Sunderland TPCT

Integrated Strategic and Operational Plan 2011 - 2015

Contents

Section 1 - Introduction

Since 2006, Sunderland TPCT has been working towards a shared vision with Sunderland PCT and South Tyneside PCT as part of "NHS South of Tyne and Wear". Within Sunderland the implementation of that vision has been built upon a detailed understanding of local need set out in the Joint Strategic Needs Assessment (JSNA), developed in partnership with Sunderland Council. Implementation plans, including finance, activity, workforce and key performance indicators have all been developed specifically for Sunderland TPCT, but the planning, delivery and performance management processes which have been put in place have been at an NHS South of Tyne and Wear level.

This Integrated Strategic and Operational Plan for 2011/15 sets out for Sunderland TPCT a four year vision for improvement supported by plans for meeting the national priorities set out in the "Operating Framework for the NHS in England 2011/12" and the local priorities identified by the JSNA.

"Equity and Excellence: Liberating the NHS" and the subsequent Health and Social Care Bill set out new structures and systems for the NHS, including the transition of commissioning from PCTs to GP Commissioners and Local Authorities. 2011/12 is the first year of this transition and the PCT is still accountable for delivery of national priorities using the £563m allocation. However the emerging GP Commissioners and the Local Authorities will increasingly be taking delegated responsibility for these functions.

This ISOP reflects the transition by describing a broad 4 year vision based on existing strategy, with detailed delivery plans for 2011/12 and a high level direction of travel for the subsequent three years. The existing Sunderland Practice Based Commissioning Chairs have been involved in the development of the ISOP along with clinical and management leads from the Sunderland PBC clusters, but until the new Board structure and leaders are in place they have not been in a position to fully shape and sign off the plans. This ISOP provides the emerging GP Commissioners with a baseline plan which ensures performance is maintained and improved for all the national and local priorities in 2011/12. As the new GP Commissioning Consortium develops and moves towards pathfinder status it will increasingly shape and reshape the detail within this plan, particularly for years after 2011/12.

Section 2 – Context and Health Needs

2.1 Context

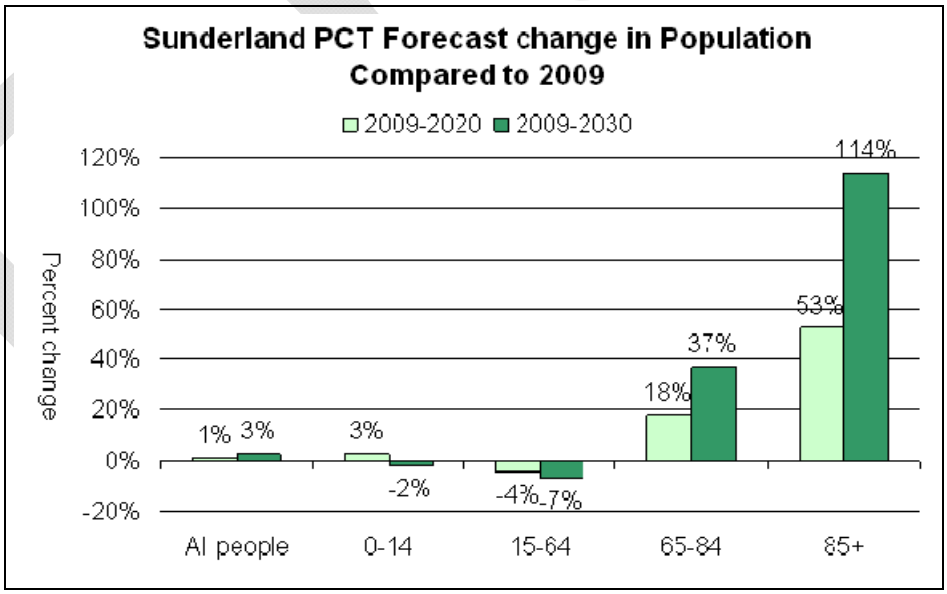
The NHS South of Tyne and Wear 2010-2014 Strategic Plan summarised detailed analyses of current health and health services in Sunderland, underpinned by the Joint Strategic Needs Assessment.

The people of Sunderland die an average of 8 years earlier than people who live in the healthiest parts of England. There is an equally stark gap of over 10 years between the most deprived and least deprived communities in our area. In Sunderland people:

- Feel that they have poorer health and well being than the rest of England;
- Are admitted to hospital more often;
- Die earlier than people elsewhere in England.

Cancer and heart disease are the main killers and many of these avoidable deaths are caused by higher than average levels of smoking, drinking and obesity. These problems are largely the legacy of a post-industrial and mining economy which over the past half a century has seen declining prosperity and increasing deprivation, with all the health and social problems which that brings.

Sunderland TPCT has a population of 280,000 which is forecast to increase by around 7,600 (3%) over the next 20 years. However, the age structure within the overall total is forecast to change significantly, as follows:



Office for National Statistics, 2008-based Subnational Population Projections, available at 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 can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group, 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.

Local health services are generally good, as shown by the Care Quality Commission ratings, with some assessed as amongst the best in the country. However, there are still areas where they can, and should, be better:

- All services should be consistently excellent – analyses show that there are still variations in performance and outcomes;
- Feedback from patients shows that sometimes services fall short of expectations and choice and access could be better;
- There is still duplication and waste in the way some services are provided.

2.2 Joint Strategic Needs Assessment

Joint Strategic Needs Assessment (JSNA) is a continuous process by which the PCT and Council, working with partners including the third sector and patient/public groups, identify the health and well-being needs of the local population. In 2008, the Sunderland JSNA was jointly developed by the Directors of Public Health, Adult Services, and Children's Services. It has been refreshed, including analysis of up to date health and well being information; insight into expressed needs of local people and identification of effective interventions including where these are not taking place.

The JSNA process used a structured prioritisation process with clear criteria, involving partners and the public, to identify the main priorities for Sunderland as follows.

- Increase life expectancy and reduce health inequalities;
- Children – improve health (including mental and emotional health) and wellbeing through specific interventions and promotion of healthy lifestyles, focusing on alcohol, drugs & tobacco, obesity, teenage pregnancy, breastfeeding, smoking in pregnancy & infant mortality;
- Adults – early identification and management of health risks, including dementia, circulatory disease and other long term conditions, alcohol, obesity, drugs and tobacco, mental ill health, cancer screening;
- Reducing health inequalities by focussing on the wider determinants of health, including deprivation, employment, education, environment and by identifying neighbourhoods to target.
- Improve immunisation rates for measles, mumps and rubella;
- Reduce child accidents and focus on cycle safety;
- Decrease falls;
- Extra care facilities for older people, commissioned with housing partners.

One of the starkest inequalities highlighted by the JSNA is in 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.

The London Health Observatory "Health Inequalities Intervention Tool" was used to analyse the life expectancy gap, and identified that over 60% of the gap is caused by CVD, cancer and respiratory diseases. The Health Inequalities National Support Team (HINST) has supported this work through the development of five supporting strategies which include tobacco control, community engagement, measuring impact, maintaining momentum and working with the Local Authority and implementation of the following 8 High Impact Interventions which are incorporated in our plans:

- 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.

2.3 Health needs – 2010 community health profile

Health summary for Sunderland

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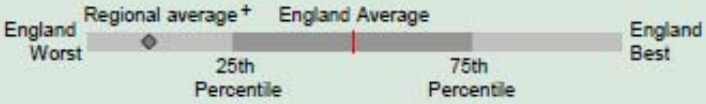
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England 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
- No significance can be calculated



+ 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	89.2		0.0
	2 Children in poverty	14317	27.4	22.4	66.5		6.0
	3 Statutory homelessness	217	1.79	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1591	45.1	50.9	32.1		76.1
	5 Violent crime	4556	16.3	16.4	36.6		4.8
	6 Carbon emissions	1864	6.7	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	665	23.4	14.6	33.5		3.8
	8 Breast feeding initiation	1484	52.3	72.5	39.7		92.7
	9 Physically active children	18312	51.5	49.6	24.6		79.1
	10 Obese children	302	11.0	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.9	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	306	55.8	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	29.4	22.2	35.2		10.2
	14 Binge drinking adults	n/a	29.5	20.1	33.2		4.6
	15 Healthy eating adults	n/a	18.8	28.7	18.3		48.1
	16 Physically active adults	n/a	9.5	11.2	5.4		16.6
	17 Obese adults	n/a	29.1	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	27	9.5	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	7658	43.5	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	7588	2370	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	12102	4.32	4.30	6.72		2.69
	23 New cases of tuberculosis	23	8	15	110		0
	24 Hip fracture in over-65s	295	526.2	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	131	14.1	15.6	26.3		2.3
	26 Life expectancy - male	n/a	75.4	77.9	73.6		84.3
	27 Life expectancy - female	n/a	80.4	82.0	78.8		88.9
	28 Infant deaths	13	3.99	4.84	8.67		1.08
	29 Deaths from smoking	621	301.7	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	284	88.9	74.8	125.0		40.1
	31 Early deaths: cancer	447	141.1	114.0	164.3		70.5
	32 Road injuries and deaths	107	38.3	51.3	167.0		14.6

Source: Association of Public Health Observatories

The overall picture is one of health and risk taking behaviours which are significantly poorer than the England average.

2.4 Current Performance

The 2010/11 Annual Operational Plan (AOP) set out the agenda for Sunderland TPCT, including delivery of local priorities from the Strategic Plan and national requirements in the 2010 Operating Framework. Throughout the year performance against this agenda has been monitored and managed (see section 7.2) and forecasts for the year end show that the majority of targets, standards, and milestones have been achieved.

In a small number of areas, risks to performance delivery in 2010/11 have been identified and these are subject to the performance escalation and recovery processes described in section 7.2 to ensure that performance in 2011/12 will recover to planned levels. Areas currently monitored as part of the escalation process include:

Smoking	Teenage Conceptions
Breastfeeding at 6-8 weeks	HCAI
Chlamydia	Stroke
Cancer waiting times 62 days urgent referral to treatment	Mortality/Health inequality
Hospital Activity	Immunisation
A&E and ambulance turnarounds	Dental Access

Section 3 – Vision for the future

The evidence paints a picture of a patch in need of major changes if local people are to be at least as healthy as the rest of the country. The Strategic Plan describes a vision in which the future will see:

Better health - *longer lives, with better quality of life and fair access to services*.

- Increased focus on the prevention of ill health;
- Reduction in lifestyle choices which pose major risks to health, such as smoking;
- Increase in the care and treatment given to people with established illness;
- Reduction in health inequalities with the rest of England, and within Sunderland;
- Full alignment with local partners so that all are working to the same targets.

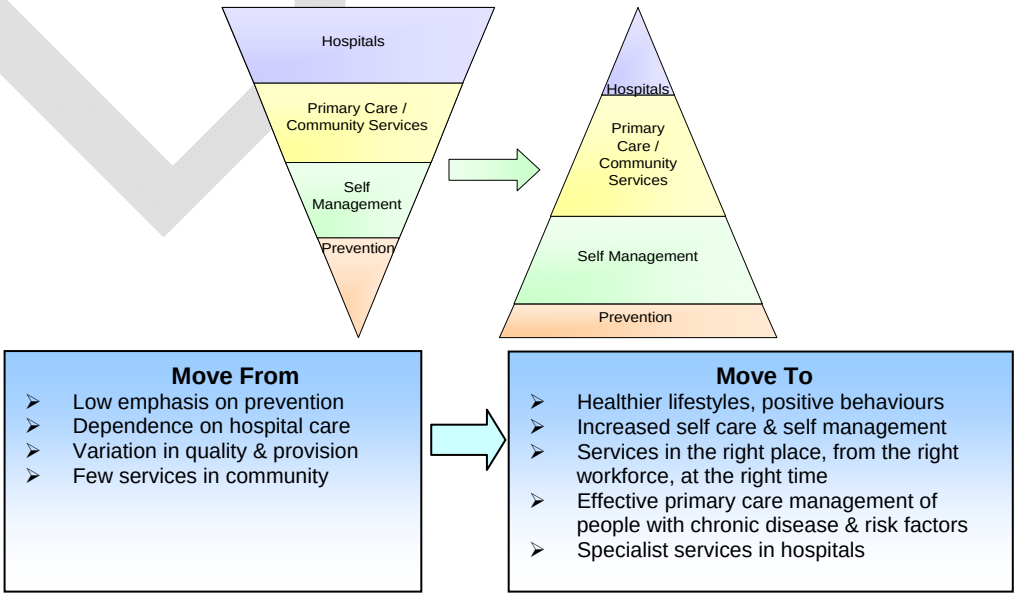
Excellent patient experience - *safe care, effective treatment and quality services.*

- Routine evidence that all commissioned services are safe and effective;
- Increase in choice of services for patients, at all stages of their care;
- Public confidence in all commissioned services;
- More personal control throughout patients' journey through health services;
- Significant increase in the care available closer to patients' homes;
- Every contact with a health professional to be a health improvement contact;
- Patient care structured in pathways across organisations and systems.

Wise use of the money - *right services at the right place, first time, reducing waste and ensuring value for money.*

- Demonstrable value for money;
- An estate which is fit for purpose;
- No unnecessary waits;
- Flexible and adaptable workforce, fit for purpose, centred on needs of patients;
- All patients to receive the right care in the right place, first time;
- Primary Care Centres providing alternatives to traditional hospital care.

This vision needs services to move away from an emphasis on treating ill health to one of helping individuals to live healthier lives, supported by an integrated tiered healthcare system as shown in the following diagram.



To achieve this "future state" the focus of change needs to be on:

- Stopping people getting ill (**prevention**);
- Actively identifying people with existing disease and those at risk of developing illness and establishing personalised treatment plans (**secondary prevention and long term conditions care**);
- When people do need treatment, providing high quality care in the right setting at the right time and so freeing up hospital space for our increasing elderly population (**care closer to home**).

This will be done by:

- **Improving health** - commissioning new services in tiered models of care with integrated pathways (moving in the future to greater joint/integrated commissioning of services);
- **Reforming services** – radical modernisation of pathways focused on safe, excellent quality services, eliminating waste and shifting care out of hospital, across a spectrum towards self care as appropriate (right services, right place, first time).

The areas in which major change is needed and the programmes of initiatives to be undertaken are:

Prevention	**Reducing CVD and cancer mortality**	• Obesity • Smoking • Alcohol
	Ensuring all children have the best start in life	• Child Health • Maternity
Long term conditions	**Identifying people with long term illnesses & risk factors then providing appropriate, high quality care and preventative treatment**	• CVD risk • Cancer
	Providing high quality intermediate and rehabilitative services	• Long term conditions & Rehabilitation
Safer, better quality services, delivered closer to home with no duplication or waste	**Streamlining high quality urgent care for adults and children**	• Sick & Injured children • Urgent care
	Providing more, high quality planned care closer to home	• Planned care
	Changing the way mental health services are provided	• Mental Health
	Providing those at the end of life with a good death	• End of Life Care

Section 4 – The Financial challenge

4.1 Change in financial outlook since publication of the Strategic Plan 2011-15

The NHS South of Tyne and Wear Strategic Plan forecast the 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.

This plan identified a Sunderland financial gap from 2010 - 2014 of £42.4 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. Schemes started in 2010/11 and are forecast to achieve £3.9m savings by the end of the financial year in addition to £16.1m savings delivered by tariff efficiencies.

In December 2010, the NHS Operating Framework for 2011/12, the Comprehensive Spending Review (CSR) for 2011-15, PCT allocations for 2011/12 and the 2011/12 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;
- The time period over which the savings needed to be realised.

These documents build upon information published within the CSR published in October 2010. The CSR gives an insight into the additional funding the NHS is likely to receive in the period from 2011/12 through to 2014/15.

In addition, there is a new tariff rule which means that commissioners will not pay for a proportion of acute re-admissions and the money released by this non-payment is required to be re-invested in reablement. This is estimated as £4.4m based on current performance for Sunderland.

Financial plans have been revised to give a refreshed outlook as follows:

Recurrent Funds Source	Sunderland				
	2011/12	2012/13	2013/14	2014/15	Total
Growth Allocation	£11,288k	£11,277k	£11,514k	£11,756k	£45,835k
Tariff Efficiency	£16,789k	£16,809k	£16,829k	£16,850k	£67,277k
RRIs	£4,345k	£3,269k	£3,109k	£3,374k	£14,097k
Readmissions	£4,387k				£4,387k
	£36,809k	£31,355k	£31,452k	£31,980k	£131,596k
Applications					
Tariff Uplift	£12,247k	£12,276k	£16,003k	£17,883k	£58,409k
Recurrent Investment	£24,562k	£19,079k	£15,449k	£14,097k	£73,187k
	£36,809k	£31,355k	£31,452k	£31,980k	£131,596k
	£0k	£0k	£0k	£0k	£0k

This will enable us:

- To meet national requirements described in the Operating Framework for 2011/12, the developing outcomes frameworks and other national policies;
- To complete implementation of existing commitments;
- To meet the costs of implementing the QIPP programme initiatives;
- To provide contingency reserves for future uncertainty given the lack of future years planning guidance

Appendix 2 sets out the detail of £73.2m recurrent investment plans.

The new planning guidelines indicate a significant shift in emphasis from "allocative" to "technical" efficiency i.e. an extra year of technical savings (2014/15) plus negative tariff assumed for 2011/12 to 2013/14.

The refreshed four year target of £18.5 million from resource releasing initiatives will be delivered through a revised programme of initiatives which are listed in Appendix 1. The schedule includes a number of technical adjustments (some of which have been previously agreed with providers) together with initiatives that continue to support the reform agenda described in the 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.

4.2 NHS Support for Reablement and Social Care

The CSR and the NHS Operating Framework 2011/12, set out a number of funding streams to enable NHS support for reablement and social care services. The NHS White Paper *A Vision for Adult Social Care,* and *Recognised, valued and supported: Next Steps for the Carers* Strategy described the aims for these new funding streams:

- To promote and enable better integrated working between health and social care systems, for the benefit of patients, service users and carers;

- To ensure that individuals are supported to regain and maintain their health and independence.

There are four key funding streams available in 2011/12:

1. £0.9m to develop post-discharge support and reablement;
2. £4.3m to be transferred to Sunderland Council to support social care services to benefit health, and to improve overall health gain (broader range of LA funded social care services);
3. £4.4m to prevent readmission to hospital within 30 days of discharge;
4. £0.6m new funds to support breaks for carers.

Discussions are underway with Sunderland Local Authority to agree the use of the money, the outcomes to be achieved and mechanisms for reviewing performance. The table below outlines examples of the potential use of the funding streams and an initial overview of how decisions will be made.

Examples of potential schemes that funding could be used for	How decisions about allocation of this funding will be made
Development of post-discharge support and reablement	
• Promote seamless discharge from hospital • Ensure rapid recovery from an acute episode • Prevent avoidable hospital readmissions • Reduce dependency on social care services following discharge including a proportion to be spent on development of current reablement capacity according to local needs	• Work with Sunderland Council, local hospitals and Community Health Services to develop locality plans and agree outcome metrics • Funding may be transferred to local partners or pooled budgets - local discretion regarding the proportion of spend on the NHS and social care • Plans used as the basis for coordination of activity on post-discharge support from 2011/12 onwards, keeping plans and outcomes under review in conjunction with GP Consortia and the Council
To support social care services to benefit health, and to improve overall health gain - broader range of LA funded social care services	
• Short term residential care places • Respite and intermediate care; home care support • Investment in community equipment • Adaptations and telecare • Crisis response teams and services that prevent hospital admission • Further investment in reablement. • Funding may be used to support and maintain existing services as well as new investment.	• Funding to be transferred to Sunderland Council via S256, to spend on social care services which also benefit health • Agree jointly with Sunderland Council how the funding should be spent and the outcomes to be achieved • Decisions to take into account the JSNA and existing health and social care commissioning plans • Sunderland Council to update on performance using appropriate local mechanisms
To prevent readmissions within 30 days of discharge	
Schemes that improve the support available to patients with the 30 days following discharge from hospital	Work with local hospitals and other agencies to introduce appropriate services in 2011/12, whilst also anticipating and preparing for the change in responsibility for the care of patients in this period to acute care providers and the subsequent change to the tariff
New resources for carers breaks	
To provide carers breaks, as far as possible, via direct payments or personal health budgets	Agree policies, plans and budgets to support carers with Sunderland Council and local carers organisations and make them available to local people

Section 5 – Overview of key changes in finance, activity and workforce

A key part of the development of this ISOP is ensuring that:

1. Planned / contracted hospital and community activity levels reflect our forecasts of demand changes and impacts of planned resource releasing 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.

This section describes how these elements are balanced within our plan.

5.1 Hospital Activity

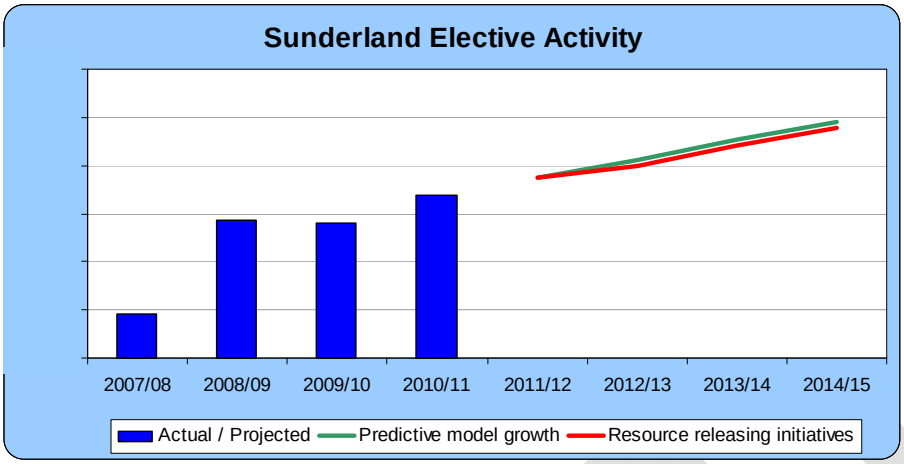
We use a predictive model to forecast changes in hospital and community activity levels. The model looks at the likely impact of those changes over which we have little or no influence, such as population changes, clinical technology, patient expectations etc. This model shows that for Sunderland TPCT, 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 four years.

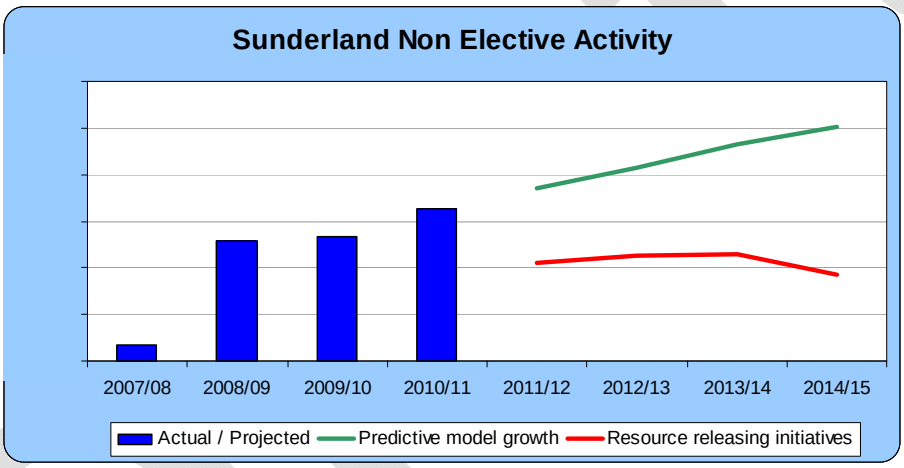
	2011/12	2012/13	2013/14	2014/15
Elective Hospital Spells	1.43%	1.49%	1.65%	1.48%
Non Elective Hospital Spells	1.24%	1.32%	1.43%	1.14%
First outpatient attendances	1.50%	1.53%	1.82%	1.69%

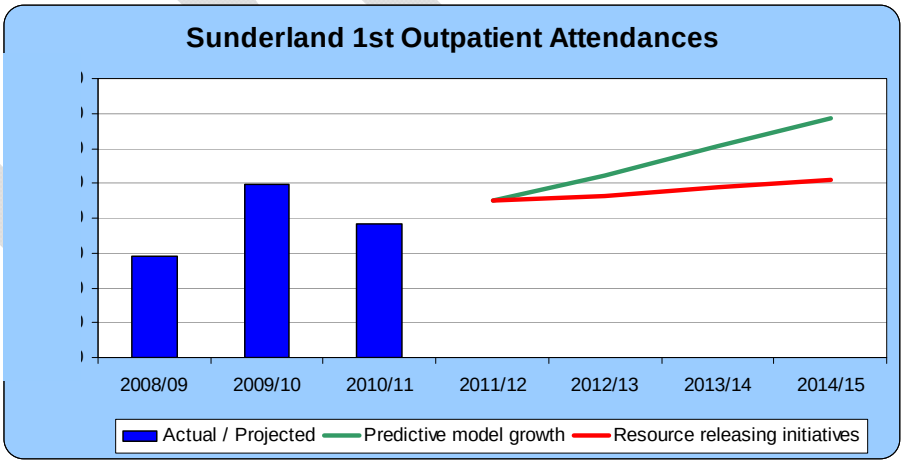
Similar increases in accident and emergency (A&E) activity are expected, if we do not change how these services are provided.

However, as detailed in the delivery section of this ISOP, we have a range of plans in place to reduce hospital activity (inpatient, outpatient and A&E) through redesign of services, better care of people with long term conditions and more streamlining of urgent care services.

The green lines on the following graphs show the forecast growth in activity, while the red lines show how the plans for activity reductions mitigate this growth. The numbers shown by the red line are those in our activity trajectories, submitted to the Strategic Health Authority and Department of Health (see Appendix 3).







The planned activity reductions in the original 2010 -14 Strategic Plan were significantly higher than those above. Section 4.1 in this plan describes how increased efficiency in the payment by results tariff, together with savings already achieved in 2010/11, have reduced the need for PCT resource releasing initiatives by 2014/15 from £42.4m to £18.5m

(including £4.4m non-payment for readmissions which is earmarked to be spent on re-ablement).

The reduction in non-elective activity is still significant, reflecting the need to actually reduce re-admissions which will not be paid for, to avoid unsustainable financial pressure on our local hospitals, as well as a strategic need to reduce admissions so that future demographic pressures do not exceed local hospital capacity.

However, the reductions in planned activity (from moving services out of hospital closer to home) have been scaled back significantly, to reflect the reduced PCT management capacity to undertake detailed pathway reform, but also in recognition of the significant financial pressures already placed on local providers through the increased tariff efficiency (estimated at a 4% efficiency needed from each provider in each of the next 4 years). The move of planned care out of hospital is now focused on outpatient rather than inpatient services. Further loss of income in the short term could impact on provider viability which would potentially reduce local access, choice and patient safety.

5.2 Community Activity

The reduction of 225 elective hospital spells and 3,540 outpatient attendances over 4 years will be achieved by moving services out of hospital into primary or community care and will require an increase of around 7,530 primary / community contacts.

The reduction of 3,199 non elective spells over the same time period will be achieved through better care of people with long term conditions outside hospital and the streamlining of urgent care services. These changes will require an increase of around 12,800 primary care contacts and / or community contacts.

5.3 Financial Implications

The expected hospital activity changes shown in the above graphs (and our trajectories at Appendix 3) will have the following financial impact:

	2011/12 £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000	Total £'000
Cost of predicted activity growth					
Elective admissions	£741	£783	£876	£799	£3,200
First outpatients	£208	£215	£257	£240	£921
Non Elective Admissions	£744	£766	£834	£665	£3,009
A&E, review outpatients, other hospital investments & contingency	£4,157	£1,585	£1,383	£1,646	£8,770
Total in Investment Plan	**£5,850**	**£3,350**	**£3,350**	**£3,350**	**£15,900**
Savings from Resource Releasing Initiatives					
Elective admissions	£0	-£400	£0	£0	-£400
First & review outpatients	-£239	-£681	-£681	-£442	-£2,043
Non elective admissions	-£4,387	-£616	-£926	-£1,680	-£7,609
Non acute activity related disinvestments	-£4,106	-£1,572	-£1,502	-£1,252	-£8,432
Total in disinvestment plan	**-£8,732**	**-£3,269**	**-£3,109**	**-£3,374**	**-£18,484**

The £15.9m cost of the modelled activity growth, plus other hospital investments plus a contingency for hospital activity is included in our investment schedule at Appendix 2. The £18.5m saving from the resource releasing initiatives is the total of the disinvestment schedule (Appendix 1).

We also need to provide for the costs of approximately 20,330 additional primary / community activity as services and patients shift out of hospital. Until detailed pathways and business cases are developed for each service, these costs cannot be accurately estimated other than at a very high level, so a substantial contingency / moving out of hospital provision has been made in the disinvestment plan to cover these costs.

5.4 Workforce

In modelling the potential impact of the changes in activity and finance on the workforce across the SOTW collaborative area, we have used a NE-wide McKinsey workforce model and shared the initial output with local providers.

The generic assumptions used in the modelling are;

- Activity increases and reductions are as per activity section above;
- Pay inflation is 0.3% to take into account the pay uplift for staff earning under £21,000 per year;
- Pay drift is 1.0% to take into account the incremental progression.

The additional assumptions for the "Worst Case" model are:

- Trusts will need to make 4% per annum efficiency gain re tariff efficiency, this gain would be made through workforce productivity;
- No skill mix changes;
- Sickness absence remains as currently.

The additional assumptions for the "Base Case" model are:

- Trusts will need to make 2.8% per annum efficiency gain re tariff efficiency, this gain would be made through workforce productivity;
- Sickness absence reduction of 0.5%;
- Efficiency savings out of none workforce areas, e.g. estates, day case and medicines costs.

The additional assumptions for the "Best Case" model are:

- Trusts will need to make 2.3% per annum efficiency gain re tariff efficiency, this gain would be made through workforce productivity;
- Skill mixing of the workforce, increasing the numbers of band 1-4 workforce and increasing the shift of work from Medical to Nursing practitioners, AHPs and ST&T.
- Sickness absence reduction of 0.5%.

The modelling work would indicate that there is a potential for workforce reductions between 6% and 10% across the SOTW collaborative area. However discussions with Providers indicate that plans are not yet finalised, and they are considering the following productivity initiatives to mitigate the potential workforce reductions:

- Efficiency savings out of none workforce areas, e.g. estates, day case and medicines costs;
- Reducing sickness absence, in line with SHA targets and Audit Commission recommendations;
- Changing the skill mix of the workforce, with the potential to employ more band 1 - 4 workforce;
- Increasing use of technology to increase productivity of the workforce

- Reduction in temporary staffing and agency costs;
- Reduction of the use of overtime;
- Reviewing and re-profiling of posts as they become vacant;
- Reviewing terms and conditions of employment, pay and incremental progression;
- Putting more activity through less beds.

The need for greater efficiency and productivity is being jointly reviewed by the PCT and FT Chief Executives and Medical Directors, referred to as Accelerated Bigger Picture Group, to consider the best future configuration of NHS hospital services in order to achieve significant financial savings. Therefore greater efficiency including workforce productivity improvements will be a combination of all the initiatives noted above; the mixture of which will be specific to each provider. We will continue to work with providers to understand this changing landscape and inform future education commissions.

Section 6 - Implementation Plans

6.1 Programmes of Work

2011/12 is the 2nd year of the implementation of our Strategic Plan which identified the key strategic programmes to be delivered in order to achieve our vision. The programmes were developed for implementation across South of Tyne and Wear with generic initiatives to be delivered within each PCT. However with the transition to GP Commissioning and the establishment of the Health and Well Being Board, it is anticipated that the Plan will be reshaped over the next year to reflect a more local approach to implementation.

The following section details for each of following 15 programmes:

Obesity	Smoking	Alcohol
Sexual Health	Child health	Maternity
Cancer	Long Term Conditions	Sick and Injured Child
Urgent Care	Planned Care	Mental Health
CAMHS	End of Life	NHS Health Checks

- The longer term vision for improvement;
- Specific actions to be undertaken in 2011/12 including actions to deliver national requirements set out in the Operating Framework;
- Detailed investments and disinvestments planned for 2011/12 with a broad view of financial plans through to 2015;
- Activity implications of the actions;

- Workforce implications of the actions;
- Informatics implications of the actions;
- Estates implications of the actions;
- Communications implications of the actions;
- Measures and milestones we will use in-year to track progress against the programme.

In addition to these 15 strategic programmes, there is a section describing the medicines management strategy which will maintain primary care prescribing cost growth below 2% per annum, releasing £1.05m for investment in other services. The PCT and GP Commissioners will work jointly with partners across the following four areas:

- Enabling prescribers to make high quality and cost effective prescribing choices;
- Examining and improving supply routes for a range of products;
- Ensuring robust processes for decision-making and commissioning of new medicines;
- Reducing medication waste.

We will work with stakeholders to improve communication about medicines at the interface between primary and secondary care to reduce medication adverse events and inappropriate hospital admissions. We will optimise the use of GP and community pharmacy contracts to improve the quality of prescribing and to commission new services to support patients to take their medicines effectively.

6.1.1. Emerging GP Commissioner

As part of the programme of disinvestments (Appendix 1), a target has been set to reduce the prescribing expenditure to the North East average. Delivery of the savings relies on continued GP Consortia and GP practice ownership and implementation of action plans jointly developed with the Medicine Management Team.

6.2 Additional requirements in the 2011/12 NHS Operating Framework

There are a number of requirements detailed in the 2011/12 NHS Operating Framework together with some Resource Releasing Initiatives that are not included in our strategic programmes. These include:

- Cleanliness and Health Care Associated Infections
- Mixed Sex Accommodation
- Military Personnel
- Emergency Preparedness
- Acute Access
- Primary Care Access
- Experience, Satisfaction and Engagement
- Safeguarding

We have developed integrated action plans for each of these requirements; a summarised example of this is Emergency Preparedness which is shown below. Appendix 4 identifies where each of the individual requirements in the NHS Operating Framework is addressed within this Plan i.e. within a program identified in section 6 or an integrated plan.

Emergency Preparedness Integrated Plan - ISOP Project Overview 2011/12

Month:

Operating framework Ref:	Projects	Key milestones 2011/12			Risk to year end target 2011/12	
			Key milestones *(identify top 4 milestones for each project)*	Target date	Risks to year end target	Mitigating actions if red or amber
4.61	Ensure all NHS organisations, other contracted healthcare providers, local authorities and other local organisations maintain and test plans and arrangements to deliver an effective response to threats and hazards	1	Develop a revised NHS SoTW Strategic Major Incident Plan to meet the role and responsibilities of the organisation and its commissioning role, and coordinate with partner's plans to provide the tactical and operational response to any incident.	Apr-11	Key staff absence preventing completion of documentation and plans. Not being able to fulfil plan due to an occurrence of an incident as the same personnel would be involved in both	Early draft disseminated to key individuals across commissioning and provider organisations to expand and ensure awareness and familiarity. Consideration, in accordance with the regional calendar, would be given to suspend exercise in order to ensure any incident is prioritised.
		2	Develop a programme for multi-agency exercises to include Command and Control systems, along with all aspects of strategic management and tactical/operational response	Apr-11		
		3	Ensure compliance with the Civil Contingencies Act 2004 is integral to all plans, including Business Continuity and include within the exercise programme.	Apr-11		
4.61	Maintain the current capability and capacity of the existing 12 Hazardous Accident Response Teams (HARTs) in Ambulance Trusts now that funding for HARTs is in their allocations	1	This is being picked up by the SHA for 2011/12. Arrangements for 2012/13 onwards have yet to be finalised.	SHA Timescale		
4.62	Ensure all NHS organisations have well developed plans in place to manage exceptional surges in activity	1	Develop revised strategic level Plans to meet the role and responsibilities of NHS South of Tyne and Wear, each to have their own command and control system that can function independently of the others. A Generic SoTW NEEP (North East Escalation Plan) is being revised and will be applied during winter 2011	Nov-11	N/A Plan is a living document and subject to continuous refinement	
		2	Develop a Heatwave Plan - to address surge activity during extreme summer temperatures.	May-11		
4.62	Ensure all NHS organisations have necessary plans in place to maintain service provision and meet any additional demands arising from events associated with the Olympic and Paralympic Games in July 2012	1	The PCT will participate in early and further planning stages in relation to identified training sites etc in the region and potential demands including associated events during summer 2012 in line with SHA guidance.	SHA Timescale	This is regionally-led by the SHA and Local Resilience Forum, working to national calendar.	
4.63	Ensure NHS organisations maintain and continue to test with their local partners the ability to operationalise and coordinate their pandemic response plans across local areas	1	Review and finalise NHS SoTW Strategic Pandemic Influenza Plan to coordinate with partner's tactical/operational response plans. Plans will be flexible, as directed, in managing different levels of clinical attack.	Nov-11	Risk of summer pandemic requiring a sufficiently robust plan to be ready.	In such circumstances the existing plans would be used, and whilst some revisions would have been outstanding if such an event occurred they remain fit for purpose in ensuring a robust response.

OBESITY

Why is change needed?

- Higher than average levels of adult and child obesity, Sunderland features in the worst 25% areas in England
- 21% of adults living in Sunderland are obese
- 1 in 5 children (year 6) living in Sunderland are obese
- Big rise in obesity over the last fifteen years (1 in 7 adults were obese fifteen years ago)

Objective

Develop and maintain comprehensive obesity prevention, management and treatment service to reduce obesity prevalence and reduce the obesogenic environment

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

- Reduction in obesity rates in children and adults
- Work with partners to increase the physical activity and healthy eating rates in children and adults
- Sustain and improve effective multi-agency partnership work
- Ensure equity of access and delivery of activity services for patients across Gateshead
- Sustain and improve effective multi-agency partnership work
- Workstreams underpinned by robust data on health related behaviour among the population
- Delivery of communication across Sunderland, supporting national and regional campaigns such as 'Lets Get Moving' and 'Change4Life', to increase awareness of healthy lifestyle advice and services on offer for patients

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Commission new health and lifestyle Survey				
Evaluate current obesity service provision to assess outcomes and effectiveness of established models for Children and Adults				
Implement the Obesity Strategy action plan including working with planning and regulatory services to influence the spatial environment and access to unhealthy food.				
Delivery of Marketing Strategy across Sunderland				
Review of National Child Measurement Programme processes through RPIW to ensure accurate recording of obesity levels to support targeted work with schools				
Work with partners to deliver reduction in obesity and support the increase in physical activity and the staying healthy agenda				
Review GP referral patterns for activity services to ensure equity across Sunderland				

How much will this cost or save?

In 2008-09 £3.3m was invested in new, tiered obesity services based on national guidelines. There are no plans to make additional investment this year but plans include delivery of improvements within existing budgets

What KPIs will we use to monitor progress?

Headline Measures

Supporting Measures

- Childhood obesity rates coverage at reception and year 6
- Childhood obesity rates prevalence at reception and year 6

Local Measures

- Percentage of demonstrable weight loss
- Percentage demonstrable reduced BMI
- Percentage physical activity

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Demand for Slimming on Referral programmes is outstripping budget allocated to it.	Re-organised budgets to increase allocation. Renegotiating contracts to better align programmes to outcomes achieved.
Evaluation is required prior to end of initial 3 year contract agreements. However it may be difficult to benchmark NHS South of Tyne and Wear services as they are delivered on a larger scale than in comparator localities.	Request national providers such as Weight Watchers and Slimming World to provide analysis against non-subsidised programmes. Carry out evaluation exercise in 2011/12 based on first 2 years of large scale activity.
NCMP uptake rates have dropped in 2009/10 and prevalence of obesity in year 6 has not reduced.	Kaizan event to ensure methods of monitoring are maintained scheduled in April. Targeted interventions to be rolled to schools with identified high prevalence rates.

Communications Implications

Develop a detailed communications plan to:

- Raise awareness of existing services
- Support national and regional change 4 life and lets get moving programmes
- Promote opportunities for physical activity

Informatics Implications

- Improve data capture & validation for referral into specialist services at point of intervention
- Access to analysis and presentation tools re outcome and activity data
- Mechanisms to share information with public on obesity services

Estates Implications

- Stronger links between exercise/leisure facilities and health.
- New dietetic facilities Washington & Houghton PCCs.
- Expansion of wellness at Houghton PCC
- Bookable consulting, interview and group space is being expanded in health centres and PCCs.

Workforce Implications

- Increased skills and training for all front line staff, particular focus on motivational interviewing skills
- Specialist obesity skills scarce and will be subject to competition from neighbouring PCTs as they implement tiered obesity models

SMOKING

Why is change needed?

- It is estimated that 25% of adults in Sunderland smoke, compared to 22% nationally
- 1 in 5 adults living with a chronic condition smoke
- 22% of women smoke during pregnancy – significantly higher than the national average (16%)
- Higher numbers of deaths from lung cancer than national average
- Higher number of deaths from CVD than national average

Objective

To develop a comprehensive and co-ordinated system for smoking cessation and tobacco control and contribute to a smoke free Sunderland

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

- Reduced smoking prevalence, particularly pregnant women & routine / manual workers
- Increased smoking quitters
- Fewer young people taking up smoking
- Comprehensive tiered stop smoking services targeted at areas of greatest need
- Sustain and improve effective multi-agency partnership work

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Maintain a robust multi-agency tobacco alliance plan and deliver cross-agency programme of tobacco control, incorporating the 7 strands of the regional tobacco plan				
Commission systematic NHS Stop Services, ensuring robust pathways developed and social marketing plan delivered to increase uptake				
Regular monitoring systems will be further developed to support further targeting of services to key groups				
Develop plan to recommission specialist services in line with national guidance and best practice.				
Utilise CQUIN scheme to increase health promotion contacts and smoking intervention in both community and hospital, focussing on pregnant women				
Develop provision of prevention and treatment services for young people, working closely with partners				
Work with Trading Standards to reduce the supply of illicit tobacco				

How much will this cost or save?

In 2008-09 £1.4m was invested in new, tiered smoking services based on national guidelines. There are no plans to make additional investment this year but plans include delivery of improvements within existing budgets

What KPIs will we use to monitor progress?

Headline Measures

Supporting Measures

- 4 week smoking quitters

Local Measures

- Smoking during pregnancy
- Smoking among people with a chronic condition
- Smoking quitters per 100,000 population aged 16 and over

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Recommissioning of Tier 3 service may create instability	Paper to be presented to Commissioning Executive Team to plan to manage re-commissioning process
Smoking slips from local agenda replaced by competing priorities	Working closely with Tobacco Alliance and FRESH to monitor the focus on smoking and tobacco control.
Reduced investment in FRESH and Department of Health campaigns	Funding has been agreed locally to support FRESH for the coming year.
Capacity to deliver targeted schemes to areas of greatest need	Undertake review of capacity required to deliver priorities within the development plan

Communications Implications

- Deliver communication campaign across Sunderland and in support of regional and national work with FRESH

Informatics Implications

- Improve data capture & validation for local information following roll-out of smoking database
- Access to analysis and presentation tools re outcome and activity data

Estates Implications

- Access to facilities to deliver services to target groups in a variety of settings e.g. community and workplace

Workforce Implications

- Increased skills and training for all front line staff, particular focus on motivational interviewing skills
- Workforce capacity to deliver priorities within development plan may not be sufficient

ALCOHOL

Why is change needed?

- Higher than average levels of binge drinking, Sunderland featuring in worst 10 areas in England
- Higher than average admissions to hospital for alcohol related conditions
- Children under 16 are consuming twice as much alcohol as 10 years ago
- Disease modelling shows expected increases in obesity and alcohol use if action is not taken

Objective

Promote positive healthy culture of alcohol consumption and commission 4 tiered service model to reduce alcohol related harm

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

- Create positive healthy culture of alcohol consumption across Sunderland
- Ensure commissioned services provide comprehensive treatment services
- Halt & reverse rise in hospital admissions for alcohol related harm back to 2010 levels
- Ensure data is available to monitor service delivery and the outcomes for patients
- Sustain and improve effective multi-agency partnership work

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Evaluate current service provision to assess outcomes and effectiveness of established pathways				
Develop Communication Plan and work with Balance to promote healthy culture in relation to alcohol				
Undertake pilot of residential rehabilitation placements which will support the development of PBR tariff				
Implement LES for GPs				
Work with providers to increase data completion rates within Cardiff model				
Continue to enhance delivery of recovery based pathways by developing recovery champions and respond to emerging model of care				
Work with partners to continue delivery of Hidden Harm Strategy and enhance family based approaches to service delivery				

How much will this cost or save?

In 2008-09 £6m was invested in new, tiered alcohol services based on national guidelines. There are no plans to make additional investment this year but plans include delivery of improvements within existing budgets

What KPIs will we use to monitor progress?

Headline Measures

- Rate of alcohol related hospital admissions

Supporting Measures

-

Local Measures

- Waiting times for treatment
- Planned discharge rates from services

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Alcohol related admissions continue to rise	Comprehensive Hospital Liaison Service commissioned and in place. RPIW scheduled for April 2011 to look to ensure full efficiency of service delivery.
GP Enhanced service not currently in place to assure broad based access to tier 2 and 3 interventions.	Agreed reached by LMCs with service be roll-out from 01 April 2011. Training is required in each area.
NHS Health Checks are evidencing high levels of high risk drinking, but alcohol interventions not offered within pharmacy settings.	Pharmacy LES agreed by LPCs to support the NHS Health Checks programme. Training is required in each area.

Communications Implications

- Deliver marketing campaign re: hazardous and harmful drinkers
- Development of NHS South of Tyne and Wear communication plan
- Support national and regional campaigns, working with BALANCE

Informatics Implications

- Commissioning Portal to enable production and dissemination of all performance reports
- PCT support with non-NHS providers re: data flows
- Further develop service specifications

Estates Implications

- Expansion of wellness services at Houghton PCC
- Support clinicians in entering into occupation licenses in range of settings
- Bookable consulting, interview and group space expanded in health centres and PCCs.

Workforce Implications

- Provide accredited brief intervention training to non-clinical and clinical staff, including providers and those services involved in the wider social/healthcare agenda
- Criminal justice training using external agency
- GP training for alcohol LES

SEXUAL HEALTH

Why is change needed?

- Lack of coordination and consistency of Sexual Health delivery across Sunderland
- Significantly worse teenage conception rates compared to the England average
- Increase Chlamydia screening rates within the 15-24 year old age group across Sunderland

Objective

To ensure all sections of the population have access to information, education and services that encourage safe sex in order to reduce sexually transmitted infections and emotional distress

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

- Work with the GP clinical lead on sexual health to raise awareness of issues in primary care, and increase access to Long Acting Reversible Contraception through Primary Care
- Increase Chlamydia Screening within generic services
- Reduced teenage conception rates
- Equitable access to sexual health provision including condom card schemes
- Increase in awareness of sexual health within Primary Care
- Work in partnership with the Local Authority to ensure a joined up approach to sex and relationship education and communication

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Implement Sexual Health LES to increase uptake of LARC within Primary Care				
Implement Emergency Hormonal Contraception LES within Pharmacy setting including Chlamydia screening				
Children's Trust Risk and Resilience needs assessment, strategy and action plan				
Implementing electronic C Card system to support the co-ordination of registration, stock control and distribution				
Procuring new Primary Care Business Model to ensure increased awareness of Sexual Health Services within Primary Care				
Develop Sexual Health Strategy ensuring all aspects of the wider sexual health agenda in incorporated including HIV				

How much will this cost or save?

Over the last 3 years investment has been made in this priority area. There are no plans to make additional investment this year but plans include delivery of improvements within existing budgets

What KPIs will we use to monitor progress?

Headline Measures

Supporting Measures

Local Measures

- Under 18 conception rates
- Access to GUM (100% offered an appointment to be seen within 48 hrs)
- Access to GUM (95% seen within 48 hrs)
- Chlamydia Screening (number of 15-24 yr olds screened)
- Chlamydia Screening (% offered within mainstream services)
- Chlamydia Screening (% take-up within mainstream services)

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
A lack of engagement and reluctance to train will result in a lack of sexual health services delivered in Primary Care.	Having clear communication with both commissioners and providers regarding appropriate way forward
As an impact of Comprehensive spending review, area based grant funding reducing from the Local authorities, which may impact on levels of service provision and targeting of interventions. Significant decrease in levels of investment for services by local authorities.	Discussions with children's leads and Sunderland Local Authority to determine the impact of the Comprehensive Spending Review
Due to the failure to achieve Chlamydia Screening over the last two years there is an inherent risk to achievements of any national targets set.	Scrutiny of performance of services will take place on a regular basis to ensure early rectification of issues that will arise.

Communications Implications

- Future communications planning
- Support national and regional campaigns

Informatics Implications

- Development of electronic Condom Card System
- Ensure data systems in place for performance reporting for Chlamydia screening

Estates Implications

- Physical capacity to deliver any significant and unexpected increases in demand

Workforce Implications

- Training required for current workforce regarding the electronic Condom Card system
- GP training for sexual health LES / Primary Care Business Model

CHILD HEALTH

Why is change needed?

- Child health is significant predictor of life expectancy & health in later life
- 1 in 5 children (year 6) living in Sunderland are obese (see obesity section)
- Significantly worse teenage conception rates compared to the England average
- Higher numbers of unnecessary hospital admission
- The integration agenda requires a review of therapy services – remodelling to meet need

Objective

Support all **children** and young people to experience the best possible quality of life, reducing health inequalities and maximising life expectancy

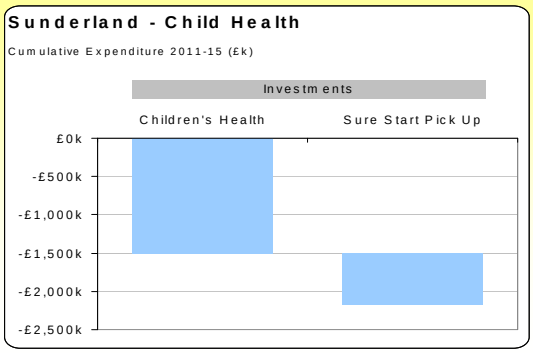
How do we want the future to look and what are the transitional issues?

- All children to receive regular health checks with appropriate referral to services as required
- Reduced child obesity by 10%
- Reduced teenage conception rates
- Young people able to make informed choices about health-related behaviours
- Therapy services available to all children who require them

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Review of National Child Measurement Programme processes and existing Universal and Tier 2 Programmes				
Develop a health programme campaign in line with JSNA and Children's Plan Priorities				
Review Child Health System across Sunderland				
Develop Strategy for families having difficulties in accessing immunisation services				
Implementation and review of the healthy child programme inc Health Visitor and Family Nurse Partnership expansion				
Children's Trust Risk and Resilience needs assessment, strategy and action plan				
Review Children and young peoples therapy services				
Implement national guidance for continuing care				
Review current configuration of community nursing teams				
Increase access to services for vulnerable groups				
Safeguarding training strategy implemented across Sunderland				
Review of domestic violence care pathways and access to service for children experiencing domestic violence				

How much will this cost or save?



What KPIs will we use to monitor progress?

Headline Measures

-

Supporting Measures

-

Local Measures

- Under 18 conception rates
- Childhood immunisation rates aged 1 (DTaP/IPV/Hib)
- Childhood immunisation rates aged 2 (PCV), (Hib/MenC), (MMR)
- Childhood immunisation rates aged 5 (DTaP/IPV), (MMR)
- Childhood immunisation rates aged 12-13 years (HPV)
- Childhood immunisation rates ages 13-18 years (DTaP booster)
- Childhood obesity rates – reception and year 6
- Percentage of children living in poverty (age <16 years) (LA measure)

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Changes to service provision for universal and tier 2 may result in medium to long term changes in outcomes	Work with existing providers to identify areas where improvements in outcomes can be made in the short term
Provider IT system not able to report outcome measures required to demonstrate performance against healthy child programme	Discussions currently underway with provider to ensure core outcome measures / performance measures are agreed and included within service specification s for April 2011 onwards
As an impact of Comprehensive spending review, area based grant funding reducing from the Local authorities which may impact on levels of service provision and targeting of interventions. Significant decrease in levels of investment for services by local authorities	Discussions with children's leads x 3 and respective LA's to determine the impact of the Comprehensive Spending Review
Comprehensive spending review and reductions in resources currently associated with continuing care	Kaizen event to review existing and future resource allocations
Resources not available to develop the CCN team to meet the requirements of AHDC	Review of existing core offer to establish if alternative model of provision is achievable

Communications Implications

Communications and engagement strategy to:

- Promote services available
- Support & enhance national and regional campaigns (e.g. change for life, breastfeeding, Chlamydia)

Estates Implications

- Main sites (schools) are as per existing but with increased activity and health checks.
- Need to explore and understand opportunities with Children's Trusts/Children's centres. Issue about control over venues within commissioning contracts
- Need for flexible booking space for out of hours working

Informatics Implications

- Capture of "outcome" data from the Family Nurse Partnership service
- Define minimum data sets for new community contracts
- Sharing information re referral pathways to all agencies / health professionals
- Community children's nurses access to GP Emis system
- Paper based systems need updating to e-solution
- Extended hours & new venues impact on infrastructure

Workforce Implications

- Reshape / additional capacity & new skills in HV & school nurse teams to deliver child health check
- Flexible working to improve access outside of 9am-5pm
- Capacity of therapy services

MATERNITY

Why is change needed?

- On average 24% of women smoke during pregnancy – significantly higher than the 16% national average
- Breastfeeding rates significantly lower than national average - 1 in 4 mothers breastfeeding at 6-8 weeks
- High rates of still birth, perinatal mortality & infant mortality compared to England average

Objective

Deliver high quality **maternity** services with greater choice, offering easy access to supportive, seamless care, designed around individual needs

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

- Reduce smoking in pregnancy by average of 26%
- Increased breastfeeding rates
- All services meeting national quality standards
- Agreement across patch on whether to move to 98 hour consultant cover
- Process in place for identification & management of high risk women
- Optimum mix of staff between midwives & support workers
- Reduced rates of still birth, perinatal & infant mortality

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Breastfeeding peer support programme developed and implemented with City Hospitals Sunderland Foundation Trust				
Breastfeeding action plan agreed and steering group established with clear terms of reference				
Maternity and community action plan developed to facilitate baby friendly status				
Develop and undertake audit of maternity assessment audit tool to identify risk factors for late booking				
Explore the feasibility of 1:1 midwifery care for women in established labour				
Evaluate the effectiveness of the Maternity Liaison Committee in Sunderland				
Review existing arrangements against NICE guidance for smoking during pregnancy and agree consistent pathway				
Review commissioning arrangements and implement recommendations for newborn hearing screening including audiology				
Agree pathway for Maternal Mental Health and implement local action plans				

How much will this cost or save?

In 2010-11 £15k was invested in a Breast Feeding Peer Support Co-ordinator. The post will commence during 2011-12. There are no plans to make additional investment this year

What KPIs will we use to monitor progress?

Headline Measures

-

Supporting Measures

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

Local Measures

- Breastfeeding initiation rates
- Smoking during pregnancy rates
- Maternal obesity rates

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Problem persisting in terms of two kinds of data capture at time of birth	Work with FT's / breastfeeding Co-ordinators further to resolve problems
Lack of capacity to complete maternity audit. Failure to detect high risk women	Further discussions/negotiations with FT's
Lack of capacity to delivery 1:1 midwifery care in established labour	Discussion/ negotiations with FT's
Identification of key personnel to increase service user involvement. Failure to improve services	Further discussion with FT's. Ensure service user feedback used in service reviews and redesign
Although numerous initiative in place, failure to engage women in stopping smoking. Impact in terms of poor outcomes for babies	Use NICE guidance to review provision. Redesign current system/approach to support women. Consider incentives to encourage women to stop smoking
Failure to implement newborn hearing programme to quality standards. Failure to detect abnormalities. Impact on infant mortality rate	Commissioning / Public health lead identified to ensure standards met
Failure to deliver on Maternal Mental Health NICE guidance within existing resources	Work with Mental Health lead to deliver cross cutting outcomes

Communications Implications

- Campaign to promote benefits and support for breastfeeding
- Promote user involvement in maternity services
- Improving access to maternity care

Estates Implications

- Flexible accommodation will be provided in the PCCs including expansion of ultrasound.
- Continued use of GP surgeries and home settings.
- Continue to incorporate breast feeding rooms into as many locations as possible

Informatics Implications

- Capture of outcome data
- Access to analysis and presentation tools re outcome and activity data

Workforce Implications

- Review skill mix in Maternity units, including use of Maternity support workers
- Consider implications of 98-hour consultant cover

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

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

Objective

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

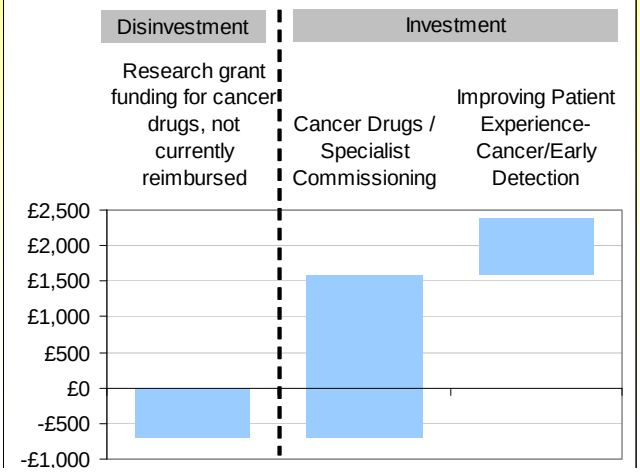
What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Promoting awareness of the four main cancers				
Early diagnosis, increasing access to diagnostics and reducing reporting times – moving to one stop services				
Better treatment – early intervention and access to appropriate treatments				
Survivorship – access to rehabilitation and promoting self care				
Inequalities – reducing variation in treatment i.e breast, lung and access to radiotherapy				
Care in the appropriate setting				
Cancer drugs – implementing robust data management systems				

How much will this cost or save?

Sunderland - Cancer

Cumulative Expenditure (£k) 2011-15



What KPIs will we use to monitor progress?

Headline Measures

- 2 week wait (aggregate measures for urgent and breast referrals)
- 62 day wait (urgent referral from GP and consultant)
- 62 day wait (referral from national screening service)

Supporting Measures

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

Local Measures

- Reduction in cancer mortalities in under 75s

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Capacity in Primary Care to engage with projects	Working with all teams to identify innovative ways to deliver services and not duplicate effort.
Engagement with out of area tertiary centres	Build relationships with key stakeholders
Patients failing to present with early symptoms	Targeted awareness programmes

Communications Implications

- Social marketing to inform & increase screening uptake amongst target audience
- Development of a communications plan to support the above

Informatics Implications

- GP practice data needs to be robust enough to conduct specialist audits
- Identification of information / analysis support for the cancer programme

Estates Implications

- Expansion of diagnostics/screening required.
- Potential future need for endoscopy facilities
- Potential capacity for local radiotherapy

Workforce Implications

- Additional capacity for screening programmes (specifically radiology)
- Workforce scarcity e.g. breast radiologists, bowel specialist nurses
- Training to skill workforce
- Potential increase in specialist nurses for bowel screening

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

Develop a generic Commissioning Model for LTCs which will deliver high quality, out-of-hospital support for people with chronic conditions, and eliminate unnecessary hospital admissions and shorten necessary admissions. Pilot with CVD, diabetes and COPD then rollout to all LTCs. Develop rehabilitation model with specialist and generic support across acute and community care, longer term support and self management.

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

- People with LTCs 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.

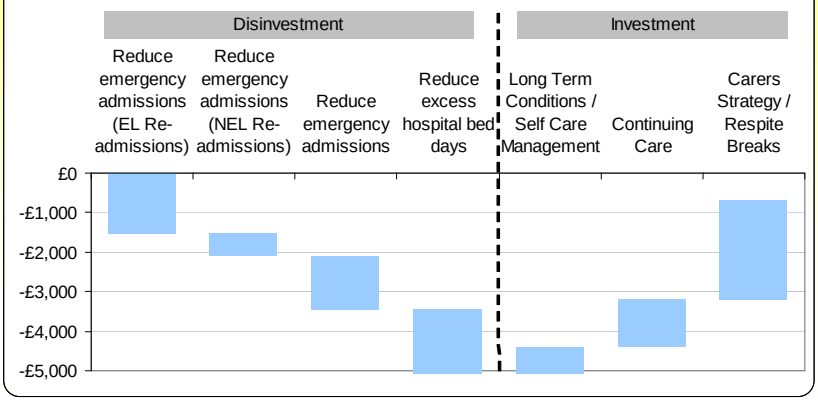
What are we doing about it?

Project Gantt Chart	2011/12 Q1	Q2	Q3	Q4
CVD (4 treatments), Heart Failure & Arrhythmia/AF - Three elements - Grasp AF, diagnosis and increase of anticoagulation & pathway reform to increase community services. Implementation of INR Services				
Diabetes - Finalise and develop action plan for implementation of intermediate diabetes model including patient education.				
COPD – Work with emerging consortia to determine next steps re development of local model. Ongoing implementation of QIPP Ignition Phase action plan.				
Intermediate Care (Cardiac Rehab & Neuro Rehab) – Model implementation, including specification for integrated teams.				
Residential rehabilitation – specification and procurement of Houghton PCC nursing intermediate care beds, review of Farmbrough Court beds and need for transitional beds, Houghton Extracare Intermediate Care Model				
Case management / Integrated community teams – SOTW kaizen followed by local work to specify model				
Diabetic Retinopathy – Implement action plan from self assessment in preparation for EQA. Review of commissioning model across SOTW				
Primary Care Dashboard - Rollout implementation plan to support practices to interpret and use data.				
Combined Predictive Model - Implement and evaluate pilot. Rollout learning to all practices.				
Self Care - Finalise model and commissioning strategy.				
Stroke/TIA – Implement hyper acute stroke model				

How much will this cost or save?

Sunderland - Long Term Conditions

Cumulative Expenditure 2011-15 (£k)



What KPIs will we use to monitor progress?

Supporting Measures

- Proportion of people spending 90% of their time on a stroke ward
- Proportion of TIAs treated within 24 hrs
- Diabetic retinopathy screening
- People with LTCs feeling independent and in control of their condition
- Emergency admissions for LTCs
- Readmissions within 30 days
- Delayed transfers of care

Local Measures

- All-age all cause mortality (Males)
- All-age all cause mortality (Females)
- Proportion of individuals admitted to Care Homes
- People supported to live independently
- % diabetic patients on registers called for review
- Rapid access chest pain clinics (contractual measure)

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Capacity to deliver	Identified lead for SoTW. Working collaboratively with GP Consortia Clinical Leads, LA, Public Health and Social Care partners.
Competing agendas	Clinical engagement in prioritisation.
LTC 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. LTCs and Urgent Care.

Informatics Implications

- Standard sets of information/data sets (recurring).
- Real time data – monitoring.

Communications Implications

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

Workforce Implications

- 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

- Potential vacation of the Galleries by CHS/NTW to provide needed office and storage space.
- Space at Houghton PCC for retinal & foot screening.
- Group space in all PCCs and many health centres.
- Community ECHO facilities within PCCs.
- Consider community based services for Heart Failure.
- Consider opportunity to co-locate community teams and facilitate team working and integration.
- Consider opportunity to include additional integrated care services within Houghton PCC to support Rehab Beds.

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

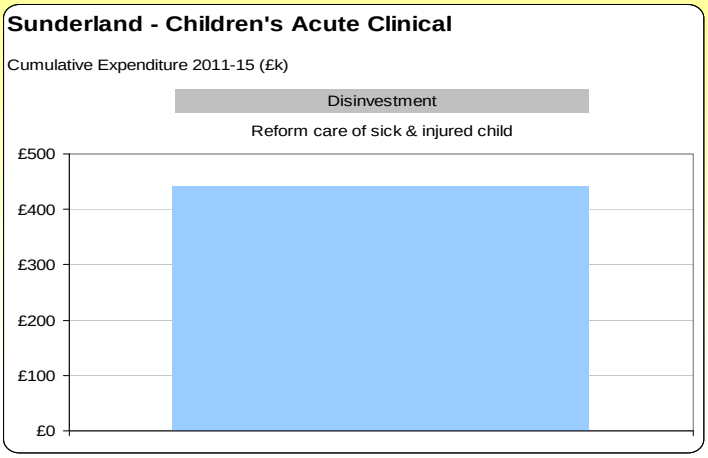
How do we want the future to look and what are the transitional issues?

- 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 short stay facilities
- Continued good access to high quality tertiary paediatric services

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Expand the role of MIU's and Walk in centres				
Expand the role of Children's community nursing				
Change the model of service to include children's assessment units with short stay facilities				
Develop and agree model of inpatient care and related pathways				
Public consultation re: Inpatient units				
Implementation of agreed pathway following Public consultation				

How much will this cost or save?



What KPIs 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
Effective use of resources is dependent on negotiation of appropriate tariff for children's assessment and short stay units. Public consultation may impact on preferred option and timescales	Regular meetings with Directors of Finance. Options appraisal to review risks, benefits and costs
Expansion of role of Minor Injury Units and Walk in centres dependent on ability of CHSFT to deliver training programmes within limited time restraints	Working closely with CHSFT. Payment on delivery of training programmes. Working closely with providers and reimbursing consultants time where appropriate
Risk to delivery of expansion of role of Children's community nursing in that contract variation cannot be agreed prior to agreement of pathway as a whole	Regular meetings being held with providers
Long term funding of paediatric short stay assessment unit is dependent on increase in capacity from other localities, short term arrangements in place	Regular steering group meetings and meetings with providers and Directors of Finance.
Risk that Paediatric short stay assessment unit local tariff will not be agreed due to costs linked to preferred option	Regular meetings with Directors of Finance
New process for service reconfigurations in letter from DH on 29th July may slow process	Informal discussions with HGT, NCAT and SHA have commenced.
Public consultation may impact on preferred option and timescales	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

- Promotional activities to increase awareness and use of community children's nursing teams and short stay assessment wards
- Public consultation for proposed change in inpatient care in SOTW
- Ongoing communication with parents and young people accessing the service

Informatics Implications

- Detailed measures established – routine reporting needs formalising
- Children's community nursing team – currently paper based, need to move to electronic system essential for monitoring and evaluation

Estates Implications

- Ensure waiting areas in MIUs are appropriate for children aged < 2 years
- Flexible booking consultant rooms potentially used by community nursing teams

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?

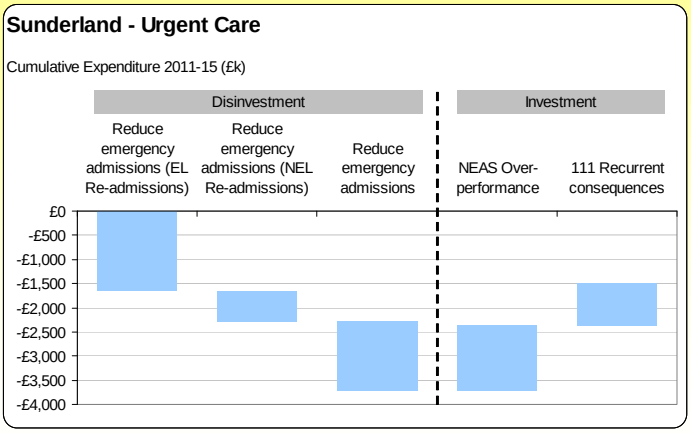
- Integrated 24/7 urgent care system across all sectors, which delivers quality care in appropriate settings
- Reduced acute ambulatory care sensitive emergency admissions

What are we doing about it?

Project Gantt Chart	2011/12 Q1	Q2	Q3	Q4
Share information on urgent care and associated services through the development of a GP Commissioning Website				
Single point of access & associated transport for all health and social care				
Rationalise urgent care services to make better use of existing resources, improve access and reduce inappropriate use of A&E				
Reduce avoidable admissions (0-1 day length of stay admissions and long term condition admissions)				
Reduce emergency readmissions				
Evaluate Telehealth strategy with a view to further roll out				
Standard admission assessment for GPs and community teams				

How much will this cost or save?

Sunderland - Urgent Care



What KPIs will we use to monitor progress?

Headline Measures

- Ambulance quality - Cat A response times
- A&E Quality Indicators (5 measures)
- Emergency Readmissions
- Acute Bed Capacity
- Non elective FFCEs

Supporting Measures

- Ambulance quality indicators (all other measures)
- A&E quality indicators (all other measures)
- Emergency admissions for Long Term Conditions
- Length of stay (Acute and MH)
- Delayed Transfers of Care (Acute & MH)
- A&E attendances
- Ambulance Urgent & Emergency Journeys

Local Measures

- Urgent care metrics
- MRSA Screening (contractual measure)

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Provider engagement	Urgent care board and locality networks
Financial pressures	Performance metrics
Agreement to collaborative model	Clinical engagement sessions and kaizen workshops, RPIW
Workforce and infrastructure	
PBR tariff changes (emergency admissions)	Close contract monitoring
Pace of change required to deliver initiatives	Learning from best practice

Communications Implications

- Continue to use “Choose well" public education programme subject to any improvements following evaluation
- Introduction of single point of access services (111)
- Information around accessing appropriate urgent care services
- Potential roll out of Telehealth service
- Promotion of the combined predictive model
- Access to directory of services

Estates Implications

- 24/7 expansion of urgent care team requires 24 hour staff base.
- Reduction in MIU hours will give efficiencies.
- Expansion of service to all ages - increased daytime demand.
- All PCCs have expansion capacity for MIUs
- Expansion of telehealth initiatives could reduce demand for space over time.

Informatics Implications

- Evaluation of Choose Well initiative
- Production of performance data (activity and outcome) from WIC and MIU
- Shared electronic record
- Single point of access (111) and EMIS web
- Telehealth and roll out of model
- Capacity Management System hosted by NEAS / CfH

Workforce Implications

- Single point of access & associated transport for all health and social care require additional training in use of new standard clinical protocols
- Training for Telehealth
- Impact of new stroke rotas on FT staffing – possible shortage of stroke physicians & supporting radiology

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

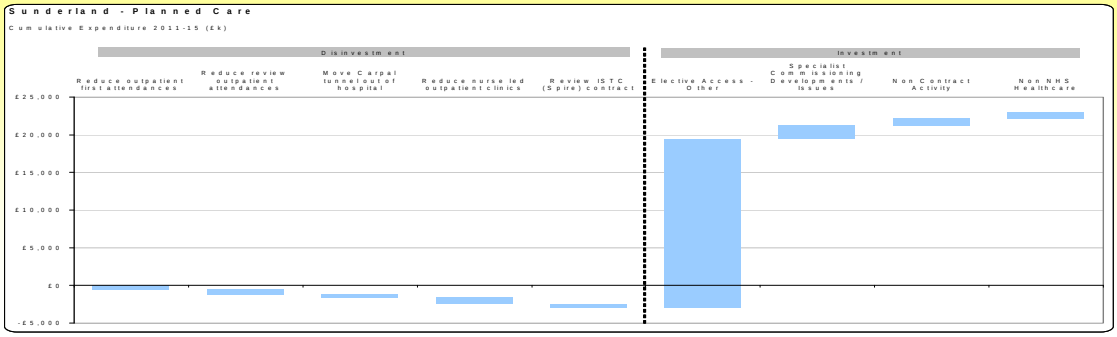
Objective

Reform planned care services to be streamlined, high quality, patient-centred and close to home, using Primary Care as a vehicle for capacity in community settings.

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Reduce outpatient first attendances				
Reduce outpatient review attendances				
Move Carpal tunnel out of hospital				
Reduce Nurse led outpatient activity				
Review ISTC (Spire) contract				
End short term funding to community services for HCAIs				
Cancer and Specialist Commissioning				
Reduce number of procedures of limited clinical value				

How much will this cost or save?



What KPIs will we use to monitor progress?

Headline Measures

- RTT waits - 95th percentile (admitted, non admitted, incomplete)
- Number waiting on incomplete RTT pathway
- Patient experience survey

Supporting Measures

- VTE risk assessment
- Low value procedures
- PROMs Scores
- Referral to Treatment – median wait measures
- Length of stay (acute)
- Daycase Rate
- GP written referrals to hospital
- Other referrals for a 1st outpatient appointment
- 1st outpatient attendances following GP referral
- All 1st outpatient attendances
- Elective FFCEs
- Bookings to services where named consultant led team available
- Proportion of GP referrals to 1st op appointments booked using C&B
- Trend in value/volume of patients being treated at non NHS hospitals

Contractual Measures

- 6 week diagnostic waiting times (15 key diagnostics)
- Cancelled elective operations for non clinical reasons
- Choose and Book – direct booking
- Choose and Book – slot issues

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Failure to secure Clinical engagement of GPs	Working in partnership with Commissioning Development Unit
Capacity to accommodate new services	Development of PCCs
Ability of FTs to engage in reform work due to internal pressures	Strong engagement at all levels

Communications Implications

- Stakeholder engagement
- PPI
- 4 Tests – GP and Public engagement

Informatics Implications

- Technological support for developing community services information pathways
- Timely routine data to monitor progress
- 4 Tests – Management Data for reform

Estates Implications

- Availability of flexible high spec treatment space to support intermediate services.

Workforce Implications

- Transfer in activity from acute sector to primary / community care setting may have TUPE implications and may require up skilling of existing staff
- Economies of scale with regards to workforce

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

Develop a fully integrated model of **mental health care,** underpinned by robust whole population Emotional Health and Wellbeing strategies; including comprehensive primary care services, redesigned specialist services, reprovision of inpatient services, and implementation of national dementia strategy.

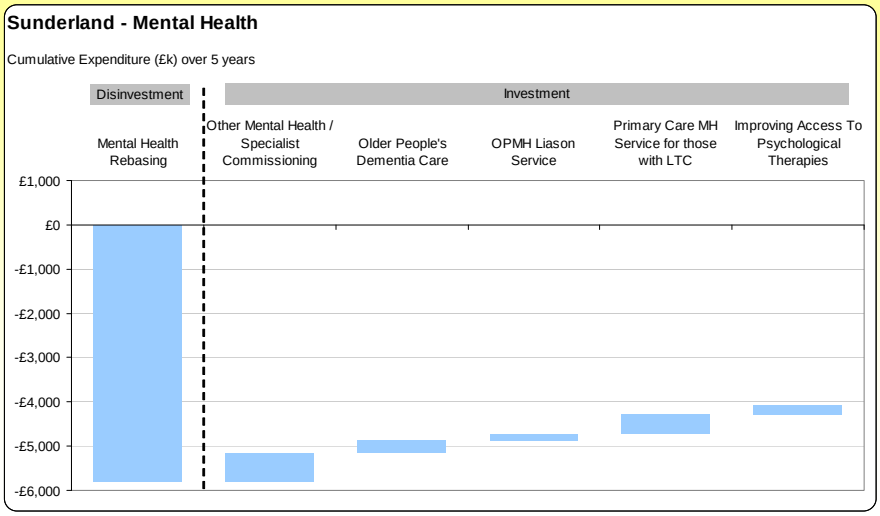
How do we want the future to look and what are the transitional issues?

- 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	2011/12			
	Q1	Q2	Q3	Q4
Local implementation of the National Dementia Strategy including memory protection services, liaison services and publication of joint local action plans				
Re-provision of Sunderland inpatient services				
Formal review of Primary Care Mental Health Services				
Continuation of roll out of the IAPT programme, ensuring that services are available to persons with other Long Term Conditions and inclusive of military personnel and older persons				
Implementation of NTW Service Re-design plans across South of Tyne and Wear				
Implementation of the Health and Wellbeing Strategy				
Local implementation of pathway for diagnosis of autism				
Implementation of Sunderland emotional health and wellbeing action plan				

How much will this cost or save?



What KPIs will we use to monitor progress?

Headline Measures

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Supporting Measures

- Length of stay (mental health)
- 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 EIP caseload

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Capacity to deliver plans at risk due to management cost reductions	Representation to Exec Team made to retain current temporary project manager
Current concerns from PBC groups/LMC re: NTW community services may lessen support to proposed changes to Community Mental Health Services	Engagement with Primary care to ensure support to proposed changes
Engagement and agreement of Primary care mental health model with primary care clinicians	Engagement with Primary Care to ensure support to proposed changes
Current economic situation will necessitate increased financial scrutiny of investment proposals	Robust business case to be developed by NTW, supported by commissioners.
Financial resources available to implement action plans	Ensure funding implications of action plans are fully articulated, identify alternative sources of funding
Competing priorities for funding and pressures on LA's re funding streams especially within the voluntary sector.	Review of funding streams to be carried out ensuring appropriate finance is available to meet the developed plan. Carer strategy groups in each LA area with NHS SOTW lead for carers identified.

Communications Implications

- Public and staff awareness of dementia and well being strategy
- Communication of reforms

Informatics Implications

- Provision of outcome and performance Information
- Gap in contract information systems with third sector providers

Estates Implications

- Potential use of all PCCs and Health Centres on a flexible booking basis
- Need expanded MRI capacity in PCCs re dementia diagnosis
- Potential use of all PC facilities for the delivery of memory protection service

Workforce Implications

- New model of care for Mental Health necessitate changing roles and new responsibilities for all providers and staff (all levels)
- Recruiting new workforce to deliver IAPT
- Enhance skills with regards to dementia – workforce modelling required
- Enhance skills with regards to Autism – workforce modelling required

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.

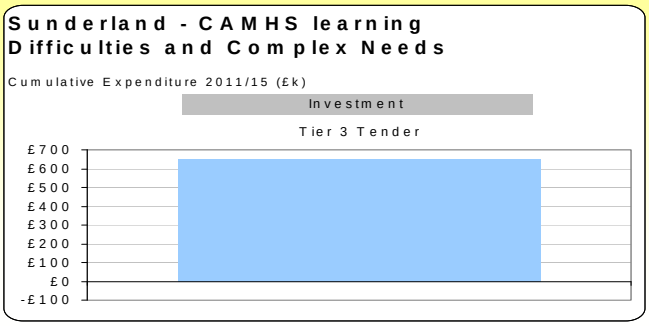
How do we want the future to look and what are the transitional issues?

- Improved access to talking therapies (IAPT) for children and young people as part of the development of Tier 2 CAMH Services
- Improved access to effective CAMHS 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 CAMH 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	2011/12			
	Q1	Q2	Q3	Q4
Commission integrated tier 3 CAMHS and Learning Disability Services for children and young people 0-19 years across SOTW				
Develop and agree, with partners, a model of resourcing of Tier 2 CAMH Service provision – to include improved access to talking therapies for children and young people				
Develop clear pathways of care between community, regional and in-patient services				
Describe clear pathways of care for children and young people with Neuro-developmental disorders including Autistic Spectrum Disorder				
Review of multi-agency pathways to support children & families with multiple problems, complex needs (High level placement panels, Out of Area Treatments, Individual Funding Requests , Special Educational Needs , Looked After Children)				

How much will this cost or save?



What KPIs will we use to monitor progress?

Headline Measures

-

Supporting Measures

- Improved access to psychological therapies (IAPT)

Local Measures

- Commissioning comprehensive CAMHs service

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Differences in configuration of services in different localities;	DCS sign up for programme; clarity around definitions (tiers of need and provision of universal, targeted and specialist support; specialist health input into multi-agency tier 2 CAMHS)
Resources not available to meet requirement to improve access to psychological therapies and reduction of resource available to LA's as a result of CSR 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
Lack of clarity in relation to future commissioning arrangements for tier 2 CAMHS	Alignment with developing PBC and health and well being board / children's LSP arrangements
Transition between current and new service provision; TUPE implications; transfer of care, transfer of records implications	Establishment of transition programme board to develop and implement transition plan
New service fails to deliver required changes	Agree and monitor service development plan with new provider
Changes to way in which Tier 4 services are commissioned may result in less effective planning and partnership with local commissioners	Establish clear links between locality and specialist commissioners to agree process and work with providers to ensure clear transition arrangements are in place between community and in-patient services
Complexity of arrangements to support children and young people with neuro developmental difficulties resulting in difficulty reforming pathway	Ensure involvement of local CAMHS and LDD partnerships, FT, community and CAMHS commissioners in process
Lack of engagement of key partners in developing pathways for children, young people and families with multiple and complex needs	Kaizen event with key partners across the pathway – continuing care, OAT, LAC and young people involved in the criminal justice system,

Communications Implications

- Engagement and communications plan for the reprovision of CAMH service

Informatics Implications

- Information systems – PCT and provider system to be developed to support collection of performance information

Estates Implications

- Shift from hospital to community / Childrens settings to support a new model of service provision

Workforce Implications

- Transfer of employment and significant workforce remodelling to support a new model of service provision

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
- Increasing bed days in hospital for people who die after 14 days or more – over 40,000 in 2008/9 with 3,500 of these being in excess of expected length of stay

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?

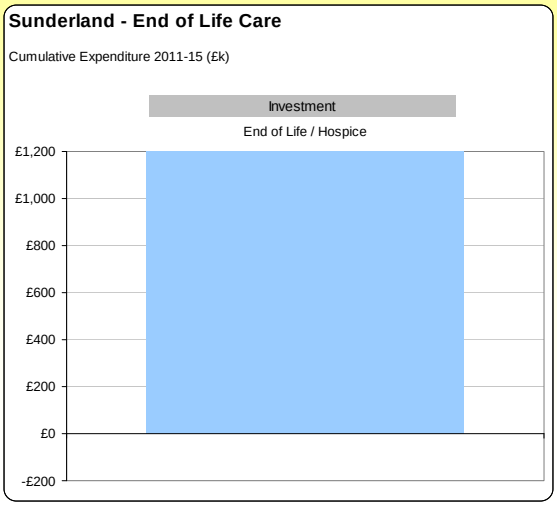
- All people in Sunderland towards the End of Life will have their needs, priorities and preferences for End of Life Care, including care after death, identified and met, throughout the last phase of life and bereavement
- People can choose their place of death
- 5% reduction in numbers of people dying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

What are we doing about it?

Project Gantt Chart	2011/12			
	Q1	Q2	Q3	Q4
Commissioning end of life coordinated care service				
Review overnight nursing care				
Review of bed capacity for end of life				
Education programmes i.e. care homes				

How much will this cost or save?

In 2009-10 £800k was invested in new end of life care services based on national guidelines. There is additional investment planned from 2011 below:



What KPIs will we use to monitor progress?

Headline Measures

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-

Supporting Measures

- Proportion of Deaths at Home
-

Local Measures

-
-

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Procurement guidance may have negative effect on market	Business case reflects need for 3 year contract
Protracted timescale for policy implementation due to regional agreement	Key stakeholders engaged in regional forum

Communications Implications

- Stakeholder engagement
- PPI
- 4 Tests – GP and Public engagement

Informatics Implications

- Develop a commissioning data set including outcome and activity data
- Access to analysis and presentation tools
- Summary care record

Estates Implications

- Local access to palliative care beds

Workforce Implications

- Staff training at a specialist and generalist level across health & social care to ensure knowledge, skills, competencies & attitudes necessary to deliver evidence based EoLC
- Increase capacity to ensure 24/7 provision in all care settings
- Forward assessment of workforce required
- Scarcity of palliative care consultants

NHS HEALTH CHECKS

Why is change needed?

- Vascular disease is a major cause of early death in Sunderland
- These deaths account for a significant proportion of the health inequalities gap
- Many people are living with undiagnosed disease (number of hypertensives/diabetes)
- CVD is a major cause of emergency admissions
- Smoking prevalence, obesity, and alcohol levels all above national average and contribute to CVD

Objective

Deliver systematic NHS Health Checks to 40-74 year olds to identify the risk of vascular disease, manage appropriately via treatment of referral to lifestyle services and reduce health inequalities

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

- All 40-74 years olds have received a health check and the opportunity to make lifestyle changes and receive treatment as appropriate.
- Health checks are delivered in a universal and targeted way to reduce inequalities, via a variety of settings including workplaces and community venues
- Undiagnosed disease is uncovered and deaths from vascular disease reduce
- Increased engagement of Local Authority and community partners in commissioning

What are we doing about it?

Project	2011/12			
	Q1	Q2	Q3	Q4
Deliver NHS Health Checks as part of Health inequalities programme 8 priority interventions				
Commission systematic NHS Health Checks via GP practices to cover 100% practices and increase uptake				
Commission opportunistic NHS Health Checks in the community, pharmacies & workplaces and via Third Sector to increase uptake				
Deliver a co-ordinated communications and social marketing campaign to ensure programme deliver is supported				
Target the delivery of health checks in priority neighbourhoods as part of local neighbourhood planning process				
Work with partners to improve uptake of Health Checks				
Evaluate NHS Health Check programme, including Point of care pilot, to inform future commissioning model,				
Utilise modelling, GP dashboard, NETS methodology to inform programme delivery and improvement of quality				

How much will this cost or save?

In 2008-09 £2.6m was invested in the NHS Health Check programme. Additional investment of £1.8m was made during 2010-11. There are no plans to make additional investment this year but plans include delivery of improvements within existing budgets

What KPIs will we use to monitor progress?

Supporting Measures

- Percentage of eligible people who have been offered an NHS Health Check in 2011/12
- Percentage of eligible people that have received an NHS Health Check in 2011/12

Local Measures

- Analysis of uptake to ensure equity of access
-

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Scale of case finding required.	Embedding the promotion of NHS Health Check take up into partnership planning processes
Changing commissioning responsibilities	Discussions underway with City Council to embed a range of Public Health strategies into commissioning arrangements (including NHS Health Checks)
Aligning data flows to DH reporting arrangements	Discussions with IT and GP consortia

Communications Implications

- Social marketing and media campaign to increase awareness and uptake of health checks – align this campaign with other national initiatives
- Evaluation of marketing and media strategy

Informatics Implications

- Capture the detail of NHS Health Checks undertaken and the results of the checks
- Data sharing issues
- Data quality and validation of information – information flows well documented

Estates Implications

- Legal implications of NHS health checks in non-NHS premises (e.g. supermarkets)
- Use of mobile facilities to increase uptake

Workforce Implications

- Competence of staff in community setting to deliver – high staff turnover
- Skill mix of staff to deliver agenda
- Train staff to deliver point of care testing pilot

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

To ensure safe, legal and effective use of **medicines** within commissioned services

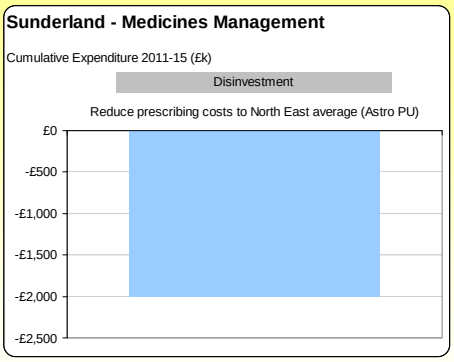
How do we want the future to look and what are the transitional issues?

- Ensure PCT statutory obligations with respect to medicines use continue to be met
- Ensure emergent GP commissioning consortia develop 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	2011/12 Q1	Q2	Q3	Q4
Ensure formulary management plan in place				
Agree governance framework for medicines management in GP consortia				
Agree action plan to manage high cost prescribers and reduce spend per Astro-PU to SHA average				
Agree action plan with Mental Health Trust to rationalise mental health prescribing				
Examine and improve supply routes for a range of products				
Agree and implement action plan to facilitate improved working with secondary care				
Explore options and develop services to support patients to take their medicines more effectively				
Complete review of local decision making processes and present options to GP commissioners				
Participate in regional procurement projects led by regional pharmacy specialist				
Participate in regional public awareness campaign to reduce medicines waste				
Continue to support work on drug related deaths, to help ensure safe prescribing practice				
Complete roll-out of Scriptswitch to all practices				
Carry out RPIW of repeat dispensing and follow up actions				

How much will this cost or save?



Technical efficiencies in year:
Target saving – 4% prescribing budget efficiencies £1.9m
Investments in Year:
Investment in services to support people taking medicines - £255K
Investment in public awareness campaign and supporting resources - £30K

What KPIs will we use to monitor progress?

Headline Measures

Supporting Measures

Local Measures

- Prescribing Cost growth
- Prescribing cost per Astro-Pu
- Percentage of prescribed items as repeat dispensing
- All practices to achieve a target of 2 ADQ per STAR-PU or reduce prescribing of benzodiazepines by 5%

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of medicines management resource to deliver objectives; lack of engagement from GPs and secondary care clinicians; transfer of responsibility for QIPP to emergent GP commissioning consortia; drug tariff price fluctuations;	**Requirements for medicines management resource highlighted at senior level. Programme of engagement with key stakeholders. Monitoring arrangements in place for primary care medicines expenditure.**
lack of investment in financial resource to support project plan	**Initial exercise to be undertaken to identify potential investment required.**
Lack of support / access to procurement expertise: challenge to proposed model from local community pharmacy representatives, possible legal challenge.	**Funding identified for regional procurement expertise; programme of engagement with local pharmaceutical committees.**
Lack of regional agreement to drug approvals, engagement of emergent GP consortia, engagement of secondary care	**Plan for regional collaboration on drug approvals process.**

Communications Implications

- Communication strategy required with all key stakeholders

Informatics Implications

- Minimal

Estates Implications

- Minimal

Workforce Implications

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

Section 7 – Delivery and Transition

7.1 Context

Over the next 4 years it is imperative that a tight grip is kept on maintaining current performance, financial stability and safe, high quality services. In addition we need to deliver:

- A range of key new commitments set out in the Operating Framework;
- A set of key performance indicators which demonstrate delivery of our QIPP efficiencies;
- Actions and changes in the priority areas out in the Strategic Plan to drive health improvement and reduce health inequalities.

All of these need to be delivered against a backdrop of transition. 2011/12 is the first year of transition to a new system of commissioning and this will need a range of changes to be made across all parts of the service. Sunderland TPCT has a key role in leading this change and shaping the future, working jointly with other local organisations, while continuing to manage the local health economy.

It is expected that further national policy and guidance will be issued over the coming months to guide implementation of the NHS Health Bill, therefore the detail in this ISOP will continue to be revised, expanded and updated throughout the year to reflect developing national policy.

7.2 Performance Management

Delivery of all the components in this ISOP is critical to the success of both the PCT in the short term and increasingly of GP Commissioners as they become pathfinders. It is therefore critical that there is visible, timely measurement and reporting of performance together with continual evaluation of risk to delivery. We must respond quickly to underperformance and risks of underperformance by taking remedial actions to ensure delivery of the objectives set out in this ISOP.

We have established a robust performance management framework for delivery of "integrated plans" which incorporate local and national priorities and targets, together with our QIPP efficiency programme. All priorities, targets and QIPP programmes have agreed actions, milestones, trajectories and risk assessment (based on the impact on the organisation and likelihood of non-achievement at the year end). This integrates our performance monitoring with the management of risk into a single in-year performance management process. Key organisational risks and controls are added to the organisational risk register and reviewed as part of the Trust Assurance Framework.

Performance is reviewed on a weekly, monthly or quarterly basis as appropriate, by internal teams, the Commissioning Executive and PCT statutory Boards and made available to the public. Forecast outturn projections against targets are produced to ensure the risks of not achieving targets are identified and addressed. As part of this process, risks associated with

delivery of each programme are reviewed and if circumstances change, the risk management plan is amended to reflect the latest position. Where key risks have been identified, routine reporting is supplemented by escalation, exception reporting, development and close tracking of performance recovery plans. The focus is on the root causes of underperformance and remedial action plans include, where appropriate, the use of contractual interventions to ensure delivery and sustainability of improvement. Initiatives and targets ranked as high risk are closely scrutinised to ensure performance remains on track, and deviation from plan / trajectory is quickly identified so that appropriate action can be taken. In addition, external benchmarking of performance is undertaken to provide assurance of comparative performance and identify opportunities for improvement.

Understanding provider contributions to overall PCT delivery is critical and commissioned providers have agreed information schedules including both national and local requirements with required submission dates and named recipients or departments within the PCT, where appropriate. Performance targets are specified in contracts across a broad range of key performance domains including activity, access, health improvement, safety and quality. Formal reports are produced monthly to support the performance improvement discussions which form a key part of monthly contract review mechanisms. However some key measures are monitored much more frequently, e.g. waits in accident and emergency departments are reviewed daily, activity and waiting times are monitored weekly, and there is immediate reporting of any cases of MRSA bacteraemia infection.

Our approach is one of continuous performance assessment and review. Formal reporting to the Chief Executive and Executive Directors is weekly, more frequent when there is escalation of a performance issue and there are both weekly and monthly routine performance reports to Directors via 'Achieving the Targets' forum and to the Boards, made available to the public via PCT Statutory and Local Engagement Boards. Additional detailed reports are provided to the Commissioning Executive and the Boards on a range of areas including Quality and Patient Safety, Finance, Workforce, Patient Experience together with specific service reports including Mental Health and Learning Disability Services, Cancer and Cardiovascular Networks, Joint Commissioning and Specialised Commissioning, ensure a comprehensive view of performance across the full range of PCT accountabilities.

Building on the success of the North East Transformation System (NETS) as our corporate improvement methodology we will continue to work with partners and consortia to embed the transformation systems and processes to drive quality and continuous improvement through commissioning. Examples of the actions to be undertaken in 2011/12 include:

- A programme of Rapid Process Improvement Workshops and Kaizen events to support service reform covering the full breadth of health care provision and health improvement;

- Weekly Visibility Wall stand-up meetings linking performance improvement with reform activity.

The breadth of our internal performance management will reduce over time reflecting the shift of accountability to the Local Authorities for the delivery of health improvement with regard to public health outcomes and delegated commissioning accountability to GP pathfinders. Our focus will shift from direct performance management of the delivery of the

ISOP to supporting GP consortia to develop local performance frameworks and the performance assessment of their progress in delivering their commissioning plans.

We will measure success year on year through the delivery of the milestones and agreed trajectories within our integrated plans including the delivery of national targets.

7.3 Transition and reform

7.3.1 PCT Transition

The PCT will be the statutory body of accountability up until April 2013; however the PCT will increasingly review and establish alternative mechanisms to discharge their formal statutory accountability as the new system architecture develops. A key role moving forwards will be to support the development of emerging GP consortia, and empower consortia to take on new responsibilities at an appropriate pace with effective levels of infrastructure and support through the appropriate assignment of staff. The PCT oversee and are accountable for delivery during the transition and at close down of the "old" system.

We will work with the Consortia to disaggregate QIPP to consortia level and support the Consortia taking on further areas of QIPP delivery over time. We will establish support teams to provide technical functions that consortia can draw on to develop their ongoing responsibilities effectively. We will oversee commissioning planning, contracting and management for all services in the cluster area not delegated to GP consortia i.e. primary care and national/regional specialized services and ensure an effective transition to the new commissioning board as it becomes established during 2011/12.

We will work jointly with the Local Authority and partners to develop health and well being boards and ensure a smooth transition for the transfer of the PH function by April 2012. We will ensure a partnership approach to the whole commissioning cycle and consider the scope for greater joint commissioning where appropriate.

The NE SHA has established a multi-stakeholder Programme Board to coordinate a work programme to deliver a seamless transition from the current commissioning and service configuration to that set out in 'Equity and Excellence: Liberating the NHS'. Seven work streams have been established and we will aim to play an active role in shaping the development and implementation; work streams include:

Corporate and HR Transition	Workforce Development	Outcomes and Quality	Provider development
Public Health Services	Health and Well Being Boards	Commissioning Development	

7.3.2 Development of GP Commissioning

A new Sunderland-wide GP Commissioning Board will replace the current three Sunderland PBC groups. An election process is currently underway to establish the new Board, led by the LMC, to ensure the new Board has a mandate from its colleagues.

Key features regarding Sunderland are as follows:

Number of GP Practices within Consortium	55	Number of GPs within Consortium	219
Consortium patient population	279,836	Coterminous with Sunderland Local Authority	Yes

The new Board will be in situ by 1st April 2011 at the latest. It is anticipated that the new Board will aim to achieve pathfinder status by summer 2011. Initial focus will on the effective functioning of the Board, development activities in order to develop the pathfinder bid including identification of initial commissioning responsibilities, which will include:

- Identification of need for and recruitment to clinical lead roles;
- Governance arrangements and management of conflicts of interest;
- Further work on the organisation's structure including patient, carer and stakeholder involvement as well as Local Authority engagement;
- Prioritisation of activities based on the ISOP and including delivery of QIPP priorities.

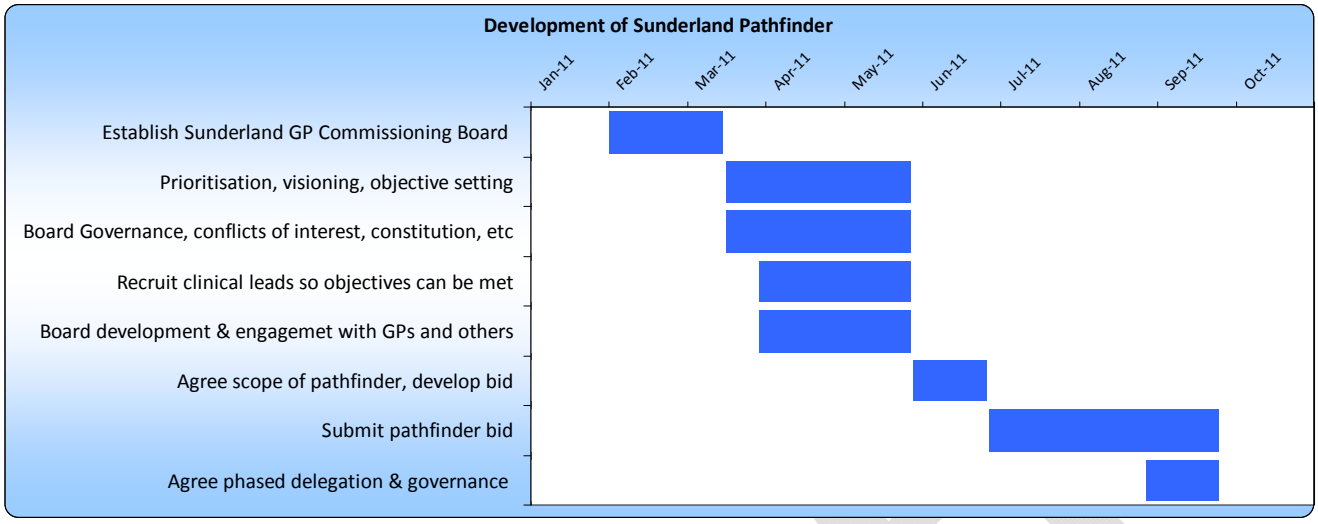
A Board member will be a member of the Sunderland shadow health and well being board which is currently in development, ensuring early critical links with the Local Authority.

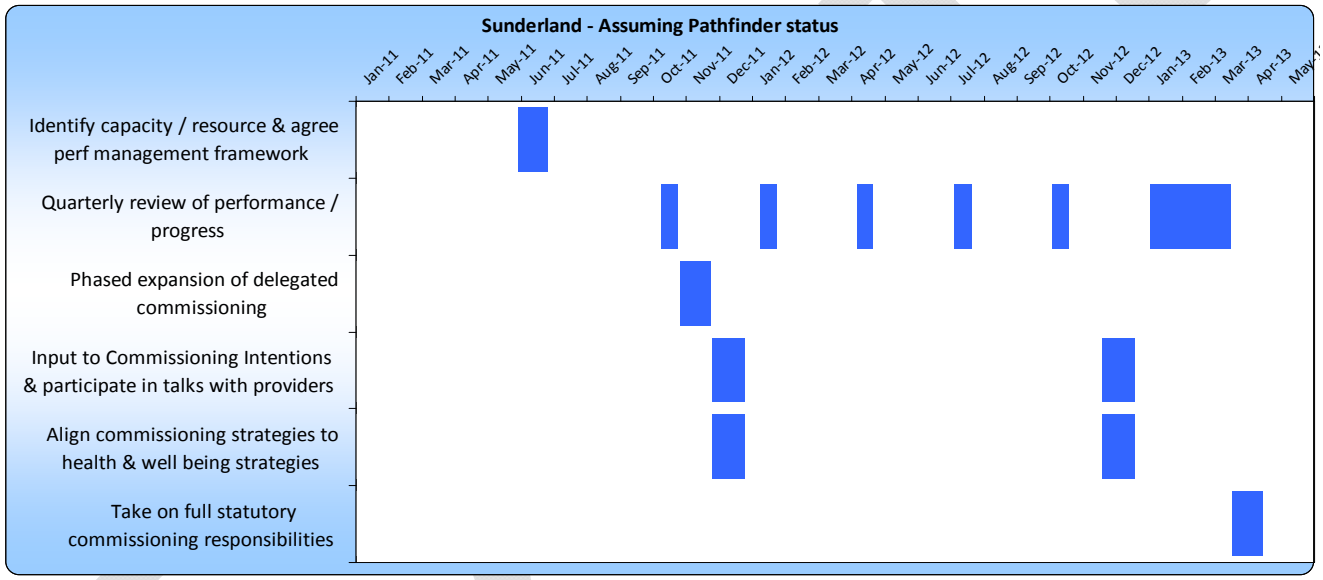
Subsequent to the successful achievement of pathfinder status in summer 2011, the Commissioning Consortia will over time increasingly take on devolved responsibility for a commissioning portfolio. The pace of change will be governed by a number of factors including:

- Development of commissioning skills and expertise / access to support;
- Development of other pathfinders and added value resulting from joint collaboration;
- Additional national policy and supporting guidance.

It is anticipated that the Consortium will expand their remit in phases and will take on full commissioning responsibility from April 2013. The indicative timeline below gives an initial view of the phased expansion noting the key activities to be undertaken. The timeline needs to be discussed with the new Board once established; however it is anticipated the activities will be undertaken within these indicative timescales. As noted above, this overview is a high level view and will be driven by a number of factors including the pace of change noted above.

The PCT is committed to working closely with the Consortia Chair and Board to help them identify their specific local development needs and formulate plans to meet their requirements. There is an identified Head of Commissioning Development and OD lead, for the Consortia, who will provide resource and expertise to support their development agenda.


Development of Sunderland Pathfinder
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Establish Sunderland GP Commissioning Board
Prioritisation, visioning, objective setting
Board Governance, conflicts of interest, constitution, etc
Recruit clinical leads so objectives can be met
Board development & engagemet with GPs and others
Agree scope of pathfinder, develop bid
Submit pathfinder bid
Agree phased delegation & governance


Sunderland - Assuming Pathfinder status
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
Identify capacity / resource & agree perf management framework
Quarterly review of performance / progress
Phased expansion of delegated commissioning
Input to Commissioning Intentions & participate in talks with providers
Align commissioning strategies to health & well being strategies
Take on full statutory commissioning responsibilities

7.3.3 Development of the Health and Well Being Board

Sunderland City Council has applied to be a second wave early implementer of Health and Wellbeing Boards. The Council has already established a cross directorate Strategic Commissioning Board as part of internal reorganisation taking account of the Sunderland Way of Working workstream.

The intention is for the newly configured Health and Well Being Board to be in place by June 2011; Sunderland Local Authority is keen to learn from the experience of early implementers including North Tyneside. The Board will be chaired either by the Leader or a Cabinet Member /Portfolio Holder and will have identified statutory members including representation from the recently elected GP Commissioners.

As part of development of the Board, the initial focus is a refresh of the Joint Strategic Needs Assessment (JSNA) and the establishment of a Sunderland Outcomes Framework (based on current local work as well as the NHS Outcomes Framework, the Adult Social Care Outcomes Framework and the Public Health Outcomes Framework). It is not the intention to redraw the Joint Strategic Needs Assessment for a number of reasons including the impact of transition on partners, and 2011 being a Census year, meaning up-to-date information will be available during 2012. There will be reconsideration of a small number of thematic elements and the Council will look to work jointly with Public Health and GP Commissioners regarding evidence based commissioning arrangements for 2012/13.

A review of all current joint commissioning arrangements (including Alcohol, Drugs, Mental Health, linked health and social care commissioning for adults and children) is to be undertaken to establish a commissioning model for inclusion in the framework. Further consideration is to be given regarding the Local Authority's role as a Strategic Commissioner together with the Health and Wellbeing Board's responsibility to facilitate governance arrangements of a range of functions including Children's and Adults Safeguarding and Safer Partnerships; and to integrate commissioning activity across a range of Place partners. The Health and Well Being Board will need to link closely with the recently established Economic Leadership Board tasked with implementation of the Economic Masterplan. A review of current Local Strategic Partnership arrangements has been undertaken and the outcomes will be implemented by September 2011, essentially a reduction in permanent Partnership Delivery Boards and engagement with time limited task and finish groups and an enhanced focus on improvement and innovation.

The Director of Health, Housing and Adult Social Care is convening a steering group to oversee implementation. Sunderland has established a Health and Well Being Implementation Group to oversee this process over the next 3-6 months, to be chaired by the Director of Health, Housing and Adult Social Care. This will be supported by an operational group chaired by the Assistant Chief Executive.

7.3.4 Transforming Community Services

All Community Health Services will have moved to South Tyneside Foundation Trust by the end of March 2011. Our aim is to develop high quality community services that are personalised and coordinated for patients and are based on integrated models of health and social care provision and provided closer to patients home. The community service reform is an integral element throughout a number of our priority programmes including

Long Term Conditions, Mental Health and Staying Healthy as part of the delivery of the Strategic Plan and our QIPP programme. All programmes work closely with acute and community providers to agree best practice regarding models of service, pathways of care and assess impact. Strong partnership working will improve communication and provide opportunities for increased productivity and reduced reliance on secondary care. New entrants into the market will create competition, where appropriate, thereby increasing patient choice, increasing productivity and ensuring value for money. Reform will be increasingly driven by GP Consortia who will continue to set standards and develop integrated pathways in order to ensure flexibility in models of provision.

We have an agreed reform programme for community services to be reviewed moving forward i.e. District Nursing in order to further improve service standards. A refreshed business case is being developed for a new Community Information System which is critical to the delivery of our QIPP programme relating to urgent care, LTC as well as ensuring improvement in the patient safety agenda. A key requirement in the business case being the need to integrate with a range of provider systems in order to share electronic patient records thereby improving patient care and increasing productivity. Proposed changes to service provision are advised in the PCT Commissioning Intentions and changes to contracted services will be finalised via contract mechanisms.

7.3.5 Reforming Commissioning

PBC Commissioners are involved in all aspects of the commissioning process; from development of the 2011/12 plans, contracting negotiations with providers, delivery of the reform agenda and QIPP delivery.

With regard to the development of ISOP Plans, PBC Commissioner are members of the PCT Commissioning Executive and have participated in the development and approval of 2011/12 Commissioning Intentions, commissioning schedules including CQUIN, contract penalties etc. PBC Commissioner plans have been refreshed to support the delivery of specific RRIs (prescribing efficiencies, excess bed days, LTC) together with a menu of options focused on the key areas of reduction of emergency admissions to hospital (includes reablement schemes).

The involvement of PBC representatives in the 2011/12 contract negotiations with major providers has been recognised as a key area for preparation for the transition to GP Consortia. Working with PBC Chairs and the Commissioning Executive Team, development work has progressed on the effective management of providers to ensure commissioned services are delivered to the required quality standards and within financial limits. This includes briefings on the contractual framework including use of national standard contracts; CQUIN and development of local penalty schemes and the effective use of contracts and contract processes from the annual negotiation through to the in year actions to ensure compliance. Specifically for the 11/12 contract negotiations, PBC nominated leads have been identified and briefed by senior staff on the contracts and negotiation strategies with City Hospital Sunderland NHS Foundation Trust and other major providers for their locality and have input views and advice both prior to and during negotiations, the emphasis being on added clinical value, for example in negotiation with acute providers on actions to reduce outpatient review appointments and the development of appropriate indicators in CQUIN and penalty schedules to drive improvement in discharge communication.

To build upon this and robustly prepare for transition to GP Commissioning, Sunderland leads have approved the setting up of a GP Commissioner Reference Group where GP commissioners will come together with PCT staff responsible for the effective management of providers and the underpinning contracts. Following the confirmation of the GP Consortia, the Group will develop in the coming year, ensuring GP commissioners are clearly sighted on accountabilities in relation to contracting and fully briefed on contract management processes and outcomes throughout the year and enable them to play an active role in provider management during 2011/12 and the contract negotiations for the following year as part of the development and transition to GP commissioning.

7.4 Quality

7.4.1 Quality agenda

Quality is central to our vision and encompasses the three key components of healthcare quality; patient safety, clinical effectiveness and patient experience. Our approach to commissioning for quality through provider management and pathway reform is integral to achieving the vision. This approach has been developed, refined and strengthened in order to be fit for purpose and will continue to evolve to reflect transition. A further development is the transfer of responsibility for the management of serious untoward incidents from the NE SHA to the PCT from April 1st 2011. This is a further opportunity to influence provider performance and have a closer understanding of the issues that are identified and ensure recommendations are implemented.

Quality mechanisms built into contractual agreements with providers aim to secure the provision of safe, effective services that provide positive patient experience and also make best use of contractual levers e.g. 'Commissioning for quality and innovation (CQUIN) schemes' and best practice tariffs to deliver continuous quality improvement. CQUIN schemes have been developed with input from a broad range of stakeholders particularly clinicians and incentivise quality improvement in priority areas that are evidence based.

GP Commissioning Consortia and pathfinders will increasingly drive the quality agenda as they take on responsibility for the commissioning agenda. Through the transition however, it is imperative that the established quality review mechanisms continue to operate effectively to maintain a focus on quality, particularly to ensure that patient safety is not compromised. Furthermore acknowledging the need for providers to increase productivity, the need to maintain a focus on safety and quality is critical. The National Quality Board (NQB) is conducting a review into how best to maintain quality and safety in a time of transition; the first report is expected in the Spring 2011 and relevant requirements or recommendations will need to be addressed including:

- Maintaining capacity and capability for quality throughout transition;
- Ensuring that the voice of patients is heard at all times;
- Working with key partner organisations to collectively consider risks to quality;
- Delivering a robust handover to successor organisations and ensuring no loss in corporate memory on issues relating to quality.

'Equity and Excellence: Liberating the NHS' (July 2010) places significant emphasis on developing and implementing quality standards to improve healthcare outcomes for

patients. The new NHS Outcomes Framework published in December 2010 will drive quality improvement moving forwards; we will work jointly with the Local Authority and GP Commissioners to develop indicators for implementation in 2012/13.

Our local quality improvement priorities in quality schedules or CQUIN schemes for 2011/12 align well to the NHS Outcomes framework, examples of which are detailed below:

Patient safety

- Hospital mortality (Including reducing deaths from veno-thrombo embolism)
- Infection control
- Reducing harm from pressure damage and falls
- Discharge communication
- Local SUI management

Clinical effectiveness

- Improving care for people with long term conditions particularly stroke, heart failure, COPD
- 'One stop' cancer care
- Improve quality of 7 day follow up for people with mental ill health

Patient experience

- Patient reported outcome measures (PROMS)
- Delivering single sex accommodation

Productivity

- Review procedures where there is limited evidence of clinical effectiveness
- Use of high cost of drugs
- Implementation of enhanced recovery model of care

7.4.2 Patient safety

The development of a safety culture is integral to our commissioning arrangements with providers. Our acute and community NHS providers are signed up to Safer Care NE and the national DH Safety Express. We are actively engaged in regional Patient Safety forums and assurance groups including those for infection control and safeguarding. As noted earlier, we are taking responsibility for managing the process of Serious Untoward Incidents (SUIs) from NHS Northeast from April 2011. Our programme of Non Executive Director quality assurance visits to healthcare providers including walkarounds will ensure that the patient voice is firmly at the centre of our patient safety work.

a) Infection Prevention and Control

We together with our providers are committed to ensuring a zero tolerance approach to healthcare acquired infection (HCAI) within all of our commissioned services; which is reflected in reductions in the number of infections in 2010/11. Our Infection Prevention and Control Performance and Practice Group is a key mechanism for engaging, performance monitoring and learning for our providers and has resulted in significant improvements in performance and practice.

Our GP lead for infection prevention and control has worked closely with GP practices as part of the root cause analysis process. Alongside other initiatives, this has resulted in significant improvement in the numbers of clostridium difficile cases. The use of our Infection prevention and control dashboard has proved valuable to identify areas for focus and supporting development of joint action plans between community and acute providers.

We are working with our healthcare providers to ensure the continued focus on existing targets for HCAI and the additional DH requirements MSSA and E Coli infection. The plans for 2011/12 will include ensuring that providers are collecting this information and carrying out appropriate root cause analysis to inform their action plans, setting in-year targets in line with DH guidance.

Engagement of GP commissioning consortia in the HCAI agenda will be through reviews of variation in prescribing (particularly in relation to c difficile), and also through engagement of GP consortia leads in quality review meetings.

b) Safeguarding

The safeguarding of children and adults from abuse and neglect continues to be a priority. The initial report from the national Munro Review of safeguarding children recently published, will direct future developments for health and partner organisations. To contribute to safeguarding work at a national level, Sunderland Council (and the PCT as a partner) is currently piloting a potential new system for addressing safeguarding concerns to inform the national review. With regard to safeguarding adults, we work closely with the Local Authority to improve the quality of care for vulnerable older people who are living in care homes; this is an key priority given our ageing population and increasing health needs. Furthermore we are actively involved in supporting the quality assurance of this sector of healthcare with the Care Quality Commission and the Local Authority. We are early adopters of the national Department of Health Safeguarding adults assurance framework and have contributed to the national evaluation process.

7.4.3 Clinical effectiveness

As commissioners, we strive to ensure that our patients receive the best care and health outcomes possible through decisions based on the best clinical evidence available. This involves all aspects of the commissioning cycle including management of existing providers through quality and contract review mechanisms, pathway reform initiatives and development/review of service specifications. Our key mechanisms to achieve this include:

- Promoting a culture of clinical engagement that encourages the involvement of strong clinical voices of all disciplines driving forward the clinical effectiveness agenda;
- Raising awareness of existing evidence and cost effectiveness information and promoting access to and use of such information both within the PCT and in collaborative work with partners;
- Use of systems that provide assurance or demonstrate compliance with national guidance e.g. NICE guidance and quality standards.

7.4.4 Patient experience and the information revolution

Ensuring excellent patient experience is a cornerstone of our vision and is an integral part of the wider quality agenda. Safe care, effective treatment and high quality provision combined together enable patients to have confidence in the care they receive. It is vital that patients are actively engaged in shaping the planning and delivery of services in order to ensure their needs and wants are met. We have a broad range of mechanisms to ensure patient and public engagement in the planning and delivery of local services. This ensures that the voice of patients is heard and used as part of the early warning system together with other information sources to understand the quality of services provided and identify areas for improvement. The mechanisms include:

- Our local Engagement Board is a forum for direct dialogue with patients, service users and the public; additionally a range of other groups and mechanisms exist in each locality enabling us to reach a wider audience.
- Through establishment of quality improvement and review mechanisms agreed with provider organisations including:
    a. Use of quality schedules within contracts to require complaints, surveys, PROMS and other patient reported experience information to be shared through the Quality Review Group;
    b. Use of CQUIN to incentivise improved patient experience against the national composite measure for responsiveness to personal needs and also against locally identified measures (specific measures with Mental Health include visits to MH services and meetings with users/carers, undertake a carers satisfaction survey and personalised recovery (health and wellbeing) outcomes)

c. Local and nationally published (e.g. national surveys) patient experience information is formally reviewed by the Quality Review Groups with learning shared and action plans developed and monitored as appropriate.
d. Formal consideration within contract performance meetings of any published patient survey/experience reports
e. Provider organisations share their plans for gathering and reviewing patient reported experience information through the Quality Review Group;

Through specific service redesign activities in that all service redesign includes public engagement ; an example being the Urgent Care Programme has tested the use of 'kiosks' to gather real time feedback from patients using A&E and MIUs. This information was used to inform the redesign process and monitoring of delivery.

Through the collection of real time patient experience data; we are exploring the use of Patient Line technology within Providers to collect data in order to inform service delivery, service redesign and also the development of both CQUIN and Quality schedules.

We are establishing a programme of assurance visits to provider organisations to provide a mechanism for patients to provide real time patient qualitative feedback. These visits will include Non-Executive Directors who will then report back through our Quality review mechanisms. These assurance visits together with the quality review processes contribute to assurance against the Francis recommendations.

Other mechanisms for seeking public views include local Links' and Overview and Scrutiny Committees, locality PPI/Voluntary sector networks, and advice and support from PPI Officers in each Locality as part of the new Commissioning Development Unit.

We are also in the early stages of developing patient experience metrics linking with the development work on this topic led by the SHA; we will publish the results once the data is robust and routinely available.

Quality reports are published on a regular basis and are presented at PCT Boards and other relevant committees. These reports include a broad range of information about safety, effectiveness and patient reported experience both from local and national sources and where possible include comparisons with similar organisations or national standards.

We are working with all providers on actions to enable patients to make personal decisions about their care and use of a wide range of services. This will build upon the NHS Constitution and current contractual requirements, including those in CQUIN and quality schedules, patient choice, provision of and access to information for service users. Work underway is focused on areas including personalised care planning and shared decision making which, for example, are key strands of the development and improvement of services for patients with long term conditions.

7.5 Workforce

Developing and remodelling the workforce is critical to the delivery of the ISOP 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 strategic programmes referenced in Section 6, a number of generic workforce requirements have been identified, including the need to:

- Build capacity and capability both internally and across the economy 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;
- Identification of the short and medium term workforce risks utilising a jointly agreed standardised risk rating system and collaborative action to implement creative solutions;
- Support recruitment in specific disciplines including nursing, radiography and biomedical sciences 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;
- Partnership commitment to work together to effectively manage shifts in the workforce landscape between providers to ease potential redundancy scenarios, increase flexibility to support the effective transition of activity from hospital to community based settings;
- Develop robust and meaningful workforce productivity measures including a standardised currency and means of measurement across the service, with early emphasis on community services.

To quantify the impact of the ISOP and QIPP programme on the workforce, discussions with providers are continuing as noted earlier in section 5.4.

7.6 Informatics

We will continue to support organisations across Sunderland local health community, providing shared business and technology solutions. The ICT service supports a wide range of customers including GPs, Dentist, Optometrists, Foundation Trusts, Public Health, PCT Corporate and Commissioning, Community Health Services and other local shared services.

We will further exploit the excellent work done on implementation of EPS Release 2 within Sunderland, which has seen a number of GP practices and linked pharmacies enabled to use the enhanced functionality and in the case of the practices has also initiated the move to the next generation of EMIS clinical information systems EMIS Web which also demonstrates movement through the GPSOC maturity model.

Planning and design is underway to establish a GP practice blueprint which will set a common standard infrastructure and systems, updating or introducing some technologies

and optimising the use of existing solutions, for example patient appointment booking over the internet, workflow solutions already procured but partially exploited.

Migration to next generation of GP clinical systems with exploitation of secure data sharing through developments in line with the Interoperability Toolkit (ITK) will see enhanced pathway support through initiatives such as the End of Life Early Alerts which will introduce the ability of 999 call handlers to manage end of life patients through visibility of advanced care plans and key contact details. Use of the NHS number will be key to the successful delivery of these initiatives.

Understanding, design and planning for implementation of the 111 service which will be heavily supported by ICT solutions will be a key focus and is expected to require ITK enabled solutions to support this new model. We will continue to seek opportunities to support clinical pathway development re-design through use of technologies such as Map of Medicine (MoM).

As rich information sources such as GP clinical systems will become more accessible; the intelligence can be joined with other information sources such as SUS and used for enhanced decision making. Clinical dashboards are being piloted and will be further developed to support clinicians and commissioners. Along side this Sunderland Information Portal (SIP) will be further developed to provide enhanced moderation, publication navigation and search capability. Deployment of solutions such as Grasp AF which will assist practices in the management of patients with LTC's will also be supported.

During 2011/12 GP Commissioning Consortia in Sunderland is expected to evolve and we will support transition by firstly understanding immediate requirements (such as collaboration, communication and access) and then provision of ICT services and solutions as the role of the consortia is shaped and defined.

Modernising the way community based staff work through IT enabled solutions is a key aspect of the plans across Gateshead, South Tyneside and Sunderland as is the ability to support integrated working supporting care pathways and across organisational boundaries. As such, we will continue to work closely with Community Health Services in each of the areas to establish a robust business case for the implementation of an integrated Community Health Information System. The requirements of this system are based on the foundations of interoperability and information sharing. Implementing such a system across Community Health Services enables these services to be best equipped for the new landscape of the NHS, and will ensure that the infrastructure is in place to support the delivery of key national programmes such as Summary Care Records and 111. The new system will introduce a common tool across community based staff and will support future processes to be efficient and lean; NHS Number compliant administrative and clinical processes will also be enhanced by mobile technologies such as 'tough books' that will give access to the full range of information resources staff need to perform their work and achieve productivity gains and efficiencies. The introduction of these solutions is critical to the delivery of QIPP RRIs relating to urgent care, LTC as well as ensuring improvement in the patient safety agenda. The Community Information System will support the collection and reporting of the Community Data Set from implementation, this ensures that contractual reporting requirements will be maintained and that community services can be benchmarked and performance reviewed in a transparent and standard approach, supporting commissioners to fulfil their role. Approval of the business case for the CIS, and

swift deployment of the successful solution is critical to the delivery of many supporting initiatives and the successful transition of Community health Services, as part of TCS. Improved personal safety of lone-worker staff is also being improved by the introduction of personal safety devices.

Implementation of the solution delivering pathology and radiology order communications and results reporting is nearing completion; further exploitation of this solution will see discharge communications also being included and working towards delivery of the Clinical 5 within Sunderland.

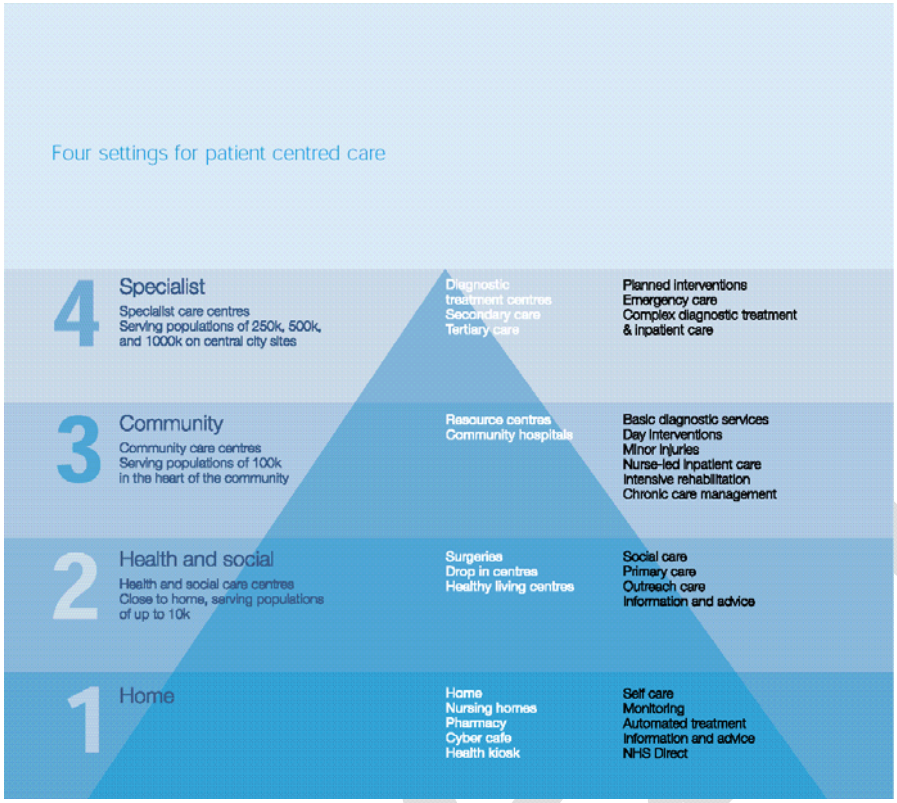
Use of new technology to support self care for patients with long term conditions in the Sunderland locality as part a of telehealth pilot is enabling greater integrated care across providers and social care and improving patient quality (increasing confidence in their ability to manage their condition). Phase 2 of the telehealth initiative is presently being planned and will expand this model.

Underpinning the processes, data sharing and systems and technologies will be an enhanced, robust and flexible Wide Area Network (WAN) that will connect South of Tyne and Wear organisations and supporting;

- Migration of GP practices to hosted clinical systems;
- IP telephony;
- Unified communications (such as instant messaging, presence information, video conferencing, email, fax, SMS) ;
- Collaboration using solutions such as SharePoint, and information portals;
- Secure remote access to ICT services.

We will use a mixture of “vested brokerage” plus elements of the 2% non recurrent fund to finance these developments. The recurrent consequences have been built into our investment plans.

7.7 Estates



Our estates strategy is based on a model of **four patient care settings**, and provides a hierarchy of service provision and a framework of building types used within each setting. It underpins our intent of shifting care from a hospital setting into community facilities, primary care facilities and ultimately the patient's home, thereby enabling the right services to be delivered in the right place, first time and ensuring value for money.

The ongoing development of our estate has been informed by a number of important factors including:

- Flexibility - we have incorporated the NETs methodology and Health Building guidance to ensure our accommodation can 'flex' to serve many different services and fulfil many roles, with only changes to equipment required. We have also ensured regular break clauses in leased premises wherever possible to ensure retraction from facilities can be implemented;
- Avoiding 'ownership' of clinical space wherever possible - developing sessional booking and charging regimes so that all providers can access modern facilities in a flexible way thereby driving up the efficiency and utilisation of our buildings and empower the commissioner;
- Considering the infrastructure needed to deliver our future programmes of initiatives, including how planned and recently completed schemes could accommodate these requirements with minimum alteration;
- Developing our "Commissioners' Investment and Asset Management Strategy" (CIAMs) 'Understanding your Estate' and 'The Planning Function' has resulted in a

comprehensive review of the primary care infrastructure, whether owned or leased by the PCTs or by GPs and other providers themselves. We now have detailed information on the main sites delivering services and these are mapped geographically and graded according to physical condition, quality, safety, environmental performance, location, functionality and utilisation.

The development of our estates strategy to date has focused on two key elements:

- Developing **Primary Care Centres** (PCCs) within band 3 above (community premises, resource centres, community Hospitals);
- Refurbishing or replacing **Health Centres** within band 2, whilst also expanding these to incorporate flexible bookable space for a broad range of services requiring flexible accommodation on a 'session by session' basis.

The PCCs bridge the gap between a traditional health centre and acute hospitals. Furthermore they provide an important platform to stimulate the market and enable new providers to deliver new and innovative primary and community services through availability of high quality, state of the art facilities and infrastructure. The PCCs are zoned into planned care, diagnostics and urgent care. Recent schemes to accommodate new types of provision include:

- Planned care: rehabilitation inpatient facilities, chemotherapy, renal dialysis, a range of out patients services, minor surgery, diabetes care and dermatology;
- Diagnostics: X ray, cardiac echo, ultrasound, breast screening, facilities for mobile MRI, retinal camera and bio mechanics;
- Urgent care: Minor Injuries units and GP facilities.

7.7.1 Future developments

The infrastructure within Sunderland is nearing completion with three PCCs (Grindon Lane, Bunnyhill and Washington) in operation and the fourth on site at Houghton-le-Spring, due for completion in August 2011. Only one health centre still requires replacement at Pallion and this will be completed in December 2011.

One of our key Strategic Plan priorities is end of life care. Our future capital plans have identified a potential investment in a new end of life care centre and hospice. More work is needed on the service vision for end of life care before the project can proceed but a number of possible sites have been identified and strategic planning and consultation is continuing. It is envisaged more support for people wanting to die at home should be provided as well as a number of hospice beds and in-patient support functions.

Additional funding has also been set aside for further improvements to health centres as GP consortia priorities are identified.

Significant investment in the estates infrastructure over the past five years has resulted in much of the estate now being in place to facilitate a wide variety of planned and evolving service change. The premises in Sunderland are recognised as exemplar projects

nationally by the Department of Health, and Houghton PCC is the first health building in the UK to achieve the BREEAM outstanding grade for sustainability at design stage. Washington PCC was awarded the best Local Authority Building control healthcare building in 2010. The PCT own a significant proportion of the primary care estate and this is a significant strength in driving the reshaping of healthcare provision.

There is a need to continually review our use of this valuable and expensive resource, particularly as the impact of other QIPP initiatives are felt. In Sunderland all owned health centres are relatively large with a range of tenants including multiple GP practices in each building in easily accessible locations. However, we have already commenced a program of retraction from leased premises including Answers, 6 The Green and the BIC. Further retraction from the main HQ bases at Pemberton House, Loftus House and Rapier House is likely after April 2013.

Where premises are retained we are investing heavily in reducing running costs, particularly around energy consumption.

The Department of Health is expected to make a national decision on the future ownership of the Primary Care Estate and this could have a fundamental impact on our plans.

7.8 Proactive Management of Risks

We face two types of risk to delivering our plans:

- Financial risks;
- System risks.

Both types of risk are interconnected as some of the system risks (e.g. relationships with local providers) can both exacerbate the financial risks (e.g. underachievement of planned savings from initiatives) but can also be the mitigating factors to address the financial risks. The mitigating actions which are planned and shown in this section will mitigate both types of risk.

7.8.1 Financial Risks

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

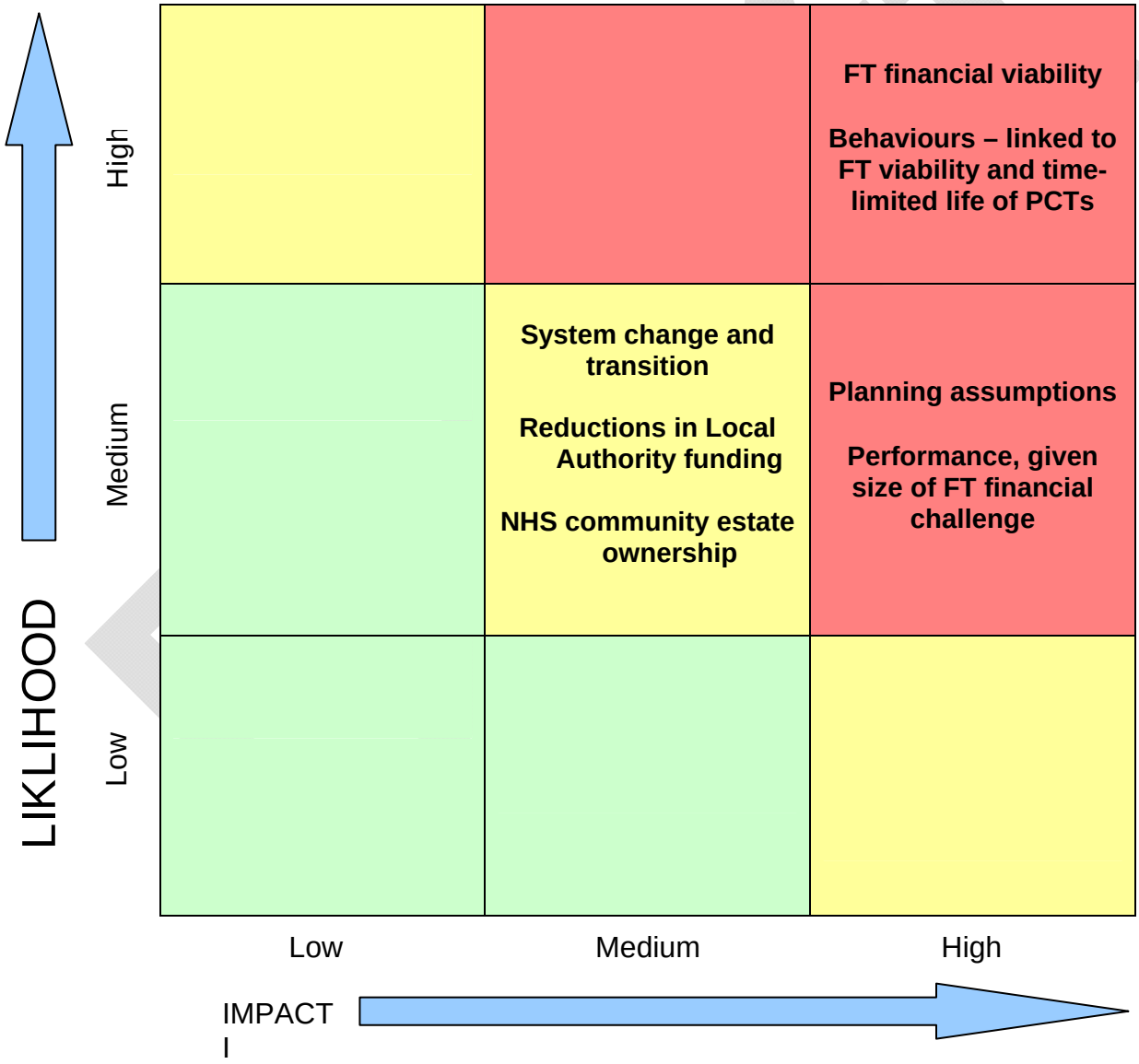
- Underachievement of the £18.5m savings planned from our resource releasing initiatives;
- Under realisation of the savings expected from the reduced national tariffs if local provider Trusts work to recoup those reductions through technical adjustments to contract charges rather than through true efficiency improvements;
- Increases in non-elective hospital activity, over and above those included 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).

7.8.2 System 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.

Assessment of cross cutting risks



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

FT financial viability ***Impact – High, Likelihood – High***	
Delivery Risk • Impact of tariff and rules re emergency admissions and readmissions • Lose of income results in providers no longer being viable • Impact of Patient choice	**Mitigating actions** • Reablement schemes agreed with LAs support timely discharge and reduce readmissions • LTC / Urgent care integrated plans have range of initiatives to reduce emergency admissions • No additional pressure arising from reduced disinvestment schedule
Planning assumptions ***Impact – High, Likelihood – Medium***	
Delivery Risk • PCT allocations agreed for 2011/12 only • Lack of central guidance re planning assumptions, efficiencies or tariff rules results in organisations operating in vacuum • Lack of national direction creates potential for organisations to adopt different assumptions	**Mitigating actions** • Planning assumptions proposed by SOTW adopted by local PCT Clusters – standard approach across SHA • Flexible headroom in financial plans • Flexibility within Plan to rebalance disinvestment with investment once national assumptions and allocations known
System change and transition ***Impact – Medium, Likelihood – Medium***	
Delivery Risk • System changes are constrained by national policy and nationally determined contractual arrangements • Too much change quickly may result in instability in the market – need to maintain local provider viability • Pace of development of GP Pathfinders • Balance delivery of ISOP with development to GP Commissioning • Capacity to deliver	**Mitigating actions** • Acknowledge lead time for providers to reshape business to respond to new service specifications • Flexibility in financial planning to enable pump priming or double running costs whilst new services become established • Delivering a GP Commissioner development programme • Develop a transition plan to support development of pathfinders
Behaviours – linked to FT viability and time-limited life of PCTs ***Impact – High, Likelihood – High***	
Delivery Risk • Increasing competitive market as providers seek to maximise income • Lack of system management • Failing organisations	**Mitigating actions** • Accelerated Bigger Picture Group considering best future configuration of NHS hospital services given need for significant financial savings • Compacts with partners underpin a shared understanding of the need for rapid and sustainable change and commitment to the culture / behaviours needed to “go further faster”

NHS community estate ownership ***Impact – Medium, Likelihood – Medium***	
Delivery Risk • No guidance re future ownership of PCT community estates after April 2013	**Mitigating actions** • Full inventory of properties owned / leased undertaken • Service level agreements for all tenants updated • Full review of property overheads / rents to be completed spring 2011
Performance, given size of FT financial challenge ***Impact – High, Likelihood – Medium***	
Delivery Risk • Cost improvement programmes reduce capacity and impact on performance, quality, patient experience	**Mitigating actions** • Standards agreed within contract performance schedules • Ability to activate penalties and sanctions as appropriate • Comprehensive performance management frameworks enable early identification of risks
Reductions in Local Authority funding ***Impact – Medium, Likelihood – Medium***	
Delivery Risk • Impact of LAs disinvestment on health provision and vice versa	**Mitigating actions** • Regular dialogue with LAs to share plans and identify risks and mitigating actions

These high level assessments will be developed into a full risk plan for each initiative as part of our local planning methodology in which we have integrated the planning framework with risk management. This will ensure:

- Identification of risks;
- Quantification of risks for likelihood and impact;
- Development of mitigation plans for identified risks;
- Integration of the risk plans into the ongoing in-year risk management and performance management processes.

7.9 Governance

As part of the PCT transition process, governance arrangements within NHS South of Tyne and Wear continue to be refreshed to reflect the changing context.

Under our existing Board arrangements, the three PCT Boards hold Joint Board meetings to discuss areas that they have in common such as future plans and performance and approving items such as business cases for major investment. Each PCT Board also holds a separate Annual General Meeting in their locality. Moving forward, each of the PCT Chairs will continue to provide Board leadership during the PCTs' transition period leading up till 2013, supporting the development of new commissioning arrangements with GP

Commissioners and transfer of the health improvement function to Local Authorities. In addition, the PCT Chair in South Tyneside will undertake a further coordinating role where issues require a combined response from the three PCTs to the North East SHA and to the new National Commissioning Board as this becomes established.

Our governance arrangements are also being refreshed in response to the development of GP Commissioning Consortia, planned transfer of community services under the Transforming Community Services programme, and new Once North East arrangements such as the establishment of the NE Primary Care Services Agency which South Tyneside PCT is hosting. Following approval of GatNet as a 2nd wave GP Commissioning pathfinder from February 2011, whilst the PCT Board retains ultimate responsibility and accountability for the services commissioned and activities undertaken on its behalf, the GP Consortium will be established as a Board Committee to take forward commissioning plans under an agreed accountability framework. A similar arrangement will be in put in place with other GP pathfinders as they come on stream. Their commissioning portfolios will be expanded under agreement as the national policy agenda further develops in terms of proposed functions of GP Commissioning Consortia and as their knowledge and skills build.

7.10 Equality Impact Assessment

In accordance with our equality duties, an Equality Impact Assessment was on the carried out on the five year Strategic Plan and the supporting integrated plans. There is no evidence to suggest that the plans have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights. The plans are accessible to everyone regardless of age, disability, race, gender, sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health.

Throughout the development of the integrated plans that support the ISOP, 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 involving partners, stakeholders and local communities in the design, planning and development of services. Full Equality Impact Assessment scoping will continue to take place on each programme to ensure that the needs of all local communities are fully reflected in the design, planning, implementation and evaluation of services.

Section 8 – Board Approval

The Commissioning Executive signed off the Plan on 17 March 2011. The Plan will be submitted to the PCT Board on 30 March 2011 for approval noting that it is subject to formal sign off by the NE SHA in May / June 2011.

Although the emerging consortia was not established and so not in a position to shape and sign off the plan, the PBC Chairs participated in the development of the Plan and a number of clinical events were held to review the integrated plans and it was felt the Plan reflects local priorities. We will actively work with the emerging GP consortia to support their internal development together with the construction of their pathfinder bid in order to ensure that integrated plans (including strategic programmes, Operating Framework requirements and delivery of the resource releasing initiatives) continue to be aligned and reflected in their bid as appropriate.

As part of the broader transition arrangements, we will continue to activity work with partners to ensure delivery of the Plan in 2011/12 and ongoing development and refinement of the detail in subsequent years reflecting our common agenda's and future changes in accountability.

Appendix 1 – Resource Releasing Initiatives 2011 - 2015

SUNDERLAND TPCT						
Programme Board	RRI	Year on year target savings £'000				
		2011/12	2012/13	2013/14	2014/15	Total
Children's						
	Reform care of sick & injured child	£0	£221	£221	£0	£442
	Total	£0	£221	£221	£0	£442
Long Term Conditions & Urgent Care						
	Reduce emergency admissions (EL Re-admissions)	£3,160	£0	£0	£0	£3,160
	Reduce emergency admissions (NEL Re-admissions)	£1,227	£0	£0	£0	£1,227
	Reduce emergency admissions	£0	£395	£705	£1,680	£2,780
	Reduce excess hospital bed days	£442	£442	£442	£442	£1,768
	Total	£4,829	£837	£1,147	£2,122	£8,935
Mental Health						
	Reduce price paid for Gateshead FT older peoples mental health service	£0	£0	£0	£0	£0
	Total	£0	£0	£0	£0	£0
Planned Care						
	Reduce outpatient first attendances	£0	£177	£177	£177	£531
	Reduce review outpatient attendances	£239	£239	£239	£0	£717
	Move Carpal tunnel out of hospital	£0	£400	£0	£0	£400
	Reduce nurse led outpatient clinics	£0	£265	£265	£265	£795
	Review ISTC (Spire) contract	£0	£320	£160	£0	£480
	End short term funding to community services for HCAIs	£0	£0	£0	£0	£0
	Research grant funding for cancer drugs, not currently reimbursed	£0	£0	£400	£310	£710
	Total	£239	£1,401	£1,241	£752	£3,633
Primary & Community based services						
	Reduce Primary Care budgets	£1,084	£0	£0	£0	£1,084
	Total	£1,084	£0	£0	£0	£1,084
Medicine Management						
	Reduce prescribing costs to North East average (Astro PU)	£500	£500	£500	£500	£2,000
	Total	£500	£500	£500	£500	£2,000
Support Functions						
	Reduce PCT management Costs (Including Community Health Services)	£2,080	£310	£0	£0	£2,390
	Total	£2,080	£310	£0	£0	£2,390
	Total	£8,732	£3,269	£3,109	£3,374	£18,484

Appendix 2 – New Investments 2011 – 2015

SUNDERLAND INVESTMENTS	2011-12 Rec	2011-12 Non Rec	2011-12 Total	2012-13 Rec	2012-13 Non Rec	2012-13 Total	2013-14 Rec	2013-14 Non Rec	2013-14 Total	2014-15 Rec	2014-15 Non Rec	2014-15 Total	Total Rec	Total Non Rec	Total Total
CHILDREN & YOUNG PEOPLE															
CHILDREN'S HEALTH	304,000		304,000	460,000		460,000	460,000		460,000	280,000		280,000	1,504,000	0	1,504,000
SURE START PICK UP	670,000		670,000										670,000	0	670,000
LONG TERM CONDITIONS															
LONG TERM CONDITIONS / SELF CARE MANAGEMENT	200,000		200,000	200,000		200,000	200,000		200,000	200,000		200,000	800,000	0	800,000
CONTINUING CARE	300,000		300,000	300,000		300,000	300,000		300,000	300,000		300,000	1,200,000	0	1,200,000
CARERS STRATEGY / RESPITE BREAKS	630,000		630,000	630,000		630,000	630,000		630,000	630,000		630,000	2,520,000	0	2,520,000
MENTAL HEALTH															
OTHER MENTAL HEALTH / SPECIALIST COMMISSIONING	350,000		350,000	100,000		100,000	100,000		100,000	100,000		100,000	650,000	0	650,000
NTA ALLOCATION REDUCTION - NHS PICK UP	200,000		200,000			0			0			0	200,000	0	200,000
OLDER PEOPLE'S DEMENTIA CARE	280,000		280,000			0			0			0	280,000	0	280,000
OPMH LIAISON SERVICE	37,500		37,500	112,500		112,500							150,000	0	150,000
PRIMARY CARE MH SERVICE FOR THOSE WITH LTC				450,000		450,000							450,000	0	450,000
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	190,000		190,000			0			0			0	190,000	0	190,000
BALANCE OF INVESTMENT TO DELIVER MH STRATEGY	473,000		473,000	178,000		178,000	850,000		850,000	310,000		310,000	1,811,000	0	1,811,000
MENTAL HEALTH REBASING	-1,450,880		-1,450,880	-1,450,880		-1,450,880	-1,450,880		-1,450,880	-1,450,880		-1,450,880	-5,803,520	0	-5,803,520
PLANNED CARE															
ELECTIVE ACCESS - OTHER	7,850,000		7,850,000	4,850,000		4,850,000	4,850,000		4,850,000	4,850,000		4,850,000	22,400,000	0	22,400,000
NON CONTRACT ACTIVITY	1,000,000		1,000,000										1,000,000	0	1,000,000
NON NHS HEALTHCARE	900,000		900,000										900,000	0	900,000
SPECIALIST COMMISSIONING DEVELOPMENTS / ISSUES	1,240,000	-91,000	1,149,000	200,000		200,000	200,000		200,000	200,000		200,000	1,840,000	-91,000	1,749,000
IMPROVING PATIENT EXPERIENCE--CANCER / EARLY DETECTION ETC	200,000		200,000	200,000		200,000	200,000		200,000	200,000		200,000	800,000	0	800,000
CANCER DRUGS / SPECIALIST COMMISSIONING	390,000	0	390,000	950,000	0	950,000	450,000	0	450,000	500,000		500,000	2,290,000	0	2,290,000
END OF LIFE / HOSPICE	200,000		200,000	500,000		500,000	500,000		500,000			0	1,200,000	0	1,200,000
STAYING HEALTHY															
OTHER PUBLIC HEALTH AND HEALTH INEQUALITIES	200,000		200,000	200,000		200,000	200,000		200,000	200,000		200,000	800,000	0	800,000
URGENT CARE															
NEAS OVER-PERFORMANCE	420,000		420,000	530,000		530,000	200,000		200,000	200,000		200,000	1,350,000	0	1,350,000
111 RECURRENT CONSEQUENCES				890,000		890,000							890,000	0	890,000
MEDICINES MANAGEMENT															
PRIMARY CARE															
GP ACCESS		582,000	582,000		582,000	582,000		582,000	582,000		582,000	582,000	0	2,328,000	2,328,000
DENTAL SERVICES		13,396,000	13,396,000		13,504,000	13,504,000		13,504,000	13,504,000		13,504,000	13,504,000	0	53,908,000	53,908,000
OPHTHALMIC		2,878,000	2,878,000		2,878,000	2,878,000		2,878,000	2,878,000		2,878,000	2,878,000	0	11,512,000	11,512,000
PHARMACY		4,889,000	4,889,000		4,889,000	4,889,000		4,889,000	4,889,000		4,889,000	4,889,000	0	19,556,000	19,556,000
SUPPORT FUNCTIONS															
CAPITAL PROG FINANCED FROM REV RETURN OF BROKERAGE		5,450,000	5,450,000	0	7,250,000	7,250,000		0	0			0	0	12,700,000	12,700,000
IM&T ADD RUNNING COSTS	100,000		100,000	100,000		100,000	100,000		100,000	100,000		100,000	400,000	0	400,000
COMMUNITY SERVICES															
COMMUNITY SERVICES - CES/CONTINENCE/ENT FEEDS ETC	755,000		755,000			0			0			0	755,000	0	755,000
COMMUNITY SERVICES -DMARDS	261,000		261,000			0			0			0	261,000	0	261,000
COMMUNITY DIAGNOSTICS (MOBILE MRI FYE)	350,000		350,000										350,000	0	350,000
CAMHS															
TIER 3 TENDER	650,000		650,000			0			0			0	650,000	0	650,000
OPERATING FRAMEWORK															
CONTINGENCY/MOVING CARE OUT OF HOSPITAL	1,746,866		1,746,866	8,434,478		8,434,478	7,360,303		7,360,303	7,178,529		7,178,529	24,720,176	0	24,720,176
OTHER															
OTHER POLICY - CENTRAL BUNDLE IN YEAR ALLOCATIONS		1,332,000	1,332,000			0			0			0	0	1,332,000	1,332,000
2% NR (NEED £10.7m, HOWEVER £7.7m IN REC RESERVCES = BAL £3m)			0	300,000		300,000	300,000		300,000	300,000		300,000	900,000	0	900,000
REABLEMENT	5,468,000		5,468,000	945,000		945,000			0			0	6,413,000	0	6,413,000
£2/HEAD GPCC DEVELOPMENT FUND	648,000		648,000										648,000	0	648,000
SOCIAL CARE FUNDING		4,339,000	4,339,000		4,339,000	4,339,000		4,339,000	4,339,000		4,339,000	4,339,000	0	17,356,000	17,356,000
	24,562,486	**32,775,000**	**57,337,486**	**19,079,098**	**33,442,000**	**52,521,098**	**15,449,423**	**26,192,000**	**41,641,423**	**14,097,649**	**26,192,000**	**40,289,649**	**73,188,656**	**118,601,000**	**191,789,656**

KEY

MUST DO - NO CHOICE
LIMITED FLEXIBILITY
CAN BE AMENDED

Appendix 3 – Hospital activity plans submitted to Department of Health

SRS11 GP Written Referrals from GPs for a first outpatient appointment in G&A specialties

		2011									2012			2011/12	2012/13	2013/14	2014/15
		April	May	June	July	August	September	October	November	December	January	February	March	Total			
SRS11_02	Number of GP written referrals in the period	4701	4661	4892	4850	4329	4918	5173	4688	3984	4648	4515	4918	56277	56405	56698	56923

SRS12 Other referrals for a first outpatient appointment in general & acute specialties

		2011									2012			2011/12	2012/13	2013/14	2014/15
		April	May	June	July	August	September	October	November	December	January	February	March	Total			
SRS12_02	Number of other (non-GP) referrals for a first consultant outpatient episode in the period	4974	5092	5185	5502	4975	5491	5773	5269	4930	5080	4561	5391	62223	62365	62689	62937

SRS13 First Outpatient Attendances (consultant-led) following GP Referral in general & acute specialties

		2011									2012			2011/12	2012/13	2013/14	2014/15
		April	May	June	July	August	September	October	November	December	January	February	March	Total			
SRS13_02	Number of 1st outpatient attendances (consultant-led) following GP referral in general and acute specialties	4366	3966	4653	4629	3789	4583	4775	4638	4108	4044	3968	4379	51898	52015	52285	52492

SRS14 All first outpatient attendances (consultant-led) in general and acute specialties

		2011									2012			2011/12	2012/13	2013/14	2014/15
		April	May	June	July	August	September	October	November	December	January	February	March	Total			
SRS14_02	All first outpatient attendances (consultant-led) in general and acute specialties	7627	6851	7936	7972	6755	8159	8251	7917	7224	7178	6843	7818	90531	90737	91209	91570

SRS15 Elective Admissions

		2011									2012			2011/12	2012/13	2013/14	2014/15
		April	May	June	July	August	September	October	November	December	January	February	March	Total			
SRS15_04	Number of elective FFCEs ordinary admissions	1010	983	1003	961	969	1050	1124	1055	878	1042	1035	1143	12253	12379	12583	12769
SRS15_05	Number of elective FFCEs daycases	3029	2980	3099	3102	2934	3063	3292	3064	2762	3081	3111	3239	36756	37136	37749	38308
SRS15_06	Total number of FFCEs in the period	4039	3963	4102	4063	3903	4113	4416	4119	3640	4123	4146	4382	49009	49515	50332	51077

HRS06 Non-elective Admissions

		2011									2012			2011/12	2012/13	2013/14	2014/15
		April	May	June	July	August	September	October	November	December	January	February	March	Total			
HRS06_02	Number of G&A non-elective FFCEs in the period	2587	2655	2591	2618	2670	2644	2836	2747	2855	2769	2559	2809	32340	32459	32461	31991

Appendix 4 – Operating Framework 2011/12 Planning Checklist

PCT Cluster: NHS SoTW

Initiative / Programme	Reference in The Operating Framework	Programme Reference / Detail
Military and veterans' health		
Develop and maintain their Armed Forces Networks to ensure the implementation of the Ministry of Defence / NHS transition Protocol	4.17	Military Personnel Integrated Plan and Mental Health Integrated Plan
Ensure the implementation of the Murrison Report to improve access to mental health services by veterans	4.17	
Ensure NHS employers are supportive towards those staff who volunteer for reserve duties	4.17	
Regional trauma networks		
Ensure completion of implementation of regional trauma network configurations by the end of 2011/12, including ensuring that designated Major Trauma Centres are planning the continuous provision of consultant let trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage.	4.52	SHA led programme at this stage
Workforce planning and education		
Ensure local provider skills networks cover all providers of NHS services, including non-NHS organisations and primary care.		Maintain the provider networks established under the SOTW workforce coallaborative arrangements.
Ensure that local skills networks have the capacity to deliver the required outcomes.		
Map funding and activity to the proposed new skills networks.		
HCAIs		
Provide assurance that commissioners and providers are making sufficient progress in collecting and analysing data on MSSA and E. *coli* bacteraemia	4.29	HCAI Integrated Plan
Patient experience: PCTs should -		
Continue to ensure that appropriate systems are in place to capture the views and experiences of patients, service users and carers. Raising awareness of local feedback options and demonstrate how feedback has been used.	3.10, 3.12	Patient Experience Integrated Plan
Work with partners to ensure patient experience and feedback are inherent parts of service design, delivery and improvement.	3.14	
Ensure their statutory obligation under the Duty to Involve is effectively and efficiently discharged during transition to commissioning and GP consortia.	3.14	
Quality accounts		
Ensure providers publish quality accounts for 2010/11.	3.19	NHS Foundation Trust Quality Schedule (Included within Legally Binding Contract)
Choice		
Consider amended guidance on choice informing providers' obligations under the NHS standard contract, to ensure that from April 2011, all patients referred for an outpatient appointment should be able to choose a named consultant-let team by requiring providers to:		Acute Access Integrated Plan and NHS Foundation Trust Penalty Schedule (Included within Legally Binding Contract)
- accept patients who are referred to a named consultant-let team, as long as the referral is clinically appropriate;		
- list their services on Choose and Book in a way that allows users to book appointments with named consultant-let teams; and		
- publish information about services so that people can use it to make choices about their healthcare, and support people to use this information	3.22	
Subject to conclusion of choice consultation, consider further changes to guidance on choice informing providers' obligations under the NHS standard contract that may follow during 2011, to ensure that		
from April 2011, patients should be offered greater choice of treatment and provider in some mental health services;		
during 2011, patients should be offered greater choice in diagnostic testing and post-diagnosis care; and		
during 2011, choice should be introduced in care for long term conditions as part of personalised care planning	3.23	
Begin to introduce a phased manner, the commitment to allow from April 2011, patients to be able to start to choose any healthcare provider in a range of community services	3.24	
Work with GP practices and other stakeholders to make preparations for introduction of choice of GP practice from April 2012, subject to the policy framework to be published in 2011	3.25	
Develop and implement plans for shared decision making and information giving and include these areas in contracts	3.26	
Publish, via *Your Guide* or similar mechanisms, an account of how they have delivered shared decision making and information giving	3.26	
Data quality		
To ensure the NHS use the Secondary Uses Service (SUS) as the standard repository for performance, monitoring, reconciliation and payments by April 2012, operating in shadow form from October 2011. Use contract sanctions if they are not satisfied about the completeness and quality of a provider's data.	4.6	NHS Foundation Trust Information and Data Quality Schedule (Included within Legally Binding Contract)
To ensure that there will be full NHS Number compliance (to improve patient safety and experience and to support greater integration across local health and social care services)		NHS Foundation Trust Information and Data Quality Schedule (Included within Legally Binding Contract)
Reconfiguration		
Continue to ensure their statutory duty to consult Overview and Scrutiny Committees about substantial service change is maintained throughout transition	4.13	Dedicated Locality Team in place to support transition with accountability for engagement including OSC; routine meetings in place with specific focus on development / implications of business cases and commissioning intentions.
Health Visitors		
PCTs to develop and implement plans to deliver the health visiting commitment	4.14	Child Health Integrated Plan
Family Nurse Partnerships		
Maintain existing delivery of the Family Nurse Partnership, alongside planning for an expanded service in appropriate areas in order to contribute to more than doubling the current capacity to at least 13,000 clients in England at any one time by April 2015. SHAs will work with the Family Nurse Partnership Unit on the detail that underpins this assurance	4.15	Child Health Integrated Plan
Services for people with Autism		
Take action to assess the needs of people with autism in their areas, then plan and commission services as appropriate to address those needs (guidance to be issued in December 2010)	4.18	CAMHS Integrated Plan and Mental Health Integrated Plan

PCT Cluster: NHS SoTW

Initiative / Programme	Reference in The Operating Framework	Programme Reference / Detail
Dementia Services		
Ensure that NHS organisations and providers:		
Make progress on the National Dementia Strategy, covey the four priority areas as set out in the implementation plan published in September 2010; and		Mental Health Integrated Plan
– agree with their social care commissioning partners the aspects of the strategy that could be delivered by using section 75 flexibilities	4.19, 4.20	
Support for carers		
Agree and make available to local people policies, plans and budgets to support carers with local authorities and local carers' organisations and ensure that NHS organisations consider *Recognised, valued and supported: next steps for the Carers Strategy*. PCTs should also pool budgets with Local Authorities to provide carers breaks.	4.21, 4.22	Carer Strategy Groups in each LA area with SOTW NHS lead for carers identified.
End of life care; Ensure implementation of the End of Life Care Strategy – promoting high quality care for all adults at the end of life by:		
– ensuring that staff are trained to offer patients the choice of where to be cared for as they approach the end of life, and where to die, including using the e-learning modules available as part of blended learning	4.33, 4.34	Planned Care Integrated Plan
– ensuring that adequate 24/7 community services are available in their locality	4.33, 4.34	
Cancer reform		
Implement the *Improving Outcomes Strategy for Cancer*. In particular:		Planned Care Integrated Plan
– consider the four priority areas for diagnostics for improving earlier diagnosis of cancer (chest x-ray, non-obstetric ultrasound, flexi sigmoidoscopy / colonoscopy and MRI brain) and ensure continuity of commissioning and provision is secured in the move to commissioning by the NHSCB and GP consortia		
– develop local plans to ensure that access rates to radiotherapy and the use of advanced radiotherapy techniques, such as Intensity Modulated Radiotherapy, Image Guided Radiotherapy and Proton Beam Therapy, are appropriate for their populations;		
– work with their cancer networks to plan full implementation of NICE Improving Outcomes Guidance (IOG) for Cancer (particularly upper gastro-intestinal, urology, head and neck and haematology)		
– ensure providers include staging information in their cancer registration dataset in order to provide data needed to assess whether progress is being made on improving survival rates through earlier diagnosis	4.35	
Cancer screening		
– Work with their local services and NHS Cancer Screening Programmes to implement HPV testing as triage for women with mild or borderline results	4.36	Planned Care Integrated Plan
Stroke		
Improve stroke outcomes by:	4.37	
– prevention: improving diagnosis and treatment of people with atrial fibrillation;		Long Term Conditions Integrated Plan
– all patients are assessed for thrombolysis, receiving it if clinically indicated; and		
– post hospital and longer term care: developing Early Supported Discharge arrangements and community specialist stroke rehabilitation, with effective reablement support where responsibility rests with the PCT *(4.37)*		
Mental Health		
Support treatment for offenders, by ensuring NHS organisations work with local partners to deliver joined up local commissioning of drug services based on the Prison Drug Treatment Strategy Review Group's outcome framework	4.38	Mental Health Integrated Plan
Increase choice and control for many users of mental health services, including introducing *Any Willing Provider* for a range of services (subject to consultation)	4.39	
IAPT		
Work in partnership with the Department of Health to extend access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions	4.41	Mental Health Integrated Plan
Safeguarding		
Ensure that statutory duties, as set out in the statutory guidance *Working Together to Safeguard Children*, and partnership working arrangements are maintained and handed over to new organisations, such as GP consortia, in good order	4.42	Child Health Integrated Plan
Dentistry		
Work with dentists and other agencies to promote improvements in the oral health of children	4.43	NHS SOTW commissions an Oral Health Promotion service from the Salaried Dental Service – part of Community Health Services.
Identify and support potential pilot sites to take part in development of a new dental contract	4.43	Dental Pilots are included within existing workplans; activity and finanace to be closely monitored.
Learning disabilities		
Ensure actions are taken to improve healthcare and health outcomes for people with learning disabilities and their families, with particular emphasis given to ensuring staff are trained to make reasonable adjustments, communicate effectively and follow the Mental Capacity Act Code of Practice in all their interactions with patients with learning disabilities	4.44, 4.45	Mental Health Integrated Plan
Children and young people's mental health		
Ensure NHS organisations consider the needs of children, young people and families in commissioning and delivering services, paying particular attention to groups with specific needs including disabled children, palliative care, CAMHS, children in care and families with multiple problems	4.46	CAMHS Integrated Plan
Diabetes		
Ensure insulin pumps are available for those people with diabetes that meet the criteria recommended by NICE	4.47	Long Term Conditions Integrated Plan
Commission the relevant structured patient education to support people newly diagnosed with diabetes and at appropriate points in their life as their condition progresses	4.48	
Ensure NHS providers consider the overall management of inpatients with diabetes in order to reduce their length of stay, improve their experience of care, ensure that they do not develop diabetic foot complications whilst in hospital and that their blood glucose is managed safely	4.49	
Sharing non-confidential information to tackle violence		
Ensure acute trusts share non-confidential information with Community Safety Partnerships in order to support reductions in the number of violence-related attendances in A&E departments	4.50	Information is currently shared with Community Safety Partnerships.

PCT Cluster: NHS SoTW

Initiative / Programme	Reference in The Operating Framework	Programme Reference / Detail
Violence against women and girls		
Ensure NHS organisations properly identify women and children who are victims of violence or abuse and have suitable care pathways in place to ensure that they get the sensitive, on-going care they need	4.51	Review training on domestic violence for front line professionals is included within the Child health integrated plan.
Respiratory disease		
Continue the task of delivering the 24 recommendations identified in the 2010 public consultation on the Strategy for Services for Chronic Obstructive Pulmonary Disease (COPD) in England	4.53	Long Term Conditions Integrated Plan
Public Health		
Work closely with local authorities and health and wellbeing boards to ensure the healthy living programme is in place and create an identifiable health improvement budget	4.56	Continued engagement with Local Authority colleagues to understand the impact of budget changes and ensure spend is applied to gain maximum impact and deliver priority programmes.
Ensure NHS organisations continue to maintain performance against the existing public health indicators whilst also managing the transition towards the new commissioning and governance arrangements of the NHSCB and GP consortia and local authority health and wellbeing boards	4.58, 4.59	Firm focus on maintaining performance against existing public health indicators and even with the abolition of the Local Area Agreement, our local authority colleagues continue to support action in these areas. Work is underway to secure transition arrangements in relation to commissioning and governance around a local Health and Wellbeing Boards. This includes establishing new arrangements with the Local Strategic Partnership.
Pharmacy		
Ensure NHS organisations continue to maintain and develop pharmaceutical services, including local enhanced services to meet pharmaceutical needs	4.60	Medicines Management Integrated Plan
Actively engage in optimising the use of medicines in people with newly diagnosed long term conditions, and targeting of Medicines Use Reviews	4.60	
Emergency preparedness		
Ensure all NHS organisations, other contracted healthcare providers, local authorities and other local organisations maintain and test plans and arrangements to deliver an effective response to threats and hazards	4.61	Emergency Preparedness Integrated Plan
Maintain the current capability and capacity of the existing 12 Hazardous Accident Response Teams (HARTs) in Ambulance Trusts now that funding for HARTs is in their allocations	4.61	
Ensure all NHS organisations have well developed plans in place to manage exceptional surges in activity	4.62	
Ensure all NHS organisations have necessary plans in place to maintain service provision and meet any additional demands arising from events associated with the Olympic and Paralympic Games in July 2012	4.62	
Ensure NHS organisations maintain and continue to test with their local partners the ability to operationalise and coordinate their pandemic response plans across local areas	4.63	
Physical activity		
PCTs should engage with local authorities and other partners to support and embed community physical activity initiatives for all ages alongside activity in schools in preparation for the 2012 Games. In particular,		
- Ensuring implementation of the *Let's Get Moving* physical activity pathway will enable GPs and other healthcare practitioners to identify adults who do not currently meet recommended activity levels and support them in being more active		Staying Healthy Integrated Plan
- Directors of Public Health, working with local authorities, are encouraged to promote activities that improve the health of all sections of the populations they serve, such as schemes to promote physical activity, building on and complementing 5-A-DAY activity and the *Change4Life* campaign	4.64	
NHS health checks		
Continue to progress the implementation of NHS Health Check programmes and ensure that	4.65	Long Term Conditions Integrated Plan
- they look at ways to reduce health inequalities from vascular disease	4.65	
- consider the results of pilots of health checks for carers in the development of NHS health check	4.65	
Abdominal aortic aneurysm screening		
Support the phased implementation of the Abdominal Aortic Aneurysm national screening programme by:		Long Term Conditions Integrated Plan
- continuing screening for programmes that are currently operational;		
- implementing screening as planned for the 2011/12 phases; or		
- developing a robust implementation plan for 2012/13, ensuring surgery providers fulfil the requirements for implementation of screening	4.66	
Fragility fractures in the elderly, especially in women		
Take steps to reduce incidence of fragility fractures in the elderly, especially in women by recognising precursor or "herald" fractures and give patients a bone health assessment and treatment when they first show clear signs of being at risk *(4.67)*	4.67	All FTs have strategies in place to indentify people with fragility fractures and have bone assessment services to support screening. Reductions in incidence will need to be monitored to assess effectiveness of plans.
Workforce planning and education		
Will SHAs and PCTs be ready to identify and report all current staff by grade band, occupational group and existing business function, by January 2011 to help the Department produce a clear map for SHAs showing how their existing business functions migrate to the new organisations? This is essential to ensure that the transition process is carefully managed to minimise uncertainty and disruption for the staff affected.		Addressed through SHA & PCT People and Function Migration Process.
Can SHAs and PCTs currently identify the staff employed to deliver Special, Hosted and Shared-Service functions provided to other NHS bodies?		
Can SHAs and PCTs identify staff numbers deployed to functions that will potentially cease under the new organisational arrangements?		
Social Care and integrated working		
Are arrangements in place to transfer funding to Local Authorities under section 256 (NHS Act 2006) arrangements and have joint plans been drawn up to agree on the investment of this money in services which benefit health and improve overall health gain?	5.25, 5.26	Arrangements are in place to transfer funding. The Joint PCT/LA Commissioning Steering Group in each PCT area will review all funding to ensure allocations are made to initiatives that maximise outcomes for health improvement and develop a plan to deliver investment.
Are arrangements in place for funding contained within recurrent PCT allocations for reablement services and post-discharge support to be invested additionally to support rehabilitation services and homecare equipment services?	5.12	Work will be undertaken within 3 x locality Intermediate Care / Reablement Task Groups and Joint Commissioning Steering Groups to undertake a review of schemes, re-shape to avoid duplication and maxismise use of current funding which will ensure there is wider and proportional coverage in each locality.