Appendix

NHS
Sunderland
Clinical Commissioning Group

Operational Plan 2014-2016

Refreshed March 2015
Version 0.6

Better health for Sunderland

Contents

1.0 Who are we?

Sunderland CCG (SCCG) are the statutory body responsible for planning, purchasing and monitoring the delivery and quality of most of the local NHS healthcare and health services for the people of Sunderland. We are made up of doctors, nurses and other health professionals with management support.

All 51 GP practices in Sunderland are members of NHS Sunderland CCG - so in the most part we are practising family doctors, although we do have a range of other clinical professionals working with us. The members have elected six GPs to lead the CCG on their behalf, working as part of a wider Governing Body which includes the local authority, lay members, senior managers, a hospital consultant and a senior nurse. The Governing Body and its formal committees are responsible for setting the strategy for health improvement in the city and ensuring the CCG delivers the improvements signalled in the strategy. In doing this we work very closely with other partners as members of Sunderland's Health and Wellbeing Board to improve the overall wellbeing of local people.

2.0 Our Vision and Strategic Objectives

2.1 Our Vision for 2018/19

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

We will deliver this through:

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

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

This operational plan describes the work we have undertaken in year 1 (2014/15) and the further work we will be undertaking in 2015/16 to lay the foundations to ensure the delivery of our vision and strategic objectives.

2.2 Our Strategic Objectives

The following table provides further detail on what our strategic objectives mean in terms of outcomes:

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

2.3 What will the future look and feel like?

The following table outlines what the future will look and feel like by 2019:

<table>
<tr><th colspan="3">Citizens (Adult, Child, Older Person, Carer)</th></tr>
<tr><td colspan="3">

- People are educated to self-manage where possible with the necessary support if required;
- Easily accessible advice;
- Once diagnosed someone co-ordinates the care you require and there is only one record which is shared with those who need it;
- Best use of Information technology to enable this to happen;
- Responsive providers;
- As local as possible.

</td></tr>
<tr><th>Member Practices</th><th>A&E Consultant</th><th>District Nurse</th></tr>
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<td>

- Feel part of a system which is efficient and joined up;
- Belonging to a community / locality;
- Able to use time effectively to influence change in the system.

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- Only see accidents and emergencies;
- Have great communications with primary care, social care and the rest of the system;
- Make best use of skills;
- Provide ‘remote’ advice via technology;
- Trust in the system;
- Wait for patients to arrive.

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- Will be part of a multidisciplinary team (24/7) in the community;
- Have a relationship with GP Practices;
- Make use of all skills;
- Specialist knowledge / advice to call upon;
- Understand how the system works.

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3.0 Values and Principles

3.1 Core Values

Informed through local engagement with member practices, patients and local people, we have identified a set of core values which will continue to shape and underpin all of the work we undertake to deliver our vision. These seven core values are outlined below around our vision:

3.2 System Principles

In order to deliver the transformational change set out in this plan the following system wide principles have been agreed:

- Our approach will be one of a single system for health and social care across Sunderland;
- Mental and physical health will be equally important, recognising both impacts on each other;
- To develop, as a principle, a team based working approach across the city;
- To share learning and approaches around demand management across the health and social care sector, but also wider public sector e.g: Sunderland City Council;
- A single Transformational Programme Board will oversee this work;

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

4.0 Meeting the needs for local people

4.1 Big Challenges for Sunderland

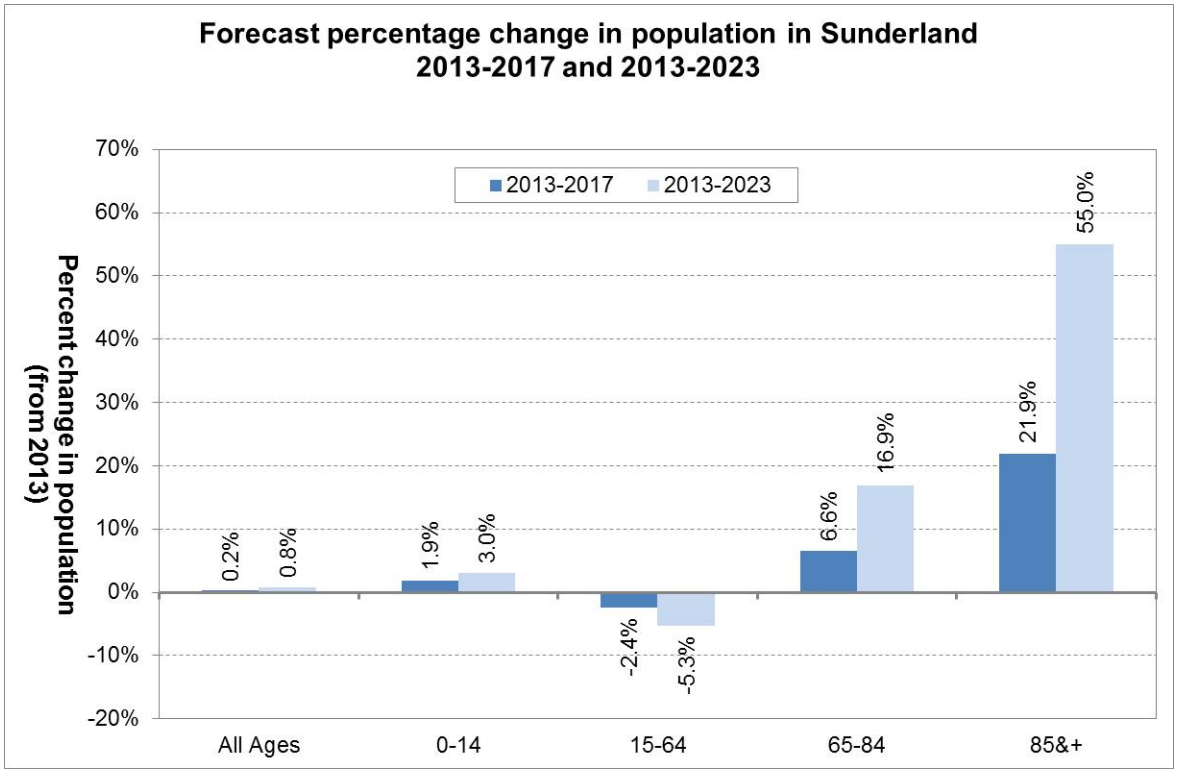
We have used a range of information and analyses to identify the big challenges facing the NHS in Sunderland. The challenges which we need to address through our commissioning and joint work with our practices and partners can be summarised as:

- **Mental Wellness as demonstrated by our poor outcomes in relation to depression and self-harm;**
- **Excess deaths, particularly from cancer, respiratory and circulatory disease;**
- **Health which is generally worse than the rest of England;**
- **A growing population of elderly people with increased care needs and increasing prevalence of disease who need to be supported to live independently;**
- **An over-reliance on hospital care;**
- **Services which are fragmented and lack integration.**

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.

4.2 Overview of the Sunderland population

There are approximately 276,080 people in Sunderland, with an increase of 2,179 (0.8%) forecast over the next 10 years. The age structure of our population is forecast to change significantly, as follows:



Source: 2013 mid-year population estimates, ONS; 2012-based subnational population projections, ONS

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five, ten and probably twenty years. Even if the general levels of health in these age groups continues to improve, the shape and structure of health services will need to change to meet the needs of this growing population, particularly as older people use services more often, have more complex needs and stay longer in hospital.

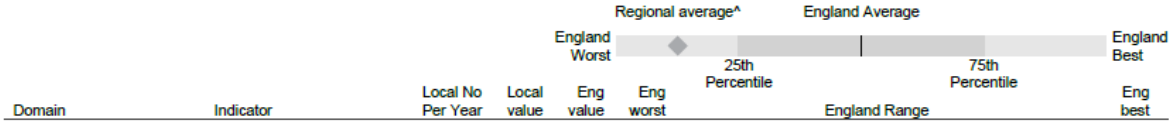
4.2.1 Overview of health in Sunderland

Levels of deprivation remain high within Sunderland. Seventy of Sunderland's 188 Super Output Areas are among the most disadvantaged fifth of all areas across England, and 37% of the Sunderland population lives within these super output areas. Levels of health and underlying risk factors in the area are amongst some of the worst in the country.

The 2014 Community Health Profile, shown overleaf, prepared by the Public Health England compares health in Sunderland to England averages, highlighting in red those measures which are significantly worse and in green those which are significantly better. The Community Health Profile for Sunderland can be seen overleaf. It is clear that on most health measures, Sunderland is significantly worse than the rest of England.

Health Summary for Sunderland

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.



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	102,038	37.0	20.4	83.8	0.0
	2	Children in poverty (under 16s)	12,655	25.7	20.6	43.6	6.4
	3	Statutory homelessness	125	1.0	2.4	11.4	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1,945	60.1	60.8	38.1	81.9
	5	Violent crime (violence offences)	1,907	6.9	10.6	27.1	3.3
	6	Long term unemployment	3,058	17.1	9.9	32.6	1.3
Children's and young people's health	7	Smoking status at time of delivery	523	18.5	12.7	30.8	2.3
	8	Breastfeeding initiation	1,705	60.3	73.9	40.8	94.7
	9	Obese children (Year 6)	546	21.3	18.9	27.3	10.1
	10	Alcohol-specific hospital stays (under 18)	47	86.1	44.9	126.7	11.9
	11	Under 18 conceptions	207	43.1	27.7	52.0	8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	23.4	19.5	30.1	8.4
	13	Percentage of physically active adults	n/a	47.8	56.0	43.8	68.5
	14	Obese adults	n/a	26.6	23.0	35.2	11.2
	15	Excess weight in adults	500	68.9	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma	35	12.3	14.8	31.8	3.6
	17	Hospital stays for self-harm	1,084	388.6	188.0	596.0	50.4
	18	Hospital stays for alcohol related harm	2,884	1,071	637	1,121	365
	19	Drug misuse	1,549	8.4	8.6	26.3	0.8
	20	Recorded diabetes	14,616	6.3	6.0	8.7	3.5
	21	Incidence of TB	18	6.5	15.1	112.3	0.0
	22	Acute sexually transmitted infections	2,222	807	804	3,210	162
	23	Hip fractures in people aged 65 and over	321	669	568	828	403
Life expectancy and causes of death	24	Excess winter deaths (three year)	121	13.6	16.5	32.1	-3.0
	25	Life expectancy at birth (Male)	n/a	77.0	79.2	74.0	82.9
	26	Life expectancy at birth (Female)	n/a	80.7	83.0	79.5	86.6
	27	Infant mortality	9	2.8	4.1	7.5	0.7
	28	Smoking related deaths	596	405	292	480	172
	29	Suicide rate	32	11.7	8.5		
	30	Under 75 mortality rate: cardiovascular	236	99.9	81.1	144.7	37.4
	31	Under 75 mortality rate: cancer	412	174	146	213	106
	32	Killed and seriously injured on roads	87	31.5	40.5	116.3	11.3

Indicator Notes

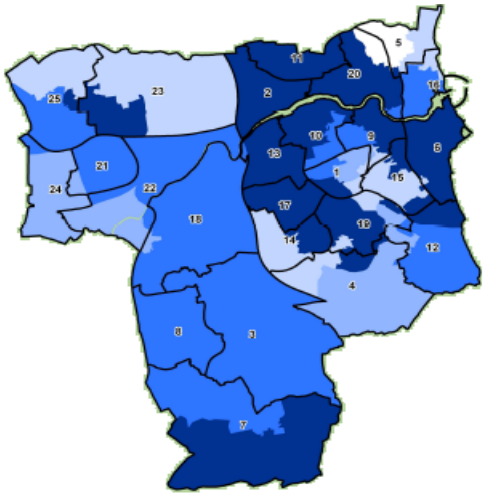
1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

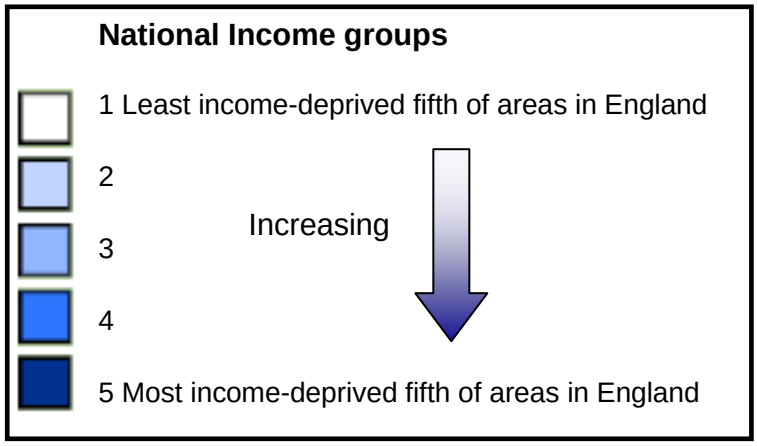
More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Source: Sunderland Health Profile 2014, Public Health England, © Crown Copyright 2014

4.2.2. 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.





4.3 Challenges identified in the Joint Strategic Needs Assessment

The JSNA is the process by which Sunderland City Council and Sunderland CCG, working in collaboration with partners and the wider community (including the third sector and patient/public groups), identify the health and wellbeing needs of the local population. It provides an insight into current and future health, wellbeing and daily living needs of local people and informs the commissioning of services and interventions to improve health and wellbeing outcomes and reduce inequalities. It sets out key priorities for commissioners and provides a health baseline for the development of this plan.

The Sunderland JSNA covers the wider determinants of health, takes account of priorities from the Marmot Review, updates the analysis of health and wellbeing information, gives greater insight into the expressed needs of local people, identifies where effective interventions to address needs are available but not taking place, and includes equality impact assessments as they are developed.

The JSNA uses a structured process with clear criteria, and continues to involve partners and the public. The Health and Wellbeing Board periodically reviews its priorities, based on the JSNA. Because we are in a time of economic uncertainty, it is crucial that the JSNA recommendations are clearly prioritised based on a "one Sunderland strategy", and identifies 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.

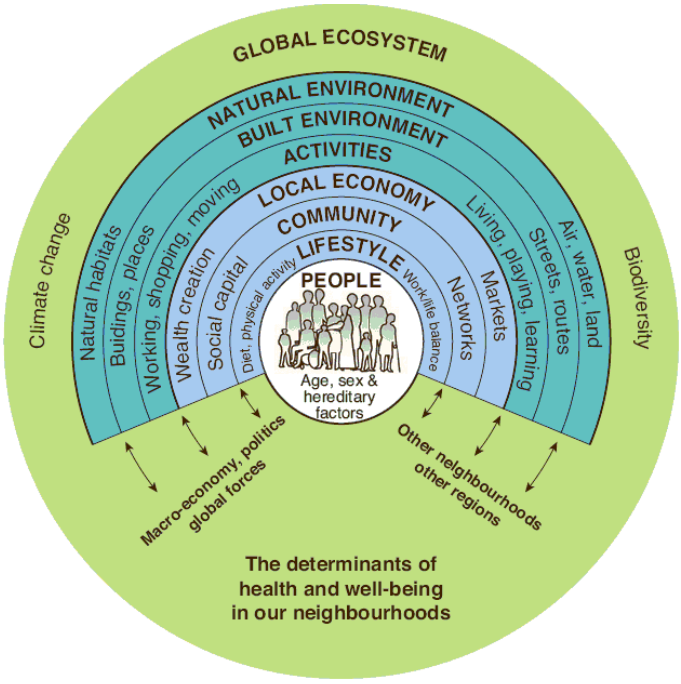
4.3.1 Summary of JSNA messages

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

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

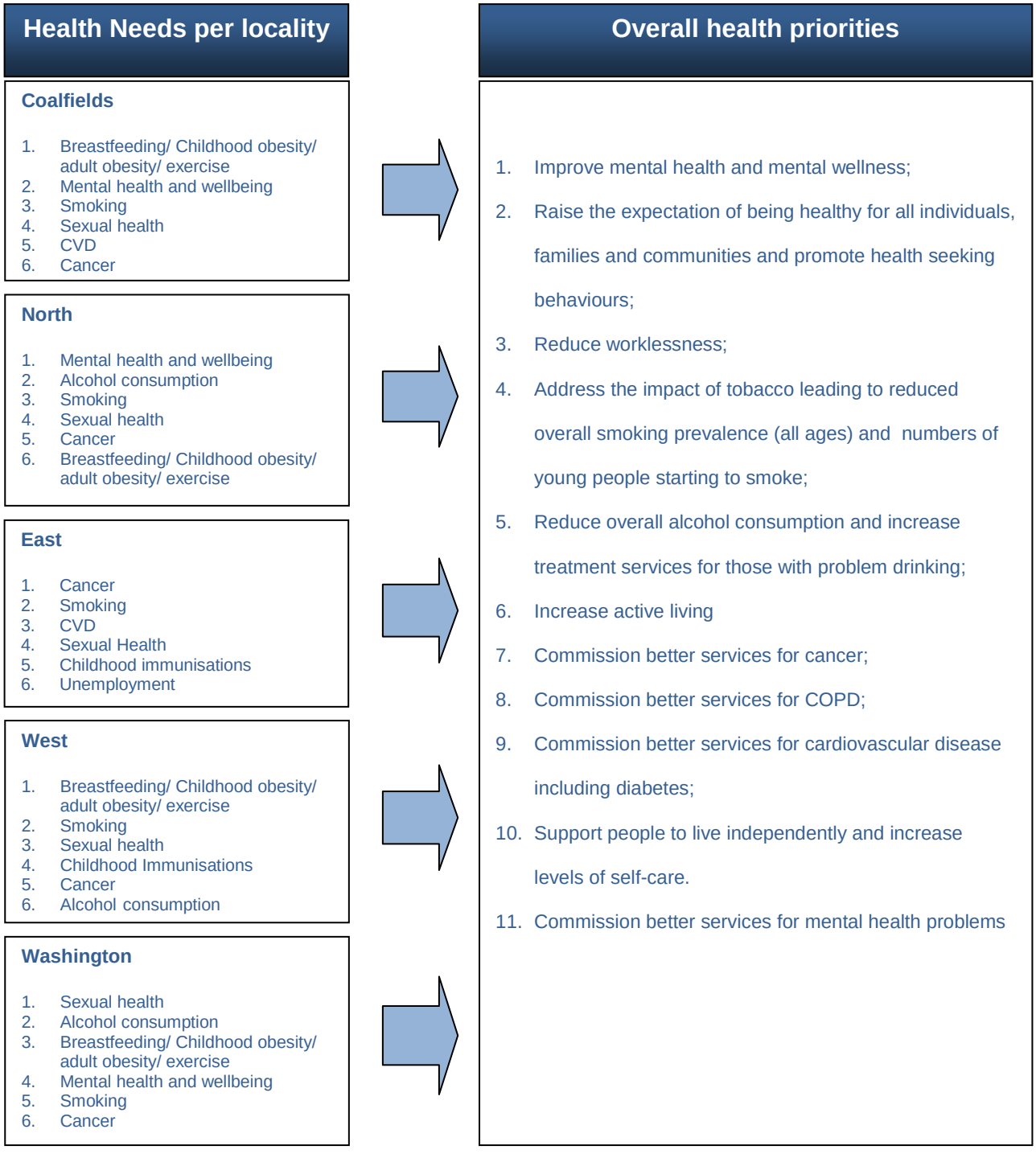
We have traditionally focused on treating illness but to improve health, we need to move, as represented by the following diagram, out into the concentric circles working with a broader range of partners, delivering our direct responsibilities and influencing partners to deliver theirs.

The main determinants of Health and Wellbeing



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

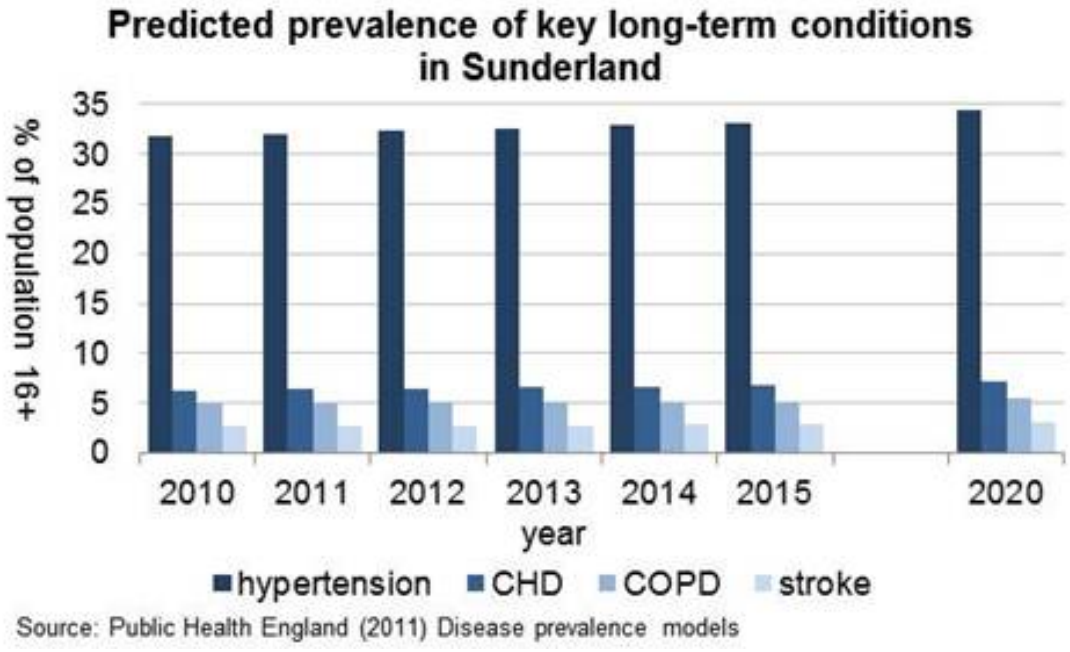
The JSNA is set out using profiles to highlight the needs of individual health groups and community areas; we continue to work closely with public health colleagues to identify health needs. The top 6 health needs per locality are outlined below along with the top ten priorities to improve health in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



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, through our participation in the Health and Wellbeing Board through added value that can be delivered from the services we commission and through ensuring that all of our member GP practices play a full part in this agenda. The locality structure, which enables groups of practices in a locality to work together, is a key mechanism through which we will deliver these improvements. From April 2015, we have also taken responsibility for commissioning core primary care general practice services.

4.3.2 Expected disease prevalence

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



Source: Public Health England (2011) Disease prevalence models

4.3.3 Life expectancy challenge

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

	England Average Life Expectancy	Sunderland Life Expectancy	Gap (%) *
Males Females	79.4 83.1	77.3 80.9	-2.7% -2.7%

Source: Life expectancy at birth and at age 65, England and Wales, 2011-13,

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

Just over 70% of the gap is caused by cancer, respiratory diseases and CVD and to address this, we have built on previously identified "High Impact Interventions" to deliver an effective approach to improving health and transforming care which our commissioning and work with partners and our GPs will contribute to:

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

5.0 National drivers and mandated areas

The NHS Five Year Forward View was published by NHS England on 23 October 2014 and sets out a vision for the future of the NHS.

The Five Year Forward View articulates why change is needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

The Forward View outlines that a radical upgrade in prevention and public health is needed and that NHS England will back hard hitting national action on obesity, smoking, alcohol and other major health risks.

The plan also outlines that strong public health related powers for local government and elected mayors will be given to enable local decisions.

Patients will also gain far greater control of their own care and there is a need to break down barriers in how care is provided across the health care economy.

There will be a focus on supporting people with multiple health conditions, rather than single diseases, however, there is recognition that one size will not fit all and so local health economies will be supported to choose from a small number of radical new care delivery options such as:

- Multispecialty Community Providers – Groups of GPs combining with nurses and other community health services, hospital specialist and perhaps mental health and social care to create integrated out-of-hospital care potentially employing hospital consultants, having admitting rights to hospital beds, running community hospitals or taking delegated control of the NHS budget.
- Primary and Acute Care Systems – The integrated hospital and primary care provider.

- Urgent & emergency care networks – Urgent and emergency care units re-designed to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services.
- Viable smaller hospitals - Smaller hospitals having new options to help them remain viable, including forming partnerships with other hospitals further afield and partnering with specialist hospitals to provide more local services.
- Specialised care – Specialised services to develop networks of services over a geography, integrating different organisation and services around patients using innovations such as prime contracting and / or delegated capitated budgets.
- Modern Maternity Services – NHS England will commission a review of future models for maternity services and midwives will have new options to take charge of the maternity services they offer.
- Enhanced care in care homes – new models of in-reach support, including medical reviews, medication reviews and rehabilitation services.

In all cases one of the most important changes will be to expand and strengthen primary and out of hospital care, with a new deal for GPs recognising primary care as the cornerstone of the NHS.

6.0 Vanguard Sites

In January 2015, NHS England invited individual organisations and partnerships, including those within the voluntary sector to apply to become 'vanguard' sites for the New Care Models Programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services.

More than 260 individual organisations and health and social care partnerships expressed an interest in developing a model in four of the areas of care, with the aim of transforming how care is delivered locally.

On 10 March 2015, the first wave of 29 vanguard sites were chosen. This followed a rigorous process, involving workshops and the engagement of key partners and patient representative groups.

Sunderland were successful in being a vanguard site for Multispecialty Community Providers and will take a lead on the development of this new care model which will act as the blue print for the NHS moving forward and share learning with the rest of the health and care system.

Sunderland CCG and Sunderland LA, in partnership with our key providers in the city, believe we are already a Vanguard site because of our work to transform out of hospital care. We believe there will be benefits in being accepted as an area to co-produce the models of care in terms of access to national support to address potential barriers to integration, external challenge/ advice to support our next steps; peer support and funding.

7.0 Better Care Fund

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

Better Care fund plans must deliver on the following national conditions:

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

The Better Care Fund has been seen as a real opportunity within Sunderland to drive change through a system wide approach with a pooled budget of £24.8m identified in 2014/15, in comparison to the minimum required value of £12m, and up to £169m identified moving forward into 2015/16.

The fund will facilitate the transformation of our out of hospital model of care across Sunderland, along with vanguard status.

8.0 Our Outcome Ambitions

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

Critical Indicator of Success	Outcome Ambition by 2019	RAG Rating *(As at 31/03/2015)*
Securing additional years of life for the people of England with treatable mental and physical health conditions	Reduce years of life lost by 15%	
Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Improve quality of life for those with long term conditions by 8.9%	
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Reduce emergency admissions by14%*	
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Improve patient experience of hospital care by 7.2%	
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the	Improve patient experience of out of hospital care by 8%	
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Healthcare associated infections ▪ MRSA Zero tolerance; ▪ Cdifficile nationally set trajectory	MRSA Cdifficile

**14% reduction is related to the composite measure which does not include all emergency admissions. Overall aim is to reduce emergency admissions by 15%.*

Our operational plan outlines the key transformational changes which we are implementing to lay the foundations to ensure we achieve these outcome ambitions, as well as achievement of the NHS Constitution rights and pledges.

In addition to these outcome measures we will also aim to make improvements against the following mental health measures:

Measure	Ambition by 2016	RAG Rating (As at 31/03/2015)
Improved access to psychological therapies (Access and recovery)	16% access by 2016	
	Maintain 50% recovery rate	
Increase in Dementia diagnosis	68% by 2016	

8.1 Quality Premium

The Quality Premium was introduced in 2013/14 and is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The guidance for 2015/16 sets out both the measures and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards and NHS England local NHS England teams to agree measures to be selected from menus, local measures and levels of improvement in preparation for 2015/16.

The Quality premium will be paid in 2016/17, to reflect the quality of health services commissioned by them in 2015/16 – will be based on the following measures which cover a combination of national and local priorities. These are:

- **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);
- **Urgent and emergency care** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the

quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure;

- **Mental health** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure;

- **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

- **Two local measures** which should be based on local priorities such as those identified in joint health and wellbeing strategies (20 per cent of quality premium-10 per cent for each measure).

However, the total payment for a CCG (based on the performance against the measures outlined above) will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to the following:

- 18 weeks RTT;
- 4 hour waits in A&E;
- Maximum 14 day wait from an urgent GP referral for suspected cancer;
- Maximum 8 minute responses for category A red 1 ambulance calls.

A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money during 2015/16; or
b) ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position; or
c) incurs a qualified audit report in respect of 2015/16.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2015/16.

The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs (285,000 for Sunderland) which equates to a total value of approximately £1,425,000 (This is in addition to a CCG's main financial allocation for 2015/16 and in addition to its running costs allowance.)

Regulations set out that quality premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities.

The Quality Premium measures for Sunderland in 2015/16, agreed by both the CCG Executive Committee and the Health and Wellbeing Board are outlined below:

Area	% of Quality Premium	Proposed Measure
Potential years of life lost	10%	6% improvement from 2013/14 baseline
Urgent & Emergency Care	30%	Avoidable emergency admissions composite measure of: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in children; Emergency admissions for acute conditions that should not usually require hospital admission (adults); Emergency admissions for children with lower respiratory tract infection
		Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays
Mental Health	30%	Reduction in the number of patients attending an A&E department for a mental health related needs who wait more than 4 hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.
Improving antibiotic prescribing in primary and secondary care	10%	Composite measure comprising of three parts: Part a) reduction in the number of antibiotics prescribed in primary care; Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care Part C) secondary care providers validating

		their total antibiotic prescription data.
Locally Selected Measures	20% (10% each)	**Increase in the proportion of patients who have an emergency health care plan coded in EMIS practice systems.** The baseline is 0.12%. The proposed increase is 0.25% which is equivalent to approximately 352 additional care plans. This will help to ensure people feel supported to manage their condition, reduce the time spent in hospital by people with long term conditions and reduce emergency admissions and re-admissions.
		Increase in direct referrals to the new Sunderland Intermediate MSK service, from 40% to 50%. A new intermediary service will be in place from October 2015. Increasing the number of referrals to this service will support in reducing the pressure in elective activity for orthopaedics at City Hospitals.

9.0 Improvement Interventions

9.1 Our Progress so far

In 2014 we identified 10 transformational changes which would lay the foundations to ensuring delivery of our 5 year vision. Work has progressed well against these transformational changes in the first year of our plan:

- **Integrated Community Locality Teams** - Developed partnership working in Sunderland, model and make up of teams agreed in principle, Investment of both non-recurring and recurring funds agreed to enhance medical / nursing input, Looking to mobilise, test and refine over the next 12 months. Each team includes community nurses, social workers, living well workers, carer workers and GPs wrapped around groups of GP Practices to provide enhanced care to our most complex patients.

- **Enhanced Healthcare in Care Homes** – Pilot in Coalfields produced very good outcomes, including 45% reduction in emergency admissions, high patient, carere and staff satisfaction and more people dying in their preferred place. Looking to roll out across the city as part of Integrated Community Locality Teams;
- **Intermediate Care Hub (now known as Recovery at Home)** – Hub and linked nursing and care teams operating from one base and now operating extending hours and investment in additional community beds available at Farnborough Court moving towards 24 hour single point of access to Hub by September. The hub includes a contact centre, nursing and care teams which support people at home ;
- **End of Life deciding right** - Care Home training to enable people to die in their preferred place has progressed well with most homes engaged. Additional resource agreed to support GP Practice Training;
- **Mental Health** – 5 year programme to develop a model of care for Sunderland is now near the end: New model of psychological therapy, new hospital environments at Ryhope & Monkwearmouth, Ongoing implementation of improved community mental health services;

- **Urgent Care** – GP led urgent care centres are now operational, GP Out of hours procurement is currently underway following agreement of the new model that is fit for the future as well as the development of City Hospitals emergency department urgent care centre;
- **MSK** – The procurement of the new MSK service is complete and the new provider will be operational from October 2015;
- **Dementia** – A dementia friendly community pilot is running well in Houghton. All staff in GP practices across Sunderland have been trained on Dementia Awareness with additional Dementia friends training planned. The Essence service is now in place and receiving referrals to support newly diagnosed patients who do not yet require care but need to keep connected with what is important to them.
- **Reducing the use of procedures of limited clinical value** - Phase one of the value based commissioning policy, reflecting national guidance, was implemented in January 2015, focusing on varicous veins and minor skin lesions with full implementation by April 2015.

9.2 CCG Plan on a Page

The CCG plan on a page, shown overleaf, summarises the following:

- CCG Vision;
- Strategic Objectives;
- Outcome ambitions;
- Transformational changes moving into 2015/16;
- Key enablers;
- Governance arrangements;
- How our success will be measured;
- Values & Principles.

Version 1.3

Plan on a Page 2014/15 – 2018/19 (Revised for 2015/16)

NHS Sunderland Clinical Commissioning Group

Better Health for Sunderland

Transforming out of hospital care (through Integration and 7 day working)			Transforming in hospital care, specifically urgent & emergency care (7 day working)			Enabling Self Care and Sustainability		
Improve health related quality of life for people with LTC by 8.9% by 2019	Put in place 352 more Emergency Health Care plans by 2016	Improve patient experience of out of hospital care by 8% by 2019	Reduce Emergency Admissions by 14%* by 2019	Increase direct referrals to the MSK Intermediate service to 50% by 2016	Improve patient experience of hospital care by 7.2% by 2019	Increase no of people receiving treatment for IAPT from 12% to 16% by 2016	Reduce years of life lost by **15%** by 2019	Improve diagnosis of dementia from 62% to 68% by 2016

Transformational Changes 2015-2016	
OUT OF HOSPITAL	Implement the out of hospital model, including locality integrated teams for people at home and in care homes, city wide recovery at home services and the end of life standards in GP Practices
URGENT CARE	Improve timely access to urgent care by concluding the procurement of the GP Out of Hours service & supporting implementation of the whole system Emergency Care Intensive Support Team recommendations.
DEMENTIA	Conclude the implementation of the national dementia strategy in Sunderland e.g. supporting dementia friendly communities by specific focus on Primary Care awareness, development, training and environment
MSK	Mobilise the new integrated musculoskeletal service
MENTAL HEALTH	Continue to support the implementation of the new principal mental health community pathways
PREVENTION	Influence a prevention and self management approach with commissioned health services, working jointly with the local authority / public health
CHILDREN	Develop a joint strategy and joint commissioning approach with Sunderland city council to improve outcomes for children
GENERAL PRACTICE	Develop and implement a strategy for general practice across the city
LEARNING DISABILITIES	Implement the transforming lives programme for people with learning disabilities and / or autism
CONTINUING HEALTHCARE	Implement the new model of care for people needing continuing healthcare

Enabled by	Governed by	Measured by	Values and Principles
Joint Commissioning & Better Care Fund Co-commissioning Primary Care IT infrastructure Telehealth Contract Management (CQUIN) CCG Localities Medicines Optimisation Research & Development Organisational Development Reform Methodology	CCG Governing Body System Wide Transformation Board Health & Wellbeing Board	Achievement of outcome ambitions Delivery of QIPP cost reduction plan 2015/16 – 2018/19 of £16m Delivery of prescribing savings £8m	One system for health and Social Care 7 day services Person centred Prevention focused Development of team based working across Sunderland Mental and Physical health of equal importance Evidence based approach

*14% reduction is related to the composite measure which does not include all emergency admissions. Overall aim is to reduce emergency admissions by 15%

9.3 Transformational Programmes

The impact of the health priorities, outlined within the JSNA, on long term conditions and on the frail and elderly more generally is significant and so much of our focus is on ensuring we have sufficient initiatives in place to address the impact of these.

We have undertaken a 'lite touch' review of our priorities moving forward taking into account our progress to date and recent national guidance including NHS England's 5 year forward view.

We will still be continuing to deliver the priorities we identified in 2014 where not fully complete, however, we have also identified some additional priorities. Some of which are new and others are priorities that we are already addressing which we feel are significant enough to highlight them on our plan.

The additional priorities identified moving forward in to 2015/16 include:

- Influencing a prevention & self management approach
- Developing a strategy with Sunderland Council to improve outcomes for children
- Development and implementation of a strategy for General Practice
- Implementation of the national 'Transforming lives' programme for people with learning disabilities
- Implementation of the new model of care for people needing continuing healthcare

Further detail on each of our transformational changes is outlined in the following pages:

9.3.1 Implementation of the Out of Hospital Model of Care

Principle Changes planned to the delivery of care are set out below:

City wide recovery at home service

- This city wide service currently exists to provide both Step up and Step down health and care which is time limited and rapid response both in peoples own home and in community beds. It is focussed on preventing an emergency admission and supporting timely discharge with a strong re-ablement philosophy.
- This service will be enhanced through 24/7 working; single point of contact; all core health and social care teams including the GP Out of Hours provider being based in the same building along with the assisted technology services; under one management arrangement and a more effective community beds function which will enable an overall reduction in community beds.

Locality Integrated Teams

- These services will be enhanced by being brought together into multi-disciplinary teams which will be wrapped around groups of 10-15 GP Practices in each of 5 Localities (approx. 50,000 patients per locality). Whilst meeting the needs of the whole practice list, they will provide an enhanced level of response to those complex patients, often elderly frail and or with multiple co morbidities both at home and in supported housing including care homes identified via a risk stratification approach. This enhanced level will be proactive, planned, coordinated and case managed based on the outcomes that are important to the patient. The teams will have a single management structure. The teams will also include Living Well workers who will be very familiar with the local voluntary and community resources and connect patients with those resources where needed to improve quality of life for those individuals.

- The teams will be able to access city wide specialist resources where it is not viable to have those resources in each team e.g. Consultant Geriatrician. Wherever possible there will be a named contact for each Locality e.g. 3 older people mental health teams will have a key contact for each of the 5 teams. There will be a key relationship with the city wide Recovery at Home service, when despite a proactive and planned approach, emergencies can occur, although they should be less frequent. The patient groups are likely to be very similar for both services. These patients will have direct access to the Recovery at Home service and have a joined up electronic health record. They will also be able to support the development of personal budgets building on the current joint arrangements with the council to provide personal budgets

to people with continuing health care needs.

General Practice

- 51 practices in the city currently with 42 recently forming a local federation covering 85% of the practice population and all 5 localities. A smaller federation of 5 practices approximately 30,000 practice population has also formed in one part of one of the 5 Localities. This locality sits on the border of Sunderland and Gateshead as the new town of Washington and is geographically a discreet locality. The CCG has supported the development of both federations.

- These services will be enhanced through the ongoing development of the Localities providing peer support as commissioners and through the federations as providers of extended, standardised and proactive primary care particularly for people with long term conditions.

Communities

- Sunderland has a population of c 284,000 with 3 well defined localities (Washington; Coalfields and North) and the rest of the city being divided into the East and West – 5 Localities in total with very similar health and wellbeing status, whilst clear inequalities between wards and within and across localities. There is an active and vibrant voluntary and community sector with some organisations operating across the city and some locality/ward focussed.

- These communities are being enhanced through the development and or recognition and support of Community Connectors. Individuals and groups that enable people to become and stay well connected with others and or access support when they are temporarily or permanently vulnerable. The majority of these connections are provided by voluntary and community organisations of all sizes. The concept of Community Connectors will be further developed, current provision mapped and better supported and gaps considered.

9.3.2 Procurement of the GP Out of Hours service & supporting implementation of the whole system Emergency Care Intensive Support Team recommendations

The proposed GP Out of Hours service model will deliver a comprehensive integrated OOH service across Sunderland.

The aims and objectives of the service are to provide a clinically safe and exceptional GP OOH service providing access to unplanned urgent care, working in partnership with the wider urgent care system across primary, community, secondary health and social care. The service will be an integral part of the Sunderland Recovery at Home (RAH) team providing telephone advice and a home visiting service. Face to face appointments will be delivered via the Sunderland Urgent Care Centres (UCCs). The GP OOH provider will have access to book appointments.

We invited the emergency care intensive support team, which is a national team, to review the whole urgent care system in Sunderland. Following this the following recommendations were identified:

- Early senior review of all patients along all parts of the pathway is required;
- In order to maintain the momentum of care there should be a senior review of every patient's care plan every day;
- To ensure patients are on the right pathways they should be managed in 'flow streams';
- The implementation of internal/ external professional standards across the entire pathway;
- Plan and manage capacity to meet demand;
- Manage variation in discharge planning;
- Avoid unnecessary overnight stays across the entire system through implementation of the ambulatory emergency care/ frailty model.

The CCG will support the urgent care system in Sunderland to implement these recommendations throughout 2015/16

The 4th urgent care centre as part of the new accident and emergency (A&E) build

at Sunderland Royal Hospital will also progress during 2015/16. The centre is currently adjacent to A&E at Pallion Health Centre until the new build is in place. The aim is to have primary care response as the first response to those attending wherever appropriate.

9.3.3 Improved community mental health pathways, access and waiting times for all mental health conditions

The 5 year programme to develop a model of care for Sunderland is now near the end with enhanced IAPT services and new hospital environments at Ryhope & Monkwearmouth,

The Mental Health provider, NTW, will continue to develop and improve community mental health pathways, access and waiting times for Attention deficit hyperactivity disorder, personality disorder, autism and psychosexual disorders.

9.3.4 Conclude the implementation of the national dementia strategy in Sunderland e.g. supporting dementia friendly communities by specific focus on Primary Care awareness, development, training and environment

The dementia friendly communities programme focuses on improving the inclusion and quality of life of people with dementia. In these communities: people will be aware of and understand more about dementia; people with dementia and their carers will be encouraged to seek help and support; and people with dementia will feel included in their community, be more independent and have more choice and control over their lives. This work will complete the intensive pathway reform that has been underway across Sunderland for the last few years e.g. memory protection service already in place; work with practices to increase the dementia diagnosis rate.

9.3.5 Mobilise the integrated musculoskeletal service

The existing musculoskeletal service has been redesigned to offer an integrated service, streamlining patient pathways and reducing handoffs. This will increase patient experience by responding to patient preferred outcomes, reduce waste in the system and improve patient outcomes. The focus for 2015/16 will be to

mobilise the new service, now the procurement has completed.

9.3.6 Influence a prevention and self management approach with commissioned health services, working jointly with the local authority / public health

Across Sunderland, there is significant work underway in relation to prevention. We will continue our focus on cancer in terms of prevention, identification, treatment and survivorship. We will also continue to build on the work we have undertaken in relation to diabetes prevention and management.

The CCG have funded the exercise on referral programme moving forward into 2015/16 which is a weight management programme for adults aged sixteen years and over, who are not taking part in any form of exercise and have a condition that their GP or healthcare professional thinks will be improved with physical activity. We have also implemented a new Tier 3 obesity service to ensure patients are appropriately managed prior to going to Tier 4 (Bariatric Service)

In addition we have implemented a successful LVSD (Left ventricular systolic dysfunction) scheme providing high quality care for people within their familiar place of care as well as an effective atrial fibrillation service in order to identify previously undiagnosed patients who have AF and initiate their investigation and treatment.

Moving into 2015/16, the clinical forum will be working with public health colleagues to develop a robust prevention and self management plan specifically relating to ways in which the CCG and its member practices can support this agenda.

9.3.7 Develop a joint strategy and joint commissioning approach with Sunderland city council to improve outcomes for children

Our aim is to improve Health and well being outcomes for children, young people and families. In 2015/16 we will develop a joint strategy and joint commissioning approach with the local authority to improve outcomes for children. This will include:

- Ensuring clarity in relation to partnership arrangements for children and young people;
- Supporting the development of integrated pathways of care;
- Ensuring the CCG are meeting their statutory requirements in relation to children with complex needs.

9.3.8 Develop and implement a strategy for general practice across the city

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

The CCG has taken on delegated responsibility for the co-commissioning of primary care, specifically general practice in 2015/16. We believe this will help to ensure achievement of our overall vision and strategic objectives.

In 2015/16 we will develop our strategy for general practice across Sunderland taking account of:

- Current state of primary care
- National expectations
- Review of strengths, weaknesses and opportunities
- CCG drivers

We will be engaging with member practices and stakeholders to agree the key strategic priorities for general practice over the next few years.

9.3.9 Implement the transforming lives programme for people with learning disabilities and / or autism

The CCG and our partners across the health and care system in Sunderland are committed to transforming care for people with learning disabilities and/or autism who have a mental illness or whose behaviour challenges services.

Sunderland has a long-standing, comprehensive approach to individual care planning, so that people do not stay longer than necessary in hospital, specialist treatment centres, or in out of area placements. A robust and careful approach is taken with regards to discharge planning. Discharge only takes place when clinicians, family, commissioners, social workers and, where relevant, the courts decide it is safe and best for the individual.

Long-standing relationships with NHS specialised commissioners and between the CCG and the Council mean that a whole-system approach can be taken to all people with learning disabilities and complex needs admitted to hospital from Sunderland. Pooled budgets mean that discussions about responsibility for funding take place up front, rather than on a case-by-case basis. Close working between commissioning and care management functions mean that commissioning decisions are fully informed by individuals' care needs.

The Winterbourne View programme of work has not required to major changes in how Sunderland supports people with learning disabilities and behaviour that challenges, however the focus brought by the programme has meant a number of lessons have been identified to improve the assessment and discharge process.

These include:

- Develop a better understanding of why individuals need to be admitted to hospital and identify any themes or trends that would inform commissioning and/or practice; discussions about themes will take place in care review and planning meetings;
- Ensure that people admitted to hospital have had a physical health check in the past 12 months and if not offer one; this will be built into the hospital protocol and picked up at care review meetings;
- Better information for people admitted to hospital **and** their families; an information pack has been developed which will include letters from the Carers Centre and People First advocacy.

9.3.10 Implement the new model of care for people needing continuing healthcare

NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'… Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness.

The CCG have been working with the council around documentation and raising awareness across the city of personal healthcare budgets (PHBs). There is also an ongoing programme of discussing PHB's at individuals' annual review.

In 2015/16 we will work in partnership with the local authority and South Tyneside FT (provider of the assessment) to implement the new model of care for continuing healthcare. This new model is intended to address the current inefficiencies / duplication in the system which can lead to poor patient experience.

10.0 Enablers

10.1 Telehealth

Telehealth (also referred to as telemedicine) covers the remote monitoring of physiological data e.g. temperature and blood pressure that can be used by health professionals for diagnosis or disease management. Examples of Telehealth devices include blood pressure monitors, pulse oximeters, spirometers, weighing scales and blood glucometers. Telehealth also covers the use of information and communication technology for remote consultation between health professionals or between a health professional and a patient e.g. providing health advice by telephone, videoconferencing to discuss a diagnosis or capturing and sending images for diagnosis. (Telehealth can collect this data via SMS text).

Within Sunderland we have dedicated resource assigned to drive forward the Telehealth agenda and ensure this technology is integrated across all transformational changes. Some of the work we have implemented to date include:

- Smoking cessation supportive tool for smokers hoping to quit
- Smoking in pregnancy supportive tool for pregnant mums
- Hypertension – accurate diagnosis of hypertension and appropriate treatment
- Daily monitoring of blood glucose levels for those with gestational diabetes

Moving forward into 2015/16 we have a number of improvements planned including:

- Weight monitoring – targeting specific at risk groups to assist with weight control including those on the Bariatric pathway prior to surgery.

- Supportive tool for carers – signpost and alert raising to avoid crisis;
- MSK pain management text tool to support self management and control;
- Asthma – text support tool for inhaler reminders, prescription renewals and inhaler techniques.

10.2 Medicines Optimisation

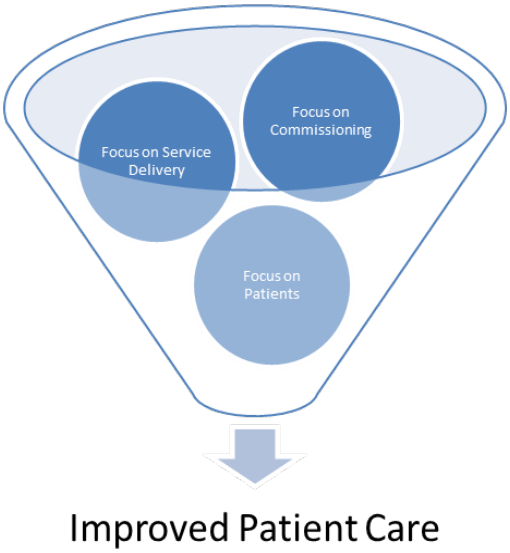
Our medicines optimisation plan will be a key enabler across each of these transformational changes and will aim to deliver savings of £8m by 2018/19.

We have reviewed our medicines optimisation strategy for 2015-6 which will include a focus on the following:

- GP Practice prescribing and a proposed strategy for providing additional medicines optimisation support to practices;
- Optimisation of prescribing of appliances e.g.;Appliances for urinary incontinence, Stoma Appliances and Accessories;
- Care Homes;
- Diabetes Specialist Nurse to support practices with management of patients in primary care;
- Additional measures to support improvements in, and better monitoring of prescribing in SCCG:
    - Locality working and development of locality prescribing reports;
    - Subscription to PresQIPP – Medicines Optimisation Web Resource;
    - High Cost – PbR Excluded Drugs;
    - Formulary and Guideline Development.

10.3 Informatics

Moving forward into 2015/16, we have developed an Informatics strategy. The diagram below illustrates the three key elements of our strategy:



10.3.1 Focus on Commissioning

Securely linking data from different healthcare settings to support commissioning intelligence

We will continue to improve our business intelligence resources to ensure accurate, relevant and timely information to enable the CCG to design and plan services and ensure that they are open, responsive and transparent for patients, carers and members of the public

Communicating with member practices

We will continue to develop robust and efficient digital methods and channels of communication between the CCG Head Quarters and member GP practices with a focus on document management solutions and intranet / extranet development.

10.3.2 Focus on Service Delivery

Supporting integrated care delivery within improved information and technology

We will improve the delivery of care through the introduction and adoption of modern clinical information systems with the ability to:

Share information electronically within and across organisational boundaries supported by adoption of the NHS number as the key patient identifier;

Utilise robust channels of communication for transactional based information flows such as discharge communications, referrals and diagnostic services;

Support health care professionals to deliver services in different care settings such as the patients home or in remote locations;

Provide assurance to patients that their data processes securely and confidentially.

Support care professionals to make the best use of data and technology

We will provide users of information and technology with the skills and support to exploit and realise the benefits of the solutions and services available.

Value for money systems and services

We will ensure the provision of IT systems and support services provide value for money through the use of national and local frameworks along with regular review to ensure waste in service provision and service level agreements are removed and levels of quality match customer expectations

Maintaining Robust Infrastructure

We will ensure the IT infrastructure supporting delivery of GP services is stable, secure and resilient. Refreshing the infrastructure is critical to maintaining this position and making improvements in availability. Our focus will include an upgrade for the local NHS network (COIN), GPIT Hardware Refresh Programme, Virtual Desktop Environment Pilot and Remote Practice Backup Solution.

10.3.3 Focus on Patients

Social Media to facilitate access to personal health information

We will enable access to health information for Patients and Public through the development of excellent communications channels and high quality information resources including the use of social media, apps for specific conditions and healthcare service and advice and digital signage in practices.

Automating routine transactions with patients

We will enable patients to interact with NHS services through digital methods making contact convenient, personal and efficient. We will do this through booking appointments online, electronic prescriptions including EPS R2 and Patient messaging using MJog

Patient and carer access to electronic records

We will enable patients and their carers to access care records and be informed and involved in decision about their own care and treatment.

10.4 Organisational Development

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people; it is often termed as the “oil that keeps the engine going”. In Sunderland we fully embrace this philosophy and the concept of continuous improvement and development. This strategic approach is critical as we continue to develop and grow as an organisation.

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

- Support the delivery of the 5 Year Strategic Plan and 2 Year Operational Plan to deliver our vision and transformational changes to improve health outcomes;
- Ensure a system wide approach with partners to organisational learning;
- Ensure the actions we take in the shorter term support delivery of our longer term objectives;
- Ensure that the organisational enablers for delivery are in place and are being progressed;
- Establish a cross-cutting approach by connecting our efforts, skills, experiences and competencies to continually improve our commissioning process.

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

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

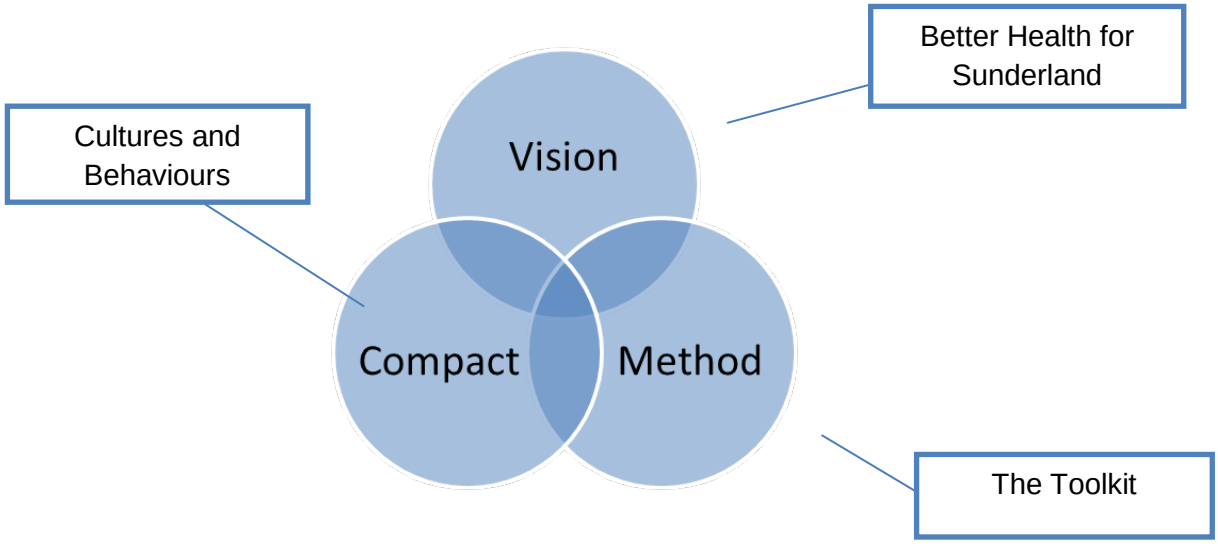
As an organisation we promote organisational learning and are committed to promoting a learning culture to ensure that all staff are developed to ensure safe and effective care and to achieve their full potential.

10.5 Improvement Methodology

We know all organisations involved in the commissioning and delivery of health and social care face the daily challenge of managing change. We recognise the importance of having a clear approach to continuous improvement and as stated by NHS Improving Quality (2013)[1]: "…using an evidence-based improvement methodology ensures that the change will be delivered in a planned, proven way that follows established methods. The improvement methodology is the game plan.

We have adopted the North East Transformation System (NETS) as our reform methodology, which has been identified by NHS IQ as evidence based improvement methodology. However, we will also adopt other complimentary approaches as needed.

The NETS framework, outlined below, comprises of 3 key elements namely, Vision, Compact and Method:



The framework incorporates transformation and change techniques from international exemplars in industry as well as healthcare. Each element of the framework is considered equally important for success and for this reason, the framework is often *referred to as the '3 legged stool'*.

In Sunderland, we have tailored our approach to utilise our resources where they are most needed and ensuring individual providers are clear of their own responsibilities to lead and demonstrate their improvements. Our ambitious transformation programme comprises of 10 programmes many of which will require commissioners to take the role of facilitator due to the complexity and involvement of multiple stakeholders. A continuous improvement approach will prove invaluable in capturing the current issues, encouraging providers to collectively undertake root cause analysis and work collaboratively to commission/provide innovative solutions.

We recognise that we are overfunded by £50m using the national formula with therefore very little financial growth anticipated and an ambitious cost improvement Programme.

This lean approach aims to release capacity within existing resource and we are committed to ensuring quality is maintained in the backdrop of financial austerity, and ensuring savings or resource released are reinvested wisely, for the benefit of the people of Sunderland.

11.0 Impact of our Improvement interventions on activity

We have reviewed activity levels in previous years and forecasted the expected activity levels over the next five years taking into account the anticipated impact of our transformational changes. The table below outlines the forecasted activity levels:

Activity Measure	Position in 5 years
GP referrals	Reduced growth by 3%
Other referrals	Reduced growth by 2%
First outpatient attendances	Reduced growth by 1.5%
Elective daycase admissions	Reduced growth by 2%
Elective ordinary admissions	Reduced growth by 2%
Non elective admissions	15% reduction (already 12% reduction in 13/14)

12.0 Ensuring Quality and improved outcomes

Quality is at the centre of Sunderland CCG's vision and values and we are dedicated to ensuring that the services we commission on behalf of the people of Sunderland are of the highest quality and delivered with respect and compassion. Our Quality Strategy 2014-17, which was approved in August 2014, describes a quality service as being one that recognises the individual needs and circumstances of the patient and ensures services are accessible, appropriate and effective for all and that workplaces support and empower the staff to deliver high quality care.

We are committed to delivering quality improvement across the three areas of quality, namely effectiveness of care, patient experience and patient safety. We have reviewed the recommendations from the key quality and safety reports and strategies i.e., Francis 2, Berwick, Keogh, Clwyd & Hart, Compassion in Care and Hard Truths and whilst we have not identified any specific risks currently, we have developed and made significant progress on the implementation of a robust action plan to ensure continuing improvement from a commissioning and provider perspective. The overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people and patients at the centre of the NHS. As an organisation we are committed to ensuring clinically led commissioning, ensuring safety, quality and outcomes drive everything we do, informed by efficient and effective engagement with patients, carers and the public.

Alongside our overarching quality aims and objectives, Sunderland CCG has always been committed to ensuring and improving quality in primary care in Sunderland, which will be strengthened now that the CCG has taken on delegated responsibility for the co-commissioning of primary care (GP practices).

Examples of the range of actions we continue to take include:

- Quality impact assessments undertaken on all key transformational changes;
- Develop and maintain relationships with all key providers and co commissioners to ensure continuous dialogue on quality of services and quality improvement;

- Secure and use quality assurance data and information from a broad range of sources both external and local;
- Identify areas for improvement and respond to areas of concern in relation to quality quickly and monitor accordingly;
- Maximise use of contractual levers to secure quality improvement e.g. use of quality indicators and Commissioning for Quality and Innovation (CQUIN) schemes;
- Promote the implementation of national best practice guidance and standards with all providers;
- Ensure that systems and processes are in place to fulfil specific duties of co-operation and best practice in relation to the safeguarding of vulnerable adults and children.
- Work with associate/lead commissioners, including the Local Authority, to maximise quality assurance/improvement in commissioned services;
- Summarise quality assurance reports to the CCG Governing Body as the accountable body outlining key areas of assurance, risks and mitigating actions.

13.0 An NHS centred around patients

We have recently reviewed our engagement activity against national priorities, to consider our key local priorities for the future. In particular we are keen to enhance involvement and to further ensure commissioning activity reflects the communities the CCG serves.

We will ensure patient experience is central to service development and that patients, carers, and the public (our citizens) are actively and systematically involved in all aspects of public service design and change. Communities will feel empowered and enabled and will know how they can engage with us on everything to do with their Health and Wellbeing. We will also ensure that patients are fully empowered to make informed choices regarding their own care.

The CCG has recently revised its Patient and Public Engagement Strategy to demonstrate its commitment to working with our partners and the public, patients, carers and communities and their representatives, to ensure health and social care services are shaped around what the people need. As a health and care economy our focus is to ensure we engage collaboratively with the people of Sunderland.

Public Participation

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

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

As a health and social care system we have developed an Altogether Sunderland approach, which includes the move from local engagement boards to Sunderland Health Forum which will be led jointly by the CCG and Local Authority.

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

We will also continue to seek the views and opinions of local people, patients, voluntary and support groups about the services we provide through a wide range of activities including surveys, focus groups, formal consultations and events. ‘My NHS’ is being be proactively populated to represent Sunderland demographics and engagement opportunities related to individual interests actively marketed using this tool.

There is an open invitation for patients and members of the public to attend the Sunderland Health Forum, which is held every 2 to 3 months, to engage with the CCG. These are held in a central location within the city to update the public on key developments and seek views about proposals and meetings are advertised in the local press and via social media.

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

We will continue to ensure that appropriate action is taken in response to patient and staff feedback through the Friends and family Test and other patient experience activity.

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

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

Individual Participation

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

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

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

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

This work is being overseen by the safety, risk and quality committee – and in particular the following areas have been identified for development

- Accessibility and protected groups;
- Developing community assets through voluntary and community sector engagement;
- Co-ordination of relationships with the wider voluntary and community sector;
- Development of health champions led by public health;
- Make better use of VCS ability to reach further into communities, further meet equality duties;
- Developing community assets through practice participation groups (PPGs);
- Insight and feedback – understanding people's experiences of care – development of patient stories;
- Developing better CCG engagement planning and capacity for delivery;
- Development of a programme for engagement delivery – enhancing staff skills and knowledge base to better commissioning activity;
- Work with reform leads to identify specific engagement needs as part of existing transforming methodology;

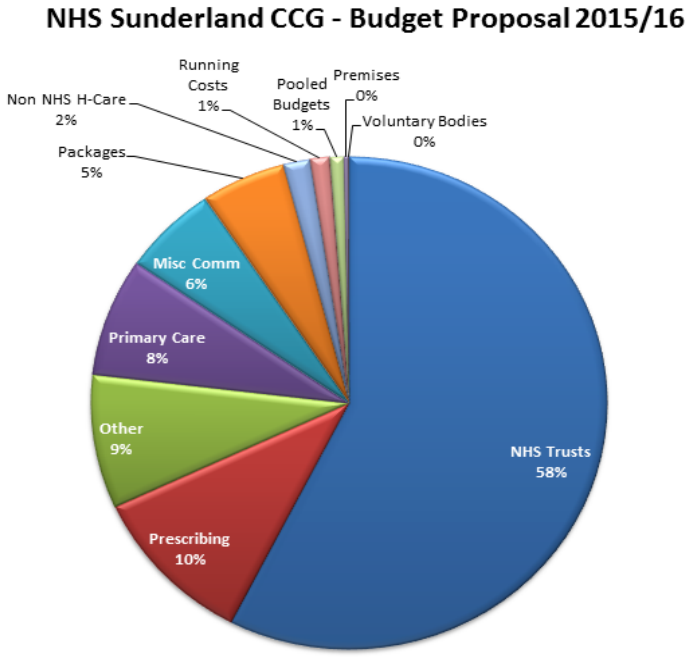
- To become more intelligence-led organisation, using easy ways to share what thematic insight has been gained from engagement activity across the CCG.

14.0 Our Financial Plan and Sustainability

We have been identified as one of a small number of CCG's who are substantially overfunded, according to the latest national formula, and so we recognise the potential for our future financial picture to change if the formula is fully enacted. Our cost improvement programme is therefore based on being prudent, preparing for the future and reducing our recurrent run rate. The Chief Officer of NHS England, Simon Stevens has indicated the desire to move all CCGs to within 5% of their targeted allocation as fast as possible which validates the prudent approach the CCG is taking in their financial plans.

We have undertaken detailed impact assessments to understand the potential impact of our transformational changes on finances over the next four years from 2015/16 to 2018/19, which outline the £16m savings we intend to make. Triangulation of finance with both outcome ambitions and activity trajectories has also been undertaken. There are also a number of transactional savings we plan to make as well as £8m savings through a medicines optimisation plan. The savings help us to invest in improvements. Our financial plan on a page can be found in Appendix 1**.**

For 2015/16 we have been allocated a budget of £501m. The diagram below outlines how we will spend this money in order to improve health outcomes for the people of Sunderland:



15.0 Delivery of our plan

15.1 Performance and Planning Framework

We have set in place a framework and structure to ensure that all of the components of this operational plan are efficiently and effectively implemented including a comprehensive performance management regime and a governance framework to routinely advise the CCG Executive and Governing Body on progress. In addition to this we have agreed the formation of a system wide Transformational Board to drive the delivery of our vision and strategic objectives, supported by a multi-agency Out of Hospital Programme Board, Mental Health Programme Board and the Urgent Care Programme Board.

Performance is reviewed on a monthly basis by the CCG Executive Committee and covers delivery against our operational plan (including national targets and progress of transformational programmes), contracting position at each of our providers and delivery against our cost improvement programme. The report documents, for each of the key performance indicators, the actual position against plan, trend month on month, an assessment of risk to year end delivery and key actions to recover any underperformance. The reporting regime is also supplemented by specific high risk key measures being monitored more frequently e.g. A&E 4 hour standard and healthcare associated infections.

A key part of the performance framework is the systematic review of the risks associated with the delivery of each aspect of performance, and if circumstances change, the risk management plan is amended to reflect the latest context. Where key risks have been identified, routine reporting is supplemented by escalation, exception reporting, development and close tracking of performance time limited recovery plans. These are focused on root causes of the problems and remedial action including, where appropriate, the use of contractual interventions to ensure delivery and sustainability of improvement. Initiatives and targets ranked as high risk are closely scrutinised to ensure performance remains on track, and any deviation from plan is quickly identified so that appropriate action can be taken.

Understanding of provider contributions to overall delivery is critical and commissioned providers have agreed information schedules including both national and local

requirements with required submission dates. Performance targets are detailed in contracts across a broad range of key performance domains such as activity, access, health improvement, safety and quality. Our internal monitoring supports the performance improvement discussions which form a key part of monthly contract review mechanisms.

Building on the success of the North East Transformation System to date, we are continuing to embed the methodology throughout the CCG to drive quality and continuous improvement in our commissioning processes, by undertaking:

- Regular Tier 2 Visibility Wall stand-up meetings to ensure continuous improvement in performance are at the heart of our management method;
- Continued enhancement of the Tier 1 Performance Wall and the Tier 2 Improvement Wall and also improving the linkage between them.

15.2 Governance

In line with our values as a CCG to be open, honest and inclusive, the CCG have developed a planning process to ensure patients, the public, partners and providers are part of developing our plans for the future.

We have developed a gateway process which is a mechanism for providers to share ideas which will support us in delivering our priorities.

Our three programme boards, (Out of Hospital, Urgent Care and Mental Health) are an integral part of our planning process which has membership from the local authority, partners and providers.

We actively engage with the Health and Wellbeing Board (HWBB) and have established a Transformation Board with key partners to oversee the delivery of the Transformation programme. We meet regularly with Healthwatch Sunderland who are also part of the HWBB and our Programme Boards. Our Locality teams meet regularly with their counterparts in the LA e.g. Local Councillors, voluntary sector and partners who form the locality People and Place Boards linked to the local Area Committees.

To ensure that the CCG and its Board are delivering on its strategic objectives, a committee structure has been developed to provide assurance on the key aspects of plans under the Governing Body. This committee structure includes:

- An Audit Committee;
- Remuneration Committee;
- Quality, Safety & Risk Committee
- Primary Care Commissioning Committee

They are supported in their work by an Executive Committee comprising elected GPs together with Directors within the CCG.

Importantly, the Audit Committee will ensure that we have effective internal controls and risk management arrangements in place to ensure that risks to delivery of plans are identified and mitigated through effective action at an early stage.

The Audit Committee will also assist the Board in providing additional scrutiny of the cost improvement programme, implementation of which will be managed by the Executive Committee. The Executive Committee will be supported by the relevant Programme Boards in delivery of operational plans for which they have been assigned lead responsibility. The Quality, Patient Safety & Risk Committee will provide assurance that for those services which we commission as part of the commissioning plan they are of high quality and safe for the patient and that risks are being effectively controlled with mitigation action put in place.

Underpinning all of our work is a commitment to the Nolan principles of openness, accountability and transparency; with these principles in mind we have adopted a Standards of Business Conduct and Declaration of Interests Policy in keeping with the NHS Commissioning Board's guidance. All members of the governing body, its committees, member practices and senior employees are required to adhere to the policy, including registering of their interests and arrangements are set out as to how such conflicts of interest will be managed.

16.0 Equality & Diversity

Following an in depth consultation exercise, the CCG has developed a number of equality objectives:

Objective	Description
1	Work with partners to improve the safety and quality of commissioned services across Sunderland.
2	Ensure all patients and carers can be involved and that patient experience is captured and acted upon to inform service change and delivery where possible.
3	That Sunderland CCG has sufficient organisational data to demonstrate that staff from all protected groups are paid equally and in line with pay levels for the organisation as a whole and that appropriate training has been given on equality and diversity matters.
4	That the Governing Body receives adequate assurance around equality and diversity including the equality objectives, strategy and progress towards achievement.

An action plan has been developed to support the delivery of these objectives and a process established to monitor progress via the Executive Committee, with formal reporting to the Governing Body on a six monthly basis.

Full Equality Impact assessments part of the business case for any transformational change to ensure that the needs of all local communities are fully reflected in the design, planning, implementation and evaluation of services.

17.0 Conclusion

We have outlined in this plan the operational detail of the work we have undertaken in 2014/15 and our focus moving forward into 2015/16 to lay the foundations to ensure the delivery of our five year vision and strategic objectives in Sunderland.

Appendix 1 – 5 year Financial Plan on a Page

PLAN ON PAGE v5 Feb-15

PLANNING ASSUMPTIONS FOR CCG 2/5 YEAR FINANCIAL STRATEGIES

	2015/16 %	2016/17 %	2017/18 %	2018/19 %
CCG Allocation Uplifts	*1.94*	*0.50*	*0.50*	*0.50*
TARIFF				
General Uplift	2.54	4.70	3.70	3.70
CQUIN Increase	0.00	0.00	0.00	0.00
Tariff Efficiency	-3.80	-4.00	-4.00	-4.00
Net Tariff Impact	**-1.26**	**0.70**	**-0.30**	**-0.30**
Prescribing Uplift	6.50	6.00	6.00	6.00
Prescribing Efficiency	-3.00	-4.00	-4.00	-4.00
Net Prescribing Impact	**2.50**	**1.00**	**1.00**	**1.00**
	Within CSR	<----------	------New Gov to Decide---------->	

Growth Allocations by CCG for 2015/16 were announced in December 2014 by NHS England.
Indicative growth figures for the following 3 years have been issued by NHS England within Everyone Counts Guidance (page 45)
Although this document states that Commissioners as a whole should assume growth increases of 1.8% to 1.7% over the next three years, given Sunderland CCGs distance from target of 12% it has been deemed prudent to assume growth of just 0.5% for the remaining years of the plan. This strategy is further supported through the recent announcement by Simon Stevens of NHS England's intention to move CCGs within 5% of their target allocations over the next 5 years.

SOURCES	2015/16 £,000	2016/17 £,000	2017/18 £,000	2018/19 £,000	Totals £,000
Increased Allocations	8,244	2,166	2,177	2,188	14,775
Tariff Efficiency	11,108	11,546	11,626	11,592	45,872
Prescribing Efficiency	1,498	2,048	2,068	2,089	7,704
R.R.I.'S	*9,599*	*6,412*	*3,000*	*3,001*	*22,011*
Total Sources	**30,450**	**22,172**	**18,870**	**18,869**	**90,361**
APPLICATION					
Tariff Uplift	7,426	13,566	10,754	10,722	42,468
Prescribing Uplift	2,747	2,560	2,585	2,611	10,504
Investments--General	*20,278*	*6,045*	*5,530*	*5,536*	*37,389*
Total Application	**30,451**	**22,171**	**18,870**	**18,870**	**90,361**
Tariff Efficiency	11,108	11,546	11,626	11,592	45,872
Tariff Uplift	7,426	13,566	10,754	10,722	42,468
Net Tariff Contribution	**3,683**	**-2,020**	**872**	**869**	**3,404**

Included within the mapping exercise was a substantial share of the reserves held by the PCT. As a consequence of this within the opening budgets the planning need to identify a 2.5% Non Rec budget and a 1% cumulative surplus have already been identified.

The planning guidance requires a 0.5% contingency and a minimum 1% surplus.

The 2015-16 tariff assumptions are based on 2015-16 planning guidance but it should be noted these have not been agreed due to more than 50% of providers (by income) rejecting the proposed tariff arrangements for 2015/16

Given the degree of uncertainty growth assumptions and tariff efficiency have been reduced over the later years of the plan. Once more information is available the CCGs financial plans will be reviewed, however it can be seen that even by taking a "prudent" approach the aspirations and plans of the CCG are affordable.

RESOURCE RELEASING INITIATIVES (R.R.I.'S)

		2015/16 £,000	2016/17 £,000	2017/18 £,000	2018/19 £,000	Totals £,000
Long Term Conditions						
	M.I.U. Tender	400				400
	O.O.H. Tender	250	250			500
	Others					0
	Totals	**650**	**250**	**0**	**0**	**900**
Urgent Care Conditions						
	CITs, Care Homes, Dementia & EOL	0	3,960	1,980	1,980	7,920
	RAID - Reduction in Non Electives		1,000			1,000
	Misc			*739*	*869*	*1,608*
	Totals	**0**	**4,960**	**2,719**	**2,849**	**10,528**
Mental Health Conditions						
	S.Tyne / GH use of Sund beds	1,000				1,000
	Cost of Care Packages	250				250
	Totals	**1,250**	**0**	**0**	**0**	**1,250**
Planned Care Conditions						
	Comm Servs Review	1,000				1,000
	Community Cardiology	200				200
	Procs of Ltd C.V.	200				200
	High Cost Drugs - Lucentis		1,000			1,000
	NEAS PTS	200				200
	MSK Pathway Changes		202	281	152	634
	Totals	**1,650**	**1,202**	**281**	**152**	**3,234**
Support Functions (business rules adj)		**6,099**				**6,099**
TOTAL ALL R.R.I.'S		**9,599**	**6,412**	**3,000**	**3,001**	**22,011**

The RRI plans for 14/15 and 15/16 were discussed and agreed in principle at CCG development session on the 8th Oct 2013. This assumes a "draw down" from reserves in 14/15 and the reducing the 2.5% NR budget in 15/16 (£6,099k). Plans for 15/16 are as discussed on the 8th Oct and have been refined by the CCG QIPP Group. Work is ongoing to quantify other schemes however for this version of the plan the need to save £6.4m in 16/17 and £3m in 17/18 has been factored into calculations.

PLANNED INVESTMENT AREA'S

		2015/16 £,000	2016/17 £,000	2017/18 £,000	2018/19 £,000	Totals £,000
Out of Hospital						
	Pathway Reforms	750				750
	EMIS Web	250				250
	Readmissions nr to rec	1,000				1,000
	Exercise on Referral	360				360
	Continuing Care etc.	1,946	600	600	600	3,746
	BCF Investments	3,421				3,421
	Telehealth	130				130
	Community Services	1,000				1,000
	Total Out of Hospital	**8,857**	**600**	**600**	**600**	**10,657**
Mental Health						
	MH Growth (LD Patients)	1,000	250	250	250	1,750
	MH 2 Year Investment Prog.	1,013				1,013
	Total Mental Health	**2,013**	**250**	**250**	**250**	**2,763**
Planned Care						
	Access Growth	3,000	3,000	3,000	3,000	12,000
	Total Planned Care	**3,000**	**3,000**	**3,000**	**3,000**	**12,000**
Urgent Care						
	Winter Resilience Top Up	2,310				2,310
	Total Urgent Care	**2,310**	**0**	**0**	**0**	**2,310**
Growth to be spent N/R		**2,998**				**2,998**
7 Day Access / Working			**1,500**	**1,500**	**1,500**	**4,500**
Prescribing (to local Astro PU)		**1,100**				**1,100**
CCG Reform Fund (all aspects)			**695**	**180**	**186**	**1,061**
TOTAL ALL INVESTMENTS		**20,278**	**6,045**	**5,530**	**5,536**	**37,389**
Utilisaiton of Surplus N/R		**3,000**	**3,000**	**3,000**	**3,000**	**12,000**

Our 5 year period investments total £42m. Of this £1.8m is available for Reform activities in the 16/17 to 19/20 period.
Where there are known "pre-commitments" these are detailed (mainly in 15/16). Additionally each year there are changes to tariff structure / issues / growth arising within the acute contracts. Knowing this an allowance has been made within the Planned Care section, however it is to cover all aspects.
As with any "long term" plan there is greater detail in the early years compared to the later ones and there is a need to identify & refine later years QIPP plans
The risk of known commitments / reform in later years will need revisiting once further clarity is known about wider pathway reform activities.
We aware of the need to create the Better Care Fund in 15/16 and have allocated most of the "growth" in 2015/16 to this.
The CCG plans to draw down £9m of the surplus generated at the end of 2015/16 and will invest this to support the transformation of services in Sunderland.
Due to a new Business Rule CCGS more than 5% over target such as Sunderland cannot draw down surplus beyond a 2% level (c£9m)