NHS
Sunderland
Clinical Commissioning Group

Operational Plan 2019 to 2020

April 2019

Contents

1. Introduction

Our vision is to achieve ***Better Health for Sunderland.*** Our seven core values informed by engagement with member practices, patients and local people, shape and underpin all the work we undertake to deliver this vision.

We will deliver our vision through three strategic objectives:

- Prevention;
- Transforming Community Care; and
- Transforming in Hospital Care.

Quality and safety are implicit in our vision and values. Our Quality Strategy, and the underpinning quality framework, will enable us to ensure that quality is at the heart of everything we do.

1.1 2019/20 operational plan

This 2019/20 operational plan has been informed by and responds to a range of information including, the NHS Operational Planning and Contracting Guidance 2019/20, the Five Year Forward View (FYFV) and the recently published NHS Long Term Plan, the Joint Strategic Needs Assessment (JSNA) for Sunderland, benchmarking information, including NHS RightCare, and a review of our 2018/19 strategic objectives and transformation programmes.

1.2 National vision

The NHS Long Term Plan (NHS LTP) was published in January 2019 setting out key ambitions and commitments for the NHS over the next 10 years. 2019/20 will be the foundation year laying the groundwork for implementation.

The NHS Long Term Plan builds on the current national NHS plan - the Five Year Forward View (FYFV), published in October 2014 – and supporting strategies covering general practice, cancer, mental health and maternity services. The FYFV sets out a vision for a better NHS by addressing three gaps between where we are now, and where we need to be in relation to:

- The health and wellbeing of the population.
- The quality of care that is provided.
- The finance and efficiency of NHS services.

1.3 Key challenges

This operational plans sets out our transformation plans for 2019/20 to meet the needs of our local population and drive improvements in health and wellbeing, quality and care and the efficiency of local NHS services to ensure sustainable services for the people of Sunderland.

Much of the 2019/20 operational plan is a continuation or development of the 2017 to 2019 operational plan.

2. System planning and system working

For a number of years, a key feature of national NHS policy has been a shift towards integrated care and place based systems to support sustainable improvements in health and care. As shown in figure 1 'place' is at a number of levels covering different population sizes. Integrated care partnerships (ICPs) and Integrated Care Systems (ICSs) bring together commissioners and providers to drive improvements in health outcomes, tackle systemic challenges and take collective responsibility for planning and managing the financial, quality and operational performance of services across a wider geographic footprint (also called 'system').

The CCG's operational plan focuses on the 'place' of Sunderland and it has been developed in the wider context of the 2019/20 operational plans for the 'North East North Cumbria (NENC) Integrated Care System and 'Central' Integrated Care Partnership.

The 2019/20 'Central' Integrated Care Partnership (ICP) operational plan is a product of the partnership of commissioners and providers across the three constituent places of 'Central'.

The 2019/20 NENC operational plan has been built up from place level discussion through to ICP level plans and in collaboration with NENC wide priority programmes and teams including Health Education England and clinical networks.

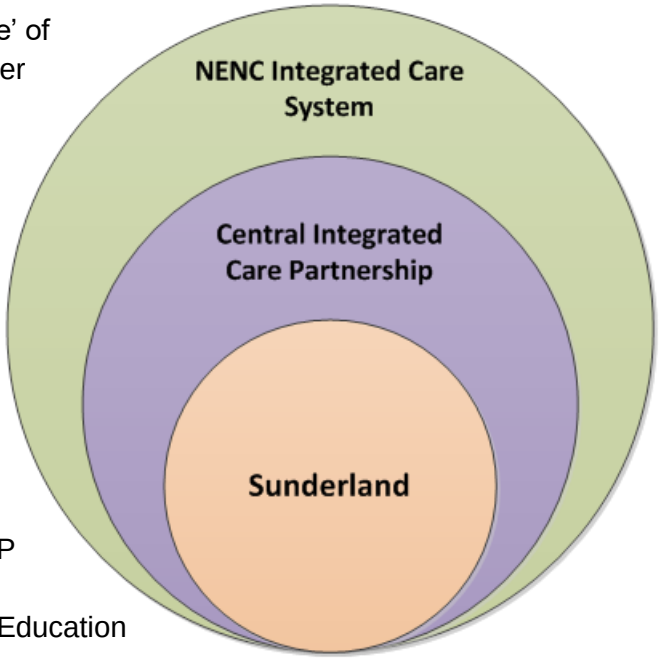


Figure 1

2.1 North East North Cumbria system

The North East North Cumbria system has been working as an aspirant ICS. It is a partnership between 12 clinical commissioning groups and 12 unitary authorities developing a shared vision and high level plan across NHS commissioners and providers collaborating across geographic and organisational boundaries.

The North East North Cumbria ICS comprises four Integrated Care Partnerships: North, Central, South and North Cumbria.

2.2 'Central' system

As shown in figure 2, 'Central' is a partnership of commissioners and providers across the places of County Durham, South Tyneside and Sunderland comprising: three foundation trusts (two from 01 April 2019); four CCGs including Sunderland; three local councils; Northumberland Tyne and Wear NHS Foundation Trust (FT) and North East Ambulance Service NHS FT.

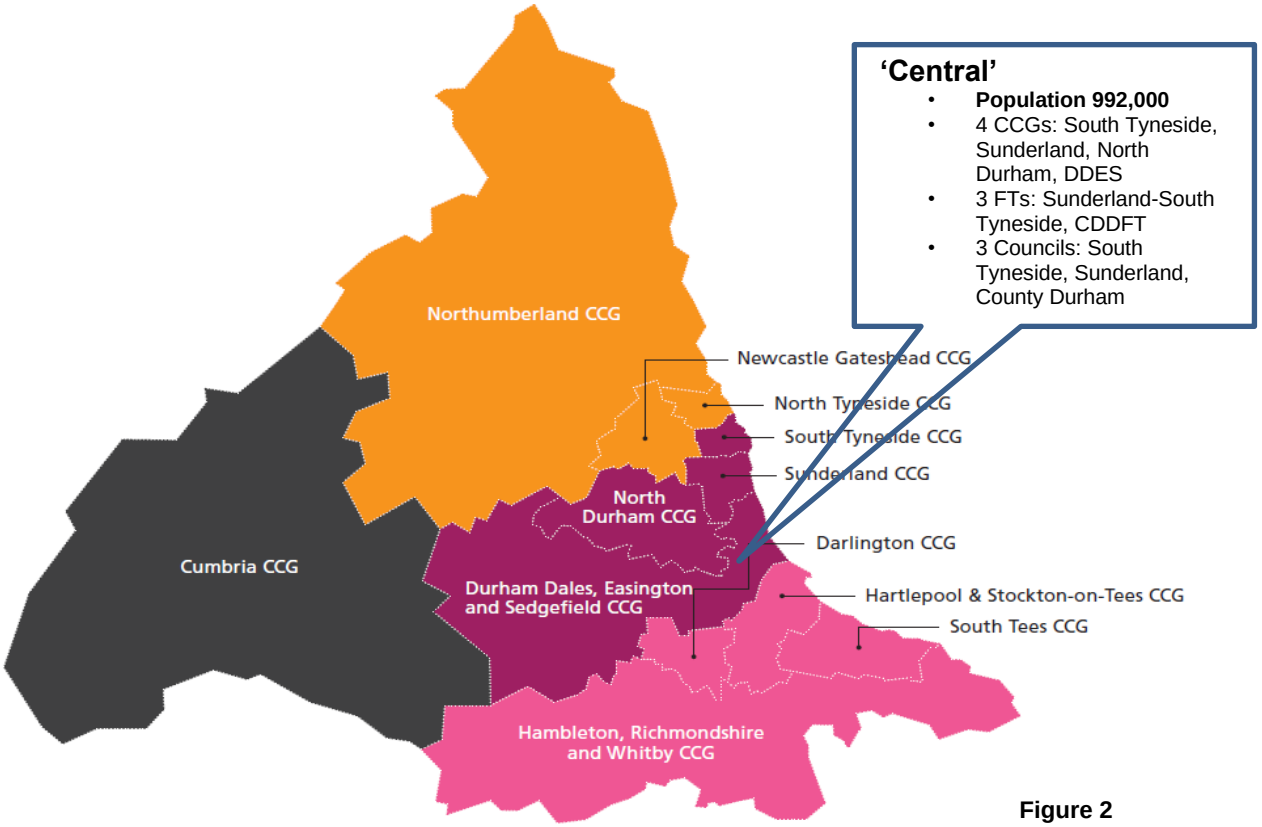


Figure 2

2.3 Working across South Tyneside and Sunderland Local Health Economy

Since 2016, we have worked closely with NHS South Tyneside CCG and South Tyneside and Sunderland NHS Foundation Trust (formerly City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust) to review and plan hospital services through a strategic transformation programme, known as Path to Excellence. The programme has been established to secure the future of local NHS hospital services in South Tyneside and Sunderland and to identify new and innovative ways of delivering high quality, joined up, safe, sustainable care to benefit both our populations now and in the future (figure 3).

Building on the successful collaborative working across the two places of South Tyneside and Sunderland to reform hospital services, the four organisations have worked together to develop a three year Local Health Economy (LHE) and system recovery plan to address the financial challenges faced by the South Tyneside and Sunderland local health economy. The LHE has agreed three workstreams – prevention, out of hospital and in hospital – and within these a number of transformation projects to deliver together.

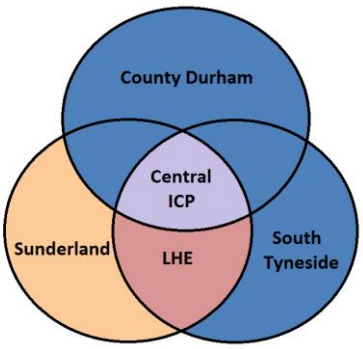


Figure 3

Sunderland CCG Plan on a Page 2019/20

SUSTAINABILITY - Finance, Workforce & Quality & Safety

Our Vision:	**Better Health for Sunderland**							
Delivered by:	**Prevention**		**Transforming Community Care**			**Transforming In Hospital Care**		
Measured by:	**CCG Improvement & Assessment Framework, All Together Better Alliance Outcomes**							
Underpinned by our values:	**Inclusive**	**Patient centred**	**Responsive**	**Innovative**	**Empowering**	**Integrity**	**Open and Honest**	

	Transformation Programmes	**Objective**
Prevention	Maternal Health & Wellbeing	Ensure safe and sustainable services for improved outcomes in maternity and ensure the best start in life.
	Child Health & Wellbeing	Improve child health; mental, physical and emotional wellbeing and reduce avoidable illness in later life.
	Cancer	Improve cancer outcomes, reducing smoking, increase screening uptake, early diagnosis and improve patient cancer pathway experience including survivorship and end of life care.
	Respiratory	Improve health outcomes and optimise the length and quality of life for people with and at risk of respiratory disease including care at end of life.
	Cardiovascular Disease (incl. Diabetes)	Optimise the length and quality of life for patients with, and at risk of CVD, through robust primary and secondary prevention, streamlined pathways and integrated services that meet national standards .
Community Care	**Transformation Programmes**	**Objective**
	General Practice	Further Development of Primary Care Networks, increasing workforce and digital transformation
	Mental Health, Learning Disabilities and Autism	Working with partners to ensure the successful implementation of system wide Mental Health, Learning Disabilities and Autism programmes
	Enhanced Primary and Community Care	Deliver integrated and patient centred care through the transformation of enhanced primary and community services.
	Intermediate and Urgent care	Ensure patients benefit from treatment, in the right place, at the right time, by the right professional through the provision of a simple seamless pathway across Intermediate and Urgent Care.
In hospital	**Transformation Programmes**	**Objective**
	Path 2 Excellence	Ensure a safe and sustainable model for acute services by delivering a single clinical operating model across the local health economy

Enabled by:					
	Integrated commissioning	Digital & Technology	Training & Leadership	Medicines Optimisation	Locality Networks
	Engagement	Patient & Carer Empowerment	Population Health Analytics	Collaboration	Research Evidence & Innovation

ICP ICS

3. Sustainability

Sustainability is a cross cutting theme in our operational plan and its significance is wider than long term financial sustainability. That said, increasing productivity and ensuring the services that we commission are good value for money remain a priority in our plan.

Workforce shortages pose a threat to delivery and quality of care nationally as well as locally in Sunderland. In 2019/20 our plan continues to focus on supporting the sustained delivery of services by addressing in hospital and community workforce challenges working with partners.

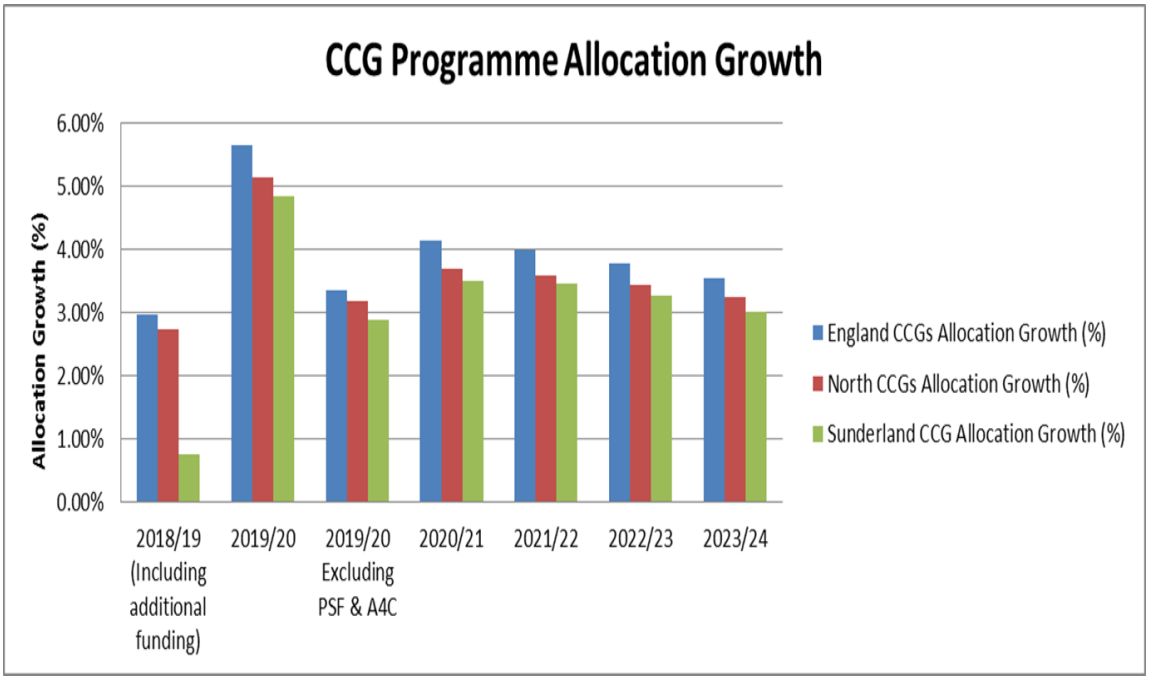
Gaps in workforce can challenge the delivery of high quality patient care, because it can make it very difficult for important clinical quality and safety standards to be met. Continuously improving care and maintaining a clear focus on the quality of care is essential for the sustainability of services. Our three year quality strategy, with its focus on effectiveness, safety and experience of care, maintains our commitment to assure the quality of services provided to patients.

3.1 Finance

a) Funding 2019/20 to 2023/24

Delivering safe and sustainable services for the people of Sunderland within available funding is a key part of our plan.

Following the refresh in 2018 of the allocation formula, Sunderland CCG is deemed to have an opening distance from target allocation of 7.35% in 2019/20. Sunderland CCG will receive growth at a rate lower than the national average but higher than the minimum. That said, it is worth noting that the CCG allocation growth for 2019/20 includes elements of funding which are already allocated in the system, such as Provider Sustainability Funding and Agenda for Change pressures.



The additional growth in allocation for 2019/20, announced in the Autumn Budget in 2018, will enable us to meet national requirements, such as:

- Delivering the Mental Health Investment Standard (MHIS).
- Funding activity driven pressures to support the achievement of Constitutional Standards.
- Community and primary care investments.

It will, along with drawdown access, also support the wider South Tyneside and Sunderland Local Health Economy system recovery plan currently under development.

b) Productivity

2017 to 2019 was a financially challenging period for the CCG with productivity requirements – QIPP – of £14.3m in 2017/28 and £11.3m in 2018/19 to remain within available allocations following low levels of allocation growth.

We have a strong record of delivery against financial plans and statutory financial duties and overall we are on track to deliver the 2018/19 QIPP of £11.3m.

Target	Outcome	Target Met
Delivery of 1% cumulative surplus on total revenue allocation	Cumulative surplus delivered of £20,760k (4.1%) against a total revenue resource allocation of £507,112k.	✓
Maintain running costs within the running cost allocation	Reported surplus of £345k on running cost budgets.	✓
Maintain capital spending within capital allocation	No capital resource provided to the CCG and no capital spend in year.	N/A
Ensure cash spending is within the cash limit set	Cash forecast to be managed within available resources.	✓

At this time QIPP plans of £6.9m will be required in 2019/20 (1.3%). However, the CCG has not reported In Hospital QIPP requirements due to block contract arrangements. Once these arrangements have been agreed as part of the LHE updates, the QIPP requirements will be refreshed.

The CCG is utilising £4.5m of drawdown funding to support LHE transitional sustainability in 2019/20, to fund Health Pathways implementation and to fund enhancements to the general practice quality premium in 2019/20.

c) 2019/20 Financial Risks

The risks in 2019/20 include

- Demand growth above expected funding requirements (e.g. Acute, Prescribing, Packages) - £4m in 2019/20.
- Non-delivery of productivity plans - £2.4m in 2019/20
- Other risks arising within system - £2m in 2019/20

We currently expect to be able to mitigate financial risks in 2019/20.

d) Sunderland and South Tyneside Local Health Economy Collaboration

As a local health economy system, we have committed to work across organisational boundaries to tackle the financial challenge that we will face. The CCGs and trusts have agreed block contract arrangements with a financial risk share to support pressures across the system.

The Sunderland and South Tyneside local health economy submitted a financial recovery plan in 2018/19 for the period 2018/19 to 2020/21 which identified a system financial efficiency requirement of £133m over the three year period. Following the release of planning guidance business rules and allocation growth figures the LHE are undertaking a refresh of this plan in order to assess the revised requirements for 2019/20 to 2023/24.

e) NHS RightCare

We have used the NHS RightCare benchmarking data to identify unwarranted variation and opportunities to improve health outcomes for the people of Sunderland. In 2019 we will continue to work on areas identified in 2016/17 and 2017/18 and apply the RightCare approach.

For 2019/20 the NHS Long Term Plan asks systems to work with the NHS RightCare programme with a focus on cardiovascular and respiratory disease. Therefore, the CCG will continue with the work already implemented to address variation in those areas. In line with the NHS Long Term Plan the CCG has committed to implement a High Intensity User service to support urgent and emergency care services and increasing demand.

3.2 Workforce

The performance of Sunderland's healthcare system is significantly dependent on people working in healthcare.

In Sunderland workforce pressures in hospital present a significant threat to health services and compromise the ability to deliver the very best quality of care to Sunderland patients. Sustaining safe staffing levels across both hospitals is challenging resulting in high usage of locum and agency staff. In addition the age profile of staff forecasts future pressures as more staff reach retirement. Workforce pressures also impact on staff morale and wellbeing.

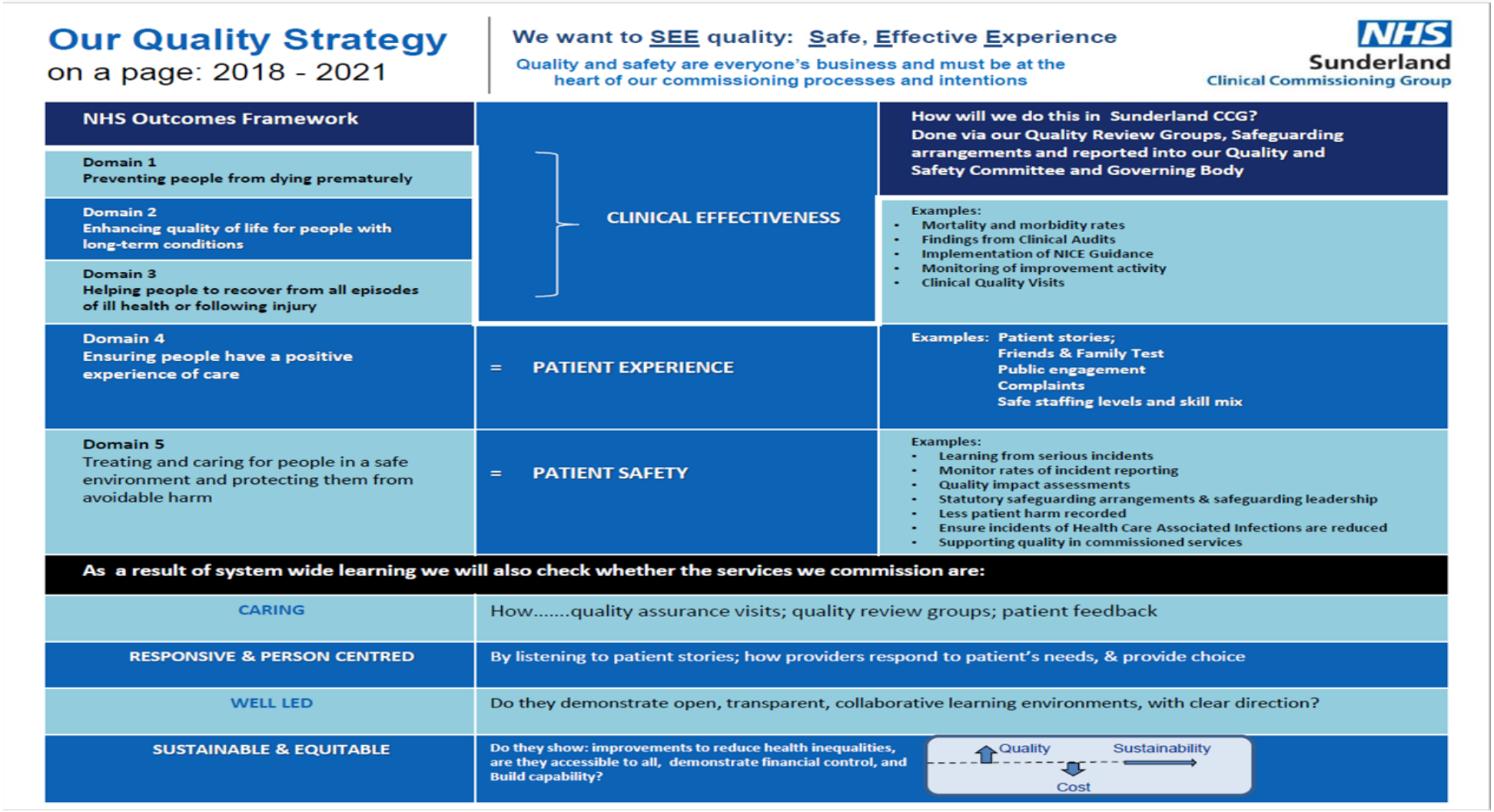
Workforce is therefore a key driver for the transformation of the services across the two hospitals.

The Path to Excellence transformation programme aims to improve the way current hospital services are delivered in South Tyneside and Sunderland in order to support service sustainability, improve staff wellbeing and morale and attract more potential new recruits.

Equally, workforce is a key enabler to the success of the All Together Better Alliance – the programme to transform care in a primary and community setting. A GP workforce group has been in place for four years and will continue to support the recruitment and retention of staff in general practice via a range of initiatives and in line with the CCG's commissioning strategy for general practice, and the GP Forward View with its focus on workforce. The NHS Long Term Plan commits to continue to increase the number of members of the primary care team, such as clinical pharmacists and physiotherapists, to support general practice. This proposed expansion will need to be worked through in 2019/20 to factor into workforce plans.

3.3 Quality and Safety

In order to achieve our vision to improve the health and wellbeing of local people so they live longer with a better quality of life, we must reduce variation in the quality and safety of the care. The quality of the services that we commission and that are provided to our patients will be assured through our refreshed quality strategy with its clear focus on the effectiveness, safety and the experience of that care. The strategy is underpinned by a quality framework which enables us to ensure that quality is at the heart of everything we do.



Overall objective for 2019/20
Quality is everybody's business

Deliverables in 2019/20

- Continue to review and refresh the quality toolkit and quality framework in line with the quality strategy.
- Continue to review transformational schemes using the quality impact assessment policy.
- Continue to provide support, oversight of audits and learning processes and challenge to the various groups that monitor quality and safety, for example, provider quality review groups, the CCG's QSC, NHS England's (NHS E) quality surveillance group (QSG) and the safeguarding boards/partnerships.
- Continue to lead the learning disability mortality review process and ensure dissemination of learning and to elicit recommendations to influence commissioning intentions.
- Continue to provide assurance to the Governing Body that the quality and safety of services is being robustly monitored and action is taken when required to make improvements.
- To lead and support multi safeguarding arrangements in accordance with new legislation in our role as a key statutory safeguarding partner.
- Continue to ensure considerations relating to safeguarding children and adults are integral to commissioning services and robust processes are in place to deliver safeguarding duties.
- Continue to provide leadership to the statutory Child Death Review Process as the key statutory partner alongside the local authority.
- To ensure safeguarding is 'core business' within strategic plans.
- To work with academic colleagues to influence research and development and embed the use of good quality research and evidence in CCG commissioning functions.
- Continue to support the CCG's contracting and performance team to provide assurance that commissioned services are delivered to the required standards of performance under the terms of the NHS Constitution, the NHS standard contract and any other national/local performance metrics as may be stated within individual contracts and via regulators.
- Continue to provide assurance in relation to patient equality and inclusion.
- Continue to provide oversight and learning from patient experience reports, litigation, complaints and serious incidents.
- Continue to ensure quality and safety representation on procurement panels.
- Continue to ensure the governing body is sighted on how commissioned services and member practices are delivering safe and effective services via a number of early warning systems.
- Continue to support providers to develop a culture where learning from patient safety incidents and from patient experience is embedded in everyday practice.

4. 2019/20 operational plan requirements

Published in January 2019, the revised planning guidance (*NHS Operational Planning and Contracting Guidance 2019/20*) requires NHS organisations to produce a one year plan which is to address specific requirements in order to deliver the transformation described in the NHS Long Term Plan. The organisation level plans combine to form a system level operating plan (ICS plan) and are the starting point for the development of five year system plans.

The planning guidance identifies key priorities for 2019/20, along with deliverables, to transform the provision of care in the following areas which were also priorities for the FYFV:

- Emergency care
- Referral to treatment (RTT)
- Cancer
- Mental health
- Learning disabilities and autism
- Primary care and community health
- Workforce
- Data and technology
- Personal health budgets

4.1 Referral to Treament (RTT)

We are forecasting in 2019/20 delivery of the constitutional standards in relation to overall delivery of referral to treatment (not specialty level) and cancer treatment standards.

In 2018/19 there have been pressures to deliver the RTT standard in specialties such as orthopaedics, urology and rheumatology at City Hospitals Sunderland NHS Foundation Trust (CHS NHSFT) and dermatology in County Durham and Darlington (CDDFT) due to workforce issues and demand. Rheumatology, gastroenterology and dermatology are pressures for the wider Central ICP and as such will be a focus of the ICP plan in 2019/20.

We are also forecasting to deliver the waiting list reduction as set out in planning guidance and have agreed some additional activity in quarter four 2018/19 with CHS NHSFT and CDDFT to deliver a reduction which will aid delivery in 2019/20. Due to the increased waiting list at CHS NHSFT, the risks to delivery are high and the CCG is working with CHS NHSFT to construct a plan to reduce the waiting list to the required March 2018 levels. The additional activity levels required have been agreed and a plan is being delivered to focus additional activity on-site at CHS NHSFT as well as additional activity in the Independent Sector (IS) due to the additional capacity that will be needed to reduce the waiting list.

Orthopaedics is a cost pressure, as well as a performance pressure, to the system. Following work in 2018/19 we are now in the process of mobilising a new pathway from April 2019 which has been developed by clinical teams to ensure patients are seen by the right professional first time. A single point of access will be put in place, maximising the competencies and capacity of Sunderland's Intermediate Musculoskeletal service. GP orthopaedic referrals will be managed by the service and streamed to the appropriate service (community or secondary) for care and treatment. We expect the scope to expand and include First Contact Practitioners (national requirement) and pain management and to take account of wider ICP work in relation to rheumatology.

Dermatology is a pressure because of workforce shortages in the hospital service – there is a national shortage of Consultant Dermatologists. Dermatology is pressure for the Central ICP as the provider, CDDFT, provides specialist services to South Tyneside, Sunderland and County Durham. We are supporting the work of the clinical teams from CDDFT and our community dermatology service (provided by South Tyneside Foundation Trust) to ensure that we secure a sustainable service using a pathway approach.

Ahead of the commitment outlined in the NHS Long Term Plan to redesign outpatient services we commenced work during 2018/19 with our LHE partners to transform outpatient care in South Tyneside and Sunderland. In 2019/20 we will build on the progress we have made implementing a number of work streams including using digital technology and alternatives to outpatients.

4.2 Emergency care

Urgent care remains a pressure because of increasing demand during 2018/19 for emergency services at CHS NHSFT. Working with system partners in the All Together Better Alliance (ATBA) we have develeped our transformation plan for urgent and emergency care in Sunderland in 2018/19, signed off by our Governing Body in January 2019. We anticipate the implementation of the transformation plan in 2019 should contribute to improving performance in this area and reducing pressure on emergency services at Sunderland Royal hospital by ensuring access to local urgent care services – additional capacity in General Practice extended access, an Urgent Treatment Centre (UTC) with direct booking from NHS 111 alongside the Integrated Urgent Care (IUC) service.

In light of the national requirement for a hospital frailty service to be in place by December 2019 for seventy hours a week, the ATBA will focus early in 2019/20 on developing and implementing a whole system frailty model to ensure synergy and alignment across the pathway from diagnosis to treatment and management of patients who are frail.

4.3 Mental health

In 2019/20 we anticipate potential risks to delivery of national requirements in relation to Increasing Access to Psychological Therapies (IAPT), increasing the number of people on GP learning disability registers who receive an annual health check and improving the access rate to children and young people's mental health services.

In 2019/20 we will increase investment in mental health services in line with the Mental Health Investment Standard. The investment will fund transformation and expansion of services as set out in the Mental Health Five Year Forward View as well the 2019/20 deliverables of the Long Term Plan, notably for: perinatal mental health; early intervention in psychosis service graded at level 3; stabilise and bolster core adult and older community mental health teams and services for people with the most complex needs alongside preparing to mobilise a new integrated primary and community model as part of the Long Term Plan as part of the ATBA.

In order to meet the 2019/20 requirement to increase the access rate to IAPT services for people with depression and or anxiety disorders to 22 percent at the end of 2019/20 and 25 per cent by the end of 2020/21, we will build on earlier work when we were a trailblazer for IAPT for long term conditions. We will implement plans to expand the IAPT workforce and have agreed recurrent funding into the IAPT services for patients with long term conditions.

Health checks for patients on the learning disability register is in a better position now in 2018/19. The CCG moved from 'needs improvement' to 'good' for learning disability in the CCG Improvement and Assessment Framework (CCG IAF) as a consequence of the work providers have done with general practice to ensure that the annual health checks are delivered and accurately coded. Plans to achieve the target in 2019/20 to ensure patients on the register and additional patients are offered an annual health check will be led by the Mental Health, Learning Disability and Autism programme of the ATBA.

For 2019/20 our spend on Children and Young People's (CYP) mental health must also increase as a percentage of our overall health spend to ensure we continue to deliver enhanced access to mental health services for children and young people. We are currently above the national requirement for 2018/19 (32 per cent) for the percentage of children and young people with a diagnosable condition who receive treatment from a community mental health service. We are currently discussing commissioning an online mental health service for children and young people with the local authority.

Delivery of mental health and learning disability requirements, including continuing to reduce the number of people with a learning disability, autism or both in inpatient care and the enhancement of community services, will be key outcomes for the ATBA.

4.4 Primary care and community health

We are in the process of refreshing our CCG general practice strategy (section 5) which aims to ensure the sustainability and transformation of general practice in Sunderland. 2019/20 is year 4 of the strategy and we have made significant progresss in previous years in relation to workforce sustainability issues, workload and care redesign. We describe in our delivery plan (section 7) how we will meet the requirement by the end of June 2019 for every practice to be part of local primary care network, which support groups of practices to come together in partnership to deliver care across neighbourhoods.

4.5 Data and technology

Digital technology has the potential to transform the way patients engage with services, improve the efficiency and co-ordination of care, and support people to manage their health and wellbeing.

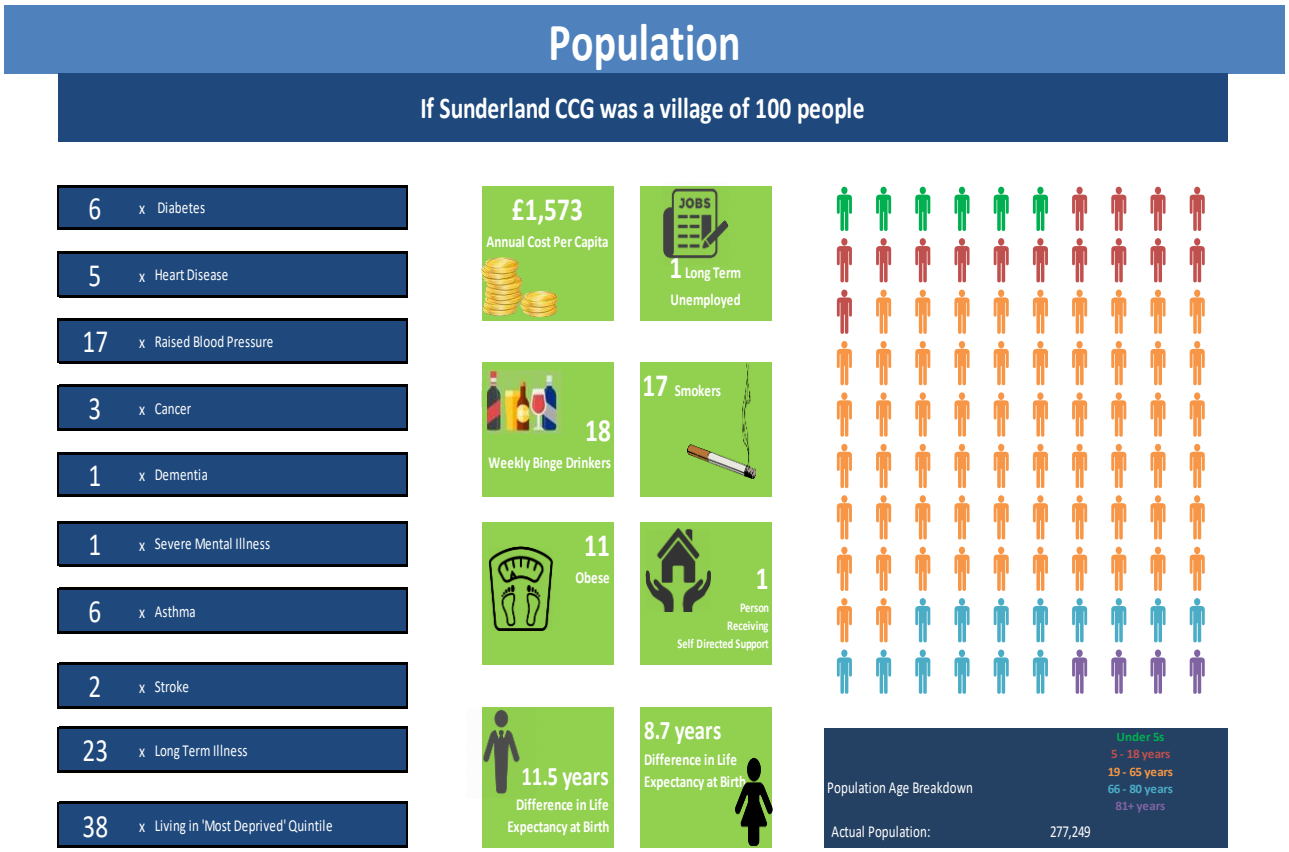
As a city we have a solid baseline position with the level of digital maturity across our key providers which have supported them to be part of the Global Digital Exemplar (GDE) programme. The GDE programme is an internationally recognised NHS provider that delivers improvements in the quality of care through the use of digital technology and information. Our plans involve developing new capabilities to enable greater choice of access for patients while still maintaining equality for those not ready or able to take advantage of these new methods.

We will continue to deploy the technology that underpins and enables the range of new digital channels into general practice for patients. Our focus will remain on achieving the target of 75% of the population able to access on-line consultations across the city in 2019/20 yet we will aim to move further than this target. The other channels, such as video conferencing between patient and practice, advanced telephony, patient messaging and patient access, will be allowed to mature within our digital exemplar practices and the share and spread approach will see its growth and coverage increase across the city.

New capabilities from NHS Digital such as the NHS App will be reviewed at a regional level and we will develop a strategy for our patients to access the most appropriate technologies to utilise and receive benefit from our new digital channels. These channels will be further embedded into general practice as part of the change management approach defined by our New Consultations Types Programme and is the first step in delivering the NHS Long Term Plan of vision of a digital-first primary care offer to patients.

4.6 Meeting health needs

The diagram below shows the challenges to be faced, represented in the context of Sunderland being a village of 100 people.



5. Strategic objectives

Our transformational programmes, summarised on the plan on a page, support the delivery of three big strategic objectives which align with the LHE priorities and in turn our vision for Better Health:

1. Prevention
2. Transforming community care
3. Transforming in hospital care

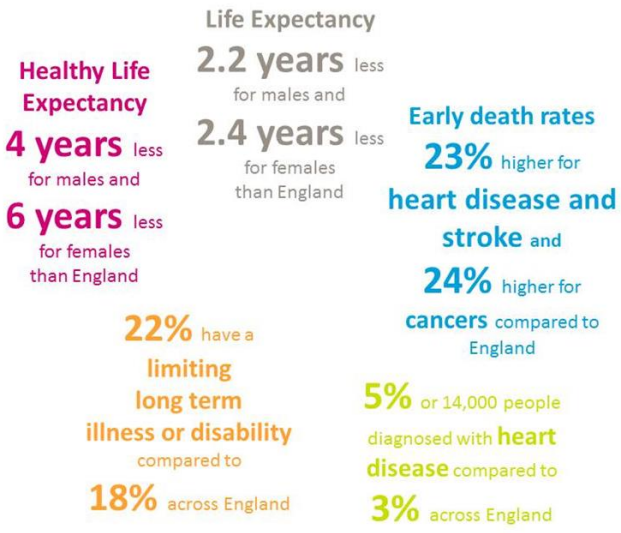
5.1 Prevention

The NHS Five Year Forward View and the NHS Long Term Plan make it clear that the NHS must get serious about prevention. Much ill health could be prevented and although progress has been made in helping people to live longer, people in Sunderland are spending too many years in poor health.

Better health should reduce the pressures on NHS, social care and other public services. However we recognise that there are many determinants of health – where we live, whether we work and the support we get from others makes a difference to our health.

Health services can directly influence health, especially by working together, but a broader approach is needed. More can be achieved by working closely with partners, agencies, schools, employers, the voluntary sector and the public themselves.

We know that we lag behind the England position in key health outcomes. Getting prevention right in Sunderland is key to improving health outcomes, reducing health inequalities and preventing wholly avoidable illness and avoidable use (and pressure) on health services.



There is a substantial amount of evidence which shows that people living in the most deprived areas have worse health and health indicators than those in more affluent areas. 38% of the Sunderland population live in areas that are the 20% most disadvantaged across England. In 2019/20 we will continue to take action to narrow inequalities, for example in reducing smoking in pregnancy and increasing the uptake of physical health checks for people with a serious mental illness or learning disability. However we recognise that the burden of ill health and disability, as well as early death, is disproportionately focussed on the

most deprived populations and they are often the least equipped and resourced to make best and appropriate use of services. Addressing health inequalities is key to slowing the growing burden (and cost) of disability, loss of independence and premature mortality. In 2019/20, working with partners, we will need to plan how we will narrow health inequalities to improve outcomes over the next five to ten years.

Preventing early deaths from respiratory, cardiovascular disease and cancer is a key challenge that we need to address as a health and care system in Sunderland. Our transformation plans seek to pick up problems earlier (detection), stop the problems from getting worse, by providing the right care in the community and putting people in control of their health (protect), and supporting the whole person – across physical and mental health.

Tackling the big four lifestyle risk factors to prevent the illness upstream is also a key challenge for us to improve the health of local people as much of the ill health could be prevented from occurring in the first place.

We are working in partnership with South Tyneside CCG and the two hospital trusts in the local health economy on prevention, as we recognise that we can achieve more by working together. There is a *Prevention and Self-Care* work stream within the local health economy plan and this will support, strengthen and complement our approach to prevention in Sunderland.

Cancer and cardiovascular disease continue to be a priority in our 2019/20 plan with a focus on picking up problems earlier as well as stopping problems from getting worse and supporting recovery. In 2019/20 we have selected respiratory disease as a new clinical area to focus on.

Prevention and supporting good health is important at every stage of life. It matters not only in the decisions we make throughout our lives but also in the decisions taken by parents. Child health and wellbeing continues to be a priority in our plan in 2019/20 as it was in 2017 to 2019 including a focus on services targeted at giving children the best start in life and educating and supporting the generation of tomorrow.

The CCG aims to work closely with local partners, to have an evidence based, collaborative whole system approach to improve child health with a focus on vulnerable children and families.

Our second strategic objective to transform community care, also addresses prevention. The model of care, that has been tested and developed over the three years of the vanguard programme, aims to provide proactive personalised care by integrating health and care services around the needs of individuals, with multiple long term conditions, to enable them to live well in the community including helping people to get better at managing their own conditions and stop the condition from getting worse.

a) Maternal Health & Wellbeing

Maternity services were prioritised for change in phase 1 of Path to Excellence because of workforce sustainability issues (staff shortage and reliance on temporary staff) faced by the services in South Tyneside and Sunderland and the challenge to meet national standards for quality of care.

The proposed changes to the way the services would be provided in the future sought to address the challenges faced to ensure a better, safer service for every woman in the long term. The proposal, to combine resources across South Tyneside and Sunderland to help achieve sustainable maternity services, was consulted on as part of the Path to Excellence programme. In addition the proposals fitted with national recommendations that suggest that maternity providers and commissioners work together across populations of at least 500,000 in order to ensure services are safe and fit for the future.

In 2019/20 work will be ongoing with South Tyneside and Sunderland NHS Foundation Trust to implement the agreed changes to the maternity pathway to ensure sustainable services and to implement the proposals to deliver *Better Births* – national maternity transformation plan.

Giving every child the best start in life is essential for reducing health inequalities across the life course as what happens during those early years has a lifelong impact on the health, wellbeing and attainment of a child. Working with partners we will continue to drive improvements in women's health by:

- Reduction of the prevalence of smoking during pregnancy.
- Promotion of breastfeeding and good early nutrition.
- Supporting emotional wellbeing and the development of resilience.

Whilst there are universal NHS stop smoking services, provided locally through pharmacies, primary care and maternity services, a new smoking in pregnancy pathway is to be implemented by April 2019 by Public Health. At a regional level the Local Maternity System (LMS) is also focused on reducing smoking in pregnancy through its prevention workstream.

Perinatal mental health is a key area of improvement in the Five Year Mental Health Forward View and the national and local maternity transformation programme. We are continuing to increase capacity to specialist perinatal mental health services. In September 2018, we joined a regional pilot along with South Tyneside, which allowed pregnant and new mothers, experiencing mental health difficulties access to specialist perinatal mental health community services. This pilot expanded the existing provision of specialist perinatal link workers within the IAPT service and the mental health rapid assessment, interface and discharge service (RAID) based in Accident and Emergency at Sunderland Royal hospital.

Along with other CCGs in Northumberland, Tyne and Wear we have agreed to recurrently fund this service from April 2019.

b) Child Health & Wellbeing

This transformation programme within our operational plan is part of a whole system approach, working with our partners, to change children's' lives for the better.

Our child health and wellbeing transformation programme wholly supports the delivery of priority three of Sunderland's Children and Young People's Plan (2017– 2020), namely 'children and young people enjoy good health and wellbeing'.

Sunderland's Children and Young People's Mental Health and Wellbeing Transformation Plan (2015-2020) is refreshed annually. The priorities for 2019/20 plan were developed and agreed by the Child and Adolescent Mental Health Partnership, using insights and data from partners including NHS, third sector providers, the local authority, Together for Children and representation from local schools, carers and Sunderland University. Feedback from children and young people, gathered by Together for Children, also informed this prioritisation work.

The following principles will guide the delivery of the 2019/20 priorities set out in section 7:

- Ensuring children and young people and their families and carers have input into the reform and development of services.
- Enabling children, young people and their families/carers to access the most appropriate intervention for their level of need, at their point of need.
- Intervening quickly, and reducing unnecessarily long waiting times is important to prevent deterioration in children and young people's mental health.
- Ensuring access to services in the least stigmatising setting, which meets their needs.
- Ensuring capacity meets the demand for high volume, low intensity interventions to moderate demand for more specialised services.
- Ensuring the provision of early years interventions to deliver whole family approaches to promote effective therapeutic parenting.
- Empowering all front line staff, including those that work in schools, to support the mental health needs of children and young people.
- Ensuring equitable access to mental health support, including across all schools.
- Promote evidence based competency across all professionals working with children and young people with mental health issues.
- Harness digitally-enabled therapies to improve access.
- Ensuring children and young people receive support that meets their individual needs and not their circumstances.
- Ensure the needs of children and young people presenting with increasingly complex mental health issues (who may be in crisis) are addressed to continue to reduce the use of inpatient services.
- Ensure young people are supported to transition into adult services.

The Children's Strategic Partnership in Sunderland has made a commitment to develop a strategic and collaborative approach to prevention and early help for children. The Partnership has sponsored a three year '*Preventing illness in later life and promoting self-care'* programme to improve health and wellbeing outcomes in children and reduce illness in later life focusing on obesity, alcohol attachment and mental health.

The programme is a collaboration between the CCG, providers, partner agencies and volunteers with the aim of:

- Creating a greater understanding among children (and families) of good physical and mental health.
- Communicating the importance of lifestyle choices.
- Empowering families to achieve healthier lifestyles through improving physical activity levels.

- Reducing childhood and teenage obesity levels.
- Reducing alcohol related injuries.
- Reducing levels of anxiety, mental illness and self-harm.
- Improving feelings of wellbeing and happiness.

c) Cancer

The FYFV, the NHS Planning and Contracting Guidance 2019/20 and the NHS Long Term Plan identify cancer as a clinical priority. For Sunderland cancer is one of the main causes of mortality accounting for 30 per cent of the deaths. Collectively cancers account for 17.9 per cent of the gap between the Sunderland and England average for male life expectancy and 29.1 per cent of the gap in female life expectancy. In response we set cancer improvement as a priority in our 2016/17 operational plan and developed a five year local cancer plan to implement the strategic aims and priorities of the national five year cancer strategy. This plan was launched with our member practices in December 2016 and was agreed by the Sunderland Health and Wellbeing Board in March 2017.

Our vision is 'to prevent as many people from ever having to experience cancer in the first place'.

Our local cancer plan sets out how we aim to improve cancer outcomes by implementing 28 local priorities across six areas: prevention, early diagnosis, waiting time standards, patient experience, living with and beyond cancer, investment and commissioning.

In 2019/20 we will continue taking forward our activities across these six areas.

d) Respiratory

This transformation programme is new to our operational plan in 2019/20 because we recognise as a system that despite highly committed NHS staff delivering great care across primary, community and hospital care settings, health outcomes are poor when we compare Sunderland to similar systems.

Along with cancer and cardiovascular disease more people die early from respiratory diseases in Sunderland compared to other areas:

- Smoking remains the greatest contributor to premature death and a key risk and it is a priority for Sunderland's Health and Wellbeing Board. Although we have made progress over recent years to reduce smoking prevalence we are significantly worse than other systems and the England average – 18 per cent of adults smoke compared to 15 per cent across England.
- Sunderland has a higher proportion of people diagnosed with chronic obstructive pulmonary disorder (COPD) recognising that there could also be more people with this condition who have not yet been diagnosed.
- Compared to other areas, more people with respiratory diseases in Sunderland are admitted into hospital as an emergency and although this will be seasonal there appears to be a link to immunisation (for flu and pneumonia), deprivation and wider determinants of health.

Over the course of the last few years we have tested and implemented new approaches:

- Implementing of MyCOPD, a digital app to support patients to self-manage including improving inhaler technique;
- Reviewed and revised prescribing guidelines for primary care;
- Delivered accredited training for practice nurses and healthcare assistants to support accurate diagnosis of COPD.

A number of outcomes for the All Together Better Alliance are also aligned to driving improvement in these conditions.

In 2019/20, we will work collaboratively with partners across the four programmes of the ATBA as well as hospital services to review the current pathway for prevention, detection, treatment, management and end of life. We will identify opportunities to prevent respiratory diseases, reduce variation and improve health outcomes. The output will be an agreed system plan of the key priorities that we need to get behind to drive improvement in the health outcomes for Sunderland.

e) Cardiovascular disease including diabetes

We selected cardiovascular disease (CVD) in 2016/17 as a priority for transformation because of health need and following a review of benchmarking information from NHS RightCare. Furthermore, CVD disproportionately affects people from the poorest communities. Thirty eight per cent of the Sunderland population live in areas that are among the twenty per cent most disadvantaged across England. Poor cardiovascular health can cause heart attacks, strokes, heart failure, chronic kidney disease, peripheral arterial disease and the onset of vascular dementia.

We recognised that there is a huge opportunity to make a difference in improving CVD outcomes given that the majority of CVD cases are preventable. Risk factors, such as obesity, physical inactivity, smoking and drinking at unsafe levels, can all be modified to help reduce a person's risk of developing CVD. The NHS Long Term Plan includes a major ambition to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years.

Early detection and treatment of CVD can help patient's live longer and healthier lives as too many people are living with undetected high-risk conditions. Improving the detection and treatment of the high risk conditions of atrial fibrillation (AF), hypertension (high blood pressure) and high cholesterol has the potential to unlock considerable health gains.

Our 2019/20 delivery plan focuses on improving the detection and management of hypertension, atrial fibrillation (AF), cholesterol and hyperglycaemia. We will build on work undertaken in 2018/19 with our GP practices to ensure that once identified, patients are treated optimally.

In 2018/19, our plans in relation to diabetes have focused on the prevention of type 2 diabetes as well as improving care and outcomes for patients who are diagnosed with the condition. In 2019/20, we will continue to build on this approach including:

- Continuing to support GP practices with the roll out of the NHS Diabetes Prevention Programme, sharing good practice to ensure as many people as possible get to benefit from the programme.
- Reducing variation to ensure optimal care is provided for patients with diabetes.
- Improving the support available for people to manage their own health (including adopting digital solutions and improving access to structured education)

5.2 Transforming community care

The Long Term Plan describes how the NHS will move to a new service model where patients access better support and joined up care at the right time in the optimal care setting. The expansion of community (integrated) health teams and the establishment of primary care networks (PCNs) will be required under the new national standards to provide support to people in their own homes as an alternative to hospitalisation. This reform will be enabled by investment in primary medical care and community services growing faster than the overall NHS budget.

Securing the care model

In Sunderland since May 2013 we have been working towards delivering a vision for the future for out of hospital care with the aim of promoting health and wellbeing, delivering quality care for patients and carers, and ensuring sustainability of the system.

As a 'Vanguard' site we had an opportunity over three years to develop, test and implement our out of hospital care model under the All Together Better (ATB) Sunderland programme making major progress and achieving significant success. When the programme ended in 2018 we took the decision to enhance the care model and secure it for the longer term. It was agreed that the care model would be enhanced by including and integrating all out of hospital services into one model of care, which is secured formally using an alliance approach. The aim was to have an effective alliance in place by April 2019.

Establishment of the Alliance

Since March 2018 we have worked collaboratively with providers and the Local Authority to develop the alliance approach for Sunderland, now known as the ***All Together Better Alliance*** (ATBA). The development and implementation of formal alliance arrangements have been overseen by a Shadow Board during 2018 with extensive engagement from stakeholders and providers in Sunderland.

It is intended that the alliance approach will focus on "person centred proactive and coordinated care which will support appropriate use of health and care services, will improve patient and carer experience and outcomes, ensuring people will live longer with better quality of life".

The All Together Executive Group is now established as an independent alliance to undertake and be principally responsible for the overall integrated delivery of all out of hospital services in line with the strategic objectives of the CCG.

Scope of the Alliance

The out of hospital services have been organised into four programmes acting as the implementation and delivery mechanism for the ATBA Executive Group. The programmes are **General Practice**, **Mental Health**, **Learning Disabilities and Autism**, **Enhanced Primary and Community Care** and **Intermediate and Urgent Care**.

The Executive is responsible for establishing, resourcing and facilitating each programme. Each programme's objectives include the oversight of service delivery, transformation, outcomes, and financial efficiencies across organisational pathways where appropriate. Programmes will have a lead Senior Responsible Owner (SRO) and Senior Responsible

clinician (SRC) who will be a member of the executive group, ensuring governance and clinical leadership at every level.

Membership of the programmes will be inclusive and bound by terms of reference supporting integration, transformation and collaboration. The ATBA will proactively work across organisational boundaries to improve pathways, ensuring engagement and transparency in developing recommendations for decision making, within the scheme of delegation.

A number of enabling workstream groups are also established to recommend to the ATBA how each area may be undertaken within the alliance e.g. recommend how quality is undertaken within the ATBA. Reporting mechanisms to provide assurance, of delivery across the system, to the CCG's Governing Body will also be established.

Deliverables for 2019/20

Implementation of the ATBA model

- Ensure the Alliance Executive Group continues to implement the alliance model to become principally responsible for overall integrated delivery, performance, outcomes and system-wide overview of:
    - General practice; and
    - Mental health, learning disability and autism services;
    - Enhanced primary and community care services;
    - Intermediate and urgent care services.

Implementation of programmes

- Resource and facilitate the development of each programme to undertake and be responsible for overall integrated delivery, performance, quality, outcomes and system-wide overview of its programme and work with other programmes. A key priority is the development of the transformation agenda.

Implement enabler workstreams

- Review and consider implementation of any recommendations of enabling work stream groups to ensure the effectiveness of the alliance model. In particular this will include the development and implementation of a:
    - Communication strategy, including regular provider forums
    - Financial framework including, planning, governance and control, reporting and management.

Develop an ATBA Long Term Delivery Plan

- Develop and agree a long term (5 year) plan for the All Together Better Alliance that aligns to the NHS Long Term plan and the vision and objectives of the CCG.

Wider system working

- Ensure the ATBA represents out of hospital within the Integrated Care Partnership /Integrated Care System arrangements, collaborating effectively with other stakeholders to

plan and develop services, innovative approaches and strategies that impact positively on the health and wellbeing of the population within the available budget.

a) General Practice

General practice is at the heart of our care model. The CCG developed a five year GP Strategy (2016 – 2020) which aims to sustain and transform general practice to ensure the provision of high quality primary medical care delivering improved health outcome for local people, now and in the future.

A number of the objectives of the strategy have been delivered over the first three years including initiatives to increase capacity and build the general practice workforce, developing a quality assurance model to reduce variation and implementing the national extended access requirements in hubs. The strategy is currently being refreshed in line with the NHS Long Term Plan, the All Together Better Alliance care model and the current General Practice Forward View initiatives which are ongoing in relation to workload, practice infrastructure including estates, technology and digitally enabled care.

Engagement with GP Practices is now underway to ensure the refreshed GP strategy takes into consideration all innovative ideas and any concerns. The engagement also presents the opportunity to engage with our practices on establishing locality primary networks in line with the national deadline. We aim to accelerate the development and mobilisation of Primary Care Networks, through the required level of investment, to help sustain general practice and healthcare services in Sunderland.

Estates Strategy

The CCG has a good level of high quality premises infrastructure in the city – much of which is now owned by NHS Property Services (NHSPS). The CCG (working with partners including the ATBA) will review it's estates strategy taking into account the need to ensure the sustainability of primary and community services, the need to develop Primary Care Networks, the need to make optimum use of estates and the need to whilst ensuring value for money

b) Mental Health Learning Disabilities & Autism

The Mental Health Five Year Forward View (MHFYFV) set an ambitious vision to transform mental health services and 2019/20 is the fourth year of its implementation. The Long Term Plan re-affirms the commitment to put mental health care on a level footing with physical health services requiring CCGs to increase investment in mental health services in line with the MHIS. The additional growth in the CCG's 2019/20 allocation will enable us to meet this requirement. Locally we will invest recurrently in specialist perinatal health services, IAPT for people with long term conditions and children's services.

In 2019/20 we will continue with actions to meet national requirements to improve access to and availability of mental health services. We will continue to expand access to IAPT services for adults and older people with common mental health problems, with a focus on those with long term conditions.

In 2019/20 we will continue with actions to ensure patients requiring access to community health treatment – IAPT services, early intervention in psychosis – do not have long waits and are treated within national waiting time standards.

The life expectancy of people with severe mental illness can be up to twenty years less than the general population. We will continue building on work with Northumberland, Tyne and Wear Mental Health Trust to improve physical health for those with a serious mental illness by working collaboratively with our GP practices to ensure people on the GP practice serious mental illness register receive an annual health check.

We will continue in 2019/20 to work with the provider to ensure their workforce can provide NICE recommended treatment for people experiencing first episode psychosis through the implementation of a training improvement plan. We will also support STP/ICS to reduce all out of area placements and the need to achieve local trajectories.

The Long Term Plan commits to the development of a new integrated primary and community mental health service by 2023/24 to support adults and older adults with severe mental health illnesses and 24/7 community based mental health crisis response for adults and older adults by 2021. In 2019/20 we will need to work on plans to develop and mobilise these new services for severe mental health problems and emergency mental health support in Sunderland within the timeframes set.

The focus of the Transforming Care programme (collaboration between CCGs, local authorities and NHS specialised commissioners) is to move away from inappropriate outmoded inpatient facilities and build up community capacity to reduce reliance on inpatient beds for people with a learning disability and/or autism. Our plans in 2019/20 will build on existing work including:

- Exploring the development of 'safe space' where there is a risk of hospital admission as well as 'step down' provision and accommodation as a step before moving into the community.
- Continuing to support NHS England, Stopping over medication of people with learning disability (STOMP LD).
- Supporting Sunderland residents to leave hospital in line with the Transforming Care agenda.
- Delivery of the enhanced community model for Transforming Care including the development of an autism pathway and expansion of the Community Treatment team and the 'All about Me' course.
- Ongoing delivery of the learning disability and autism primary care strategy specifically around the development of:
    - Autism register
    - Primary care Liaison Nurse role
    - Quality annual health checks
    - Training for practices

- Roll out of processes implemented successfully for adults with a learning disability and/or autism to support the care programme approach and community treatment reviews implemented successfully children.

c) Enhanced primary and community care

The enhanced primary and community care transformation programme within the ATBA comprises a number of transformation plans in 2019/20 for:

- Community Integrated Teams

- Care Homes
- End of Life
- Community equipment service
- Continuing Healthcare

i. Community Integrated Teams

Community Integrated Teams (CITs) are a key enabler to developing system working and further enhanced care that is wrapped around the patient as supported by the national agenda in the NHS Long Term Plan. The ATBA is crucial in supporting CITs to work with providers that would otherwise work independently and in ensuring CITs are integrated within primary care networks. The role of CITs in the promotion of patients to better manage their own health care cannot be ignored and will be an area for further debate as the ATBA evolves.

Having been established in 2015, the model for community integrated teams has derived considerable success in the way the teams have integrated to deliver patient centred care across a range of disciplines. The multi-disciplinary approach is further enhanced with the addition of MDT coordinators and living well link workers who have been pivotal in supporting the benefits of co-location and joined up working.

In light of considerable financial pressures and as part of a commitment to continuous improvement, a review of CITs was undertaken in 2018. The review acknowledged the success of the CITs to date however there were some areas identified for improvement in order to maximise the investment and hopefully realise a more significant reduction of non-elective activity/ED attendances.

Whilst the function and overall service scope of CITs were the main themes underlying the recommendations, it was also recognised that the overall governance of CITs will change in 2019 to reflect the emerging format of the ATBA.

The review made two long-term recommendations for transformation which will be considered by the ATBA programme group for progression:

- To develop a fully integrated approach to the delivery of CITs, including a single operational management structure, budget and ways of working.
- To review the roles of staff working across CCG localities, streamlining activity and developing a new way of working that supports localities strategically and operationally.

The CIT priorities for 2019/20 are set out in the delivery plan in section 7:

ii. Care homes

During 2018/19 the Care Home Group (CHG) has been working to implement the national Enhanced Health in Care Homes Framework. The Enhanced Health in Care Homes (EHCH) model is based on the NHS England requirement to support people in care homes. Nationally one in seven people aged 85 or over live in a care home. Residents of care homes account for 185,000 emergency admissions to hospital each year, with 35-40% of those emergency admissions being potentially avoidable. The EHCH model consists of a suite of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner in order to make the biggest difference to its residents. To implement the framework Sunderland has established the Care Home Group (CHG).

Since the establishment of the CHG significant positive progress has been made, including:

- Implementing the Red Bag scheme.
- Establishing a model for GP alignment and MDT meetings in care homes.
- Developing cross area policies for hydration and nutrition.
- Sharing of best practice between care home managers.
- Creating relationships, networks and cross organisation decision making.
- Inviting care home managers to attend the CHG and participate in the design of the future model for care homes.
- Ensuring regular discussions and updates for care home managers.

2019/20 will see the continued roll out of the EHCH Framework and our priorities are set out in section 7.

iii. End of life

End of Life care continues to be a priority and is a key part of many areas of transformational change contributing towards equity of services received by patients. We are working towards having a whole system approach to end of life across health and social care in Sunderland, which would mean that patients will receive high quality individualised care, delivered at the right time by the most appropriate service. We are working in partnership with providers to deliver the End of Life Plan.

iv. Community equipment service

The provision of high quality care equipment, aids and adaptations are a vital component to the independence of people of all ages with health conditions, disabilities and/or mobility issues. Care equipment services provide the gateway to the independence, dignity and self-esteem of not only the person using the equipment but their families and carers too.

In 2019/20 the community equipment service, will be part of the All Together Better Alliance transformation plan to ensure the delivery of sustainable care equipment services including children's wheelchairs to improve access and meet national waiting time standards. In 2019/20 we will continue work to reduce access times for children's wheelchairs.

v. Continuing Healthcare

Continuing Healthcare (CHC) is an important component to the NHS response to supporting people with continuing health care needs, who through appropriate support, personalisation and choice can live either independent, semi-independent or supported lives. Nationally and locally there is a pressing need to get control of rising CHC expenditure. Benchmarking information show that Sunderland is outlier in its expenditure and in its eligibility rate for fully funded CHC. A three year CHC transformation plan has been developed, endorsed by the CCG, to realise a key objective - to ensure that CHC is sustainable for the future.

CHC transformation will sit within the ATBA with its focus on integrated working across all organisations and partners in Sunderland. The work has already commenced with the establishment of the CHC Programme Group that will look at how the CHC can be delivered in an integrated way with the initial focus on working with the Local Authority to understand what this means for the future. The group will set out the future direction of CHC looking at:

- Quality and safety.

- Contract monitoring.
- Case management.
- Potentially Personal Health Budgets.

d) Intermediate and urgent care

Extensive engagement with hundreds of local people, as well as service providers and strategic partners, took place during 2018 which informed Sunderland's urgent care model for 2019/20 and beyond.

The CCG's Governing Body signed off the new care model in January 2019 to be implemented across Sunderland in 2019/20. The model is compliant with national guidance including the Five Year Forward View, Integrated Urgent Care Commissioning Standards, the NHS Operational Planning and Contracting Guidance and the NHS Long Term Plan.

Our model is underpinned by out of hospital services such as the Sunderland GP Extended Access, Community Integrated Teams (CITs), the Recovery at Home (RaH) service (urgent community support), the Clinical Assessment Service (CAS) 111 service, alongside communications to the public and patients across the system is to 'talk before you walk' to ensure patients get the right place at the right time for the treatment they need.

The new service aims to ensure that patients have access to a sustainable model of care for the future with reduced duplication to enable investment in new services. The model simplifies access to urgent care services, providing continuity of care for patients with access to their own GP and access to personal medical records.

Working with City Hospitals Sunderland since 2016 we have developed and implemented ambulatory emergency care (AEC) – or same day emergency care (SDEC) - to manage emergency patients, referred by their GP or by the Emergency Department. The AEC service ensures patients undergo the right investigations and treatment without needing a hospital admission. The AEC model has been supported by telephone advice and guidance for GPs from specialties including acute medicine, care of the elderly, acute general surgery and paediatrics to avoid unnecessary admissions/referrals to hospital. The work to implement and embed AEC across the whole system in Sunderland has been recognised by the national AEC network

5.3 Transforming In hospital care

In 2016 South Tyneside and Sunderland NHS Foundation Trust (formerly City Hospitals Sunderland and South Tyneside Foundation Trusts) recognised that significant service transformation was needed to ensure the future sustainability of the hospital services across South Tyneside and Sunderland because of workforce pressures, finance constraints, future demographic changes and shortfalls in the quality in the care provided in some areas.

a) Workforce

The workforce in the hospitals is under significant pressure because of shortages relying heavily on the goodwill of staff working longer hours or extra shifts on a daily basis – this has a negative impact on their health and wellbeing and is not sustainable.

Temporary staff are also relied on to keep services running safely. Overreliance on temporary staff is not only financially unsustainable but it is also not good for the continuity of high quality patient care and limits ability to make quality improvements to patient care.

The current set up of services across the two hospitals also makes it difficult to attract staff, who want to work as part of bigger teams impacting staff recruitment.

b) Future demand

More people than ever before are now accessing services and being successfully treated thanks to advances in medicine and technology. This means more people can now survive serious illness or injury and can live longer with health conditions such as asthma, diabetes and even cancer. All of this means demand on our NHS in Sunderland will grow even further in the years ahead.

c) Quality Improvement

The gaps in workforce are the biggest challenge to being able to deliver the highest quality patient care long term. The way services are currently set up also makes it really difficult to meet a number of important clinical quality and safety standards. By organising hospital services differently a vital critical mass of patients needed can be created to develop more specialised care and meet more of these important clinical quality and safety standards.

d) Financial constraints

Services currently cost more to deliver than the funding available and changes need to be made to help improve long-term financial sustainability of the hospitals.

e) Path to Excellence programme

A five year programme of transformation – Path to Excellence (PtE) - was established in 2016 to transform care and ensure that the hospital services across Sunderland and South Tyneside can meet the challenges now and in the future.

Phase 1 of PtE focused on reshaping stroke, maternity (obstetrics), women's healthcare (gynaecology) and children and young people's healthcare (urgent and emergency paediatrics) services. Phase 2 is the final phase of the work and a number of clinical service reviews are taking place which cover the following areas of hospital based care:

- Emergency care and acute medicine:
- Emergency surgery and planned operations
- Planned care and outpatients
- Clinical support services

A staged approach has been taken to phase 2 to develop ideas for change. Using feedback gathered over the past year with staff and patients and the public, the clinical service review design teams have been developing a long list of ideas to address the challenges.

To get to a shorter and viable list of 'working ideas' for change, the long list was tested against agreed core 'hurdle criteria, developed with clinical experts and informed by service change best practice in line with national NHS policy. The hurdle criteria are: be sustainable and resilient; deliver high quality, safe care; be affordable; and be achievable.

After testing the long list against the 'hurdle criteria' the clinical service review teams have a 'working list' of potential ideas to help solve the challenges. Phase 2 is at the stage of seeking feedback and views of staff, stakeholders, patients and the public on the working list to develop the scenarios to take forward for full public consultation later in 2019.

In 2019/20 the PtE programme will mobilise the outcomes from phase 1 and develop a pre-consultation business case to help determine the scenarios to take forward to public consultation later in 2019.

6. Enablers to support delivery of the plan

Delivery of our plan requires a number of key enablers including:

Digital and technology

At every opportunity we will consider how digital can support transformation and in particular self-care and self-management to empower patients. Our plans will involve developing new capabilities to enable greater choice of access for patients while still maintaining equality for those not ready or able to take advantage of these new methods. We will drive forward our information sharing capabilities to the next level which will enable new ways of working across providers and support improved clinical decision making within a robust information governance environment.

Medicines optimisation

This enabler is closely aligned to our strategic objectives and achieving sustainability including:

- Improving quality, safety and patient experience.
- Supporting the production and implementation of local therapeutic guidelines to standardise optimal patient care and redesign care.
- devising and implementing medicines productivity initiatives for primary and secondary care
- Supporting the sustainability of general practice.
- Supporting transformation programmes, for example cardiovascular disease.
- Supporting the secondary care teams to align and ensure best along with developing a true system wide model which is better aligned to the ICP.

Research, evidence and innovation would support improvement of outcomes in the future, enabling prevention of ill health, earlier diagnosis and more effective treatments and faster recovery.

The **locality networks** support our approach to deliver integrated health and care services out of hospital by providing person centred, proactive and co-ordinated care through the community integrated teams to ensure people live longer with better quality of life.

Leadership will be key to delivery of high quality care and to meet the challenges we face.

Patients and carers have critical role in delivering the transformation. Increasingly we need to empower people to manage their own health and support staff to have conversations that help people to make the decisions that are right for them. We also need to ensure we engage with patients and the public in any plans to reshape care.

7. Delivery plans

Maternal Health & Wellbeing

Objective for 2019-2020
Ensure safe and sustainable services for improved outcomes in maternity and ensure the best start in life.

Deliverables for 2019/20

- Implementation and mobilisation of the Path to Excellence Phase 1 decision by April 2020.
- Deliver improvements from the NHS England *Saving Babies Lives*, a care bundle for reducing stillbirth.
- Increase the number of women receiving continuity of the person caring for them during pregnancy by March 2020.
- Continue to increase access to specialist perinatal health services, so that overall capacity is increased.
- By June 2019, agree trajectories to improve the safety, choice and personalisation of maternity.
- Continue to work with partners locally, regionally and nationally to plan the expansion of Peri-natal mental health service provision (maternity services).
- Continue to work with the Local Maternity System and Public Health to achieve levels of smoking in pregnancy of less than 10% by 2020, and less than 5% by 2025.
- Continue to embed the *Babyclear* programme across maternity services.
- Implementation of a model of delivery for flu vaccine delivery to increase coverage in line with or above regional uptake.
- Work with Public Health around the implementation of a new stop smoking in pregnancy pathway.
- Continue to receive assurance around the membership of City Hospitals Sunderland Maternity and Neonatal service is part of the National Maternal and Neonatal Health Safety Collaborative and is in receipt of support from Local Learning Systems.
- Develop plans for the roll out of access to Maternity digital care records by October 2019.
- Continue to receive assurance regarding the accreditation of City Hospitals Sunderland regarding evidence–based infant feeding programme.
- Support the implementation of the City Hospitals Sunderland trust-wide smoke free action plan, the Sunderland Health and Wellbeing Board's Tobacco Alliance working group.
- Consider through the Path to Excellence work the incentivised support for midwives to increase attempts to quit with South Tyneside CCG.

Child Health & Wellbeing

Objective for 2019/20
Improve child health; mental, physical and emotional wellbeing and reduce avoidable illness later in life

Deliverables for 2019/20

- Review integrated commissioning arrangements for children and young people's mental health provision.
- Develop a Single Point of Contact for Children's Mental Health Services.
- Ensure we have effective delivery of early intervention treatments.
- Increase access to training to raise awareness and empower people to support children and young people with mental health issues.
- Review the eating disorder service.
- Submit a revised bid for Trailblazer funding to deliver Mental Health Support Teams as part of wave 2.
- Continue reform of the Autistic Spectrum Disorder (ASD) pathway, Attention Deficit Hyperactivity Disorder (ADHD) pathway.
- Continue with partners to deliver the CAMHS Transformation Plan.
- Increase school participation in the Sunderland Mental Health Kite Mark Incentive Scheme and the Daily Mile.
- Commence the Digital Wellbeing and Lifestyle Coach for Sunderland children and young people.
- Commence the redevelopment of the alcohol injury and substance misuse pathway.
- Develop olfactory resilience training to promote vegetable awareness in school age children.
- Develop an enhanced obesity pathway for school children, disseminating trends in nutrition science to healthcare practitioners.
- Develop the Connected Sunderland model (improving community resilience, social prescribing and self-care).
- Develop a collaborative approach to tackling the impact of Adverse Childhood Experiences (Aces).
- Develop a programme of mindfulness for all children in Sunderland primary schools Train the Trainer programme.
- Health, Lifestyle and Avoidable Illness: Health Care Professionals and Expert Patients Support to Secondary School Assemblies.
- Launch Sunderland Health and Happiness Week.

Cancer

Objective for 2019/20
Advance delivery of the National Cancer Strategy to promote better prevention and early diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience.

Deliverables for 2019/20

Waiting times standards

- Continue to support the Trust to meet the waiting time standards for cancer with oversight and coordination by Cancer Alliances.
- Support secondary care on the implementation of the 'new faster diagnosis standard' which will be introduced in 2020 for most patients to 'receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening.

Early diagnosis

- Continue to support the rollout of FIT pilot with the bowel cancer screening programme during 2019/20 in general practice and produce an evaluation to inform the future commissioning of the service.
- Continue with the lung cancer pilot in 2019/20 and produce an evaluation to inform the future commissioning of the service.
- Hold a learning event for GP practices based on the results of the significant event audit on cancers diagnosed as an emergency that was performed in 2018/19.
- Incentivise practices to complete a national database to report significant events.
- Ensure that primary care is aware of the new guidance to lower the threshold for referral by GPs.
- Support the NHS commitment to expand mobile CT scanning units to boost access to rapid screening and diagnostic centres which will begin to be rolled out across England in 2019/20.

Prevention

- Implement human papillomavirus (HPV) primary screening for cervical cancer across England by 2020.
- Support the requirement that from September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer.

Living well beyond cancer

- Support the continuation of living well beyond cancer pilot in 2019/20, this includes; the implementation of a holistic needs assessment.

- Implementation of treatment summaries.
- Hosting Health and Wellbeing events.
- Enhancing the quality of the cancer care review in general practice.
- Stratified follow up for breast cancer has already been implemented. Implementation for prostate and colorectal stratified pathway will be delivered during 2019/20.

Respiratory

Objective for 2019/20 Improve health outcomes and optimise the length and quality of life for people with and at risk of respiratory disease including care at end of life
Deliverables for 2019/20 • Review the current pathway from prevention, detection, treatment, management and end of life. • Identify key priorities to take forward underpinned by a delivery plan with actions, outputs, outcomes and timescales for 2019/20 and beyond. • Link the work with the Local Health Economy 'Prevention and Self-care' work and the wider STP/ICP Prevention workstreams to support implementation and avoid duplication.

Cardiovascular disease including diabetes

Objective for 2019/20
Optimise the length and quality of life for patients with, and at risk of, CVD, through robust primary and secondary prevention, streamlined pathways and integrated services that meet national standards.

Deliverables for 2019/20

Hypertension

- To build on the work implemented through the local Sunderland General Practice quality premium to ensure that once patients are identified with hypertension they are treated with the appropriate medication.

Atrial Fibrillation

- To increase detection of patients with atrial fibrillation by:
  - Incentivising practices to case find through the General Practice Quality Premium.
  - Identifying patients with a high CHA2DS2VASC risk score who are not on anticoagulants and give patients the choice of anticoagulation.
- To review the evaluation of the introduction of Alive Cor devices into practices in Sunderland and use the evaluation to roll out the devices across the city to support savings in both time and resources.

Heart Failure

- To continue the work developed through the heart failure workshop held with South Tyneside focusing on the following areas:
  - Development of standardised data entry templates (working alongside regional groups).
  - Data sharing across heart failure services.
  - Standardised pathways.

Training

- To develop and deliver a training programme for practice nurses in Heart Disease.

Early Diagnosis

- The NHS Long Term plan discusses ensuring patients are aware of their ABC (AF, blood pressure and cholesterol) to support early detection of high risk conditions. In 2019/20 the CVD Programme group will research how this is done other areas and

implement a plan to introduce across the city.

Diabetes

- Reduce variation by ensuring optimal care for patients with diabetes by:
  - Engaging with practices to improve control in line with the 3 NICE treatment targets for glucose, blood pressure and cholesterol.
  - Continue the community Diabetes Specialist Nurse (DSN) service focusing on high risk patients as well as offering support to practices and mentorship to practice nurses.
  - Continuing to develop the primary care workforce in the management of diabetes by enrolling GPs and Nurses in the Bradford University Post Graduate Diploma in Diabetes. This will include training clinicians in each locality network to ensure there is a cascade mechanism for the dissemination of new guidance as well as providing access to advice from peers with specialist diabetes knowledge.
  - Including diabetes in our city-wide Time in Time Out programme.
  - Continuing to encourage practices to participate in the National Diabetes Audit.

- Improving the support available for people with diabetes to manage their own health, including adopting digital solutions and improving access to structured education by:
  - Continuing to support GP practices with the roll out of the NHS Diabetes Prevention Programme.
  - Training practice nurses in the delivery of DESMOND for patients newly diagnosed with type 2 diabetes.
  - Continuing to engage in national discussions regarding the development of the new HELP diabetes digital education tool, and look to mobilise within Sunderland as soon as possible, including exploring expressing an interest in becoming an early adopter site.

General Practice

Objective for 2019/20
Further development of Primary Care Networks increasing the workforce and digital transformation.

Deliverables for 2019/20

Primary Care Networks

Sunderland has 5 locality networks. Each locality network has a patient population of at least 50k with one locality having approximately 80k.

- Increase the knowledge of the All Together Better Alliance (ATBA) and the General Practice Programme.
- Provide data to each locality on the health of their population to enable joint working on the delivery of the ATBA outcomes.
- Achieve level 3 on the primary care maturity matrix.
- Develop community hubs – one (or more) in each locality for the delivery of key services such as: treatment rooms for the management of complex dressings and the management of deep vein thrombosis (DVT).
- Identify rapid solutions to shared care management, including the management of medication and follow up of people with chronic conditions.
- Prepare GP Practices for the changes to QoF, including quality improvement element.
- Increase locality working – shared resources and back office functions.

Workforce

- Utilise the newly implemented workforce toolkit which looks at both capacity and demand, Apex.
- Continue with schemes to attract more GPs to Sunderland.
- Continue with schemes that enhance nursing workforce and promote recruitment into Sunderland.
- Work with the Sunderland Medical School and GP Practices to enable additional placements, developing Educational Hubs across localities to include GPs, Nurses, Pharmacists and Paramedics.
- Encourage additional training practices where appropriate.
- Continue with the GP Career Start Scheme and expand the scheme to other professionals.

Community Integrated Teams

- Continue the development of general practice input into Community Integrated Teams (CITs) with an enhanced focus on frailty working alongside community nursing, social care, voluntary sector and GP teams to ensure that patients are seen by the right person at the right time.

- Care home realignment – work with GP practices and care homes to ensure that 100% of care homes are aligned to a GP practice. This provides continuity of care for patients and allows ongoing engagement with families and carers.
- Working with the Mental Health Trust and GP practices to enhance the mental health offer to patients, working in locality networks or practices.

Extended access

- Increase the capacity of the Sunderland Extended Access Services (SEAS) in line with the NHS England specification.
- To develop the SEAS service to deliver the vision of the urgent care strategy.
- Enable diagnostic testing and referrals from hubs.

Digitisation

- Achieve the target of 75% of the population of Sunderland to have access to on-line consultations.
- Grow coverage of digital solutions such as video conferencing, advanced telephony and patient messaging.
- Initiate the digitisations of Lloyd George paper records, to deliver a more efficient retrieval process for clinicians and support administrative processes.
- Refresh of the GPIT services to ensure compliance with NHS standards for cyber security.
- Migration to the Health and Social Care Network (HSCN) to deliver additional resilience, improved capacity and support for practices to deliver digital channels for patients.

Mental health, learning disabilities and autism

Objective for 2019/20
Working with partners to ensure the successful implementation of system wide mental health, Learning Disabilities and Autism programmes.

Deliverables for 2019/20

Serious Mental Illness health checks

- Build on the work with Northumberland, Tyne and Wear Mental Health Trust to improve physical health checks for people with a serious mental illness (SMI) working collaboratively with GP practices to increase the number of people on GP practices SMI registers who receive an annual health check:
  - Achievement of the increased 60% trajectory for the number of people with a Severe Mental Illness (SMI) receiving an annual health check.

Early Intervention Psychosis (EIP)

- Work with Northumberland, Tyne and Wear Mental Health Trust to ensure that the Sunderland EIP team meets the rating for 'good' services in the CCQI self-assessment:
  - Develop and implement an action plan agreed with CCGs across the area.
- Continue to work with providers towards compliance against the NICE recommended treatment standards.

Out of area treatment services (OATS)

- Continue to support the delivery of the STP/ICS level plans to reduce all out of area placements, including the review of all patients placed out of area to ensure their package of care is appropriate.

Improving access to psychological therapies (IAPT)

- Implement plans to improve access to Improving Access to Psychological Therapies (IAPT) for people with Long Term Conditions (LTC) through primary care:
  - Achievement of a minimum of 22% access rate at the end of 2019/20 for IAPT.
  - Maintenance of at least 50% recovery rates for IAPT.
  - Ensure 75% of people referred to IAPT receive treatment within 6 weeks and 95% within 18 weeks of referral.

Suicide prevention

- Deliver against multi-agency suicide prevention plans, working towards a national reduction of 10%.

Adult and older peoples community treatment teams

- Working with NTW to develop and implement an action plan to stabilise and bolster core adult and older people's community treatment teams (CTTs) and services for people with the most complex needs.
- Develop an action plan to mobilise a new integrated primary care and community model in line with the NHS Long Term Plan.

Dementia

- Continue the overachievement of the Dementia diagnosis rate of 67%.

Transforming Care

- Safe Space: with the LA and Transforming Care North Regional Implementation Group looking to develop crisis accommodation when there is a risk of hospital admission.
- Step Down: look to develop accommodation for patients with complex needs and ministry of justice restrictive sections as a step before moving into the community.
- Continue to support the NHS England Stopping over Medication of People with a Learning Disability (STOMP LD).
- Supporting Sunderland residents to leave Hospital in line with the delivery of the transforming care agenda and the Regional Transforming Care Programme closure and reform work linked to Rose Lodge.
- Ongoing delivery of the Learning Disability and Autism Primary Care Strategy specifically around the further development of:
  - An Autism Register.
  - A Primary Care liaison Nurse role.
  - The Quality Annual Health Checks.
  - Bespoke training for General Practice Staff.
- Delivery of the enhanced community model for transforming care including the development of an autism pathway and expansion of the CTT within NTW and the All About Me programme within Autism in Mind.
- Continue to implement the Learning Disabilities Mortality Review (LeDer) process.
- Working with NTW and regional commissioner to come to a mutual agreement of development of a memorandum of understanding with regards to capacity of Sunderland's CTT staff who are regularly working with individuals from out of area placed within Sunderland.
- Roll out of Sunderland CCG's processes around Care Treatment Reviews (CTRs) and Care Programme Approach (CPAs) for adults and into the children's arena to fulfil our requirements of Care Education Treatment Reviews (CETRs) ensuring quality throughout. This will require a training programme for Together for Children Social Workers and other partners.

- Working with NTW around development, agreement and roll-out of a Provider Training offer across Sunderland.
- Working with NTW and wider partners to consider options around out of area placements and registration with local GP Practices to develop a memorandum of understanding between NTW, the CCG & local general practices.

Enhanced primary and community care

Community Integrated Teams

Overall Goals for 2019 – 2020
Deliver integrated and patient centred care through the transformation of enhanced primary and community services.

Deliverables for 2019/20

- Review the governance arrangements for CITs to reflect the transition of the service to programme 3 (Enhanced Primary and Community Care) of the ATBA and ensure staff are regularly updated via an effective communications and engagement strategy to reduce uncertainty as to their roles.
- Re-affirm the vision of CITs and approach to risk stratification in light of emerging evidence to suggest that the patients for whom intervention would have most impact are those affected by drug and alcohol misuse.
- Look to better integrate mental health provision to the MDTs and facilitate ease of access to mental health services via a city-wide network arrangement.
- Explore ways to make GP input to CITs more efficient i.e. using video technology to reduce travel time, undertake an agreed triage process of patient lists to determine those that need MDT with GP input in order to maximise GP time.
- Review the current provision and use of estates and facilities taking into account emerging digital solutions to enable more mobile working where it will derive efficiencies.
- Review the MDT coordinator role to establish whether this temporary post is desired as a permanent role within the system.
- Explore the MDT referral process to encourage referrals from the multi-disciplinary team and not only GPs.
- Implement, embed and evaluate the GP Alignment with Care Home model.

Care Homes

Overall Goals for 2017 – 2019 Deliver integrated and patient centred care through the transformation of enhanced primary and community services.
Deliverables for 2019/20 • Development and pilot of a Trusted Assessor model. • Implement the Capacity Tracker – Bed State Tool. • Embed and evaluate GP Alignment model. • Establish Care Navigation role and support network. • Continuing the Hydration and Nutrition Task and Finish group to develop standard policies and support offers for Care Homes. • Evaluate the red bag scheme and look to embed as business as usual. • Support Care Homes with the process to obtain NHS Mail. • Embed and spread the use of the Care Home Tablet across all Care Homes in the city. • Linking closer with the CCG End of Life Group (EOL) which develops and implements the EOL strategy for Sunderland to ensure Care Homes are included in future EOL strategies. • Focus on the workforce and the required skills to support the Care Home Model to effectively manage this complex population.

End of Life

Overall Goals for 2019 – 2020 Deliver integrated and patient centred care through the transformation of enhanced primary and community services.
Deliverables for 2019/20 ***Integrated Working*** End of Life is part of the role of the Community Integrated Teams (CITs). The CITs ensure that patients have accurate and up to date care plans which are delivered by the appropriate provider. The aim of this is to ensure that the patient's wishes are met during their care and at end of life. ***Training and Education***

The CCG is continuing its education and training programme in 2019/20, which is delivered by clinical staff at St. Benedict's Hospice. Training is provided across all health and social care organisations, including Care Homes and GP Practices. The training aims ensure that staff delivering end of life care are competent in their roles as well as to be able to provide emotional, psychological and spiritual support to service users, their families, friends and carers both during the patient's illness and into bereavement.

During 2019 we plan to hold the following additional training for GPs;

- Communication skills; this aims to and improve confidence when having difficult conversations with patients and families when someone is thought to be approaching end of life.
- Anticipatory drugs; training is being arranged to ensure that GPs are confident and competent in prescribing anticipatory drugs.

Across Sunderland a number of Care Homes are taking part in the Gold Standard Framework for end of life. Once the pilot has been evaluated it is hoped that the standard will be rolled out to all Care Homes.

Emergency healthcare plan training will take place across the health system to ensure that there is a standard and consistent approach of the use of emergency health care plans.

High quality end of life care

We are working with providers to identify areas of improvement in end of life care.

Electronic Palliative Care Co-ordination System

The Electronic Palliative Care Co-ordination System, allows different providers of end of life care (such as District Nurses and General Practitioners) to be able to view patient records and input into them. This will ensure that the most up to date information is available to staff who are then able to respond appropriately to the patient's condition and needs. At present City Hospitals Sunderland, NHS and GP practices are able to view the patient records but there is no interoperability, this is longer term aim.

Community Equipment Service

Overall Goals for 2019 – 2020 Deliver integrated and patient centred care through the transformation of enhanced primary and community services.
Deliverables for 2019/20 • Create a new integrated wheelchair service. • Understand the increasing demands on children related equipment and wheelchairs. • Implement a new Sunderland Equipment 'Statement of Purpose' which will enable prescribing pattern custom and practice is refreshed and changed, so that the service offer meets the needs of the population. • Create a sustainable service to support the providers to deliver economies of scale by creation of a sub-regional hub and spoke model for both CES and wheelchair services.

Continuing Healthcare

Overall Goals for 2019 – 2020 Deliver integrated and patient centred care through the transformation of enhanced primary and community services.
Deliverables for 2019/20 • Deliver savings of £1m pa for the next two years. • Continue to deliver the targets set by NHS England for eligibility assessments. • Continue to deliver on the target for the ratification or fast track applications. • Work towards delivery of reviews following an appeal to a 'not eligible decision'. • Work towards the CHC service being delivered sustainably. • To further develop integrated working with the Local Authority and the All Together Better Alliance (ATBA). • Align the Quality Strategy between the CCG and the Local Authority. • Initiate and complete a CHC fast track service user research project. • Initiate service user satisfaction surveys informed by the CHC Improvement Framework. • Update the local CHC information guide.

- Continue to collaborate with the Local Authority to strengthen next year's Section 75 agreement and the quality and safety processes.
- Work with CCGs across the region to share best practice and lessons learnt to support consistency.

Intermediate and urgent care

Overall Goals 2019/20
Ensure patients benefit from treatment, in the right place, at the right time, by the right professional through the provision of a simple seamless pathway across Intermediate and Urgent Care.

Deliverables for 2019/20

CAS 111

- Implementation and embedding of the new CAS 111 Service.
- Increasing the number of patients using the CAS 111 Service to ensure the right services are accessed at the right place and at the right time.

Urgent Treatment Centre

- Mobilisation of the Urgent Treatment Centre.

Recovery at Home

- Review and transform Recovery at Home (RaH) by agreeing a single service specification to cover all of the different elements of the service delivery.
- Redesign therapy pathways to enable people to be assessed in their normal environment rather than in a hospital bed (acute or community).
- Continue the use of assistive technology, telecare and equipment to enable people to be supported to stay at home rather than being admitted to long term care or remain in receipt of large package of care.
- Review the RaH workforce with aim to work in an interdisciplinary way using a trusted assessor approach underpinned by a large pool of well-trained support workers.
- Ensure a seamless pathway from hospital discharge through the RaH service as quickly as possible and as clinically appropriate.
- Reconfigure the criteria for the use of community beds.
- Create a pathway so patients can use all of the RaH service elements on their journey to recovery.
- Reduce duplication at points of transfer in terms of numbers of assessments and re-assessments that add no value for patients.
- Create a seamless pathway between RaH and Community Integrated Teams so that patients going through RaH services where

appropriate are part of the MDT review to ensure long term plans are in place to manage the patients' needs.
- Work towards an improvement in service delivery of within two hours of referral in response to a community health crisis, where clinically judged to be appropriate, within five years.
- Work towards an improvement in the delivery of reablement care to within two days of referral to those patients who require it, within 5 years.

Enablers

Digital & Technology

Digital & Technology

Deliverables for 2019/20

Focus on General Practice

- We will continue to deploy the technology to achieve the 75% target of the population able to access on-line consultations across the city in 2019/20.
- Grow the coverage of video conferencing between patient and practice, advanced telephony, patient messaging and patient access across the city.
- Development of a strategy for our patients to access the most appropriate technologies (NHS App) to utilise and receive benefit from our new digital channels.
- These channels will be further embedded into general practice as part of the change management approach defined by our New Consultations Types Programme and is the first step in delivering the NHS long term plan of vision of a digital-first primary care offer to patients.
- We are supporting and in some cases leading the development of regional governance to manage and steer how GP IT is planned and delivered across the region.
- The key areas of development under this governance are;

    - Development and publication of a two year GPIT strategy aligned to the NHS long term plan and local general practice strategies.
    - Production of a revised Service Level Agreement between CCGs and the local GPIT delivery partner ensuring the core and mandated services outlined in the new GPIT Operating Model are clearly defined, delivered and financially sustainable.
    - Development of a pipeline of general practice investment opportunities that could attract local and/or national funding and also be delivered at a region wide level and support delivery of the GPIT strategy.
    - Development of the Clinical Digital Resource Collaborative (CDRC) as a sustainable mechanism for the development of digital tools

that can be developed once and shared across the region which supports standardisation of data capture and coding.
    - Locally we will invest in and develop our expertise to support the CDRC and local requirements through the appointment of a Clinical Data Quality Lead (CDQL).

- Updating of the technical infrastructure supporting the delivery of GPIT services in early 2019/20 and practices migrated to the latest Windows 10 operating system to ensure compliance with NHS standards for cyber security.
- We will start the process of digitising Lloyd George paper records within general practice.

Focus on Acute and Community

- We will work with partner organisations to ensure their plans under the Global Digital Exemplar (GDE) programme to deliver the expected benefits in digital maturity that support organisational priorities and system wide transformation whilst bringing financial efficiency.
- The redesign of the outpatients model will be underpinned design principle of 'digital by default'. To enable patients and clinicians to remotely support and monitor care requirements and recall / access processes.
- There will be specific focus on the Mental Health Digital Strategy which will be integral to the development of the ABTA model.
- At an ICS level the investment made through the devolved £25 million Health System Led Investment Fund will see a number of new capabilities start to be developed through a series of approved projects outlines below;

    - Federated Picture Archiving and Communication System (PACS) workflow and reporting platform (Radiology) - Optimising acute services including key diagnostic services (i.e. Pathology and Radiology) are key priorities for the NENC ICS: To provide a federated PACs workflow and reporting platform for near instant image look up diagnostics and collaborative reporting.
    - Digitalising Haematology across the North East and North Cumbria (Pathology) - Investment will build on the Digital pathology project to include haematology, enabling haematology consultants to view diagnostic quality blood film images remotely, this enables clinical collaboration and shared care across the region.
    - Enabling Frailty Management Services - Frailty is a key ICS priority: Delivery of frailty management services through appropriate identification, procurement and delivery of digital solutions and services. NHS Health Call will be a primary consideration for this service.
    - Regional Patient Engagement Platform - The creation of a regional patient engagement platform to provide a single patient portal initially covering Clinic Letters, Appointments and relevant results to remove paper, print and postage costs.
    - Community EPR & Mental Health Mobile Working - Enabling community and community mental health teams to access the community EPR systems plus the traditional hospital systems (EPR, Documentation, Orders and Results) whilst with the patient.

- We will mainstream the operational and support aspects of the Care Home Tablet technology that supports management of patients in

these locations and the use of national tools such as NEWS.

Focus on Information Sharing

- Our plans include widening the scope of our existing information sharing capabilities such as the Medical Interoperability Gateway (MIG) to include the End of Life EPaCCS dataset into mental health and emergency care providers.
- We will also increase the range of services to share information between general practice and our community provider which underpins closer out of hospital working under the All Together Better Alliance.
- We will develop local interoperability capability with providers of health and care and their suppliers to connect to the Health Information Exchange (HIE) infrastructure to both publish and consume the data available with a robust information governance framework.
- We will work with our Local Authority partners to support them with the rigorous requirements of connectivity to NHS infrastructure and preparation for connectivity to the HIE.
- The HIE will deliver a new capability that will assist with transformation across the LHE and we will develop specific 'use cases' to guide how data flows and is presented. In particular the engaged work streams are; advice and guidance, outpatients remodelling, non-value added diagnostics and tests.

Focus on prevention and self-care

- We will develop the content within the platforms to align to the national 111 on-line guidance already available on-line and through the NHS App.
- We will increase the use of the MyCOPD app as part of annual reviews and will further explore similar capabilities that support other long term conditions.
- We will work with the ICS digital community to develop a strategy for the application of the Health call platform within the ATBA model.
- We will support our Local Authority partners in the mobilisation of their National Test Bed project which will see connected 'Internet of Things (IoT)' devices piloted within 120 homes across the city capable of supporting both health and care needs initially focusing on;

    - Moving around the home
    - Nutrition and hydration
    - Monitoring mood
    - Managing medication use

Medicines optimisation

Medicines Optimisation

Deliverables for 2019/20

- Integrating system wide formulary and medicines use decision making bodies across the South Tyneside and Sunderland footprint.
- Improving the care of people with diabetes through developing and implementing new guidelines, ensuring appropriate use of insulin analogues and promoting best value testing technology (which will include testing strips and flash monitoring).
- Supporting patients with respiratory conditions to get the best impact and value from their medicines, by developing and implementing new guidelines for COPD and paediatric asthma.
- Embedding a cost effective and waste reducing supply model for dressings.
- Implementing community review services for patients using stoma and other appliance services.
- Tackling the disproportionately high prescribing of opiates and other analgesics in Sunderland.
- Continuing to promote antimicrobial stewardship and responsible prescribing.
- Ensuring effective and collaborative transfers of care between settings by leading the development of an innovative shared care prescribing and monitoring model.
- Addressing unwarranted variation through engagement with NHS Right Care, OpenPrescribing and a number of other data sources.
- Reducing medicines waste by embedding changes to the repeat prescription ordering model.
- Gaining engagement with the medicines optimisation workplan through regular practice visits and attendance at locality meetings.
- Identifying opportunities to maximise the impact of community pharmacy on the delivery of healthcare.
- Ensuring that those patients prescribed Valproate and are of child bearing potential are informed of and kept safe from the risk of harm.
- Collaborating with partners in the All Together Better Alliance to redesign practice pharmacist models.
- Encouraging self-care in patients by reducing inappropriate prescribing of medicines which are available for purchase over the counter.

9. Glossary

AEC	Ambulatory Emergency Care
ATBA	All Together Better Alliance
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
CDDFT	County Durham and Darlington Foundation Trust
CHC	Continuing Healthcare
CHS FT	City Hospitals Sunderland Foundation Trust
CIT	Community Integrated Teams
CNE	Cumbria and the North East
CVD	Cardiovascular Disease
CYP	Children and Young People
EHCH	Enhanced Health in Care Homes
FYFV	Five Year Forward View
GDE	Global Digital Exemplar
GH NHSFT	Gateshead NHS Foundation Trust
IAF	Improvement Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
ICP	Integrated Care Partnership
IS	Independent Sector
IUC	Integrated Urgent Care
JSNA	Joint Strategic Needs Assessment
LD	Learning Disability
LMS	Local Maternity System
LHE	Local Health Economy
MDT	Multi-Disciplinary Team
MHIS	Mental Health Investment Standard
NEAS	North East Ambulance Service
NENC	North East North Cumbria
NHSE	NHS England
NHS LTP	NHS Long Term Plan
NTW NHS FT	Northumberland Tyne and Wear NHS Foundation Trust
PBR	Payment By Results
PCN	Primary Care Networks
PHB	Personal Health Budgets
QSG	Quality Surveillance Group
RaH	Recovery at Home
RAID	Rapid Assessment Interface and Discharge
RTT	Referral to Treatment
SIMs	Sunderland Intermediate Musculoskeletal service
SPoA	Single Point of Access
SRC	Senior Responsible Clinician
SRO	Senior Responsible Officer
ST NHS FT	South Tyneside NHS Foundation Trust
STOMP	Stopping Over Medication of People with a Learning Disability
TCP	Transforming Care Partnership
UTC	Urgent Treatment Centre
VBC	Value Based Commissioning