Item No. 3

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **25 NOVEMBER 2011**

UPDATE FROM SUNDERLAND CLINICAL COMMISSIONING GROUP

1. PURPOSE OF THE REPORT

Sunderland Clinical Commissioning Group (SCCG) are at the beginning of their journey to becoming an authorised statutory body responsible for the commissioning of the majority of local health services no later than April 2013. The SCCG are aiming to be ready to be authorised by October 2012.

A national framework for authorisation is now available although more detail on the actual authorisation requirements is due to follow early in the New Year.

The purpose of this report is to update the Board on the journey and initial requirements

2. CONTEXT

The first stage is to review the configuration of the emerging CCG and Appendix 1 sets out the SCCG response to the first stage.

The SHA also requested a trajectory from each CCG to authorisation attached as Appendix B and this sets out key milestones and timeframes including the configuration milestone.

The next milestone is to develop a Clear and Credible Plan (CCP) by the end of December. The CCP will be the CCG's 3 year Strategic Plan which will continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources in line with national requirements and the local joint health and wellbeing strategy. Appendix C sets out an overview of the requirements and how these link with the PCT requirement to produce a Sunderland Integrated Strategic and Operational Plan (ISOP).

The 2012/13 year is a transition year recognising that the CCG will not take responsibility for all commissioning of health services in the future so in the interim the PCT needs an ISOP which covers all the current services commissioned.

The SHA have recently agreed that the timeline for the CCP should align with the timeline for the ISOP. A draft of the CCP will need to be provided by the end of December, however, it is possible to refine the Plan and engage with key stakeholders with a final Plan by the end of March 2013.

The third milestone is the requirement to engage with the development of Commissioning Intentions for 12/13. These intentions provide a signal to providers about the potential changes to their contracts. A draft or interim set is produced and was circulated to providers in early October by the PCT. (Appendix D)

The CCG engaged in this process for the first time in September when the focus was on an initial review with the understanding that there would be to the end of December to conclude the Intentions. Again the intentions cover all the PCT current statutory requirements, some of which will move to the Local Authority, Public Health England and the National Commissioning Board. The remainder will be in the CCG remit although over the transition year they need to consider which intentions they will actively lead and which the PCT will lead and the CCG will influence. This exercise is to take place over November and the Deputy Director of HHAS will be part of the Board Development sessions to conclude the work. As a result the current interim intentions attached will be managed jointly via the PCT and SCCG.

The Commissioning Intentions will also influence the CCP for 12/13 and will inform the CCG track record required as part of the authorisation process. The track record is referred to as the Operational Period and is the 5th milestone on the trajectory to authorisation.

Finally the fourth milestone requires the CCG to lead the contracting round for 2012/13. SCCG has agreed a position with the other 2 CCGs in the SOTW area and will be leading on the mental health and acute contracts.

RECOMMENDATIONS

The Board is recommended to receive the update for information and note the draft Clear and Credible Plan will be presented to the January HWBB. Further CCG updates will follow at each meeting.

Author: D Burnicle, Head of Commissioning Development (Sunderland)

Appendix A

CCG configuration

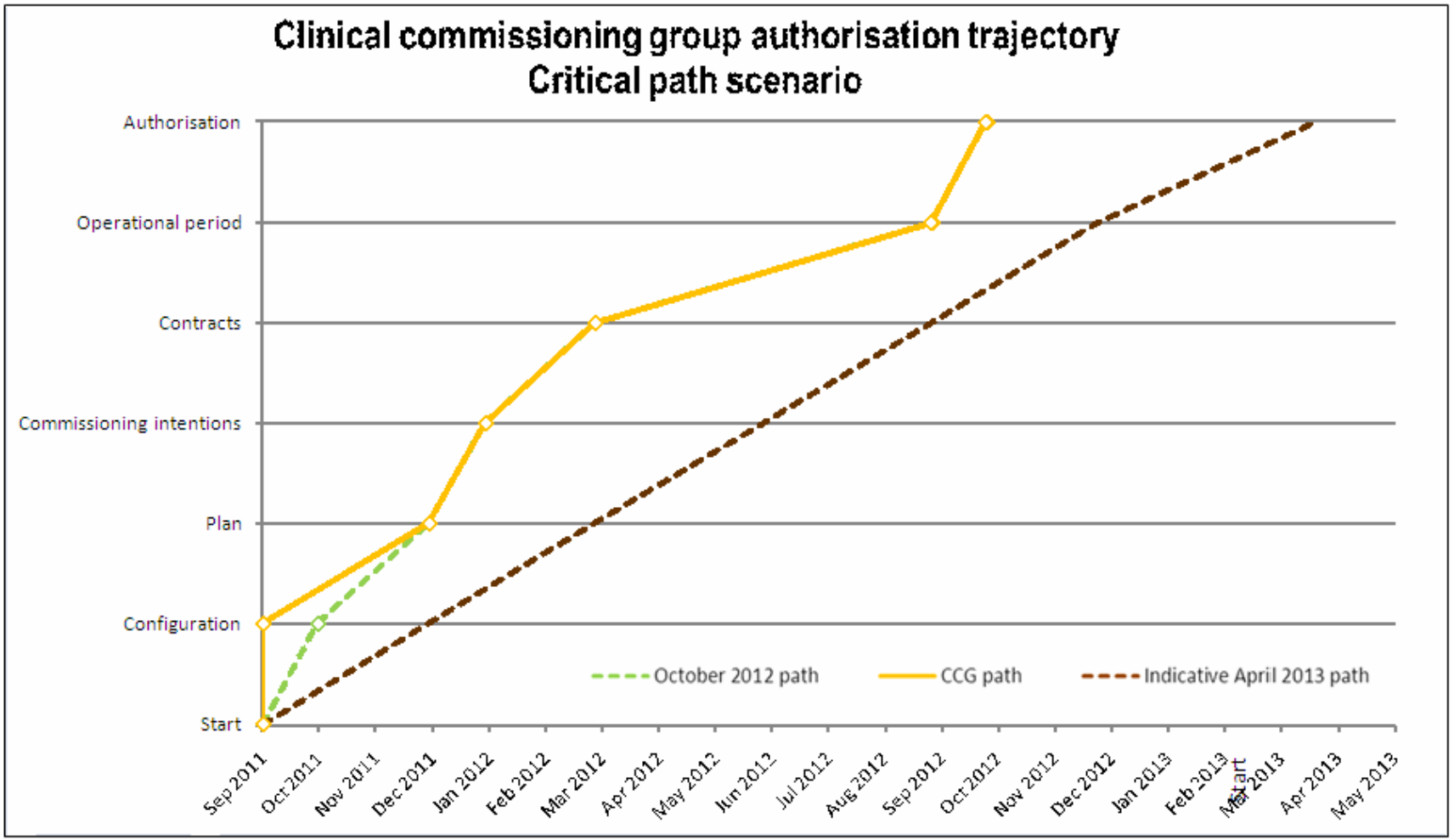
Sunderland Clinical Commissioning Group

Please select the RAG rating appropriate for your CCG and hit any key in the blue RAG box for each question. The appropriate colour will show.
Please provide any additional notes on the 'notes column

		R	A	G	Notes
1. Member practices:					All Practices were consulted about forming 1 city wide CCG, facilitated by the LMC early in the year and Practices elected the Board. All Practices are in the process of signing individual Practice Agreements by 7th October 2011.
R	Practices do not support proposed CCG configuration				
A	Moving towards all practices supporting CCG configuration especially re shape, LA boundaries and organisational variability				
G	Practices support proposed CCG configuration especially re shape, LA boundaries and organisational variability				
		R	A	G	Notes
2. Proposed CCG geography - boundary / population					Practices were consulted about options for localities to support the Board and 5 Localities were agreed and all Practices responded and have now agreed which Locality they sit within. The 5 Localities reflect the 5 Local Authority area regeneration frameworks which make up the city of Sunderland.
R	Does not reflect entire geographic population				
A	Is convoluted and/or contains a practice not contiguous with others				
G	Reflects entirety of geography				
		R	A	G	Notes
3. Geography - LA Boundaries					See above (notes question 2). The Local Authority supported the Pathfinder application and 5 localities infrastructure. The application includes suport for Joint Commissioning - this will be informed by the corporate Board as well as the Localities. One of the purposes of Localities is to faciltate joint working between LA, Health and community staff within communitites.
R	CCG cannot demonstrate reason for straddling upper tier LA boundaries				
A	CCG can demonstrate reason for straddling upper tier LA boundaries but cannot demonstrate LA support				
G	CCG boundary is coterminous with upper tier LA boundary or falls within boundary or can demonstrate population centres reason for straddling boundary and has LA support for joint				
		R	A	G	Notes
4. Impact of CCG size					300 000 weighted population connected by 1 CCG supported by 5 localities and a cadre of clinical leads (latter in development) and individual Practices signed up to the CCG. Constitution to support the relationship nearing completion.
R	Very small and cannot identify future capacity and capability for commissioning responsibility within RCA OR very large and no plans for practice engagement				
A	Very small and developing options for capacity and capability for commissioning responsibility within RCA OR very large and developing options for practice engagement				
G	Very small and confident of securing capacity and capability for commissioning responsibility within RCA OR very large and on track for practice engagement				

Appendix B

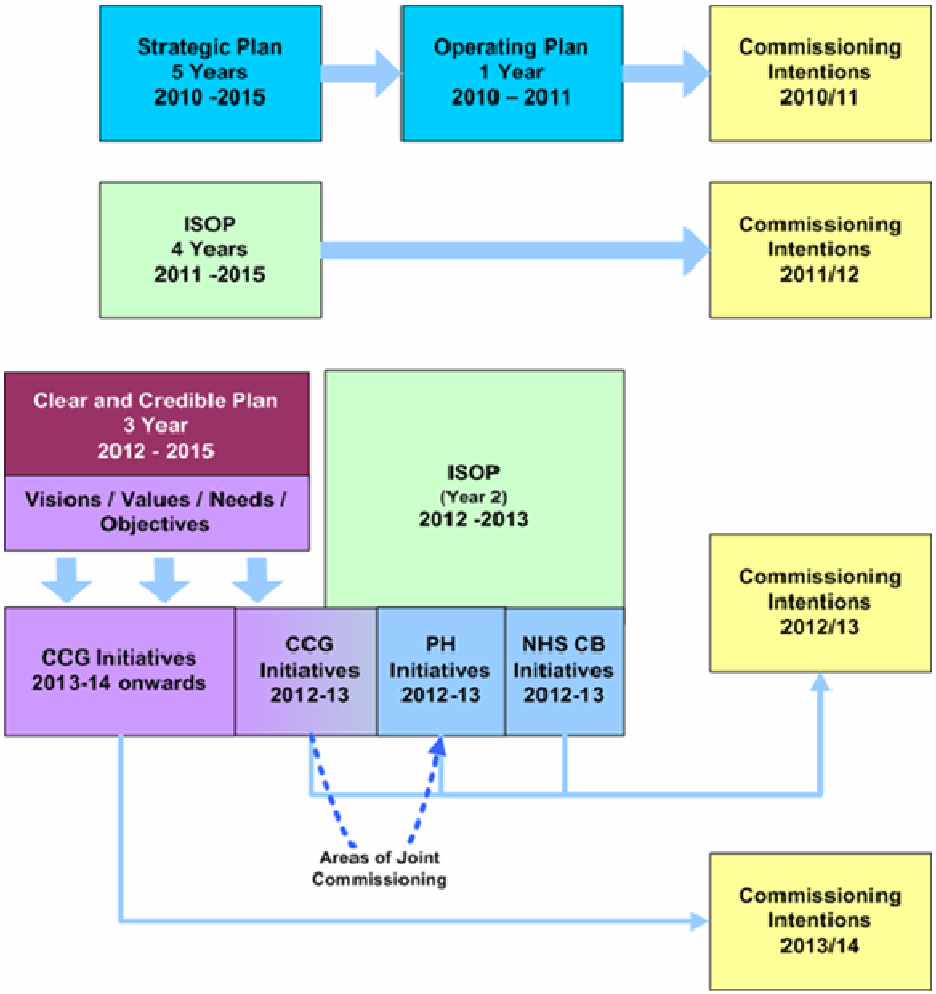
Clinical commissioning group: Sunderland Clinical Commissioning Group



Appendix C


What's in a plan?
Where are we now?
Demographics, health, services, patient views, clinician insights, money, providers
What do we need to do to close the gap?
Strategic objectives, initiatives, prioritisation
Delivery
Capacity, risks, estates, workforce, informatics, money, leadership, partnership, performance, governance
Where do we want to be?
Vision, values, future state, outcomes
Where will we be if we do nothing?
Population change, clinical developments, political changes

ISOP & Clear and Credible Plan



Appendix D

NHS South of Tyne and Wear

serving Gateshead Primary Care Trust, South Tyneside Primary Care Trust and Sunderland Teaching Primary Care Trust

SUNDERLAND CLINICAL COMMISSIONING GROUP and PCT

2012/13 Interim Commissioning Intentions

September 2011

Sunderland Clinical Commissioning Group

2012/13 Commissioning Intentions

1. Introduction

This document sets out initial high level commissioning intentions for Sunderland for 2012/13. The Sunderland Clinical Commissioning Group (CCG) has played a leading role in developing these intentions, but the continuing statutory responsibilities of the PCT and the need to provide a comprehensive assessment of commissioning plans across the broad range of services means that the document also outlines plans for those services expected to transfer to other commissioning organisations from April 2013, including a range of Public Health initiatives.

This paper will be superseded by a more detailed document at the end of December following the release of the 2012/13 Operating Framework and tariff. That document will set out a detailed analysis of intended contract activity and costs for 2012/13, including the activity and cost implications of the 2012/13 resource releasing initiatives (RRIs).

The Interim Commissioning Intentions for Sunderland have been developed to deliver the longer term strategic objectives described in the Sunderland Integrated Strategic and Operational Plan (ISOP) and those emerging from the developing plans of the CCG, but focus in particular on investment and disinvestment priorities we intend to progress in 2012/13.

The document makes reference to the following key issues:

Sunderland Integrated Strategic and Operational Plan
Sunderland Clinical Commissioning (SCCG)Group Pathfinder priorities
Resource releasing/QIPP programme initiatives
National priorities/local contracting issues
National tariff and planned activity
Investing in quality

The 2012/13 Interim Commissioning Intentions outline our plans in relation to acute, primary care, mental health/learning disabilities and community based/provider services contracts and set the scene for the 2012/13 contract discussions. The document describes the SCCG and PCTs' approach to a variety of issues which will impact on 2012/13 contracts with local providers.

This high level document is intended to reinforce and update, where necessary, on the Commissioning Intentions document which was published in January 2011 and does not therefore signal a material departure from the plans that have previously been shared with providers. This document will support the agreement of 2012/13 contracts by 28th February 2012.

2. Sunderland Clinical Commissioning Group (SSCG)

SCCG is made up of 54 constituent practices led by a Board of 6 GPs elected by their peers. The CCG is a pathfinder testing the arrangements for clinically led commissioning over the next 12 months. The Pathfinder sub committee of the PCT (with both executive, non executive and SCC membership) will be the committee that assures the PCT statutory board during transition and has given delegated responsibility for commissioning to the CCG.

In terms of interim delegation of responsibility for the overall commissioning budget until the CCG becomes a statutory body, a timetable has been agreed with the PCT. The total budget amount excludes the current PCT budget on areas such as primary care, specialised services and public health which will transfer to other bodies. A high level overview has been agreed of the programme and service areas which will become the delegated responsibility of the CCG to commission and the suggested timetable for that transfer of delegated responsibility. Day to day responsibility for service areas will be agreed with indicative amounts over time and this will increase in percentage terms until 100% in April 2012. This will be aligned with the PCT's scheme of delegation and standing orders.

The CCG has taken a lead role in developing the intentions for 2012/13, supported by the PCT management team particularly over the transition period to authorisation as a statutory body in 2013.

The commissioning intentions reflect the SCCG Pathfinder priorities. These areas are where the CCG is currently taking a leadership role and responsibility and these align to the local Quality, Innovation, Productivity and Prevention (QIPP) agenda for improving use of resources and are supported by Practice engagement:

- **Improving the whole system Urgent Care response**
- **Improving the quality of care for people with chronic obstructive pulmonary disease (COPD) across the whole system as a key step to taking on more responsibility for patients with a range of long term conditions**
- **Improving the quality and reducing the cost of prescribing**
- **Addressing clinical effectiveness in primary care**

This focus follows work with the Health Inequalities National Support team and the Director of Public Health to identify the factors contributing to the significant life expectancy gap in Sunderland and the worsening position for men in particular. Over 60% of the gap is as a result of cardio-vascular disease, cancer and respiratory diseases. Eight high impact interventions have been agreed and the CCG is leading on four of these.

- Consistent use of beta blockers, aspirin, ACE inhibitor and statins following a circulatory event
- Systematic treatment for COPD
- Cancer awareness and early detection
- Identification and management of atrial fibrillation

The initial focus is on delivery of the 4 areas above as these are priority health requirements for the people of Sunderland and achievable within the pathfinder timeframe.

However, the CCG is increasingly taking a lead role with the commissioning of local health priorities out with the pathfinder but part of the Sunderland Integrated Strategic and Operational Plan (ISOP). This leadership is subject to capacity issues (both clinical and managerial) and the level or impact of the proposal currently and in the future e.g. where a decision taken now by the PCT may impact on the CCG when it becomes a statutory body. This leadership will increase over 2011/12 as the CCG develops as an organisation and agrees the level of commissioning support from the PCT.

As part of the transition, the CCG expects to be authorisation ready by October 2012 and authorised to take on statutory responsibility for commissioning no later than March 2013.

3. Sunderland Integrated Strategic and Operational Plan (ISOP)

The Sunderland ISOP, refreshed in April 2011, just as SCCG were forming, sets out how (with the current PCT until April 2013) the CCG will change the shape of health services across Sunderland over the next three years, and shift the balance from treating illness to helping and supporting individuals to live longer and healthier lives.

The CCG embraces the intention behind the current NHS South of Tyne and Wear vision for the future as it applies to Sunderland - to work together to **make South of Tyne and Wear healthy for all** which is under pinned by the following key aspirations:

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

Underpinning this vision, is the need to change the shape of services away from an emphasis on treating ill health to one of enabling and supporting individuals to live healthier lifestyles and adopt positive behaviors, supported by an integrated tiered healthcare system.

In order to achieve this “future state”, the focus of the strategy is on prevention, secondary prevention and long term conditions. Care will be delivered closer to patient’s home through the commissioning of new services supported by integrated pathways together with the radical reform of current provision aimed at eliminating waste and moving care out of hospitals.

In particular SCCG are committed to providing excellent health outcomes for patients. The CCG is passionate that these outcomes will be best achieved by developing closer and more effective working relations between primary and secondary care whilst integrating the health needs with the social and community needs of patients.

The CCG will work in collaboration with the PCT, local providers, the Local Authority and patients to ensure that the vision is targeted via a whole system approach. They will work within the ISOP and also the Joint Strategic Needs Assessment and are

committed to delivering collaboratively on the local QIPP agenda to which CCG plans are aligned.

Together with the PCT, the CCG has identified seven areas (strategic objectives) in which major change is needed in order to move towards the vision of the future and the thirteen programmes of initiatives to be undertaken:

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

The CCG and PCT will publish a refreshed ISOP in early 2012 which will outline the key initiatives to be undertaken in 2012/13 building upon progress achieved in this financial year. The initiatives outline the activities to be undertaken in delivering strategic objectives including the full QIPP programme, in all sectors of healthcare provision including primary care, community, mental health and acute.

The plan will also address the specific actions required to address the national requirements as outlined in the forthcoming 2012/13 Operating Framework.

4. Resource releasing initiatives (RRIs)

In order to fund the extensive investment programme and absorb additional financial pressures (inflation, increasing elderly population, clinical developments etc) given the expectation of nil or minimal growth in PCT budgets, a range of disinvestment initiatives were identified in the ISOP and have continued to be updated and refreshed.

2012/13 is the 3rd year of the QIPP / RRI programme and detailed plans are in place to deliver these challenging savings. These plans will be subject to detailed review by the CCG and PCT over the next 3 months, with a detailed activity and financial breakdown of individual RRIs included in the final version of the Commissioning Intentions to be issued early next year.

5. Delivery of National Priorities

The 2012/13 Operating Framework will be published in December 2012 and is expected to be accompanied by revised PbR tariffs and updated versions of standard legally binding contracts.

The framework is also likely to provide further clarity on the key priorities the NHS is required to address in the new financial year and which will need to be reflected in contract negotiations and final agreements. Until such time that national priorities are revised to reflect any changes proposed by the coalition government, commissioners will continue to pursue the 2011/12 Operating Framework objectives within contract agreements, as follows:

Improving cleanliness and reducing Healthcare Associated Infections (HCAIs): Specifically reducing MRSA and Clostridium difficile infections in line with agreed trajectories.
Improving access: Ensuring that the requirements of the NHS Constitution are fulfilled and that patients are offered a choice of provider and a guarantee of receiving treatment within 18 weeks from GP referral.
Keeping adults and children well, improving their health and reducing inequalities: The CCG and PCT will continue to work with partners to implement initiatives linked to the key service priorities.
Military veterans: The CCG and PCT will work with providers to ensure our contracts provide military veterans with appropriate treatment, ensuring a smooth transition for injured personnel into NHS care as well as providing priority treatment for conditions relating to their service.
National Dementia Strategy: The CCG and PCT will work with partner organisations to implement the requirements of the National Dementia Strategy and in line with the revised Operating Framework published in June 2010, will publish how we are implementing the strategy to increase local accountability for prioritisation.
Increasing access to psychological therapies (IAPT): the CCG and PCT is expected to continue expanding access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions.
Mixed sex accommodation: We will actively monitor compliance in respect of this important patient experience issue.
30 day re-admissions: Subject to any revised PBR guidance, the CCG and PCT expects acute providers to remain responsible for a patient for thirty days following their discharge from hospital. As such the commissioner will not fund the cost of treating patients who are re-admitted within this timeframe and expects Foundation Trusts to work with community based and local authority providers to address this issue and make significant improvements to patient experience.

The CCG and PCT will continue to work with partners to address the following key issues.

Improving patient experience, satisfaction and engagement.
Emergency preparedness.
Improving the health and well being of the population.

The key priority of ensuring the services we commission are of the highest quality will be addressed through further development of the CQUIN scheme and via the continued development of the infrastructure to support quality improvement with our providers as outlined later in this paper.

The final Commissioning Intentions to be published in January 2012 will reflect the requirements of the updated Operating Framework which we expect to reflect within contract agreements.

6. National tariff and planned activity profiles

Detailed financial and activity schedules outlining the impact of commissioning intentions and reflecting modelled activity requirements will be published in January, in conjunction with an update to this document.

The final commissioning intentions will reflect any updates to the PbR rules which may be published in the Operating Framework in December.

7. Any Qualified Provider

Plans to implement the AQP initiative are currently being developed in accordance with the national timeframe which requires PCOs to have commissioned a minimum of three services on this basis with effect from October 2012.

Providers will be kept informed of the implications this may have on existing contract agreements as the implementation process develops.

8. Investing in quality

National context

'Equity and Excellence: Liberating the NHS' (July 2010) placed a significant emphasis on developing and implementing quality standards to improve healthcare outcomes for patients. As the architecture of the new NHS develops the mechanisms to do this are evolving. The NHS Commissioning Board (NHSCB) will have a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of health services. Securing improvement in outcomes, as defined by the *NHS Outcomes Framework* will be particularly important as the Board will be held to account using this framework. It is anticipated that the NHSCB will use Quality Standards developed by NICE to drive its commissioning processes. NICE Quality Standards – and accredited evidence produced by other groups such as the Royal Colleges – will underpin the *Commissioning Outcomes Framework*, through which clinical commissioning groups will be held to account. Quality Standards are intended to be the backbone of the commissioning system, supporting consistent improvement in all parts of the country.

It seems clear from the emerging national picture that the NHS Outcomes Framework underpinned by NICE Quality Standards will increasingly influence the focus of attention within quality improvement work going forward. It is important therefore whilst the statutory duty of quality lies with PCTs that in 2012/13 our quality review mechanisms take these into account. Existing quality schedules and Commissioning

for Quality and Innovation (CQUIN) schemes align well with the NHS Outcomes Framework and this alignment will be made more explicit in 2012/13.

The Operating Framework for NHS England 2012/13 is expected as in previous years to outline requirements linked to quality and these will also need to be taken into account.

During this transition period NHS SoTW and the CCG will maintain a focus on quality assurance and improvement during 2012/13 using existing quality mechanisms linked to contractual process for instance quality review meetings, monitoring against quality schedules and CQUIN schemes in addition to safety systems such as serious incident reporting.

Local priorities for quality assurance or improvement
The process of identifying priorities for quality assurance and improvement has begun and it is anticipated that these will be agreed in December by relevant groups.

Patient safety

- Strengthening of Serious Untoward Incidents (SUIs) processes and development of consistent reporting
- Infection control
- Safeguarding
- Reducing hospital mortality (Including reducing deaths from veno-thrombo embolism)
- Reducing harm from pressure damage and falls
- Discharge communication

Clinical effectiveness

- NICE guidance compliance
- NICE quality standards, particularly stroke, heart failure and dementia
- Specific clinical areas linked to strategic priorities

Providers will be asked to share and discuss their clinical audit programme for 2012/13 through the relevant quality review group by end of April 2012.

Patient experience

- Collection and review of patient experience information and completion of related actions
- Patient reported outcome measures (PROMS)
- Delivering single sex accommodation
- Continued development of a programme of PCT non-executive director visits to provider organisations focused on patient experience.

Providers will be asked to share and discuss their patient experience programme for 2012/13 through the relevant quality review group by end of April 2012.

Commissioning for Quality and Innovation (CQUIN) 2012/13
Where an NHS Standard Contract is in place 1.5% of the contracts outturn value is awarded to the provider for the achievement of CQUIN goals. It is expected that the Operating Framework for NHS England 2012/13 will indicate the CQUIN arrangements for 2012/13 e.g. any nationally mandated goals and the value of schemes.

North East PCOs have worked together, and in conjunction with the SHA, on a timetable for the 2012/13 commissioning round; the CQUIN timetable has been agreed as part of this wider commissioning timetable referred to below.

A range of stakeholders including Clinical Innovation Teams, the North East Quality Observatory, providers and commissioners are currently involved in the development of suggested measures for CQUIN schemes. Proposals for CQUIN indicators should have a clear rationale, existing data flow where possible and sufficient baseline data to adequately inform goal setting prior to contract agreement.

It is expected that draft CQUIN schemes will be reviewed/agreed by the Quality, Patient Safety and Clinical Governance Committee and Clinical Commissioning Groups in December.

9. Timetable

Attached as an appendix to this document is a timetable which outlines the key tasks and milestones to be achieved to ensure that 2012/13 contract negotiations are successfully completed and contracts are formally signed off by the 15th March 2012.

10. Local contracting issues

Final Commissioning Intentions to be issued in January 2012 will outline in detail the commissioner approach to a range of contracting issues. The following list reflects a flavour of what this is likely to include and should not be viewed as exhaustive at this point:

Contract documentation: Where appropriate, the revised standard contract will be adopted and where existing contracts extend beyond the one year term, discussions will take place regarding the potential, by mutual agreement, to adopt the revised standard contract.

Local Tariffs: Where appropriate, local tariffs will continue to be reviewed with a view to identifying areas of potential efficiency. The emphasis will be on identifying opportunities for reduced expenditure which allow providers to release costs.

Block Contracts: Review of remaining block contracts will be undertaken in accordance with the ongoing contract management arrangements.

Coding and Counting Changes: Where counting and coding changes are agreed during the negotiation process a commissioner based risk assessment will be required from providers prior to entering into any discussions regarding implementation. In addition, commissioners expect that any such coding changes will be under pinned by an appropriate in year risk share arrangement to protect both providers and commissioners from unanticipated financial risk.

High Cost and Excluded Drugs: Commissioners will continue to work with providers to more accurately predict the level of expected spend in order to agree realistic baselines within contracts. Commissioners expect that providers will supply patient level details related to all high cost and excluded drugs, linked to condition.

Never events: In line with the 2011/12 Operating Framework, the commissioner will not fund those spells identified as “never events”.

Contract Management: Subject to changes in GP generated demand, the commissioner expects providers to undertake out patient and elective activity in accordance with agreed activity profiles and within annual planned activity targets and expects that contract queries raised through the contract review mechanism are resolved in a timely manner.

Trauma networks: Commissioners will work in conjunction with local providers to implement the NE SHA trauma network arrangements in accordance with the implementation timetable.

Specialised commissioning: Work will be undertaken with the North East Specialised Commissioning Group, in conjunction with providers, to effectively map out the activity and financial implications on individual contracts arising from the introduction of revised specialised commissioning definitions, the intention being to reduce the level of financial risk to both commissioners and providers.

NEAS: Commissioners will continue to actively contribute and support the lead commissioner of ambulance services, particularly in the development of PbR related tariffs. The commissioner expects that, following specific discussions with the provider, where it is clinically safe to do so, there will be a significant increase in the number of patients transported to MIUs as an alternative to A&E.

Community services and joint commissioning: Where appropriate, community based contracts will be reviewed to continue the process of ensuring high quality cost effective services which meet the needs of the local population.

Commissioners, in conjunction with CCG leads, intend to progress a number of procurements as outlined in the appendix to this document.

We will continue to work with local authorities and other local government services to deliver statutory requirements and identify opportunities to work better together to improve peoples health and well being and achieve more efficient and integrated delivery of services: developing and delivering joint commissioning arrangements for locally agreed health and care services as appropriate; pooled budgets, lead commissioner arrangements and / or commissioning of integrated health and care services.

We will review and develop the statutory NHS Continuing Health Care function; mental health and learning disability out-area-placements; and statutory s.117 (MHAct 1983) aftercare arrangements.

Mental health contracting: 2012-13 is the introductory year for what is a major change in the way that mental health care is currently funded, a shift from block grants to PbR currencies which are associated with individual service users and their interactions with mental health services. Commissioners will work constructively with providers to ensure a smooth transition to this new Care Packages and Pathways Programme (CPPP) system throughout 2012/13.

Contract penalties: Commissioners expect to re-negotiate the penalty schedule which was agreed in 2011/12 contracts. Discussions regarding the proposed content of the revised schedule are currently ongoing however, the principles governing their implementation which are reflected in current contract agreements are expected to continue to apply.

The rationale supporting the introduction of the penalty schedule remains the need to support the delivery of continued national and local targets and which enhance patient experience and good system management.

Public Health: During Autumn/Winter 2011/12 there will be further guidance and specific detail of both the ring fenced public health budget allocations and further guidance on the Public Health Services which Local Authorities become responsible for commissioning in April 2013. It is unclear how similar the ring fenced allocation will be to the current PH spends across the three PCTS in SOTW.
Services are currently commissioned across a range of providers in the NHS, Local Authorities, the Independent, Private and Voluntary Sectors with a wide range of notice periods, from three to 12 months. In these circumstances it is possible that there may be a reduction in available funding and based on Joint Strategic Needs Assessments and Health and Wellbeing Board discussions and decision making during 2011/12 and 2012/13, it is highly likely each PCT and Local Authority may need to make alterations to current commissioning arrangements. These will be dependent on individual circumstance but further detail is not available until the DH issue the budget.

Primary Care: Contract management arrangements for Local Enhanced Services will be confirmed whilst the North East Primary Care Services Agency will coordinate the re-procurement of APMS contract where these are due to come to an end.

In 2012/13, the North East Primary Care Services Agency on behalf of NHS SoTW will carry out service reviews on the four GP practices transferred to STFT. This process will enable commissioners to determine the best way of meeting the needs of the patients when the current agreements come to an end. There will be a similar process for the Blaydon MIU and GP practice timed for the end of that contract in 2014. The Blaydon service review will have two components as the MIU service will be reviewed by GP Commissioners and the GP service by the NEPCSA in line with Barbara Hakin's guidance.

Network commissioning issues: The focus of this document is on commissioning intentions related to services directly commissioned by the CCG and PCT. Services which are jointly commissioned or which are commissioned on a network basis, for example, specialised commissioning and the North East Cancer and CVD Networks will be addressed through the established routes.

Health equity: The CCG and PCT expect all providers to actively engage in initiatives at both PCT and locality level which are aimed at establishing fair access to services and in particular demonstrate, in conjunction with the commissioner, practical changes to service delivery to improve equity of delivery.

11. Equality, Diversity and Human Rights

SCCG and NHS South of Tyne and Wear are committed to promoting human rights and providing equality of opportunity; not only in our employment practices but also in the way we commission our services. The organisation also values and respects the diversity of our employees and the communities we serve. In applying this policy, the organisation will have due regard for the need to:

Promote human rights
Eliminate unlawful discrimination
Promote equality of opportunity
Provide for good relations between people of diverse groups
Consider providing more favourable treatment for people with disabilities

This policy aims to be accessible to everyone regardless of age, disability (physical, mental health or learning disability), gender (including transgender) race, sexual orientation, religion or belief or any other factor which may result in unfair treatment or inequalities in health or employment.

12. Equality Impact Assessment

Positive Impact – the Interim Commissioning Intentions sets out that there is a duty on the Provider of services to ensure equity of access to their services for people from all groups regardless of race or ethnicity, disability (physical, mental and learning disabilities), gender (including transgender), age, sexual orientation, religion and belief or any other factor which may result in unfair treatment or inequalities in health. It also recognises that there are some services for specific groups – for example, gender specific breastfeeding services. It is anticipated that the Interim Commissioning Intentions will ensure Providers deliver a service that promotes equality and has a positive impact on all groups.

The development of the Sunderland ISOP has sought to promote equality, human rights and tackle health inequalities. This has been through carrying out health needs assessments, life-style surveys, publication of the Single Equality Scheme, Health Impact Assessments, Equality Impact Assessments and involving partners, stakeholders and local communities in the design, planning and development of services.

As part of the practical work that is undertaken to develop service specifications for new or changing services as part of our commissioning development work, we will undertake equality impact assessments to ensure that our services provide equity of opportunity, equity of access and equity of outcomes.

13. Initial 2012/13 initiatives

Appendix 1 is intended to give providers a high level view of the initiatives the CCG and PCT will be implementing in 2012/13. Work has already commenced on a number of these initiatives which were identified in last year's Commissioning Intentions document.

Work is ongoing to further refine and develop this list through the next three months to produce final commissioning intentions and a draft refreshed ISOP for Sunderland by January 2012.

14. Summary

This initial Interim Commissioning Intentions document is aimed at raising awareness of the initiatives which the CCG supported by the PCT intends to implement during the next contract year, some of which are already in development. This document will be updated and re-issued in January 2012 to provide a more detailed description of our Commissioning Intentions for 2012/13 and which will be accompanied by detailed activity and cost schedules clearly outlining the expected impact of all initiatives, including those which will release resources (RRIs).

Sunderland Commissioning Intentions 2012/13

Attached below are the Sunderland Commissioning Intentions 2012/13 split by Commissioning Responsibilities. Please note that this is a provisional split based on information known to date:

Clinical Commissioning Groups

Strategic Priority	**Action**
Cancer Services	**Remodel Breast Cancer Services across NHS SoTW (excluding screening services) in order to implement a sustainable service model. Developments include; 5 year follow up clinics to be nurse led. Remove Gynaecomastia from normal breast service and send difficult cases to plastic surgery. The remodelled service is expected to be operational during 2012/13.
	Ensure cancer pathways for Foundation Trusts are in line with North East Cancer Network model pathways. Issues to consider include pathology centralisation, impact on one stop services and the ability of Foundation Trusts to report.
	Work with Foundation Trusts to ensure processes are in place to recoup funding through Patient Access Schemes for High Cost Cancer Drugs.
	Increase the uptake of Radiotherapy Services by implementing a strategy to secure local provision.

Child and Adolescent Mental Health Services and Learning Disabilities	Development of Tier 2 CAMH service provision including improved access to talking therapies. Re-alignment of resources/ changes in service provision for children and young people with ASD based on outcomes of 2011/12 review that will take into account: • Changes in specialist community service provision (newly awarded CAMHS/ LDD contract) • Newly published NICE Guidance in line with the outcome of the review of 2011/12 • Development of services to support implementation of continuing care guidance • Services for Looked After Children • Child protection services. • Services for children and young people involved in the criminal justice system.
Learning disabilities	Ensure that physical health care checks in primary care for people with learning disabilities are implemented.
	Develop an Autism Spectrum Disorder assessment and diagnostic service across Sunderland from April 2012.
Mental Health	Implement the emotional health & wellbeing plan. Implement mental health specific actions within the Suicide strategy.
	Continue to work with NTW to realise efficiencies in relation to QIPP & ensure continued engagement in the delivery of resource releasing initiatives. Use quality initiatives to support service development.
	Work with NTW to support the implementation of the business case for reprovision of in patient, out patient & community services regarding new facilities at Ryhope & Monkwearmouth during 2012/13.
	**Continue implementation of the Mental Health Model of Care for SoTW. • Secondary care remodelling including liaison & services for veterans. • Further development of mental health in primary care including a review of access to practice based counselling. • Further development of the dementia strategy including anti psychotic prescribing plan.

	Continue the process of repatriating high cost out of area placements to locally provided services.
	Develop and agree an adult attention deficit and hyperactivity disorder assessment, diagnosis and treatment service.
	Lead the implementation of CPPP (PbR for mental health) in shadow form across contracts.
	Re-provide BME and LGBT wellbeing programmes
	Review workplace health programme with improved service offer for organisations not pursuing NE Better Health at Work Award.
	Implement recommendations arising from report on outcomes of physical health improvement programme for people with severe mental illness (SMI).
Children's Services	Implement the recommendations from the review of Speech, Language and Communications needs across SOTW. Working in partnership to ensure the new model of provision is embedded and sustainable.
	Review Children's Community Nurses (CCNs) and palliative care for children in line with requirements set out in Aiming High for Disabled Children. Working in partnership with Local Authorities support the review of SEN assessment and statement framework. This will explore the potential for replacing the existing system with an assessment process, a single, joined up 'Education, Health and Care Plan'. Explore opportunities to implement personal health budgets for children as part of this overall review.
	Review occupational therapy and physiotherapy services for children and young people. This review is expected to commence during 2011/12.
Urgent Care	Implement the 111 single point of access for urgent care to signpost patients with an urgent care requirement to the most appropriate service to meet their needs. The contract to provide the 111 service will be awarded in November 2011; between November 2011 and September 2012 urgent care services will need to be aligned to the 111 operational model (including GP out of hours) which will include a range of re-procurements where necessary or variation of current contracts.

	Develop an urgent care transport strategy to support the implementation of 111.
	Arrange an annual 'Choose Well' public information campaign to publicise the range of services, points of access, hours of operation and areas of exclusion by targeting focus groups in SoTW in order to help reduce demand for secondary care services.
	**Following the evaluation of the current models of minor injury and illness units across SoTW, a standard model of GP integrated working will be implemented across all MIUs. Modelling work will also look at the number of services required, the most appropriate locations and associated commissioning actions. • Houghton MIU will be open in 2012. The model and procurement options work stream is being developed. • The exploration of a primary care presence in the A&E footprint at SRH is underway
	Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted.
	Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality.
	Review Urgent Care Services across SoTW to understand the current state of urgent care provision and develop a future state. Work on this will continue over the next four years.
	Expected impact of the introduction of Trauma Centres and locally the potential re-classification of our local FTs as Trauma Units.
	**Develop a community based cellulitis model and service.
	**Develop a community based DVT model and service.
Long Term Conditions	**Develop a commissioning model for Long Term Conditions incorporating self care and rehabilitation. Also linking LTC to EoL care at the top end of the pyramid, avoiding duplication in the hospital setting to reduce unnecessary readmissions. Consider whether a new service as required rather than individual specialities to look after the

	patient.
	Develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with LTCs and frail elderly, including care within individuals own homes and community based ‘step up’ facilities.
	**Develop Integrated Teams e.g. Joint Urgent care team and 24/7 team to avoid current confusion about roles/access points.
	**Review role and effectiveness of Community Nursing and Community Matron.
	**Complete the review and implementation of changes to the District Nursing services whilst retaining the option to procure alternatives depending on the outcomes.
	Having completed the review of the impact of the additional reablement investment in 2011/11 we will work with stakeholders to develop investment plans for 2012/13.
	Further review of heart failure services in Sunderland.
	Commission systematic cardiac rehabilitation services across Sunderland including heart manual. Introduce a minimum data set and outcome measures and ensure that all eligible patients are included for rehabilitation. This will have an impact on hospital re-admissions.
	Implement actions from the QIPP/LTC Ignition Phase. Review the COPD pathway and identify improvements that could be made to improve patient care. It is expected that this will have an impact on hospital admissions.
	Review other Ambulatory Care Sensitive conditions including asthma and non acquired cardiac conditions.
	**Improve discharge processes (including documentation) and opportunities for early supported discharge by rolling out multi-disciplinary huddles/pow wows/clusters across all inpatient wards and developing in-reach/out-reach models of rehabilitation and reablement in Sunderland.

	Develop single-site model for weekend TIA clinics in Sunderland. This should lead to a reduction in inpatient admissions for high risk TIA due to weekend service and increased outpatient activity.
	Review specialist inpatient and community neurological rehabilitation services and commission revised pathways as a result of the review.
	**Develop a revised service model for an intermediate community diabetes service and modernise current secondary services to reduce unnecessary admission and length of stay.
	Evaluate outreach community pilot arrhythmia service and make recommendations for future service commissioning. Over time this should have an impact on hospital activity.
	**Develop a community based anti-coagulation and INR model and service
	**Develop a clinician led integrated intermediate care inpatient service at Houghton Primary Care Centre.
	Review end of life service to ensure advanced care plans in place across conditions
	Improve the management of AF and develop a community model and anti-coagulation in the community.
Planned Care	Reduce the number of procedures of limited clinical value.
	Implement the revised pathway for patients with carpal tunnel syndrome and explore further alternative surgical pathways.
	Reduce outpatient first and follow up attendances.
	**Where appropriate, transfer some diagnostic test activity out of secondary care. Consider opening up CT and MRI access to primary care to reduce unnecessary referrals.
	Review dermatology services with a view to aligning the service model with services commissioned for Gateshead and South Tyneside.
	In relation to nurse led clinics, secure a nurse led tariff adjustment, scope out nurse led clinics and where appropriate de-commission and/or re-locate clinics. Scope out nurse led telephone clinics and replace nurse led outpatient attendances with telephone consultations where appropriate.
	Review Adult Hearing Services with an aim to improving access, choice and quality of care.

	Review podiatry services with an aim to improving access, choice and quality of care.
	Commissioning of home oxygen assessment service.
	**Review of provision of long term oxygen therapy.
	Potential procurement of Primary care and Secondary Care based orthodontic services.
End of Life Care	**Reduce the amount of time spent organising care packages by community nurses to enable more clinical time to be spent with patients as long as an alternative for delivering the organisation of care packages is in place agreed with SCCG. Would need to also review District Nursing team to enhance the quality of primary care.
	Evaluate the long-term sustainability of end of life facilities in Sunderland.
	Understand impact of funding review and move to tariff based commissioning of services.
	Re-provide St Benedict's Hospice.
Medicines Management	**Refresh action plans with SCCG to deliver efficiencies and improve the quality of prescribing.
	Optimise medicines usage in patients with long term conditions to ensure quality of care and cost effectiveness.
	**With regard to primary care prescribing - identify opportunities for disinvestment in collaboration with SCCG.
	Work with both secondary and primary care to develop a health economy approach to prescribing of medicines across pathways of care including improving the effectiveness of communication, the provision of shared care medicines and outpatient prescribing.
	Explore options to develop services to improve medicines management in care homes in order to reduce the number of emergency admissions and reduce medicines wastage.
	Explore options for collaborative working across primary and secondary care in relation to the provision of oral nutritional products, stoma and incontinence and wound management.

	Improve the introduction and management of the high cost drug exclusions.
	**Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including improving rates of repeat dispensing, New medicines service and targeted use of medicines usage reviews. Addressing quality and safety aspect of NOMAD and Repeat Dispensing
	Work with SCCG to ensure there are robust local mechanisms for funding approval for medicines.
	**Review the contract for provision of medicines management support to individual practices within the SCCG to ensure a Sunderland wide approach, where the contract will prioritise QOF,QP; QIPP and PIS.
	**All secondary care and primary care providers to ensure patients post MI benefit from 4 drugs – aspirin, beta-blocker, stain and ACEI

Public Health England/Local Authority Responsibilities

Strategic Priority	Action
Cancer Services	Expand upper age range to 73 for Breast Cancer Screening.
	Expand age range for Bowel Cancer Screening and raise awareness to increase uptake, whilst ensuring contract volumes reflect anticipate increases in demand.
	Introduction of HPV testing for Cervical Screening.
	**Increase the early detection and identification of cancer and increase uptake rates of screening programmes. Implement urgent lower GI investigation by adopting the Hamilton Risk Assessment Tool into TWW time frame.
	Enhance engagement and uptake of services following HEA of Breast Screening Service.
Joint commissioning	Implementation of robust joint commissioning arrangements with Sunderland LA through the use of Health Act flexibilities. Simplify & integrate commissioning of CHC, FNC & s117. Continue to implement the Carers strategy.
	Enhancement of governance & quality arrangements with independent sector providers.
	Work collaboratively to bring together plans for development of physical health, mental health, medicines management and end of life care for Sunderland care homes.
Children's Services	Review school nursing services across SOTW to ensure all key elements of the Healthy Child Programme 5-19 years are delivered and key outcomes are achieved.
	Develop an early intervention and prevention strategy with local partners to ensure effective evidence based interventions are delivered and monitored in accordance with need to reduce health inequalities and narrow the gap in outcomes.

	Review children's overweight and obesity services (across all the tiers) to ensure children and young people have access to timely, appropriate and accessible support to meet their needs. Identify opportunities to develop family based interventions (lifespan approach).
	Implement the risk and resilience model across SOTW reviewing service provision to ensure services are targeted appropriately across the four levels of need. A risk and resilience training package will be developed across SOTW in partnership with Local Authorities. Review workforce skills and competencies against the core standards of the model.
	Develop a phased approach to the implementation of 'You're Welcome' quality standards across SOTW. Ensure service providers deliver in accordance with 'You're Welcome' standards.
	**Agree with SCCG the recommendations- from the sexual review and sexual health HEA (health equity audit) and implement agreed recommendations. Ensure all providers are signed up to the new electronic C Card and are using it appropriately.
	Ensure compliance with NHS SOTW strategy, policies and procedures for Safeguarding Adults and Children.
	Implement recommendations from the CQC and Ofsted joint inspections of Safeguarding and Looked After Children. Develop the service specification for services for Looked after children in line with the tier 3 CAMHS review and following the outcome of the Looked after Children Health assessment RPIW.
	Review drug and alcohol services for children and young people in Sunderland and implement recommendations in line with the risk and resilience model.
Prevention/Staying Healthy	Following completion of evaluation, amend/re-provide NHS Health Checks services/interventions as necessary to ensure scale required is met and inequalities are reduced.
	Following completion of evaluation, amend/re-provide Obesity services as necessary (including exercise on referral) to follow a life span approach.
	Following completion of review & HEA, amend/ re-provide Stop Smoking services.

	Re-commission alcohol & drugs services in line with the National Drugs Strategy with a focus on recovery and outcomes from treatment.
	Re-provide Chlamydia screening services (this is in 11/12 and for 11/12 we have a short term arrangement with NECA but require longer term arrangement).
	Following review & evaluation, amend/re-provide Sexual Health Services as necessary.
	Develop integrated approach to domestic violence.
	Re-align pathway of care for offenders on release of prison as necessary.
	Review the commissioning arrangements of FRESH and Balance.
	Assess and enhance capacity of service for engaging with ex-service personnel where necessary.
	Re-provision of Health Trainer Service.
	Review provision and coordination of training & capacity building across lifestyle services and re-align services accordingly. Re-procure Health Champion suite of training.
	Utilise findings of the Lifestyle Survey (due March 2012) to inform in year variations in lifestyle services and inform commissioning intentions 2012/13 utilising a social marketing approach.

NHS Commissioning Board Commissioning responsibilities

Strategic Priority	Action
Children's Services	**Continue to implement the expansion programme for Family Nurse Partnership (FNP) and Health Visiting Services across SOTW. Ensure the Health Visitor service meets the requirements of the new national model and service specification in agreement with SCCG. The changes will come into affect from 1 April 2012 (as per requirements of Early Implementer Site status). Continue to review the impact of the new model working in partnership with early years providers and SCCG to ensure the best start in life is achieved. Review skill mix within the Health visiting service and explore opportunities nationally to expand the FNP offer.
	Develop a review programme of services against existing evidence base and identify opportunities to develop innovative practice to support the development of evidence base.
	Review commissioning arrangements for newborn screening programmes and develop service specifications accordingly.
Maternity Services	Carry out social marketing exercise across Sunderland using a regional model to increase the number of women breastfeeding.
	Increase breastfeeding rates by implementing peer support programmes.
	Support acute hospitals to achieve Baby Friendly Status.
	Review pathways in relation to obesity, substance misuse, mental health for pregnant women.
	Reduce the numbers of unplanned admissions during pregnancy. Review the current position and develop a future model to manage pregnancy related concerns in the community.

DRAFT 07-Jul-11

Planning Timetable 2012/13

Week commencing

Jun-11: 6 13 20 27 | Jul-11: 4 11 18 25 | Aug-11: 1 8 15 22 29 | Sep-11: 5 12 19 26 | Oct-11: 3 10 17 24 31 | Nov-11: 7 14 21 28 | Dec-11: 5 12 19 26 | Jan-12: 2 9 16 23 30 | Feb-12: 6 13 20 27 | Mar-12: 5 12 19 26

		Responsibilty
Tariff Arrangements	Tariff Sense Check — Sense Check	
	2012/13 PBR Road test — .mid Dec11 PBR Road Test	
	Agree interpretation of tariff for 2012/13 — .20 Jan 2012	Finance
	PBR guidance / tariff issued (including reablement and post discharge support) including tariff deflation — Tariff confirmed	
	Clusters, GPCC and providers review non tariff prices	
	Agree with providers what is included in tariff — .26 Jan 2012	
	Agree /understand differences in tariff interpetation in the NE — .26 Jan 2012	
CQUIN	Agree timetable and work programme for delivering 2012/13 CQUIN schemes across clusters — .mid July 2011 programme agreed	CQUIN Group
	Agree timetable with NHS Management Board North East — .15 July 2011 timetable agreed	NHSMBNE
	Agree timetable with all chief executives at Chief Executives' Forum — .22 July 2011 timetable agreed	SHA Director of Ops
	Measures for CQUIN identified by Specialist Clinical Networks, BHFH and SCNE proposed to regional CQUIN group — .30 Sept 2011	All + SHA to champion
	Identify local clinical priorities from GP commissioning consortia taking account of clinical consensus for change from Specialist Clinical Networks and provider input requested at early stage — .30 Sept 2011	CQUIN Group
	Review content from 2010/11 CQUIN for continued applicability including discussion with provider organisations — .30 Sept 2011	CQUIN group
	Alignment of CQUIN with business critical areas — .30 Sept 2011	CQUIN group
	Prioritisation process re CQUIN goals and measures to be included (early Oct and early Nov mtgs as a min) — .15 Nov 2011	CQUIN group
	NHSMBNE consider draft regional CQUIN indicators for alignment with north east priorities — .22 Nov 2011	NHSMBNE
	Standardisation of metrics and methodologies and provision of baseline data for CQUIN — Metrics and baselining etc	CQUIN group
	NORSCORE to conduct own process in parallel and formally feed in to CQUIN Leads group for consistency etc — NORSCORE process	NORSCORE
	NEQOS to provide support within SLA	NEQOS
	Discussion with providers on CQUIN — CQUIN discussions	Clusters / GPCC
	Negotiation of CQUINs with providers (early milestone end of Jan 12) — CQUIN negotiations	Clusters / GPCC
	CQUINs agreed — .28 Feb 2011	Clusters / GPCC / provide
	CQUINs signed off — .15 Mar 2	Clusters / GPCC
North east 2012/13 plan	Agree planning timetable at NHSMBNE on 15 July 2011, share at CE Forum 22 July 11. — .30 Sept 2011	SHA Director
	Seek to agree contracting deadlines with Monitor consistent with DH deadlines — .30 Sept 2011	SHA / Clusters
	Propose draft format for cluster / GPCC ISOP submissions for 2012/13 — .23 Sept 2011	CSM Executive
	DH publishes Operating Framework — .mid Dec11	Department of Health
	Review proposed format for cluster /GPCC submissions for 2012/13 ISOP for alignment with Operating framework — .mid Dec11	SHA Director of Ops
	Finance assumptions / DH Planning checklist issued — .mid Dec11	Department of Health
	Revised standard contract published — .mid Dec11	Department of Health
	Updated 2012/13 ISOPs submitted — .12 Jan11 .13 Feb11 .12 Mar1	Clusters / GPCC
	SHA feedback on activity and finance on updated ISOPs via NHSMBNE — .20 Jan11 .20 Feb11 .20 M	SHA Director of Ops
Contract negotiations	Clarify contract arrangements regarding GP / clinical involvement and lead — .7 July 2011	
	Specialised commissioning group to work with PCT clusters to identify the consequences of disaggregating specialised activity — July to October 2011	
	Identify services to be commissioned nationally and identify activity and financial implications of disaggregating specialised activity from PCT contracts — .31 Oct 2011	
	Standardise contract schedules across all contract types where this is applicable — .30 Sept 2011	
	Cluster / GPCC Demand and Capacity Assessments-potential impact for 2012/13 and future - Reconciliation with Providers	
	Cluster / GPCC Demand and Capacity impact for 2012/13 — .30 Dec11	
	Agree control totals for acute contracts — .6 Sept 2011 indicative — .3 Jan 2012 indicative	
	Clusters/GPCC commissioners and providers to confirm names of those who will negotiate contracts — .30 Sept 2011	
	Negotiating strategy for North East agreed — .30 Sept 2011 — .24 Jan 2012	
	Format of commissioning intentions to be consistent — .12 Aug 2011	
	Recommendations from Specialist Clinical Networks, BHFH and SCNE considered in commissioning intentions — .30 Sept 2011	
	Commissioning intentions finalised to align with ISOPs — .mid Dec11 Commissioning intentions finalised	
	Commissioning intentions published (including CQUIN) — w/c 16 Jan 12 Commissioning intentions published	
	Finalise Performace, Information, CQUIN Schedules and Incentives and consequences of contract breach — .mid Dec11 .12 Jan12	
	Negotations with providers-Pricing and Adjustments to Activity Levels — .12 Jan12 Pricing/activity	
	Contracts agreed by cluster and GPCC — .29 Feb12	
	Contracts signed by cluster and GPCC — .15 Mar12	
	Signed contacts to SHA — .30 Mar12	
Governance	**Meeting of NHS Management Board North East** — .10 VC .1 VC .15 Ju VC .5 VC .19 VC .2 VC .16 VC .7 VC .28 VC .11 VC .2 VC .23 VC	
	Meeting of Chief Executives' Forum — .24 June11 .22 July 11 .30 Sept .21 Oct 11 .25 Nov .16 Dec 11	
	Meeting of NE PCO contracting Group (Louise Robson) Dates tbc — .7June 11	
	• **Acute and community sub group (Colin Smith)** — .7July 11 .9 Sept 11 .10 Nov 11 .12 Jan 12 .8 Mar 12	
	• **Mental Health sub group (??Ian Holliday)**	
	• **CQUIN sub group (Lucy Topping)** - monthly meetings from August 2011	
	· **Ambulance sub group (Jeff Goldthorpe) - weekly contract review meeting**	
	ISOP assurance meetings SHA-Cluster/GPCC review meetings — .17 Jan 12 .17 Feb 12 .16 Mar12	
	Cluster ISOP review meetings with GPCC, clusters, FTs,and LAs (end April 2011)	
Supporting activities	DH workshop to explain 2012/13 contract issues — .early Jan12	