy, well and happy ▪ Improved public health outcomes ▪ Managing demand ▪ Using community assets

2.3 What will the future look and feel like?

The following diagram shows the future state by 2019 for the health and social care economy in Sunderland:



The table below outlines how the future state will feel from different stakeholder perspectives:

<table>
<tr><th colspan="3">Citizens (Adult, Child, Older Person, Carer)</th></tr>
<tr><td colspan="3">▪ People are educated to self-manage where possible with the necessary support if required;
▪ Easily accessible advice;
▪ Once diagnosed someone co-ordinates the care you require and there is only one record which is shared with those who need it;
▪ Best use of Information technology to enable this to happen;
▪ Responsive providers;
▪ As local as possible.</td></tr>
<tr><th>Member Practices</th><th>A&E Consultant</th><th>District Nurse</th></tr>
<tr><td>▪ Feel part of a system which is efficient and joined up
▪ Belonging to a community / locality
▪ Able to use their time effectively to influence change in the system</td><td>▪ Only see accidents and emergencies
▪ Have great communications with primary care, social care and the rest of the system
▪ Make best use of skills
▪ Provide ‘remote’ advice via technology
▪ Trust in the system
▪ Wait for patients to arrive</td><td>▪ Will be part of a multidisciplinary team (24/7) in the community
▪ Have a relationship with GP Practices
▪ Make use of all skills
▪ Specialist knowledge / advice to call upon
▪ Understand how the system works</td></tr>
</table>

3.0 Values and Principles

3.1 Core Values

We have identified a set of core values which will continue to shape and underpin all of the work we undertake to deliver our vision. These seven core values are outlined below around our vision:

3.2 System Principles

The following system principles have been agreed:

- Our approach will be one of a single system for health and social care across Sunderland;
- Mental and physical health will be equally important, recognising both impacts on each other;
- To develop, as a principle, a team based working approach across the city.

- To share learning and approaches around demand management across the health and social care sector, but also wider public sector e.g: Sunderland City Council;

- The establishment of a single Transformational Programme Board to oversee this work (now in place);

We will also work closely with our partners in neighbouring CCGs where our patients use services in these areas.

4.0 Meeting the needs for local people

4.1 Big Challenges for Sunderland

We serve a population of around 275,700 people in Sunderland, with an increase of 8,100 (3%) forecast over the next 20 years. Large increases are predicted in the elderly, and particularly the very elderly, populations which has 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.

The main health challenges facing Sunderland are:

- **Mental Wellness as demonstrated by our poor outcomes in relation to depression and self-harm**
- **Excess deaths, particularly from cancer, respiratory and circulatory disease;**
- **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 who need to be supported to live independently;**
- **An over-reliance on hospital care;**
- **Services which are fragmented and lack integration.**

4.2 Key messages from the Sunderland 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 has undergone a major refresh to broaden the coverage of wider determinants of health; takes account of Marmot priorities; updates the analysis of health and wellbeing 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. 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

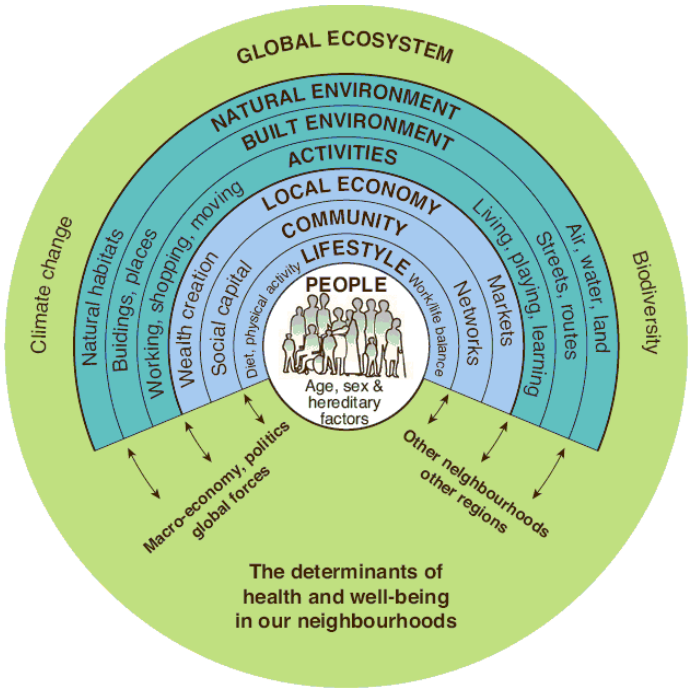
strategy; what needs can be met and how we can mitigate against unintended consequences from changes in funding and organisational arrangements over the next 3-5 years.

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 through focusing on addressing the causes of premature morbidity and mortality;
- A tiered approach to prevention, risk management and early intervention;
- Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;
- Identifying those who would benefit from wraparound health and social care services;
- Integration of services, whether NHS, social care or other services which affect health (e.g. spatial planning, housing, transport, libraries, wellness services, addressing fuel poverty, mitigating the impacts of welfare reform etc.);
- Reducing health inequalities by focussing on giving children the best start in life and strengthening ill health prevention as well as addressing the wider determinants of health, including deprivation, employment, education, housing, social isolation, 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 to build resilience at all levels to enable greater levels of self care.

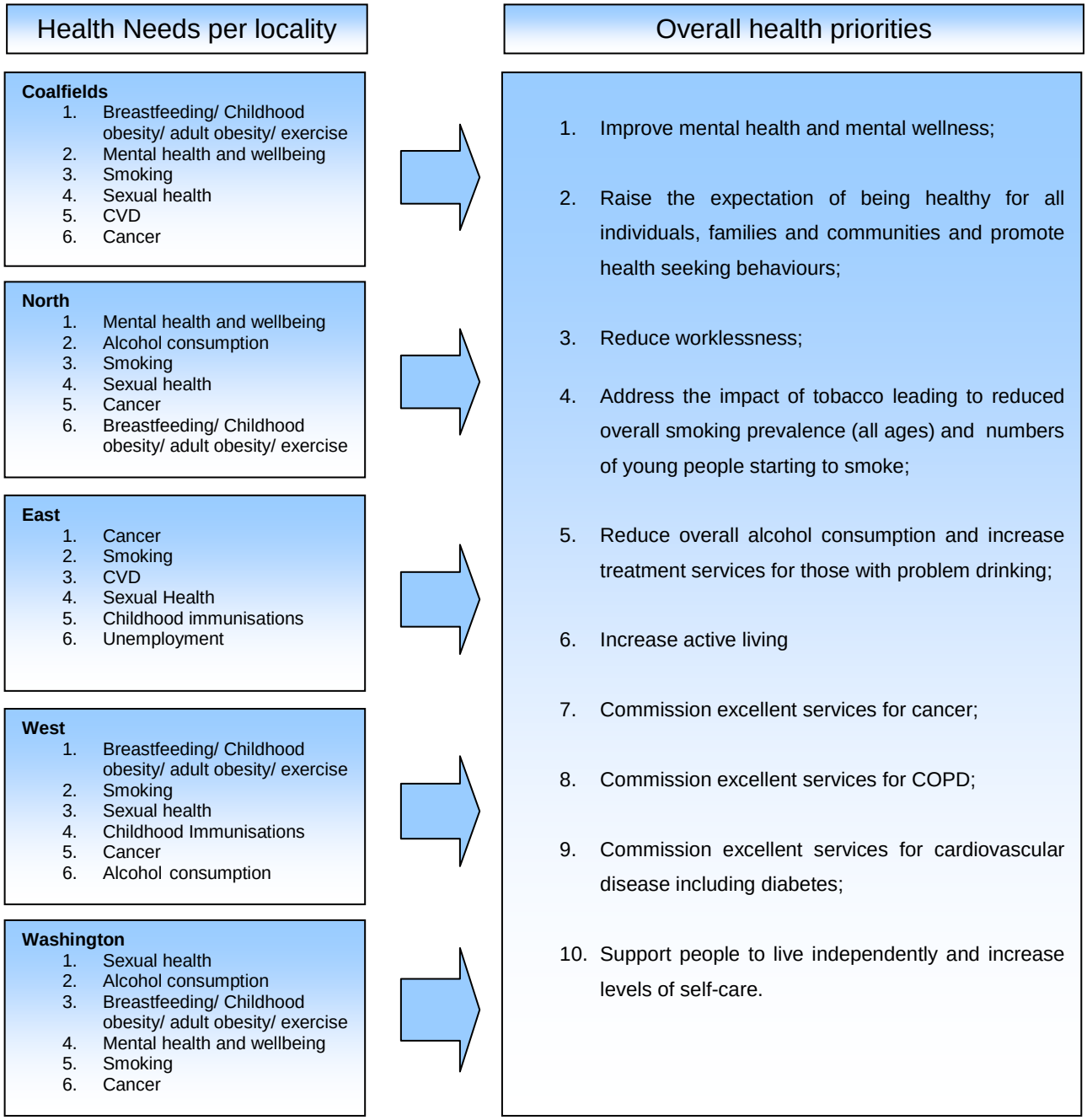
We have traditionally focused on treating illness but to improve health, we need to move, as represented by the following diagram, out into the concentric circles working with a broader range of partners, delivering our direct responsibilities and influencing partners to deliver theirs.

The main determinants of Health and Wellbeing



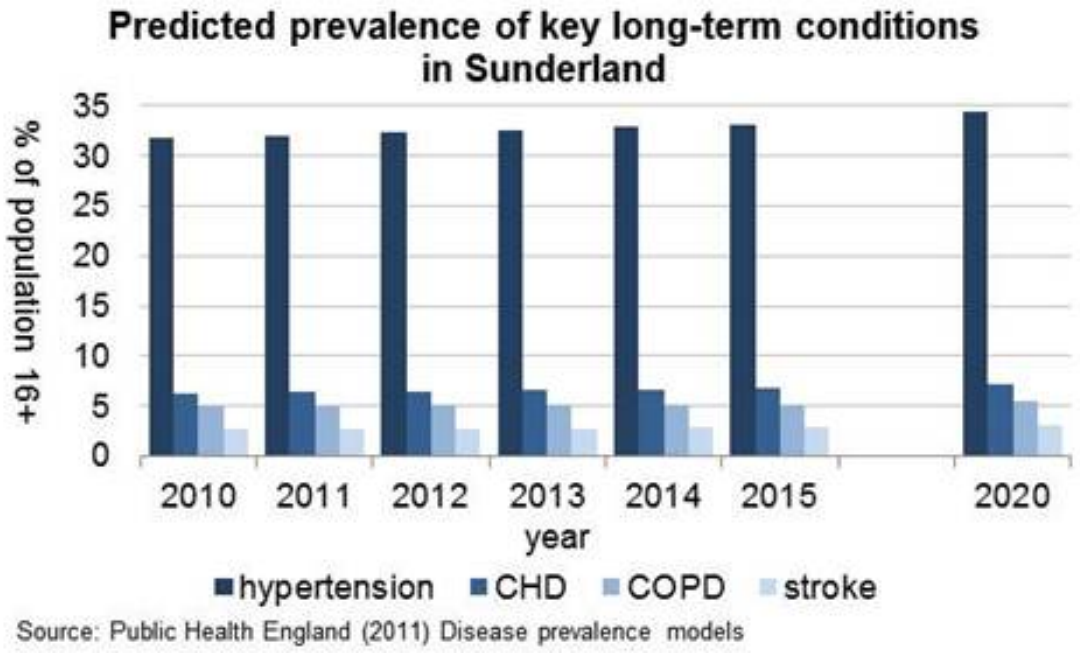
Ref: Hugh Barton and Marcus Grant (2006), drawing on Whitehead and Dahlgren (1991) and Barton (2005).

The JSNA is set out using profiles to highlight the needs of individual health groups and community area profiles and we continue to work closely with public health colleagues to identify health needs. The top 6 health needs per locality are outlined below along with the top ten priorities to improve health in Sunderland.



4.2.1Expected 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.



Source: Public Health England (2011) Disease prevalence models

4.2.2 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 Females	79.2 83.0	77.0 80.7	-2.8% -2.8%

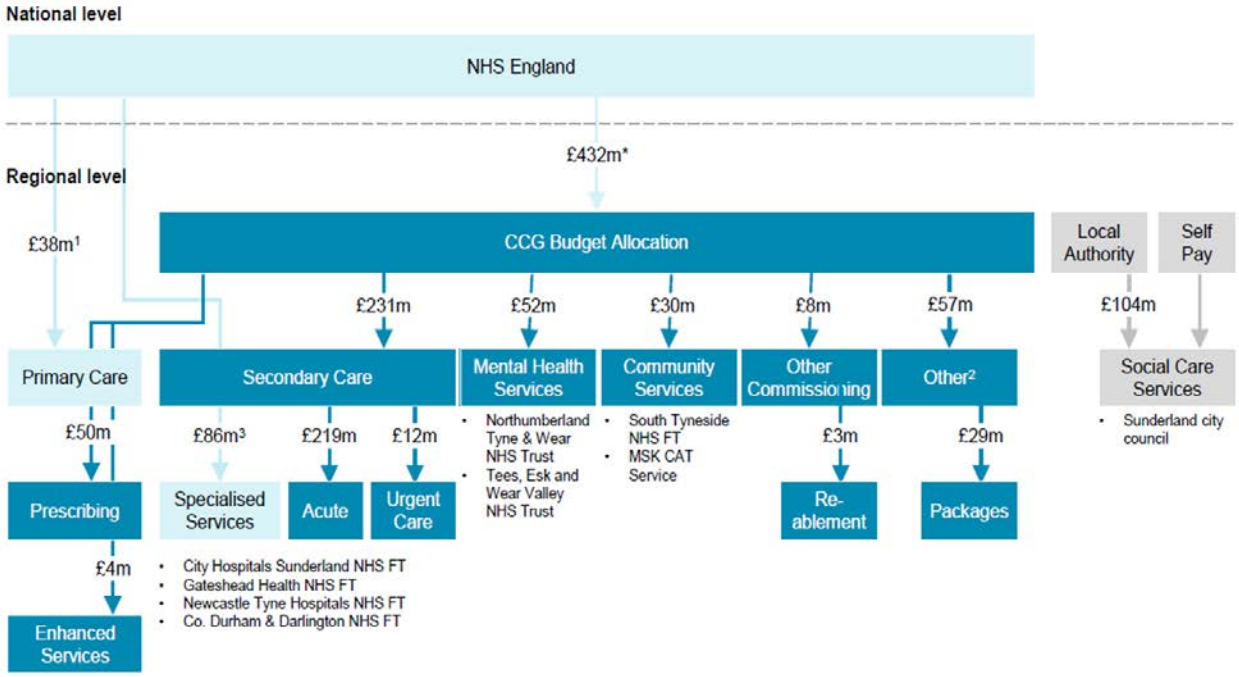
**Life expectancy gap expressed as a percentage of the England life expectancy.*

Over 60% of the gap is caused by cancer, respiratory diseases and CVD and to address this, we have built on previously identified "High Impact Interventions" to deliver an effective approach to improving health and transforming care which our commissioning and work with partners and our GPs will contribute to:

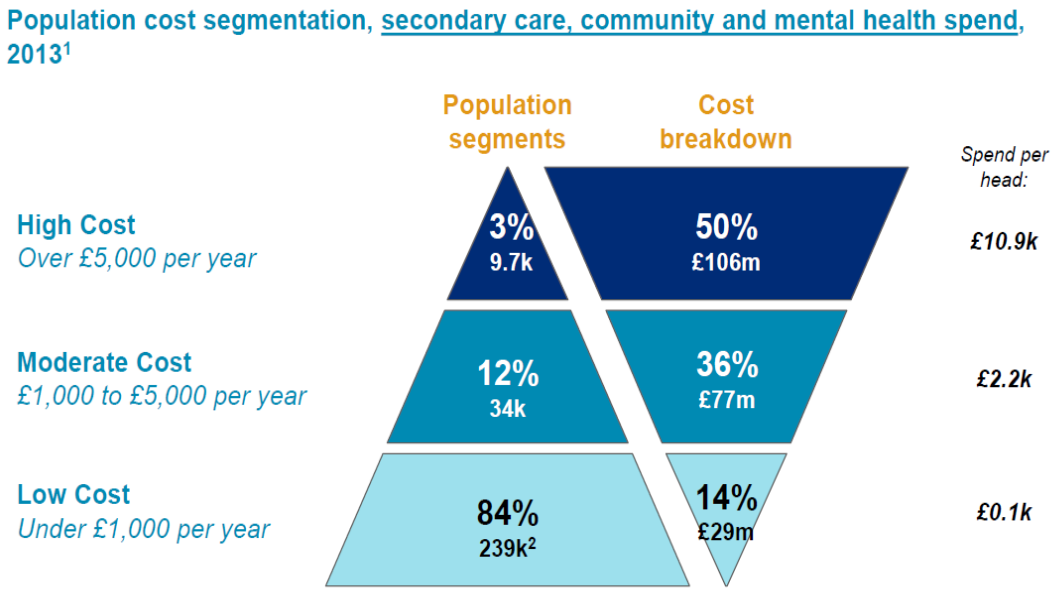
- Use of Health Checks to identify asymptomatic hypertensives age 40–74 & start them on treatment;
- Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;
- Systematic cardiac rehabilitation;
- Systematic COPD treatment;
- Develop & extend diabetes best practice with appropriate local targets;
- Cancer early awareness and detection;
- Identification and management of Atrial Fibrillation thus avoiding vascular dementia;
- Develop best practice in relation to dementia and falls to support people to live independently;
- Implement new approaches to people living in care homes and extra care facilities;
- Support people to manage their own health conditions where appropriate.

4.2.3 The Current Health & Care System in Sunderland

A range of organisations commission and provide care services in Sunderland. The approximate spend for each is outlined below:



Further analysis has found that the top 3% of patients in Sunderland drive 50% of the cost of health and care services:



Frail elders have diverse needs and use all care settings heavily. They have complicated care needs, which are difficult to coordinate:

Average Frail Elder without Cancer or Specialist Dementia care

(2,000 patients in segment – 73% of Frail Elders)

Details

Name 65+, 2+ co-morbidities no Cancer or Specialist Dementia

Age 79 (avg.)

Health

Top Comorbidities
- COPD (49%)
- Myocardial Infarction (39%)
- Diabetes (38%)

Top Risk Factors
- Hypertension (70%)
- Addictions (14%)
- Obesity (4%)

Service utilisation

		2013[1] Utilisation	2013[1] Spend
Primary[2]	Appointments	>10	£500
Inpatient	Spells	3	£7,300
Outpatient	Episodes	9	£900
A&E	Attendances	2	£300
Mental Health	Clusters	0	£200
Community	Visits	55	£2,000
Social	Visits	*Expected high user of social care*	
Total		**87**	**£11,200**

Reasons for admission (Top Primary Diagnosis CCS Codes)
- 87 – Retinal detachments; defects; vascular occlusion; and retinopathy (7%)
- 122 – Pneumonia (except that caused by tuberculosis or sexually transmitted disease) (6%)
- 127 – Chronic obstructive pulmonary disease and bronchiectasis (5%)
- 159 – Urinary tract infections (5%)
- 108 – Congestive heart failure; nonhypertensive (3%)

Source: Sunderland CCG secondary, community care and mental health data, Oliver Wyman analysis
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community care
2 – Estimates based upon previous work

Frail elders with Dementia typically use a large amount of community care:

Average Frail Elder with Specialist Dementia Care but not Cancer

(200 patients in segment – 6% of Frail Elders)

Details

Name 65+, 2+ co-morbidities, Specialist Dementia, no Cancer

Age 83 (avg.)

Health

Top Comorbidities
- Dementia (100%)
- COPD (34%)
- Diabetes (33%)

Top Risk Factors
- Hypertension (61%)
- Addictions (11%)
- Obesity (1%)

Service utilisation

		2013[1] Utilisation	2013[1] Spend
Primary[2]	Appointments	>10	£500
Inpatient	Spells	2	£7,200
Outpatient	Episodes	4	£400
A&E	Attendances	3	£300
Mental Health	Clusters	1	£1,100
Community	Visits	65	£2,300
Social	Visits	*Expected high user of social care*	
Total		**94**	**£11,700**

Reasons for admission (Top Primary Diagnosis CCS Codes)
- 159 – Urinary tract infections (9%)
- 122 – Pneumonia (except that caused by tuberculosis or sexually transmitted disease) (7%)
- 127 – Chronic obstructive pulmonary disease and bronchiectasis (4%)
- 211 – Other connective tissue disease (4%)
- 226 – Fracture of neck of femur (hip) (3%)

Source: Sunderland CCG secondary, community care and mental health data, Oliver Wyman analysis
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community care
2 – Estimates based upon previous work

5. Improving Quality & Outcomes

We currently monitor our CCG performance against a nationally prescribed delivery dashboard which covers all 5 domains of the NHS Outcomes Framework. An overview of performance at the end of 2013/14 against this framework is outlined below along with key risks to delivery:

Domain	Current Position	Risks to Delivery
1: Are local people getting good quality care?	Amber/ Green	Performance against health associated infections (MRSA and CDifficile).
2: Are patient rights under the NHS Constitution being promoted	Amber / Green	A&E 4 Hour waits at Sunderland Royal Hospital is the main area of risk.
3: Are health outcomes improving for local people?	Amber / Red	Performance against healthcare associated infections, mortality indicators, health related quality of life for people with long term conditions.
4: Are CCG's commissioning services within their financial allocations	Green	
5: Are conditions of CCG authorisation being addressed and removed (where relevant)	Green	

6.0 Our Success so far

An example of some of our successes so far include:

- Improved quality of healthcare and resident / family experience in care homes in the Coalfields Locality via an enhanced primary and community proactive approach for residents of residential, nursing and extra care.
- Implementation of a joint action plan with City Hospitals Sunderland and have instigated a clinical discussion process for each case of a health associated which has been recognised nationally as best practice. 2014/15 will implement this process in the community.
- Implementation of a GP extended hours pilot within the East Locality to provide patients with greater GP access and will use lessons learned in our approach to urgent care.
- Significant work undertaken in relation to diabetes including Human Insulin Training, Implementation to Insulin Passport, 100 % participation in the National Diabetes Audit 2012, Implementation of the North East Diabetes Network Foot Pathway, Introduction of CQUIN in Diabetes and reviewed new therapy – Dapagliflozin;.
- Delivered significant improvements in mental health pathways such as:
    - The implementation of fully operational pyschotherapy services, enhanced in 2013/14 to address the psychological needs of persons with long term conditions and carers;
    - Comprehensive memory protection services ensuring early diagnosis and support;
    - Re-commissioned CAMHS Tier 3 services including services at Tier 2 for youngsters in special circumstances;
    - Continued transformation of community services supported by an innovative initial response team, augmenting crisis services;
    - Introduction of a rapid assessment interface discharge (RAID) team into A&E / acute hospital performing exemplary liaison services;
    - New build capital projects creating world class inpatient environments for dementia and serious mental illness.

- Increased the number of people diagnosed and supported with dementia;
- Significant work on cancer including city wide lung cancer audit, Cancer peer review of seven specialties, incorporated the Hamilton Risk score into two week waits for lower gastro intestinal LGI referral, Communication to GPs about early diagnosis and referral pathways;
- Focused work within localities to significantly increase the number of COPD referrals to the pulmonary rehabilitation programme to 27.3% against a locally set target of 22.3%;
- Put in place a Carers Innovation scheme to improve the identification, registration and support offered to carers within the GP practice and encourage onward referral as appropriate. The outcome of the scheme is to ensure carers are adequately supported in their caring role. 51 GP practices delivered the scheme in 2013/14, resulting in improvements in carers registers, how practices identify carers, awareness training for staff, and a better referral system to Sunderland Carers Centre;
- Development of a Telehealth text service to support Smoking Cessation Pathways in collaboration with Public Health, Durham and Darlington Foundation Trust and NHS England;
- Telehealth established as part of Pregnancy Pathways (Mild Hypertension and Gestational Diabetes) which has gained national and international interest;
- Considerable work was carried out within SCCG practices, supported by the Medicines Optimisation Team in order to retain patients on Repeat Dispensing and to initiate new patients. For March 2014 the figure had reached 29.3% exceeding the SCCG target of 27.5%. Recently released annualised national figures indicate that from April 2013 to March 2014 the CCG was in the top 10 performers for "Percentage of all items prescribed as electronic repeat dispensing as a proportion of all electronic prescriptions" (39.0%) and for "Percentage of repeat dispensing items compared to all prescribing" (27.6%).

7. Enablers of Change

In 2013/14 NHS England outlined five offers which were seen to be the key enablers of change:

1. NHS services, seven days a week
2. More transparency, more choice
3. Listening to patients and increasing their participation
4. Better data, informed commissioning, driving improved outcomes
5. Higher standards, safer care

The NHS Outcomes Framework remains the focus to demonstrate improvement in outcomes with the introduction of seven critical indicators of success against which CCG's should track their progress:

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

In addition to these 7 critical indicators, NHS England also expect to see significant focus and rapid improvements against the following three measures:

- Improving Health
- Reducing Health Inequalities
- Parity of esteem (between mental and physical health)

In July 2013, NHS England along with national partners launched *A Call to Action* which sets out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. Specifically outlining the need to raise the quality of care for all in our communities to the best international standards while closing a potential funding gap of around £30billion by 2020/21.

In order to meet these challenges, NHS England have identified that any high quality, sustainable health and care system in England will have the following six characteristics in 5 years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care;
- Wider primary care, provided at scale;
- A modern model of integrated care;
- Access to the highest quality urgent and emergency care;
- A step-change in the productivity of elective care;
- Specialised services concentrated in centres of excellence.

Our response to these national drivers is set out in the following sections.

8. Our Outcome Ambitions

Through delivery of our transformational programmes we expect to make significant progress against the critical indicators of success outlined by NHS England and have been ambitious in setting outcomes for the future:

Critical Indicator of Success	Outcome Ambition by 2019
Securing additional years of life for the people of England with treatable mental and physical health conditions	Reduce years of life lost by 7%
Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Improve quality of life for those with long term conditions by 8.9%
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Reduce emergency admissions by 14% (composite measure)
Increasing the proportion of older people living independently at home following discharge from hospital	5% increase by March 2015
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Improve patient experience of hospital care by 7.2%
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Improve patient experience of out of hospital care by 8%
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Increased reporting of medication errors; MRSA Zero tolerance; Achievement of Cdifficile nationally set trajectory

9.0 Better Care Plan

The £3.8billion Better Care Fund has been introduced nationally to encourage transformation in integrated health and social care. This fund is a single pooled budget to support health and social care services to work more closely together to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

Better Care plans must deliver on the following national conditions:

- Protecting social care services;
- 7 day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional.

The Better Care development has been seen as a real opportunity within Sunderland to drive change through a system wide approach with a pooled budget of £24.778m identified in 2014/15, in comparison to the minimum required value of £12.052m, and up to £169m identified moving forward into 2015/16, in comparison to the minimum required value of £24.778m.

The joint initiatives within the Sunderland Better Care plan are set out in the Sunderland Health and Care System plan on a page, which can be found on Page 46.

10.0 Ensuring we have a high quality sustainable healthcare system by 2019

In identifying our priorities over the next five years, we have considered the six characteristics of a high quality and sustainable system outlined by NHS England.

Over the last few years much attention has been given locally to planned care and acute services and our system is generally performing well in relation to the NHS Constitution requirements

Our main focus over the first two years of our plan will be to focus on four of the six characteristics, namely:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care;
- Wider primary care, provided at scale;
- A modern model of integrated care;
- Access to the highest quality urgent and emergency care;

We have also considered the key messages we have heard from a Call to Action specifically outlining the need to raise the quality of care for all in our communities to the best international standards while closing the funding gap of potentially around £30billion nationally by 2020/21, approximately £150m locally for Sunderland, and identified those transformational changes which will provide us with the biggest impact in terms of improving quality whilst making significant savings over the next five years.

With all this in mind we have outlined our response against each of the six characteristics of a high quality and sustainable healthcare system for the next five years. This includes the 10 Transformational programmes of work which will be undertaken in the first two years which will lay the foundations to ensure we achieve our 5 year vision and strategic objectives.

10.1 A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care

By 2019 we will ensure patient experience is central to service development and that patients, carers, and the public are actively and systematically involved in all aspects of service design and change. We will also ensure that patients are fully empowered to make informed choices regarding their own care.

Public Participation

Being patient centred is one of our 7 core values. This really means ‘no decision about me, without me’ for patients and their own care. The same goes for the design of health and social care services. We are making sure we have effective ways to always involve patients and the public when identifying their needs, the plans we develop to meet these needs and evaluating whether services are meeting them.

The majority of GP practices in Sunderland have their own patient groups and localities will explore the most effective ways of bringing these voices together to enhance their knowledge of the patient and public perspective at a local level.

As a health and social care system we will continue to proactively engage with the wide range of local partners including the business community, community and voluntary sector and clinicians to ensure both our short and long term plans reflect local need and that partners play a key role in change for local people.

We will also continue to seek the views and opinions of local people, patients, voluntary and support groups about the services we provide through a wide

range of activities including surveys, focus groups, formal consultations and events. My NHS' will be proactively populated to represent Sunderland demographics and engagement opportunities, related to interest, actively marketing using this tool.

We will use the Local Engagement Board every 2 to 3 months which anyone is welcome to attend and is advertised in the local press. These now meet in the localities to update on key developments and seek views about proposals.

We have also developed a good working relationship with Healthwatch, the new local independent body, required by law to ensure the views and experience of people who use health and social care services are heard and taken seriously by statutory bodies such as Sunderland CCG. Healthwatch are a key member of the Health and Wellbeing Board and our Sunderland wide Transformation Board.

We will continue to work with our service providers to upon feedback from the Friends and Family Test in hospitals and are able to demonstrate the action we have taken from this feedback including plans to work with providers on further roll out from 2014/15.

We review feedback on patient experience from a wide variety of sources, especially that feedback collected via our providers and this forms part of our assessment of the quality of those services and is used in contract meetings with those providers to ensure a focus on safety, good patient experience and effective services.

We will be using new technologies and communication methods, such as Twitter and Facebook, to reach all parts of our society to listen to what is important to them in improving local health services.

Individual Participation

Enabling self care and sustainability is one of our three strategic objectives and we are committed to have a focus on helping individuals to better manage their own health and heathcare needs.

We will continue to invest in empowering local people through effective care navigation, peer support, mentoring and self-management programmes to maximize their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

Through our work in developing locality integrated community teams, we will ensure that every person in Sunderland with a long term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.

We will also ensure that any person who would benefit from it will have access to their own personal health budget.

10.2 Wider Primary Care, provided at scale

By 2019 we will have a high quality, safe, sustainable primary care system fully integrated within a whole health and social care system, operating within available resources to improve health and provide timely access to appropriate services for the population of Sunderland.

Primary care services are currently commissioned by NHS England who have a key focus on the following areas over the next two years:

Objective	Key Initiatives
Improving Health	Focus on cancer, CVD, respiratory and mental health
	Engaged and empowered citizens
	Access to primary medical services
	Access to primary dental services

	Access to ophthalmic services
	Ensuring maximum use of community pharmacy services
Reducing health inequalities	Focus on cancer, CVD, respiratory and mental health
	Implementation of GMS contractual requirements for over 75's
	Facilitate development of integrated community care systems to support vulnerable patients
Financial Management	Review impact of changes in MPIG
	Develop a strategy for PMS service reviews
	Review general dental access – shifting resource to address areas of under capacity

From 1st April 2014, GP Practices have been offered the opportunity to take part in an enhanced service, which is designed to reduce avoidable unplanned admissions by improving services for the most vulnerable patients and those with complex, physical or mental health needs. The key components of the enhanced service will be for practices to:

- Ensure that other clinicians can easily contact the practice by telephone to support decisions relating to hospital transfers or admissions;
- Carry our regular risk profiling to identify at least 2% of adult patients – and any children with complex needs who will benefit from more proactive care management;
- Provide proactive care and support for at-risk patients through developing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care co-ordinator;
- Work with hospitals to review and improve discharge processes and undertake internal reviews of unplanned admissions / readmissions.

All of these elements, taken together, will lead to GP's being more clearly accountable for co-ordinating the care of patients with more complex needs.

In addition to this the CCG have identified £5 per patient from its 2014/15 allocation to support practice plans for improving services for over 75yrs and complex patients.

In addition to the priorities outlined by NHS England, the key findings from 'Improving General practice – A Call to Action' have also been considered with the following findings of particular interest in Sunderland:

- Alignment of IT systems across primary and secondary care;
- Consideration of pooling / federating of GP practice resources;

In order to ensure alignment of IT systems across primary and secondary care the following programmes of work are currently underway:

- City wide rollout out of EMIS Web GP clinical system – to improve data sharing and system integration across Providers;

- Development of CQUIN schemes within local Providers to improve integration and delivery of clinical correspondence directly into GP systems;

- Development and implementation of data extraction tools across primary care to integrate GP Practice data alongside secondary and community care data.

- Potential roll out of EMIS Community to enable community nursing to read practice information.

In order to better enable integrated working, 26 GP practices across Sunderland have expressed a desire to pool their resources to create a GP Alliance. The benefits to Sunderland are to:

- Strengthen clinical governance and improve the quality and safety of services;
- Develop training and education capacity;
- Strengthen the capacity of practices to support, develop and tender for new services outside of hospital;
- Make efficiency savings, economies of scale, for example in back office services or the procurement of practice services;
- To improve local service integration across practices and other providers.

The CCG is working with NHS England to support the development of at scale providers of primary medical and nursing care.

The key role which community pharmacy can play in supporting patients with minor illness, promoting health and helping people to both avoid hospital admission and re-admission, has been recognised by all stakeholders and it is timely to challenge the current role and model of community pharmacy and consider a broader role for pharmacists as caregivers.

There are 61 community pharmacies in Sunderland and our aim is to improve access for patients, carers and the public to a broader range of services and care from pharmacy than the traditional dispensing and supply of medicines. This could include pharmacists working more closely with patients and healthcare colleagues in outreach teams, patients' homes, residential care, hospices, and general practice, as well as in community pharmacies, helping people to manage illness, providing health checks, supporting best use of medicines, and detecting early deterioration in patients' conditions.

NHS England has given all CCG's the opportunity to co-commission Primary care services. We have therefore expressed an interest in undertaking co-commissioning in support of our self care and out of hospital strategic objectives through the following activities:

- Supporting workforce recruitment and development in primary medical and nursing care;
- Enabling extended primary medical and nursing care at scale;
- Influencing pharmacy and dental provision;
- Co-commissioning enhanced services.

10.3 A Modern Model of Integrated Care

By 2019 people will receive the right care, for the right people, in the right place at the right time from people with the right skills.

Integration of health and social care services within Sunderland is based on a vision that has been formed by what the people of Sunderland have told us they need from health and social care services. There is a desire amongst people in Sunderland for a safe, integrated, effective and timely response that meets their individual needs.

People want choice and control, support to continue living in their own homes and communities with services that are co-ordinated to meet their individual needs at times which they require. At the heart of the vision is the ambition to deliver the right care and support, at the right time, in the right location with the right people to meet the needs of the individuals, their carers and families living within Sunderland.

The Sunderland vision for integration identifies 5 priority elements within the Integration programme:

- An overall integrated operating model;
- Locality integrated teams across health and social care;
- Integrated commissioning processes;
- Shared intelligence processes;
- Enhanced user focus both in terms of engagement and influencing behavior to manage demand.

The vision for integrated services will be built around bringing together social care and primary / community health resources into co-located, community focused, multi-disciplinary teams, linking seamlessly into hospital based services.

Those who require health and social care services will receive the right care and support in their own homes and communities through the development of community integrated locality teams organised around GP practices which will ensure:

- Services are co-ordinated around individuals and targeted to meet specific needs;
- Outcomes are improved for individuals;
- Improvements in the care experienced by individuals, their families and carers;
- Independence is optimized, by providing the right support in a timely manner, focusing on a re-ablement approach;
- People have high quality, tailored support which focuses on people staying out of hospital;
- People's care is co-ordinated and managed, with the GP at the heart of organising the care, avoiding unnecessary admissions to hospital and care homes – enabling people to regain skills and independence after episodes of ill health and / or injuries.

At the heart of this programme is the commissioning approach which is focused on defined locality populations, rather than by specific service.

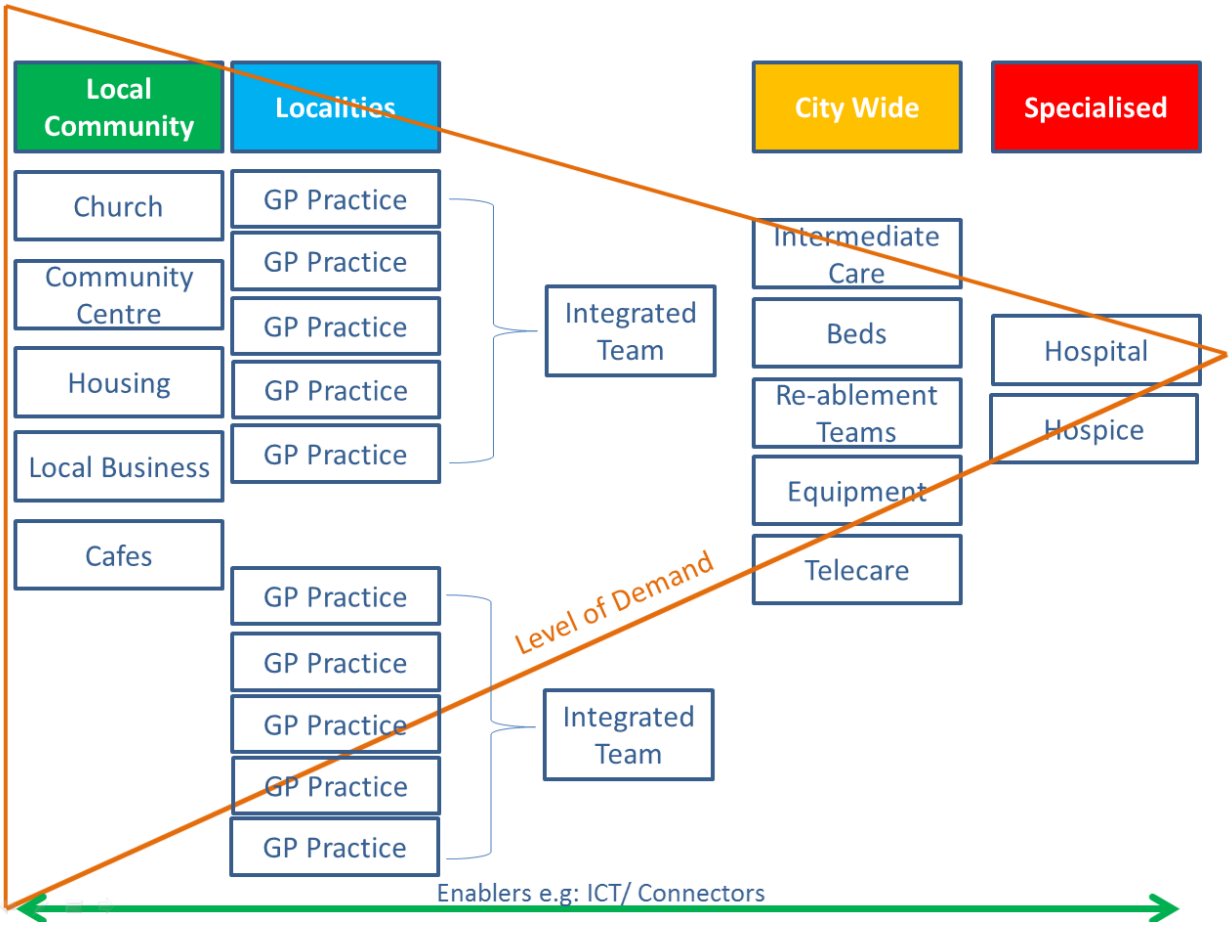
Within Sunderland it is recognised that integration of health and social care services needs to involve mental health services. Within NTW (Mental Health Trust) there has been significant work to integrate pathways of care for people using their services. It is expected that, where appropriate, mental health resources will be linked into the locality integrated teams through the Person centred co-ordinated care programme, especially in relation to supporting people with dementia symptoms and avoiding the need for admissions to residential care.

To ensure the system we are working within enables, and not hinders integrated care, the CCG and Local Authority will be commissioning jointly focusing on improving outcomes for individuals.

On the 5th & 6th June, the CCG and local authority took the lead in working with partner organisations across health, local government and the voluntary sector to further develop the health and social care integration agenda and create a shared understanding and commitment to how the agenda will be delivered. This was undertaken via an Accelerated Solutions Event with over 100 attendees from all partners including Healthwatch and the Voluntary sector. The objectives set for the event were:

- Reaffirm the vision and outcomes for Sunderland and the financial context in which this needs to be delivered;
- Understand and define HOW the health and social care integration agenda will support the achievement of these outcomes over the next 2 years
- Discuss and shape a tangible plan that will take us forward in the short, medium and long term including agreement on how to measure our success;
- Engage all key stakeholders in the programme to gain feedback on proposed service changes and identify how we will work together to drive greater quality, value and sustainability.

The Integration Board, who were sponsors for the event, felt the objectives were largely achieved. For example a model for integration, which is the overall integrated operating model was developed which is shown, in its simplest form overleaf and supports the future state set out on Page 7 of this Strategic Plan.



The aim being to enable self care in the community as far as possible, supported by local people who act as informal connectors to information / local activities and self care messages. At the other end of the spectrum to ensure only those who really need acute / specialist intervention access this level of support. Along the spectrum in between to make sure those with long term conditions and / or complex needs are identified and receive proactive person centred care from formal connectors and care coordinators who consider their overall health and wellbeing rather than only the 'sickness' aspect of their lives. Citywide intermediate services will provide the scaffolding to support the locality based teams, ensuring a rapid response to emergency issues and supporting both step up and step down care.

This model is based on a real person centred approach and takes account of national and international evidence which identifies the resulting major impact in terms of improved individual patient outcomes and reduction in health and care resources. The focus of our integrated teams will be on the top 3% of the population who currently account for 50% of the health and care spend.

This focus will over the course of this plan start to impact on the next 12% of patients with long term conditions who account for 36% of the spend.

More detailed work also took place on the commonly agreed key aspects of the model which will inform and refine current plans including the following areas:

- Prevention, early intervention and self help
- Engagement and Comunication
- Culture & Behaviours
- Joint Commissioning or Making the whole model work
- Shared information and data insight
- Connectors
- Integrated Teams – Roles & Skills
- Service Co-ordinator

These key aspects from the city wide model will be informed and supported by some of the current CCG transformation programmes over the next 2 years including:

- Improving healthcare in care homes for all localities
- Implementation of end of life ‘deciding right’ initiatives in practices
- Extension of the intermediate care hub
- Development of Dementia friendly communities.
- Once this infrastructure and person centred model is in place the focus will then move to improving clinical pathways for conditions such as CVD, Diabetes, Cancer and COPD, often the conditions that lead to 3% of people in the high risk / complex segment of the population.

In delivering Community Integrated Locality teams as well as the further transformational changes above, we will not only significantly increase the quality of care for patients, but also release savings of approximately £7.92m by 2019. This target is a prudent target based on modelling undertaken using both the national Anytown Tool and the Torbay Local Government Value Case and has also been corroborated by further modelling using the Future Forum finding s in relation to the International Extensivist and Extended Primary care patient centric models.

10.4 Access to the highest quality Urgent and Emergency Care

By 2019 there will be equality of access across Sunderland to an urgent care response. From a citizens or patients perspective, urgent care services will be accessible and responsive, and provided in the most part close to home. Only patients requiring specialist urgent care & emergency care will navigate into those services.

The main acute trust in Sunderland, City Hospitals Sunderland FT, faces a continual increase in demand for urgent and emergency care services and the need to transform the whole system to deliver seamless and joined up emergency care has never been more pressing.

Whilst significant transformation in out of hospital services is underway, it is still recognised within Sunderland that transformation of the existing Urgent and Emergency Care services are required.

Over the next two years the focus will be to develop the City Hospitals Sunderland Emergency Department Urgent Care Centre outlining an integrated way to access hospital services and wider local health service provision. This relies on a whole system approach being taken in order to create an effective and efficient delivery vehicle, from preventative medicine to social support frameworks. An integrated “front door”, as well as bed space management, will help to avoid admissions, reduce length of stay and improve recovery time.

In addition to this we have procured a provider to operate three GP Led Urgent Care Units across the city. The overarching objectives of the Urgent Care Centre service are to:

- Provide comprehensive, accessible and high quality GP led treatment to both adults and children presenting with a minor illness or injury;
- Improve access of services for patients and reduce unnecessary Emergency Department attendance and admission to hospital;
- Ensure more people have access to a minor illness and injury service close to home;
- Help people to access the right service for their need at the right time;

- Adopt a shared triage tool across all Urgent Care Units and the ED/OOH service, providing consistency to patients and ensuring the same patient outcome are achieved across all services;
- Promote the use of the 111 service to help patients and the public with any future unscheduled care need;
- Work collaboratively with the 111 provider to enable the 111 service to book direct patient appointments into the Urgent Care Units;
- Reduce inappropriate admissions at the Emergency Department.

The third key element of the transformation of Urgent and Emergency care is the re-procurement of existing GP out of hours services to ensure robust interfaces across the urgent and Emergency care system and to deliver GP extended hours.

Each of our urgent care partners have, or are in the process of, being commissioned to work in collaboration with each other to support delivery of the urgent care strategic objective.

There will also be a range of resources available to citizens to enable them to navigate to the appropriate urgent care services. Resources such as 111, NHS Choices, community pharmacy support, emergency health care plans and GP telephone consultations.

Through the navigation resources available to Sunderland residents, patients will be deemed to be appropriately managed by primary and community services until proven otherwise.

GP services (including any at scale GP provider) will provide access to telephone consultations, home visits, booked appointments at surgeries or urgent care centres. The primary care urgent care services will provide 24/7 accessible & responsive clinical services working closely with pharmacies and emergency care paramedics, integrated adult & paediatric community team and the community geriatrician service. These services will deliver see, assess & manage health and social care services for those patients most at risk of hospital admission.

Patient groups such as those with long term conditions or frailty, or those at end of life, will require intensive packages of care and will be the priority patient groups for these services.

Urgent care for acutely ill children will be provided through GP services, and in urgent care centres. Children requiring specialist urgent & emergency care will access it through the Emergency Department / Urgent Care Centre at City Hospitals Sunderland.

A range of intermediate care services, including community beds & services, will be available for primary care and community services to access to support people to remain at independent for as long as possible. The 24/7 intermediate care hub will navigate patients into the most appropriate services.

Between 2014-2019, the development of urgent and emergency care pathways will be focused on ensuring the right care is provided in the right place at the right time. Patients will experience safe, timely and effective care within the financial resources available in Sunderland. Health and social care urgent care services will be accessible 365 days a year and through 24 hours:

- Patients accessing health care directly through 999 or 111 will be triaged through established mechanisms and appropriately transported or booked into emergency care;
- When patients are deemed to require specialist urgent & emergency care, they will be navigated by primary, community & paramedic staff into specialist care. They will be pulled back into primary and community care as soon as practicable;
- Primary & community services will refer into ambulatory care pathways services to see, assess & manage patients within more specialist health care pathways such as neurology, cardiology, abdominal pain & COPD, and pull them back into primary and community services as soon as appropriate;
- Patients presenting directly at CHS will be triaged through the Big Front Door, diverted into the GP led urgent care service, ambulatory care pathways or into emergency care services as appropriate.

10.5 A step-change in the productivity of elective care

By 2019 we will deliver high efficiency care in a convenient setting with increased patient choice, improved scheduling and a higher level of quality resulting in improved outcomes.

Over the last few years much attention has been given locally to planned care and acute services and we remain committed to ensuring the rights and pledges outlined in the NHS Constitution are consistently met across Sunderland.

As a whole system, however, we have agreed that we now need to refocus our energies on the transformation of out of hospital care.

Our main providers will continue to review their potential to improve productivity and we will review the potential opportunities for a step change in the productivity of elective care each year.

City Hospitals Sunderland FT have commenced a Surgery and Theatres Efficiencies' programme (STEP) which aims to deliver a change in the productivity of elective care. The programme will have a key focus on efficient and effective scheduling and reducing waste at all stages of the patients pathway. This should maximise and make more effective use of the existing capacity and reduce waits for surgery. The use of standardised procedures and processes and elimination of bottle necks and consecutive processes will improve utilisation of theatres and improve the outputs and outcomes for patients.

The trust is also building a new state of the art endoscopy unit which will be in operation in July 2015. The unit will be the first of its type in the UK and will be built on the concepts employed by the Virginia Mason Production System to provide high quality, efficient care with an outstanding patient experience.

In addition to this, the trust will be completing a Day of Surgical admissions (DOSA) area for Urology as part of its drive to provide day case surgery wherever clinically appropriate.

Significant improvements in mental health pathways have been implemented over recent years to increase access and reduce waiting times as identified in the earlier section on improvements to date. A further £3m will be invested over the next two years and Northumberland, Tyne & Wear (NTW) FT, will continue to transform their mainstream services with a specific focus on the following mental health pathways:

- Attention deficit hyperactivity disorder (ADHD)
- Personality disorders
- Autism
- Psychosexual disorders

10.6 Specialised services concentrated in centres of excellence

Work is currently being undertaken to develop a national strategy which will set out the case for maximising quality, effectiveness and efficiency in the delivery of specialised services, and a draft will be published for consultation later this year. It is recognised that services currently designated as specialised are provided from a high number of sites across England and work is ongoing to review the portfolio of activity which is set out annually in the Manual for Prescribed Specialised Services.

City Hospitals Sunderland FT is a centre of excellence in a number of areas such as Bariatric surgery, Urology, ENT, neonatology and ophthalmology and is looking to further develop vascular services. The Northern Strategic Clinical Network has recently produced a report which demonstrates the need to remodel vascular services in the North East. The case for change, based on quality service provision and AAA screening requirements is broadly accepted by local clinicians who support the principle of reorganisation of services. Discussions are ongoing with clinicians across Sunderland and Durham/Gateshead which has resulted in agreement to work collaboratively.

The vision for specialised services in the Sunderland area will be for network or hub and spoke models which ensure local provision of services where possible (outpatients and daycases) whilst at the same time still ensuring immediate input and access to expertise from specialist teams 24/7.

Supported by the CCG, City Hospitals Sunderland will focus on consolidating and further developing the range of complex services which it provides, in line with the NHS England strategy and with appropriate alignment of investment in the workforce, technology, equipment and capital plans as required.

10.7 Valuing Mental Health equally with Physical Health

Parity of Esteem will continue to be at the heart of our health and care plans and we will value mental health equally with physical health addressing mental health issues with the same energy and priority as we address physical illness:

- Mental health as well as physical health are assessed at GP registration and in annual health checks
- There is ongoing mental health training to GP's and practice nurses across Sunderland
- Patients can now access treatment in secondary care within 4 weeks
- All appropriate mental health staff have been trained to ensure they are able to provide NICE evidence based psychological therapies
- There is equality of access to psychological therapies across Sunderland
- Patients are prescribed medicines safely and helped to take them well with appropriate guidance, leaflets and contact for advice
- Care plans include effective interventions to ensure people recover and get employment
- In the event of mental health crisis, there is an initial response service (Single point of contact) who will assess the level of need
- There is a mental health rapid assessment interface discharge (RAID) team in A&E
- Families are well supported in caring for their loved ones with carers included in care plans and carers champions in place
- Recovery Colleges provide peer support to enable people to self manage and continue to be part of the community
- We have evidence that service users of mental health services in Sunderland are very happy with the service they receive

As detailed in section 10.5, we have continued to make significant improvements in mental health pathways over recent years to increase access and reduce waiting times.

10.8 Sunderland Health & Care System Plan on a Page

The Sunderland health and care system plan on a page, shown overleaf, summarises the following:

- System Vision
- Strategic Objectives
- Outcome ambitions
- Key characteristics of a high quality, sustainable healthcare system
- Key enablers
- Governance arrangements
- How our success will be measured
- Values and principles

Sunderland Health & Care System 2014/15 – 2018/19

All together Sunderland!

Vision: Better Health for Sunderland

Transforming Out of Hospital care (through Integration and 7 day working)	Transforming In Hospital Care, specifically Urgent & Emergency Care (7 day working)	Enabling Self Care and Sustainability

Outcomes

Reduce years of life lost by 7% by 2019	Improve health related quality of life for people with LTC by 8.9% by 2019	Reduce Emergency Admissions by 14% by 2019	Increase the proportion of older people living independently at home following discharge from hospital by 5% by 2015	Improve patient experience of hospital care by 7.2% by 2019	Improve patient experience of out of hospital care by 8% by 2019	Make significant progress towards eliminating deaths in hospitals*

High Quality Sustainable System Characteristics	Key Initiatives
Citizens fully included in all aspects of service design and change and fully empowered in their own care	Communications & Engagement Strategy (including My NHS) Shared decision making Personal health budgets Intelligence Hub Wellness Service
Wider Primary Care, provided at scale	GP Alliance Proactive and personalised Primary Care programme Alignment of IT systems across Primary , Community & Secondary Care
A modern model of integrated care	Community integrated locality teams Community Connectors model Intermediate care hub 24/7 Improving health care in care homes in all localities Implementation of deciding right initiatives in practices Dementia Friendly Communities NEAS Advanced Practice Paramedic (TBC)
Access to the highest quality urgent & emergency care	GP Led Urgent Care Centres City Hospitals Sunderland Urgent Care Centre 'Big Front Door' GP Out of Hours service
A step change in the productivity of elective care	Surgery & Theatres Efficiencies programme (STEP) New Endoscopy Unit at City Hospitals Sunderland Improved community mental health pathways
Specialised services concentrated in centres of excellence	City Hospitals Sunderland's position as a recognised provider of complex care in the North East developed in line with national strategy for specialised services

Enabled by	Governed by	Measured by	Values and Principles
Localities / Joint Commissioning / Contract Management (CQUIN) / Medicines Optimisation / Evidence based Approach / Research & Development	System Wide Transformation Board Health & Wellbeing Board CCG Governing Body Integration Board	Quality & Safety of Services Achievement of Outcome ambitions Delivery of £150m efficiencies across the system	One system for Health and Social Care Patient Centred Parity of Esteem 7 day services Team based working across Sunderland

*Zero Tolerance MRSA, At least 10% increase in the reporting of medication errors, Achievement of Cdifficile nationally set trajectory

11.0 Ensuring Quality and improved outcomes

We are committed to delivering quality improvement across the three areas of quality, namely patient safety, clinical effectiveness and patient experience and have reviewed the recommendations from the Francis 2, Berwick and Clwyd Hart reports and the Keogh review and whilst we have not identified any specific risks currently, we have developed an overarching Quality Action Plan to ensure continuous improvement. One of the key lessons from events at both Mid-Staffordshire NHS Foundation Trust and Winterbourne View hospital is that a fundamental culture change is needed to put patients at the centre of the NHS. As an organisation we are committed to ensuring truly clinically led commissioning, ensuring quality and outcomes drive everything we do.

Examples of the range of actions we will continue to take 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.

5.2.3 CQUIN

There are robust arrangements in place for the review of incident reporting in general as well as a process to manage serious incident reporting, reviewing and determining lessons learned. Each provider at the Quality Review Group meetings report on progress of internal action plans with regard to incident reporting (low / near misses) as well as identification and implementation of lessons learned and changes to practice. These principles also apply to lessons learned from the safeguarding environment i.e.: serious case reviews.

Each provider also provides assurance that the six action areas of the Compassion in Practice implementation plans are a core theme throughout workforce development initiatives and this is reflected in the reports provided to the Quality Review Group meetings and ongoing discussions.

There is a Sunderland Safeguarding Children Board (SSCB) and Sunderland Safeguarding Adults Board (SSAB) in place with representation on both by the CCG Director of Nursing, Quality and Safety and the Head of Safeguarding. The CCG Safeguarding Team also support Partnerships which interface with the SSCB and SSAB, for example the Safer Sunderland Partnership and the Strategic Domestic Violence Partnership.

The CCG has effective arrangements in place to support the Serious Case Review process and offers supervision to health providers in the writing of their Individual Management Reviews. The CCG has established a process of ensuring the NHS England Area Team has oversight of all Primary Care Management Reviews to ensure recommendations are endorsed and monitored. There are established processes regarding dissemination of lessons learned from reviews, both within the CCG and across the health economy.

A Strategic Safeguarding Group has been established which monitors safeguarding activity and compliance with statutory processes across the health economy. Contractual arrangements regarding safeguarding have been strengthened and made more explicit in all commissioned services.

The CCG have secured the expertise of a range of doctors and nurses who make up the “Safeguarding Team” and who fulfil the statutory roles outlined in “Working Together to Safeguard children “(2013). In addition they have also employed a Designated Nurse for Safeguarding Adults and a Named GP Safeguarding Adults. The CCG has a named Mental Capacity Act lead.

We will also ensure that Commissioning arrangements for Safeguarding Adults support the implementation of statutory requirements resulting from the Care and Support Bill.

We will work together across the health and care economy to ensure that the Prevent requirements set out in the NHS National contract from 2013 onwards are embedded in practice and that staff in primary care have access to appropriate Prevent WRAP training as well as ensuring that Prevent is effectively integrated into local safeguarding arrangements.

12.0 Joint Working with other health economies

Sunderland will work with a variety of other health economies and these will differ subject to patient flows and contracts. We particularly work closely with South Tyneside as we share a number of joint priorities including the development of integrated teams and the configuration of acute services.

The two main acute trusts have worked together in a number of areas to date including the development of an integrated service that provides 24/7 cardiology cover and an equitable revascularisation service for all patients across Sunderland and South Tyneside.

We are also part of the Northern Forum of CCG's, meeting monthly with the aim of sharing practice and issues, and wherever possible, agreeing a whole health economy approach where it makes sense to do so for all parties.

13.0 Workforce Implications of our plans

As a health and care economy we will continue to ensure that appropriate levels of staff and skills are in place across Sunderland. This will support the delivery of safe and effective care whilst also considering the workforce implications of our plans moving forward and being open and transparent with all partners, in relation to what this means for individual organisations.

At this early stage, impact analysis undertaken on our key transformational changes, using the Any Town model and LGA toolkit and modelling using the extensivist and extended primary care models and associated analytical support have been shared across the economy and we continue to work together as further detail develops.

We will also strengthen relationships with Health Education England, the new national leadership organisation responsible for ensuring that education, training, and workforce development drives the highest quality public health

and patient outcomes, to ensure security of supply of a competent, compassionate and caring workforce to provide excellent quality health and patient care.

We are already in discussions with our Area Team and Health Education England North East colleagues regarding a career start programme for healthcare assistants in primary care. This programme will support development of the primary care workforce and provide a standard of competence and skill mix across the city.

In addition, we are closely involved with the primary care workforce scoping exercise being undertaken by Northumbria University on behalf of Health Education England North East.

14.0 Financial Sustainability

The current Chancellor of the Exchequer presented his “Spending Round” paper / proposals to Parliament in June 2013. In this document he outlined the Governments plans for public sector spending for the 2 financial years commencing 2014/15 and 2015/16 alongside some longer term projections for the overall economy going through to 2017/18. The Chancellors intention in publishing firm 2 year allocations for the public sector was to give some certainty over the remaining life of the existing parliament alongside projections for the future, however the document was very clear that it would be the new government who would ultimately decide and agree on the overall public sector finances for the years commencing 2016/17.

Following publication there was widespread agreement amongst the main stream political parties that irrespective of the makeup of the new government following the May 2015 general election the need for continuation of a strict fiscal policy would be paramount in maintaining the upturn in the economy. This is the context that the CCG has used in preparing its financial plans for the years commencing 2016/17.

Whilst central government decide on the overall public sector budgets (including the NHS) it is NHS England who agree the distribution of the total sum amongst the various sectors i.e. CCGs, Area Teams and Central Budgets. Allocations to CCGs were agreed by NHS England in December 2013 covering the 2 years commencing 2014/15. Rather than tackle the variances in actual spend to formula proposal, they decided all CCGs would receive growth funding in 14/15 and 15/16 with floor or minimum levels of 2.14% and 1.7% respectively. Putting this in context which is relevant to future years funding, NHS Sunderland's budget at the end of 2015/16 puts it at 11.54% "distance from target" (DFT). Basically the CCGs budget at the end of 15/16 is £43.9m greater than its "fair share" of the national cake as outlined in the formula. This also has a bearing on assumptions used by the CCG in formulating its financial plans for years 3 to 5 of the strategic plan.

The Chief Financial Officer of NHS England (Paul Baumann) wrote to CCGs in February 14 and outlined some potential "allocation growth assumptions" for the 3 years commencing 2016/17 which were based upon GDP deflators of 1.8%, 1.7% and 1.7% respectively. CCGs could use these figures in their plans as a "maximum", however local discretion is allowed to use "lower" growth assumptions if it is felt warranted. Given NHS Sunderland's closing DFT (+11.54%) at the end of 15/16 it was agreed to set "prudent" growth assumptions of 0.5% for each of the 3 years commencing 16/17. CCGs who are under there DFT's are already facing financial pressure and we feel this could give rise to an accelerated national "pace of change" policy targeting organisations who are 5% or greater DFT. Using some of the national assumptions in the Paul Baumann letter if NHS Sunderland were to receive growth of 0.5% it would still be approximately 8.5% DFT at the end of 2018/19. Although not covered in the life of this plan Sunderland CCG has looked at the years commencing 2019/20 to inform a "10 year" financial strategy which is being developed.

What does this mean for Sunderland?

The CCG does not work in isolation and needs the support of fellow commissioners i.e. the Local Authority, NHS England and all Providers to assist in delivery of the local system vision. Knowing this we have attempted to quantify the potential efficiency / savings requirements across the economy given the national / local fiscal scenario outlined above.

Public Sector (Health & Social Care) Savings Targets 2014/15 to 2018/19

	14/15 £M	15/16 £M	16/17 £M	17/18 £M	18/19 £M
NHS SUNDERLAND CCG	2.9	3.9	6.0	3.0	3.0
SUNDERLAND CITY COUNCIL (Peoples) DIRECTORATE	10.7	12.0?	10	10	10
CITY HOSPITALS SUNDERLAND NHS F.T	16.3	14.1	18.5	15.6	15.5
SUB TOTALS (MAINLY SUNDERLAND)	29.9	30	34.5	28.6	28.5
NORTHUMBERLAND TYNE & WEAR NHS F.T	11.3	10.8	10.7	??	??
SOUTH TYNESIDE NHS F.T.	13.8	??	??	??	??
NORTH EAST AMBULANCE SERVICE F.T	6.0	??	??	??	??
SUB TOTALS (Will include an element of Sunderland)	31.1	??	??	??	??

From the table above it can be seen that the organisations whose focus is "mainly" on Sunderland need to save in excess of £150m over the life of the strategic plan. Other organisations that also provide services into Sunderland will need to deliver efficiencies so it is feasible the wider "public" sector

economy in Sunderland will need to save circa £175m in the next 5 years. The detailed figures for Sunderland CCG are highlighted in the “financial plan on a page”, however from the table above the context for the wider public sector economy can be seen.

Fundamental to the successful delivery of the savings above, will be the need to transform “pathways of care” from traditional secondary care settings where appropriate into community / primary care settings. At the heart of our plans is the expectation that non elective admissions can be reduced by 15% over the life of the plan. For the CCG and our main acute providers this impacts from 2016/17 onwards whereas for some economies the need is now. Sunderland does have the time to work through with partners the granularity of its plans to deliver its Vision and three strategic objectives and ensure ‘universal’ sign up.

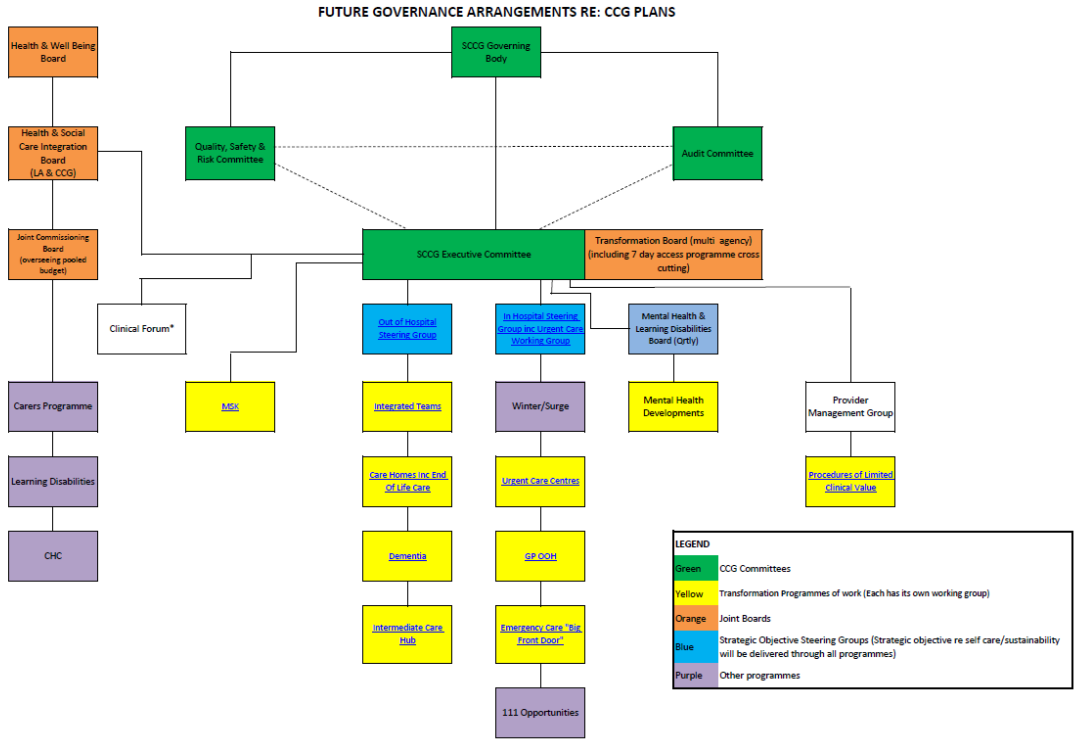
Underpinning the pathways of reform work will be the need to finance non recurrent projects and double running costs. Sunderland CCG is in a fortunate position given its sound financial situation which will be used to support the “reform” agenda outlined above. We have signalled a phased “draw down” of the financial surplus reported by the CCG at the end of 13/14, commencing in 15/16 which gives the wider economy a unique advantage to finance change effectively. Using this money wisely is key to success going forward. Failure to do this, will result in a missed opportunity which is unlikely to come around again.

15.0 Delivery of our plan

15.1 System Ownership and Alignment

As a Health and Social Care System, we have set in place a framework and structure to ensure that all of the components of this strategic plan are efficiently and effectively implemented including a comprehensive performance management regime and governance framework.

A Transformation Board, with senior representation from all key partners, has been established to ensure system ownership and alignment overseeing the delivery of this plan and a robust multi agency programme board structure, outlined below, has been established to drive delivery of key transformational changes.



NB: The clinical forum will be focused on clinical pathways to inform variation in care, however, there are also GP Executive Leads on each Programme Board.

15.2 Organisational Development

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”. In Sunderland we fully embrace this philosophy and the concept of continuous improvement and development. This strategic approach is critical as we continue to develop and grow as an organisation.

As the CCG is still in its infancy we have developed an Organisational Development Plan in order to:

- Support the delivery of the 5 Year Strategic Plan and 2 Year Operational Plan to deliver our vision and transformational changes to improve health outcomes;
- Ensure a system wide approach with partners to organisational learning;
- Ensure 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 are being progressed;
- Establish a cross-cutting approach by connecting our efforts, skills, experiences and competencies to develop a more effective system of commissioning.

As a clinically led organisation, the CCG will add value and continue to use appropriate mechanisms to seek feedback on our performance as leaders of the local health economy.

We are working with our partners to address our shared priorities and challenges and ensure our approach to organisational development across the health economy provides a strong platform to deliver our vision.

As an organisation we promote organisational learning and are committed to promoting a learning culture to ensure that all staff are developed to provide safe and effective care and to achieve their full potential.

16. Equality and Diversity

An Equality Impact Assessment has been carried out on this strategic 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.

The CCG buys support for managing the Equality Delivery System from the North of England Commissioning Service (NECS) and an in-depth consultation exercise was undertaken by NECS on behalf of the CCG with local stakeholders from the nine protected characteristics groups. This feedback, along with existing feedback from a prior consultation exercise undertaken in 2012, was used to inform the development of the CCG's equality objectives.

The objectives were reviewed by the Executive Committee and formally approved by the Governing Body in October 2013. An action plan has also been developed to support the delivery of these objectives and process established to monitor progress via the Executive Committee, with formal reporting to the Governing Body on a six monthly basis.

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.