NHS South of Tyne and Wear

STRATEGIC PLAN

2008 – 2013

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Section 1 – Foreword

"Our vision, our future", the ten year vision for the NHS in the North East, sets out a challenging agenda, ensuring that the patient is at the heart of everything we do. It aims to ensure that all services are safe, are of a high quality and demonstrate value for money. This vision is set against the backdrop within the North East of poor health and stark inequalities. Delivery of the vision will require high ambition, a new sense of common purpose and alignment of all partner organisations.

Across NHS South of Tyne and Wear, we have worked with local people and our partners to articulate our local vision to **'Make South of Tyne and Wear healthy for you',** and that this will be 'unlocked' through three components:

- **Better health** to live longer, with better quality of life and fair access to services.
- **Excellent patient experience** ensuring safe care, effective treatment and quality services.
- **Wise use of your money** with the right services at the right place and time, reducing waste and ensuring value for money.

Our achievement of this vision will be measured by high level changes in life expectancy and health inequalities, and we have chosen key outcome measures to monitor our progress.

We will **ensure better health** by minimising health risks and supporting the adoption of healthy lifestyles, demonstrated by:

- ✓ Reducing the rise in childhood obesity at Year 6.
- ✓ Reducing the rise in alcohol-related hospital admissions.
- ✓ Smoking in pregnancy becoming less common.

We will also **ensure better health** through access to treatments that minimise the impact of health risks and improve survival, demonstrated by:

- ✓ Reducing smoking prevalence in people with a chronic condition.
- ✓ Better hypertension control in people with heart disease.

We will evidence **improving patient experience** and **wise use of money** through:

- ✓ More people getting their first cancer treatment properly.
- ✓ A reduction in hospital admissions for people with Ambulatory Care Sensitive Conditions.

Underpinning these high level aspirations, this document describes the health needs of our populations, the shape of our local health economy and potential future changes in demand. These insights informed the selection and prioritisation, undertaken with our partners, of the **strategic objectives** which underpin the delivery of our vision and the North East vision and support the shared agenda described in our Local Area Agreements. We have developed a programme of goals and initiatives for each objective, outlining the changes to be made and the measures which will track progress. These initiatives are supported through our financial plan.

	NHS South of Tyne and Wear Strategic Objectives
Staying healthy Life expectancy gap to be reduced by 1% by tackling CVD mortality (greatest contributor to gap) through evidence-based, high impact changes	**1.** Develop a comprehensive **obesity** prevention, management and treatment service in each PCT to halt and reduce obesity prevalence **2.** Expand and introduce new stop **smoking** services to reduce smoking prevalence **3.** Implement the local **alcohol** strategy to reduce alcohol related harm **4.** Identify people at high risk of **CVD** and manage in Primary Care
Children's health and services	**5.** Support all **children** and young people to experience the best quality of life possible, to reduce health inequalities and to maximise life expectancy in line with Every Child Matters. Includes moving to integrated, high quality 24/7 services for **acutely sick & injured children**, across all healthcare settings, with an increased emphasis on care outside of hospital working with viable inpatient units
Maternity	**6.** Deliver high quality services to give women and their families greater choice during the antenatal and postnatal period, offering easy access to supportive, seamless **maternity** care, designed around individual needs. This will include agreeing required staffing levels and service configurations to ensure appropriate consultant cover in medical delivery suites
Acute care	**7.** Ensure integrated 24/7 **urgent care** systems across all sectors which delivers quality care in appropriate settings
Planned care	**8.** Ensure planned care services which are streamlined, high quality, patient-centred and delivered as close to home as appropriate – with an initial focus on **musculoskeletal** services then applying lessons learnt to future programmes of reform. Also continue to develop high quality **cancer** services in line with national guidance delivered through the cancer network
Mental Health	**9.** Develop an integrated model of **mental health care** which provides a personalised, holistic approach and recognises that recovery can but may not mean cure, including reprovision of inpatient services in Sunderland, implementation of national dementia strategy and new model of CAMH services
Long term conditions	**10.** Deliver high quality, out-of-hospital support for people with chronic conditions, each with a personalised care plan, to eliminate unnecessary hospital admissions and shorten necessary admissions. Pilot with **CVD**, rollout to diabetes and COPD **11.** Develop a model of **rehabilitation** for LTCs, providing both specialist and generic support, across the spectrum from acute care, community based care, longer term support and self management
End of life care	**12.** All people entering the **end of life** will have their needs, priorities and preferences identified, documented, reviewed and acted upon, with the same standards of care in all settings whatever is their preferred place of death

This is an ambitious plan. We have the opportunity to radically improve the health and well being of our local people and also the quality of local services and we are committed to implementing the comprehensive programme of initiatives outlined in this Plan. The Organisation Development Plan and Communication and Engagement Strategy which form part of this Strategic Plan describe how we will increase our commissioning expertise and improve our commissioning processes to become a World Class commissioner equipped to deliver our strategic objectives.

We have already started delivering this ambitious agenda and are confident that we will achieve our strategic objectives by focusing all our efforts and resources on achieving our vision to **'Make South of Tyne and Wear healthy for you'**.

Section 2 – Vision

2.1 Vision

"Our vision, our future" is the ten year vision for the NHS in the North East of England. The vision sets out a challenging agenda, ensuring that the patient is at the heart of everything we do. This will require systematic transformational change on a scale not previously undertaken across a whole health economy. The poor health and stark inequalities experienced in the North East require high ambition and a new sense of common purpose and alignment of all partner organisations.

The case for change outlined in the NHS North East vision (the worst health in England and an over dependence on hospital care which limits the scope for investment in wider prevention) resonates fully locally and reflects our own need for change. NHS South of Tyne and Wear is fully committed to the effective implementation and delivery of the NHS North East vision.

The NHS North East vision highlights the need to reduce ill health, uniformly ensure quality care, improve patients' experience of health services and reduce waste and errors. Our local vision is to **'Make South of Tyne and Wear healthy for you'** and is supported by three high level objectives which describe the changes we aim to make in the medium to long term:

- **Better health** to live longer, with better quality of life and fair access to services.
- **Excellent patient experience** ensuring safe care, effective treatment and quality services.
- **Wise use of your money** with the right services at the right place and time, reducing waste and ensuring value for money.

Our local vision is entirely congruent with and supportive of the North East long term direction of travel and has been agreed with partners and local people. It also encompasses the four key dimensions of care identified in Lord Darzi's interim report, for services to be fair, personalised, effective and safe. There is a clear alignment between our vision and the seven aims for transformation that underpin the NHS North East vision.

NHS North East Vision seven aims for transformation	NHS South of Tyne and Wear Vision
	Better health
No barriers to health & well being	Longer life
No helplessness	Better quality of life
No inequality	Fair access to services
	Excellent patient experience
No avoidable deaths, injury, illness	Safe care
No avoidable suffering or pain	Effective treatment
No unnecessary waiting or delays	High quality services
No waste	**Using money wisely**

Our efforts and resources will be solely focused on transforming local health, well being and service provision to realise both our local vision and that of NHS North East.

The NHS North East vision provides the context and framework for our Strategic Plan, forming part of the extensive engagement process with partners in its development. The recommendations from the clinical pathway groups provide us with the drivers for transformational change which form an integral part of our Strategic Plan. We support the continued development of the eight clinical pathway groups and will play a proactive role in leading the implementation so that our local context is fully taken into account. This will ensure that regional changes in infrastructure and pathways will deliver improved quality locally. We will ensure that our local implementation plans dovetail with the wider health economy so that change is effectively embedded throughout the North East.

2.2 What will the future of local health and service provision look like in NHS South of Tyne and Wear in 2013?

In looking ahead to 2013, health and social care services within NHS South of Tyne and Wear will be radically different from those currently commissioned following the extensive transformational change we plan to undertake in the intervening years, leading to measurable improvements in health. This section describes how we want health and health services to look and feel once the changes set out in this Strategic Plan have been implemented, across the three parts of our vision.

Better health – to live longer, with better quality of life and fair access to services

By 2013, there will be a marked shift in commissioning to address the preventable causes of chronic conditions. Using a care pathway approach, a key focus will be on preventing the onset of disease and also the causes of disease advancement and exacerbation. As a result there will be a measurable reduction in the prevalence of risk factors for disease, namely smoking, obesity, hypertension, low birth weight and an increase in the safe use of alcohol. There will also be a measurable increase in effective secondary prevention, including the management of hypertension and the use of cholesterol lowering drugs. Furthermore our expanded preventative agenda will ensure that future generations adopt lifestyles that mitigate the risks of acquiring ill health. Our strong commissioning arrangements will drive the implementation of effective, proven treatments. These will specifically focus on cardiovascular disease and cancer, both of which will impact on life expectancy so that each PCT will achieve life expectancy targets for both sexes.

CVD - increase the uptake of vascular checks and subsequent management focusing on those at highest risk

Children – implement Change4Life social marketing programme to reduce childhood obesity

There will be measurable reductions in health inequalities, both against the England and Wales position and also between small areas within each PCT. This will be demonstrated both through health equity audit and the closing of the statistical health gap. There will be comprehensive, integrated services in place to specifically address the needs of disadvantaged and vulnerable groups and the residents of the most deprived areas within each PCT.

By 2013, health improvement targets and objectives for improvements in wellbeing will be included in the strategic and operational plans of all local public sector organisations. This

will reflect a common understanding that improved health and wellbeing is a joint responsibility and also a joint commitment to their delivery. Plans will be based on an improved understanding of the needs, wants and preferences of individual communities together with a greater appreciation of the impact of culture and the need to influence it.

Excellent patient experience – ensuring safe care, effective treatment and quality services

Patients and the public have an increasingly high expectation of all parts of their local NHS. By 2013, we will fulfil this expectation by ensuring that all the services we commission are fair, personalised, effective and safe, and that this can be demonstrated by information which is readily available and shared. Choice, quality, convenience and timely access will be delivered routinely so that people can make informed decisions about where and from whom they receive their care. This will be evidenced by sustained improvements in whole system working and reflected for example, in the prompt delivery of cancer treatment.

Maternity – offer women choice regarding how to access services, type of antenatal care and type of place of birth

Acute – deliver thrombolytic therapy to appropriate patients presenting with acute stroke

The public will have confidence in local services as a result of our proactive engagement with local communities to understand and incorporate their needs and views into our decision making. There will be clarity about what is expected of patients and this will be articulated in a written compact agreement. People will be empowered and supported to look after themselves and take control over their journey through healthcare processes. Every patient contact will be effective and will also be used to deliver multiple interventions, including prevention and health promotion.

Where feasible, care will be delivered in or as close to home as possible, with more complex treatments commissioned from specialist centres. There will be a reduced reliance on hospital services, with a broader range of traditionally inpatient services available on an outpatient and daycase basis. Delivery within Primary Care settings will also be very different as the shift in procedures currently performed in secondary care to primary care increases year on year.

Mental Health – implementation of the national dementia strategy

Wise use of your money – with the right services in the right place and time, reducing waste and ensuring value for money

Acute – opening of new primary care centres in Gateshead, South Tyneside, and Sunderland

By 2013, NHS South of Tyne and Wear will be commissioning high quality, evidence based, appropriate and cost effective treatments in an increased array of settings. Primary care centres, health centres and modernised GP practices will be “fit for purpose” and will form the hub for a true “Primary Care led NHS”. Effective screening will be undertaken within primary care to ensure that patients enter the appropriate standard care pathway thus eliminating waste (e.g. unnecessary appointments and waits).

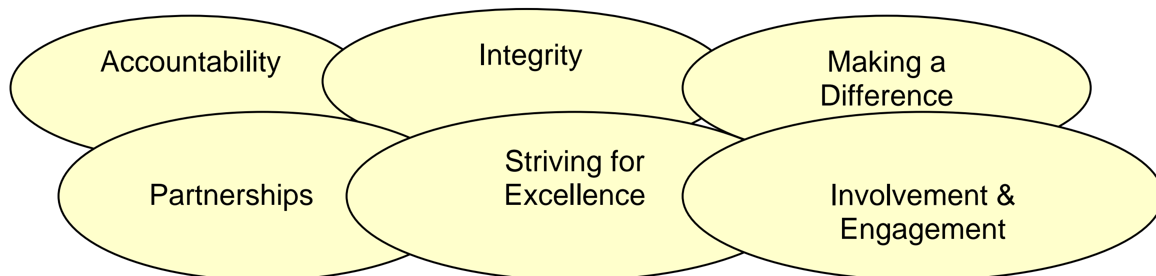
We will only commission effective proven treatments from accredited providers. A choice of providers will be standard and we will drive market stimulation to ensure the correct level of supply to match our planned levels of demand. Where appropriate the supply of healthcare from accredited providers will be a mix of public, private and third sector.

By 2013, there will be a measurable increase in efficiency and value for money, delivered through service reform and modernisation, disinvestment in services no longer 'fit for purpose', and also through the effective utilisation of tools including benchmarking and programme budgeting. An increased share of our expenditure will be targeted at health improvement and reducing health inequalities, reflecting our broader preventative agenda. The way in which we prioritise what we will and will not do will be significantly more sophisticated and will include evaluation of outcomes and understanding the impact of interventions, as well as being shaped by the views and preferences of our local communities.

Mental Health – Re-provision of inpatient services to replace current facilities in Sunderland by 2012

2.3 Core values

The Integrated Board for the three PCTs used a structured process to articulate a set of core values which will shape and underpin all the work of the PCTs; these are:

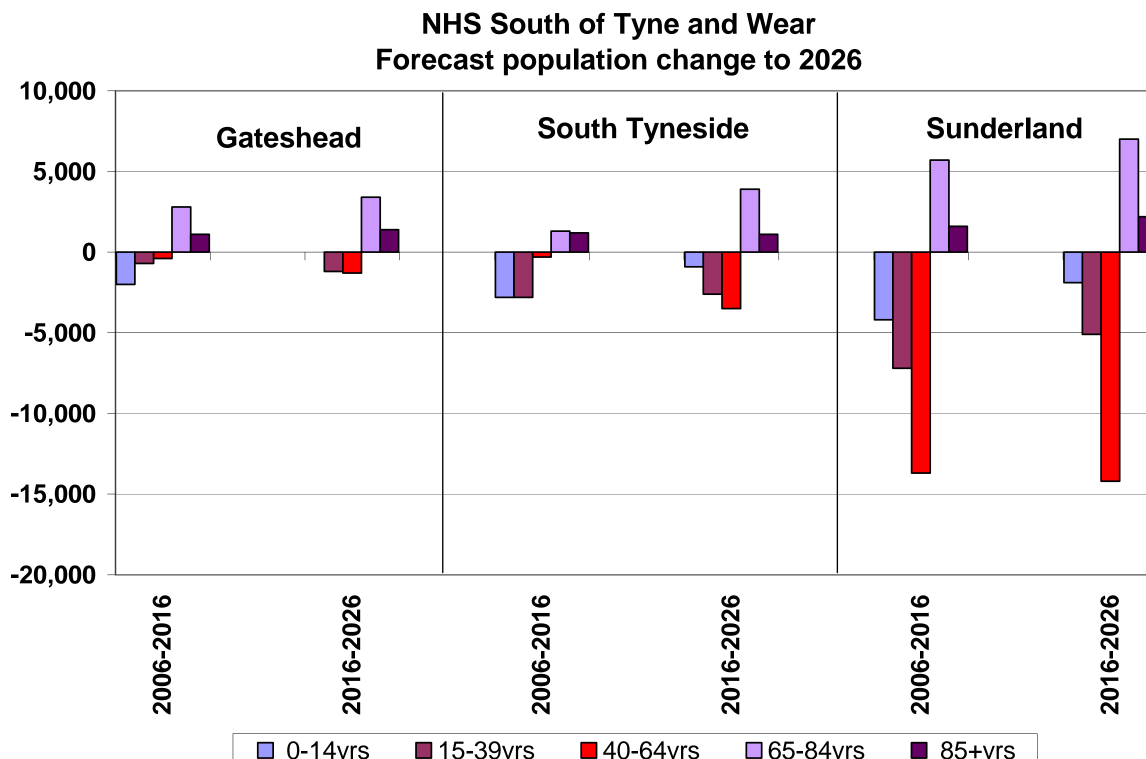


- Accountability – taking responsibility for delivering what we set out to achieve.
- Integrity – operating with openness, honesty and veracity in all our working relationships.
- Making a difference – continuously improving our performance and ensuring increased customer satisfaction.
- Partnerships – collaborating with a wide range of partners on a shared vision with a shared values basis.
- Striving for excellence in everything we do – we strive to be the best.
- Involvement and engagement – including our communities, individuals and our staff.

The Organisation Development Plan sets out the process and detailed outputs which resulted in agreement of these six core values.

3.1 Population demographics, health needs and clinical quality

The PCTs South of Tyne and Wear have a combined population of 625,000 which is forecast to reduce by around 10,000 (1.5%) over the next 20 years. However, the age structure within the overall total is forecast to change significantly, as follows:



The large increases forecast in the elderly, and particularly the very elderly, have significant implications for the provision of health and social care over the next five, ten and twenty years. Even if the general levels of health in these age groups can continue to improve (and this will be helped substantially by the initiatives set out in this Strategic Plan), the shape and structure of health services will need to change to meet the needs of this growing group.

All three PCTs are "spearhead", with overall levels of deprivation significantly higher than the England average (each is in the 10% of local authority areas with the highest deprivation as measured by the Index of Multiple Deprivation). Levels of health and underlying risk factors for the three PCTs are amongst some of the worst in the country.

The Joint Strategic Needs Assessments (JSNAs) and Director of Public Health (DPH) Reports set out a detailed analysis of demographics, deprivation, disease prevalence, mortality rates and other indicators for each PCT. The following health profiles give an overview of health and underlying risk factors compared to England percentiles and of relative income levels.

3.2 Summary health indicators

The 2008 Community Health Profiles, prepared by the Association of Public Health Observatories, show a summary comparison to England averages, highlighting in red those measures which are significantly worse and in green those which are significantly better. It is clear that on most high level health measures, our three PCTs are significantly worse than the rest of England.

			Gateshead		South Tyneside		Sunderland	
Domain	**Indicator**	**England Average**	**Local Value**	**Compared to England**	**Local Value**	**Compared to England**	**Local Value**	**Compared to England**
Our communities	**1** Deprivation	20%	35%		46%		43%	
	2 Children in poverty	22%	27%		29%		27%	
	3 Statutory homelessness	4			4		5	
	4 GCSE achievement (5 A*-C)	60%	71%		59%		59%	
	5 Violent crime	19	16		18		19	
	6 Carbon emissions	8	8		5		7	
Children's and young people's health	**7** Smoking in pregnancy	16%	20%		29%		22%	
	8 Breast feeding initiation	69%	51%		47%		40%	
	9 Physically active children	86%	81%		91%		91%	
	10 Obese children	10%	10%		12%		12%	
	11 Children's tooth decay (at age 5)	2	2		2		2	
	12 Teenage pregnancy (under 18)	41	46		47		54	
Adults' health and lifestyle	**13** Adults who smoke	24%	33%		35%		32%	
	14 Binge drinking adults	18%	27%		27%		27%	
	15 Healthy eating adults	26%	17%		17%		17%	
	16 Physically active adults	12%	10%		11%		11%	
	17 Obese adults	24%	26%		26%		27%	
Disease and poor health	**18** Under-15s 'not in good health'	12%	11%		13%		12%	
	19 Incapacity benefits for mental illness	28	46		41		46	
	20 Hospital stays related to alcohol	260	608		415		482	
	21 Drug misuse	10	12		10		5	
	22 People diagnosed with diabetes	4%	4%		4%		4%	
	24 New cases of tuberculosis	15	2		2		7	
	25 Hip fracture in over-65s	480	551		700		572	
Life expectancy and cause of death	**26** Life expectancy - male	77	75		75		76	
	27 Life expectancy - female	82	80		80		80	
	28 Infant deaths	5	6		5		5	
	29 Deaths from smoking	225	305		302		295	
	30 Early deaths: heart disease & stroke	84	103		105		108	
	31 Early deaths: cancer	117	138		146		136	
	32 Road injuries and deaths	56	41		34		35	

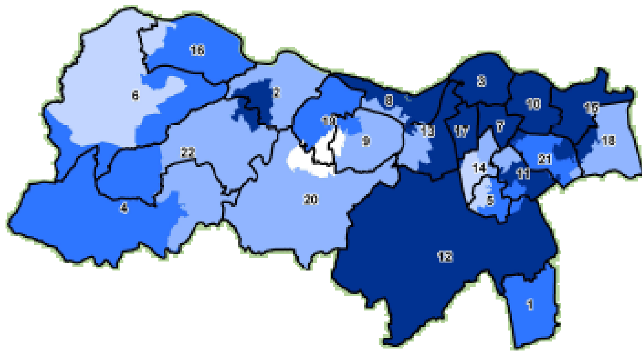
Key

(green)	Better than the England average
(red)	Worse than the England average
(white)	Same as the England average

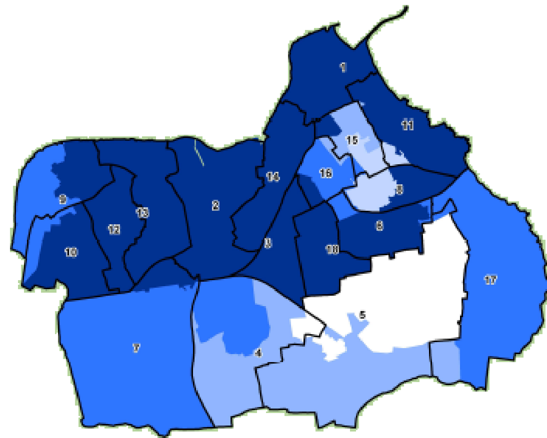
3.3 Income inequalities

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

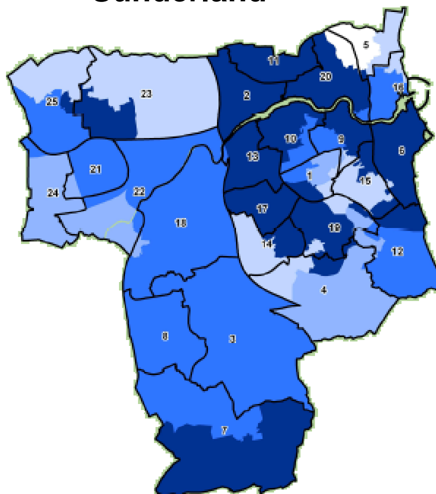
Gateshead

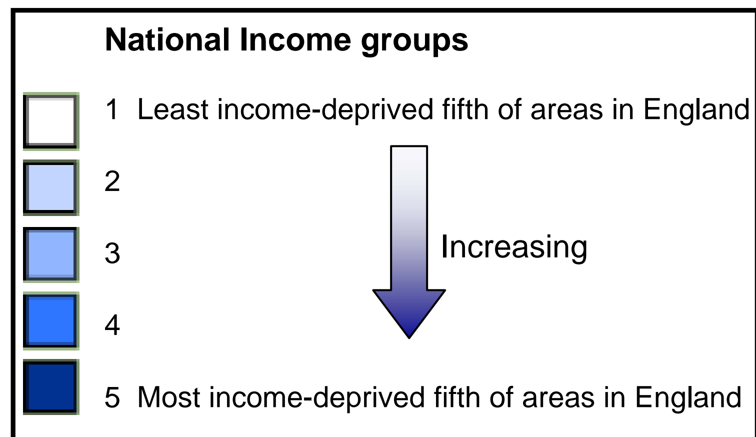


South Tyneside



Sunderland





3.4 Bridging the gap – analysis of life expectancy gap

One of the starkest inequalities highlighted by the JSNAs and DPH reports is in life expectancy. The local life expectancy gap against England and Wales is:

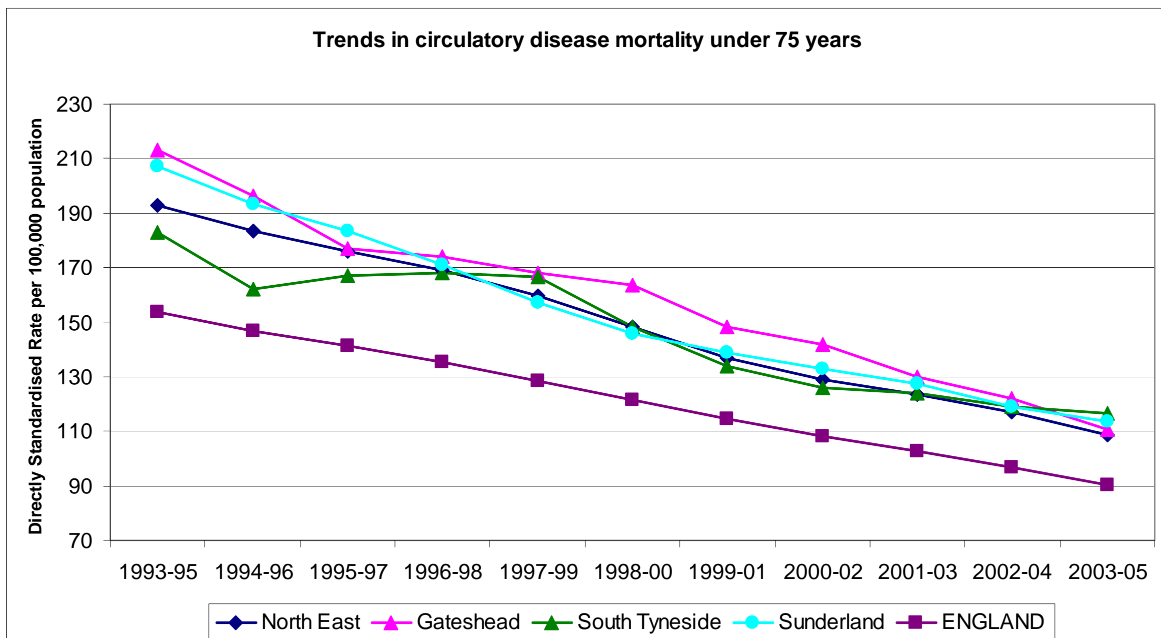
	Life Expectancy	Difference from England and Wales Average
England & Wales Average		
Males	**76.9**	
Females	**81.1**	
Gateshead		
Males	75.0	-1.9%
Females	79.5	-1.6%
South Tyneside		
Males	74.8	-2.1%
Females	79.9	-1.2%
Sunderland		
Males	75.3	-1.6%
Females	79.4	-1.7%

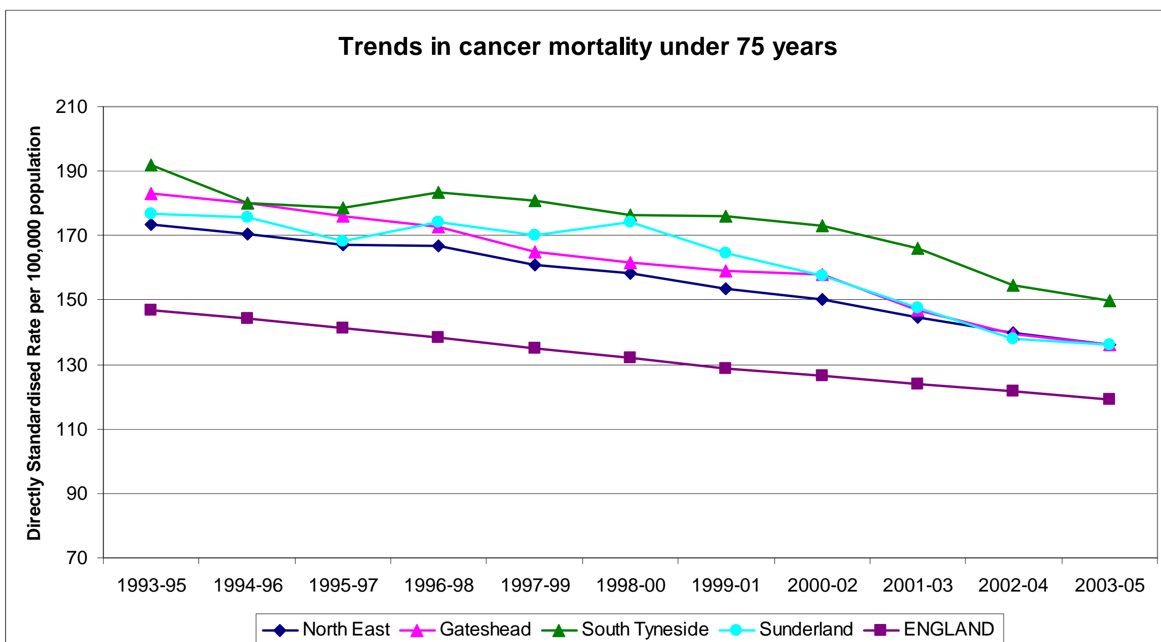
The London Health Observatory "Health Inequalities Intervention Tool" has been used to analyse the life expectancy gap, and identifies that over 60% of the gap is caused by higher than average mortality from CVD, cancer and respiratory diseases. This "Bridging the Gap" exercise also identified a set of high impact, evidence-based interventions for reducing mortality in these areas. These analyses formed a key part of the evidence used in establishing our strategic objectives and our choice of key outcome measures (see section 4).

3.5 Expected disease incidence and prevalence growth rates

The JSNAs and DPH reports set out in detail the key changes expected in disease incidence and prevalence, which will impact significantly on the health and care needs of our local populations. In particular nationally predicted rises in the prevalence of obesity and harmful alcohol use were part of the data used in our prioritisation (see section 4) which resulted in obesity and alcohol being two of our chosen strategic objectives for action.

For our major killers, CVD and cancer, we have seen a dramatic reduction in mortality over the past few years and we expect this downwards trend to continue. For CVD we have also seen a narrowing of the gap with the England average in South Tyneside and Sunderland but not in Gateshead. The cancer mortality gap has reduced slightly in all three PCTs as illustrated in the following graphs.





3.6 Activity commissioned

The activity section at Appendix 2 sets out the current and future expected levels of acute activity. In addition we commission a range of activity in the primary and community sectors. As part of the development of this Strategic Plan, we have used the routine, detailed analysis of our current position, together with a predictive activity model to forecast activity required over the next five years, including the impact of initiatives within this Plan.

3.6.1 Predictive model

A predictive model has been developed and used locally to identify potential financial and capacity consequences for the next ten years if NHS South of Tyne and Wear does not initiate strategic change. The model has also been used to determine activity requirements and the impact of planned initiatives on these requirements, translated into financial plans.

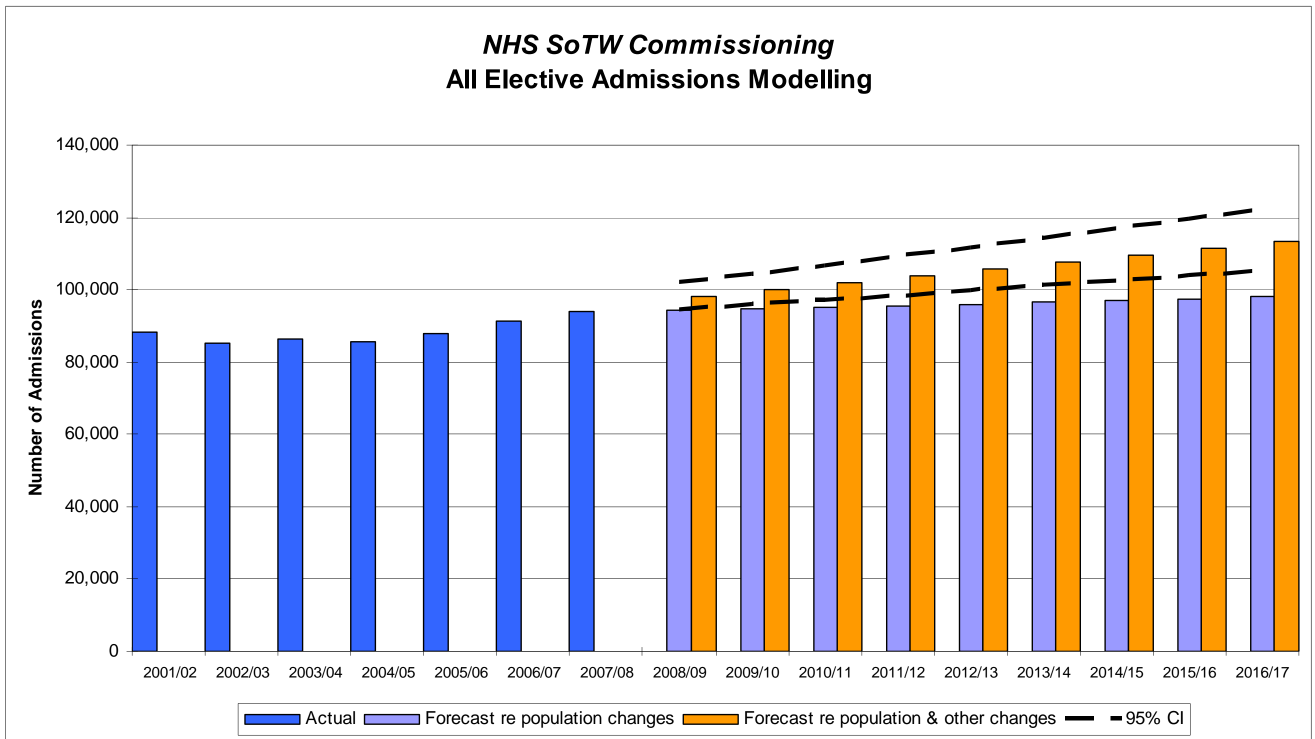
An important component in the development of our predictive modelling has been the extensive input from acute and primary care clinicians. We have met every clinical directorate in each of our local foundation trusts to discuss specialty specific issues with over 200 doctors, nurses, other clinical staff and managers. The clinical engagement programme has ensured that expert opinion and views on future clinical provision have informed the long term activity forecasts produced by the model. This expert input has also informed the development of 'strategic assumptions' which quantify the impact on activity and finance of changes initiated by the PCT.

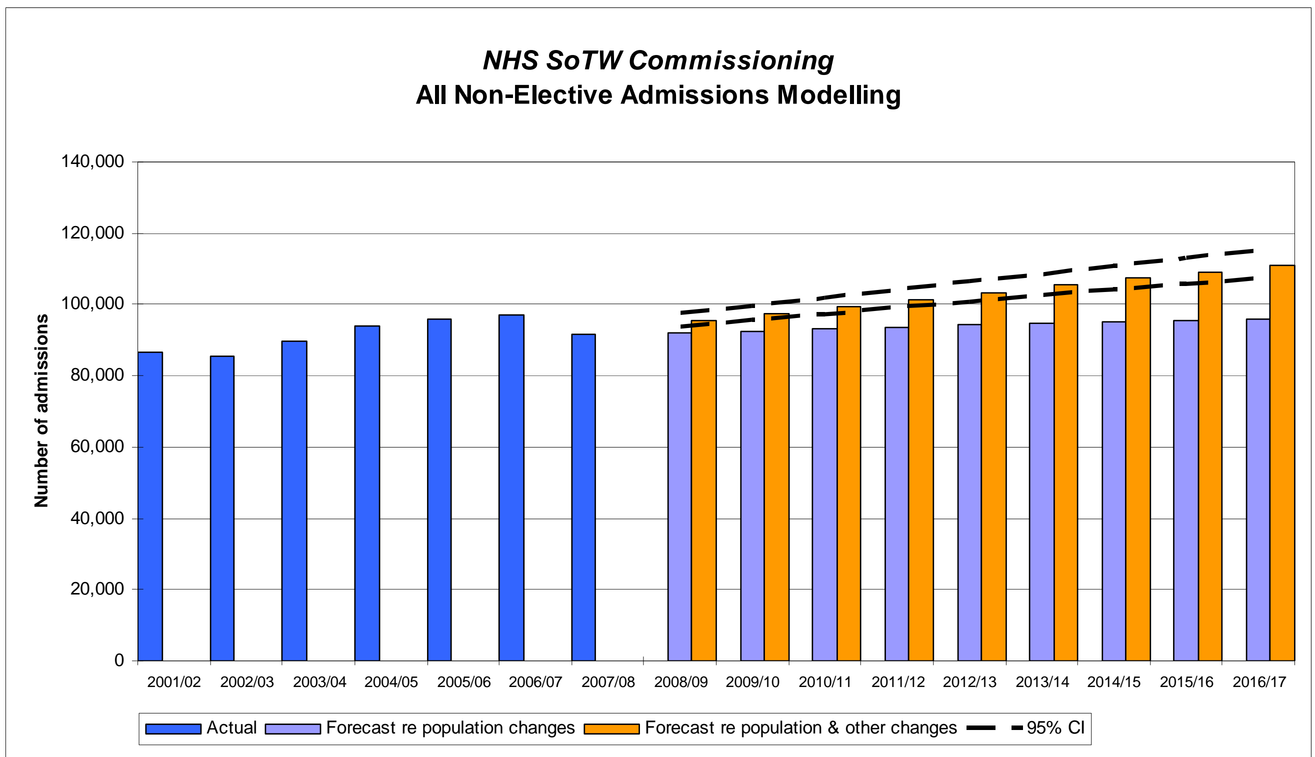
Development of the model is continuing with the application of the principles established in the modelling of hospital activity into other sectors:

- A pilot has been undertaken in primary care to identify the scope for more detailed modelling on a segmented basis, using data from GP systems and an expansion of this work to more practices is being worked on.
- Modelling of the District Nursing service is underway as part of a wider review of the service.
- Links are being explored with workforce planning and modelling the impact of activity changes on workforce.

The very strong message from the initial iterations of the model was that ***if NHS South of Tyne and Wear does not take effective action,*** the increasing elderly population with their high use of health services, coupled with the inevitable developments in clinical practice, technology and patient expectations would result, within less than ten years, in hospital capacity shortages equivalent to a small general hospital and a financial cost which the PCTs could not meet.

The following graphs show total elective and non-elective hospital activity since 2001/02, forecast forwards to 2016/17, without effective action by the PCT.





This analysis underpins our case for change and has strongly informed our prioritisation. The quantification of the expected impact of initiatives on levels of activity has enabled us to develop an activity and financial plan which is affordable, can be met by the expected local market in terms of capacity and is entirely in line with our vision, objectives and goals.

3.6.2 Key assumptions driving future forecasts

Initiatives being implemented by NHS South of Tyne and Wear to deliver both the North East and our local vision are set out in section 4 and listed in the finance template. Section 4.6 describes how the impact of these initiatives has been estimated and fed into both activity and financial forecasts.

3.7 Insights from patients, public, clinicians and local partners

We are committed to ensuring that local people are meaningfully involved in the development and implementation of our Strategic Plan and are fully engaged in the commissioning and redesign of local services. The important issues raised with us by local people continue to be the need for safe, high quality services delivered in a timely convenient manner with an increasing emphasis on local access. These views have informed our vision and have underpinned the development of our strategic objectives. Local engagement mechanisms include the Local Engagement Board in each PCT (held bi-monthly, a forum for local people to input to all aspects of PCT work) and a range of public events focusing on specific programmes; a recent example has been local consultation on increased primary care access.

Clinical input has played an important part in both the shaping and prioritisation of our strategic objectives and development of local initiatives. Local service reform groups involve clinicians from acute and primary care in reviewing current provision and developing new pathways (e.g. Musculoskeletal, Children's Services and CVD). Clinicians have played an important role in the development of our predictive model noted in section 3.6.1 above, and Practice Based Commissioners were involved in the development and testing of assumptions used to forecast the impact of planned initiatives.

A range of engagement events have been held with local partners at each stage of the development of the Strategic Plan. Partners were involved in the prioritisation of the strategic objectives ensuring that the local needs of their communities were fully represented. They also played an important role in ensuring the alignment of the Plan with Local Area Agreements and vital signs. Further detail regarding events undertaken is included in the Communications and Engagement Strategy.

3.8 Existing targets, local and national health priorities

Our strong, established performance management process has highlighted the following areas of current performance which directly link to our vision and strategic objectives and which have influenced our planning for the future:

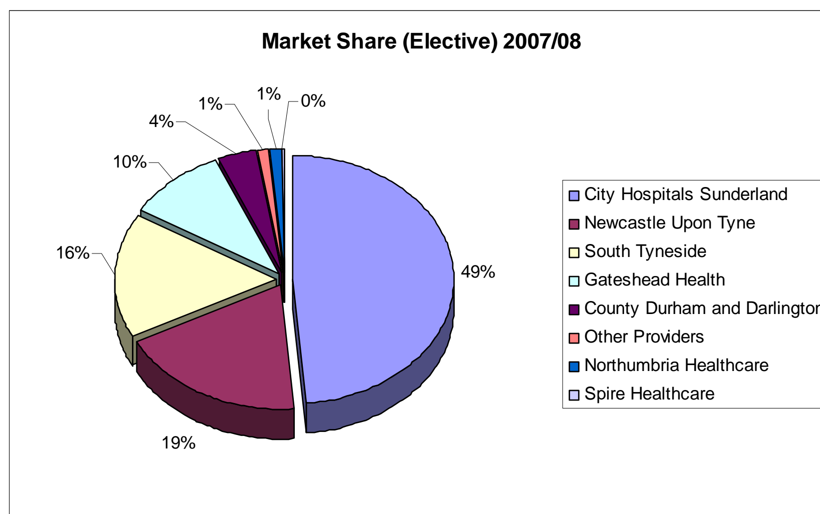
Areas of good performance	Areas of key risk
Extended opening hours for GP practices	4 week smoking quitters
% children with recorded height and weight	Convenience and choice
Access to GUM clinics	MRSA
Cancer - one month diagnosis to treatment	18 week hospital waits (specialty based)
Mental health crisis resolution / home treatment	Access to primary care

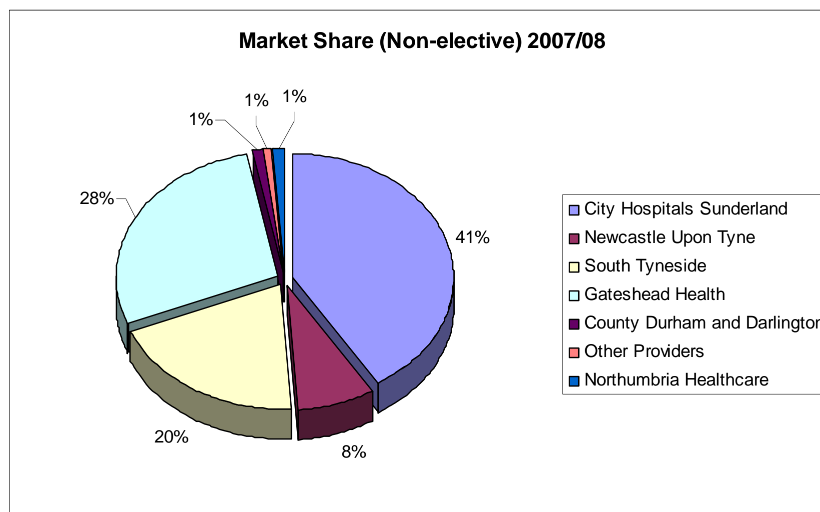
3.9 Provider landscape

We have carefully analysed our current provider landscape to understand the extent to which it meets our current and likely future needs.

3.9.1 Secondary care provider landscape

NHS South of Tyne and Wear is served by three local foundation trusts, Gateshead Health, South Tyneside and City Hospitals Sunderland. A significant amount of activity is also provided by Newcastle Hospitals, particularly for Gateshead PCT, and we commission a small percentage of activity from an independent provider, Spire, located in Washington. The following charts illustrate the market share in terms of hospital elective/non-elective activity for NHS South of Tyne and Wear.





The total value of the legally binding contracts with these providers is £447 million in 2008/09 and covers a portfolio of services including diagnostics, allied health professionals, outpatients, elective and emergency admissions and sub regional and regional specialties. The following table provides a summary of the contract value and external assessment of our local providers.

Provider	2007/08 Healthcare Commission Ratings		Total trust income	Annual Contract Value (£) 2008/09	2008/09 Monitor Assessment		
	Quality	Resource			Financial	Governance	Mandatory Services
City Hospitals Sunderland FT	Excellent	Excellent	£254m	£176m	2	Amber	Green
Gateshead Health FT	Good	Excellent	£161m	£127m	5	Red	Green
South Tyneside FT	Excellent	Excellent	£96m	£79m	3	Green	Green
Newcastle Hospitals FT	Excellent	Excellent	£641m	£65m	4	Green	Green

Each of the local foundation trusts is subject to quality monitoring arrangements set out in the legally binding contract. Our regular review considers quality indicators alongside external information, including Patient Environmental Action Team Assessments and Healthcare Commission patient and staff surveys. This provides positive assurance that required standards are being achieved, the quality of patient care is in accordance with expectation and locally agreed quality indicators are being delivered and are contributing to an improved patient experience.

3.9.2 Primary care provider landscape

Currently primary care provision is as follows:

Primary Care Contracts at 1 April 2008

	Gateshead	South Tyneside	Sunderland	Total
GP Contracts	33	29	54	116
GPs	142	92	179	413
Dental Contracts	29	21	32	82
Pharmacists	45	33	55	133
Optometrists	26	12	25	63

Medical Services – breakdown of GP contracts by type

	Gateshead	South Tyneside	Sunderland
Alternative provider of medical services	0	0	1
General Medical services	22	7	15
Personal Medical services	10	19	35
PCT directly managed practices	1	3	3
GMS/PMS budget	£30m	£21.5m	£42.8m
High Lists >2000	9	9	18

We are expecting the number of APMS contracts to expand and the number of PCTMS contracts to decrease. We are currently commissioning nine new APMS contracts as part of the National Darzi initiative. Contracts have now been signed with five new contractors, whilst two further contracts are in the final discussion stages. One scheme in Sunderland and a further one in South Tyneside will be re-advertised in the near future. Three PCTMS practices will be part of this initiative and it is expected that during the period covered by the Strategic Plan, the PCTMS practices will reduce further.

There are a number of elderly GPs and over the time span of the Strategic Plan, we expect retirements to reduce the number of GP contracts. We support the development of larger practices but will increasingly commission for a specified ratio of patients per GP. We will undertake a major PMS review in 2009.

The number of dental contracts will remain static but will change to reflect the strategic aim of not commissioning contracts specific to NHS patients exempt from charges. This activity will be commissioned from both existing and new contractors.

3.9.3 Community services provider landscape

Community services are extremely diverse and are delivered across a range of provider markets, including Community Nursing, Allied Health Professionals and Therapies, 3rd sector and the Independent sector. A number of these services are jointly commissioned through either Partnership or Pooled Budget arrangements with Local Authorities. The value of community services contracts across NHS South of Tyne and Wear is £104.6m.

Community services are currently being “profiled” to develop a clear understanding of service aims and objectives, service links to identified health needs, activity, performance, track record, access, service quality and service cost. The purpose of this is to develop commissioning intelligence primarily on a quality and value for money basis, incorporating where possible external benchmarking, in order to inform future commissioning intentions.

This activity is additionally designed to capture a broader analysis of the community services provider landscape as well as an overview of provider economics, strengths and weaknesses in current service provision, patient choice and plurality in provision. In-depth service reviews are planned, including the current substantial multi-agency review of the Provider Services District Nursing Services, incorporating Local Authorities, PBCs, providers and patients and carers, promoting a joined up health and social care approach.

Jointly with the Local Authorities, work is planned to consider the provider landscape in relation to the provision of Continuing Healthcare. This includes predictive modelling to consider capacity and demand particularly in relation to residential care homes and the personalisation agenda, to create a long term strategy for the commissioning of these services in the future.

3.10 Financial situation

Our three PCTs have an excellent track record in strong financial management and the efficient use of resources. A minimum of breakeven against revenue and capital resource limits has been achieved year on year since their inception in 2002.

In 2007/08, each PCT delivered a surplus, totalling £2.2m against a plan of £2.5m. In the current financial year 2008/09, we are planning to deliver an identical figure i.e. £2.5m against a combined revenue resource limit which is in excess of £1.1bn.

The excellent financial standing of all three PCTs has been recognised within the Audit Commissions third “Auditors Local Evaluation” report published on the 2nd October 2008. Each organisation scored level 4 on Financial Standing, with an overall performance of 3 which equates to organisations consistently performing above minimum requirements.

3.11 Need for change

The context described in this section shows that good progress has been made in recent years in reducing deaths from cancer and heart disease. However, the general health of local people remains poor with stark inequalities in life expectancy against the national position and also within our local populations.

The large increases expected in the numbers of older people will require a greater emphasis on ill-health prevention and support to enable older to live independently at home in order that they can enjoy better health and well being for longer as well as ensure sufficient hospital capacity to cope with complex future acute care needs.

Also, changing clinical practice and technology offer more options for the delivery of services in the future while current variations in quality, outcomes and performance indicate that not all patients have the best possible experience of healthcare services. One of the new financial objectives is to spend only 98% of our budget on a recurrent basis by 2012/13. This will require a reduction in the recurrent run rate across the three health economies in NHS South of Tyne and Wear.

All of this evidence provides a compelling case for change and this Strategic Plan describes the changes which will address these important drivers.

Section 4 – Strategy

4.1 National targets and priorities

NHS South of Tyne and Wear will continue to deliver all the national targets and priorities set out each year in the NHS Operating Framework.

4.2 Prioritisation

There are many demands for investment and these will increase in future years. We cannot resource all demands and so we have used a rigorous, benefits-based framework to prioritise our investment and derive our strategic objectives for the next five years.

Three complementary prioritisation methods were used to determine our strategic objectives:

- Health improvement priorities.
- Current service reform priorities.
- Future service pressures.

4.2.1 Health improvement priorities

The analyses described in section 3 quantified the gaps between current health and our desired future state. The impact of addressing each gap was estimated and potential evidence-based actions to reduce the gap identified. This analysis established an extensive list of potential priorities and a prioritisation event was held involving our local authorities, foundation trusts, practice based commissioners, clinical executive committee, non executive Directors, PCT staff, Patient and Public Forums and the voluntary agencies. Mixed groups used structured discussion to agree a ranking of potential priorities which were then articulated as a small number of strategic objectives as follows:

PRIORITISATION CRITERIA

Impact –Scores for each potential priority against 6 questions which test impact on vision (1=low, 6=high):

- To what extent would this priority address unmet health need?
- How much is this problem forecast to increase?
- How many people would benefit from addressing this priority?
- To what extent would this priority benefit a disadvantaged group?
- What is the likely future impact on services?
- To what extent would this priority be likely to release resource in future?

Desirability – what level of stakeholder support was there for each priority?

STRATEGIC OBJECTIVES SELECTED

- Implement local **alcohol** strategy to reduce alcohol related harm
- Expand & introduce new stop **smoking** services to reduce smoking prevalence
- Develop a comprehensive **obesity** service to reduce obesity prevalence
- Identify people at high risk of **CVD** and manage in Primary Care
- Support **children** & young people to experience best quality of life possible, reduce health inequalities & maximise life expectancy
- Integrated **model of mental health care** (personalised, holistic approach) including reprovision of inpatient services in Sunderland, & implement Dementia Strategy

4.2.2 Current service reform priorities

A consultation exercise was undertaken with clinical staff in all sectors including the PCTs, foundation trusts, primary care and social care to identify the elements of the service most in need of reform. The prioritisation criteria used in these discussions and the resulting strategic objectives were as follows:

PRIORITISATION CRITERIA

- Scope for quality improvement
- Scope for improvements to patient access
- Scope for productivity gains (informed by national benchmarking)
- Scope for improved patient satisfaction
- Number of patients who would benefit

STRATEGIC OBJECTIVES SELECTED

- Streamlined, high quality, patient-centred **planned care** as close to home as appropriate – initial focus on **musculoskeletal services**
- Integrated, high quality 24/7 services for **acutely sick & injured children**, across all healthcare settings, with an increased emphasis on care outside of hospital
- Integrated 24/7 **urgent care** across all sectors
- Develop model of **rehabilitation** for long term conditions

4.2.3 Future service pressures

The predictive model, described in section 3, was used to identify those service areas at risk in the next five to ten years; this can confirmed through discussions with the Foundation Trust Chief Executives and Medical Directors. The discussion criteria and the strategic objectives arising from the key pressures identified are as follows:

PRIORITISATION CRITERIA

- Safety and quality
- Future viability
- Future capacity pressures
- Clinical links between services
- Future workforce issues

STRATEGIC OBJECTIVES SELECTED

- Integrated 24/7 **urgent care** system (overlap with 4.2.2)
- High quality, out-of-hospital support for people with **long term conditions**. Pilot with CVD, rollout to diabetes & COPD
- High quality services & choice for **maternity care**, including 98 hour consultant cover on labour wards
- All people entering **end of life** will have needs, priorities & preferences acted on, same standards of care in all settings
- Integrated, high quality 24/7 services for **acutely sick & injured children** (overlap with 4.2.2)
- Streamlined, high quality, patient-centred **planned care** as close to home as appropriate (overlap with 4.2.2)

4.3 Strategic objectives

Our local analysis and prioritisation echo the regional analyses underpinning “Our vision, our future”. The following table describes in more detail the strategic objectives derived through the prioritisation process. This does not describe everything the PCT is doing, but focuses on the prioritised changes needed to deliver our vision and the NHS North East vision.

		Future state as defined by our local vision	NHS South of Tyne and Wear Strategic Objectives
Staying healthy	**Obesity**	**Better health** – Halt and reduce obesity prevalence and increase life expectancy by 9 years in obese people. **Excellent patient experience** – Expansion in the range of high quality proven effective services. **Wise use of money** – Implement and incorporate rigorous evaluation. Prevention focus will reduce long term spend.	1. Develop a comprehensive **obesity** prevention, management and treatment service in each PCT to halt and reduce obesity prevalence
	Tobacco	**Better health** - By 2013, reduce the numbers of deaths attributable to smoking by 5% and reduce the number of women smoking in pregnancy by 5% thereby reducing the number of low birth weight babies. Achieve 2% reduction in the life expectancy gap by quadrupling the throughput of local cessation services. Reduce the prevalence of smoking specifically in target groups including routine and manual workers and pregnant women in order to address health inequalities. **Excellent patient experience** - Increased range of patient choice and access to intermediate services. Services tailored to the individual needs and preferences of client groups and delivered in communities with greatest need. **Wise use of money** - Annual 4% reduction in smoking prevalence will result in reductions in emergency admissions for MI and stroke. Increased efficiency in secondary care due to reduced smoking prevalence – i.e. reduced lengths of stay, reduction in surgical complications.	2. Expand and introduce new stop **smoking** services to reduce smoking prevalence
	Alcohol	**Better health** - Improved health status of the population arising from an increasing positive healthy culture of alcohol consumption and long term reductions in liver and heart disease and cancer. Holistic approach covering spectrum of community reintegration and comprehensive 4 tier model of treatment. **Excellent patient experience** - Timely access (maximum 3 week wait) to appropriate and high quality 4 tier service. Increased quality and range of services based on Models of Care for alcohol misuser’s. **Wise use of money** – Delivery of proven commissioning model with reduced demand in all care setting i.e. reduction in the rate of alcohol related hospital admissions.	3. Implement the local **alcohol** strategy to reduce alcohol related harm
	CVD risk	**Better health** – By 2013, achieved ‘Our Healthier Nation’ premature mortality targets and reduced the gap between local and national standardised mortality rates to 20%. All adults > 25 will have their cardiac vascular risks factors checked and a personalised risk action plan in place. **Excellent patient experience** – Heart failure services will be delivered in community settings, all stroke services will be modernised in line with best practice, all patients will CVD will have personal management plans. **Wise use of money** – By 2012, investment in CVD prevention will be double the 2005 level, all practice CVD pharmaceutical profiles will be in line with national best practice.	4. Identify people at high risk of **CVD** and manage in Primary Care
Children’s		**Better health** – Enhance children and young people’s well being particularly at key transition points in their	Support all **children** and young people

	Future state as defined by our local vision	NHS South of Tyne and Wear Strategic Objectives
health and services	lives. Child health improved with the proportion of obese and overweight children reduced to 2000 levels. Fair access to services across all localities. **Excellent patient experience –** Every contact utilised as a health improvement contact. Quality services delivered close to home and flexible to respond to individual patients – services integrated through Children's Trust arrangements. High quality, safe, evidence based seamless pathway supported by excellent communication across and within each level. **Wise use of money** - Integrated services reducing duplication and waste through Children's Trust joint planning and commissioning arrangements. By 2012 programme budgeting will demonstrate a shift from hospital to community based services. Standard work that makes best use of staff skills, reduces waste and achieves VFM.	to experience the best quality of life possible, to reduce health inequalities and to maximise life expectancy in line with Every Child Matters. Includes moving to integrated, high quality 24/7 services for **acutely sick & injured children**, across all healthcare settings, with an increased emphasis on care outside of hospital working with viable inpatient units
Maternity	**Better health -** Improved health outcomes for mothers and babies resulting from early identification and effective management for women at high risk including reduction in alcohol consumption and smoking at time of delivery. Improved children's life start via reductions in low birth weights and increased breast feeding. **Excellent patient experience -** Women able to make informed choices regarding how to access services and supported to have the type and place of birth of their choice. **Wise use of money -** Better maternal and child health will reduce service demand in each health setting.	Deliver high quality services to give women and their families greater choice during the antenatal and postnatal period, offering easy access to supportive, seamless **maternity** care, designed around their individual needs. This will include agreeing required staffing levels and service configurations to ensure appropriate consultant cover in medical delivery suites
Acute care	**Better health –** Correct diagnosis and treatment initiated at first contact with urgent care services leading to improved outcomes. **Excellent patient experience –** Increased patient satisfaction with quality and ease of navigation of urgent care services. Streamlined pathways with fewer handoffs for patients and seamless transfers of care. **Wise use of money** – Reduced waste by alignment of patient pathways across organisational boundaries eliminating duplication, waits and wastes. Reduction in inappropriate activity from secondary care and shifts of care into appropriate primary or community care setting.	Ensure integrated 24/7 **urgent care** systems across all sectors which delivers quality care in appropriate settings
Planned care	**Better health –** Faster access to service leading to improved outcomes and a reduction in functional disability. **Excellent patient experience –** Innovative pathways with increased patient choice including self referral resulting in reduced waits and functional disability. **Wise use of money** – Reduced waste by shifting inappropriate activity from secondary to a primary care setting and streamlined pathways with fewer handoffs for patients.	Ensure planned care services which are streamlined, high quality, patient-centred and delivered as close to home as appropriate – with an initial focus on **musculoskeletal** services then applying lessons learnt to future programmes of reform. Also continue to develop high quality **cancer** services in line with national guidance delivered

	Future state as defined by our local vision	NHS South of Tyne and Wear Strategic Objectives
		through the cancer network
Mental Health	**Better health** – Emphasis on health and well being for whole population and enhanced quality of life and longer life for patients with a MH condition. **Excellent patient experience** – Patients and their families are empowered to influence and inform service improvements. Services value diversity and disability and ensure that needs and preferences of vulnerable groups are fully met. **Wise use of money** – New model of care together with informed benchmarking ensures maximum VFM.	Develop an integrated model of **mental health care** which provides a personalised, holistic approach and recognises that recovery can but may not mean cure, including reprovision of inpatient services in Sunderland, implementation of national dementia strategy and new model of CAMH services
Long term conditions	**Better health – There will be improved life expectancy for local people – the gap in life expectancy within NHS South of Tyne and Wear and and between NHS South of Tyne and Wear and England and Wales will have been reduced.** **Excellent patient experience – Services will be modernised in line with National best practice and all patients with vascular disease will have their own personalised management plan.** **Using money wisely – Programme budgeting will demonstrate a shift from secondary to community spending.** **Better health - Improved quality of life and increased goal attainment for patients with individuals supported to maximise ability and independence. Increased emphasis on self management of LTCs and improved secondary prevention.** **Excellent patient experience - Individuals and their families are informed and empowered to take control and self manage their own care. Services are accessible for all, as close to home as possible and seamless between agencies.** **Using money wisely - Consistent standard pathways ensure rehabilitation is delivered in the right place, first time at the right time. Reduce waste by shifting inappropriate and unnecessary activity from secondary to primary care settings thereby releasing capacity for alternative or reducing utilisation as appropriate.**	1. Deliver high quality, out-of-hospital support for people with chronic conditions, each with a personalised care plan, to eliminate unnecessary hospital admissions and shorten necessary admissions. Pilot with **CVD and r**ollout to diabetes and COPD 2. Develop a model of **rehabilitation** for LTCs, providing both specialist and generic support, across the spectrum from acute care, community based care, longer term support and self management
End of life care	**Better Health** - Enable individual's to live as well as possible for as long as possible and then to support individuals and their families in the final stages of life, to ensure a 'good death' which is free of pain, with dignity and in the place of their choice. **Excellent Patient Experience** - All end of life care provision will be personalised to the individual and will meet their needs, priorities and preferences and that of their family. All care will be of a high standard, regardless of setting, and delivered by skilled caring professionals. **Using money wisely** - Seamless consistent standard care will be delivered across all settings thereby reducing inappropriate admissions to hospital.	All people entering the **end of life** will have their needs, priorities and preferences identified, documented, reviewed and acted upon, with the same standards of care in all settings whatever is their preferred place of death

4.4 Outcome indicators

In line with the World Class Commissioning guidance, each of our PCT Statutory Boards has selected our outcome indicators which will be used to measure our success in achieving our vision and strategic objectives. Two of these are mandatory (life expectancy and health inequalities). A structured process, linked to our vision and strategic objectives, has been applied by the PCT Boards to agree a further seven indicators, which are common to all three PCTs. Trajectories have been established for each indicator setting out the progress we aim to achieve each year to 2013, and are set out in Appendix 4.

The indicators we have selected to measure our progress towards delivery of our vision are as follows:

Better health

We will ensure better health by minimising health risks and supporting the adoption of healthy lifestyles, demonstrated by:

- ✓ Reducing the rise in childhood obesity at Year 6.
- ✓ Reducing the rise in alcohol-related hospital admissions.
- ✓ Smoking in pregnancy becoming less common.

We will also ensure better health through access to treatments that minimise the impact of health risks and improve survival, demonstrated by:

- ✓ Reducing smoking prevalence in people with a chronic condition.
- ✓ Better hypertension control in people with heart disease.

Excellent patient experience and wise use of your money

We will show progress in improving patient experience and wise use of money through:

- ✓ More people getting their first cancer treatment promptly.
- ✓ A reduction in hospital admissions for people with Ambulatory Care Sensitive Conditions.

The indicators were selected based on:

- Coverage of our vision and strategic objectives.
- Feedback from our World Class Commissioning assessment and from partners.
- Clarity of the measure, including availability of good quality data and unambiguous interpretation of changes.
- A spread of indicators which do not duplicate each other.

We wanted to include an outcome indicator relating to mental health, but the only measure available in the nationally prescribed list is the number of suicides. The small numbers involved in this measure do not allow it to be used as a robust indicator of year-on-year progress. However, the selected indicators form only a small subset of the broad set of measures and milestones we will be using to track progress throughout the life of this Plan. The full set of measures is documented in the implementation plans at Appendix 1 which includes a range of metrics relating to mental health.

Initial quantified trajectories have been set for each indicator, for each year through to 2013, based on our best understanding at this stage of the likely impact of the initiatives we are putting in place.

The initiatives described in this Plan are based on the best available evidence of what will impact on peoples behaviour (for example in relation to obesity, alcohol, smoking, use of urgent care facilities etc). It is widely acknowledged that quantitative evidence of the impact of these interventions is still being developed nationally, so our initial trajectories will be subject to change as evaluations are made which allow better impact assessment.

The table below sets out our five year goals against each of the chosen outcome indicators and detailed annual trajectories are attached in Appendix 4.

World Class Commissioning Outcomes and Goals

Life Expectancy

Now	2013
75	78
80	81
75	78
80	82
75	77
79	81

Average years life expectancy at birth

Health Inequalities

Now	2013
30	n/a
31	n/a
32	n/a

Index of multiple deprivation

Childhood Obesity

Now	2013
22%	19%
22%	19%
21%	20%

% school children in year 6 who are obese

Alcohol-related Admissions

Now	2013
2,308	3,133
1,992	2,348
1,943	2,248

Alcohol related admissions per 100,000 people

Smoking in Pregnancy

Now	2013
19%	18%
29%	28%
24%	23%

% women smoking at time of delivery

Smoking Prevalence in those with chronic conditions

Now	2013
25%	23%
24%	22%
25%	23%

% people with registered chronic condition who smoke

Hypertension Control for t[illegible]ease

Now	2013
87%	89%
89%	91%
89%	91%

% people registered with CHD whose blood pressure is 150/90 or less

Cancer Treatment in 62 Days

Now	2013
96%	100%
99%	100%
99%	100%

% receiving first treatment for cancer within 62 days of urgent referral

Ambulatory Care Sensitive Admissions

Now	2013
2,27[illegible]	2,209
1,85[illegible]	1,795
1,79[illegible]	1,742

Adm[illegible] conditions per 100,000 people

Note : there is no 2013 goal for Health Inequalities as the Index of Multiple Deprivation is constructed from a broad range of component indicators which are not all directly related to health.

4. lopment of initiatives

W d a strategic planning framework known as OGIM (Objectives, Goals, Initiatives an s / Milestones), to show how the initiatives we are planning relate to our vision an d objectives. The framework also identifies the measures and milestones which wi progress and ultimately delivery of our strategic objectives. This section sets out the tives within each strategic objective; further detail regarding the associated me ilestones is shown in Appendix 1.

Staying healthy

Life expectancy gap to be reduced by 1% by tackling CVD mortality through evidence-based, high impact changes focused on obesity, smoking, alcohol and identification / management of those at high risk of CVD

Within NHS South of Tyne and Wear, we are in the process of implementing an innovative health improvement programme related to the **Staying Healthy** agenda. Core to our philosophy of improving health outcomes, is to secure the appropriate balance between health promotion and prevention with disease treatment and care, and we will routinely consider the full implications across this broad spectrum in developing our health programmes. This means that our local work on health improvement is not solely focused on “staying healthy” but instead cuts across a number of the clinical pathways.

With regard to improving life expectancy and addressing inequalities (supporting the key element of our vision of better health), our plans address the whole pathway from prevention through to treatment and care for each of the four prioritised elements of health improvement (improvement in the management of **long term conditions**, notably CVD and in tackling the underpinning risk factors, particularly **smoking**, and **obesity**; and addressing a range of unmet need regarding **alcohol**). Our local work will dovetail with the North East Public Health Strategy “Better Health, Fairer Health” on these issues.

The philosophy which underpins our approach to improving health has four components:

1. Working in **partnership with local authorities and local communities** to raise awareness of the importance of staying healthy and ensuring local and community “environments” which positively support healthy choices.
2. To establish a **wide range of easily accessible local services** to assist people in changing their health risk factors.
3. To establish the **processes** by which individuals with high levels of cardiovascular risk are identified and their risk levels managed.
4. To **proactively manage chronic disease** in accordance with evidence based practice and where possible, within a community setting.

Our approach to reducing the life expectancy gap shows how our actions meet the recommendations of the North East clinical pathway group. For each strategic objective, we have agreed the following goals and initiatives.

Staying Healthy - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Obesity
Objective	**Goal**	**Initiative**
Develop a comprehensive obesity prevention, management and treatment service in each PCT to halt and reduce **obesity** prevalence	Halt rise in obesity prevalence Halt rise and begin to reduce childhood obesity (selected outcome measure)	**Adults** Develop a comprehensive infrastructure and 5 Tier programme in each PCT area in line with NICE guidance and commission public, private, voluntary and community sectors to deliver: Tier 1 - Preventative activities and programmes targeted at patients at risk of becoming overweight/obese Tier 2 - Community based Weight Management programmes Tier 3 - Exercise on referral Programmes Tier 4 - Specialist Weight Management Service Tier 5 - Bariatric Surgery Investigate a referral system for current risk individuals from NHS to commissioned providers (public, private and voluntary sector) of life style alterations packages of care with an accompanying per patient payment by the NHS to those providers **Children** Develop a comprehensive infrastructure and 3 Tier programme in each area in line with NICE guidance and Every Child Matters and commissio private, voluntary and community sectors to deliver: Tier 1 - Universal services Tier 2 - Services for overweight children Tier 3 - Service for obese children and those with complex needs

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Tobacco
Objective	**Goal**	**Initiative**
Expand and introduce new stop **smoking** services to reduce smoking prevalence	Reduce overall smoking prevalence in the 16+ population Reduce smoking prevalence in key target groups - routine and manual; pregnant women (selected outcome measure); young people; people with chronic conditions (selected outcome measure)	Implement a comprehensive approach to combat tobacco use: • Tobacco control alliance active in each PCT • Contribution of funding to Fresh, regional Tobacco Control Office Commission integrated NHS Stop Smoking Services: • Increase tier 1 (brief intervention) provision • Increase in level 2 and tier 2 & 3 throughput • Deliver smoke free schools programme • Provide specialist stop smoking advisor in ante-natal clinics

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Alcohol
Objective	**Goal**	**Initiative**
Implement the local alcohol strategy to reduce **alcohol** related harm	• Reduce alcohol related hospital admissions across NHS SoTW (selected outcome measure)	Implement a comprehensive range of services for the treatment of alcohol misuse across NHS SoTW, based on the 4 tier model described in Models of Care for Alcohol Misusers: • Tier 1 - Screening, brief interventions, advice and referral in a variety of environments • Tier 2 – Open access support, screening, brief interventions advice and referral in a specialist environment • Tier 3 – Specialist treatment such as psychosocial interventions and pharmacological interventions in support of community detoxification and relapse prevention • Tier 4 – Specialist inpatient detoxification and residential rehabilitation Create positive healthy culture of alcohol consumption across NHS SoTW

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: High risk of CVD
Objective	**Goal**	**Initiative**
Identify people at high risk of **CVD** and manage in Primary Care	Reduce the gap in life expectancy within NHS SoTW and between NHS SoTW and England and Wales (selected outcome measure) Increase the % of people registered with CVD with blood pressure 150/90 or less Hypertension control in people with established CHD (selected outcome measure)	Introduce systematic vascular checks for 40-74 year olds within primary care and community settings focusing on highest risk and reducing health inequalities • Implement interim arrangements with primary care to increase uptake and management of vascular checks focusing on those at highest risk • Introduce dashboard approach to GP performance data • Develop arrangements to support GPs to deliver vascular risk programme • Adopt social marketing model to target particular groups and reduce inequalities • Pilot community based vascular risk identification, assessment and management

Children's services - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Children's Health & Services
Objective	**Goal**	**Initiative**
Support all **children** and young people to experience the best quality of life possible, to reduce health inequalities and to maximise life expectancy in line with Every Child Matters. Includes moving to integrated, high quality 24/7 services for **acutely sick & injured children**, across all healthcare settings, with an increased emphasis on care outside of hospital working with viable inpatient units	In line with the Children's Plan 2007 goals • Enhance children and young people's well being particularly at key transition points in their lives • Halt rise and begin to reduce childhood obesity (selected outcome measure)	In line with the Child Health Strategy develop and deliver high quality healthy child programmes across NHS South of Tyne and Wear: • Develop and mainstream childhood obesity programmes across NHS South of Tyne and Wear in line with NICE guidelines and deliver the Change4Life social marketing programme • Implement a risk and resilience model across NHS South of Tyne and Wear to align programmes for example sexual health and substance misuse to improve outcomes by promoting the resilience of children and young people and raising aspirations and enable them to balance the opportunities and risks in choices that impact on their health and well-being as they grow up • Review and re-provide Child and Adolescent Mental Health Services across all tiers to ensure effectiveness and quality of provision • Review and evaluate services for children with disabilities across all tiers to ensure service users have the best outcomes and experience possible • Review local arrangements for accident prevention and safeguarding and promoting the welfare of children to ensure statutory responsibilities are being met
	• Increase in patient satisfaction with quality and ease of navigation around the system • Reduction in patients attending inappropriate care settings • Highest ratings in acute elements of child health mapping	Agreed pathway which ensures safety, quality, consistency and VFM (including sustainability of inpatient units) implemented by 2013, with evidence of compliance Develop a NHS South of Tyne and Wear Clinical Reference and Steering group to: • Agree principles and standards which will inform the development of a future pathway • Identify clear points of access onto the pathway for users and potential users • Engage with service users to understand satisfaction levels currently and identify key opportunities for reform • Develop primary and community teams to support the pathway and ensure seamless care • Recommend options for the future to the children's commissioning team and Commissioning Board • Implement pathway recommendations within existing services where appropriate and commission new elements as appropriate • Review paediatric surgery in line with the regional child health working group for safety, effectiveness, quality and sustainability

Work to redesign **Children's acute services** is already underway across NHS South of Tyne and Wear using the NETS methodology (see section 4.7). The local Child Health Group covers the full spectrum of service provision with membership from all partners, including social care, the foundation trusts, the children's trusts and the local authorities, to ensure changes are synchronised and mutually supportive.

Maternity - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Maternity
Objective	**Goal**	**Initiative**
Deliver high quality services to give women and their families greater choice during the antenatal and postnatal period, offering easy access to supportive, seamless **maternity** care, designed around individual needs. This will include agreeing required staffing levels and service configurations to ensure appropriate consultant cover in medical delivery suites	• Reduce smoking prevalence in pregnant women (selected outcome measure) • Annual increase in user satisfaction with choice and quality of care • Highest ratings in Healthcare Commission reviews and annual health check	• Standard in place by 2013 which links primary and secondary care for the identification & management of high risk women • Services are assessed against the National Service Framework Standard 11 and Maternity Matters and actions identified where needed to meet standards • Identify opportunities for service development and reform with a key focus on Choice of how to access services, Choice of type of antenatal care and Choice of type of place of birth. • Community services are available to ensure seamless care pathways • Review the workforce and ensure skill mix (considering EWTD) to best utilise maternity support workers in hospital and community settings • Implement recommendation identified by regional maternity clinical pathway group

Acute care - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Acute Care
Objective	**Goal**	**Initiative**
Ensure integrated 24/7 **urgent care** system across all sectors which delivers quality care in appropriate settings	• Reduce hospital admissions for people with Ambulatory Care Sensitive Conditions (selected outcome measure) • Increase in patient satisfaction with quality and ease of navigation around urgent care system • Reduction in patients attending inappropriate care settings • Reduction in emergency bed days	• Single point of access for all health and social care • Integration of health and social care teams to facilitate early discharge and enable safe and effective community support. • Deliver thrombolytic therapy to appropriate patients presenting with acute stroke • Appropriate diagnostic services available in all care settings 24/7 by 2013 • Integration of pathways across organisations to deliver seamless care • Developing primary and community care including our Primary Care Centre programme • Developing Telehealth in the community supporting the opportunity for patients to be managed safely and effectively at home • Public Education programme to help patients to understand and therefore choose the services they access appropriately • Development of specialist service model for delivering hyperacute/acute strokes services across the North East

Planned care - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Planned Care
Objective	**Goal**	**Initiative**
Ensure planned care services which are streamlined, high quality, patient-centred as close to home as appropriate – initial focus on **musculoskeletal** services then applying lessons learnt to future programme of reform. Also continuing to develop high quality **cancer** services in line with national guidance delivered through the cancer network	• Sustaining the 18 week wait • Increase % receiving first cancer treatment within 62 days of urgent referral (selected outcome measure) • Increase in patient satisfaction • Improved productivity indicators (DNA rates, new/review ratio, unnecessary surgery)	• Development of CAT services and integrated Physiotherapy provision, to provide appropriate and prompt alternatives to secondary care referrals • Identify areas for pathway reform, to develop our future programme of work, and through GP engagement, promote a shared local approach • Implement cancer network recommendations

Mental Health - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Mental Health
Objective	**Goal**	**Initiative**
Develop an integrated model of **mental health care** which provides a personalised, holistic approach and recognises that recovery can but may not mean cure, including reprovision of inpatient services in Sunderland, implementation of national dementia strategy and new model of CAMH services.	Enhanced whole population well-being indicators Increased satisfaction of users and carers Increased numbers in receipt of psychological therapies Earlier access to diagnosis and interventions re. dementia	Establish MH Model of Care development programme across NHS South of Tyne and Wear to include priorities: • Development of Public Mental Health Strategy • Effective multi-disciplinary team working along multi-agency pathways delivering measurable improvements in care planning and risk assessment • Implementation of IAPT Programme across South of Tyne and Wear • Implementation of National Dementia Strategy • Early interventions in most appropriate place providing care in the least restrictive environment and as close to home as possible • Development of high quality inpatient services to include full compliance with mixed sex/ single sex guidelines
	Increased satisfaction of users and carers Improved access to appropriate CAMH Service provision for all children and young people including those in special circumstances	Commission effective needs led outcome focused model of CAMHS: • Review balance of provision across Tiers • Re provision of Tier 4 CAMHS and LD Services • Re provision of Tier 3 CAMHS and LD Services • Strengthening and development of services at Tiers 1 and 2 including Targeting Mental Health in Schools (TaMHS) programme • Provision of holistic models of care for children in special circumstances as integral part of comprehensive CAMH service provision within the context of broader services for children • Agreed framework for the routine collection of outcome information that reflects a commitment to outcome focused, evidence based practice

Long term conditions - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Long Term Conditions
Objective	**Goal**	**Initiative**
Deliver high quality, out-of-hospital support for people with chronic conditions, each with a personalised care plan, to eliminate unnecessary hospital admissions and shorten necessary admissions. Pilot with **CVD**, rollout to diabetes and COPD	• CVD prevention framework rolled out to MI rehab, cardiac arrhythmia, stroke & heart failure by 2013, with evidence of compliance • Reduce hospital admissions for people with Ambulatory Care Sensitive Conditions (selected outcome measure)	• Stroke task group to complete Health Needs Assessment (HNA) & recommendations for service improvements re TIA & Stroke management including rehabilitation • Stroke task group to develop patient pathway for TIA and Stroke • Heart failure task group to develop patient pathway and guidelines & recommendations for service improvements • Heart failure task group to complete HNA for heart failure rehab • Arrhythmia task group to develop patient pathway and recommend service improvements

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: Long Term Conditions - Rehabilitation
Objective	**Goal**	**Initiative**
Develop a model of **rehabilitation** for LTCs, providing both specialist and generic support, across the spectrum from acute care, community based care, longer term support and self management	• Reduce hospital admissions for people with Ambulatory Care Sensitive Conditions (selected outcome measure) • Increase in patient satisfaction	• Individuals with LTCs and their families are informed and empowered to take control of their care • Development of model of rehabilitation for LTCs, providing both specialist and generic support, across the spectrum from acute care, community based care, longer term support and self management • Review rehabilitation services in line with NHS SoTW Core Principles for Commissioning Rehabilitation Pathways established in 2008 and as prioritised by the Rehabilitation Health Needs Assessment undertaken in 2008. Priorities for 09/10 include: • Review intermediate tier services across SoTW providing rehabilitation and re-ablement for older people • Review community based neurological rehabilitation • Review community based stroke rehabilitation • Personalised services for individuals with LTCs, which promote health and well-being, are proactive, planned, coordinated and integrated • Development of community based prehabilitation and rehabilitation across range of surgical interventions • Implementation of NSF Neurological Conditions working with North East Neurosciences Commissioning Network • To develop and enhance resources, knowledge and skills across the North East to improve access to information and standards of care, appropriate rehabilitation and support for people with LTCs and their carers • Implementation of NSF Neurological Conditions working with North East Neurosciences Commissioning Network

End of life care - Objectives, Goals and Initiatives

Strategic Plan 2008-13 High Level OGIM		Strategic Objective: End of Life Care
Objective	**Goal**	**Initiative**
All people entering the **end of life** will have their needs, priorities and preferences identified, documented, reviewed and acted upon, with the same standards of care in all settings whatever is their preferred place of death	• Increased choice in place of care and death • Increase in deaths which take place outside of hospital from the current 40% • Increase in patient and family satisfaction with choice of place of death and standards of care received for End of Life Care, including care after death	**Commissioning** • Needs assessment to understand demand for end of life care, including specialist areas such as care of children and young people • Complete mapping/baseline review to understand current services, best practice to build upon, gaps & variation in provision which require action to achieve improvement • Review resources and funding models, reform funding models to maximise use of resources available • Make effective use of the Marie Curie Delivering Choice Programme to support baseline review and inform effective commissioning **Standards of Care** • Implementation of Advanced Care Planning & Liverpool Care Pathway • Use Regional Charter standards to implement one consistent pathway ensuring all people approaching end of life have needs & preferences assessed & care plan accessible to all professionals involved in care • Develop patient focussed 24/7 models that meet local needs & ensure best possible care for palliative care patients • Implement palliative care registers and use to support MDT system and delivery of effective End of Life care • Further develop training programmes to ensure knowledge, skills, competencies & attitudes necessary to deliver evidence based effective practice **Communication & Engagement** • Increase public and professional awareness about death and dying, End of Life Care choices and standards

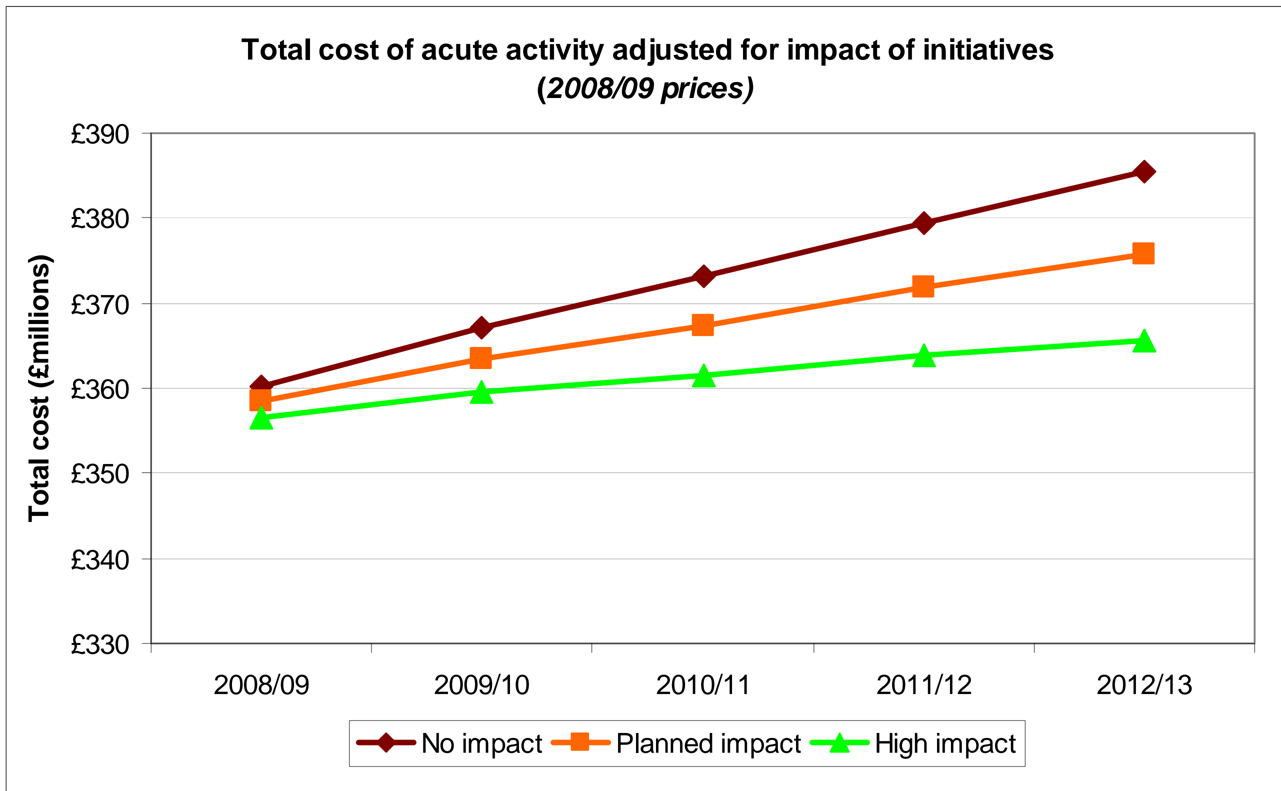
4.6 Implications for hospital activity

We have quantified the high level impact of these initiatives on current and future activity levels (where relevant) using assumptions based on national benchmarking to ensure that they are realistic, using the upper quartiles to ensure they are also ambitious.

Ranges of possible impact on activity have been assumed for each of these changes and fed through our predictive activity model to give upper, lower and mid-point forecasts for the next five years. The mid point forecasts are set out in the activity section of the financial template and inform the financial plans for the next five years.

The construction and implications of the assumptions have been discussed with the Commissioning Board, Foundation Trust Chief Executives, Medical Directors and Practice Based Commissioning consortia.

We expect there will be further reductions in hospital activity within the next five years as a result of the service reform work underway in urgent care, musculoskeletal, rehabilitation and end of life care. However, the detailed work in these areas is at too early a stage to be able to adequately quantify this impact, so current activity and financial plans assume a nil impact, to ensure the prudent management of our finances. The following graph shows the impact of the planned initiatives on the cost of acute activity over the next five years.



- Without any impact, we expect acute activity to cost an additional £25m by 2012/13.
- The planned impact of the initiatives (£9m savings reflected in our financial plan) will reduce this to £16m.
- If the initiatives were to achieve the highest impact assumed to be possible this could be further reduced to £6m.
- Our worst case scenario is that our initiatives do not materialise or have no impact which will add £9m to our planned payments for acute care.

In response to the above, our drive will be to ensure increased efficiency thereby enabling the continued investment in our strategic priorities.

4.7 Principles and approach to implementation

We consider that "how" change is planned and implemented is crucial to delivery, and the key to our local approach is continuing and developing use of the North East Transformation System (NETS) as the methodology underpinning all our service change. As a national pilot, our early adoption of the NETS approach, including the development of relationships through the agreement of local compacts, means this approach is now firmly embedded in our way of working. We therefore have the required tools and expertise necessary to effectively and efficiently implement the breadth and degree of change required. We will apply the NETS methodology in a flexible manner with regard to service redesign, ranging from system wide implementation of the tools within the production system through to undertaking Kaizen events to stimulate specific limited change on a small scale. We will complement our approach by utilising other change methodologies and best practice where appropriate, to achieve increased efficiency and productivity. All of the service reform initiatives described in our planning framework will use the NETs methodology, and is described in more detail in the Organisation Development Plan.

Our approach to implementing change locally, agreed with partners, is as follows:

- **Transparent** with a clear agreed methodology, using the North East Transformation System (**NETS**).
- **Challenging** given the need for health improvement.
- **Developmental** with a focus on continuous improvement.
- **Relative** and **flexible** acknowledging the starting point in each locality.
- **Prioritised,** to address agreed local need and service pressures.
- Ensure improvements to pathways are based on **evidence, best practice, standards** and **outcomes**.
- Ensure full **clinical engagement** in the development of pathways (including a local link with each regional clinical pathway and regional advisory groups and networks).
- Be **inclusive** and **open** and involve all stakeholders.
- To use **existing groups** and **processes** for each workstream.
- To identify themes for **quick wins** to build expertise and confidence.

In addition we will also ensure all changes meet the five pledges made by Professor Lord Darzi in "Leading Local Change" which are that:

1. Change will always be to the benefit of patients.
2. Change will be clinically driven.
3. All change will be locally lead.
4. You (the patient and the public) will be involved.
5. You (the patient and the public) will see the difference first.

This approach is aimed specifically at developing and promoting a culture of joint commitment and alignment within our local health and social care economy to the delivery of "Our vision, our future" and of our Strategic Plan. Successful change must be underpinned by positive and supportive behaviours, crucial for significant reform and reshaping of healthcare. Delivery of our strategy requires broader involvement and joint planning with our public, patients, carers, local authorities, practice based commissioning consortia and providers (including the NHS, community, private and voluntary sectors). These are important areas for development and are addressed in detail in the Organisation Development Plan and Communication and Engagement Strategy.

4.8. Flexibility in the Strategic Plan

This robust five year Strategy with its clear focus on identification and management of risks, gives us the best chance of delivering our longer term vision and strategic objectives.

However, there are a number of external factors which may require adjustment to our plans throughout the five years including the emerging recommendations from the North East "Our vision, our future" clinical pathway groups and recommendations from the Regional Advisory Groups on implementation of "Better Health, Fairer Health". In addition there is always the risk that major, unpredictable events may require amendments to our plans, for example a flu pandemic.

To accommodate both these types of event, our plans remain flexible and able to respond proactively to changes as they arise. We have prioritised the plans in a range of different ways in order to be able to respond to changes without jeopardising achievement of our vision.

Section 5 – Finance

5.1 2009/10 Operating Framework and beyond (assumptions)

The 2009/10 Operating Framework / PCT Allocations for 2009/10 and 2010/11 were published on the 8th December 2008. However, whilst a significant number of key objectives and messages are now known, PCTs continue to have to make assumptions within plans on a number of significant unknowns i.e. utilisation /availability of central budgets. We are also unaware of the extent the additional public sector savings target announced within the Chancellor's "pre budget" statement, will impact on the NHS. Whilst we may not have all the pieces of the jigsaw, we do have sufficient information to produce high quality long term financial plans which will have the ability to react as and when further information becomes available.

The NHS has been through turbulent times in the not too distant past regarding its financial performance. Having returned to an overall surplus position, a cornerstone of the 2009/10 and future NHS Operating Frameworks will be the maintenance of sound financial control accompanied by robust long term planning, and the testing of the financial resilience of our plans.

The table below highlights the uplifts used in the construction of the financial templates in support of the Strategic Plan. It should noted that the uplifts for inflation etc are Net of a 3% assumed efficiency.

	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Likely	%	%	%	%
PCT Allocation Uplift	5.5 %	5.5 %	3.0 %	3.0 %
GP Contract Inflation	1.5 %	1.5 %	1.0 %	1.0 %
Dentist Contract Inflation	3.4 %	3.4 %	3.4 %	1.0 %
Community Services Wage Inflation	2.2 %	2.2 %	2.0 %	2.0 %
PBR Tariff Inflation	2.2 %	2.2 %	2.0 %	2.0 %
Non PBR Tariff Inflation	2.2 %	2.2 %	2.0 %	2.0 %
Prescribing Inflation (before new drugs)	3.0 %	3.0 %	3.0 %	3.0 %

In addition to the recurrent increases derived by these uplifts, all three PCTs will see the return of "vested surpluses" during the first three years of the Strategic Plan i.e. 2009/10 through to 2011/12. This return of "non recurrent" resource will provide our PCTs with additional "one off" opportunities and will be one of the main sources used to finance our estates strategies.

PCTs have a statutory duty to deliver financial balance "in each and every year". In recent years delivery of this has required more rigorous monitoring / management with the advent of "control totals" which place a limit on the amount of surplus any individual organisation can

carry forward. Over the life of the Strategic Plan this situation will become even more complicated as non recurrent resource is returned to the system and we move into years of lower levels of growth funding.

With this changing financial climate in mind PCTs have been tasked with delivering the following additional principles:-

- PCTs must remain in recurrent balance throughout the life of the Plan.
- By 2012/13 PCTs should only be committing 98% of there allocations / budget on a recurrent basis i.e. 2%.
- The financial plans submitted on behalf of all 3 PCTs within NHS South of Tyne and Wear to deliver not only the statutory duty but also these additional principles.

5.2 Financial monitoring of the Strategic Plan

Through regular monthly scrutiny, reports to the Integrated, Commissioning and Provider Boards as well as the Audit Committee, the three PCTs will ensure robust monitoring of all the financial consequences associated with the Plan.

Whilst the financial schedules attached (Appendix 3) demonstrate the deployment of growth funding, the achievement of all financial objectives across the plan period, will each individual year, be the subject of bespoke “operational” plans which will lead to full detailed budgets covering all aspects of the PCTs business being produced for adoption by all Boards each March.

5.3 Investment areas

The financial plans which support the Strategic Plan identify additional recurrent growth funding of £195m across NHS South of Tyne and Wear for the period 2009/10 to 2012/13. This is in addition to the extra £55m received in 2008/09.

Each PCT has identified a number of local and national priorities and set aside additional funding accordingly. Investment can be tracked across all the strategic objectives throughout the life of the Plan whilst at the same time maintaining investments in the local areas identified within our current Operational Plan. The financial templates provide full detail, however the additional growth funding areas are highlighted within section 4.5.

A major thrust of the 2008 – 2011 Operational Plan was a substantial increase in funding to support Health Inequalities (Staying Healthy), particularly in 2008/09 and 2009/10. Funding in excess of £11m has been made available in these years; however, our plans will not stop here. A further £1.4m will be made available over the period 2010/11 to 2012/13 to support schemes aimed at reducing the life expectancy gap within our local populations.

Since the publication of the Comprehensive Spending Review, a number of Ministerial and Department of Health announcements have been made, regarding areas for targeted investment throughout the life of the plan. A thorough exercise has been carried out locally to evaluate the impact and funding set aside accordingly.

In addition to the recurrent figures highlighted above, a further £15.5m in 2009/10, £11m in 2010/11 and £12.5m in 2011/12 will be available on a non-recurrent basis as historical surpluses are returned to the area. All three PCT’s are aware of this funding stream and our

Capital and Estates Strategies have been approved in the knowledge that this income is to be returned. Consequently, our "building stock" throughout NHS South of Tyne and Wear will be considerably enhanced as a means of utilising this non recurrent resource.

One of the new financial objectives highlighted above is to spend only 98% of our budget on a recurrent basis by 2012/13. In order to achieve this, we will be creating reserves over the life of the plan which will be targeted at "non recurrent" initiatives. We intend to work with our partners to ensure this non recurrent funding is used to reduce our health economies recurrent run rate on an ongoing basis. By pump priming "invest to save" schemes and accelerating our modernisation agenda, we will deliver further efficiencies which will underpin our value for money strategy.

5.4 Delivering efficiency and value for money

Implicit within the financial templates is the requirement to deliver 3% efficiency in each year of the Strategic Plan. The tariff / inflation assumptions above are net of a 3% assumed efficiency.

A key principle underpinning our plans is the realignment of resources to match our identified strategic objectives. We will seek to work with all our providers to ensure our vision of **using your money wisely** is one of the cornerstones of becoming a World Class Commissioner, by actively:

- **Targeting the investment** of new monies in the three PCT financial plans into priority areas as identified in this Strategic Plan.
- The **elimination of waste** through pathway redesign and service reform, informed by benchmarking and productivity indicators.
- The use of **programme budgeting** information together with health indicators to identify areas of misalignment, starting with a pilot currently underway for CVD.
- The **Value for Money Strategy** agreed by the Integrated Board in May 2008.

Section 6 – Delivery

6.1 Past delivery performance

We have a successful track record in NHS South of Tyne and Wear of implementing initiatives which support the delivery of our commitment to improve health and commission high quality, value for money healthcare.

Improved health can be demonstrated by the reduction in cancer mortality together with the narrowing of the gap in relation to the England average. This has been achieved through better outcomes and the streamlining of cancer pathways resulting in the delivery of the 31 and 62 day cancer targets.

Early feedback from the September 2008 visit of the National Support Team for Health Inequalities indicates that reductions in our health inequalities can be attributed to excellent leadership, visionary clinical leadership, strong governance, organisation development and communications, supported by excellent partnership working. This gives us a very strong foundation on which to build for future delivery.

Improvements in the quality of services are evidenced by improvements in our delivery of national standards and targets, as reflected in our Healthcare Commission annual ratings.

	2005/06		2006/07		2007/08	
	Quality of services	Use of Resources	Quality of services	Use of Resources	Quality of services	Use of Resources
South Tyneside PCT	Good	Fair	Excellent	Fair	Excellent	Good
Gateshead PCT	Good	Weak	Good	Fair	Good	Good
Sunderland TPCT	Fair	Fair	Fair	Fair	Good	Good

We have established a number of initiatives that have resulted in **greater efficiency** (evidenced by improvements in the NHS Better Care, Better Value Indicators). We have enhanced primary and community care services to drive efficiencies in secondary care, including improved prescribing, implementation of urgent care teams and primary care centres, as well as the management of long term conditions outside hospital.

The Integrated Board undertook a SWOT analysis to reflect on the critical factors that have characterised recent successful and less successful initiatives. The initiatives that have proved successful can be characterised as:

- Being in direct response to identified health need;
- Supported by comprehensive needs assessment and predictive modelling;
- Reflecting our ability to instigate changes in pathway delivery utilising effective redesign methodologies;
- Being delivered with input from high calibre like-minded organisations (foundation trusts, primary care, local authorities, practice-based commissioning consortia) that are committed to health improvement.

Issues that have limited our scope for success are predominantly linked to a lack of capability and capacity in a number of the World Class Commissioning (WCC) competency areas:

- Progress in stimulating the market has been limited with difficulties experienced in increasing potential providers competing to provide new services linked to the implementation of our health improvement programme;
- Whilst we continue to undertake systematic engagement with patient, carers, the public and partners, this needs to be extended and in greater depth to ensure profound influence on our commissioning decisions and strategic planning including prioritisation, decision making and resource allocation.

Broadening the analysis to include opportunities and threats identified further insights that have guided our risk assessment (section 6.3). Our ability to instigate transformational change is enhanced considerably by the congruence between the North East vision and our locally agreed vision, reflected in our strategic objectives.

Similarly, the WCC assurance framework and NETS offer important opportunities to systematically develop and enhance the knowledge, skills and behaviours necessary to drive change through effective commissioning. The threats identified reinforce the fact that against a background of change, maintaining the status quo is not a viable option. The key critical factors are summarised below.

SWOT analysis summary

Strengths	**Weaknesses**
• Robust vision. • Commitment to health improvement. • Track record of delivery – high performing economy. • Ability to respond to change. • Resources – funding, staff. • Technical expertise – predictive modelling, needs assessment.	• Administrative demands of 3 statutory PCTs. • Limited experience in delivering scale of change required. • Specific WCC competences – market stimulation, procurement. • Patient, carer and public involvement. • Partnership working including community and voluntary sector.
Opportunities	**Threats**
• Advances in clinical practice and medical technology. • Regional vision and strategies reflect local priorities. • Develop effective relationships thru Strategic Plan. • WCC competencies – develop commissioning expertise. • NETS - drive modernisation and reform.	• Demographics – aging population. • Skills gap. • Partner reluctance to change – failure to create necessary culture and supporting behaviours. • Overlap in Commissioner / Provider functions. • Potential income loss from change in national allocation policy. • Current economic climate “credit crunch”

The learning from the SWOT analysis played an important role in the identification of key risks to delivery of our strategic objectives together with consideration of the range of mitigating actions that could be taken to limit their potential impact. The SWOT analysis has also fed into assessment of current capability around WCC competencies and has informed

the development of the Organisation Development Plan and the Communication and Engagement Strategy.

6.2 Local approach to risk management

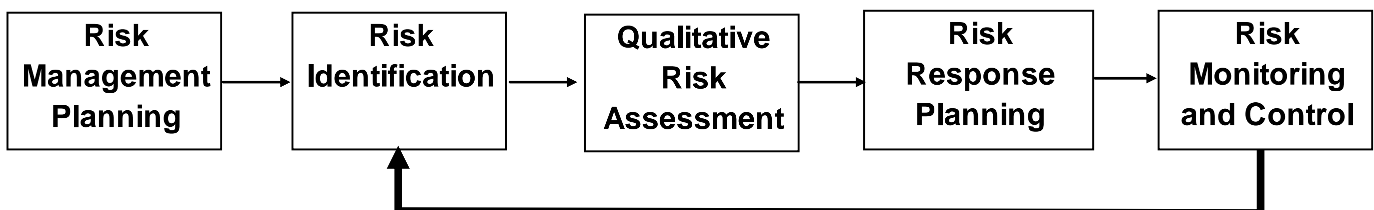
Risk management is the systematic process of risk management planning, identifying, analysing, and responding to projected risks

Our past approach to risk management has served us well but we acknowledge that this now needs to be considerably strengthened to effectively and efficiently deliver the level of transformational change required locally.

Risks and mitigating actions are identified and quantified as part of the development and implementation of initiatives, but performance management has predominantly focused on retrospective assessment and subsequent contingency planning to ensure performance remains 'on track'.

Our developing approach is based on proactively managing risk and projecting risk forward. This requires the expertise to prospectively quantify risk, based on likelihood, to identify potential impact, develop mitigating plans and monitor the residual risk; this is illustrated in the flow chart below. The process includes informed iterative learning as part of risk monitoring (which can flag up additional risks not previously identified) and also ongoing re-assessment of the risk rating.

Risk management cycle



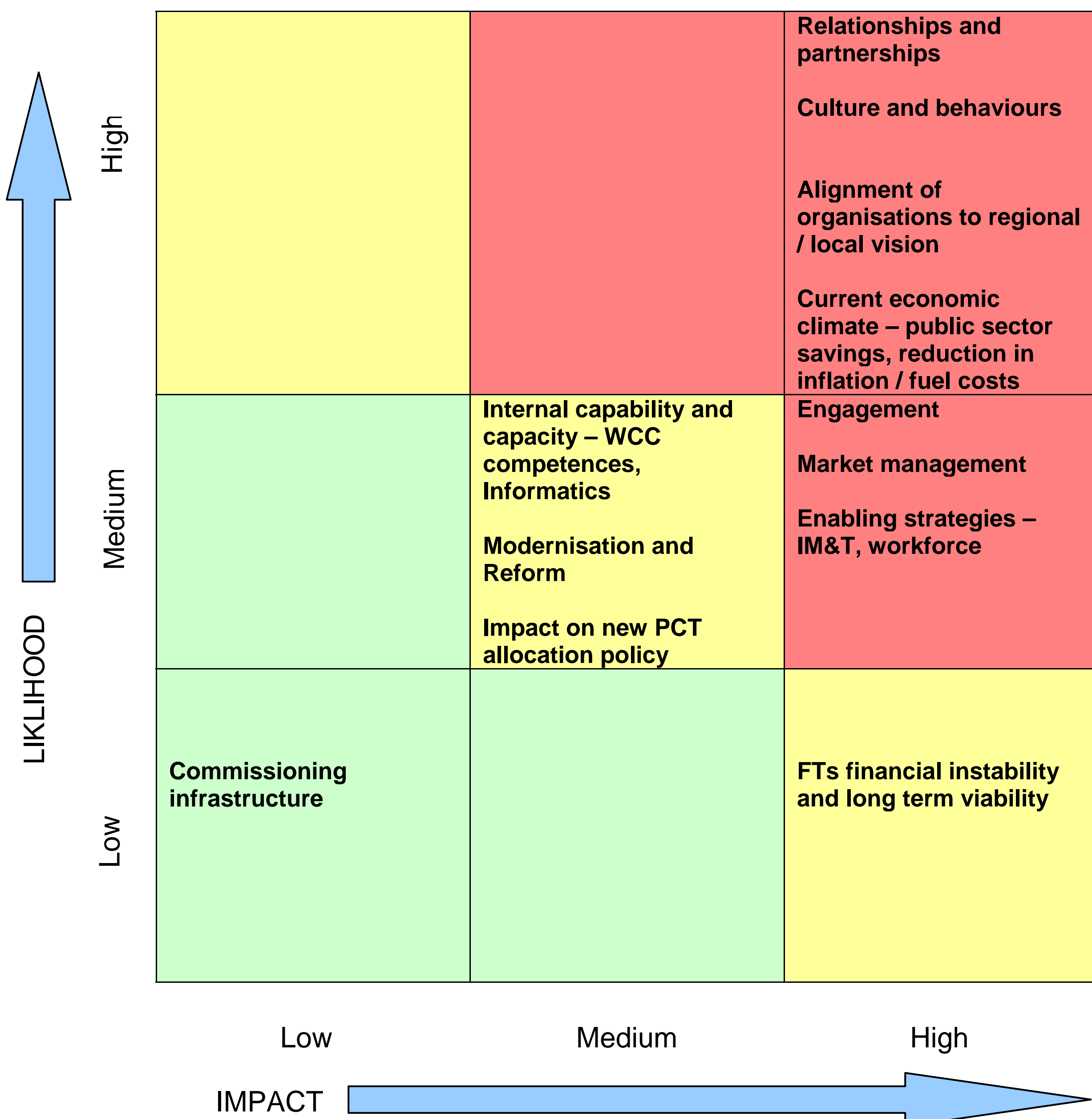
This approach will be fully implemented through the 2009-2010 Annual Operational Plan and will be an integral part of the development and implementation of future initiatives. This requires new skills and knowledge and the Organisation Development Plan outlines a multi level risk management training programme for all commissioning staff as a first step in addressing this gap.

6.3 High level risks

Risks have been systematically identified and quantified for each strategic objective through the planning process, using a consideration of likelihood and impact. We then reviewed the risks assigned to the strategic objectives overall to moderate the scoring and ensure the comparative scores remained valid. However, this is an ongoing and evolving process which will be regularly refreshed, as initiatives are implemented and evaluated and as new evidence becomes available.

From the detailed analysis underpinning these high level risks, a number of cross-cutting risks to delivery have been identified, which predominately reflect current shortfalls in a number of the WCC competences. 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.

Relationships – partners, GPs, PBC	**Delivery risk**	Planned changes depend on alignment of the entire system, commitment to implementation and agreed actions / timescales Need to develop health improvement / quality ethos and culture supported by enabling behaviours at leadership level and permeated throughout all organisations. System changes are constrained by national policy and nationally determined contractual arrangements.
	Assessment	Impact – High Likelihood – High
	Mitigating action	Agreeing compacts with organisations through NETs (includes development of appropriate behaviours and cultures) will drive reform agenda and deliver sustained continuous improvement. Implementing strategies to develop effective relationships as part of the OD Plan. Local PBC representatives participating in a national development programme. Early evidence of progress via FT compact alert system enabling corrective action to be taken before breakdown in communication and negative behaviours develop.
Engagement – patient, public and clinicians	**Delivery risk**	Need to involve local people in decisions regarding future changes to services. Need clinical ownership and sign-up to local change.
	Assessment	Impact – High Likelihood – Medium
	Mitigating action	Identified gaps in relevant WCC competency and addressed via action plans. Involving local clinicians and ensuring input from all three localities is key principle of our approach to implementing NE Clinical Pathway recommendations. Need for better engagement features as a key principle in delivering our vision and objectives.
Market risks	**Delivery risk**	Importance of stimulating the market to ensure sufficient interested providers prior to procurement stage – critical when developing new local services especially those relating to health improvement. Too much change quickly may result in instability in the market – need to maintain local provider viability. Acknowledge lead time for providers to reshape business and so be able to respond to new service specifications. Financial implications in some instances of pump priming or double running costs whilst new services become established.
	Assessment	Impact – Medium Likelihood – Medium
	Mitigating action	Involvement of all providers in developing Strategic Plan and subsequent 2009-2010 Operational Plan to understand principles of operating in managed market and clarity and input into the planning for change.

Finance position	**Delivery risk**	Impact of new allocation policy – need to establish local implications for implementation and phasing of Strategic Plan. Current economic climate, impact on future allocations, need for increasing efficiency, effects of inflation and knock on effects including fuel costs.
	Assessment	Impact – High Likelihood – High
	Mitigating action	Overall financial risks have been minimised by strong financial management, which has produced a balanced financial plan for the three PCTs which includes prudent provision for inflation, pre-commitments and local initiatives designed to deliver strategic objectives.
Internal capability and capacity	**Delivery risk**	WCC competency assessment identified weaknesses in market stimulation, procurement and public engagement. Potential capacity gap in implementing change whilst maintaining high performance and delivering key targets.
	Assessment	Impact – Medium Likelihood – Low
	Mitigating action	Established actions plans for each competency to attain the expertise required to improve WCC levels over defined timescale and incorporated into the OD Plan. Effective project and risk management to ensure sufficient capacity. External facilitation to help identify solutions to 'gaps' in specific competences.
Commissioning infrastructure	**Delivery risk**	Need to develop more robust, integrated processes to ensure comprehensive infrastructure to support and deliver change.
	Assessment	Impact – Medium Likelihood – Low
	Mitigating action	Internal review of the Commissioning Cycle identified gaps. Implementing action plans to strengthen cross Directorate working to ensure comprehensive and well informed decision making.
Modernisation and Reform	**Delivery risk**	Significant transformation required but locally and nationally only limited experience of change of this size and breadth. Importance of dovetailing local implementation with regional timescales. NETs tools and processes tested and proven effective in provider setting but not yet in a commissioning environment.
	Assessment	Impact – Medium Likelihood – Medium
	Mitigating action	Effective project and risk management through the economy to ensure realistic timescales and sufficient capacity. Implementation of Children's Review as pilot for implementing NE recommendations will identify gaps and pressures to be addressed prior to rollout of other work streams.

The Organisation Development Plan describes in more detail how those risks associated with organisational issues are being managed.

6.4 Quantification of major risks

The financial impact of major risks materialising or assumptions underpinning this Plan being too high or too low has been quantified as "upside" and "downside" scenarios to show the potential financial impact if the best or worst forecast position materialises. These have then been summed to identify the maximum potential financial impact on NHS South of Tyne and Wear, if all the upsides or all the downsides were to materialise.

The table on the following page shows that if all the worst case scenarios were to happen (very unlikely) the maximum financial impact on NHS South of Tyne and Wear would be approximately £25m which would need to be found from a mix of contingency funds, reducing existing spending and reducing the scale of planned new spending. However, if all the best case scenarios were to materialise we would have approximately £18m more to invest in the health of local people.

If spending levels had to be reduced below the levels set out in this Plan, we have identified that over the next five years, there are three areas for new investment which are so crucial to ensuring the local NHS is viable in the near future that they must be protected. They are:

- The package of measures aimed at reducing and managing CVD (including alcohol, obesity and smoking).
- The service reform programme.
- Mental Health service reform.

These absolute priorities have been identified within the PCT as being crucial to manage a potentially unaffordable demand for hospital services, and are confirmed by a ranking of our strategic objectives using the numeric scores assigned to each as part of the original prioritisation exercise, moderated by the views of local people in each PCT expressed through structured discussions at each of our Local Engagement Boards.

Any reductions in investment plans would therefore be concentrated on the other strategic objectives and existing investments. The initiatives within each objective have been ranked by the PCT specialists leading on that area to determine which would be cancelled, scaled back or delayed if the financial position required this. Disinvestment in existing services will continue with improvements through service reform, the Value for Money strategy and a continuing identification of ineffective or inappropriate interventions and services.

NHS South of Tyne and Wear – Quantification of Major Risks

Risks	Underlying factors (mitigation built into Strategic Plan)	Potential impact of risk	Estimated Value of Risk over 5 years of plan – Downside	Estimated Value of Risk over 5 years of plan – Upside
New services (CVD, smoking, obesity, alcohol) either do not get established as planned or do not achieve expected changes	• Availability of suitable providers • Staff recruitment • GPs sign up to LES • Target clients not reached • Planned services not effective (e.g. smoking cessation services do not reduce smoking levels, obesity services do not increase weight loss etc)	• Planned reductions in morbidity and mortality do not materialise • Reductions in hospital activity are not achieved (£9m reduction built into financial plans, estimated maximum achievable £16m)	**£9m**	**£7m**
Planned reform of services using NETs does not happen	• Methodology does not achieve results • Multiple RPIWs too resource intensive • Relationships not good enough to sustain joint commitment to changes • Pace of change too slow	• 18 weeks not sustainable as pathways not simplified • Activity does not move from hospital to community at desired pace • Some clinical services become unviable (e.g. paediatrics, maternity) as volumes decrease and EWTD reduces junior doctor cover • Planned quality & access improvements for public not realised	**£0m** (£ plans do not include impact – prudence)	**£3m**
New allocation policy reduces expected growth		Reduced income	**£2m**	**£2m**
Move to HRG4 tariff		• Could move cost of acute care either up or down substantially	**£2m**	**£2m**
CSR settlement revised due to economic downturn		• Reduced income allocation below assumption	**£12m**	**£0m**
VFM opportunities from all providers do not deliver efficiencies	• A rolling programme of review of existing commissioning arrangements, including provider arm, does not deliver anticipated efficiencies • Value relates to all providers over the life of the Plan	No impact built into financial plans (prudence)	**£0m**	**£4m**
		TOTAL VALUE	**£25m**	**£18m**

6.5 In year monitoring

We have a robust performance management framework in place which gives a comprehensive view of performance against the delivery of local initiatives, national targets, vital signs, Healthcare Commission Indicators and the Local Authority National Indicator Set. Each initiative / target has agreed milestones or trajectories and is assigned a potential risk assessment (impact of non-delivery and likelihood of the risk materialising) which is reviewed in-year to ensure the assumptions remain valid.

Performance is reviewed on a monthly / quarterly basis as appropriate by internal teams, the Commissioning Board and Commissioning Executive, and is made available to the public via the Integrated Board. Any shortfall in performance results in remedial actions being instigated to ensure delivery. Regular predictions against Annual Health Check targets are produced to ensure the risks of not achieving targets are mitigated. Those local initiatives and targets ranked as high risk are closely scrutinised to ensure performance remains on trajectory, and any deviation from plan is quickly identified and appropriate action taken.

We are strengthening our partnership working with the local authorities, through development of a partner performance management framework and supporting process. This will ensure a shared view of progress against the National Indicator Set national targets and Local Area Agreement actions.

6.6 Organisational requirements and enablers

The Organisation Development Plan which supports delivery of this Strategic Plan sets out our organisation development approach and philosophy, our capacity and capability gaps identified through a range of diagnostics, together with plans for closing those gaps.

6.7 Provider requirements and plurality of provision

We have made an assessment of the local provider landscape (as noted in section 3.9) and will be using this together with our predictive modelling to identify where the market needs to develop to ensure that patients receive a choice of the most appropriate care in the most suitable setting and to the highest quality and performance standards.

We acknowledge that market development is an area in which we need to do more and this is flagged up as a priority in our Organisation Development Plan. We have initiated the construction of a high level market development plan, beginning with the preparation of a detailed service map which we will have identified as our immediate action; as summarised on the following page.

Market Development Plan

Objective	Goal	Initiative
Understand current and potential service providers, including a review of service quality	• Comprehensive provider directory across all sectors produced by 2009 • A common level of understanding of the quality of service provision across all care settings	• Develop and implement a robust process for mapping all providers against an agreed set of criteria that captures VFM, quality including patient experience, outcomes and capacity
Develop market intelligence to allow an assessment of performance against investment outcomes	• Clear VFM criteria identified • Systematic process in place to gather, analyse and use market intelligence	• Linked to a comprehensive provider directory, develop a set of metrics that allows a rigorous assessment of performance on all agreed criteria • Use of this information to drive improvements and innovation in services or stimulate the need for new entrants • Working with the NE SHA on the development of a market assessment tool in conjunction with other local PCTs and Price Waterhouse Cooper (PWC). Proof of concept testing is underway working with Co Durham PCT and PWC, using orthopaedics as an initial programme of work
Develop partnership working as part of market development	• Improved links with local strategic partners that leads to a shared achievement of better health outcomes • Trusted and sustainable relationships	• Identify key strategic partnership arrangements • Use partnership structures
Develop patient and public engagement as part of market development	• Demonstrable evidence-base of patient involvement in all major commissioning decisions	• Develop a systematic process of engaging with the public that will lead to empowered patients with a voice in how services are shaped and delivered
Build capability and develop procurement services	• Improved procurement processes • Clear understanding of the roles and responsibilities around procurement • Greater standardisation of contract terms • Stronger performance levers in contracts	• Establish a joint framework and standards for procurement of services • Develop jointly with PCT partners appropriate options for developing procurement services and capabilities
Develop sustainable relationships with the voluntary sector	• Demonstrable evidence of improved health outcomes • VFM	• Develop a framework for voluntary sector contracting/commissioning • Strengthen the governance arrangement in place for voluntary sector commissioning

Section 7 - Enabling strategies

7.1 Primary and community services strategy

Fundamental to the delivery of the changes in this plan are strong, active primary and community care sectors. As the level and complexity of demand for acute care increases, the role of primary and community services needs to develop to complement this and to allow for the integration of care pathways. This change has begun but now needs to move up a level to ensure systematic, comprehensive provision across NHS South of Tyne and Wear.

Services in the community provide ongoing advice and care for patients on all health issues. The broad range and holistic nature of care and advice provided is the cornerstone of primary and community services and our challenge is to build on this important role and to commission these services more systematically to address:

- Prevention and screening;
- Inequalities;
- Care for people with long-term chronic conditions.

Primary and community services will be key to actively finding and treating the high numbers of people across NHS South of Tyne and Wear with risk factors and ill-health who are presently not identified and not receiving care. This requires an increased emphasis on a proactive service rather than a reactive demand led system.

The range of primary and community services providers has broadened and the nature of services changed significantly in the last five years. This will be a developing trend with a range of different organisations providing these services. As the market develops, we must ensure that it provides a range of opportunities to meet patients' needs and that development is targeted at reducing the health inequalities gap.

The range of primary and community service providers will also increase to meet the broader, more complex service requirements mirroring the trend in acute care. The integration of service providers into larger organisations or partnerships is developing to respond to these needs. We will increasingly commission individual services rather than generic contracts with providers, from a developing range of providers. This will increase patients' need for co-ordination and clarity so the important role of the registered GP as the co-ordinator of care and well-being for their list of registered patients will need to be further strengthened.

Previously, primary and community services were accessed by patients registered with a general practice which allowed the practice to assess and meet needs. Now, patients have more direct access to a range of community

services which are responding to patient demand rather than the greatest need.

Walk-in services for access to primary care will be available across NHS South of Tyne and Wear from 8am to 8pm, 7 days a week. These services will also be supported for urgent care out-of-hours. The commissioning of walk-in services is to complement and provide a contingency for registered general practice but does not provide the coordinating ongoing role of the registered general practice.

Community services are a key part of the PCT and will continue to be developed to provide the more complex levels of care in the community required by patients. In line with the Transforming Community Services Programme, NHS South of Tyne and Wear will pursue the health outcomes for the community that mean most in their local context, identifying the best means possible to achieve them, whilst ensuring both competition and choice. This will include working jointly with local authorities to improve health and well being and to reduce inequalities.

The strategic changes will require a significant review of commissioning arrangements to ensure that the contracts and SLA's reflect the specific service outcomes required and to ensure clarity of roles and responsibilities of each provider to ensure safe and effective service delivery that is also value for money. With a broad range of providers, it will be key to ensure that there is neither duplication of services and payments nor any gaps.

An important enabler in delivering the primary and community services strategy is the development of primary care centres. They will support the service reform and modernisation agenda to ensure that the right services are delivered in the most appropriate place at the right time and achieve value for money. The centres will support the shift activity from secondary to primary care by providing a venue for the delivery of new and improved clinical services. Furthermore the primary care centres provide an important platform to stimulating the market and enabling new providers to deliver new and innovative primary and community services through availability of high quality, state of the art facilities and infrastructure.

We currently have three primary care centres operating in Sunderland, with planning for a fourth underway which will ensure equity of provision across the Sunderland locality. In South Tyneside, building work has begun on the Cleadon Park Centre which is on schedule to be completed in May 2010. There are two primary care centres in development within Gateshead; one in Blaydon and the other in Gateshead town centre. The Blaydon project is the more advanced of the two with completion planned for autumn 2010.

7.2 Practice Based Commissioning

We are in the process of reinvigorating PBC and reviewing the local vision. This involves developing a compact which will set out the mutual expectations between NHS South of Tyne and Wear and the six clusters. This process

commenced in early August 2008 via a Time Out Development session supported by the Improvement Foundation and it is anticipated that each cluster will develop respective compacts this year which will form a strong foundation to develop a joint patch wide compact next year. This work was preceded by a survey of all the Clusters based on their views of the PCT as a Commissioner.

We have also reviewed the PBC Governance arrangements to make sure they are fully integrated with wider commissioning governance, thereby streamlining the process with the aim of making it less bureaucratic and more supportive. The Commissioning Executive and Commissioning Board are now supported by a PBC Operational Group, comprising all the commissioning teams and the PBC team. This helps to ensure consideration of potential PBC business cases as early as possible and provides feedback and support for service redesign proposals by PBC Clusters.

7.3 Vision for involving patients and the public

The Communications and Engagement Strategy provides an integrated approach to communications and engagement with staff, stakeholders and the public across NHS South of Tyne and Wear. It is an update of the Communication and Engagement Strategy agreed by the Integrated Board in May 2008. This was developed with the involvement of our staff, patients, the public and our partner organisations.

Our strategy reinforces our commitment to effective communications and engagement and sets out a structured and co-ordinated approach to influence and inform our commissioning decisions. It supports the delivery of this Strategic Plan and our vision. The strategy will ensure we develop continuous and meaningful engagement to shape services and will also support our aim to becoming a world class commissioner of services, by building our reputation as:

- The local leader of the NHS.
- A change leader for local organisations.
- An employer of choice.

The Communication and Engagement Strategy is a statement of our principles and direction of travel and will be refined and amended during 2009.

7.4 Workforce

NHS South of Tyne and Wear has established workforce cluster arrangements in line with the NE SHA guidance. The membership of the cluster is drawn from the internal commissioning and the workforce teams within the PCT. The foundation and the mental health trusts are represented mainly at Director level, and a member of the NE SHA workforce team also attends the group. The cluster has agreed to continually review membership

and representation to ensure that it continues to be fit for purpose in order to achieve its objectives, complete tasks and add value.

Terms of reference have been agreed for the cluster and priorities have been identified in three key workstreams, namely to:

- Support the development of the longer-term workforce to ensure that the cluster improves the approach to forecasting future workforce requirements in the context of appropriate labour markets and transformational change set out in this Strategic Plan.
- Ensure that education, which is commissioned on behalf of the cluster, is fit for purpose and addresses the needs of the service both in the short and longer term.
- Identify the workforce risks arising either from the current workforce profile and or, from changing service models resulting from reform, and develop mitigating plans to address them.

7.5 Information Management and Technology

High quality information will underpin commissioning processes and innovative informatics services will be essential to support the increasing range of health and social care services that will deliver the strategic objectives. The objectives and measures identified in the OGIM frameworks will drive the informatics planning process, with informatics plans developed for each of the twelve strategic objectives.

A coherent informatics infrastructure will address issues of data transfer and security to support integrated pathways across multiple organisations. Access to information will facilitate patient choice and enable care providers to deliver and improve services. Ongoing development of information services and business intelligence capabilities will be fundamental to the planning and delivery of future services.

An ambitious, enabling Information Strategy will focus on meeting the challenge of evolving information requirements to support **better health** and **excellent patient experience** and **wise use of the money** in commissioning and provision of services. The Information Strategy will outline the approach to and implementation of national directives in conjunction with the local requirements of the Strategic Plan and will describe how, as a health community, we will progress with the implementation of National Programme for IT and the recent Health Informatics Review through to 2011.

7.5.1 Major delivery platforms

Significant investment will be made in the development of current delivery platforms:

- **Application services and platforms** – development of a suite of effectively integrated platforms that help drive clinical and business processes securely and effectively.
- **Information asset management** – oversee the structure and management of information assets to ensure that they are fit for purpose and meet objectives of security and sustainability.
- **Information and collaboration processes** – transformation of the efficacy and value of current processes and allow secure information-sharing across and within organisational boundaries.

7.5.2 Patient Focussed Information

The following initiatives will deliver benefits locally and address national expectations:

- **Summary Care Record** – an evaluation of the use of the Summary Care record will be progressed in line with local needs and priorities.

- **Electronic Prescription Service** – rollout of Electronic Transfer of Prescriptions (ETP) will continue. SOTW will be an early implementer of ETP release 2 in Sunderland.
- **NHS Choices** – improved access to local information will be made available though web developments including 'Access to Health'. Activities to raise awareness will continue through collaboration with Choose and Book user groups.
- **GP 2 GP Record Transfer** – the capacity to transfer of patient records electronically, between GP practices, will be expanded to include more practices.
- **GP Systems of Choice** – maintenance and support agreements are in place for GP systems. Following an assessment of IT assets, a replacement programme will be developed.

7.5.3 Data Quality and Information Governance

Information Governance – during 2009, assurances will be sought from independent contractors and providers of commissioned services, that they are working towards compliance with the Information Governance standards and that they meet legislative and NHS requirements in relation to information security

NHS number, patient demographics and pseudonymisation of patient data – the Local Health Community Informatics Board will address issues of compliance with national requirements and further improvements to the security of patient information

7.5.4 Underpinning Local Service Transformation

The emerging recommendations from 'Our vision, our future' will be incorporated into the integrated informatics planning processes and will continue to be delivered though a range of projects and initiatives such as collating information from GP systems, ongoing development of patient administration functionality and information services initiatives.

- **Enabling local service transformation -** Informatics plans are being developed in support of each of the local strategic objectives, identifying tactical and longer term initiatives. Common themes will include improved access to information for patients, public and staff. The plans will inform the Local Health Community (LHC) Information Systems Roadmap and the required supporting Technical Infrastructure. Some key local initiatives will include:
  - Contact Point, supporting coordination of services delivered to children and young people.
  - Primary Secondary Care Interface initiative, supporting electronic discharge, order communications and reporting.

- **Governance –** the South of Tyne and Wear LHC Informatics Programme Board is the strategic body overseeing the PCTs informatics programmes and will continue to steer the direction of the cross community informatics programme. The Board will oversee the development of plans, monitor performance and ensure achievement of informatics objectives.

- **Benefits and Costs - b**udgets for delivery of informatics programmes will be managed in accordance with the priorities laid out by their governing boards. Informatics developments will be delivered through a range of benefits-led projects, in line with a robust benefits realisation framework.

7.5.5 Developing Informatics capabilities

Key to the successful implementation of the enabling strategy will be the ongoing development of Informatics capabilities. A broad range of new information management skills will be deployed to support the major delivery platforms which will in turn drive the achievement of the strategic objectives and goals.

7.5.6 Information Management & Business Intelligence

Utilising new technologies such as sophisticated visual presentation tools and integrated web based analytical tools, the Information Management and Business Intelligence Departments will take an increasingly more prominent role in the delivery of robust analysis using the latest quantitative techniques.

The development of these services will also see closer alignment of resource to directorates to provide expert analytical support. The development of standard reporting tools is also being undertaken. It is expected that these undertakings will free up time and resource to work on the development of skills in the fields of market analysis and knowledge management.

7.6 Integrated Regional Framework to support sustainable communities

We have an important role to play in supporting the development of sustainable communities both as a commissioner and also as a major employer. We are committed to ensuring that NHS investment is directed in such a way that maximises its positive impact on local communities in terms of the key objectives of the Integrated Regional Framework including developing a more sustainable employment market and establishing a strong learning and skills base.

We held a joint seminar on 8 October 2008 with our three Local Strategic Partnerships to work in multi-agency groups to assess our strategic objectives using the appraisal tool. The learning from the event will shape the implementation of our initiatives and also feed into commissioning arrangement with providers. The approach is to be considered by the

individual Local Strategic Partnerships as means of promoting wider collective ownership and contribution to individual partner strategies.

7.7 Equality impact assessment

In accordance with our equality duties, an Equality Impact Assessment has been carried out on this five year Strategic Plan. There is no evidence to suggest that the Strategy would have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights.

This Strategic Plan will be 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 this Strategic Plan, we have sought to promote equality, human rights and tackle health inequalities. This has been through carrying out health needs assessments, life-style surveys, publication of the Single Equality Scheme, equality impact assessments and involving partners, stakeholders and local communities in the design, planning and development of services.

Therefore, whilst Equality Impact Assessment of the Strategic Plan has highlighted the potential for high impact in some areas, the ongoing development and public involvement described above provides the evidence of how equality and human rights are promoted when we commission and plan services. Full Equality Impact Assessment scoping will take place on each annual operational plan to ensure that the needs of all local communities are involved in the design and planning of services.

Section 8 - Board approval

NHS South of Tyne and Wear's Commissioning Board and also at key stages in the process, the Integrated Board, has been actively involved throughout the development of the Strategic Plan. The Boards have undertaken a number of specific activities which have shaped the Plan and input into the identification and prioritisation of the strategic objectives. This input has taken the form of:

- Active participation in a Prioritisation Event and Commissioning Board Strategic Plan Development events;
- Development of core values, selection of outcome measures, SWOT analysis and development of strategic assumptions.

The Plan has been regularly reviewed by the Commissioning Board and also by the Integrated, Commissioning and Provider Boards of NHS South of Tyne and Wear at a full joint session on 27 January 2009. In line with governance arrangements, the Strategic Plan for NHS South of Tyne and Wear will formally be approved by the Commissioning Board at its meeting on the 31 March after consideration at the meeting of the Integrated Board on 25 March and feedback from the "showcasing event" with the NE SHA on 26 March. The Plan will be published and formally launched in April 2009.