Sunderland Clinical Commissioning Group

Clear and Credible Commissioning Plan

2012-2017

Draft Version 1: 24.1.12

Sunderland Commissioning Plan 2012 - 2017

Contents

Clinical Commissioning Group Chair Foreword

To follow

Section 1 – Executive Summary

Sunderland Clinical Commmissioning Group – Who are we?

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

The move from 3 PBC groups which existed for a number of years, to one CCG represents a major achievement in Sunderland and remains fully supported by all Practices. The Executive has devoted a lot of time to ensuring continual communication with its member Practices and not long after forming consulted on a locality sub structure which resulted in the development of 5 Localities along Local Authority regeneration areas. Regularly meetings with all Practices take place throughout the year, along with a monthly Newsletter and monthly Locality meetings. Locality Practice Managers have been appointed and the appointment of Locality Practice Nurses will follow shortly- all designed to ensure continual engagement of member Practices.

An example of the interest generated was the number of expressions of interest in taking Clinical lead roles – with over 50 expressions of interest. Attendance at CCG events usually has 52 of 54 practices with over 200 people each time.

As a Leadership team, the Executive have dedicated substantial time and energy to developing themselves as a corporate body. Each week has involved at least one full afternoon on our executive business meetings, pathfinder committees or development sessions. The latter also include Locality representatives. We have embraced learning opportunities, membership of the Health and Wellbeing Board' engagement with the PCT Commissioning Directors and other CCG s through a fortnightly collaborative team meeting; attend deep dive performance meetings; quality meetings; PCT Board meetings as well as lead pathfinder priority areas.

Our elected Leadership team is also enhanced by the Director of Public Health and the LMC secretary, with support from the PCT including the aligned Director (Director of Finance) and both the Director of Commissioning Development and a Non Executive along with the aligned Director sit on the Pathfinder Committee.

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

Section 2 - Vision

2.1 Vision

Our vision is to achieve **'better health for Sunderland'** and was agreed by the Executive Committee in November 2011.

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

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

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

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

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

2.2.1 Improve the health and well being of local people

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

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

Addressing inequalities

Targeting of resources to address the needs of disadvantaged and vulnerable people in the most deprived communities of Sunderland to reduce health inequalities;

Increased resilence of individuals and communities to address inequalities in coping strategies;

Prevention

A reduction in lifestyle behaviours which pose major risks to health (including smoking, alcohol abuse and obesity);

Increased identification of people with risk factors or in the early stages of disease;

Identification integration and navigation

Every contact with a health professional to be a health improvement contact;

Comprehensive care and treatment for people with identified risks or established illness;

Engagement

Improvements in the wider determinants of health through our participation in the Sunderland Health and Well Being Board and collaborative working with partners;

Improved engagement with communities of greatest need through locality working;

Choice and control

Individuals having a greater awareness and ownership of their own health and well being and that of their families;

Individuals feeling empowered and supported to adopt healthier choices and lifestyles.

By 2017 there will be: (quantified outcomes to be developed)

.....

2.2.2 Integrate services better across health and social care

Our future services will demonstrate:

Integration

Seamless integration across primary, community, secondary and social care resulting in improved health outcomes for patients;

Optimum treatment pathways with standardised care consistently provided by all GP practices thereby reducing clinical variation;

A multi disciplinary approach where appropriate (i.e. Long Term Conditions) to enable a holistic approach to care planning;

Increased synergies resulting from streamlining and integrating pathways;

Patients receiving the right care in the right place, first time thereby reducing waste and demonstrating value for money in everything that we do;

Quality

Safe, high quality care which is consistently delivered and routinely evidenced through commissioning mechanisms;

A patient-centred approach based on the needs and wishes of patients to ensure excellent patient experience;

Access and choice

More care available closer to patients' homes; with routine treatment increasingly provided in primary and community settings (e.g. more GPs with a Special Interest) and complex treatments commissioned from specialist centres;

Greater choice of services for patients, with convenient and timely access at all stages, so that patients can make informed decisions about where and from whom they receive their care.

By 2017 there will be: (quantified outcomes to be developed)

.....

2.2.3 More effective clinical decision making

By 2017 effective clinical decision making will be evidenced by:

Communication

Increased collaborative working across organisations (primary, community, secondary care, social care) to enhance knowledge and the sharing of expertise, including timely access to opinions;

Strong and mature clinical relationships between organisations so that clinical input adds value to the pathway resulting in improved outcomes and patient experience;

Evidence based

All care based on best clinical evidence available, including compliance with standards;

Application of best practice and outcome information where available complemented by local evaluation and research reflecting a commitment to continuous learning and development;

Promoting use of research in an evidence- based approach to decision making;

Using both nationally agreed and local guidance

Standardisation of provision

Consistent standard application of optimum pathways in primary care resulting in a reduction in clinical variation.

By 2017 there will be: (quantified outcomes to be developed)

.....

In summary by 2017, our patients will:

Feel empowered and supported to look after themselves and take control over their treatment regime, particularly those patients with long term conditions;

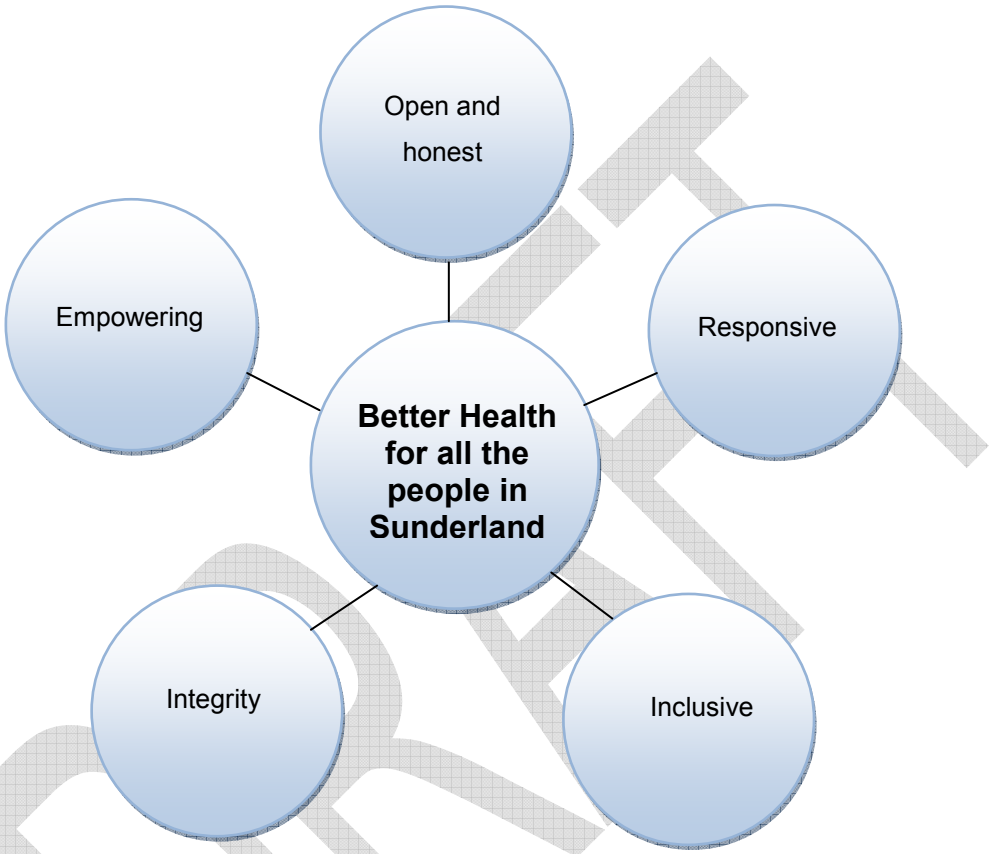
Have input into the processes for making decisions about their healthcare;

Be actively engaged in shaping the planning and delivery of services to ensure their needs are met and views taken into account;

Have confidence in the services we commission.

2.3 Core Values

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



2.4 Commissioning for Quality

Commissioning for quality is an integral part of our vision and encompasses the three key components of quality: patient safety, clinical effectiveness and patient experience. We will drive improvements in quality through provider management and pathway reform and this is a key development area for the Executive Committee in the short term.

Section 3 – The Big Challenges for Sunderland

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

Excess deaths, particularly from heart disease, cancer and respiratory;

Health which is generally worse than the rest of England;

A growing population of elderly people with increased care needs and increasing prevalence of disease;

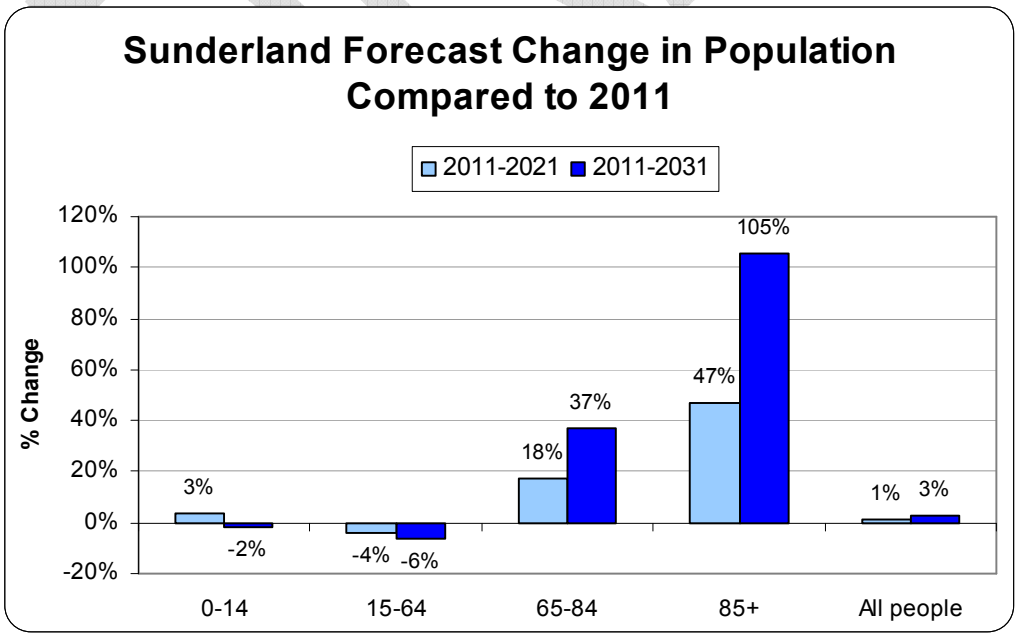
An over-reliance on hospital care;

Services which are fragmented and lack integration.

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

3.1 Overview of the Sunderland population

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



Office for National Statistics, 2008-based Subnational Population Projections, available at www.statistics.gov.uk

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

3.1.1 Overview of health in Sunderland

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

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

Health summary for Sunderland

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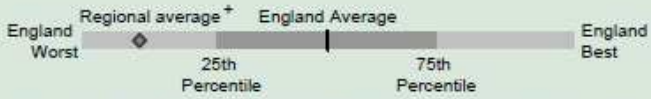
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England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

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



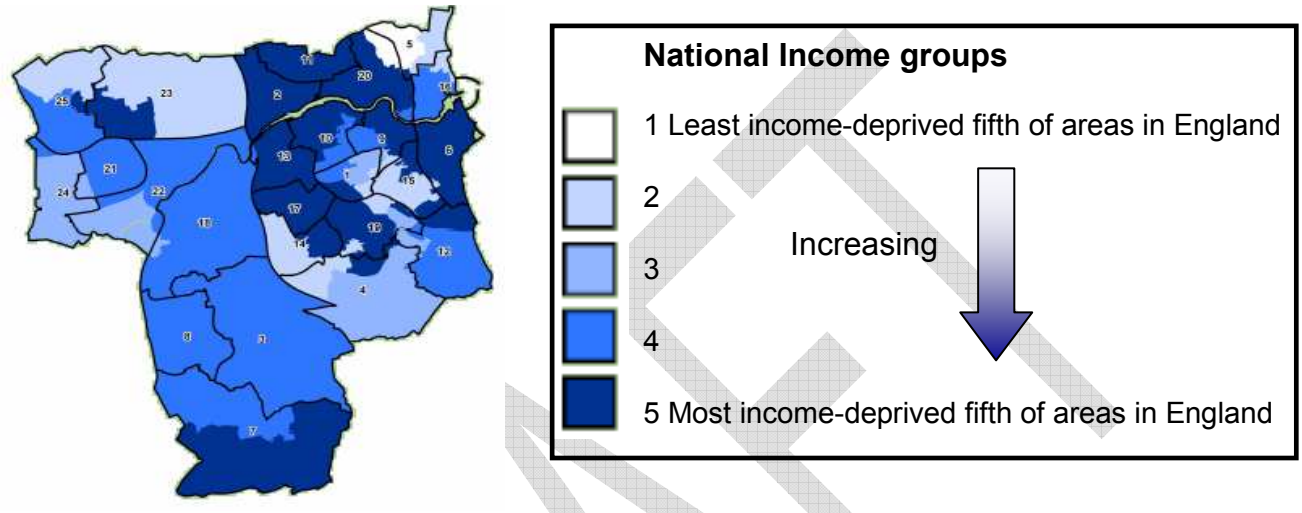
+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	119430	42.5	19.9	89.2		0.0
	2	Proportion of children in poverty	14760	25.0	20.9	57.0		5.7
	3	Statutory homelessness	166	1.37	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1812	52.6	55.3	38.0		78.6
	5	Violent crime	4027	14.3	15.8	35.9		4.6
	6	Long term unemployment	1408	7.6	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	665	22.3	14.0	31.4		4.5
	8	Breast feeding initiation	1476	51.1	73.6	39.9		95.2
	9	Physically active children	20141	57.5	55.1	26.7		80.3
	10	Obese children (Year 6)	556	21.1	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	1.1	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	302	54.9	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	29.8	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	26.6	23.6	39.4		11.5
	15	Healthy eating adults	n/a	19.4	28.7	19.3		47.8
	16	Physically active adults	n/a	12.3	11.5	5.8		19.5
	17	Obese adults	n/a	28.6	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	27	9.4	13.1	27.2		3.1
	19	Hospital stays for self-harm	1059	382.2	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	6310	2581	1743	3114		849
	21	Drug misuse	1444	7.7	9.4	23.8		1.8
	22	People diagnosed with diabetes	12788	5.63	5.40	7.87		3.28
	23	New cases of tuberculosis	20	7	15	120		0
	24	Hip fracture in 65s and over	304	517.1	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	142	15.4	18.1	32.1		5.4
	26	Life expectancy - male	n/a	75.9	78.3	73.7		84.4
	27	Life expectancy - female	n/a	80.7	82.3	79.1		89.0
	28	Infant deaths	11	3.52	4.71	10.63		0.68
	29	Smoking related deaths	636	308.1	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	260	81.5	70.5	122.1		37.9
	31	Early deaths: cancer	459	143.9	112.1	159.1		76.1
	32	Road injuries and deaths	104	37.1	48.1	155.2		13.7

Source: Association of Public Health Observatories

3.1.2. Income inequalities

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



3.2 Challenges identified in the Joint Strategic Needs Assessment

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

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

The JSNA refresh has used a structured process with clear criteria, which continues to involve partners and the public. Further prioritisation will be carried out before the JSNA is considered by the Health and Wellbeing Board in February 2012, because we are in a time of economic turmoil and major system change which make it crucial that JSNA recommendations are clear about priorities based on a one Sunderland strategy; what

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

3.2.1 Summary of JSNA messages

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

Increasing life expectancy and reducing health inequalities;

A tiered approach to prevention and risk management;

Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;

Identifying those who would benefit from services and improving navigation through those services;

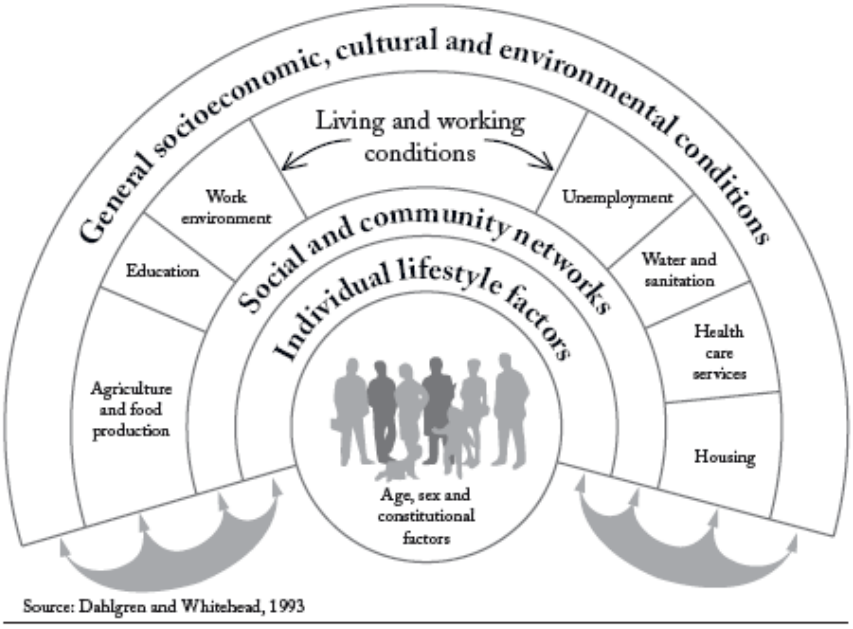
Integration of services, whether NHS, social care or other services which affect health (eg spatial planning, housing, transport, enhancing wellness and wellbeing thorugh libraries, wellness services etc);

Reducing health inequalities by focussing on the wider determinants of health, including deprivation, employment, education, housing, environment and by identifying neighbourhoods to target;

Commissioners and providers engaging with individuals, families, neighbourhoods, and communities in order to deliver on all the above.

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

Figure 1. The Main Determinants of Health



Source: Dahlgren and Whitehead, 1993

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

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

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

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

3.2.3 Life expectancy challenge

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

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

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

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

Use of Health Checks to identify asymptomatic hypertensives age 40–74 & start them on treatment;

Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;

Systematic cardiac rehabilitation;

Systematic COPD treatment with appropriate local targets;

Develop & extend diabetes best practice with appropriate local targets;

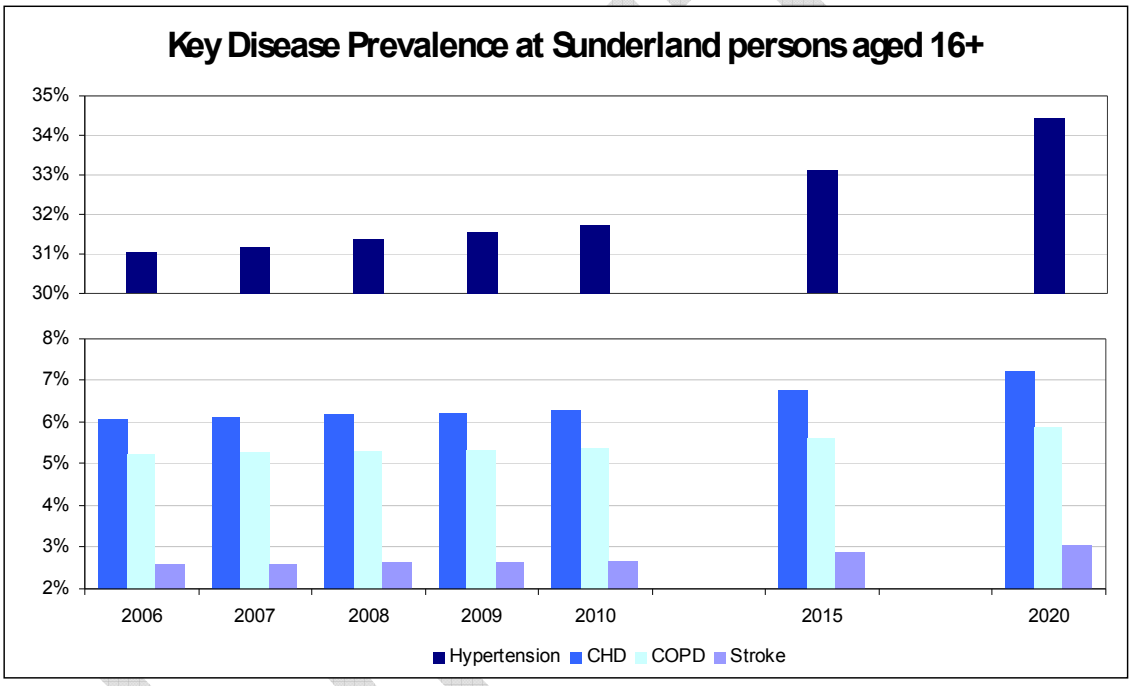
Best practice access to TIA clinics for stroke across South of Tyne and Wear;

Cancer early awareness and detection;

Identification and management of Atrial Fibrillation.

3.2.4 Expected disease prevalence

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



3.3 Challenges identified by patients, public, clinicians and partners

3.3.1 Patients and the public

Development of the JSNA includes extensive public involvement and takes into account both patient and public views. In addition there has been significant work done in Sunderland to gather the views and experiences of local people and use them to identify areas of service where we need to do better.

Further detail to follow…

3.3.2 Clinicians (including practices)

Clinicians have expressed concern in relation to the fragmentation and lack of integration of current services

Further detail to follow…

3.3.3 Partners and Stakeholders

To follow

3.4 Challenges set out in national policy

In addition to our local challenges, there are also a range of national priorities, targets and standards which we must deliver in Sunderland. These are described each year in the NHS Operating Framework.

3.4.1. Current performance challenges

The current 2011/12 PCT performance against national priorities is monitored and managed carefully but there are a few areas where the PCT are not expecting to reach the year-end targets and standards. These are shown in the table below, split between those for which we will have a direct commissioning responsibility in the future (and some are in our current Pathfinder) and those we will help our partners to deliver through their commissioning:

Clinical Commissioning Group Commissioning responsibility	§ % patients spending 4 hours or less in an accident and emergency department § Emergency admissions to hospital § Unplanned re-attendance at an accident and emergency department § Hospital outpatient attendances § Outpatient referrals from GPs § Patients waiting more than 6 weeks for diagnostic tests § Elective admissions to hospital § Patients treated in mixed sex hospital accommodation § Clostridium difficile infections § % first outpatients made via Choose and Book system
Partner commissioining responsibility	§ Deaths from cardiovascular disease per 100,000 population § Deaths from Cancer per 100,000 population § All age all cause mortality for both males and females § Chlamydia screening § % of pregnant women who smoke § Rate of hospital admissions for alcohol related harm § Teenage conceptions § Childhood Immunisations § % women totally or partially breastfeeding at 6-8 week check

3.4.2 Additional challenges in the NHS Operating Framework 2012/13

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

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

- Emergency Preparedness

The Framework emphasises that the experience of patients, service users and their carers should drive everything the NHS has to do. It sets out the key performance measures which will be subject to national assessment:

Quality

1 Preventing people from dying prematurely

- Ambulance quality (Category A response times)
- Cancer 31 day, 62 day waits

2 Enhancing quality of life for people with long term conditions

- Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)
- Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)

3 Helping people to recover from episodes of ill health or following injury

- Emergency admissions for acute conditions that should not usually require hospital admission

4 Ensuring that people have a positive experience of care

- Patient experience of hospital care
- Referral to Treatment and diagnostic waits (incl. incomplete pathways)
- A&E total time
- Cancer 2 week waits
- Mixed-sex accommodation breaches

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

- Incidence of MRSA
- Incidence of *C. difficile*
- Risk assessment of hospital-related venous thromboembolism (VTE)

Public Health

- Smoking quitters
- Health checks

Resources

- Financial forecast outturn & performance against plan
- Financial performance score for NHS trusts
- Delivery of running cost targets
- Progress on financial aspects of QIPP
- Acute bed capacity
- Activity (eg Elective and non-elective consultant episodes; Outpatients; Referrals)
- Numbers waiting on an incomplete Referral to Treatment pathway
- Health visitor numbers
- Workforce productivity
- Total pay costs
- Workforce numbers (clinical staff and non-clinical)

Reform

- **Commissioning Development**
  - % delegated budgets
  - Measure of £ per head devolved running costs
  - % authorisation of clinical commissioning groups
  - % of General Practice lists reviewed and "cleaned"
- **Public Health**
  - Completed transfers of public health functions to local authorities
- **FT pipeline**
  - Progress against TFA milestones
- **Choice**
  - Bookings to services where named consultant led team was available (even if not selected)
  - Proportion of GP referrals to first outpatient appointments booked using Choose and Book
  - Trend in value/volume of patients being treated at non-NHS hospitals
- **Information to Patients**
  - % of patients with electronic access to their medical records

3.5 Challenges posed by existing provider landscape

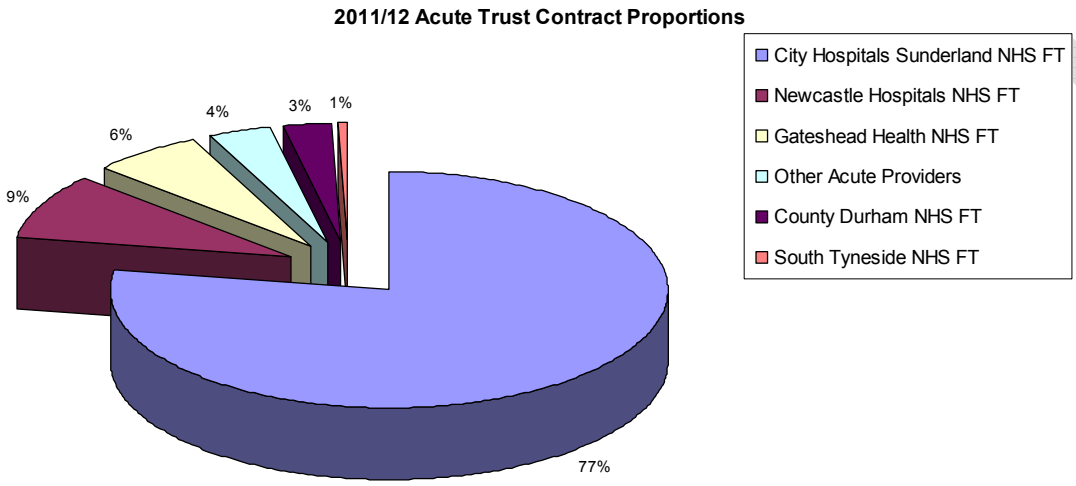
As well as the health and service challenges described in this chapter, the services which we are able to commission are constrained in the short term by the current shape and availability of local services and the major challenges involved in any significant change to this configuration and pattern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

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

3.5.1. Current pattern of acute hospital use

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

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



3.5.2. Current pattern of Community Service use

There are lots of different types of community services such as Community Nursing, Allied Health Professionals and Therapies which are currently commissioned from a range of different providers, including the community services arm of South Tyneside NHSFT, the voluntary sector and the independent sector (including care home providers). A number of these services are jointly commissioned with Local Authorities. The annual value of community services contracts in Sunderland including Continuing Healthcare and Funded Nursing Care, is £xmm:

3.5.3 Current pattern of Mental Health Service use

The majority but not all of mental health and learning disability services are commissioned from Northumberland, Tyne and Wear Mental Health Foundation Trust which provides a wide range of mental health, learning disability and neuro rehabilitation service to a population of 1.4 million people working from over 160 sites covering 2,200 square miles in the North East. Other services include urgent care mental health, Planned care services, Specialist care services and Forensic services.

3.6 Challenges likely in the future

As well as the challenges we have identified from the analyses and insights into current health and services, we have used a set of predictive models developed by NHS South of Tyne and wear to identify further challenges we will be facing in the future.

The modelling also allows us to ensure that:

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

tariff equivalent efficiencies, with a high level view of how these implications will be managed.

3.6.1 Hospital Activity Model

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

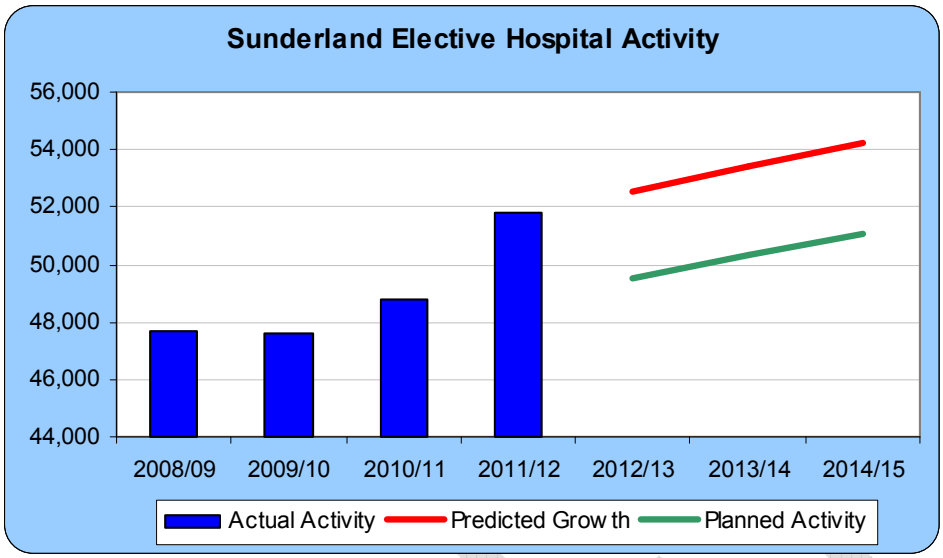
In the shorter term, if we do not change the way in which our services are provided, we would expect to see the following growth in hospital activity levels over the next three years.

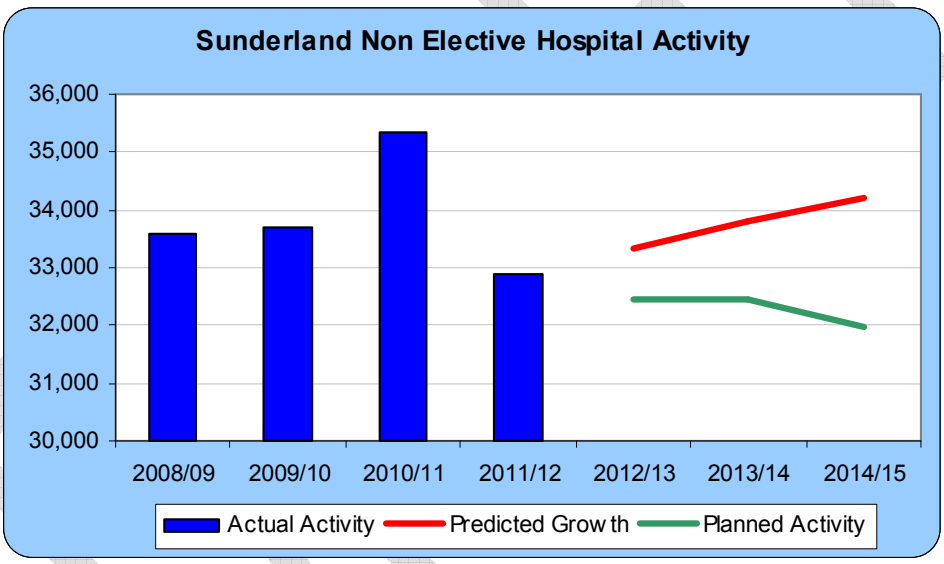
	2012/13	2013/14	2014/15
Elective Hospital Spells	1.49%	1.65%	1.48%
Non Elective Hospital Spells	1.32%	1.43%	1.14%
First outpatient attendances	1.53%	1.82%	1.69%

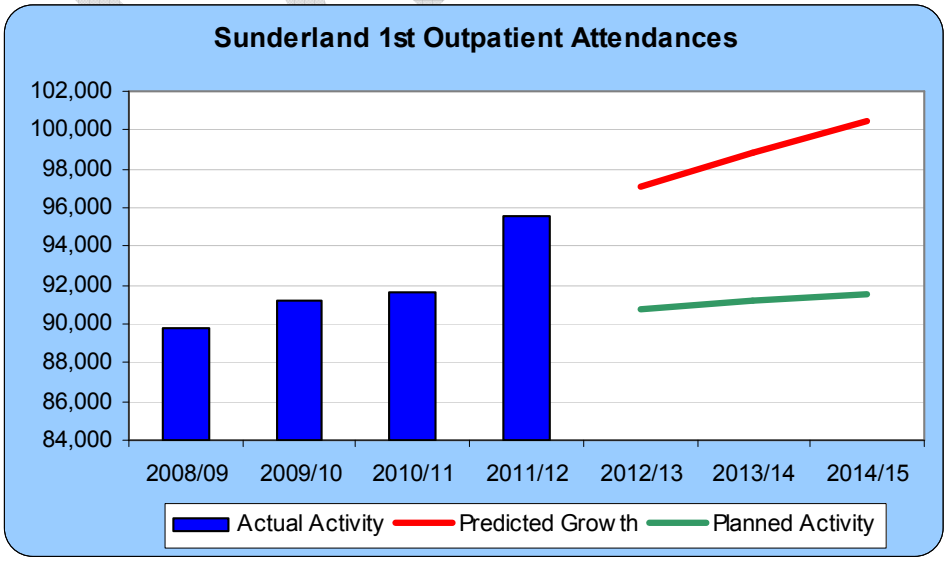
Similar increases in accident and emergency attendances are also expected, if we do not change how these services are provided.

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

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







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

3.7 Financial Challenges including QIPP

Financial allocations are not expected until late January / Early February. Until share of finance is known we are unable to detail a balanced financial plan.

However we do know that the levels of hospital activity being seen in 2011/12 exceed current contracts significantly. Until we know our likely share of the current PCT budget we cannot identify the extent of financial pressure on us in future years but we are expecting that we will have to deliver at least the current QIPP programme and are likely to have to identify further initiatives to release resources to allow us to fund the costs of healthcare in the coming years.

Section 4 – Strategy

4.1 Our Success so far

Our pathfinder application set out the following priority areas:

- Urgent Care
- COPD
- Prescribing
- Clinical Effectiveness.

Our achievements to date against these priorities are highlighted below:

Urgent Care

- We have ensured strong links between the Urgent Care and COPD agenda in work areas we have responsibility for.

- Following a review of pathway information and meetings with Community Team manager and Community Health Services at South Tyneside Foundation Trust, we have developed a project plan to address fragmentation issues with Primary and Community Teams to ensure seamless care. Recently we have agreed with the Trust to pilot a single point of access to currently 2 separate teams to minimmise the current confusion about which team to access in what circumstances.

- We have introduced a standard Emergency Assessment Proforma for all Sunderland GPs to use before sending a patient to secondary care for assessment or admission which incorporates an Early Warning Score (EWS) increasing GP awareness of any alternative services which could be used to manage the patient in the community (depending on the EWS and clinical judgment).

- We have provided all GPs with proforma pads to use on home visits for patients in need of assessment or admission to hospital and have electronic versions available within practice which pre-populate key information.

- We are currently developing a community based cellulitis pathway to allow suitable patients who require intravenous (IV) antibiotics to be treated in the community instead of triggering a hospital admission with a short length of stay and have developed a protocol using a specific IV antibiotic drug.

- We have prioritised funding to implement a community based Anticoagulation Initiation and Monitoring Service in 2012/13 and have rolled out the software tool (GRASP-AF) which identifies patients with Atrial Fibrillation who are suitable for anticoagulation to all practices providing appropriate training to ensure patients are indentified and treatment commenced for those at risk of stroke.

- We are currently developing a community based service for DVT with a clinical lead appointed to develop the pathway.

- We have discussed and agreed options for the newly built Houghton Primary Care Centre in terms of most appropriate Urgent Care facilities to best suit the local population as part of developing our short, medium and long term strategy for urgent care in Sunderland.

COPD

- We have taken leadership of improving the quality of care for people with COPD across the whole health care system and have developed the Sunderland COPD Improvement Group (SCIG) specifically to take forward these actions. We have signed a joint working agreement with the Pharmaceutical Company GSK to support some parts of the project plan. All practices are developing individual action plans, with the aim of reducing variation in the quality of care provided across Sunderland. Practices have made early progress in improving the percentage of patients on the COPD register who have disease severity coded, in quarter 1 2011/12, 70% of COPD patients had severity coded and by quarter 2 this had risen to 81%.

- We have undertaken a training needs analysis to ensure primary care staff receive appropriate training in the care of COPD patients.

- Spirometry interpretation sessions have been organised and most practices have sent along at least one GP/practice nurse and there is a waiting list for future sessions.

- All practices have reviewed their palliative care registers and completed an audit for these patients. An education session has been delivered for all practices focusing on the prognostic indicator guidance and when COPD should be considered for the palliative register.

- We have developed a standardised patient information pack for distribution to patients attending for annual reviews. A self-management plan has been agreed and is being discussed with patients as appropriate.

Prescribing

- We have appointed a Prescribing lead to take forward the prescribing agenda including cost effective prescribing. Working closely with the Medicines Management Team, a Prescribing Incentive Scheme has been developed to encourage practices to be proactive in driving down prescribing spend whilst improving the quality.

- The Prescribing group is currently developing educational materials to aid practices to increase repeat prescribing within Primary Care, as it has been proven to improve patient care whilst reducing medicines waste. This follows engagement in a week long Rapid Process Improvement Workshop with all key stakeholders on the subject. The initial data has shown a 2.2% increase in repeat prescribing from April 2011 to August 2011.

- We are currently rolling out a project to allow pharmacists to undertake Medicines Reviews within Sunderland Care Home to reduce prescribing errors.

- We have introduced a prescribing incentive scheme, setting a target of 80% for practices to achieve in relation to patients on all 4 drugs post-MI. All practices have received baseline data with regard to the 4 drugs post MI and have been given guidance on how to review patients. From Quarter 1 2011 to Quarter 2 2011, there has been a 1.5% improvement.

Clinical Effectiveness

- We have appointed a lead to address clinical effectiveness in primary care and a programme has been devised which is split into three areas: informing, changing and monitoring.

- We have identified early priorities which include raising awareness of lung cancer among patients attending COPD, CVD and smoking cessation clinics.

- The clinical lead has developed detailed guidance in the Local Incentive Scheme and “Be Clear on Cancer” leaflets have been distributed to all practices.

- We have organised an educational event in January 2012 to raise awareness of early diagnosis and practices have been asked to follow NICE guidance when referring coughs.

- We have been heavily involved with the work around QOF QP indicators for Emergency Admissions and Outpatient Appointments. Practices have been given data on both areas and have reviewed this information within their practices. The practices have taken part in an External Peer Review Process to look at pathway issues and ideas on how to reform and improve pathways. These ideas will be fed in to the Commissioning Intentions process for the next year and influence the development of alternative pathways. This work has also to an agreement for all practices to follow 6 key pathways in 2011/12 in order to have a positive eimpact on the overperformance in planned care this year and next year.

Other work Areas

- We have taken a lead on the review of the District Nursing service provided by Community Health Services at South Tyneside Foundation Trust. All practices within Sunderland have received a questionnaire in relation to current service provision and we have held a development session to ensure the service specification meets the needs of Sunderland patients.

- We have added value to the service specification and participated in the procurement of the new Houghton Intermediate Care service.
- We have added value and supported the business case for the development of the new build Hospice planned for Sunderland.
- We have assured the recovery plans for the dermatology service currently contracted from County Durham Hospitals following staffing changes to the service and will be leading the review of the model for dermatology services next year.
- We have engaged in and supported a pilot for counselling services as part of a spectrum of support for people with common mental health problems and prior to AQP developments
- We have engaged in and influenced the selection of the 3 AQP pathways for the next year.

4.2 Overview of our Strategic Objectives and initiatives

In order to achieve our Vision by 2017, we have identified three key **strategies** for moving from our current position to our desired future state:

Prevention, empowerment and resilience;

Seamless integrated pathways

Mature Clinical relationships which add value and increased standardisation

We have identified the 9 Overarching Outcome Measures detailed within the NHS Outcomes Framework for 2012/13 as key outcomes to quantify our five year ambitions and will use national and international benchmarks to identify challenging but achievable aspirations.

In order to achieve the 9 Overaching Outcome Measures we have identified 8 Strategic Objectives.

Active role in Delivery of the Health and Wellbeing strategy
Screening and early identification
Mental Health- integrated and tiered approach
Integrated Urgent Care - responseive and easily accessible
Long Term Conditions – Improving the quality of Care across the whole system

Providing More Planned care closer to home

Systematically improving the quality of prescribing in Practices

Standardisation in Primary Care – every Practice operating to agreed standards and pathways, working collaboratively with partners

The following diagram shows a "map" of our strategy:

From challenges (where are we now?);

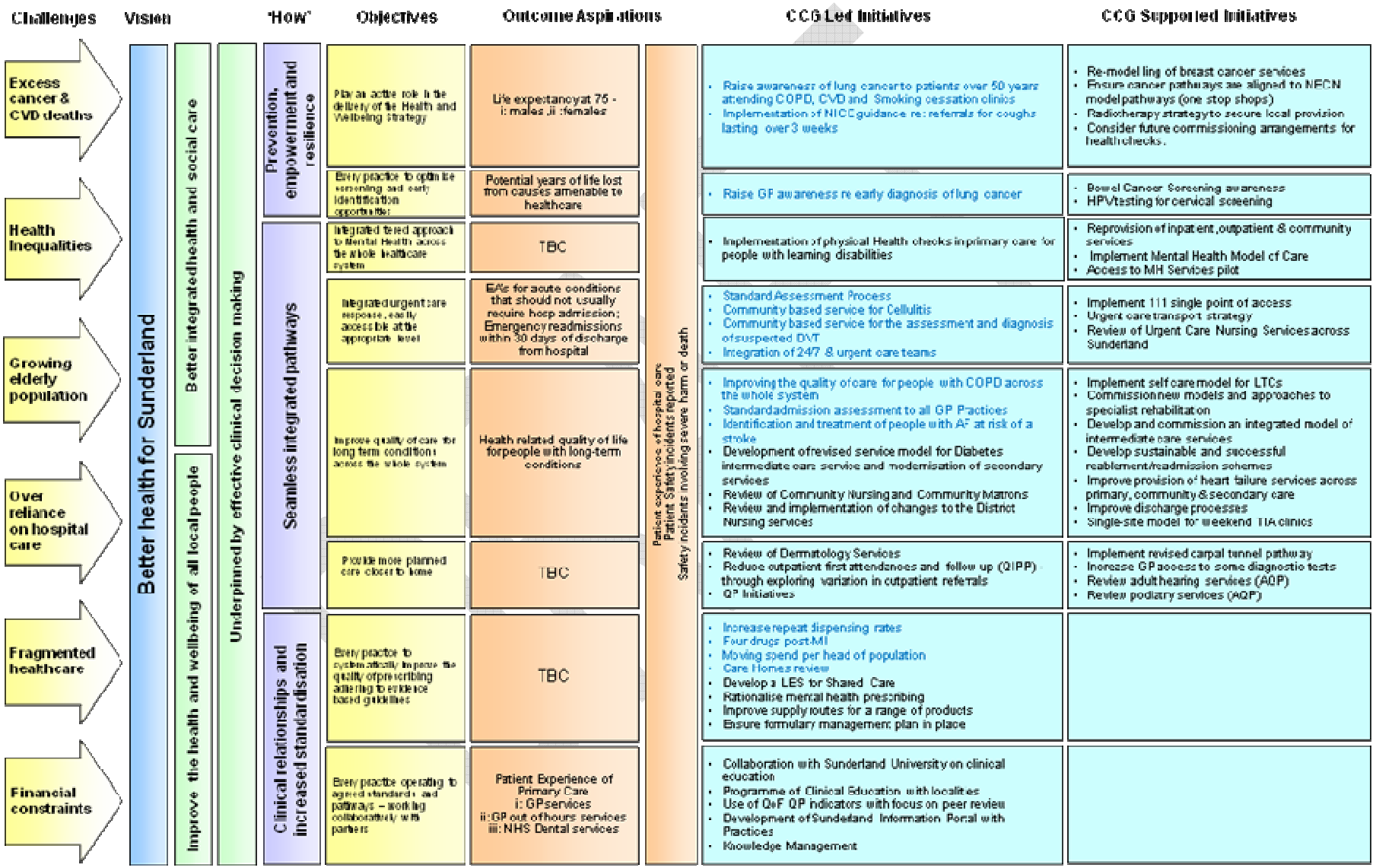
Through vision (where do we want to be?);

'The How' and Objectives (how will we get there?);

Outcomes (how will we know when we get there?);

To initiatives (what actions do we need to take?).

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



4.2 Initiatives to deliver changes

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

These detailed changes need to be well developed and agreed by the end of December 2011 so that they can be included in 2012/13 contracts (for which negotiation takes place from January to March 2012). This timescale means that our longer term strategy, which is just taking shape now as the Board develops its five year plan, has influenced and shaped the detail for 2012/13 rather than determined it, as will be the case for 2013/14 onwards. The initial list of changes was generated from the PCT legacy strategy but has been the subject of scrutiny and change from ourselves as our own longer term strategy emerges.

2012/13 is a year of transition, as commissioning transfers from PCT to CCG. We have already agreed delegated responsibility in 2011/12 for the priorities set out in our Pathfinder application. We have agreed that we wish to extend our lead delivery role to a number of other priorities in 2012/13, on a path to accountability for the full agenda from April 2013. Taking on increasing responsibilities on a phased basis will both assist with our rapid development as an effective decision making body and provide the evidence of delivery which is needed for CCG authorisation.

A process has been used to enable us to:

- become familiar with the full agenda to help in determining our 5 year plan;
- influence, shape and change the commissioning intentions or detailed changes planned for 2012/13;
- decide which areas we wish to lead in 2012/13, in addition to our Pathfinder commitments.

Over two extended Executive Committee development sessions, the PCT lead officers for each programme within the existing PCT Integrated Strategic and Operational Plan (ISOP) have described in detail the proposed changes for 2012/13, with detailed discussion and challenge by ourselves. The sessions also included the Locality Practice Manager Lead

and a Local Authority representative. The Practice Manager Leads in particular to help consider how to share the intentions with Localities.

At the end of each programme discussion we agreed a “long list” of the changes which we considered suitable to lead in 2012/13.

We then agreed a set of standard criteria against which the long listed changes would be judged and used a simple scoring system, shown below, to score each change, in a facilitated Executive discussion. The simplicity of the scoring helped the discussion but also meant some subtleties of impact and do-ability needed to be reflected in addition to the scores and this is reflected in the outcome of the process.

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

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

- Reduce outpatient first attendances through 'Exploring variation in outpatient referrals'
- Review role and effectiveness of community matrons and community nursing
- District nursing review
- Diabetes intermediate care
- Health checks for people with learning disabilities
- Dermatology

4.3 Strategic Programmes

Context, Vision, Strategy, Initiatives, Outcomes, Measures

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

Why is change needed?

How do we want the future to look?

What are we doing about it?

What impact will these actions have?

How much will this cost or save?

What capacity and capability is needed to deliver the planned changes?

What is distinctive about the planned approach?

How do planned initiatives improve quality, prevention and productivity through innovation?

How will we know we are doing what we planned and that our actions have the desired impact?

MEDICINES MANAGEMENT

Why is change needed?

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

Objective

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

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

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

What are we doing about it?

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

How much will this cost or save?

What KPIs will we use to monitor progress?

Headline Measures

Supporting Measures

Local Measures

- Prescribing Cost growth
- Prescribing cost per Astro-Pu
- Individual Practice performance versus budget
- Percentage of prescribed items as repeat dispensing
- 4 Drugs post MI

Implications, Risks and Mitigating Actions

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

Communications Implications

- Communication strategy required with all key stakeholders

Informatics Implications

- Monitoring of action plans

Estates Implications

- Minimal

Workforce Implications

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

4.4 Prioritisation and financial strategy

To follow

4.5 Impact of our strategy on the market

To follow

Section 5 – Delivery and Transition

5.1 Overview

to follow

5.2 Organisational Development

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

An Organisational Development Plan has been developed in order to:

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

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

5.2.1 Internal Leadership

5.2.1.1 Executive Committee

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

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

This baseline position therefore formed the basis of the Organisational Development Plan; twelve high level objectives were identified for development incorporating the areas for improvement in relation to each of the six domains required to achieve authorisation. The objectives were prioritised and milestones with agreed timelines agreed for implementation.

As a result a critical path for development has now been established with nominated Board leads.

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

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

9	Complete and review Locality work – including Practice Manager leads	Domain 1, 3 & 5 *Main Domain 1*	H Choi	March 2012
10	Complete Board appointments including appointing Practice Manager and Practice Nurse	Domain 1, 3 & 5 *Main Domain 1*	I Pattison I Gilmour	P Manager – December 2011 P Nurse – January 2012
11	Ensure effective Clinical Leadership - agree personal development plans and appraisals for all Board members	Domain 1, 2 & 5 *Main Domain 5*	I Pattison J Gillespie	Ongoing appraisals by March 2012 with 6 monthly reviews
12	Build an effective relationship with the Health and Well Being Board	Domain 1, 4 & 6 *Main Domains 1 & 6*	I Pattison B Arnott	Dec – March 2012 - Ongoing

5.3 Primary Care involvement

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

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

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

5.4 External Leadership

To follow

5.5 Working with partners and stakeholders

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

We recognize that there are many stakeholders and partners with whom we need to engage over time and in a variety of ways. We agreed a draft Communication and Engagement Strategy in November 2011 which sets out key objectives to support effective engagement, including reputation management. The first key action being a development session planned for early January 2012 to undertake a formal and systemic stakeholder mapping exercise together with a review regarding how best to effectively manage communications with the various stakeholders (acknowledging that we will need to utilise a range of communication mechanisms).

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

Executive Committee members meeting key stakeholders to update on the development of the Plan (initial 2012/13 Commissioning Intentions have already been shared with providers and the Local Authority);
Draft Plan being available on the website;
Opportunity for discussion at Local Engagement Board meetings with the public and also at Local Overview and Scrutiny Committee;
Accessing LINK and utilising the Voluntary Sector and Local Authority mechanisms to share information with the public;

Use of social media and interactive technology to develop interactive and responsive engagement mechanisms that can be public led (particularly useful with younger age groups).

5.6 Health and Well Being Boards

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

As part of the work programme of the Health and Well Being Board, we are participating and updating on a number of developments including:

Delivery of the refreshed JSNA which includes a broad range of health determinants (members of the CCG have input into specific aspects of the JSNA including tobacco, alcohol, long term conditions, cancer); the next phase will be to engage with local practices regarding the emerging implications;

Development of the Sunderland Health and Wellbeing Strategy;

Development of the 2012/13 NHS South of Tyne and Wear Commissioning Intentions;

Regular updates regarding the development of the CCG including development of this Plan, the CCG authorisation process and alignment with Sunderland Regeneration areas;

A review of all current joint commissioning arrangements (including Alcohol, Drugs, Mental Health, linked health and social care commissioning for adults and children)

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

5.7 Patients and the Public

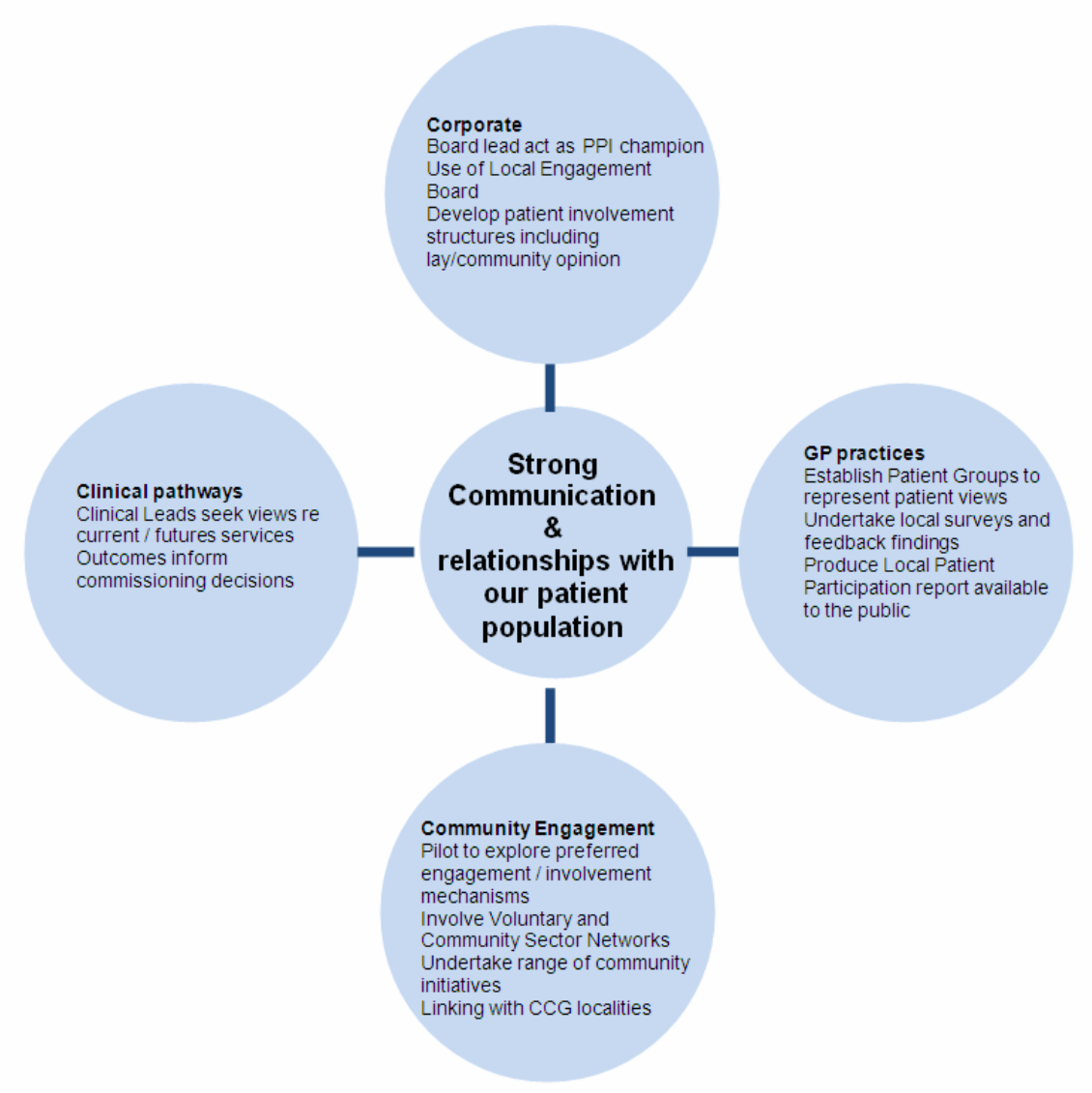
We are committed to excellent patient care and it is essential that strong communication and relationships are developed with our patient population in order that local people are meaningfully involved in the development and implementation of our Commissioning Plan. It is vital that patients are actively engaged in shaping the planning and delivery of local

services in order to ensure that their needs and wants are met, and that healthcare is accessible and responsive to their views and experiences. We have a unique position in that we communicate with patients on a daily basis and welcome the opportunity to harness this experience in order to develop strong and effective ties with the community.

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

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

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



5.8 Commissioning Support

5.8.1 Current support from the PCT

to follow

5.8.2 Commissioning Support Organisation

The shared operating model for PCTs has made clear that Clinical Commissioning Groups should be centrally involved in the development of the commissioning support that will help them to achieve their objectives. Commissioning support will need to help CCGs to achieve their objectives and give the CCGs the information and support they need to take effective commissioning decisions and then make them into a reality. We are currently considering the issue of Do; Buy or Share ie: how much support we want to provide ourselves; how mych we want to share with other CCG's and how much we want to buy from a Commissioning Support Organisation.

We will continue to help shape the commissioning support through ongoing local discussion and as part of regional discussions on the plans to develop one commissioning support organisation for the North East but with a local presence in South of Tyne and Wear.

We will look to the commissioning support to fully support our roles, responsibilities and statutory duties. Commissioning support will need to be customer focused and designed around our needs and requirements. We will require a high quality, responsive and flexible business support solution that will enable the Executive Committee to take responsibility for commissioning local healthcare successfully.

Commissioning support across a number of key service lines is envisaged including commissioning and business support services as outlined in the table below:

Commissioning support services	Business support services
• Planning and health needs Assessment • Service redesign • Provider Management • Procurement and Market Management • Performance • Quality and safety	• Business Intelligence • Assurance • Information Technology Services • Estates and Facilities management • Corporate Support Services • Medicines Management • Communications and Engagement

• Continuing Healthcare • Financial Management	

In developing our vision for local healthcare, we will require a flexible menu of services that can be tailored to meet our specific local requirements depending on the outcome of our considerations of the model of support that best suits our needs eg: provided directly; share; purchased or a hybrid of all of these options.

We will seek to be actively involved in shaping the development of commissioning support arrangements including responding to the initial offer outlined in the Prospectus from the North East CSO in December and informing the preparation of its Outline Business Plan in January and Final Business Plan in June 2012.

5.9 Delivery of safe high quality care

To follow

5.10 Workforce

To follow

5.11 Estates

To follow

5.12 Informatics

To follow

5.13 Proactive Management of Risks

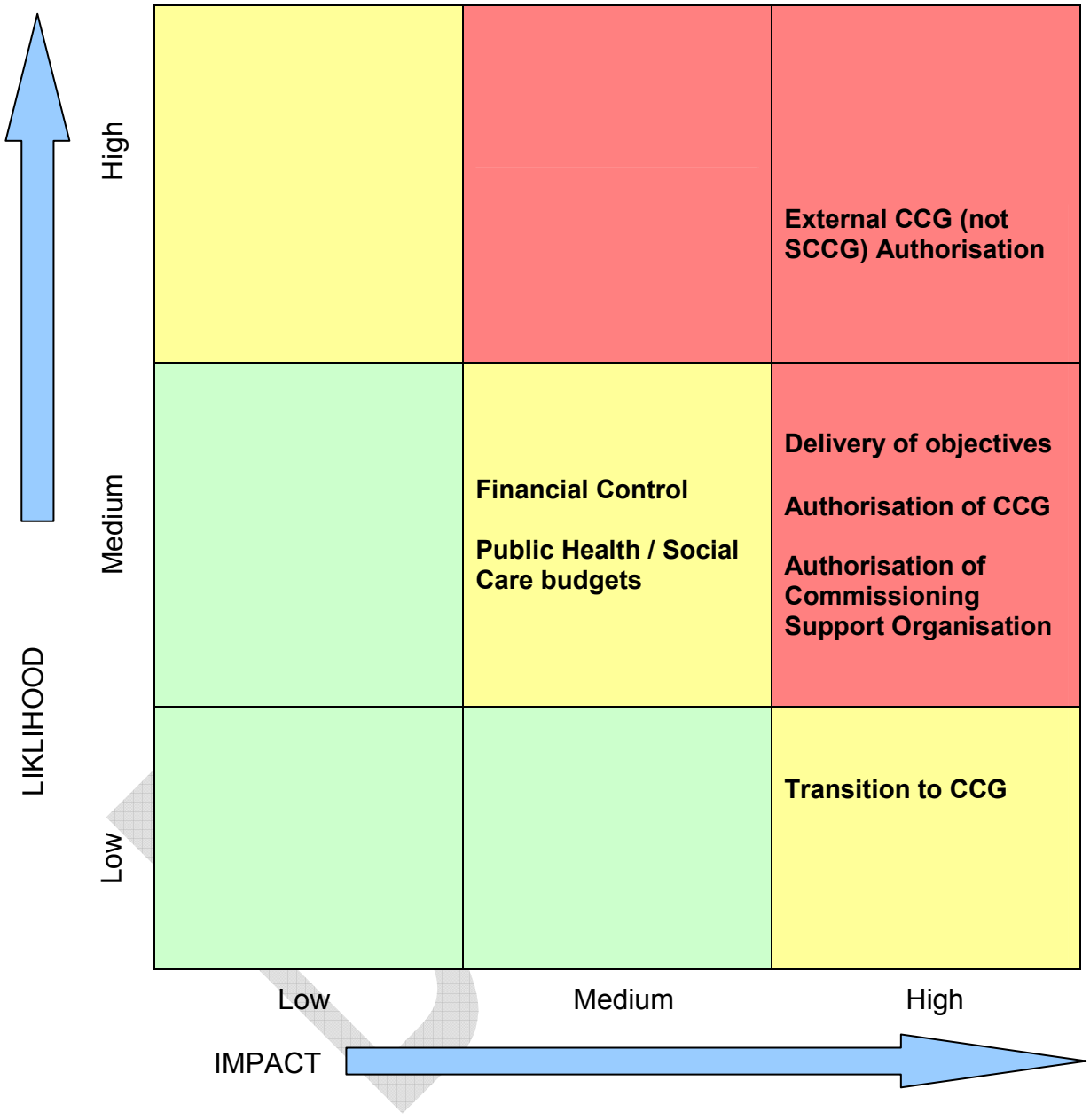
5.13.1System Risks

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

From the detailed analysis underpinning these high level risks, a number of cross-cutting risks to delivery have been identified, which predominately reflect the impact of undertaking

system wide transformational change in the short to medium term. These have been assessed for impact and likelihood and are plotted on the following chart.

Assessment of cross cutting risks



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

RISK LOG

Failure to meet control total and deliver financial balance and QIPP savings as part of the of pathfinder delegated authority ***Impact – Medium Likelihood – Medium***	
Delivery risks § Comprehensive Spending Review (CSR) confirms NHS funding through to 2014/15 with allocations only for 2012/13, consequently future plans based on assumptions derived from CSR § 40% management cost reduction over three years § Tight control totals reduce flexibility § Ability to manage/control secondary care demand and financial impact § Reduced level of resource arising from penalties within new tariff regime ? § PCT target saving includes £x.xm from xx resource releasing initiatives and £x.xm from prescribing efficiencies - CCG pathfinder bids include an element of the RRI programme relating to urgent care and prescribing – delegated accountability for delivery	**Mitigating actions** § Clear and Credible Plans incorporate financial plans based upon an agreed funding scenario for the period 2012/13 – 2014/15 § Detailed financial planning identifies range of risks and contingencies § Legally binding contracts include levers to manage activity § Additional funding for reablement services to help prevent admission and speed up discharge § Extend QIPP initiatives to generate further schemes to release efficiencies § 201 2/1 3 Integrated plans for each strategic programme include the RRI initiatives with savings to be delivered - signed off by either each Programme Board / Director § Progress against the financial savings is tracked through the integrated performance and planning system, reported to each CCG Pathfinder Committee ; note recent internal audit report on internal control confirmed that significant assurance could be given § Grip on delivery is managed via a number of internal forums including individual Programme Boards, Accelerated Bigger Picture Board (includes Chief Executives from NHS SoTW and Foundation Trusts), Collaborative Commissioning Team (involves CCG Pathfinder Committee Chair)

Failure to deliver strategic objectives and associated performance targets as part of pathfinder delegated authority *Impact – High, Likelihood – Medium*	
Delivery risk	**Mitigating action**
§ Underperformance against specific objectives during 2012/13 where CCG is the identified agreed lead § Unable to control demand for activity § Lack of clinical capacity within CCG to support deliver objectives § Lack of sufficient dedicated management capacity to support delivery	§ Integrated plans identified for delivery of specific initiatives supported by robust performance management framework including assessment of risks and mitigating actions § 2011/12 Integrated plans for each strategic programme include all the health improvement and performance requirements together with milestones, risks and mitigation actions - signed off by either each Programme Board or Director § Locally as part of Pathfinder Bid, undertaking review of outpatient referrals as part of the reduction in clinical variation and also considering alternatives to contribute to the on-going work to reduce activity levels § Menu of actions agreed with practices for better identification and management of high risk patients, referral standard and work with nursing homes § Progress against planned milestones is reported directly via Performance Update Report to Clinical Commissioning Pathfinder Committees § Activity overperformance is in escalation across all 4 PCT clusters with recovery actions and rigorous review of impact § Grip on delivery is reviewed via a number of internal forums including monthly review of performance by Clinical Commissioning Pathfi nder Committee, update at individual Programme Boards, visibility wall updates, specific escalation meetings, review at Collaborative Commissioning Team which involves CCG Pathfinder Committee Chairs § Alignment of staff Phase 2

Transition to Clinical Commissioning Arrangements *Impact – High, Likelihood - Low*	
Delivery risk	**Mitigating action**
§ Lack of clarity, capacity and capability to enable CCG Board to undertake commissioning role § PCT capacity to support transitional arrangements § Engagement of practices § Appointment of Clinical Leads	§ Production of Organisational Development Plan includes timeline of actions to enhance CCG commissioning knowledge, skills and expertise including joint working with practices, stakeholders, patients and the public § Terms of Reference, Ways of Working and Scheme of Delegation agreed with Constitution for CCG in development § CCG supported by Commissioning Development Unit with Head of Commissioning Development. PCT Executive Director aligned to each CCG § Detailed Transition Plan and Programme for Commissioning Development mapped to DoH Shared Operating Model for PCT Cluster, with supporting risk register § Locality sub structure and appointment of Locality PMs and PN's and link GP Executive Lead; TITO's Newsletter. § Lots of interest expressed and ability to flex offer to meet needs and use Executive Member and Locality Leads influence.
Failure to achieve Authorisation by local agreed date October 2012 ***Impact – High, Likelihood – Medium***	
Delivery risk	**Mitigating action**
§ Clear and credible plan is not signed off by North of England SHA § Capability and capability gaps within the CCG Board § Lack of support by partners including local Health and Well Being Board § Failure by Commissioning Support Organisation to achieve Authorisation within timescales § Failure to resolve the Do;Buy:Share option for commissioning support	§ Project plan in place to develop Plan including dedicated CCG Board development sessions § Ensure alignment of PCT 's ISOPs with Clear and credible Plan with regard to Finance, Performance and QIPP § Re-aligned capacity with PCT to support development of the Plan § Production of Organisational Development Plan includes timeline of actions to enhance CCG commissioning knowledge, skills and expertise § Proactive input in the development and implementation of the Health and Well Being Board – key link being DPH who is joint PCT / LA appointment on Health and Well Being Board and is also a member of CCG Board and the Chair and Governance Lead on the CCg Executive Committee are members of the Health and WellBeing Board. § Developing a comprehensive communication and engagement strategy including stakeholders, patients and the public § Development of CSO build upon identification of CCG customer requirements with engagement in the production of the business plan § Work on Do;Buy; Share model is underway and support from SHA and independent advice and

	appointment of AO and DoF, §

Failure of authorisation of neighbouring CCG's ***Impact – High, Likelihood – High***	
Delivery risks §	**Mitigating actions** § Relationships between 3 SOTW CCG Chairs and support from LMC's

Public Health and social care budgets prove insufficient to deliver required outcomes ***Impact – Medium Likelihood – Medium***	
Delivery risks §	**Mitigating actions** §

Failure of Commissioning Support Organisation to achieve authorisation ***Impact – High, Likelihood – Medium***	
Delivery risks §	**Mitigating actions** §

5.14 Governance

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

As part of our "internal" governance arrangements, we are preparing a Constitution which regulates the relationship between the Member Practices within the CCG and the elected members. The structure of the Constitution includes:

- Membership of Member Practices;
- Nominated representatives of Practices and their role;
- Arrangements for meetings of members such as through a “council of members”;
- Establishment of an Executive Committee consisting of Member leads – to have delegated powers from Member Practices for the overall management and Strategic direction of the CCG;
- Enabling the CCG through its Executive Committee’s representatives on the Clinical Commissioning Pathfinder Committee to have delegated responsibility for delivery of a key part of the PCT’s commissioning function and undertake the preparatory work for establishment as a statutory organisation;
- Matters that should be considered through the “council of members” in that we recognise the importance of engaging with member practices on a ongoing basis regarding commissioning decision making.

Whilst the PCT Board continues to be accountable for ensuring that it discharges its statutory duties for the commissioning of healthcare, governance arrangements have been put in place between the CCG and the PCT which provide for an accountability framework under which the Clinical Commissioning Pathfinder Committee operates as a sub-committee of the PCT Board under delegated authority during the transition period and until such time as the CCG is authorised and becomes a statutory organisation. Specifically, detailed terms of reference are in place governing the CCG’s role as a sub-committee of the PCT Board together with a detailed Scheme of Delegation with timescales setting out details of the functions for commissioning of healthcare, for which over time, the CCG will assume responsibility. Underpinning all of this work is the our commitment to the Nolan principles of openness, accountability and transparency; with these principles in mind, we have adopted a Conflicts of Interest policy which all Clinical Commissioning Pathfinder Committee members have signed up to.

As part of our journey towards authorisation, we are developing, in parallel with our Organisational Development Plan, a Governance Development Plan which takes into account the work of the National Leadership Council and the draft national Governance Framework for CCGs in supporting them with the development of their governance arrangements. Using this framework, we are developing effective governance and assurance arrangements which will be necessary in the short and longer term to meet our statutory responsibilities.

Section 6 – Declaration of Approval from Pathfinder Committee

To Follow