GOVERNING BODY
31 JANUARY 2017

Report Title: Sunderland Clinical Commissioning Group’s 2017-2019 Operational Plan

Purpose of report
To present Sunderland CCG’s 2017 – 2019 Operational Plan to the governing body for final endorsement.

Key points, risks and assurances

1. Introduction

On 22 September the NHS published its operational planning and contracting guidance bringing forward the planning process by three months. Key deliverables from the planning process include: a written operational plan; a financial plan, including productivity plans; and signed contract agreements. This report focuses on the operational plan.

We submitted the first draft of our operational plan in accordance with the national deadline of Thursday 24 November 2016. Following the 24 November submission, NHS England (NHSE) reviewed our plan (all deliverables), along with plans of other CCGs and provided feedback which we were to address in the final submission due on 23 December. NHSE provided feedback on a range of areas and also asked subject experts to review specific elements including, workforce, strategy and transformation; learning disability and transforming care; nursing and quality; public health and primary care.

The governing body received the final draft of the operational plan for endorsement on Tuesday 21 December at a special business meeting prior to the submission deadline. Following consideration by the governing body, revisions were made in accordance with the feedback received. Our operational plan, including the financial plan, was submitted on Friday 23 December 2016 to NHS England in accordance with the national deadline.

This report presents Sunderland CCG’s 2017 to 2019 operational plan to the governing body for approval.

2. Key points

Following the report to the governing body on 21 December, the following activities have taken place:
Feedback has been acted upon.

The full organisational time out held in December 2016 provided the platform to update and engage with all staff across SCCG on our operational plan, including the key priorities and major transformational changes across the patch.

We have shared our operational plan with Sunderland’s Transformation and A&E Delivery Board. Post plan submission, this Board is focusing on system alignment and delivery together.

The Delivery Team of NHSE North East and Cumbria has undertaken an assessment of the credibility of CCG operational plans. We await their feedback which we understand will be different to that provided at earlier submissions. There will be a particular focus on the local delivery plan in the operational plan (annex 4).

3. Next steps

- To share the plan with our practices, partners and stakeholders.
- To continue to work as a system to support delivery and manage risk together.
- To prepare for delivery of our 2 year plan by ‘taking stock’ of our current implementation processes and plans to ensure delivery, tweaking arrangements where required.

Recommendation/Action Required

The Governing Body is asked to endorse the plan.

| Sponsor/approving director | Debbie Burnicle  
                          | Deputy Chief Officer |
|---------------------------|-------------------|
| Report author             | Helen Steadman    
                          | Head of Strategy, Planning and Reform |

Governance and Assurance

Link to CCG corporate objectives (please tick all that apply)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>CO1: Ensure the CCG meets its public accountability duties</td>
<td>✓</td>
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<td>CO2: Maintain financial control and performance targets</td>
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<td>CO3: Maintain and improve the quality and safety of CCG commissioned services</td>
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<td>CO4: Ensure the CCG involves patients and the public in commissioning and reforming services</td>
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<td>CO5: Identify and deliver the CCG’s strategic priorities</td>
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<td>CO6: Develop the CCG localities</td>
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<tr>
<td>CO7: Integrating health and social care services, including the Better Care Fund</td>
<td>✓</td>
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<tr>
<td>CO8: Develop and deliver primary medical care commissioning</td>
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Any relevant legal/statutory issues
Are the identified risks on the risk register?

Not applicable

If issue/report has been previously reviewed please specify meeting and date

This is the third paper in relation to planning for 2017/18 to 2018/19 to be brought to the Governing Body.

The first report in November provided an overview of the NHS planning guidance published in September 2016 and described the process to develop the CCG's operational plan in accordance with national guidance and timeline.

The second report in December presented the plan to the Governing Body following engagement with the Executive Committee and clinical and management leads and partners, for endorsement prior to submission to NHS England and in accordance with the national deadline.

<table>
<thead>
<tr>
<th>Equality analysis completed (please tick)</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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### Key implications

<table>
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<tr>
<th>Are additional resources required?</th>
<th>Yes, clinical and managerial resource to deliver the 2017 – 2019 transformational programmes and productivity plans within the plan.</th>
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<td>Has there been appropriate clinical engagement?</td>
<td>Yes via the Executive GPs, Clinical Leads and the clinical representatives on the strategic transformational groups.</td>
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<tr>
<td>Any current or expected impact on patient outcomes/experience?</td>
<td>It is expected that by implementing our operational plan we will realise the triple aim of the Five Year Forward View (better health; better care; and financial sustainability) and our own vision of Better Health for Sunderland.</td>
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<td>Has there been member practice and/or other stakeholder engagement if needed?</td>
<td>Yes, through the Executive Development sessions and Sunderland Transformation and A&amp;E Delivery Board</td>
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Operational Plan
2017-2019

December 2016
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Executive summary

This document is our 2017 – 2019 operational plan which builds upon our prior 2016 – 2017 operational plan published earlier this year. It takes account of the evolving policy context, for example the publication of the Five Year Forward View for Mental Health, the GP Forward View and guidance relating to the development of five year Sustainability Transformation Plans.

This document describes our strategic priorities for the next two years, which have not changed from 2016/17. Our priorities will be delivered through our transformational change programmes, which have developed further. We describe progress to date in 2016/17 and our plans for the next two years to address the triple aim of the Five Year Forward View. We therefore set out how we will meet the needs of our local population by improving health and wellbeing; driving transformation to improve quality of care; and by improving the efficiency of local NHS services to ensure financial sustainability.

We also outline how we will achieve the nine national ‘must-do’ priorities and meet the NHS Constitution standards through the delivery of our plan, comprising our transformation programmes and summarised on our plan on a page (PoaP).

The Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (STP) is an ‘umbrella plan’. For the most part, it is built out of existing programmes of work within the local health economies within the STP footprint although there are some additional transformational changes. Our two year operational plan, sitting below the STP, is the detailed delivery plan for years two and three of the remaining four years of the STP.
**Better Health for Sunderland**

### Our Vision

**Delivered by:**

- Transforming care out of hospital (through integration and 7 day working)
- Transforming in hospital care, specifically urgent and emergency care (7 day working)
- Enabling self care and sustainability

### Measured by:

**National targets**

- CANCER: Continue to perform well
- DEMENTIA: Improve to performing well
- DIABETES: Improve to performing well
- LEARNING DISABILITIES: Improve to performing well
- MENTAL HEALTH: Continue to perform well

**Local targets**

- Reduce emergency admissions by 12% by 2019
- Maintain the number of smoking quitters at 2015/16 levels
- Reduce years of life lost by 15% by 2019
- Improve health related quality of life for people with LTCs by 8.9% by 2019
- Deliver a productivity plan of £22.5m
- Deliver prescribing savings of £7.1m

**Underpinned by our values**

- Patient centred
- Inclusive
- Responsive
- Innovative
- Empowering
- Integrity
- Open and Honest

### Transformational Changes 2017/18 - 2018/19

**Sustainability**

- Maximise the use of resources to improve outcomes for the people of Sunderland

**In Hospital**

- Ensure a safe and sustainable model for acute services by delivering a single clinical operating model across the local health economy.

**Community Care System**

- Jointly commission a fully integrated unplanned and planned community care system that interfaces effectively with specialist services.

**General practice**

- Sustain and transform general practice in line with the General Practice Forward View.

**Mental health**

- Deliver the Mental Health Forward View in full, including Child and Adolescent Mental Health Services Transformation Plan.

**Learning disabilities**

- Continue Transforming Lives programme including the Primary Care Learning Disabilities/Autism strategy.

**Childrens & maternity**

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

**Cardiovascular disease**

- 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.

**Prevention**

- Implement a whole system approach to increase healthy life expectancy and reduce smoking and alcohol related admissions through prevention with an initial focus on self-care, making every contact count and smoke-free NHS premises.

### Enabled by

- Joint commissioning & Better Care Fund
- IT infrastructure
- Contract management (CQUIN)
- Organisational development
- Medicines optimisation
- Primary care co-commissioning
- Telehealth
- CCG Localities
- Research and development
- Reform methodology

### Governed by

- CCG Governing Body
- Transformation and A&E Delivery Board
- Health & Wellbeing Board

### Underpinned by system wide principles

- One system for health and social care
- 7 day services
- Mental health and physical health of equal importance
- Effective, safe care and positive patient experience

### To deliver

**NHS England The Five Year Forward View**

- Better Health
- Care and quality
- Sustainable funding
- Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (NTW ND STP) at a local level
- Scaling up prevention, health and wellbeing
- Out of hospital collaboration
- Optimal use of the acute sector

Version 0.4 21.12.16
1. Introduction

1.1 Our Vision for 2018/19

Our Vision, agreed by all our member practices, is to achieve Better Health for Sunderland.

We will deliver this through:

- Transforming out of hospital care (through integration and 7 day working);
- Transforming in hospital care, specifically urgent and emergency care (7 day working);
- Self-care and sustainability.

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

This Operational Plan describes the work we will be undertaking during 2017 – 2018 and 2018/19 to ensure the delivery of our Vision and strategic objectives.

1.1.1 Values

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

The following system wide principles have been agreed and underpin the delivery of the transformational change programmes described in this plan:

- Evidence based;
- Effective, safe care and positive patient experience;
- Prevention focused;
- Mental and physical health of equal importance;
- 7 day services;
- One system for health and social care across Sunderland

1.2 Strategic Context

Sunderland Clinical Commissioning Group’s (SCCG) two year operational plan (the ‘plan’) needs to be read and understood in the context of NHS England’s Five Year Forward View and the requirements of national NHS planning guidance published in December 2015 and in September 2016.

1.2.1 NHS England’s Five Year Forward View

Published by NHS England in 2014, the Five Year Forward View (the ‘Forward View’) identifies three key challenges facing the NHS, including:

- **Improving health and wellbeing**, focusing on preventing illness, supporting people to improve their own health and wellbeing and bending the demand curve;
- **Improving the quality of care** that people receive, focusing principally on care redesign, delivery of the NHS Constitution standards and outcomes in clinical areas, including for example: cancer; dementia; diabetes; learning disabilities; maternity; and mental health.
- **Sustainability**; this is about ensuring services are efficient to sustain a high quality NHS and securing good value for patients and the public from the money spent on commissioned services.

According to the Forward View the future of the NHS depends on addressing these challenges and to do this fundamental change is needed. The Forward View sets out a vision for the future and plans to overcome these challenges, including the development and implementation of Sustainability and Transformation Plans (STPs), delivered by health and social care organisations working together in a geographic footprint to ensure the transformation and sustainability of local services (section 1.2.3).
1.2.2 National NHS planning guidance

The *NHS operational planning and contracting guidance 2017-19*, published in September 2016, updates the planning guidance published in December 2015 and the requirements to have two separate but connected plans - a one year organisational plan for 2016/17 and a five year Sustainability and Transformation Plan which is place based to deliver the triple aim of the Forward View: better health and wellbeing; better care; and financial sustainability.

1.2.3 Sustainability and transformation plans

The December 2015 planning guidance introduced Sustainability and Transformation Plans. During 2016 NHS organisations were asked to come together, working with local authorities and other partners, to develop these plans for the future of health services in their area to meet the challenges outlined in the Forward View.

The focus during 2016 has been to develop the STP. Having agreed the STP footprint of Northumberland, Tyne and Wear and North Durham (NTW ND), the health and social care organisations within the STP footprint, including Sunderland Clinical Commissioning Group, have come together and developed the draft STP, which has been published and is available on the our website.

The development of the NTW ND STP has been led by a strategic partnership board of senior representatives from the organisations involved working within the local health and social care system footprint. Whilst the partnership is new, the work to be taken forward in the plan is largely built on developments that had already been agreed and in progress.

The draft STP sets out what the organisations will be working on over the next two years. The NHS operational planning and contracting guidance 2017 – 2019 updates the earlier guidance and shifts the focus to STP *implementation*, through individual organisation operational plans.

1.2.4 Organisational operational plans

In December 2015, NHS organisations were asked to produce a one year operational plan for 2016/17. The recent guidance published in September 2016 requires the development of two year organisational operational plans (2017-2019), backed up by 2 year contracts which align with the two year activity and performance assumptions agreed within the STP.

The two year organisational operational plans are years 2 and 3 of the STP.

The 2016 national planning guidance re-affirms the 2015 nine national ‘must-do’ priorities as the priorities for 2017/18 and 2018/19. However, there have been some updates in the nine areas reflecting the evolving policy context.
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<tr>
<td>STPs</td>
<td>Implement agreed STP milestones</td>
</tr>
<tr>
<td>Finance</td>
<td>Deliver CCG and NHS provider organisation control totals and achieve local system financial control totals</td>
</tr>
<tr>
<td>Primary care</td>
<td>Ensure the sustainability of general practice by implementing the General Practice Forward View</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>Deliver the NHS Constitutional standards including the five elements of the A&amp;E Improvement Plan and implement the Urgent and Emergency Care Review</td>
</tr>
<tr>
<td>Referral to treatment times and elective care</td>
<td>Deliver the NHS Constitution standard; streamline elective pathways and implement the national maternity services review, Better Births.</td>
</tr>
<tr>
<td>Cancer</td>
<td>Implement the cancer taskforce report; deliver the NHS Constitution standards and make progress in improving one year survival rates; roll out stratified follow up pathways and commission all elements of the Recovery Package.</td>
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<td>Mental health</td>
<td>Full implementation of the Mental Health Five Year Forward View</td>
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<tr>
<td>People with learning disabilities</td>
<td>Deliver the Transforming Care Partnership plans including reducing inpatient bed capacity, improving access to healthcare for people with learning disabilities and making reasonable adjustments for people with learning disabilities and autism</td>
</tr>
<tr>
<td>Improving quality in organisations</td>
<td>Implement plans to improve quality of care</td>
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1.3 Our operational plan 2017 - 2019

This two year operational plan comprises years four and five of our five year strategic plan, covering the period 2014/15 to 2018/19.

To inform the development of our operational plan for 2016/17, we undertook a comprehensive review of our transformational change programmes for 2015/16 taking account of our progress over years one and two of our five year plan, national guidance and the Forward View. Our operational plan, published in April 2016, covered a three year period because we continued with some of the existing priorities from 2015/16 but also because we identified additional new priorities. Our experience tells us that a twelve month period is not sufficient to implement transformational change.

Despite the fact that our prior plan was for three years, we have reviewed it against the updated national planning guidance, developing policies and alignment with NTW ND STP priorities.

During the period 2017 to 2019 we will continue to focus on the priorities we identified in 2016/17 which have been updated in the light of progress. They are summarised on our plan on a page (PoaP).
Our plan reflects progress to date in respect of our transformational programmes and sets out our plans over the next two years. It also includes how we will achieve the national nine ‘must-do’ priorities through the delivery of our transformation programmes and how our plan supports the delivery of the three STP transformational areas:

- **Scaling up Prevention, Health and Wellbeing** to improve the health and wellbeing of our public and patients designed by the Directors of Public Health from each of the local authorities;
- Improve the quality and experience of care through **Out of Hospital Collaboration** by scaling up the new models of care from our Vanguards and the development of a resilient and robust primary care sector; and
- **The Optimal Use of the Acute Sector** by exploring and developing alternate service models which ensure high quality sustainable care.
2.0 Key Challenges

Our plan aims to address the three key challenges identified in NHS England’s Forward View to improve health and wellbeing; improve care and quality; and ensure sustainability.

2.1 Health and wellbeing challenge

Health is determined by a complex interaction between individual characteristics, lifestyle, and the physical, social and economic environment. People in Sunderland are living longer but are at risk of spending their extended years in poor health as a result of high levels of poverty, deprivation and lack of opportunity which influence behaviours such as poor diet, lack of exercise, smoking and excessive alcohol use. Without greater focus on prevention and the wider determinants of health, health inequalities will widen.

A summary of the high level health challenges for Sunderland is summarised below:

- Responding to changes to the population structure including, fewer children and younger working age adults, more elderly population and increasing ethnic diversity. 8.3% of the Sunderland population is aged 75 years and older compared to the England average of 8.1% (based upon 2014 mid-year population estimates);
- Tackling poverty through increasing employment, educational attainment and skills to give every child the best start in life and break intergenerational cycles of disadvantage. For Sunderland, prevalence of childhood poverty is 23.6% against the England average of 18.6% (based on the 2013 snapshot from HMRC). In Sunderland 25.3% of the population aged 16-64 are qualified to NVQ level 4 or equivalent or above (higher education) compared to 36.7% for England (based on 2015 data from the Annual Population Survey);
- Tackling the big four lifestyle risk factors – smoking, excessive alcohol use, poor diet, and low levels of physical activity – including for people with multiple unhealthy behaviours. The prevalence of smoking in adults aged 18 years and over is 22.8% in Sunderland compared to the England average of 18.0% (based on 2014 data from the Integrated Household Survey);
- Preventing early deaths from cancer, cardiovascular disease and respiratory disease. The people of Sunderland on average live shorter lives than the England average. Life expectancy at birth is 77.3 years for males and 80.8 years for females compared to 79.5 for males and 83.2 years for females in England (based on data for 2012-2014);
• Managing the likely increase in the level of long term conditions, including increasing proportions of people with multiple long term conditions;
• Delivering better integrated care for individuals and reducing the over-reliance on hospital services, through promotion and support for self-care;
• Tackling poor mental health through prevention and building individual and community resilience; and
• Addressing teenage pregnancy, smoking during pregnancy, breastfeeding and child obesity.

2.2 Care and quality challenge

The quality of general practice is high but pressures are increasing (rising demand for GP appointments; increasing workload; growing complexity of need; and changing patients’ expectations) and workforce recruitment and retention in Sunderland and the wider North East has historically been challenging.

There are a number of challenges facing our two hospital providers, City Hospitals NHS Foundation Trust and South Tyneside NHS Foundation Trust. To provide the level of service to the required quality standards, duplication in service provision at each hospital site is no longer sustainable due to workforce and financial pressures. The two hospital trusts are working more closely together undertaking a clinically led service review programme to look at the best service configuration to ensure the services are the highest quality within existing and reducing resources.

Using the NHS RightCare programme packs, we have benchmarked ourselves across a range of clinical areas and indicators, for example, cardiovascular disease, cancer and maternity, to understand where we can increase quality of care; drive improvements in patient outcomes to deliver better health for our local population and reduce inequalities; and deliver better value for the investment. We are progressing this work to reduce variation, improve quality and identify opportunities for more efficient service delivery.

Pressures have arisen this year in Children and Young People services because the service has been unable to manage throughput given the increased numbers of referrals. Waiting times have increased. We have provided additional non-recurrent funding to address and improve waiting times in light of increased referral pressures.

We have made significant progress in 2015/16 and 2016/17 in implementing our Out of Hospital model of integrated care to provide person centred, co-ordinated care for some of the most vulnerable people in the City. We continue to mainstream the three work streams (Community Integrated Teams; Recovery at Home; and Enhanced
Primary Care) and build upon the progress to date to drive quality improvements through risk stratification, multi-disciplinary working and care at the right time and place. Sunderland is one of fourteen national Vanguards testing the Multi-Specialty Community Provider care model for out of hospital care.

2.3 Funding and efficiency challenge

NHS England’s ‘pace of change’ funding policy was designed to bring all CCGs closer to their target funding. The adjustments made to the funding formula have resulted in SCCG being deemed to be the most overfunded CCG in England outside London, moving from 12% to 18.6% over funded position. As a result of our distance from target (DFT), we receive minimal programme growth over the next three years (2017 to 2020), compared to other CCGs, which effectively is a real terms cut in funding (figure 1 below).

In addition to the minimal growth allocations that we will receive, the HRG4+ allocation adjustments recently announced have added an additional financial pressure to our plan leading to a further financial efficiency requirement of £2.1m. Due to this challenging financial position we have identified the need to support the productivity plan in 2017/18 with drawdown of historic surpluses, whilst transformation plans are developed and implemented.

2017/18 and 2018/19 will be the most financially challenging period in the history of the CCG. Rapid delivery of productivity requirements will need to be achieved in order to remain within available allocations.

In addition to the significant financial challenges we face, local health economy (LHE) partners have worked together to understand the overall financial gap in Sunderland and South Tyneside. All stakeholders agree that the significant scale of the LHE financial challenge will require a collaborative approach in order to ensure whole system sustainability.
3.0 Addressing the challenges

As discussed in section 1.3, our priorities for 2017 to 19 remain unchanged from our prior 2016 to 2019 plan.

Our transformational programmes, which will deliver our priorities, also seek to address the Forward View challenges – the ‘triple aim’. They will also deliver the national nine priorities and support the delivery of the NTW ND STP.

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<th>CCG transformational programme</th>
<th>National ‘must-do’</th>
<th>STP transformation area</th>
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<td>In hospital</td>
<td>Improving quality/finance</td>
<td>Optimal use of acute sector</td>
</tr>
<tr>
<td>Community care system</td>
<td>Urgent and emergency care/STP</td>
<td>Out of hospital collaboration</td>
</tr>
<tr>
<td>General practice</td>
<td>Primary care</td>
<td>Out of hospital collaboration</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental health</td>
<td>Out of hospital collaboration</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>People with learning disabilities</td>
<td>Out of hospital collaboration</td>
</tr>
<tr>
<td>Childrens’ and maternity</td>
<td>RTT and elective care</td>
<td>Optimal use of acute sector</td>
</tr>
<tr>
<td>Cancer</td>
<td>Cancer/ Improving quality</td>
<td>Scaling up prevention, health and wellbeing</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>Improving quality/prevention</td>
<td>Scaling up prevention, health and wellbeing</td>
</tr>
<tr>
<td>Prevention</td>
<td>Prevention</td>
<td>Scaling up prevention, health and wellbeing</td>
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<tr>
<td>Sustainability</td>
<td>Finance/Improving quality</td>
<td>Finance</td>
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3.1 Implementing the NTW ND STP

Our transformational programme supports the delivery of the STP transformation areas.

<table>
<thead>
<tr>
<th>STP transformation area</th>
<th>Scaling up prevention, health and wellbeing</th>
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<tbody>
<tr>
<td>SCCCG transformation programme</td>
<td>Community care system including the Out of Hospital model</td>
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</table>

Sunderland’s All Together Better programme is part of the national New Care Models vanguard programme aimed at achieving the triple aim through the integration of services around the patients.

Empowering patients to self-care is an essential element of the approach:
- Multi-disciplinary teams empower patients to take control of their health and social care needs;
- The Recovery at Home service maximises independent living;
- Enhanced primary care will support patients with moderate needs and long term conditions to manage their conditions more effectively; and
- Our telehealth and telecare projects have enabled and promoted self-care, for example the Florence text messaging service

Self-care and patient activation is an area for development in 2017/18 and we will have a model operational by September 2017, and embedded by March 2018. This will build upon a pilot project delivered by Sunderland Carers Centre during 2016/17 and learning from our neighbours in South Tyneside’s Pioneer programme, a ‘Better U’. We will work closely with our partners in the Third Sector, particularly Age UK Sunderland and Sunderland Carers Centre as well as statutory partners, to deliver this element of the care model.

<table>
<thead>
<tr>
<th>SCCG transformation programme</th>
<th>Prevention</th>
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<tbody>
<tr>
<td>There was agreement in January 2016 by Sunderland’s Transformation Board to focus on prevention. The Board have agreed alcohol and smoking as priorities and to implement ‘Making every contact count’ (MECC) into healthcare settings across the Sunderland system. MECC is an approach to behaviour change that utilises millions of day-to-day interactions to support people to make positive changes to their physical and mental health and wellbeing. The aim is to create a healthier population, improve health outcomes and reduce plan health inequalities. The Board have agreed to take forward the action plan that has been developed.</td>
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<table>
<thead>
<tr>
<th>SCCG transformation programme</th>
<th>CVD (secondary prevention)</th>
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<tbody>
<tr>
<td>Our plans in 2017/18 focus on secondary prevention to ensure people with CVD risk factors, for example high blood pressure, atrial fibrillation and raised cholesterol, are optimally treated and managed in primary care. We will also develop and implement a new model of integrated self-care and rehabilitation to support people with pre-existing long term conditions and also those at risk of developing long term conditions.</td>
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<tr>
<th>STP transformation area</th>
<th>Out of hospital collaboration</th>
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<tr>
<td>SCCG transformation programme</td>
<td>Community care system including the Out of Hospital model</td>
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To date two separate models of Out of Hospital provision have been developed in Sunderland and South Tyneside localities reflecting the different contexts, local relationships, challenges and opportunities although each have similar aims and objectives. We have received confirmation of the award of transformation funding in 2016/17 of £400k relating to testing/ further developing the South Tyneside model, working closely with Sunderland’s All Together Better programme around learning, sharing, spreading. South Tyneside CCG will then be expected to bid for transformation funding over the next three years to support the implementation of the MSCP care model. This will enable further opportunities for joint working and a potential single out of hospital model across the local health economy where this provides benefits for both localities.

<table>
<thead>
<tr>
<th>SCCG transformation programme</th>
<th>General Practice</th>
</tr>
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<tbody>
<tr>
<td>To support the transformation described in this plan, we need to sustain and transform general practice. We agreed a five year commissioning strategy and financial plan in 2015 for general practice and our focus in 2016/17 has been to deliver a key strategic objective of the strategy: to increase capacity and build the</td>
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</table>
workforce. Our strategy aligns with the GP Forward View (GPFV) and is a solid foundation to build upon to deliver the GPFV commitments, including to improve access to general practice services and to help manage the workload pressures in general practice. Our GP Alliance is a key partner in the delivery of the Enhanced Primary Care work stream of Sunderland’s All Together Better programme and is now enabling the provision of primary care at scale.

<table>
<thead>
<tr>
<th>STP transformation area</th>
<th>Optimal use of the acute sector</th>
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<tbody>
<tr>
<td>SCCG transformation programme</td>
<td>In hospital</td>
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</table>

The collaboration between City Hospitals Sunderland NHS FT and South Tyneside NHS FT is a blueprint for the STP system. The establishment of the South of Tyne HealthCare Group, accompanied by a single integrated management structure across the trusts, enables and oversees the ‘Path to Excellence’ programme. This programme is based upon a series of clinical service reviews to reconfigure and transform clinical pathways across both hospital trusts to address workforce pressures and to ensure safe, high quality services whilst continually improving patient and staff experience. The services being reviewed in phase one include maternity and gynaecology, stroke and paediatrics.

3.2 Our transformational programmes

The diagram below (figure 2), drawn from the CCG Improvement and Assessment Framework, aims to show how our plan supports the delivery of the Forward View. However, whilst our programmes have been aligned to the delivery of one of three aims of the Forward View, there are interdependencies. We anticipate that the impact of the priorities within our transformation areas will be wider than the domain to which they have been aligned. An example of this is prevention; whilst this is a separate programme to develop and implement a whole systems approach across the City, prevention is built into our transformation programmes, wherever possible. In addition there are two transformation programmes where delivery is not led by us, namely Prevention and In Hospital.
Cardiovascular disease

Of the health conditions that lead to more early deaths for our local population compared to England, circulatory diseases account for 18.4% of the gap between Sunderland and England for male life expectancy and 13.5% of the life expectancy gap between Sunderland and England for women. Preventing early deaths is a priority.

The NHS RightCare programme also highlighted cardiovascular disease (CVD) as an area where we can improve quality of care, health outcomes and make efficiencies. Opportunities for improvement exist in detection, prevention, and disease management.

During 2016/17 we looked at how we provide care for cardiovascular disease and used the STAR (Socio-Technical Allocation of Resources) method to help us to understand where to prioritise resources for coronary heart disease and ensure outcomes shape future provision and deliver best value.

Initial analysis also highlighted variation between our practices both in recorded prevalence and in how patients are managed. For coronary heart disease, recorded prevalence in Sunderland is 4.8% (13,691 persons) compared to a prevalence of 3.2% in England; despite this an estimated 2,269 persons in Sunderland are likely to have undiagnosed heart disease (based on data from the 2016 Cardiovascular Disease Profiles). Our plan for CVD requires a targeted approach on identifying and managing long term conditions within this area with a focus on prevention and self-care, delivered through evidence based interventions including secondary prevention and appropriate treatment and monitoring.

Our ambition in Sunderland is that people, at high risk of, and diagnosed with cardiovascular disease, will live longer and healthier and have a better quality of life as a result of implementing evidence based primary and secondary prevention interventions. We will deliver this by working with and supporting primary care to ensure patients with hypertension, hyperlipidaemia, hyperglycaemia and non-diabetic hyperglycaemia receive optimal care and drug treatment. Work has been ongoing to develop an incentivised CVD bundle (covering high blood pressure, cholesterol, glucose and pulse check) for potential inclusion in the General Practice Quality Premium in 2017/18 which should support improvement of HbA1c control.
We will also develop an innovative and integrated self-care and rehabilitation service, which will treat a person holistically, and not as a condition, offering a menu of options to support people to make positive lifestyle changes. This service will help to address a gap in current services, for patients who are at high risk of developing CVD. This will be complimented by implementation of the National Diabetes Prevention Programme in 2018/19.

People with diabetes are at risk of a range of health problems including CVD and those who are obese or overweight are at risk of developing diabetes. During 2016/17 we have implemented a number of programmes of work focusing on the management and treatment of diabetes including:

- A local incentive scheme (LIS) has been offered to our practices with a focus on type 2 diabetes. This LIS aims to improve outcomes for patients in Sunderland with type 2 diabetes through a number of interventions; and
- Sunderland General Practice Alliance (GPA) have been leading on the development of Enhanced Primary Care within the Vanguard MCP, including:
  - 4 locality GP access insulin initiation hubs with education and mentorship provided by the Diabetes Specialist Nurse
  - Launched MYDiagnostick for atrial fibrillation (AF) to case find AF patients.

What will we do?

<table>
<thead>
<tr>
<th>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.</th>
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</table>

From 2017 onwards, we will deliver this by:

- Improved management for patients with hypertension, hyperlipidaemia, hyperglycaemia and non-diabetic hyperglycaemia in primary care;
- Developing and implementing an innovative and integrated self-care and rehabilitation service;
- Bidding for national transformation funding to support our diabetes treatment and care priorities; and
- Being part of wave 3 of the National Diabetes Prevention Programme to ‘go live’ in April 2018.

Prevention

Early in 2016 Sunderland’s Transformation Board identified and agreed prevention as a priority for the Sunderland system. The Board is a partnership Board attended by Executive Directors from SCCG; City Hospitals Sunderland NHS FT; South Tyneside NHS FT; Northumberland Tyne and Wear NHS Mental Health Trust; Director of Public Health; Chief Executive of Sunderland’s General Practice Alliance;
Implement a whole system approach to increasing healthy life expectancy and reducing smoking and alcohol related admissions through prevention with an initial focus on self-care, Making Every Contact Count and smoke free NHS premises.

During 2016, the Transformation Board held two workshops to agree the focus and approach to prevention. The Board agreed to focus on smoking and alcohol and to roll out ‘Making Every Contact Count ‘(MECC). MECC aims to maximise the opportunities for health professionals to engage people in conversations about how they can make healthy choices. The Board recognised that this initiative needs to be implemented in a structured and consistent way but recognise the starting point of each organisation.

Having identified organisational leads provider partners are taking forward the agreed action plan, supported by Public Health, to embed MECC into every healthcare setting in Sunderland.

Joint working has also started to take place within our local health economy. South Tyneside’s Integration Pioneer, well known for its ‘Better U’ programme, facilitated a workshop in November 2016. The purpose of the workshop was to learn from our neighbour and broaden the impact of the All Together Better programme to increase independence and the health and wellbeing of local people, and reduce their use of statutory health and care services.

**What will we do?**

- We will implement the action plan developed by the Sunderland Transformation Board using the national CQUIN to support its implementation;
- We will continue joint working with South Tyneside to ensure long term condition management is maximised through proactive self-care (secondary prevention);
- We will continue the NHS Rightcare pathway transformation (CVD and cancer) with a focus on primary and secondary prevention;
- We will embed the self-care approach into our Vanguard Programme in 2017/18 using the Patient Activation national tool. Our successful bid for funding for 2017/18 includes £150k to support this work;
- We have appointed a Falls Co-ordinator for the next year to review our approach to falls across the community care system and ensure all opportunities for reducing falls are optimised; and
- We will continue the roll out of the Care Homes tablet using the NEWS score across all care homes across Sunderland engaging with general practice to ensure the benefits are realised.
Personal health budgets

Children eligible for NHS Continuing Care and adults in receipt of NHS Continuing Health Care have been eligible for personal health budgets (PHB) to ensure continuity of care in the services they receive and choice, and direct control of how their budget is spent. This was extended to everyone with a long term and/or mental health condition from 2015/16.

Progress in 16/17
• We have arrangements in place with the Local Authority to offer all patients who are eligible for Continuing Health Care funding (CHC) a personal health budget. The take up has been low within this client group. However, we are making full use of the regional forums and masterclasses to help to develop our improvement plans.

What will we do?
• To expand our offer we will develop an outline plan to determine what our local offer will be and put the required actions in place to achieve this recognising that the local offer should be produced in partnership with stakeholders to identify where personal budget would be most beneficial for the Sunderland population;

• We will also consider the operational elements, which would be needed to support the expansion of the PHB offer and how a staged roll out/expansion can be project managed; and

• As the All Together Better programme develops, the new model of care will enable in time more people to access the benefits of a PHB as it is a component of the MSCP structure.
3.4 Improving care and quality

Community Care System

Delivering integrated, seamless care and reducing the over-reliance on hospital services is an aspiration shared by both SCCG and Sunderland City Council (SCC). Having reviewed the governance arrangements during 2016 to support the delivery of our transformation programmes, we are now integrating the Out of Hospital and Urgent Care transformation programmes on our 2016-2017 plan and establishing a community care system transformation programme.

Jointly commission a fully integrated unplanned and planned community care system that interfaces effectively with specialist services

The community care system transformation programme aims to ensure that patients in Sunderland are able to have both their urgent and planned health and social care needs met in a safe, effective and efficient way in the community, including through self-care; leaving hospital care for those whose needs require specialist services. It will ensure Sunderland has an integrated whole system of care where patients have access to the right information, staff with the right skills, at the right time and in the right place according to their needs.

This programme covers the following priorities: urgent care and mainstreaming the Out of Hospital model of care - All Together Better Sunderland programme (incorporating also end of life, whole system ambulatory emergency care and the development of a single commissioning model for out of hospital from 2017/18 onwards).

Urgent care

We have undertaken significant reform in urgent care across the City during years one and two of our five year plan (section 1.3), completing the implementation of the previous urgent care strategy. However, during this period national and regional urgent care models have changed in light of the National Urgent and Emergency Care Review, led by NHS England.

At the same time as undertaking the reform of urgent care in recent years, we have accelerated the delivery of our Out of Hospital model through the All Together Better Sunderland programme transforming care by delivering more planned and proactive services out of hospital, based on the principle of integrated or patient centred co-ordinated care, particularly for those who have a number of long term conditions and have
regular contact with the health and care system. The approach is illustrated in figure 3 below:

A refresh of the strategy was agreed as a priority in the 2016/17 plan and this is now complete. Our refreshed urgent care strategy is the next stage of our journey to ensure that we have the best fit between urgent and planned care in and outside of hospital.

Having completed the refresh of the strategy earlier this year, we are undertaking a Listening Exercise with stakeholders and importantly with the people who use urgent care services in Sunderland during November and December 2016 to seek their views on current services. This feedback will support the development of a new urgent care model, led by clinicians. The new model of care will take a whole system approach, considering not only the existing urgent care centres and GP Out of Hours contracts, general practice and pharmacies but also Sustainability and Transformation Plans across South Tyneside and Sunderland, and reform work underway in Ambulatory Emergency Care, the Ambulance Service, and General Practice at scale (including Extended Hours in Primary Care) as set out in our Commissioning Strategy for General Practice. Key interdependencies include the Out of Hospital commissioning model (Multi-Specialty Community provider) and the regional North East Urgent and Emergency Care Vanguard.

Following the development of a clinical model, the next step will be to develop options for future service configuration which we will formally consult upon during March to June 2017. The results of this consultation and engagement work will inform our urgent care commissioning plans. The final services are expected to be in the scope of our MSCP.
What will we do?

During 2017/18:
- We will consult with patients, the public and stakeholders on the proposed service configuration;
- We will implement the commissioning plan for urgent care in Sunderland that results from the engagement process; and
- We will ensure urgent care is a key consideration in the scope to be agreed for the MSCP.

Ambulatory Emergency Care

Ambulatory Emergency Care (AEC) is a way of managing a significant proportion of emergency patients on the same day, without admission to a hospital bed. It is a transformational change in care delivery.

‘AEC is not a location, but a philosophy of care’

The AEC programme within Sunderland during 2016/17 consists of five key areas, tackling specific patient pathways as well as the AEC concept itself.

1. AEC pathways: Cellulitis and DVT
2. AEC Decision Makers: Clinical Leadership and Challenge. Capacity is decision makers and action takers not cubicles, beds or trolleys or chairs
3. Direct Access to AECU: Patient accessing right service first time
4. Patient, Public and Staff Engagement: Engage key stakeholders in change
5. IT Solutions: Map of Medicine to support pathways within General Practice

Initiatives undertaken during 2016/17 include:
- We began a pilot in October 2016 to provide direct telephone advice/contact between GPs and Acute Physicians (Consultant Connect) based on the learning from Stockport MSCP. The project aims to support admission avoidance, and stream patients to the right place within the hospital, so patients get to the right specialty first time or attend as a planned attendance rather than an urgent case;
- In April 2016, we held an improvement event focusing on implementing Deep Vein Thrombosis (DVT) and Cellulitis pathways across acute, primary and community services, supporting the wider AEC Whole System Work Programme. The DVT pathway has introduced Point of Care Testing to Nurse Practitioners and GPs to help avoid patients attending hospital for unnecessary diagnostics and treatment;
- Further pathways are currently being explored for 2017/18, and the Consultant Connect project is providing rich information as to what these pathways could
be, rather than the traditional way of reviewing the most prominent Health Resource Groups.

We will continue to develop AEC within City Hospitals Sunderland and the community supporting admission avoidance, as well as reducing length of stay during 2017/18 and beyond.

End of Life

End of Life Care (EoL) is a key element of many areas of transformational change. We are working towards having a whole system approach to End of Life across health and social care in Sunderland to ensure 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 our End of Life Plan. Our 2016/17 plans will continue into 2017/18 and beyond and include;

- **Integrated Working**
  End of Life is part of the Community Integrated Team, which will include an End of Life Specialised Nurse in each Locality Team to ensure that the patient wishes are met during their care and at end of life.

- **Training and Education**
  We are continuing our education and training programme, 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 to 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. The training meets national standards.

  In 2017/18 we are planning to implement the Gold Standard Framework across providers.

- **Service Review**
  We are currently reviewing the End of Life services that we commission to ensure that they reflect nationally recommended standards and guidance.

- **Electronic Palliative Care Co-ordination System**
  We are developing an Electronic Palliative Care Co-ordination System to allow 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 and enable them to respond appropriately to the patient’s condition and needs.
Out of hospital

The NTW ND STP is currently in the process of developing a system-wide offer for out of hospital care which will allow services to be delivered closer to home, reducing pressure on the hospital sector and unwarranted variation in care.

The All Together Better Sunderland is our transformation programme for Out of Hospital care (OOH) in Sunderland. The £6.5m award in 2015/16 and £4.8 million award in 2016/17 to Sunderland is supporting the delivery of our care model and has enabled us to accelerate delivery and testing the MCP approach. In November we submitted a third value proposition for further funding in 2017/18.

During 2016/17 we mobilised the three key work streams of the transformation programme: Community Integrated Teams; Recovery at Home and Enhanced Primary Care.

During 2017/18, we will:

- Learn from the work of our neighbour, the South Tyneside Pioneer Programme, and broaden the impact of our care model as we recognise that the self-care and prevention element of our care model requires further development and this will be a key element of our work programme. We will have a model of self-care operational by September 2017 and embedded by March 2018;
- Learn from the pilot projects delivered in 2016/17 as part of our Enhanced Primary Care programme, to support leadership development, organisational learning and infrastructure required to enable general practice at scale to become part of a future MSCP;
- Review pathways in the Recovery at Home service and use of the service by general practice and Emergency Department (ED);
- Further integrate community mental health pathways with our Community Integrated Teams to support a more holistic approach;
- Refine our risk stratification to improve outcomes for our most complex and vulnerable patients;
- Learn from the Newcastle/Gateshead Care Home Vanguard and regional learning on frailty pathways;
- Work with our local hospice and EoL strategy group to align our processes and have clear information sharing arrangements in place; and
- Continue our joint approach to learning across each of the five vanguards in the North East to inform and support the development of the STP, the spread of the MCP model, including opportunities for shared models of operation with South Tyneside.

Out of Hospital Commissioning

Partnership structures for provider delivery of OOH care model, and commissioner
assurance functions have been in place since April 2015. Joint Better Care Fund (BCF) arrangements are also in place across SCC and the CCG, and both commissioners have agreed to work to a single model of commissioning for OOH from 2017/18 onwards in line with the MSCP framework, published in July 2016. The framework states that whilst care redesign is by far the most important job, no system can just restructure its way to transformational change through transactional processes; every MSCP, sooner or later, needs to be commissioned.

What will we do?

We are part of the ‘fast follower’ programme, and have been working with Attain to progress our work in this area.

Key aspects of the work (figure 4) have started at pace and will continue through 2017/18 including:

- A Joint Senior Leadership Group of the main integration partners, including South Tyneside NHS Foundation Trust, Sunderland Care and Support, Sunderland City Council and Sunderland GP Alliance, has recently been established to support the development of the MSCP with independent organisational development (OD) support and facilitation overseeing provider and commissioner key actions;
- The Leadership group have agreed to work to a Memorandum of Understanding (MOU), as a sign of an active commitment to working towards a shared end goal and system vision. In addition to the MoU, there is also a roadmap being created and documented;
- Further work is required with partners in order to confirm the scope of the budgets which should be included within the MSCP contract;
- The MOU describes an ambition for the contract to include all elements of the OOH model, including Urgent Care Centres, all community nursing, all adult social care, mental health and learning disability services, community healthcare services, GP services and GP out of hours. Analysis needs to be undertaken as to what is appropriate out of hospital, and what is appropriate in hospital, in effect aiming to reduce the number of contracts and enabling providers to work together...
to achieve two key contracts - in hospital and out of hospital. The ambition is to commission the MSCP by April 2018, whilst recognising that not all services may be in the scope until April 2021; and

- Both providers and commissioners are considering their key actions required including working in shadow MCP format from 1st April 2017.

**General Practice**

We took on responsibility to commission general practice in 2015 because of the central role of general practice in out of hospital care and because of the need to ensure sustainability for general practice. 2015/16 saw the development of a commissioning strategy for general practice, supported by a financial plan.

During 2016/17

- We successfully re-procured three Alternative Provider Medical Services (APMS) contracts which were due to terminate in 2015/16. We commissioned a single APMS contract to sustain service provision. Variation in quality of care would be reduced by one provider delivering primary medical services across three sites. With current recruitment difficulties in Sunderland in the current and medium term, the size of contract (registered list size of 13,541) could increase the opportunity for potential providers to attract staff and deploy a wider skill mix. This approach supports the national strategy of larger practices to ensure sustainability.

- We have worked with NHS England to develop a primary medical care services assurance framework to enable local NHS England and CCG teams to respond to primary care medical quality issues. We have established a Local Quality Group (LQG). The LQG will develop, in collaboration with member practices, a dashboard which can be shared with practices on a quarterly basis to illustrate key areas of performance for practices to consider where there are identifiable variations in clinical care.

- The focus over 2016/17 in implementing the strategy has been on building the general practice workforce and increasing capacity both to support core general practice activity and the out of hospital transformation.

- We have invested £1.75 per registered patient to enable General Practice to engage in the reducing variation in primary care and make full use of the Map of Medicine software.
Workforce

We have always adopted a proactive approach to supporting general practice to increase capacity and build the workforce. Work commenced in November 2014 to support the recruitment of GPs through the development of a GP Career Start programme - a developmental programme for newly trained GPs to be placed with a GP mentor in a GP practice, whilst undertaking additional education and development in line with their career interests and aspirations. Ten GPs are now participating in the Career Start Programme with funding identified for another five GPs per annum over the next three years.

Earlier this year we developed and commissioned a provider for a Practice Nurse Career Start scheme and Health Care Assistant Career Start scheme. This will bring an additional twenty Practice Nurses into the workforce along with twenty Health Care Assistants over the next two years. Many of the posts are in practices that have not previously had access to Practice Nurses and Health Care Assistants. The Health Care Assistant programme also facilitates the nursing career pathway by providing a twenty seven month development programme from apprenticeship to pre-registration nursing entry level.

We have match funded the national clinical pharmacy pilot to encourage practice participation. The national pilot currently provides clinical pharmacy services to fifteen practices across Sunderland.

Workload

In general practice, there are many schemes that practices are incentivised to participate in which are above and beyond the tasks detailed in their core contract. Practices can sign up to deliver a range of enhanced services with different payment mechanisms and monitoring requirements. We know from our engagement work when developing the general practices strategy that the current combination of nationally directed and locally commissioned GP services and incentive schemes overwhelm GP practices in their day to day work. Practices found these additional services time consuming and bureaucratic, limiting ability to engage to achieve sustainable, transformational change.

Delegated co-commissioning provides the opportunity to reduce bureaucracy and duplication for practices involved in the provision of these services and focus on a smaller number of key outcomes rather than delivery of detailed outputs through the development and implementation of a General Practice Quality Premium.

During 2016 we have been reviewing all the enhanced services to develop and implement a local outcome based Quality Premium from April 2017. We are working with our GP Practices to develop a framework which will focus on outcomes as opposed to transactional ‘number crunching’ outputs, ensuring that the areas link with our transformation programmes, for example, cancer, CVD, learning disabilities and autism.
Out of Hospital model and general practice

General practice is at the heart of the OOH care model. The Enhanced Primary Care programme within this model will help to support the sustainability and quality in general practice because it is supporting general practice to develop interventions which will improve the quality of services, reduce unnecessary variation and help practices to work together and provide care closer to home.

During 2016/17, working with Sunderland GP Alliance, we have:

- Launched Map of Medicine (MoM) as a clinical reference tool to standardise care pathways;
- Fully integrated primary care colleagues into Community Integrated Teams;
- Started to align GP practices to care homes to reduce handoffs between primary and community teams;
- Developed an ‘at scale’ hub and spoke ambulatory ECG service to bring this diagnostic testing into a general practice setting for GPs to access directly preventing the need to refer to secondary care. We are collecting patient and clinician feedback and monitoring the impact this pilot has on existing services. We will develop a further hub and spoke model during 2017/18;
- Rolled out a diabetes audit and review process to all practices, which supports improving diabetes outcomes;
- Mobilised four locality GP access insulin initiation hubs;
- Launched a screening programme using MyDiagnostick for Atrial Fibrillation (AF) with an incentive to find missing AF patients;
- Developed a plan for post discharge clinic pilot in the Washington locality between November 2016 and March 2017.

What will we do?

During 17/18 and 18/19, we will focus on:

- The continued implementation of the General Practice Forward View (Annex 3);
- The development of Practice Managers, including succession planning and building the skills of those working in a deputy management role;
- A step down programme for nurses with a focus on educator roles to create an educational footprint for new and emerging roles and thus building capacity for medical placements;
- A city wide training and development plan for general practice looking at maintaining skills, enhancing skills and the development of specialist skills that can be used at scale within localities;
- Continued exploration of new roles, such as Physicians Associates, in conjunction with local higher education providers;
• Joint working with South Tyneside CCG and Sunderland GP Alliance as collectively we have been awarded Community Education Provider Network status by Health Education England;
• Having a new Quality Premium in place with our practices to improve the quality of patient care;
• Extended GP access for all patients (evenings and weekend – the latter where needs determines this) to the national core requirements by September 2017;
• Explore devolving outpatient budgets to general practice in order to determine if such appointments are appropriate and whether needs could be met in a different way;
• Implement the outcome of the review this year by practices of the ‘10 High Impact Changes’ with support from the national Primary Care Development programme;
• Continue to support practices that may be less resilient in order to increase their resilience moving forward; and
• More detail on our progress and plans in relation to General Practice is set out in annex 3 of this plan showing how we will deliver the GP Forward View.

Children and maternity

Ensure safe and sustainable services for improved outcomes in maternity and ensure the best start in life

Best start in life

Giving every child the best start in life is essential for reducing health inequalities across the life course. What happens during those early years has a lifelong impact on many aspects of health and wellbeing.

Sunderland has higher levels of children living in poverty. Reducing the numbers of children and families who live in poverty needs to underpin our approach to giving every child the best start in life and Sunderland’s Joint Health and Wellbeing Strategy has a strong focus on early years. Sunderland also has higher levels of young people aged 16 to 18 who are not in education, employment or training than the England average.¹

During 2016/17 the partnership arrangements for children and young people have been strengthened with the establishment of the Children and Young People’s Strategic Partnership and the development of the Strategic Plan for Children and Young People (CYP).

The CCG and Local Authority (LA) have jointly appointed a Programme Director to strengthen joint commissioning arrangements, including those for children and young people.

¹ Source: Public Health Outcomes Framework for Sunderland (Updated November 2015)
We have continued to work in partnership with the LA to improve outcomes for children and young people including safeguarding; services for Looked After Children (LAC); Young Offenders; prevention and early intervention including Healthy Child Programme and childhood obesity; and services for children with Special Educational Needs and Disability (SEND).

During 2016/17 we have continued to work with the Local Authority to implement the SEND Code of Practice 0 to 25; establishing Children and Families Act 2014 statutory duties and continuing Ofsted preparation (outlined in the SEF: Self-Evaluation Framework).

In 2017/18 work will continue to enhance the local offer, continuing care, speech and language therapy services, wheelchair services, Child and Adolescent Mental Health Services (CAMHS) and Learning Disabilities services.

What will we do?

Key actions supporting the delivery of the Children and Families Act and Sunderland’s Health and Wellbeing Board Plan and Children and Young People’s Plan from 2016/17 into 17/18 and onwards include:

- Develop a joint commissioning plan and arrangements to support the delivery of the Health and Wellbeing Board Strategy and the Children and Young People’s Plan;
- Support the joint commissioning activities, which are being taken to effectively deliver the SEND agenda including Continuing Care, Speech and Language Therapy Services, Special School Nursing Services, support the wheelchair services improvement programme and continue to develop SEND data to forecast future service demand and delivery;
- Implement the multi-agency preparing for adulthood protocol and pathway for CYP with SEND;
- Work in partnership with the Local Authority to promote healthy lifestyles, physical activity childhood obesity; and
- Work in partnership with the Local Authority to improve transition planning for Looked after Children.

Maternity

Through NHS RightCare, maternity and early years were identified as an area where we can make significant improvements in health outcomes. Compared to our peer CCGs, we are worse for some elements of the maternity pathway, for example the number of low birthweight babies in Sunderland and smoking at the time of delivery with a higher spend on A&E attendances in early years.

South of Tyneside and Sunderland Healthcare Group have undertaken a review of maternity and gynaecology as part of the clinical review programme for 2016/17.
supported by both Sunderland and South Tyneside CCGs. Following the outputs from the current listening exercise with the public, options for the future provision of the services will be the subject of consultation in the Spring of 2017. Following intelligent consideration of the outcomes, the CCG will decide the future configuration for maternity services in Sunderland.

As part of the review, we have made clear to the provider, the need to substantially improve the numbers of mothers still smoking at delivery due to the resulting health impacts on the baby concerned. From reviewing the national integrated assessment framework, and our baseline compared to the national average on the four key indicators, it is clear that we can only improve from a focus on reducing the number of mothers smoking at time of delivery. We perform relatively well on choice and patient experience, and are comparable to others across the region on still births. We are however substantially below the national average in relation to smoking.

We have also reviewed the national maternity strategy – Better Births - and we and providers have assessed provision against the standards and identified areas for improvement. The Sunderland Maternity Delivery group will progress these improvements whilst working with the Clinical Network.

**What will we do?**

Key actions continuing from 2016/17 into 2017/18 onwards include:

- Establish a local Maternity Board to support the work programme;
- Work with NTW ND STP, following the submission of the expression of interest to become an early adopter, to understand the footprint for maternity services i.e. planning for Sunderland and South Tyneside or Sunderland, South Tyneside and Durham or STP ND wide;
- Continue to work with partners in Sunderland to consider the contribution of maternity to broader strategic objectives e.g. Better Start, vulnerable mothers, health visiting and family nurse partnership, development of multi-agency hubs etc, smoking in pregnancy (to influence plans for 2017-18); and
- Work with regional and local partners to develop plans for 2017-18 to further implement the maternity review and develop peri-natal mental health services

**Dementia**

In years one and two of our five year plan we have invested time working with our member practices to improve early diagnosis of dementia. At the end of 2015/16 we achieved a 78% diagnosis rate and we are currently above the 70% target as at December 2016.

We have ensured the delivery of the target by improving referral rates to memory detection services to support early diagnosis. We have also improved practice and
primary care centre environments for people with dementia and increased the referral rate into post diagnosis services.

**What will we do?**

Our focus in 2017/18 needs to be on maintaining the 70% target and increasing the percentage of patients diagnosed with dementia who have an annual 12 month face to face review within primary care.

**Cancer**

In response to the Forward View ambition to improve outcomes across the cancer pathway, NHS England established the Independent Cancer Taskforce which published its report in July 2015 – *Achieving World Class Cancer Outcomes: A Strategy for England, 2015-2020*. In response to this and other national and local drivers, we agreed that the development of a Sunderland Cancer Plan, to implement the national strategic aims, was a priority in 2016/17.

Following a prioritisation exercise on the 96 recommendations in the national strategy, the following key priorities were identified for Sunderland:

- to improve cancer outcomes by reducing smoking;
- to increase screening uptake;
- early diagnosis; and
- improving the patient cancer pathway experience, including survivorship and end of life care.

The Cancer Plan was launched with our member practices in December 2016 and its implementation plan is monitored by a multi-agency group.

Our plan spans 2016 to 2020 and it focuses on:

- **Early diagnosis:**
  - Implementing direct access pathways for GPs, for example. direct access to MRI and CT scanning in quarter 4 of 2016/17 for patients with suspected cancer of unknown primary will enable patients to be diagnosed at an earlier stage and potentially reduce the number of diagnosed emergency presentations;
  - Another initiative to support early diagnosis, introduced in 2016/17, is to support GPs working with Cancer Research UK, to undertake significant event audits of patients diagnosed through emergency admissions in order to implement the learning in practice and prevent more patients being diagnosed in this way;
  - We will commission direct access to flexi sigmoidoscopy at CHS NHS FT in 2017/18 to improve access to early diagnosis; and
- Implementing standardised pathways of care through Map of Medicine (a decision support tool).
- Improving screening rates through implementing an incentive scheme for practices to free up time to undertake recalls for breast, bowel and cervical screening programmes. The impact of the scheme on improving screening rates will be evaluated and, if successful, proposed for inclusion in the General Practice Quality Premium.
- Improving the patient cancer pathway experience:
  - Implementing standardised follow-up: the one stop breast assessment service will implement standardised follow up for breast cancer patients in March 2017 as part of the pathway as we recognise that historically access to follow up pathways for breast cancer patients has been variable. This approach will be monitored throughout 2017/18 working with NHS England and, if proven to be successful, we would look to roll this out for prostate and colorectal cancer patients in 2018/19; and
  - Working with CHS NHSFT and MacMillan, to map out and implement the Recovery Package in line with the national specification and regional approach.

What will we do?

<table>
<thead>
<tr>
<th>National requirement</th>
<th>Our response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the cancer taskforce report</td>
<td>Developed and implementing a local Sunderland Cancer Plan</td>
</tr>
</tbody>
</table>

During 2017/18, we will:

- Evaluate the impact of the incentive scheme for General Practice to increase the screening rates and implement through the General Practice Quality Premium (to be determined);
- Commission direct access to flexi sigmoidoscopy at CHS to improve access to early diagnosis;
- Continue to roll out regional standardised pathways, based upon NICE, for the main cancers through Map of Medicine;
- Evaluate the direct access pathways and impact;
- Evaluate the implementation of standardised follow up pathways for breast cancer patients against national requirements;
- Map out and implement the Recovery Package through national transformation funding; and
- Maintain good performance and improve pressure areas as shown in the table.

The table below shows how we are meeting the national requirements in relation to cancer:
<table>
<thead>
<tr>
<th>Member of the emerging Northern Cancer Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improve 1 year survival rates</strong></td>
</tr>
<tr>
<td>Improve access to screening by implementing an incentive scheme in 16/17 for general practice to recall patients who have not attended screening. Implement and evaluate direct access to MRI and CT for GPs for patients with suspected cancer. Roll out standardised regional pathways based upon NICE for the main cancers through Map of Medicine.</td>
</tr>
<tr>
<td><strong>Stratified pathways for breast cancer patients</strong></td>
</tr>
<tr>
<td>Commissioned a breast one stop assessment service.</td>
</tr>
<tr>
<td><strong>Commission all elements of the Recovery Package</strong></td>
</tr>
<tr>
<td>Map out and implement the Recovery Package in line with the national specification and regional approach through the Northern Cancer Alliance.</td>
</tr>
</tbody>
</table>

### Learning Disabilities and autism

The focus of the Transforming Care Programme is to move away from inappropriate outmoded inpatient facilities and establish stronger support in the community. Sunderland participated in the North East fast track programme and developed a Transforming Care plan for Sunderland. We have reduced the commissioned inpatient bed capacity to 2 beds and have invested in community learning disability teams.

During 2016, Sunderland’s plan is being refreshed because the North East and Cumbria Transforming Care Board have recently developed a new model of care (MoC) for people with Learning Disabilities and/or autism.

We are currently benchmarking existing services and work streams within Sunderland against the best practice outlined in the new MoC. This exercise will identify existing good practice in Sunderland as well as any gaps in service provision which will inform and shape the refreshed Sunderland plan. The outcome of this benchmarking exercise will be reported to the CCG Executive Committee with recommendations and next steps.

During 2016/17 our transformational programme for people with learning disabilities and/or autism has focused upon two areas: learning disabilities and autism in primary care and care programme approach (CPA) and care and treatment review (CTR). This work will continue through 2017/18.

- **Primary care learning disability and autism programme**
Overall 22% of people with learning disabilities were found to have died before they reached the age of 50, compared with just 9% of the general population. People with autism are dying up to 14 years prematurely without epilepsy and those with epilepsy, learning disabilities and autism are dying up to 34 years prematurely. Individuals with learning disabilities and autism are less likely to receive their flu immunisation due to a number of different issues.

There has been no formal training or guidance since 2005 for primary care around the understanding of these conditions. Practices have not had guidance on what is a reasonable adjustment and how to make that reasonable adjustment for individuals with learning disabilities and autism. There is a lack of knowledge and understanding and process around health checks for learning disability and autistic patients, and standardisation of care and codes.

The overall aim of this project is to help primary care to gain knowledge and understanding about how best to meet the health needs of these patient groups and including making personalised adjustments to prevent early deaths.

Through the delivery of this project within this transformation programme, we aim to deliver a range of outcomes including:

- improved staff knowledge and skills;
- improved staff understand of LD and autism;
- increased understanding of reasonable adjustment;
- increase staff awareness of the importance of a health check;
- improved quality of health;
- improved screening and flu immunisation rates;
- improved patient experience of primary care; and
- improved knowledge of existing learning disability and autism pathways and resources;

This year we are developing a comprehensive resource document to support delivery of the above aims. This resource will be launched with practices in March 2017. We are working in partnership with Northumberland Tyne and Wear Mental Health Foundation Trust and Autism in Mind to develop a learning disabilities and autism primary care programme which includes bespoke training for clinicians, practice managers and administrative staff. The education will be individual training sessions which will start early 2017 for each cohort of staff within primary care.

This will continue through 2017/18 and following implementation we will be able to build on this and transfer the learning and processes to mental health in primary care.
• **Care Programme Approach and Care and Treatment Review**

The care programme approach (CPA) is the legal framework to support people with complex needs and a statutory requirement for all in-patients as well as those with complex needs who live in the community. Established following the Winterbourne, care programme reviews (CPR) are mandated to take place every six months for individuals who are in hospital. In 2015 it was identified that reviews should take place within the community setting to ensure that the right support and care is given in order to avoid inappropriate hospital admissions. Sunderland commissioners attend all care treatment reviews (CTRs) and CPAs for Sunderland residents who require them. This year we are undertaking a review of these processes in order to improve the experience for individuals and their families; streamline the processes to reduce duplication and overproduction; and establish an agreed, standardised process for all of Sunderland.

We have worked collaboratively with Northumberland, Tyne and Wear Mental Health FT, the Local Authority, Experts by Experience and clinical reviewers to map both the inpatient and community processes. We have agreed a joint process to be trialled in early 2017. Following the trial, there will be consultation and engagement with staff, patients and carers. In early 2017 we will have the final proposal with evidence to support the agreed process; this will enable us to share our work with other organisations and areas. The outcomes will be shared with the North East and Cumbria Transforming Care Board who are very interested in this transformation.

**What will we do?**

<table>
<thead>
<tr>
<th>Continue Transforming Lives programme including the Primary Care LD/Autism strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will implement the recommendations arising from our benchmarking review of the North East and Cumbria care model for people with learning disabilities;</td>
</tr>
<tr>
<td>• We will implement the learning disability and autism programme with primary care developed in 2016/17; and</td>
</tr>
<tr>
<td>• We will implement an agreed standardised process for CPA and CPRs.</td>
</tr>
</tbody>
</table>

**Mental Health**

We have a strong history of investing resource to ensure the development of mental health services and ensure good access to acute and mental health services. 2015/16 concluded a six year transformation programme.

• **Improving access to psychological therapies**
We have been successful in becoming an early implementer in the expansion of Improving Access to Psychological Therapies (IAPT) during 2016/17 and 2017/18. This includes a commitment to expand our current IAPT services to meet 25% of need by 2020/21.

The expansion will be ‘Integrated IAPT’ services, co-located in and integrated with the primary care physical health services in our five localities. Building on the long term condition pathways already developed within Sunderland, IAPT will have representation in the five multi-disciplinary teams (MDT) in primary care to build effective working relationships and devise referral pathways between GP Surgeries and Primary Care Staff to IAPT. Specialist Nurses for the named groups (diabetes, cardiovascular, respiratory and obesity) and associated outpatient/inpatient clinics will also be targeted to build on current pathways; working towards a stronger IAPT presence in the patients journey, enabling ease of access to IAPT Services. It will also be imperative to strengthen relationships with RAID (Rapid Assessment and Intervention Service) who work in Liaison Psychiatry Sunderland Royal Hospital, raising awareness of the opportunities for onward referral to IAPT following their brief inpatient interventions. IAPT Expanded Service professionals will work to foster and develop relationship with primary care staff to enable pathway development and increased access.

The expansion will focus on people with anxiety/depression in the context of long-term physical health problems and/or people with distressing and persistent medically unexplained symptoms. Expanded IAPT aims to build on existing pathways and develop new ones in relation to obesity and cancer.

- **Mental Health Trailblazer**

We are part of the North East Mental Health Trailblazer to better integrate mental health and employment support to help keep people in work and get them back to work. The Trailblazer will implement the Individual Placement and Support (IPS) model of intensive employment support co-ordinated with psychological therapy, in partnership with IAPT services. IPS/employment coaches are co-located and fully integrated with IAPT teams in each Local Authority area. Sunderland will be allocated four employment coaches to be located with the Sunderland Psychological Well Being Service IAPT team.

- **Child and adolescent mental health services**

During 2016-17 we have continued to work with key partners to develop and deliver the child and adolescent mental health services (CAMHS) Transformational Plan.

Since publication of our 2016/17 operational plan, the CAMHS Partnership has been significantly strengthened and three key work streams have been established to support the effective delivery of the transformational plan in line with THRIVE model: *Thriving and Coping; Getting Help/More Help*; and *Risk Support*. 
The focus of the **Thriving and Coping Work** stream during 2016/17 has been on improving the capacity of the universal workforce to address the mental health needs of children and young people at an earlier stage. To support this thirty schools have participated in the CAMHS schools link pilot; mental health lead roles with identified CAMHS links have been established in these schools and CAMHS schools cluster arrangements have been developed. Partners are working with Sunderland Youth Parliament to develop a Charter Mark for Mental Health.

In addition, maternity and early years services are being strengthened. Northumberland CCG are leading with NTW NHSFT the implementation of newly funded community perinatal service across all CCGs and within Sunderland perinatal mental health posts have been established. The role of health visitors and school nurses in supporting mental health is being considered as part of the review of 0 to19 Child Health.

The **Getting Help / Getting More Help work** stream is well established however, in addition to delivering the transformational plan this work stream is also focused on the pressures within existing NTW NHS FT Children and Young People (CYP) services, that is. significant increases in referrals; an increase in waiting times; the capacity of the service to manage the increased number of children and young people accepted into the service to reduce waiting times and the service advising that they are unable to sustain the current level of service provision within the current financial envelope. We have provided additional non-recurrent funding to address these issues and together with NTW NHSmFT have received additional funding from NHS England for additional capacity to address improved waiting times in light of increased referral pressures.

We are required to demonstrate increased funding; service provision and additional workforce within CAMHS, specifically to achieve the Forward View targets:

- 30 per cent of children with diagnosable conditions to access services by end of 2017/18;
- to develop a CYP Community Eating Disorder Services in line with Access and Waiting Time Standards; and
- to further develop services for children and young people in crisis including psychiatric liaison service and to develop Multi-systemic Therapy (MST) services for children with complex behavioural, mental health and social care needs.

We are currently reviewing existing services and commissioning arrangements and are considering changes the way in which services are commissioned i.e. establishing an alliance or Lead Provider Model to support more efficient and effective service delivery. We are working with NTW NHS FT, STFT, Sunderland Counselling Service and Washington MIND to model existing pathways, resources and workforce across CAMH services creating the transparency required to inform...
future service provision and to inform workforce development in line with CYP IAPT programme.

We are working with NTW NHSFT to establish compliance with national guidance in relation to eating disorder and crisis services. To ensure NTW NHSFT are compliant with the KPI for CYPs to receive treatment within four weeks from referral for routine cases, and one week for urgent cases. NTW NHSFT have submitted an initial Community Eating Disorders proposal in line with the Access and Waiting Time document. This plan is dependent on receiving funds from both Sunderland and South Tyneside CCGs to support a service that will meet the needs of a population of approximately 500,000 and deliver enhanced home based treatment, provide family/systemic therapy, prevent hospital admission and reduce length of stay whilst scaffolding other providers including tier 2 and paediatric services to ensure early identification.

It is expected that the additional funding will enable dedicated staff to offer support, supervision, advice and training to universal and tier 2 services and offer timely assessment and agreed community based treatment interventions to moderate and severe cases who have a primary diagnosis of eating disorders in line with Access and Waiting Standards. Other areas of the enhanced provision i.e. Intensive Home Based Treatment and Enhanced Support to Paediatric services during admission that currently cannot be provided will also be achievable with the financial investment.

Services for children and young people in crisis are being further developed to include psychiatric liaison services for children and young people.

In addition, work to develop an agreed NICE compliant Autism Spectrum Disorder (ASD) pathway across CAMHS and paediatric services is underway with the expectation that a new pathway will be agreed during 2016/17 to enable implementation during 2017/18.

The risk support work stream has been established and work has begun to understand training and support needs of LAC workforce including foster carers and children’s home staff; prevention of avoidable admissions; and the development of a MST Service to provide high level wrap around care for children and young people with complex behavioural mental health and social care needs. This service will require additional resource from NTW NHS FT CYP service and also from Children’s social care services but should support improved outcomes for children and young people and a reduction in the number of out of area placements. It will also support services already attempting to engage the young person and provide a high level in extended hour’s therapeutic service.

What will we do?
Deliver the Mental Health Forward View in full including CAMHS transformation plan

- We will implement the expanded IAPT service and meet the roll out, waiting time and recovery time standards;
- We will continue with Trailblazer implementation; and
- We will Implement the CAMHS transformation plan

**In Hospital**

This programme is led by the South Tyneside and Sunderland Healthcare Group, working in close collaboration with South Tyneside and Sunderland CCGs.

The focus in 2017/18 and 2018/19 will continue to be the Path to Excellence programme led by CHS NHS and South Tyneside NHS FTs. This will continue the work undertaken in 2016/17 to develop a programme of clinical service reviews to deliver better quality care across the local populations of Sunderland and South Tyneside, addressing workforce vulnerability and thus ensuring that key quality standards can be achieved which should also make some contribution to a more financially stable local health economy.

This work is done in collaboration with Sunderland and South Tyneside CCGs with oversight by a Clinical Service Review Group with membership from both hospital trusts and Executive GP and Director leads from the CCGs. A case for change has been reviewed and endorsed by Sunderland and South Tyneside CCGs

Over the next two years there will be an ambitious programme to review all clinical services through a number of defined phases (figure 5)

<table>
<thead>
<tr>
<th>Phase 1 underway</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>Pharmacy</td>
<td>Emergency Care</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics - including Ortho-geriatrics</td>
<td>Anaesthetics &amp; Theatres</td>
<td>Critical Care</td>
</tr>
<tr>
<td>Obstetrics (maternity) &amp; Gynaecology</td>
<td>Cardiology</td>
<td>Acute Medicine</td>
</tr>
<tr>
<td>General Surgery – including endoscopy</td>
<td>Gastroenterology</td>
<td>Therapy Services</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Respiratory</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Increasing delivery of elective work at STFT</td>
<td>Diabetes</td>
<td></td>
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<tr>
<td></td>
<td>Care of the Elderly</td>
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<tr>
<td></td>
<td>Specialist Rehabilitation</td>
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</tr>
</tbody>
</table>

Figure 5
Clinical reviews have been undertaken by clinical teams proposing how each service might be better organised to improve care and get the best from staff, skills and resources. Figure 5 shows the services included in each phase and to date clinical reviews have been completed for stroke, maternity and gynaecology services and paediatrics. Along with STCCG, we have considered the output of the reviews for stroke and maternity and gynaecology services and are due to consider paediatrics in January 2017. Following the current listening exercise with the public, potential scenarios for each service will be agreed and go out to formal public consultation in Spring 2017, to be followed in the Autumn by CCG decisions on the future configuration of services.

There is a separate engagement and communications strategy delivered by an operational Communications and Engagement group, including representation from Sunderland and South Tyneside HealthWatch. The strategy involves communicating and engaging with staff, the public, partner agencies and the community and voluntary sector about the progress of this work and consult, where service change is required, regarding the proposals as they are developed. This group is overseen by a senior Communication and Engagement Governance group with representatives from the Clinical Services Review group to ensure alignment of reviews with both listening and consultation exercises.

Progress is also shared with a formal Joint Scrutiny Committee as well as each of the respective CCG Governing Bodies.

**Continuing Healthcare**

Whilst the quality of assessments remains high, both the costs and numbers of packages of care have increased during 2016/17 putting pressure on the Continuing Healthcare (CHC) budget. The amended guidance on Funded Nursing Care rates has seen rates increase from £112.11 in 15/16 to £156.25 in 16/17, an uplift of almost 40%. This uplift applies to all CHC placements in nursing homes.

During 2016/17:

- We have focused on implementing improvements in the processes underpinning the assessments and care planning by South Tyneside NHS Foundation Trust Funded Nursing Care Team and the Sunderland City Council Social workers. The Funded Nursing Care Team (STFT) and Review Team (SCC) are planning to co-locate in premises within the City, which should lead to improved communications and efficient ways of working.
- We have undertaken a significant amount of prioritisation in order to achieve the target for restitution cases by October 2016, which may have a small impact on the achievement of the 28 day assessment target through till March 2017. However, we will be working closely with STFT to ensure all mitigating actions
are in place to minimise the numbers. We await a future announcement concerning a further round of restitution.

- With the Local Authority we have agreed to do joint work on the Transformation of Care Packages due to pressures on our budget. After one improvement event (November 2016) early proposals include the development of an Integrated Team which will deliver CHC functions across the city and a local CHC policy for Sunderland. A joint working group will develop plans, which will need CCG and LA approval by March 2017, for implementation in 2018/19.

**What will we do?**

- We will establish a joint SCGG and SCC Working Group to focus on the delivery of Choice, Quality and Value for money including the development of a policy for CHC.
3.5 Ensuring sustainability

We have a track record of strong delivery against financial plans and statutory financial duties. In 2016/17 we are on track to deliver a challenging productivity plan of 3.1% (£15.8m). In addition, a key focus for us in 2016/17 has been to strengthen governance structures to ensure delivery of productivity schemes. This review has led to the establishment of a Sustainability Delivery Group (SDG) chaired by the Chief Officer which provides assurance to both the Executive Committee and Audit Committee on productivity planning and delivery.

Due to the minimal levels of growth funding over the period and the cut in CCG funding in 2017/18 following HRG 4+ allocation changes, we need to deliver a significantly challenging productivity plan for 2017/18 and 2018/19. A key part of our plan is to focus on delivering safe and sustainable services for the people of Sunderland within the funding that is available. We have been working on the development of additional productivity schemes as part of the planning process to ensure delivery of statutory financial duties and the financial business rules outlined in the planning guidance.

One of the key elements of the CCGs focus in terms of ensuring long term system sustainability is the implementation of out of hospital reforms linked to the All Together Better Sunderland MSCP. 2017/18 represents a key year in the development of the new care model and transition to the new MSCP contracting form with an expectation of continued delivery of reductions in non-elective admissions, A&E attendances and outpatient attendances.

We continue to develop our transformation programmes to ensure long term sustainability with a focus on gaining the best value. We are implementing schemes which focus on ensuring the best use of resources such as reducing procedures with limited clinical value and ensuring standardisation of care across care settings. We are working collaboratively with other CCGs in the region to develop appropriate evidence based schemes in relation to access thresholds. The plan is based upon continued optimal use of medicines with detailed plans in development to centralise functions where possible (such as repeat prescribing) and reduce prescribing of over the counter drugs.

Through our planning process we have worked with partners across Sunderland to agree a joint approach to sustainability and schemes for implementation. This process has seen the identification and further development of ‘big ticket’ schemes where we believe as collective health system we can achieve the greatest efficiencies without compromising on patient care.

In 2016/17 we have been focused on delivery of NHS Right Care in Cancer and Cardiovascular services. Through the development of these schemes a number of issues have been identified which have influenced the ability to deliver productivity
savings on CCG expenditure following transformational changes. For example, the opportunities identified for Cancer relate to specialised commissioning activity and the cardiovascular savings require longer timescales for achievement. We have therefore reviewed our opportunities for productivity savings linked to the implementation of NHS Right Care and have committed to further expand the programme. Our current thinking is to implement the approach in Respiratory services building on work already undertaken by our local health economy partners (South Tyneside) in this area to accelerate delivery.

Recognising the challenges within the Sunderland and South Tyneside Local Health Economy we have been working with partners to seek agreement from NHS England and NHS Improvement on shared control totals. Our view is that this approach is fundamental in ensuring a relentless focus on delivering best value across the health system.

**Performance**

The 2017/18 and 2018/19 financial plan will meet all the business rules set out by NHS England, including the delivery of a cumulative surplus which is in excess of the minimum requirement of 1%. The CCG will meet the requirement to set aside 1% of its resources non-recurrently with half of this being held in a risk reserve for system wide pressures.

Our plans currently assume access to drawdown of £6m in both 2017/18 and 2018/19 in order to support transformation and the challenging productivity plan requirements. This will be fundamental to the success and achievement of our financial plan.

Sunderland has been at the forefront of transforming mental health services which puts us in a good place to deliver the requirements set out in the Mental Health Forward View. We have previously invested significant sums into mental health services and the financial plans assume continued delivery of the mental health investment standard in line with planning requirements.
4.0 Enablers to support delivery of the plan

4.1 Informatics

We have established robust governance arrangements with our health and social care partners by introducing a community wide Informatics Board to drive forward the implementation of the national strategy towards a paperless NHS. Commissioners and providers across South Tyneside and Sunderland have worked together to undertake digital maturity assessments and develop a single roadmap for how technology will help improve how health and social care is delivered to patients.

While many of the technical details are contained within individual organisational strategies and plans the collaborative development of the Local Digital Roadmap (LDR) enables our efforts to be aligned to a common set of priority areas and reduces the risk of effort and investment duplication.

The objectives of the LDR are;

- To make a reality by 2020, the expectations of patients today that the NHS is one seamless organisation where information is collected once and shared amongst those delivering care and duplication of effort and costs is eliminated.
- To deliver a ‘channel shift’ across the Local Health Economy where delivery of health and care services using digital channels becomes the norm for both patients and staff.
- To support prevention and self-care for patients and carers by establishing digital resources which inform and assist in healthier life styles and management of conditions.
- To collaborate and innovate on the development of shared care record and interoperability capability locally and be the main contributor for the establishment of the Great North Care Record.
- To establish the North East and North Cumbria to become the safest place in the world to receive care and the best place in the world to do research underpinned by the Great North Care Record.

Our priority areas for 2016/17 are delivery of 10 Universal Capabilities;

- Professionals across care settings can access GP-held information on GP prescribed medications, patient allergies and adverse reactions.
- Clinicians in emergency care settings can access key GP held information for those patients previously identified by GPs as most likely to present (in U&EC)
- Patients can access their GP record.
- GPs can refer electronically to secondary care.
- GPs receive timely electronic discharge summaries from secondary care.
- Social care receive timely electronic Assessment, Discharge and Withdrawal notices from acute care.
• Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.
• Professionals across care settings made aware of end-of-life preference information.
• GPs and community pharmacists can utilise electronic prescriptions.
• Patients can book appointments and order repeat prescriptions from their GP practice.

Across the Local Health Economy (LHE) we have active projects that will deliver each of these capabilities using a range of national and local solutions which are detailed in our Universal Capabilities Delivery Plan.

Our plans include support for major transformation work with enabling digital technology that will standardise and simplify clinical and business processes. Our plans will ensure secure, robust and reliable clinical information systems that have been fully exploited and optimised to achieve identified benefits through a process of continuous improvement of our change management, project management and training techniques and capabilities across the LDR footprint that will have sustainability of new ways of working at the core.

What will we do?
The focus of this work in 2017/18 will be:

• Support for one clinical model of acute care by implementation and adoption of common standards, configurations and supporting information systems across acute organisations in South Tyneside and Sunderland. By Q4 2016/17 we expect to have firm plans in place to take this work forward.

• Delivering new models of care for out of hospital services that will be enabled by an agile and mobile workforce with patient information available to the full range of services that deliver care. By the end of March 2017 the deployment of an electronic patient record for community services is expected to be complete along with the use of mobile technology. We will also have a shared care record ‘proof of concept ‘ delivered by the end of March 2017 which will inform the local strategy and way forward for developing further sharing capability.

• Additional record sharing capability for urgent and emergency care services will in place by Q4 2016-17 which will enable a view of the GP record to be available by secure methods.

• Digitally enabling general practice to re-shape the way services can be delivered to meet increasing demand and move towards seven day services and enabling a channel shift for patient interaction with health and social care services and facilitating standardisation of care across general practice through the adoption of
decision support technologies that are integrated with core clinical systems. A range of technologies are to be deployed throughout 2017-2019 as part of the Primary Care Estates and Technology Transformation Fund. In 2016/17, we aim to deploy:

- Video consultation technologies;
- SMS appointment and campaign functionality and apps;
- Advanced telephony systems that provide a 24/7 virtual receptionist; and
- Collaboration technologies that enable practices to work at a federated level and improve operational efficiency.

- Modernising Mental Health care by digitally enabling clinicians and digitally empowering patients through technologies such as:
  - Choice of real or virtual clinic;
  - Choice of communication mode including email;
  - Self-check in and assessment;
  - Repeat Prescriptions;
  - Peer Support;
  - Access to self-treatment; and
  - Automated customer feedback

**Our plans** also address key financial challenges by:

- Rationalising the taxonomy of digital capabilities across the LDR footprint in order to simplify support and development arrangements. This will increase local knowledge and expertise and support long term sustainability along with financial benefits of procurement at scale and consolidation on common and complementary digital capabilities.

- Making mobile working normal behaviour and expanding WIFI capability for health and social care staff across the LDR estate and wider which will reduce the need to ‘return to base’ freeing up time to focus on patients and service users. By the end of 2017 we will have both joined up Wi-Fi across our health and social care providers and will also provide Wi-Fi for patients within general practice.

- Digitising the transactional, the diagnostic and transfer of care information flows between primary and secondary care providers to ensure coded data and workflow increase productivity and reduce manual intervention and administration within general practice.

- Reducing face to face contacts and follow up requirements by using technologies such as video consultations and messaging services that enable patients to communicate their preferences and current status with regards to follow up review
appointments. By the end of 2017 we will have demonstrated how technology can make this a reality and understand the change management requirements to make it a sustainable way of supporting patients.

4.2 Workforce

Having a workforce that can deliver our OOH care model is integral to its successful implementation and workforce is a key enabler and there are workforce, organisational development and educational plans within this programme.

Our All Together Better Sunderland programme has commissioned Sunderland University, working collaboratively with the CARE (Collaboration, Achievement, Research and Engagement) Academy to support the development of a workforce strategy. This is in addition to the training programme already in place which has a focus on leadership and culture as well as clinical areas.

A GP Workforce Group has been in place for two years now and has and will continue to support the recruitment and retention of staff 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.

South Tyneside NHS FT and City Hospitals Sunderland NHS FT are working closely together through the establishment of the South Tyneside and Sunderland Healthcare Group and the ‘Path to Excellence’ programme to address the workforce challenges they face in common with other NHS organisations nationwide. The trusts are also members of the NTW ND STP Local Workforce Action Board that is being established.

Some progress has already been made through both organisations key roles in the CARE Academy where they have worked closely with other partners, in particular Sunderland University of Sunderland, to secure approval and implementation of a ‘local’ ‘Pre-registration’ Nurse programme. Whilst the individuals will not qualify until early 2019, it will offer the trusts a pipeline of locally trained nurses from that point enabling them to better control and plan their nursing workforce numbers going forward.

With both trusts working together the workforce risks can be better managed and reduced.

4.3 Medicines optimisation

Our medicines optimisation (MO) strategy for 2017-19 is closely aligned with our strategic priorities and will support the delivery of the national priorities.

This includes:

- Improving quality, safety and patient experience by the development of a joint formulary of medicines across primary and secondary care;
• Supporting the production and implementation of local therapeutic guidelines to standardise optimal patient care;
• Devising and implementing medicines productivity initiatives for primary and secondary care, aligned with the STP and supporting the CCG to achieve financial balance; and
• Provision and authorisation of PGDs for practices to improve access to medicines without the need for a prescriber.

We also commission pharmacist-led medicines optimisation support for:

• General practices;
• Care homes; and
• People being cared for by the Multidisciplinary Teams.

These services promote the safe, evidence-based, and patient-centred use of medicines to deliver optimal care. We devise an annual work-plan for these services that focuses on quality, safety and productivity in medicines use aligned with our priorities. The services are responsible for leading on implementation of the work in primary care.

The Practice Support Service is being re-procured for 2017-19 with a service specification that provides additional pharmacist resource to release capacity in general practice.

Examples of how medicines optimisation enables the delivery of specific NHS England are:

4.3.1 Supporting General Practice

During 16-17, the SCCG MO team have supported the sustainability of general practice by working with the Sunderland GP Alliance on the NHS England (NHSE) clinical pharmacists in general practice pilot in thirteen practices. We provide training sessions and clinical support to the pilot pharmacists. This support will continue for the next two years of the pilot. During 2017-18, we will explore the introduction of referrals from these pharmacists to community pharmacists to support patients with their medicines.

During 2016-17, we are also piloting point of care CRP (C-reactive protein) testing in general practice for suspected lower respiratory tract infections. This has been shown to help reduce demand in GP practices. The pilot will be evaluated at the end of the year.

We have also provided funding and training for GP administration staff to review and improve prescription ordering processes to reduce queries and free-up clinical time.
As outlined above, the Practice Medicines Optimisation Support Service is currently being re-procured and includes additional funding to support the development of clinical roles for pharmacists that will release GP and nurse capacity.

During 2017-18 a pilot "prescription ordering direct scheme", based on a model developed in Coventry and Rugby CCG, is planned. This aims to manage repeat prescription requests on behalf of practices. Similar schemes have been shown to release GP administration and clinical time as repeat prescriptions are synchronised and rationalised.

4.3.2 Supporting older people in care homes or in their own home

The commissioned Medicines Optimisation Support Service to care homes and patients in the care of Multidisciplinary teams provides structured, patient-centred medication reviews to these patients. To support this, in 2017-18, we will promote national guidance on de-prescribing and shared decision making to reduce medicines burden and achieve patient centred outcomes.

4.3.3 Streamlining of elective care pathways, including through outpatient redesign and avoiding unnecessary follow-up appointments

We are supporting the development of a shared care commissioning framework and shared care agreements for drugs classified as “amber” in the joint formulary i.e. those which require specialist initiation and oversight, but which can be prescribed in general practice.

In 2016/17 we have produced documents to support hormone treatments for prostate cancer. This supports safe transfer of care out of hospital to the GP and provides care closer to home for patients.

During 2017 to 2019 further shared care protocols will be developed and updated, starting with those for Disease Modifying Anti-Rheumatic Drugs (DMARDs).

4.3.4 Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.

The Practice MO Support Service has run audits in practices to identify patients with a learning disability that are prescribed antipsychotic medications, so that they can be reviewed or referred to specialist services as appropriate.

4.3.5 Reduce child obesity as part of the government’s obesity strategy

During 2017/18, the practice MO work plan will include the identification in practices of children who take medicines that can cause weight gain so that practice can implement a process to monitor and support them.
4.3.6  Urgent and emergency care

The CCG MO team promote opportunities to use community pharmacy as part of the urgent and emergency care strategy.

4.3.7  Cardiovascular disease

We have a local incentive scheme in place for practices during 2016/17 that requires practices to participate in the National Diabetes Audit and complete a practice based programme to optimise metformin. We have also provided clinician education about diabetes and nurse clinical supervision sessions with a Diabetes Specialist Nurse.

We have also commissioned the services of a Diabetes Specialist Nurse to support practices to improve prescribing between 2015 and 2017.

During 2017 to 2019, the Practice Medicines Optimisation Support Service will support practices to improve identification and optimise treatment of patients with atrial fibrillation, hypertension and diabetes.

4.3.8  Cancer patient experience.

During 2016/17 we have reviewed and updated shared care and supporting documents to support care closer to home for patients with prostate cancer. This is being launched at the end of the year and implementation will be supported in 2017/18.

4.3.9  Improving antimicrobial prescribing

We have an antimicrobial strategy in place which during 2016/17 has focussed on NHSE targets for reducing overall antimicrobial prescribing and broad spectrum antibiotics. The Practice Medicines Optimisation Support Service has audited prescribing at practice level and discussed findings with prescribers. We provide regular benchmarking reports to practices, have run patient-facing antibiotic campaigns to reduce demand and are implementing a pilot of CRP point of care testing in general practice. Prescribers will be similarly supported to achieve the targets for 2017-19.

4.4 Primary care co-commissioning

The opportunity for Clinical Commissioning Groups to co-commission primary care was introduced in 2014 and is an enabler in developing seamless, integrated out of hospital services based around the needs of local populations. We welcomed this offer to take on an increased role and assumed full responsibility in April 2015. This has afforded us the opportunity to further develop an integrated health and social care system in Sunderland by enabling greater influence over a wider range of services for the benefit of the people of Sunderland. It also brings greater flexibility with finances and resources and greater determination at a local level on how these can be used.
The benefits of co-commissioning include:

5 Making the commissioning of primary medical care more locally sensitive;
6 Supporting integration of care across pathways
7 Supporting improvement in quality
8 Supporting the alignment of primary care commissioning with the health and social care agenda
9 Reducing health inequalities in health provision

Further detail is provided in annex 3 in relation to our plans to deliver the GP Forward View.

4.5 Health and Social Care Integration

Sunderland City Council and Sunderland CCG have identified the development of an Integrated Commissioning function as a key priority in order to achieve outcome and evidence based cost-effective commissioning. By pooling capabilities and purchasing power, both organisations can exercise much greater control over what we need, buy, at what price and at the right level of quality. Nationally and locally there is increasing need and demand, with reducing resources, which means that we cannot continue as we are. Integrated commissioning is seen by us and the Council as a key enabler to achieve this aim.

It is proposed to develop a formal business case for integrated commissioning to be presented to Sunderland’s Health and Social Care Integration Board at the January meeting of the Board. Dependent on approval of the business case by the Board, the current planned implementation date for the formal integrated Commissioning Unit would be April 2017.
5.0 The national 9 ‘must-do’ priorities

5.1 9 ‘Must-dos’

In relation to the nine national must do’s, we have set out in section three our transformation programmes which will address and achieve the national requirements.

The table below seeks to summarises this and indicates where more detail can be found in this document.

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5.2 Delivering the Constitutional standards

We will deliver all commitments outlined in the NHS Constitution for 2017/18 as detailed in annex 2.
6.0 Quality

The NHS Constitution clearly articulates the patients’ right to high quality care which is defined as clinical effectiveness, patient safety and excellent patient experience.

Quality is at the centre of our vision and values and we are dedicated to ensuring that the services that we commission on behalf of the people of Sunderland are of the highest quality and delivered with respect and compassion. Our Quality Strategy, 2014-2017, sets out our vision, our ambitions and explains how we will deliver the vision.

Our vision for quality is straightforward. Our patients should:

- Receive clinically **effective care** and treatment that delivers the best outcomes for them;
- Have a **positive experience** of their treatment and care which meets their expectations; and
- Be **safe** and the most vulnerable protected.

6.1 Quality assurance system and processes

6.1.1 Patient safety

We ensure systems are in place to track and manage performance including taking action when required standards are not met. Where a serious incident occurs we will be informed within an agreed timeframe and will monitor the investigation and learning from the incident. We expect our providers to demonstrate improvements in Healthcare associated infections (HCAI) in line with agreed trajectories. Additionally we expect providers to have robust infection prevention and control plans, policies and capacity in place.

We ensure that systems and processes are in place to fulfil specific duties of cooperation and best practice in relation to safeguarding of vulnerable people. All contracts and service level agreements require providers to ensure robust safeguarding policies are in place which promote the welfare of adults and children. We also expect providers to inform us of all incidents involving children and adults including death or harm whilst in the care of the provider and support any statutory learning review processes.

6.1.2 Effectiveness

We hold regular meetings with providers to monitor quality and provide assurance through the Quality, Safety and Risk Committee and on to our Governing Body highlighting any risks as they occur.

6.1.3 Patient experience
Robust complaints processes ensure that we are notified of all complaints relating to our patients as soon as they are recorded. We also monitor feedback using national (Friends and Family Test) and local mechanisms. Providers are expected to use the feedback to improve their services. We seek out and share patient stories with the Governing Body.

We will work closely with providers to involve, engage and consult patients, their families, carers and the public in the planning and review of services. The acute hospital reconfiguration is a current example of this. We will improve our involvement activity, increase the use of robust market research techniques and engagement mechanisms including the increased involvement of the voluntary and community sector, recognising their ability to reach deeper into local communities. We will work to embed ‘Empowering Communities six principle of person centred care’ into our strategies.

Our ambition is to gain a mutual understanding of patient insight and experience across the Sunderland health and care economy and triangulate the themes and trends in order to provide better qualitative insight.

These will be reported to the Quality Review Groups and reported to the Quality Safety and Risk Committee.

6.1.4 Culture of dignity, respect and compassion

We systematically monitor how our providers respond to feedback concerns and complaints about communication dignity and respect. We closely monitor compliance with national policy on mixed sex accommodation. Themes from ‘soft intelligence’ (Quality Surveillance Group; patient websites; Sunderland HealthWatch; whistleblowing) are discussed at Quality Review groups and reported to the Quality Safety and Risk Committee.

6.2 Monitoring provider performance

Quality is monitored and discussed directly with providers at regular Quality Review Groups (QRGs). The Governing Body is responsible for the quality of commissioned providers and reviews performance, based upon a range of metrics, across all providers.

The Quality Safety and Risk Committee has been established to maintain the system and processes that ensure we have a clear focus on quality. The Governing Body is receives detailed reports that provide effective oversight of provider performance. The Committee also receives the minutes of each Quality Review Group. The Committee reports directly to the Governing Body through the minutes of the meeting. We also undertake a programme of announced and unannounced assurance visits to verify information reported by providers.
7.0 Taking the plan forward

7.1 Governance

The Governing Body, and its formal committees, are responsible for setting the strategy for health improvement for Sunderland and ensure we deliver the improvements set out in our commissioning plans, which includes this operational plan.

We use governance as the system of control, accountability and decision-making at the highest level of the organisation. Our governance framework comprises of the systems and processes and the culture and values which enable us to monitor the achievement of our strategic objectives and to consider whether those objectives have led to the delivery of appropriate, high quality and cost-effective services for the residents of Sunderland.

The Executive Committee is established as a management committee to support the CCG, the Governing Body and the Chief Officer in the discharge of their functions. Including in the development and implementation of strategy, monitoring and delivery of statutory duties, operational, financial, contractual and clinical performance as well as ensuring the coordination and monitoring of risks and internal controls.

7.2 Implementation of the operational plan

The development of our 2016/17 operational plan led to a review of our existing project management framework, and its fitness for purpose to deliver the planned transformation programmes in 2016/17, by our Programme Management Office (PMO). Following this review, working with Management Leads and the PMO team, we have implemented a new project toolkit to support the monthly monitoring and reporting on progress of the projects within the transformation programmes against plan to provide assurance to our Executive Committee.

The governance arrangements, underpinning the PoaP programmes, were also reviewed. Each transformation programme has assigned management, Executive Director and GP leadership. We have put in place multi-agency groups of relevant stakeholders to oversee and influence the development and delivery of the transformation programmes. In light of the 2016/17 plan, we took the opportunity to review and strengthen these arrangements putting in place new groups, where they previously did not exist, and refreshing those already in place.
Annex 1  STP technical narrative

1. STP technical narrative

In this section we describe how the operational plans reconcile to the NTWND STP plan.

Our STP is built upon established programmes of work within each of our Local Health Economies as well as additional new proposals for transformation over the next 5 years with common priorities being delivered at an STP level.

The NTWND health and social care system is one of the strongest in England. We have some of the highest performing providers in the country (consistently delivering NHS Constitution standards) and we have six Five Year Forward View ‘Vanguard’ and pioneer programmes. Through the implementation of our programmes of work at all levels, our STP indicates how we propose to deliver financial stability.

2. Transformational areas

On that basis, our STP plan will focus on a number of key transformational areas that will:

- **Scale up Prevention, Health and Wellbeing** to improve the health and wellbeing of our public and patients utilising an industrialised approach designed by the Directors of Public Health from each of the local authorities.
- Improve the quality and experience of care through **Out of Hospital Collaboration** and the **Optimal Use of the Acute Sector** by:
  - Scaling up of the New Care Models from our Vanguards and development of a resilient and robust primary care sector.

The NTW ND health and care system is planning to provide clinical services through integrated models of care that are significantly more effective and efficient for patients. While work on integrated models of care is well developed in many areas of the footprint through vanguard programmes - such as the **All Together Better** Sunderland MSCP, the Northumberland Primary and Acute Care System (PACS) model and the Newcastle Gateshead Enhanced Health in Care Homes vanguard - the system is currently working to define a unified core offering for out-of-hospital services across the system.

Similarly work is underway around acute service change in our LHEs, for example, the Accountable Care Organisation (ACO) in Northumberland and opening of a new hospital in Cramlington (Northumbria Specialist Emergency Care Hospital), and more recently, South Tyneside NHSFT and City Hospitals NHSFT coming together to be managed under a single management team.
Further speciality level review is underway to meet the emerging challenges around workforce pressures required to deliver clinical standards within a 7-day service.

The core ambition of the STP is to ensure “no health without mental health”. This will involve the development of an integrated life span approach to the integrated support of mental health, physical health and social need which wraps around the person, from enabling self-management, care and support systems within communities, through to access to effective, consistent and evidence based support for the management of complex mental health conditions.

Joint work streams have been established to take forward this transformation work, including mental health.

3. **Financial shortfall**

The STP has identified a financial shortfall across its providers and commissioners of circa £641m in 2020/21. This financial challenge is driven by an increasing demand for healthcare services and a healthcare budget primarily covering inflationary pressures going forward.

In order to close this financial gap, the system has developed a range of solutions that will make more efficient use of the resources available and ensure that patients are managed and treated in the right care setting at the right time.

The specific areas of focus are:

- **Efficiencies.** These incorporate both provider and commissioner efficiencies, and are assumed to close c. £385m (c. 60%) of the 2020/21 funding gap.

- **Out-of-Hospital model.** The NTWND STP is currently in the process of developing a system-wide offering for out-of-hospital care which will allow services to be delivered closer to home, reducing pressure on the acute sector and unwarranted variation in care. Top-down benchmarking identifies an opportunity of up to 15% reduction in non-elective admissions which the system is seeking to achieve by 2020/21.

- **Optimal use of the acute sector,** this work is looking actively into options for closer working at a service based level to make better use of available resources and ease workforce pressures. The collaboration between City Hospitals Sunderland and South Tyneside FT exemplifies the opportunities for cooperation that the STP is looking to build on.

In addition to these focus areas, a range of additional solutions will help to bring the system into overall financial balance by 2020/21. These include pathology consolidation, shared back office arrangements, greater efforts on prevention, QIPP
schemes for specialised services, and Sustainability and Transformation funding made available by NHS England.

4. Waterfall chart

The impact of each of these solution areas on the 2020/21 financial challenge is summarised in the waterfall chart below:
5. High level timeline

The high level timeline below identifies when the effects of the additional solutions which will help to bring the system into overall financial balance are expected to take effect by 2020/21.

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6. Activity shifts

The activity shifts currently assumed by the STP are outlined in the table below:

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<tr>
<td>Non elective</td>
<td>- 10%</td>
<td>- 15%</td>
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<tr>
<td>Elective</td>
<td>- 10%</td>
<td>- 105</td>
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<tr>
<td>Outpatients</td>
<td>- 10%</td>
<td>- 10%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>- 15%</td>
<td>- 15%</td>
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It is noted that while the activity shifts relate to a reduction in acute activity, some of the activity may have to be re-provided within existing or new community and primary care settings.

All CCGs have included STP growth assumptions in their operating plans.
Getting to this point has been more than a technical process. It has been required a genuine commitment for local leaders to run a shared, open-book process to deliver performance and improvement within the growing, but fixed, funding envelope available to that local area.
Annex 2  SCCG Technical Narrative

1. Introduction

Northumberland, Tyne and Wear and North Durham’s Sustainability and Transformation Plan (STP) is built upon established programmes of work within each local health economy, as well as additional transformational changes over the remaining four years of the STP.

Sunderland Clinical Commissioning Group’s (SCCG) strategic priorities and transformational change programmes in its operational plan (the ‘plan’) align to the STP transformation areas of upscaling prevention, health and wellbeing; out of hospital collaboration and optimal use of the acute sector. Our plan also aligns to the local health economy delivery plan for South Tyneside and Sunderland within the STP which sets out at a high level how we will deliver better health, better care and improve the efficiency of services and ensure financial sustainability.

Sunderland’s Transformation Board and A&E Delivery Board, chaired by the CCG’s Accountable Officer, held a joint planning workshop in early October with the aim to ensure that in Sunderland individual organisational operational plans align to support the delivery of the STP/South Tyneside and Sunderland Local Health Economy (LHE) delivery plan including, activity and performance assumptions and financial balance. Following an in principle agreement at the workshop, Sunderland and South Tyneside have subsequently submitted an expression of interest for a system control total to support system transformation and financial sustainability given the significant financial challenge across our LHE footprint. A SCCG and South Tyneside and South Tyneside and Sunderland HealthCare Group Executive to Executive meeting took place at the end of November to get ownership of and a joint approach to managing the system financial issues in 2017 – 2019.

Our operational plan is the detailed plan for 2017/18 and 2018/19 of the LHE delivery plan of the STP and this section sets out our assumptions in relation to baseline activity levels, projected outturns and modelling used to underpin the activity submissions. It also explains our rational for our KPI trajectories.

2. CCG Technical Narrative

2.1 Modelling assumptions

2.1.1 2016/17 Forecast outturn (FoT)

We have taken 2016/17 outturn activity from the national team which is very close to the CCGs forecast out turn due to the detailed validation work carried out by the CCG throughout 2016/17 which ensures that the national Temporary National Repository (TnR) data matches the CCG reported activity in SUS.
2.1.2 2017/18 and 2018/19 activity projections

Activity for 2017/18 and 2018/19 is based on 2016/17 FOT, adjusted for demographic and non-demographic growth, based on STP assumptions.

The monthly profile for planned care elements is based upon working days in both 2017/18 and 2018/19 for all planned care elements and seasonal for all unplanned areas such as non-electives and emergency bed days. Impact of transformational changes on activity has been phased which is discussed later in the narrative.

Checks were undertaken to ensure correlation between referral, constitutional and activity data.

Baseline adjusted for the following:

- Agreed service changes;
- Full year effect of demand moderation schemes (e.g. impact of the local community MSK pathway; Standardisation of care and implementation of the decision support tool, Map of Medicine) and Value Based Commissioning implemented during 2016/17;
- Waiting list movements over the baseline demand period and factored in additional activity to ensure delivery of RTT for at risk specialities; and
- Data reconciliation and coding and counting changes as they stand at this point.

2.1.3 Growth assumptions

We have applied consistent STP growth assumptions for 2017/18 and 2018/19.

For population growth we have projected forward using the ONS population projections for 2016, 2017 and 2018 to calculate adjustments at an age-band and gender level.

Non-demographic growth is also projected forward including:

- Prevalence in key conditions CHD, COPD, Diabetes, hypertension and Cancer;
- Change in NICE guidance, including the impact on drugs and devices;
- Coding and counting changes;
- Non-recurrent activity such as RTT backlogs, changes in clearance times and the current clearance times
- Service developments; and
- Change in working days.
The growth assumptions used are slightly different to the historical trends due to a number of factors which are detailed above. When looking at historical trends across all of the points of delivery, there are some key non-recurrent issues which affect the use of the historical trends for forecast forward. A good example of this would be a coding and counting change agreed with City Hospitals Sunderland NHS Foundation Trust in 2016/17 around the recording and charging of Lucentis injections, previously recorded as day cases, but now recorded as outpatient procedures and subsequently included in first and follow up outpatient attendances using TnR. This significantly distorts the levels of growth between 2016/17 and previous years and distorts the historical trends and as such, the STP underlying growth assumptions have been used as they broadly are aligned to the levels of growth seen in previous years when these non-recurrent adjustments are accounted for.

The historical trends can be seen in the following charts for all points of delivery which were used to calculate growth levels.
We have worked closely with NHS England specialised commissioning team to understand the impact of the new specialised commissioning identification rules (IR) for the providers where we are the coordinating commissioner. Activity has been identified using the latest 12 months’ worth of data run through the latest PSS tool (IR rules) and then transacted in the activity trajectories and in contracts. This was also validated on a regional level using NECS Business Intelligence outputs. There is still a minor issue with the IR rules around bariatric surgery which is due to be transferred back to CCGs from April 2017 which is being discussed with NHS England.

We have included an estimate based on 2016/17 forecast outturn assessments rather than the 2014/15 baseline assessment on the basis that it is more up to date. We have agreed a time-limited piece of work which will look at activity forecasts for bariatric surgery at providers to ensure the correct level of activity is commissioned from April 2017. The outcome of this work is likely not to be material.

The main shifts from the new IR rules are as follows:

- Transfers from NHS England to CCG:
  - Bariatric surgery both electives, outpatients and non-electives;
  - Some cardiac surgery for both electives and non-electives;
  - Some paediatric surgery;
  - Chemotherapy core HRG (£0 priced activity) and a significant amount of activity;
  - Respiratory for electives;
  - Nephrology both elective and non-elective; and
  - Neurosurgery outpatients.
Transfers from CCG to NHS England:
- Urology cancer for electives and non-electives;
- ENT cancer for electives and non-electives;
- Specialised paediatrics for electives and non-electives;
- Plastic surgery for electives;
- Dermatology for electives; and
- Gynaecology oncology for electives.

The following adjustments have been included in the Monthly Activity and Other Requirements (MAOR) template for the IR rules:

- Elective 4,234 spells;
- Non elective 44 spells;
- First outpatients 396 attendances; and
- Follow up outpatients 4,180 attendances.

Due to the nature of the services which are transferred between commissioners, the CCG have not factored in any additional activity for referrals on the basis that the vast majority of activity is not known to be specialised until it is coded so the referrals would be already allocated to the CCG.

The table below shows the growth by POD using the STP ‘Do nothing’ levels and the CCG ‘Do something’ reductions based on QIPP (excluding non-recurrent shifts between CCGs and NHS England) activity reductions as they currently stand:

<table>
<thead>
<tr>
<th>Year</th>
<th>POD</th>
<th>Do nothing STP</th>
<th>STP Do Something</th>
<th>CCG Do something*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Referrals</td>
<td>2.4%</td>
<td>-0.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>2017-18</td>
<td>First Attendances</td>
<td>2.4%</td>
<td>-0.1%</td>
<td>1.1%</td>
</tr>
<tr>
<td></td>
<td>Follow Up</td>
<td>2.4%</td>
<td>-0.1%</td>
<td>3.5%</td>
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<tr>
<td></td>
<td>Attendances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective Admissions</td>
<td>2.4%</td>
<td>0.2%</td>
<td>10.9%</td>
</tr>
<tr>
<td></td>
<td>Non elective</td>
<td>2.4%</td>
<td>-1.3%</td>
<td>-2.0%</td>
</tr>
<tr>
<td></td>
<td>Admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A&amp;E</td>
<td>2.4%</td>
<td>-1.3%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>POD</th>
<th>Do nothing STP</th>
<th>STP Do Something</th>
<th>CCG Do something*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Referrals</td>
<td>2.5%</td>
<td>0.0%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>2018-19</td>
<td>First Attendances</td>
<td>2.5%</td>
<td>0.0%</td>
<td>-0.4%</td>
</tr>
<tr>
<td></td>
<td>Follow Up</td>
<td>2.5%</td>
<td>0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td></td>
<td>Attendances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective Admissions</td>
<td>2.5%</td>
<td>0.3%</td>
<td>1.0%</td>
</tr>
<tr>
<td></td>
<td>Non elective</td>
<td>2.5%</td>
<td>-1.0%</td>
<td>-4.0%</td>
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<tr>
<td></td>
<td>Admissions</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>A&amp;E</td>
<td>2.5%</td>
<td>-1.0%</td>
<td>1.5%</td>
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</tbody>
</table>

* adjusted for non-recurrent adjustment for transfers between CCGs and NHS England for identification rules
The activity submission does not fully align to the STP ‘do something’ and our financial plan and efficiency requirements are not aligned to the STP solutions to deliver the ‘do something’ scenario of reduced growth. In most areas we have gone further than the STP requirements in 2018/19 due to the transformational changes that have been developed and discussed later in this narrative.

The activity assumptions provided by CHS NHSFT, which are different to our activity assumptions for a variety of reasons, have been reviewed. The reconciliation between the trust’s activity assumptions and our assumptions is very difficult given the IR rules which for us are significant but zero effect on activity for the trust as it is simply a transfer between commissioners. CHS NHSFT also provides a significant amount of activity for other CCGs which has an impact on activity assumptions. We have agreed activity levels for 2017/18 and are in the process of agreeing those for 2018/19 so in reality are aligned, particularly where transformational changes have an impact on secondary care activity.

2.1.4 CCG Transformational Changes

We have developed an ambitious and challenging sustainability programme to meet the £29.6m efficiency requirements over the next two years (note this includes efficiency requirements linked to HRG4+ allocation changes). Currently we are showing an efficiency saving gap of £4m in 2017-18 which is being supported through use of draw down funds. Plans have originally been predicated on receiving £6m draw down of cumulative surpluses in 2017/18 to support efficiency requirements and transformation programmes. The Chief Finance Officer is continuing discussions with NHS England on the actions required to secure additional draw down in 2017/18 above the confirmed level of £3.4m.

We have a number of schemes in place, at an early stage of implementation and in development to deliver activity reductions. The following have been factored into the activity trajectories:

- **Non-elective and A&E**: The impact of the Out of Hospital model of care which was outlined in the 2016/17 Operational Plan. We are tracking impact at patient level to understand the impact on activity and outcomes for patients who are part of a Community Integrated Team. Further developments are already underway around the tracking of impact of the model. The activity waterfall table shows the expected impact for 2017/18 and 2018/19, which are the second and third years of the model.
  - The planned impact on A&E attendances and non-elective admissions has been modelled at the most granular level and takes into account activity reduction estimates from various tools used in previous planning rounds and local analysis to underpin measuring the impact. The Out of Hospital transformation programme is underpinned by a robust performance management framework which also has external evaluation input which has been commissioned regionally. The underpinning principles have been validated against local analysis which is why the reduction in activity is higher than that of the STP.
assumption. We are now going into year two of implementation and the work is underpinned by both bottom up modelling and top down (use of pre-populated models and third party modelling). Through this work, the CCG is estimating a reduction in non-elective admissions of 1,350 in 2017/18 and 1,900 in 2018/19. This has been underpinned by patient level tracking of patients who have had an MDT in 2016/17 which is showing a reduction in non-elective activity and A&E activity by approximately 15% for the initial cohort of patients. As the CIT programme moves from 2% of the population up to 5% of the population, the number of patients will increase and scale of the challenge will also increase.

- Phasing of impact has been reviewed and given this is now year two of implementation, impact will be seen from April 2017 so no adjustments to the phasing has been made for this transformational change.

**Outpatient Attendances:** we are expecting a reduction in outpatient attendances by circa 4,000 attendances in 2017/18 and 10,770 in 2018/19 due to various initiatives, some of which a continuation of schemes in 2016/17 which are now embedded but still require focus.

- The Sunderland Intermediate MSK Service is now in its second year and the provider is actively working with practices to ensure appropriate utilisation of the service to ensure patients are treated in the most appropriate setting. The predicted impact for 2017/18 is a reduction of 1,000 first outpatients and 1,000 follow ups. We are also expecting reductions in dermatology outpatients due to work around Standardisation of Care and the Map of Medicine.

- Standardisation of Care (enabled by Map of Medicine) will be focusing on three main areas in 2017/18 which are respiratory medicine, gastroenterology and dermatology with increased scope in 2018/19 to cover more specialties looking at variation in referrals from primary care. The initial scoping suggested that a reduction in activity in these specialties could be a 5% reduction in first outpatient attendances and the subsequent impact on follow up attendances. This equates to 934 first outpatient attendances and 934 follow up attendances in 2017/18. As patients will not be referred into secondary care from primary care, a reduction in GP referrals has also been factored in.

- For 2018/19, there will be a continuation of those schemes in 2017/18 (with adjusted impact for MSK and standardisation of care) and an increasing work programme to reduce follow up attendances in secondary care as part of a joint programme with CHS NHSFT. The programme will look at two things; firstly those follow ups which are being carried out which add little to no value and patients can be safely discharged back to primary care and secondly, those patients who do not need any follow up care in secondary care but shared care is needed. Areas such as urology, nephrology, orthopaedics and respiratory medicine are opportunities to reform the patient’s pathway.

- Given the clinical engagement needed across primary and secondary care, the planned reduction in outpatient activity in 2018/19 has been
phased throughout 2018/19 with the greatest impact being seen in the latter half of the year. This work will begin in 2017/18.

- Given the standardisation of care work around respiratory medicine, gastroenterology and dermatology has already begun, the impact has been phased seasonally into 2017/18 from April 2017.
- A commensurate reduction in GP referrals has been phased the same way but is likely to be slightly different due to referrals and attendances not taking place in the same month. The impact of this will not be material on profiles.

- **Elective admissions**: we have factored in a reduction of 1,179 spells over two years relating to the implementation of the regional Value Based Commissioning Policy Patient Access Ticket (PAT) over the two financial years and implementation of surgical thresholds in 2018/19.

  - Based on indicative information available from the outcome of referrals into the Individual Funding Request Team (IFR), we are expecting to see a reduction in electives (and the equivalent number of first outpatient attendances and GP referrals) of 383 spells in both 2017/18 and 2018/19. This impact is based on locally available intelligence around varicose veins, carpal tunnel surgery, excision of bunions, benign skin lesions and ganglia procedures and is based on the proportion of PAT requests sent to the IFR team which have subsequently been rejected due to not meeting the criteria set out in the VBC policy. We are currently working with NECS to create a full dashboard to allow impact to be tracked which currently includes for each procedure listed, the level of requests by procedure, practice and provider as well as the numbers accepted and rejected which gives a good level of detail on what activity reductions we will expect to see going forward.

  - An audit is planned for Jan 2017 at CHS NHSFT where a prior approval scheme is in place and this will be used to understand the level of compliance within secondary care. This will be then reconciled as per normal contract mechanisms and it is likely to inform further contract variations in 2017/18.

  - Given the PAT process is already in place and the audit scheduled to take place in quarter four 2016/17, impact of this has been phased from April 2017.

  - We are also working with CHS NHSFT as part of the 2018/19 contract discussions to implement surgical thresholds for a number of procedures and services. Not all of the initiatives under this banner impact on activity but the main ones which impact on activity are cataract procedures, spinal procedures and knee replacements. Given the MSK service being run by ST NHSFT and the joint work between ST NHSFT and CHS NHSFT, the system is in a good place to implement these changes and this to be clinically led. This work is being developed regionally as part of STP discussions and we are expecting to see a reduction of 413 spells in 2018/19 with a reduction of 154 knee procedures, 52 spinal procedures (low level spinal procedures) and 207 cataract procedures.
Given the clinical engagement and most importantly the patient engagement related to this programme, implementation has been phased into the back end of 2018/19 but plans are being worked through now for implementation as part of contract negotiations.

A commensurate reduction in GP referrals has been phased the same way but is likely to be slightly different due to referrals and attendances not taking place in the same month. The impact of this will not be material on profiles.

- **Emergency bed days**: The impact of the Out of Hospital model is currently having an impact on emergency bed days with the first six months of 16/17 approx. 1,000 bed days lower than the same period in 15/16. Delayed transfers of care (DTOC) continue to be approx. 22% lower than 15/16 and saw record low levels in August 2016 as CHS NHSFT continue to work closely with the Recovery at Home service with flow through the system significantly improved. 2017/18 and 2018/19 will see further reductions.

Activity adjustments including the financial ramifications and phasing can be found in the locally submitted activity and finance waterfall charts.

We are currently in a good position with RTT waiting times and clearance times and activity has been modelled and transformation programmes implemented to ensure that the CCG is sustainable and standards are achieved. We are not anticipating any deterioration in clearance times and any standards as a result of implementing the transformation programme.

Please note, these adjustments to activity are those which are known at this time and will change for further submissions as detailed plans are being drawn up, particularly for 18/19 where there is a joint commitment between the CCG and CHS NHSFT to reduce system costs which may include schemes over and above those discussed above.

**3. Reaching Contract agreement**

We agreed and signed two year contracts with our main providers for the CCG as coordinating commissioner and on behalf of our associate commissioners.
## 4. Rationale for the submission of our KPI trajectories

<table>
<thead>
<tr>
<th>Target</th>
<th>Current performance</th>
<th>Planned performance</th>
<th>Trajectory Construction</th>
<th>Issues /Actions to sustain/improve performance and expected impact</th>
<th>Timescale</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E: CHS NHSFT 95%</td>
<td>2016/17</td>
<td>Plans for 2017/18 at this time are aligned to the STF trajectory for 2016/17 until this has been agreed with NHS Improvement. 2018/19 assumes delivery of the standard.</td>
<td>CCG have discussed activity levels with CHS NHSFT and have agreed growth levels via contract negotiations and are working on delivery of the standard from March 2017 as per the 2016/17 STF improvement trajectory.</td>
<td>The A&amp;E Delivery Board will oversee the achievement of the A&amp;E target and delivery of the 5 elements of the A&amp;E Improvement Plan and delivery of a CHS NHSFT improvement plan. A&amp;E Delivery Board Baseline Assessment has been undertaken. Currently pulling together information to turn the baseline assessment into an AEDB action plan setting out clear actions and timescales to achieve the 5 elements set out in the Improvement Plan. Continue to develop the Big Front Door model (including streaming), with particular focus on better integration with community services to enable the appropriate sharing of clinical risk so that no patients are seen in ED due to lack of clear clinical risk ownership. Further development of the CCGs Out of Hospital Model which will be looking at</td>
<td>March 2017</td>
<td>Dependent upon other parts of the region managing their own demand. Demand levels increasing over and above those modelled and impact of Out of Hospital model not impacting on demand as planned. New build due to be operational in May 2017 and any delays could impact on performance. The North East Handover Concordat is expected to have a positive impact on patient outcomes (adopting a ‘zero tolerance’ approach to handover delays and divers/deflections).</td>
</tr>
<tr>
<td>NEAS response times 75% standard</td>
<td>September YTD NEAS 66.4%</td>
<td>Recovery trajectories currently demonstrate compliance at 31st March 2017. Trajectories reflect anticipated seasonal pressures and individual months of non-compliance.</td>
<td>Modelled regionally with oversight by the system</td>
<td>Current performance in 2016/17 is under target. Significant risk to delivery at Q4 at a NEAS level. NEAS pressures continue.</td>
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<tr>
<td>Emergency Bed Days</td>
<td>Reduction in DTOCs for first six months of 16/17 22% lower than 15/16</td>
<td>Maintaining DTOCs at 16/17 levels due to significantly low level but reduction in emergency bed days of 1.6% in 17/18 and 2.4% in 18/19.</td>
<td>Activity levels monitored in year as part of the CCG’s Out of Hospital Model and national dashboard produced by the NHS England New Models of Care Team. The indicator is a key indicator for the CCGs Out of Hospital model and actuals are monitored closely. Reductions applied are consistent with levels of reduction being seen in 2016/17 as part of the Out of Hospital performance framework.</td>
<td>Sunderland has a low number of DTOCs due to our whole system ways of working. DTOCs are managed via Surge Group. Individual cases can be brought to Surge Group and learning from individuals is applied to cohorts of similar patients The CCG are seeing an impact on emergency bed days and flow through the system particularly at CHS NHSFT who are frequent users of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTT</td>
<td>September YTD 94%</td>
<td>Continued delivery of the standard in 17/18 and 18/19 with improved performance in respiratory medicine and orthopaedics</td>
<td>Demand into secondary care modelled as per section two looking at referrals over time, growth levels, impact on clock starts and current waiting times to understand impact on RTT position. Factored in reductions in activity as part of the CCGs transformation programme to ensure delivery of RTT and triangulation.</td>
<td>CCG are looking at ensuring patients are treated in the most appropriate setting and initial focus of this work is focused on gastroenterology and respiratory medicine due to the pressures in the system. This will be taken forward via the Standardisation of Care work and Map of Medicine. The South Tyneside and Sunderland Healthcare Group are also undertaking clinical reviews of specialties to ensure sustainability across services and maximising capacity. For respiratory medicine, consultant capacity will be increased in 17/18 to ensure additional capacity is in the system to improve performance. Continued work with the Community MSK provider will look to reduce 2017/18</td>
<td>Increased demand into secondary care and reduction in consultant capacity are the main risks. Increased flow from other Commissioners into CHS NHSFT could also affect performance</td>
<td></td>
</tr>
<tr>
<td>Cancer standards</td>
<td>September 16 YTD positions: 2WW: 95.5% 2WW Breast: 95.7% 31 Days: 98.6% 62 Days: 87.4%</td>
<td>Delivery of all standards throughout 17/18 and 18/19</td>
<td>As with RTT</td>
<td>Urology remains a key pressure due to volume and capacity at CHS NHSFT. The CCG are planning clinical discussions between the CCG and CHS NHSFT to develop more streamlined pathways and better access to diagnostics to improve flow through the system. This includes increased direct access for certain diagnostics to improve cancers diagnosed at an earlier stage. This will also be taken forward via the CCG Quality Premium in 16/17 and 17/18. The South Tyneside and Sunderland Healthcare Group are also undertaking clinical reviews of specialties to ensure sustainability across services and maximising capacity. The Sunderland Breast Assessment Service is now live based on a phased approach with full roll out planned throughout 16/17 which will alleviate pressures on other providers and improve flow through the pathway.</td>
<td>Q1 2017/18</td>
<td>Additional capacity required not coming on stream in time. Be clear on cancer campaigns which increase demand in secondary care.</td>
</tr>
<tr>
<td><strong>Diagnostic waiting times within 6 weeks</strong></td>
<td><strong>August 16 YTD 0.48%</strong></td>
<td><strong>Delivery of the standard</strong></td>
<td><strong>As with RTT</strong></td>
<td><strong>Minor pressures at NUTH which are being progressed by the coordinating commissioner. Endoscopy pressures at CHS NHSFT which will be addressed by the South Tyneside and Sunderland Healthcare Group are also undertaking clinical reviews of specialties to ensure sustainability across services and maximising capacity. The CCG’s Standardisation of Care work and Map of Medicine will help manage patients in the most appropriate setting which could see the reduction in endoscopy patients who don’t need one.</strong></td>
<td>2017/18</td>
<td></td>
</tr>
<tr>
<td><strong>Dementia diagnosis</strong></td>
<td><strong>September 2016 75.4%</strong></td>
<td><strong>Plans to maintain performance in 2017/18 and 2018/19 above the national standard at 70%</strong>.</td>
<td><strong>Retained the current position which is monitored locally aligned to the new estimated prevalence position.</strong></td>
<td><strong>Ongoing review to sustain delivery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IAPT roll out, recovery and waiting times</strong></td>
<td><strong>Q1 16/17 4.5% against a target of 4% for access Q1 16/17 50% recovery rate In excess of the waiting time standards</strong></td>
<td><strong>Set to achieve the 16.8% access rate at end of 17/18 and 19% by the end of 18/19 and 25% by 2020/21</strong></td>
<td><strong>Demand forecasted from validated nationally submitted and published figures and growth assumptions applied and validated by the main provider (NTW).</strong></td>
<td><strong>Sunderland CCG has been successful in becoming an early adopter in the expansion of IAPT 2016/17 and 2017/8. This includes a commitment to expand our current IAPT services to meet 25% of need by 2020/2021. The expansion will be ‘Integrated IAPT’ services, co-located in and</strong></td>
<td><strong>Ongoing review to sustain delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Improvement Area</td>
<td>Plan/Requirement</td>
<td>Status/Additional Information</td>
<td>Notes</td>
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<tr>
<td>Delivery of the recovery standards in 17/18 and 18/19</td>
<td>Integrated with our 5 localities primary care physical health services. Implementation by the end of the 16/17. Workforce development and recruitment plans are in development</td>
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<tr>
<td>Improve Access Rate to CYPMH for an additional 70,000 children a year</td>
<td>Plan to achieve an increase of 7.8% in 17/18 and 7% in 18/19 to meet 30% of local need in 2017/18 &amp; 32% in 2018/19</td>
<td>Detailed discussions with the provider aligned to service developments and contract negotiations.</td>
<td>part of the LTP</td>
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</tr>
<tr>
<td>Community eating disorder teams for children and young people to meet access and waiting time standards: Within 4 weeks Within 1 week</td>
<td>Work towards 95% children and young people to receive treatment within 4 weeks of referrals for routine cases and 1 week of referral for routine cases throughout 17/18 and 18/19.</td>
<td>Data availability is limited in this area so the CCG liaised with NTW to review what baseline data is available and the quality of the data. Detailed discussions with the provider aligned to service developments and contract negotiations.</td>
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<tr>
<td>Expand capacity so that more than 50% of people</td>
<td>Target in 17/18 is 50% and in 18/19 to increase so that more than</td>
<td>Detailed discussions with the provider aligned to service developments and contract negotiations.</td>
<td>Ongoing Ensure NICE concordant standard is met for all staff</td>
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</table>
experiencing a first episode of psychosis receive NICE-concordant care within 2 weeks of referral

| Rate of PHBs per 100,000 population | Very low numbers of PHBs in place | 0.03% population 17/18 and 0.05% 2018/19 | Discussions internally around the current position which is very low in comparison to other CCGs locally and the actions being taken and opportunities available to increase the number of PHBs in 2017/18 and 2018/19. | At present there is a mechanism in place between the CCG and Sunderland City Council to offer PHB to CHC patients. This is also available for children. Continue with the CHC offer and develop and implement system plan to improve performance | 17/18 and 18/19 | Opportunities to increase not being available or coming on-stream in time. Patients not taking up PHBs. |

<p>| Children Waiting more than 18 Weeks for a Wheelchair | Current performance 77% which is below the 17/18 standard (based on early validated information from the Sunderland Community) | Delivery of the standard in 2017/18 and 2018/19 | The CCG have worked with the provider over the past two months to ensure the CCG are in a position to begin to submit the national wheelchair data collection from quarter four 2016/17. This allowed the CCG and provider to understand the current position, pathways and any data quality issues. | The CCG now have a baseline assessment of the number of children who are waiting for a wheelchair for equipment provided by the Community Equipment service. Total numbers are steady and current performance is just short of the standard. 2017/18 and 2018/19 will see the standards on the back of | Q3 2016/17 to submit the national data requirements and 17/18 to deliver the standards | Increase in demand could impact on service delivery as well as the planned contracting changes not being implemented in Q4 2016/17. Data availability is limited in this area is limited. |</p>
<table>
<thead>
<tr>
<th>Equipment Service)</th>
<th>These are being progressed as part of the national data submission and the trajectory has been constructed based on these discussions and work agreed to ensure submission in quarter four 2016/17.</th>
<th>planned improvement work in Q3 and Q4 2016/17 such as additional clinics which will increase “assess and provide” in a more timely fashion and better planning.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended access (evening and weekends) at GP services</td>
<td>Working towards 100% by the end of quarter 2 of 17/18 and 100% throughout 18/19</td>
<td>In 16/17 extended access pilots are in place in 2 of the 5 CCG localities. 2 of the remaining 3 localities are mobilising to offer extended access by the start of quarter 4 of this year. Discussions continue with the fifth to ensure full coverage across Sunderland. As a vanguard MSCP the CCG has the offer of £1.50 per patient to support city wide coverage. Funding available in 2017 will be used to develop infrastructure to meet full city wide coverage by September 2017.</td>
</tr>
<tr>
<td>Extended access (evening and weekends) at GP services</td>
<td>2017/18: Months 1-6 87.8%, Months 6-12, 100%</td>
<td>2017/18</td>
</tr>
<tr>
<td>e-Referral Coverage</td>
<td>Current performance 76%</td>
<td>Delivery of the standards in 17/18 and 18/19</td>
</tr>
<tr>
<td>e-Referral Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Referral Coverage</td>
<td></td>
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<tr>
<td>e-Referral Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Referral Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being made. The CQUIN for 2017/18 and 2018/19 offers the opportunity for Secondary Care and Primary Care to work together to ensure compliance.</td>
<td>confidence to use e-RS to book appointments. The Quality Premium, Contract and CQUIN will provide the mechanism to deliver the standards. The CCG have also engaged the national team to look at best practice. CHS NHSFT is also a Global Digital Exemplar where NHS e-RS is a mandatory requirement and CHS NHSFT will be working to ensure that NHS e-RS is fully utilised.</td>
<td></td>
</tr>
</tbody>
</table>
4.1 Urgent care standards

National planning guidance sets out the requirement for CCGs to demonstrate how they will deliver the national nine ‘must-do’ priorities including for urgent and emergency care.

Ensuring delivery of the Constitutional requirements remains a priority for us. We have developed our transformational programmes with a specific focus on improved access and greater out of hospital care to support the delivery of these Constitutional requirements.

During 2016/17, we have worked closely with partners across the city to support the delivery of the four hours A&E access standard through the following initiatives:

- the Sunderland Surge Group meets regularly throughout the year, working collaboratively to support system resilience through collective troubleshooting, proactive pooling of resources and shared learning. We have a citywide surge escalation protocol in place to enable any partner in the city to call a meeting/conference call for support to manage flow across the system. The Surge Group also manages a non-recurrent budget which can be used to provide additional targeted resources during times of surge
- We are piloting with NEAS the use of Advanced Practitioners in the community to treat people in their own homes instead of conveying to hospital.
- We are rolling out the Paramedic Pathfinder project across Sunderland which enables Paramedics to convey patients, where appropriate, to services other than the Emergency Department (ED).
- Extended Hours is available in primary care in two of our five localities with full data sharing. Two further localities are to be commissioned and in place before the end of March 2017 and options for the remaining smaller locality, where capacity is an issue, are being explored, for example their needs may be met by another locality.
- We continue to work closely with City Hospitals Sunderland to facilitate the streaming of people who present at ED if their health needs could be better met elsewhere.
- We will continue to roll out NEWS (National Early Warning Score; MUST – Malnutrition Universal Screening Tool) to care homes in Sunderland, supported by a digital tablet that incorporates software that can be used to monitor a resident’s health and wellbeing and support decision making relating to early recognition, treatment and escalation to the most appropriate service and where appropriate avoid admission.
- We continue to work closely with the NHS 111 team to ensure profiles on the Directory of Service enable each individual to get directed to the service which will best meet their needs.
- We continue to work closely with the regional Urgent and Emergency Care Vanguard to maximise the impact of regional initiatives, for example the Childhood Illness app which was originally developed in the Washington Locality of Sunderland.
- We continue to raise awareness of alternatives to ED as part our local communications.

**What will we do?**

The table below sets out the actions we will take to meet national requirements.

<table>
<thead>
<tr>
<th>‘Must-do’</th>
<th>Current position</th>
<th>2017-18 plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver the four hour A&amp;E standard, and standards for ambulance response times including through implementing the five elements of the A&amp;E Improvement Plan.</td>
<td>A&amp;E Delivery Board baseline assessment is complete. The baseline assessment is the basis for an action plan for the A&amp;E Delivery Board setting out clear actions and timescales to achieve the 5 elements set out in the Improvement Plan.</td>
<td>Continue to develop the Big Front Door model (including streaming), with particular focus on better integration with community services to enable the appropriate sharing of clinical risk so that no patients are seen in ED due to lack of clear clinical risk ownership</td>
</tr>
<tr>
<td>Sunderland has a low number of delayed transfers of care (DTOCs) due to our whole system ways of working. DTOCs are managed via Surge Group. Individual cases can be brought to Surge Group and learning from individuals is applied to cohorts of similar patients Gateshead FT is now a member of the Surge Group and it is hoped joint learning will ensure Sunderland DTOCs from the QE will be minimised</td>
<td></td>
<td>Continue with Surge Group and Surge Protocol</td>
</tr>
<tr>
<td>By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.</td>
<td>£1.5million in additional funding awarded to CHS NHSFT to provide 7 day services (including system resilience)</td>
<td>Contract offer includes an amount for system resilience and 7 day services</td>
</tr>
<tr>
<td>Urgent and Emergency care Networks rolled out to 100% of the population</td>
<td>We are a member of the regional Urgent and Emergency Care Network. SCCG is also a member of the Urgent and Emergency Care Network Operational Group</td>
<td>SCCG is committed to working as part of the NE UEC Network SCCG will also continue to progress regionally agreed initiatives and where appropriate will act as a test site where proof of concept is</td>
</tr>
<tr>
<td>Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.</td>
<td>Clinical Hub is being developed and delivered via the regional North East Urgent and Emergency Care Network Revised service specification for 111 is being developed at a regional level and will reflect the Integrated Urgent Care requirements. New service will go live from 1st April 2018 Once the implications of the revised service specification for the regional 111 service are clarified SCCG will review the GP Out of Hours Service specification. SCCG will continue with the implementation of the Urgent Care Strategy as per the agreed implementation plan</td>
<td>Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an Emergency Department. Additional clinical staff employed as part of regional clinical hub. Regionally, the green ambulance assessment continues at a level consistent with previous months, with around 7,000 green ambulance incidents per month currently receiving enhanced assessment ED disposions from 111 within the ED Hub opening times (Monday &amp; Friday 6 – 10pm and Saturday &amp; Sunday 8am – 4pm) continue with just under 1,000 patients referred since the pilot began on 9 July In Sunderland we are currently trialling Advanced Practitioners (3). See and treat rates of approx. 60% but low numbers of referrals. Evaluation due in December 2016</td>
</tr>
</tbody>
</table>
5. CCG Improvement and Assessment Framework (IAF)

We are working to the new CCG IAF and are in the process of aligning the transformational change programmes to the components of the IAF. Fortunately, we are already have plans across all of the six clinical priority areas and have identified opportunities to improve (where needed) performance across the six clinical priorities. The opportunities available relate to opportunities to reform clinical pathways right through to coding in primary care but we understand where they are against each of the indicators and what is needed to improve performance against all indicators where needed. The detail of these can be found in the Operational Plan narrative.

The CCG baseline position against the six clinical priority areas is as follows:

- Cancer – Performing well
- Mental Health – Performing well
- Diabetes – Needs improvement
- Dementia – Needs improvement
- Learning disabilities – Needs improvement
- Maternity – Needs improvement

Due to the nature of some of the indicators and timeliness and availability of published data, we are aware that things have moved on since publications have been made available and have actions to improve overall clinical priority ratings over the course of the plan. For instance, due to the latest available data for cancer patient experience along with the year to date performance for the cancer 62 day standard, we believe at this point that we have moved from performing well to top performing but risks remain around the cancer 62 day standard which is described above. We have short term actions about to be put in place to review the technical specifications for the Learning Disabilities and dementia care plan indicators with primary care to ensure coding is consistent and performance reflects reality. Other issues such as diabetes (structured education course attendance) and maternity indicators require medium to longer term system reform and new ways of working but again, this is already a part of the CCGs transformation programme under the CVD work stream.
The following is our current understanding of performance against the six clinical priorities as part of the IAF including current performance based on the latest data available which attempts to show the grip we have on the framework.

### Cancer

<table>
<thead>
<tr>
<th>Cancer Indicators</th>
<th>Trajectory</th>
<th>Latest Data</th>
<th>Performance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed - (Quality Premium Indicator - National Priority)</td>
<td>50.70%</td>
<td>2014</td>
<td>53.40%</td>
<td>Trajectory is based on national average baseline 2014.</td>
</tr>
<tr>
<td>People with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
<td>85%</td>
<td>Sept-16 YTD</td>
<td>87.43%</td>
<td>80% operating standard</td>
</tr>
<tr>
<td>Adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis</td>
<td>70.20%</td>
<td>2013</td>
<td>69.40%</td>
<td>Trajectory based on national average baseline 2013</td>
</tr>
</tbody>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Mental Health Indicators</th>
<th>Trajectory</th>
<th>Latest Data</th>
<th>Performance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who were initially assessed as “at caseness”, attended at least two treatment contacts, are coded as discharged, and are assessed as moving to recovery</td>
<td>50%</td>
<td>Aug-16 YTD</td>
<td>51.76%</td>
<td>Nationally published monthly data - time lag.</td>
</tr>
<tr>
<td>People with first episode of psychosis starting treatment with a NICE-recommended package of care and treated within 2 weeks of referral</td>
<td>75%</td>
<td>Jul-16</td>
<td>96.90%</td>
<td>Rolling quarter</td>
</tr>
</tbody>
</table>

### Cancer - Overall rating methodology

The overall CCG ratings for cancer are based on the following rules:

- In box 1 (top performing); if it has a green rating on 3 or 4 of the underlying metrics and no red rating
- In box 2 (performing well); if it has a green rating on 1 or 2 metrics and no red ratings
- In box 3 (needs improvement); if it has an amber rating on all metrics or a red rating on no more than 2 metrics
- In box 4 (greatest need for improvement); if it has a red rating on three or more metrics
### Dementia

<table>
<thead>
<tr>
<th>Dementia Indicators</th>
<th>Trajectory</th>
<th>Latest Data</th>
<th>Performance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated diagnosis rate for people with dementia</td>
<td>70%</td>
<td>Sep - 16 - YTD</td>
<td>79.80%</td>
<td></td>
</tr>
<tr>
<td>Patients diagnosed with dementia who have had a face to face review of their care plan within the last 12 months</td>
<td>2014/15</td>
<td></td>
<td>75.40%</td>
<td>Expected to be published in CCGIAF dashboard - Jan '17 (23/01/17)</td>
</tr>
</tbody>
</table>

#### Dementia - Overall rating methodology

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis rate</th>
<th>Care plan reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>76.7 - 100%</td>
<td>75.5 - 100%</td>
</tr>
<tr>
<td>2</td>
<td>66.7 - 76.6%</td>
<td>75.7 - 77.6%</td>
</tr>
<tr>
<td>3</td>
<td>56.7 - 66.6%</td>
<td>75.7 - 77.6%</td>
</tr>
<tr>
<td>4</td>
<td>0 - 56.6%</td>
<td>0 - 75.6%</td>
</tr>
</tbody>
</table>

### Diabetes

<table>
<thead>
<tr>
<th>Diabetes Indicators</th>
<th>Trajectory</th>
<th>Latest Data</th>
<th>Performance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes patients that have achieved all the NICE-recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one for children-HbA1c</td>
<td>40%</td>
<td>2014/15</td>
<td>42.40%</td>
<td>Annual publication</td>
</tr>
<tr>
<td>People with diabetes diagnosed less than a year who attend a structured education course</td>
<td>5.7%</td>
<td>2014/15</td>
<td>1.80%</td>
<td>Annual publication</td>
</tr>
</tbody>
</table>

#### Diabetes - Overall rating methodology (current position)

<table>
<thead>
<tr>
<th>Category</th>
<th>Treatment targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Top performing</td>
</tr>
<tr>
<td>Amber</td>
<td>Performing well</td>
</tr>
<tr>
<td>Red</td>
<td>Needs improvement</td>
</tr>
</tbody>
</table>

#### Diabetes - Overall rating methodology (current position)

<table>
<thead>
<tr>
<th>Category</th>
<th>Diabetes patients who have achieved all of the NICE-recommended treatment targets (Three targets for adults-HbA1c, cholesterol and blood pressure: one target for children-HbA1c)</th>
<th>People with diabetes diagnosed less than a year who attend a structured education course.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>&gt;40.2% (current median)</td>
<td>Significantly above national average (5.7%) based on a comparison using 95% confidence intervals.</td>
</tr>
<tr>
<td>Amber</td>
<td>37.8% - 40.2% (between 25th percentile and median)</td>
<td>Same as national average (5.7%) based on a comparison using 95% confidence intervals.</td>
</tr>
<tr>
<td>Red</td>
<td>&lt;37.8% (current 25th percentile)</td>
<td>Significantly below national average (5.7%) based on a comparison using 95% confidence intervals.</td>
</tr>
</tbody>
</table>
Learning Disabilities

Learning Disabilities Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top performing</td>
<td>Performing well</td>
</tr>
<tr>
<td>Performing well</td>
<td>Needs improvement</td>
</tr>
<tr>
<td>Needs improvement</td>
<td>Greatest need for improvement</td>
</tr>
</tbody>
</table>

Maternity

Maternity Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Smoking</td>
<td>Neonatal mortality and stillbirth</td>
</tr>
<tr>
<td>Experience of maternity services</td>
<td>Choices in maternity services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator rating category</th>
<th>Maternal Smoking</th>
<th>Neonatal mortality and stillbirth</th>
<th>Experience of maternity services</th>
<th>Choices in maternity services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rate is significantly below the average rate</td>
<td>Rate is significantly below the average rate</td>
<td>Score is significantly above the average score</td>
<td>Score is significantly above the average score</td>
</tr>
<tr>
<td>2</td>
<td>Rate is not significantly different to the average rate</td>
<td>Rate is not significantly different to the average rate</td>
<td>Score is not significantly different to the average score</td>
<td>Score is not significantly different to the average score</td>
</tr>
<tr>
<td>3</td>
<td>Rate is significantly above the average rate</td>
<td>Rate is significantly above the average rate</td>
<td>Score is significantly below the average score</td>
<td>Score is significantly below the average score</td>
</tr>
</tbody>
</table>

Note: All indicators are based on national average.
# Annex 3

General Practice Forward View (GPFV) Implementation Plans

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Introduction

NHS England published the General Practice Forward View in April 2016. It set out a plan, backed by a multi-billion pound investment, to stabilise and transform general practice.

It includes practical and funded actions in five areas:

1. Investment
2. Care redesign
3. Workforce
4. Workload
5. Practice Infrastructure

It sets out the ambition to invest a further £2.4 billion a year by 2020/21 into supporting general practice services. This represents a 14% real terms increase – almost double the 8% real terms increase for the rest of the NHS. It increases the proportion of investment in general practice services by 2020/21 to over 10%.

This document provides an update on Sunderland’s progress against the General Practice Forward View must do’s:

• Ensure the sustainability of General Practice by implementing the General Practice Forward View, including the plans for Practice Transformational Support and the ten high impact changes;
• Ensure that local investment meets or exceeds minimum required levels;
• Tackle workforce and workload issues; and
• Support General Practice at scale, the expansion of Multispecialty Community Providers or Primary and Acute Care Systems, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

Prior to the publication of the GPFV, we had already developed and begun to implement a General Practice Commissioning Strategy with the following aim and objectives:

**AIM:** We aim to sustain and transform general practice to ensure the provision of high quality primary medical care delivering improved health outcomes for local people, now and in the future.

**Objectives:**

• Supporting general practice to increase capacity and build the workforce
• Improving patient access
• Ensuring the central, co-ordinating role of general practice in delivering out of hospital care
• Supporting better health through prevention and increasing patients’ capacity for self-care
• Encouraging new working arrangements between practices

This puts us in a strong position to implement the vision of the General Practice Forward View. We also benefit from strong relationships and leadership with member practices. There are 49 GP Practices within Sunderland and they are split into five localities which are coterminous between the CCG and the Local Authority: Coalfields, East, North, West and Washington. Each Locality has approximately 10 GP Practices with the West having the biggest number of 15. Each Locality has management and leadership support i.e. Locality Commissioning Manager employed by the CCG, Locality Practice Management support, Locality Practice Nurse support and a GP Executive aligned to each locality with dedicated time funded by the CCG. This gives a strong leadership team for each of our localities and enables the CCG to work with groups of practices and communicate effectively.

In addition Sunderland has a GP Alliance Federation which has 44 member practices. This Alliance has been a key player within our Vanguard MSCP programme. The Alliance also allows us to work more efficiently with a limited number of providers of general practice as opposed to working with all GP Practices as individual providers. Wherever the Alliance has been commissioned to provide services they do this for all General Practices across the city.

1 Investment

1.1 Sustainability & Transformation Package

a) Transformational Support from CCGs

Over 2017/18 and 2018/19, we will invest £3 per head of population from our allocations to support the transformation of Primary Care despite a challenging real terms cut in funding following the rapid pace of change policy associated with target allocations.

As we have already stimulated at scale providers for extended access and consideration of the 10 high impact changes to free up time in general practice. The funding will be protected to support the outcomes of the practices review of the 10 high impact changes and securing the sustainability of general practice in hours.

As a delegated commissioner for general practice since 2015/16, we have already embarked on significant investments in General Practice across Sunderland on schemes associated with workforce and transformation which, puts us 'ahead of the game' in terms of supporting general practice.

We have already started working with GP Practices to increase workforce across the city through the development and commissioning of a career start programme for
GPs, Health Care Assistants and Practice Nurses. In addition we have used funds released from the Primary Medical Services (PMS) review to initiate some thinking around the High Impact Actions and the proposed ability to free up GP time. Investment is also going into General Practice to improve clinical variation using a standardisation of care approach. The priority areas are determined by the right care documentation for Sunderland which includes Gastroenterology and Respiratory.

During 2016 we have invested in two workshops for GPs and Practice Managers to enable them to understand what is involved in a CQC visit and prepare the practice for the visit. These workshops were supported by GP Primary Care Leads with local Practice Managers who are also CQC assessors facilitating and presenting at the workshop.

As a CCG with delegated responsibility for commissioning general practice, we have been able to protect up to £1.5m underspend on the delegated GP budget in 2016/17 to support developments in general practice that are intended to increase the sustainability and transformation of general practice. A number of these developments e.g. supporting the 10 high impact interventions; workflow optimisation training are referenced throughout this plan. More recently incentive schemes to pump prime earlier diagnosis of cancer and the identification of veterans across all practices have been agreed for 2016/17.

The following examples of developments have also been funded in 2016/17 from the core CCG budget, over and above the delegated GP budget of £39m:

- The Extended hours service (£300,000);
- The GP input into integrated teams and recovery at home (£1m);
- The current GP Career start scheme (£641,000);
- The Local enhanced services (£727,000);
- The GP IT (circa £726,000); and
- The Out of Hours GP budget (circa £1.9m).

b) **Online General Practice Consultation Software**

We will invest in technology that will enable patients to use multiple channels for consultation with their GP. These will include the traditional face-to-face consultation, consultations using video technology and also the ability to use on-line symptom checkers (with signposting to appropriate service) and feed information into an on-line form which the GP can review and take appropriate/further action on. We will work with a number of practices that have identified on-line consultation as a priority and will test the technology and develop operational processes that will ensure benefits can be delivered. A combination of local funding, Estates and Technology Transformation Fund (ETTF) funding along with the national £45m funding available over the next three years will be used to procure technology and video services along with change management support to ensure sustainability across all practices in Sunderland.
c) Training Care Navigators and Medical Assistants for all Practices

In 2016 during a Time in Time Out event, we initiated the delivery of training to GP reception and administration staff on signposting and how to have the conversation with a patient about accessing services to meet their needs. This was specific to smoking cessation services to support pregnant ladies to quit.

In 2017/2018 we will be carrying out with member practices, a process to identify training for receptionists on active and appropriate sign posting via the Time for Care programme.

Building on the training already received the idea is that receptionists will receive training to enhance their ability to connect patients directly with the most appropriate source of help. When patients contact the practice the receptionist identifies what their need is and they are then able to refer to information about services in the practice, other NHS providers and the wider care and support sector. Where appropriate, they direct the patient to these services. Training will continue in 18/19, covering all practices with the aim of 100% of all staff trained, taking into account staff turnover and changes.

There are a number of vanguard sites who have already implemented this training with positive outcomes and we will be gaining support and learning from these sites including Wakefield MSCP Vanguard

Plans are being developed to look at work flow optimisation and 30 practices have already expressed an interest in becoming part of this work, being led by the GP Alliance and funded by the CCG. The amount of communication GP practices have to filter, code, and file and signpost for relevant clinically indicated follow up has increased and can cause significant burden in terms of GP time. The workflow optimisation work includes a comprehensive training package and supporting materials, to train members of the GP practice clerical team to read code and action incoming clinical correspondence according to a framework based on safe practice protocols. Advice and help is also given to the wider practice team to support the implementation. This is linked to our work on the Ten High Impact Actions. Initial training will cover 19 practices with 2 representatives from each practice. To complement this project we have invested in medical terminology and read code training. This funding will provide 60 places for each training area. Further training will be offered in 2018/19 for any remaining practices.
d) **General Practice Resilience Programme**

This programme aims to deliver a menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future.

We have supported practices to participate in this programme and developed an approach for identification. We are keen to ensure that the support offered complements and builds on locality working arrangements and existing local support (such as the CQC and the support given to practices when going through a practice merger). The GPRP support will allow more upstream work – practices at a tipping point who may be struggling with workload but otherwise operationally stable. A qualitative approach making use of local intelligence is key in identifying where support can build resilience, targeting practices or groups of practices before urgent need arises.

Views have been sought from a range of sources to support gathering local knowledge. This includes giving all Executive Committee GPs, Locality Lead Practice Managers and Locality Lead Nurses and the LMC the opportunity to feed in.

Practices needing support in 2016/17 have now been identified and a memorandum of understanding has been sent to successful practices within the Sunderland area with a list of support mechanisms provided by NHSE. There were 6 applications with 4 being accepted and Sunderland CCG will be supporting practices to achieve their desired outcomes.

During 2016/17 we have supported two separate mergers, two branch closures and an emergency contract where a single handed GP contract was terminated and the practice patients had to be moved at short notice. The CCG Locality Commissioning Team in particular has worked closely with the NHSE Cumbria and North East primary care contracting team and clinical leaders to provide the practical support to enable these changes to take places, working closely with the affected practices. Support has included developing business cases, mobilisation plans, public and stakeholder engagement and identifying a budget to support this activity. The budget has been used for HR support, solicitor and accountancy support and communication and engagement activity in order to encourage practices to work together and be sustainable for the future.

In 2016/17 3 APMS contracts were reviewed and commissioned as a single larger APMS contract with a longer term contract in order to increase the sustainability of general practice and the money saved has been reinvested in general practice across the city.

In 2017/18 this support will continue and it will be linked to the practices identified via the Resilience Programme. The Locality Commissioning Team will review all applications put forward in 2016/17, look at any themes and discuss within localities how practices can be supported going forward. This will be in line with the objective
of encouraging practices to work together/at scale. The CCG will look to put a city wide bid into the resilience programme for the GP Practices of Sunderland.

1.2 Improved Access

In 2015 we established and funded Extended Access pilots which are being delivered in two of the five localities within Sunderland from £300k of core recurrent investment. One service offers pre-bookable and urgent appointments across seven days and the other offers bookable appointments across six days. We commissioned Durham University to evaluate these two services to establish the best model for the City going forward. In line with the national extended access requirements we have reviewed the gap for city wide extended access cover.

Two further localities are mobilising extended access plans and are aiming to offer bookable and urgent appointments over five evenings to their patients by January 2017. We are in discussion with the remaining locality to ensure Extended Access covers the whole of the Sunderland patient population by March 2017. This activity is being funded from the £400k pump priming monies made available to us in the latter half of 2016/17 to prepare for full implementation of the national specification.

Plans Going Forward 17/18

New and additional dedicated and recurrent national funding available from 2017/18 of £6 per patient will be used to develop the infrastructure to enable the city to meet the full requirements of the national specification by September 2017 at the latest. As Sunderland is in 1 of 18 national transformation areas, the full funding will be made available earlier than in most CCG areas whilst the timetable for implementation is also earlier. Mobilisation plans will begin implementation by Q1 2017/18.

1.3 Estates and Technology Transformation Fund (Primary Care)

The Estates and Technology Transformation Fund (ETTF) is being used to drive forward the General Practice Forward View within Sunderland, supporting the adoption and development of technology that;

- Enables self-care and self-management
- Helps reduce workload in practices
- Helps practices to work together at scale
- Supports greater efficiency across the whole system

This includes a number of schemes outlined below:
In addition we have been successful in bidding for ETTF funds of £162k to support premises developments in general practice. Four premises schemes are currently under implementation in 2016/17 and 2017/18 which will support the transformation of primary care estate.

1.4 Other funding for General Practice

We are committed to funding nationally procured GPIT systems and are seeking improved efficiency of our GPIT services to ensure this commitment can be met.

We are deemed to be overfunded and as such will receive minimum growth in allocations in 2017/18 and 2018/19. We are committed to maintaining investment in CCG funded general practice at current levels in line with the overall requirement to increase based upon CCGs’ growth allocation.

2 Care Redesign

2.1 Improved access

We have developed a specification for GP extended access that reflects both the local requirements, derived from the learning from the current pilots noted earlier and incorporating the national requirements as detailed in the planning guidance. The national requirements are set out below:

- Weekday provision to pre-bookable and same day appointments in the evenings (after 6:30pm) – to provide an extra 1.5 hours a day;

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Priority Group</th>
<th>Cohort 1 or 2 (a) (b)</th>
<th>Cohort 1 or 2 (a) (b)</th>
<th>Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care at Scale - Centrally Managed Discharges</td>
<td>1</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care at Scale - Consolidated Infrastructure</td>
<td>1</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care at Scale - CRM Capability</td>
<td>1</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care at Scale - eConsultations / Practice Communication</td>
<td>1</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care at Scale - Mobile Clinician</td>
<td>1</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care at Scale - Collaboration Tool</td>
<td>1</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Practice Efficiency - Bi Directional Messaging</td>
<td>2</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Practice Efficiency - Patient Check-in Systems</td>
<td>2</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Practice Efficiency - Surgery Pods</td>
<td>2</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Practice Efficiency - TECS for Respiratory Monitoring</td>
<td>2</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interoperability - EPaCCS Functionality</td>
<td>3</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interoperability - Care Home Tablet Integration</td>
<td>3</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interoperability - Florence Information Flows into GP Record</td>
<td>3</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interoperability - Transfers of Care</td>
<td>3</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Telephony - Integrated Appointment Booking</td>
<td>4</td>
<td>2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Support - Clinical Advice Service</td>
<td>5</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Support - Clinical Triggers and Alerts</td>
<td>5</td>
<td>2b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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2 Care Redesign

2.1 Improved access

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- Weekday provision to pre-bookable and same day appointments in the evenings (after 6:30pm) – to provide an extra 1.5 hours a day;
• Weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
• Appointments can be provided on a hub basis with practices working at scale
• Will be available for 100% of the population; and
• Use the nationally commissioned tool, to be introduced during 2017/18 to automatically measure the appointment activity by all participating practices, both in-hours and in extended hours.

The national guidance states that CCGs should ensure their population have access to pre-bookable and same day primary medical services appointments equating to an extra 30 minutes of consulting capacity per 1,000 patient population. For Sunderland this is an extra 142 hours of appointments to be delivered in evenings (after 6:30pm) to provide an additional 1.5 hours a day; and at weekends. Weekend access slots will be delivered based on locality need but initially will be modeled on intelligence from practice and national patient survey results as well as the learning from the East, West and North pilots.

There is sufficient capacity currently in the city, based on the East, West and North pilots and those practices offering extended hours under the DES, to provide the required hours for 2017/18. In 2018/19 the requirement rises to 45 mins per 1,000 population, which equates to 213 hours of provision across the city and whilst this is more challenging for Sunderland. The learning from 2017/18 will be used to develop implementation plans to meet this requirement, taking account of demand and need across the city.

To ensure a standardised approach to delivery and enable us to understand the outcome of its developing Urgent Care Strategy and develop a model that is more aligned with the MSCP it has been agreed to apply a tender waiver and delay the procurement for up to 2 years. We have therefore commissioned the GP Alliance (GPA) for the next 2 years to act as an Integrator, working with practices and localities to secure the full specification no later than September 2017. GP Executive Leads and Director Lead for general practice will support the work with the GPA to ensure the final proposal and mobilisation plan meets the requirements and provide assurance to the Executive committee that the GPA can deliver the full specification by September 2017. As well as the national requirements there are a set of core local requirements that will be specified to ensure the service engages with all of its practices to develop a scale primary care. Over the 2 years the proof of concept will be further tested and developed in order to be clear about what should be procured from 2019/20.

We have also refreshed our urgent care strategy which will include urgent access to general practice and have developed a communication and engagement plan to help determine the future configuration of urgent care services across the City. A listening exercise with the public will be complete by 23.12.16 and formal consultation on scenarios will take place from March 2017. The contract with the
local provider of UCCs has been extended into 2018 to enable the final proposals to be determined and secured.

2.2 Support General Practice at Scale

We are working with partners, and in particular the GP Alliance, to develop general practice at scale, as the foundation for the multi-speciality community provider (MSCP) care model in the city. Sunderland is one of 14 national Vanguards testing and developing this model of care. The model is about integrating out of hospital care to ensure better outcomes for the whole population and the local system, covering prevention, urgent care, continuing care for people with long term conditions and care for those with the most complex needs.

To date general practice, facilitated by the GP Alliance and CCG Clinical Leaders have played a crucial part in the establishment and provision of the five Community Integrated teams in each locality proactively targeting the most complex patients at risk of hospital admission, supported by the city wide Recovery at Home service. In addition General Practice through the GP Alliance has led the development of enhanced primary care for people with long term conditions. This includes hubs in each locality for diabetes titration/management and ECG testing to inform Atrial Fibrillation detection and management. Plans are being developed to expand on this hub model to include other areas and schemes from April 2017, aligned to our operational plan and priorities. Practices are also currently going through a process where they will be aligned to a care home to improve continuity of care for the patient and reduce house calls for GPs and their staff. Map of Medicine has also been funded and support provided to enable all practices to use Map and the GP Alliance have facilitated the development of a range of standardised pathways to be used on Map, all aimed at reducing variation and increasing a standardised approach across general practice for the benefit of patients.

We will develop an offer for each General Practice with the GP Alliance and undertake a communication and engagement exercise in 2017 in preparation for a new organisation to be commissioned to deliver the MSCP model from April 2018.

Further work is needed on the scope of the MSCP; the business case and the outcome based specification including risk share, prior to engagement with Practices on the offer to join the MSCP i.e. voluntarily want to move their contract into the new MSCP. It is likely that a menu of options would be available to General Practice.

High level milestones are outlined below and may be subject to change as the work to commission the MSCP starts to go at pace over 2017/18:

- Final scope for MSCP to be concluded end of January 2017.
- Approach to communication and engagement plan with Practices – March 2017
- Business Case for MSCP April 2017
- Listening exercise with Practices Q1 of 2017/18
- Offer to practices re MSCP in Q2 of 2017/18
• Review outcome of engagement on the offer in Q3
• Subject to outcome start planning implementation in Q4
• Milestones for 18/19 depend on the overall milestones for the commissioning of the MCP from April 2018 and are still being determined.

2.3 Self-care and Prevention
The multi-agency Transformation Board in Sunderland, which includes the GP Alliance, has recently agreed to prioritise prevention and in particular the Making Every Contact Counts programme. In 2017/18 Proposals will be developed to support health providers including General Practice to deliver the programme.

In addition, the Medicines Optimisation Team is supporting the Urgent and Emergency Care (UEC) Vanguard communications campaign to incorporate self-care, also developing a strategy to improve use of self-care by patients in an attempt to divert requests for appointments and prescriptions.

The MSCP is also working with STCCG who have Pioneer status for early prevention and self-care via their 'Better U' programme which has rolled out this approach on an industrial level across all partners. The Sunderland MSCP is keen to learn from this approach and ensure the community integrated teams and recovery at home, as well as enhanced primary care consider the learning and best way to implement the approach in Sunderland.

2016/17 has seen an increased interest and use of digital technology as a mechanism to prevent exacerbations in particular conditions. This includes COPD and heart failure. The use of the simple telehealth system ‘Flo’ has begun to increase across general practice. Using simple text messages to gain health information and advice to help support patients to self-care. A further focus on technology can be seen with the introduction of Holter ECG devices in dedicated practice hubs across the 5 localities.

The City, in particular, has focused on care homes. The Vanguard programme has introduced MDT’s along with dedicated nursing resource to support the front line care workers to look after their residents. Technology has been designed and implemented across the city with a view to all care homes being digitally enabled by the end of March 2017. The tool includes the monitoring of vital signs using the National Early Warning Score (NEWS), Must and Abbey pain score. This allows the care homes to monitor the health of their residents and work with the local General Practices to better manage their patients out of hospital wherever possible. As noted above our GP Alliance is also supporting the alignment of GP practices to care homes across the city to increase efficiencies for Practices and better outcomes for patients.

With regard to diagnostics the ambulatory care work across the city has introduced qualitative d-dimer testing for DVT in each General Practice. Pharmacy have also introduced CRP testing in two practices as a pilot. Early feedback from practices
show that they are using it effectively and it is supporting the clinical decision making.

Looking forward into 2017/2018 the focus of the vanguard MSCP will include self-care. This will be supported with a number of technology advancements as well as looking at Patient Activation Measures. Technology will include the use of apps, self-care videos and simple Telehealth. We will also be redesigning community ECGs for those who are less mobile. Successful app development has already taken place in one of our 5 localities with an app for childhood illness which has been adopted by the UEC Vanguard for the North East.

2.4 General Practice Quality Premium/Standardisation of Care – Improving the Quality of General Practice

The standardisation of care in general practice is one of the enablers to the delivery of our overall vision of Better Health as well as supporting the sustainability and transformation of general practice. It will also support a significant proportion of the Quality, Innovation, Productivity and Prevention (QIPP) programmes.

We will support the member practices in reducing variation in outcomes and activity and improving care quality in primary care and ultimately throughout the patients pathways. There is a need to support localities in taking a proactive approach that ensures patients’ conditions are effectively managed and reduce unnecessary hospital outpatient attendance. This support will drive improvements in care and reduction in unwarranted variation by providing timely data, information and robust business intelligence that is required to identify and prioritise areas for quality improvement. We will determine the areas which will allow localities and practices to concentrate on the right areas.

Until the recent introduction of Map of Medicine, there was no single system in place to support clinical decision making. This situation can lead to inappropriate referrals and also lack of quality referral information. General Practice had to manage any updates to pathways manually which is why it is inevitable that variation will occur. As noted in the section on care redesign, under the MSCP Vanguard enhanced primary care programme, it was agreed to fund map of medicine software in every practice in Sunderland and this has now been installed in all practices. This software will act as a clinical reference tool to enable clinicians to easily obtain evidence based pathways management advice, referral criteria and referral forms (which could be local, national or international).

As all of the productivity areas are being developed, map of medicine will support delivery by making the new pathways visible to practices.
Success is dependent on practices engaging with the software and giving feedback on their findings of the new pathways. The feedback will allow pathways to be adapted accordingly and also determine what education is required for clinicians.

We have invested £1.75 per registered patient of the PMS funding released in 2018/19 along with some CCG funding to enable General Practice to free up capacity to engage with the implementation of Map of Medicines in order to reduce variation.

We have also adopted the national and regional Primary Medical Assurance framework and put in place a local Quality Group which uses data on key national measures to identify practices that may be an outlier in those areas. Measures include the national GP patient survey indicators. The group also access local intelligence to inform any discussion on why a practice may be an outlier and the aim is to support practices to improve wherever this is required. The group report to the CCG Quality, Safety and Risk Committee as well as share key issues with the Primary Care Committee to ensure a coordinated approach to the commissioning of general practice.

**Plans for 2016/2017**

Areas of work that we have asked practices to participate in regarding Map of Medicine include;

- Engagement with map of medicine including practice super users, attending training and clinician use of pathways
- Recording referrals that do not fall within the pathways on Map of Medicine in defined clinical areas to ensure that all pathways are developed as part of Map of Medicine
- Attending training sessions which may be identified when following a particular pathway
- Internal review of practice activity with feedback to CCG via locality commissioning meetings
- Peer review at locality level either at TITO or at Locality Commissioning Meetings
- Practices to flag specific referrals for which they wish to follow up the outcome of, to support learning and education
- Practices will be asked to submit outcomes from the referral meetings to support ongoing development and influence commissioning decisions
Plans for 17/18 and 18/19

One of the priorities within our General Practice Strategy is to review all enhanced service, to develop and implement a local outcome based Quality Premium. From April 2017 we intend to offer GP Practices a Quality Premium which will replace all of the Locally CCG commissioned Services and the national Directed Enhanced Services.

In general practice there are many schemes that incentivise practices to participate in work that is above and beyond their core contract. The main scheme that does this is the Quality and Outcomes framework (QOF) this was introduced in 2004 as a financial incentivisation contract that rewarded practices for adherence to detailed performance of specified clinical processes. Practices can also sign up to Enhanced services. Enhanced services are currently commissioned through each of the primary medical care contracting vehicles (GMS, PMS, APMS). They currently comprise:

- Locally commissioned services/Local incentive schemes – schemes agreed by CCGs in response to local needs and priorities, sometimes adopting national service specifications;
- There are also Public Health services commissioned; and
- Directed enhanced services (DESs) – these schemes are nationally commissioned by NHS England who are required to offer contractors the opportunity to provide these services, they are linked to national priorities

Across the country CCGs have implemented Quality Premium schemes for General Practice. These schemes bring together enhanced services and in some areas QOF into one scheme, with several quality standards all monitored with KPIs.

We are working with GP Practices in 2016/17 to develop a workable framework which will focus on key outcomes as opposed to ‘number crunching’, freeing up practice time to make a difference and providing long term recurrent funding to support long term change. As a CCG with delegated responsibility for commissioning general practice, we will be asking practices to give up directly enhanced services in order for the budget along with the PMS monies to be used to fund the quality premium recurrently.

From April 2017, we will have a new Quality Premium for General Practice in place with a simple system for claiming, achievable outcomes and measures which can improve the quality of patient care. This will be supported through the release of PMS funding over the period

During 2017 and 2018 we plan to continually review the effectiveness of the new Quality Group and the approach taken to support practices where improvement in quality may be required.
3 Workforce

We have a proactive approach to supporting general practice to increase capacity and build the workforce. Work commenced in November 2014 to look at supporting the recruitment of GPs into Sunderland following an LMC survey which indicated a potential loss to the GP workforce of up to 30 GPs within the following 3 years. This led to the development of a GP Career Start programme which would provide a developmental programme to newly trained GP to be placed with a GP mentor in a GP practice whilst undertaking additional education and development in line with their career interests and aspirations. Despite the competitive marketplace and Sunderland being a historical and known hard to recruit to area 10 GPs are now participating in the Career Start Programme with recurrent funding identified and a plan for another 5 GPs per annum over the next 3 years subject to review of the impact.

3.1 GPs

As part of the recruitment strategy it was highlighted that there was not enough focus on recruiting new GPs but it was also imperative to support the existing GPs in Sunderland. As part of this support infrastructure the CCG have commissioned:

- A childcare co-ordinator service to support all staff working in general practice with childcare solutions, including emergency childcare and the administration of childcare vouchers.
- A mental health occupational health service for GPs experiencing burn out. The service has been in provision now for 18 months and will continue until the new national service is in place to ensure that there are no gaps in service and to allow for double running whilst the reach and scope of the new national service is known.
- A bursary scheme has been developed for both existing GP trainers and new intending trainers. Both bursaries allow for protected time for GPs who undertake training or wish to become trainers. This will be particularly pertinent given the indication from Newcastle University who has proposed an expansion of medical student numbers and the launch of the 2017 undergraduate curriculum in 2017 which could equate to the doubling in time in primary care and an assistantship in general practice in final year.

In conjunction with South Tyneside CCG and Sunderland GP Alliance, we bid for and have been awarded Community Education Provider Network (CEPN) status by Health Education England and this joint working will continue to be developed. The initial focus will be on scoping the current state with regard to numbers of GP trainers and practices who undertake training of medical students along with the creation of a relationship manager/placement facilitator to liaise with local medical schools and schools of nursing.

The general practice workforce work stream is now a key part of the work plan for the CCG and over 2016/17 has been one of the key transformational changes in our operational plan and encompasses roles within general practice. This focus on
workforce will continue in this next operational plan as part of delivering the GP Forward View.

3.2 Practice Team

Earlier in 2016 we developed and commissioned a provider for a Practice Nurse Career Start and Health Care Assistant Career Start. This will bring an additional 20 practice nurses into the workforce along with 20 Health Care Assistants over the next 2 years. Many of the posts are in practices that have not previously had access to Practice Nurses and Health Care Assistants. The Health Care Assistant programme also facilitates the nursing career pathway by providing a 27 month development programme from apprenticeship to pre-registration nursing entry level.

We have match funded the national clinical pharmacy pilot to encourage practice participation, with the GP Alliance being successful in being awarded the pilot. The national pilot currently provides clinical pharmacy services to 15 practices across Sunderland provided by the GP Alliance Federation. This pilot is exploring how embedding clinical pharmacists can affect workload and release time for GPs. A condition of committed funding is to also deliver the CCG's medicines optimisation (MO) programme previously delivered to participating practices by the current MO practice support service. During 2017/18 a procurement exercise will be underway for MO support to practices not participating in the pilot which will allow lessons learned from the pilots to be incorporated in the support for all other practices over time.

Weaknesses have been identified in the appraisal processes for both practice nurses and practice managers. Taking on board feedback from both these staff groups peer appraisal is being introduced. Training and support will be provided to appraisers and this has been pump primed from slippage on the GP delegated budget in 2016/17.

Implementing the Five Year Forward View for Mental Health includes a commitment to expand Improving Access to Psychological Therapies (IAPT) services to meet 25% of need by 2020/21. The majority of the expansion will be ‘Integrated IAPT’ services, co-located in and integrated with physical health services, and focused on people with anxiety/depression in the context of long-term physical health problems and/or people with distressing and persistent medically unexplained symptoms.

In 2016/17 and 2017/18 integrated IAPT ‘Early Implementers’ will develop and provide new integrated services, preparing the whole NHS to implement integrated services from 2018/19. There are four goals for the early implementer programme:

- To implement integrated psychological therapies at scale – improving care and outcomes for people with mental health problems and long-term physical health problems, and distressing and persistent medically unexplained symptoms.
- To learn how best to implement integrated psychological therapies at scale in an NHS context – moving from trials and pilots to business as usual.
• To build the return on investment case for integrated psychological therapies – demonstrating savings in physical health care.

• To build capacity in the IAPT workforce, starting the expansion of the workforce needed to meet 25% by 2020/21.

This development will link in with the five locality Community Integrated Teams, wrapped around practices, supporting the practice to manage people with long term conditions. This will build on the service that is already in place for people with long term conditions and the relationships that have already been formed with general practice.

A breakdown of funding, trainees and people using services is outlined in the table below:

<table>
<thead>
<tr>
<th>Agreed numbers</th>
<th>2016/17</th>
<th>2017/18</th>
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</thead>
<tbody>
<tr>
<td>Local funding</td>
<td>£100,000</td>
<td>£50,000</td>
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<tr>
<td>National funding to provider (in salary support for trainees)</td>
<td>£372,192</td>
<td>£614,580</td>
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<tr>
<td>National funding to CCG (excluding training courses and trainees)</td>
<td>£329,494</td>
<td>£1,297,802</td>
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<tr>
<td>Places on Continuing Professional Development (CPD) courses for therapists in working with people with co-morbid long term conditions</td>
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<tr>
<td>High intensity therapists</td>
<td>10</td>
<td>0</td>
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<tr>
<td>Psychological wellbeing practitioners (PWPs)</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>IAPT trainees (course fees and salary support funded nationally in 2016/17 &amp; 2017/18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High intensity therapists</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Psychological wellbeing practitioners (PWPs)</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Number of people planned to be seen in new integrated services</td>
<td>20</td>
<td>620</td>
</tr>
</tbody>
</table>

A workforce data toolkit is currently being piloted in one of the localities and 8 practices are currently inputting data. It is anticipated that the toolkit will provide more robust data regarding not just workforce numbers but also the skills, knowledge
and experience to allow for enhanced workforce planning and development and also to provide greater insight into areas of need or pressure in the workforce population.

During 17/18 and 18/19 workforce plans will be focussing on:

- The development of practice managers including succession planning and building the skills of those working in a deputy management including a bespoke access course to degree level management qualification with Sunderland University.
- A step down programme for nurses with a focus on educator roles to create an educational footprint for new and emerging roles and thus building capacity for medical placements.
- A city wide training and development plan for general practice looking at maintaining skills, enhancing skills and the development of specialist skills that can be used at scale within localities.
- Continued exploration of new roles such as Physicians Associates in conjunction with local higher education providers.
- Implementing the Community Education Provider Network status by Health Education England and this joint working will continue to be developed.
- Supporting University of Sunderland with general practice placements for paramedic students.
- Implementing the expanded GP career start and the nurse and health care assistant career starts in both years.

## 4 Workload

### 4.1 Time for Care Programme

We will be submitting an application within the required deadline i.e. before August 2018. We have assessed themselves against the readiness self-assessment tool and the findings at that time were that although we have good engagement with our GP Practices, this area needs to be scored at least 3+ and that commitment to the programme needs to be at least 80% of practices to ensure any outcomes. To enable this to be as attractive a programme as possible for our member practices in 16/17 the CCG has committed £1.75 per head to enable practices to free up capacity for the whole practice to take time out and look at the 10 high impact actions and think about how the actions could help address their workload pressures and free up GP time. 100% of practices are signed up to creating the capacity.

This scheme asks practices to:-

- Look at the 10 High Impact actions as a practice and discuss the areas that have already been implemented by the practice and areas that the practice would like to introduce;
- Bring these areas to a locality meeting and discuss with other practices within the locality – sharing best practice and also discussing areas that could be
introduced as a locality or group of practices or needs a city wide introduction; and

- Submit a pro-forma detailing the discussions to the CCG

The CCG Locality Commissioning Manager will support this review.

**Plans going forward - 2017/18**

Once the actions are complete (31 March 2017) we will collate the responses from the practices and theme the areas that practices have decided they would like to look at. At this point we will apply for the national Releasing Time for Care support programme and engage with a development advisor. This approach will allow for the identification of our time for care champion(s), have an idea of the priorities practices have identified and continually assess ourselves against the readiness tool. This approach will enable us to be assured that at least 80 per cent of practices are on board and able to participate in this valuable programme.

A growing number of practices across the country are already making use of these impact actions and the application will enable practices to access their learning of developing new systems or how they increase patient self-care.

**Plans going forward - 2018/19**

SCCG will continue to support practices in the implementation of the high impact changes in 18/19. All practices are involved in this piece of work, and the plans for 18/19 will be developed following a review of 17/18 to ensure full adoption.

Further details are included within the investment section of this document (see pages 93 and 94, Training for Care Navigators). The plans for deployment have been developed in consultation with general practice. Funding for the training has been ring fenced for the intended purpose and will be delivered in alignment with other activities as part of the time for care programme, and wider work on workforce and technology strategies.

**4.2 E-consultation**

We will invest in technology that will enable patients to use multiple channels for consultation with their GP. Further details regarding this can be found in the investment section on page 92 (On-line General Practice Consultation Software). These will include the traditional face-to-face consultation, consultations using video technology and also the ability to use on-line symptom checkers (with signposting to appropriate service) and also to feed information into an on-line form which the GP can review and take appropriate / further action on. This will reduce workload in primary care.
4.3 Other workload initiatives

Other workload initiatives include practice manager development (and development of deputies) and the General Practice Improvement Leader Programme. These will be promoted and uptake monitored and encouraged from April 2017. The workforce section of this document details more information about programmes to upskill in order to make most appropriate use of the whole workforce within General Practice enabling better management of workload pressures.

5 Practice Infrastructure

5.1 Local Digital Roadmap & Shared Care Records

We have established robust governance arrangements with our health and social care partners by introducing a community wide Informatics Board to drive forward the implementation of the national strategy towards a paperless NHS.

Commissioners and providers across South Tyneside and Sunderland have worked together to undertake digital maturity assessments and develop a single roadmap for how technology will help improve how health and social care is delivered to patients.

While many of the technical details are contained within individual organisational strategies and plans the collaborative development of the Local Digital Roadmap (LDR) enables our efforts to be aligned to a common set of priority areas and reduces the risk of effort and investment duplication.

The objectives of the LDR are;

- To make a reality by 2020, the expectations of patients today that the NHS is one seamless organisation where information is collected once and shared amongst those delivering care and duplication of effort and costs is eliminated.
- To deliver a ‘channel shift’ across the Local Health Economy where delivery of health and care services using digital channels becomes the norm for both patients and staff.
- To support prevention and self-care for patients and carers by establishing digital resources which inform and assist in healthier life styles and management of conditions.
- To collaborate and innovate on the development of shared care record and interoperability capability locally and be the main contributor for the establishment of the Great North Care Record.
- To establish the North East and North Cumbria to become the safest place in the world to receive care and the best place in the world to do research underpinned by the Great North Care Record

Our priority areas are delivery of 10 Universal Capabilities;
- Professionals across care settings can access GP-held information on GP prescribed medications, patient allergies and adverse reactions.
- Clinicians in emergency care settings can access key GP held information for those patients previously identified by GPs as most likely to present (in U&EC)
- Patients can access their GP record.
- GPs can refer electronically to secondary care.
- GPs receive timely electronic discharge summaries from secondary care.
- Social care receives timely electronic Assessment, Discharge and Withdrawal notices from acute care.
- Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.
- Professionals across care settings made aware of end-of-life preference information.
- GPs and community pharmacists can utilise electronic prescriptions
- Patients can book appointments and order repeat prescriptions from their GP practice.

100 per cent of practices have Wi-Fi for corporate use, and in 2017/19 this will be expanded to cover public use.

Across the Local Health Economy we have active projects that will deliver each of these capabilities using a range of national and local solutions which are detailed in our Universal Capabilities Delivery Plan.

Many of the universal capabilities relate to patients having a greater level of access to their clinical records while also supporting improved access to general practice by using digital methods. This is a key theme within the LDR which supports the objective of creating both a ‘channel shift’ towards using technology to improve access to and delivery of health and social care services. The use of digital services to access the NHS is also an enabler to help people move towards the use of digital methods for self-care such as on-line information resources and apps that help signpost to appropriate services and manage suitable conditions.

Our plans include support for major transformation work with enabling digital technology that will standardise and simplify clinical and business processes. Our plans will ensure secure, robust and reliable clinical information systems that have been fully exploited and optimised to achieve identified benefits through a process of continuous improvement of our change management, project management and training techniques and capabilities across the LDR footprint that will have sustainability of new ways of working at the core.

The focus of this work will be;

- Support for one clinical model of acute care by implementation and adoption of common standards, configurations and supporting information systems across
acute organisations in South Tyneside and Sunderland. By Q4 2016/17 we expect to have firm plans in place to take this work forward.

- Delivering new models of care for out of hospital services that will be enabled by an agile and mobile workforce with patient information available to the full range of services that deliver care. By the end of March 2017 the deployment of an electronic patient record for community services is expected to be complete along with the use of mobile technology and bi-directional view of the GP-Community electronic records.

- We will also have a shared care record ‘proof of concept ‘delivered by the end of March 2017 using a locally developed capability which will inform the local strategy and way forward for developing further sharing functionality. The focus of the proof of concept will be supporting multi-disciplinary team meetings for practice patients with complex needs who need care co-ordination.

- Additional record sharing capability for urgent and emergency care services across the region will be in place by Q4 2016-17 and will enable a view of the GP record to be available by secure methods.

- Digitally enabling general practice to re-shape the way services can be delivered to meet increasing demand and move towards seven day services and enabling a channel shift for patient interaction with health and social care services and facilitating standardisation of care across general practice through the adoption of decision support technologies that are integrated with core clinical systems.

Plans for 17/18-18/19

A range of technologies are to be deployed throughout 2017-2019 as part of the Primary Care Estates and Technology Transformation Fund. In 2017/18 we aim to deploy;

- Video consultation technologies;
- SMS appointment and campaign functionality and apps;
- Advanced telephony systems that provide a 24/7 virtual receptionist; and
- Collaboration technologies that enable practices to work at a federated level and improve operational efficiency.

We will invest in technology that will enable patients to use multiple channels for consultation with their GP as noted earlier. During 2017/18, as part of our #DigitalExemplarPractice Programme we will work with a number of practices which have identified on-line consultation as a priority and will test solutions along with operational processes that will ensure benefits can be delivered.
We will then share and spread the learning from these practices to the remaining practices in Sunderland during 2018/19. A combination of local funding, Estates & Technology Transformation Fund (ETTF) funding along with the national £45m funding available over the next three years will be used to procure technology and video services along with change management support to ensure sustainability across all practices in Sunderland.

Our plans also address key financial challenges by:

- Rationalising the taxonomy of digital capabilities across the LDR footprint in order to simplify support and development arrangements. This will increase local knowledge and expertise and support long term sustainability along with financial benefits of procurement at scale and consolidation on common and complementary digital capabilities.

- Making mobile working normal behaviour and expanding WIFI capability for health and social care staff across the LDR estate and wider which will reduce the need to 'return to base' freeing up time to focus on patients and service users. By the end of 2017 we will have both joined up Wi-Fi across our health and social care providers and will also provide Wi-Fi for patients within General Practice.

- Digitising the transactional, the diagnostic and transfer of care information flows between primary and secondary care providers to ensure coded data and workflow increase productivity and reduce manual intervention and administration within general practice.

- Reducing face to face contacts and follow up requirements by using technologies such as video consultations and messaging services that enable patients to communicate their preferences and current status with regards to follow up review appointments. By the end of 2017 we will have demonstrated how technology can make this a reality and understand the change management requirements to make it a sustainable way of supporting patients.

Where investment has been made centrally we will maximise the use and exploitation of national digital assets. Where these do not align to local requirements we will collaborate with other LDR footprints in the region to ensure solutions are scalable and information flows are not constrained by technology. Significant savings will be realised as a result of reducing the costs associated with paper (E.g. printing, handling and postage) and increased digitisation.

Much of the volume of paper has been reduced for clinical correspondence between secondary and primary care such as discharge communications where digital transport mechanisms have been in place since 2015 however we will further exploit national infrastructure such as the Messaging Exchange for Social Care and Health
(MESH) and move forward with structured CDS messaging in 2017/18. This development also complements the Global Digital Exemplar (GDE) requirements for the City Hospital Sunderland NHS Foundation Trust.

Our plans for developing the underpinning infrastructure that supports delivery of GPIT will see ETTF funds used to move our practices onto a single administrative domain which will improve the support from our GPIT Delivery Partner and enable an enhanced range of services to be delivered to practices while removing some of the technical barriers that have hampered collaboration between practices and the CCG.

Our plans in 2017/18 are to explore the potential of a Virtual Desktop Infrastructure (VDI) environment and the benefits this may bring for enhanced resilience and support along with federated working across practices and secure mobile/remote working together with less reliance on local PC infrastructure. This is a significant investment and the approach will require ETTF funding to be approved by NHS England with a robust business case supported by this pilot.

Working with our GPIT Delivery Partner we are progressing with an updated Community of Interest Network (COIN) during 2017/18 that will see increased resilience and improved speed for general practice with considerable cost savings that have been placing pressure on GPIT budgets during the transition from legacy arrangements. When available, improved access to the Health and Social Care Network will also be enabled.

5.2 Estates

We have a Strategic Estates Strategy for 2015-2020. This was developed following a review of the health estate of Sunderland. The work was overseen by a Local Estates Forum (LEF) which incorporated representatives from the CCG, City Hospitals Sunderland Foundation Trust, South Tyneside Foundation Trust, NHS England, Sunderland City Council, Northumberland Tyne and Wear Mental Health Trust, GP Federations in Sunderland, Sunderland University and NHS Property Services.

Currently there is a significant reliance on acute hospital care. We are keen to see a shift in emphasis to prevention, self-care, primary and community care and less reliance on hospital based services. Currently the health and social care services suffer from fragmented provision. Working with partners, the CCG are keen to improve the integration of health and social care service provision and are keen to improve mental health in the population. The strategy gives consideration to relationships between agencies and the communities they serve and how services can be delivered in the future to make best use of all resources in order to achieve better health and wellbeing outcomes. By building on and utilising the resources and energy of our communities, we can support people to take greater control of their lives to bring about better health and wellbeing outcomes that matter to them, their families and communities.
The objectives of the Strategy are as follows:
• Ensuring the right services are in the right place – care delivered closer to home wherever possible;
• Improve the effective utilisation of out of hospital clinical estate;
• Reduce the community estate running costs by 10%;
• Reduce the carbon footprint of primary and community estate by 10%;
• Reduce void / unutilised community space by 50%;
• Support the improvement of patient experience when accessing out of hospital care; and
• Support all local agencies to implement their organisation and estate strategies

GP Estate in Sunderland is generally very good following significant capital investment in community estate by the previous Primary Care Trust. There is very little unutilised primary care estate. Estate reconfiguration has taken place to support delivery of the Out of Hospital Community Integrated teams and it is recognised we may require further reconfiguration to support delivery of the Out of Hospital Care Model and General practice Froward View. ETTF bids have been developed with this in mind.

Where practices want to work together we will support them in future bids to deliver the infrastructure needed to deliver co-location or the sharing of facilities such as reception and IT where this is physically possible. This is linked to the technology ETTF bids to support the digital maturity of primary care and reduce its running costs.

**Plans for 2017/18**

We will work with partners and to reduce community estate running costs by approximately 10% and £200k per annum in NHSPS and where possible pass these savings onto tenants. The CCG will also work with partners to reduce community void costs by either giving notice on such accommodation or helping find suitable tenants
• NHS Property Services will look to ensure assets are revalued to reduce running costs
• Multi-Agency opportunities will be identified and considered by the local estate forum
• All CCG led projects will relate to our strategic objectives and priorities over the next 5 years
## Annex 4 Delivery plan

<table>
<thead>
<tr>
<th>SCCG transformation programme</th>
<th>Priority</th>
<th>Developing</th>
<th>Implementing</th>
<th>Expected impact</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Q4 2016/17</td>
<td>Q1 2017/18</td>
<td>Q2 2017/18</td>
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<td>Q3 2017/18</td>
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<td>Q4 2018/19</td>
<td>Q1 2019</td>
<td>Q2 2019</td>
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</table>

### 1. In Hospital

**To deliver high quality, cost effective, sustainable healthcare (Best start in life)**

- 1.1 Clinically review maternity and gynaecology services to develop future service delivery options
- 1.2 Commence formal consultation on service delivery options
- 1.3 Commence formal consultation on service delivery options
- 1.4 To undertake a mid-term review of consultation activity
- 1.5 To publish the consultation report and provide feedback to stakeholders and the public
- 1.6 To formally decide the outcome of the consultation
- 1.7 To implement the next steps, where appropriate

### 2. Prevention

**To roll out ‘Making every contact count’ (MECC)**

- 2.1 To have a framework in place to oversee the systematic implementation of MECC
- 2.2 To work with service provider staff to identify who to work
- 2.3 To train staff in brief interventions for alcohol and smoking
- 2.4 To review and evaluate to ensure spread and sustainability

### 3. Community care system

**To formulate and implement a self-care strategy**

- 3.1 To embed carers into self-care
- 3.2 To develop a workforce plan to support self-care
- 3.3 To develop a communications strategy around self-care
- 3.4 To implement the Patient Activation Measures tool to identify those most receptive to self-care/self management
- 3.5 To embed the self-care model

### 4. Cardiovascular disease

**To improve the management of people with CVD, and those at high risk by addressing factors, e.g. AF, hypertension, high cholesterol and type 1 and 2 diabetes**

- 4.1 To develop a hypertension and cholesterol protocols for use in practices
- 4.2 To agree measures to evaluate project and collect
- 4.3 To pilot ‘CVD bundle’ with identified practices
- 4.4 To have a hypertension pathway on Map of Medicine
- 4.5 To implement the ‘CVD bundle’ in General Practice
- 4.6 To agree the services in scope
- 4.7 To hold a market engagement event
- 4.8 To undertake a listening exercise with existing patients
- 4.9 To develop the new model
- 4.10 To implement the new model
- 4.11 To apply for transformation funding to improve achievement of treatment targets and expanding specialist inpatient nursing services

**To develop a new model of integrated self-care and rehabilitation for patients with pre-existing long term conditions as well as those at risk of developing LTCs**

- 4.12 To undertake an assessment of implementation readiness

### 5. Cancer

**To support patients to self manage**

- 5.1 To evaluate the standardised, local follow up pathways for breast cancer against national requirements
- 5.2 Engage with Cancer Alliance to undertake a review of breast services including stratified follow ups
- 5.3 Cancer Alliance to submit a Transformation bid on behalf of CCGs for stratified follow ups
### 6. General Practice

**To make use of additional investments in primary care to support delivery of the GP Forward View (GPFV)**
- **6.1** To invest in online consultation software
- **6.2** To roll out Care Navigator and Medical Assistant training
- **6.3** To support the GP Resilience Programme including adding to the national programme
- **6.4** To invest in improving access to GP services (2 localities)
- **6.5** To use the Estates Technology Transformation Fund to drive forward GPFV
- **6.6** To deliver full coverage of extended access in line with the national specification
- **6.7** To support the development of general practice ‘at scale’
- **6.8** To implement a general practice Quality Premium
- **6.9** To implement Standardisation of Care
- **6.10** To explore new roles e.g. Physicians Associates, Nursing Associates, paramedics
- **6.11** To develop and implement a step down programme for practice nurses
- **6.12** To develop a city wide training and development plan
- **6.13** Practice management development
- **6.14** To continue to develop the Community Education Provider Network (CEPN)
- **6.15** To implement the review by practices of the 10 High Impact Actions
- **6.16** To participate in the national programme
- **6.17** To implement hub arrangements for diabetes and ECGs
- **6.18** To expand services for hub arrangements
- **6.19** MSCP including primary Care

**To drive forward care redesign to deliver sustainable and transformed primary care services in line with the GPFV vision**

**To develop, fund and implement local workforce plans**

**To implement workforce initiatives to help manage the workload pressures in General Practice**

**To support the development of ‘primary care at scale’**

### 7. Cancer

**To achieve earlier diagnosis by supporting General Practice to improve screening and direct access pathways**
- **7.1** To implement the Cancer Improvement Scheme (CIS) for General Practice focussing on screening recall and significant event audit and safety netting
- **7.2** To explore the inclusion of the CIS in the Quality Premium for General Practice under development to be implemented in 2017
- **7.3** To commission direct access to flexi sigmoidoscopy
- **7.4** To launch the Direct Access pathways to CT and MRI for suspected cancer of unknown primary
- **7.5** To evaluate the impact of Direct Access Pathways
- **7.6** To support the use of Map of Medicine to make cancer referrals using regional 2WW guidance
<table>
<thead>
<tr>
<th>SCCG transformation programme</th>
<th>Priority</th>
<th>Milestones</th>
</tr>
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<tbody>
<tr>
<td>8. Community care system</td>
<td>8.1</td>
<td>To scope what the Provider Management function includes</td>
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<td></td>
<td>8.2</td>
<td>To agree the services to be in the MSCP contract</td>
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<td>8.3</td>
<td>To develop the business case for the MSCP</td>
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<td>To agree the contract form</td>
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<td>8.5</td>
<td>To work with the Provider Board to explore options for organisational form</td>
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<td>To develop and implement an education plan</td>
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<td>8.7</td>
<td>To develop and deliver a system leadership programme</td>
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<td>8.8</td>
<td>To facilitate a skills analysis for All Together Better staff</td>
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<td>8.9</td>
<td>To develop and implement integrated support team working</td>
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<td>8.10</td>
<td>To review current workforce and explore different ways of working</td>
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<td>8.11</td>
<td>To contribute and support STP discussions on Out of Hospital models</td>
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<td>8.12</td>
<td>To share and spread the model to support wider STP footprint development and implementation</td>
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<td></td>
<td>8.13</td>
<td>To support the spread of model/development of MSCP in South Tyneside</td>
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<td></td>
<td>8.14</td>
<td>To commence a listening exercise with patients and the public to get their views on local urgent care provision</td>
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<td>8.15</td>
<td>To develop service configuration proposals</td>
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<td></td>
<td>8.16</td>
<td>To consult on the proposals</td>
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<td></td>
<td>8.17</td>
<td>To publish the consultation report and provide feedback to stakeholders and the public</td>
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<td></td>
<td>8.18</td>
<td>To implement the outcome of the consultation and engagement</td>
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<td>8.19</td>
<td>To review existing whole system pathways (DVT/cellulitis)</td>
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<td>8.20</td>
<td>To scope and new pathways for 2017/18</td>
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<td>8.21</td>
<td>To implement the new pathways</td>
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<td>8.22</td>
<td>To pilot Consultant Connect</td>
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<td>8.23</td>
<td>To evaluate the Consultant Connect and agree next steps</td>
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<td></td>
<td>8.24</td>
<td>To undertake a case mix audit</td>
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<td>8.25</td>
<td>To trial and evaluate paramedic pathfinders to go direct to Ambulatory Emergency Care (AEC) Unit</td>
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<td></td>
<td>8.26</td>
<td>To develop and implement a patient and staff engagement strategy to improve both patient and staff experience in relation to AEC - promote AEC across both patient and</td>
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<tr>
<td></td>
<td>8.27</td>
<td>To develop and cost an AEC service specification across the Sunderland system</td>
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<tr>
<td>SCCG transformation programme</td>
<td>Priority</td>
<td>Milestones</td>
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</tbody>
</table>
| 9. Mental Health              | To implement integrated IAPT | 9.1 To recruit 26 trainee practitioners  
|                               |          | 9.2 IAPT to work with Community Integrated Teams  
|                               |          | 9.3 To develop pathways for long term conditions  
|                               | To integrate mental health and employment support by introducing employment coaches in IAPT (Mental Health TrailBlazer) | 9.4 To increase access to patients with long term conditions and with medical unexplained symptoms  
|                               |          | 9.5 To develop new pathways, e.g cancer, obesity  
|                               | To refresh Sunderland’s Transforming Care plan to support delivery of the new model of care | 9.6 To recruit and appoint employment coaches  
|                               |          | 9.7 To introduce employment coaches into IAPT  
|                               |          | 9.8 To develop pathways  
| 10. Learning disabilities    | To implement the primary care learning disability and autism programme | 10.1 To benchmark existing services against the new Service Model/model of care developed by the North East and Cumbria Learning Disabilities Transformation Programme and agree next steps  
|                               |          | 10.2 To ensure alignment with new regional model of care  
|                               |          | 10.3 To launch the programme with member practices  
|                               |          | 10.4 To train all cohorts of staff in general practice  
|                               |          | 10.5 To develop a comprehensive information resource relating to Learning Disabilities and autism, including guidance, on how to make reasonable adjustments for people with Learning Disabilities  
|                               |          | 10.6 To develop signposting and referral pathways  
|                               |          | 10.7 To develop guidance to support practices to improve health checks for people with learning disabilities  
|                               |          | 10.8 To develop easy to read documentation for patients, carers and families  

Out of hospital collaboration
### Optimal use of the acute sector to improve experience of care, achieve better outcomes and create a sustainable model

<table>
<thead>
<tr>
<th>SCCG transformation programme</th>
<th>Priority</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11. In Hospital</strong></td>
<td>To deliver high quality, cost effective, sustainable healthcare</td>
<td>11.1 To complete phase 1a full clinical service reviews for stroke, paediatrics, maternity and gynaecology&lt;br&gt;11.2 To complete phase 1 ‘Listening exercise’ including gathering the views of local people of the services under review&lt;br&gt;11.3 To undertake travel impact, health impact and equality impact assessments&lt;br&gt;11.4 To consult on options for service delivery where proposals are significant&lt;br&gt;11.5 To publish the report and formally decide the outcome&lt;br&gt;11.6 To reconfigure services where appropriate&lt;br&gt;11.7 To complete phase 1b (trauma and orthopaedics and general surgery) and phase 2 full clinical service reviews&lt;br&gt;11.8 To consult on options for service delivery where proposals are significant&lt;br&gt;11.9 To publish the report and formally decide the outcome&lt;br&gt;11.10 To reconfigure services where appropriate&lt;br&gt;11.11 To complete phase 3 full clinical service reviews&lt;br&gt;11.12 To consult on options for service delivery where proposals are significant&lt;br&gt;11.13 To publish the report and formally decide the outcome&lt;br&gt;11.14 To reconfigure services where appropriate</td>
</tr>
<tr>
<td><strong>12. Community care system</strong></td>
<td>To involve Out of Hospital clinical leaders in phases 1, 2 and 3 of the clinical service reviews</td>
<td>12.1 To agree actions to transfer appropriate services to the community</td>
</tr>
</tbody>
</table>

**Developing**<br>**Implementing**<br>**Expected impact**

<table>
<thead>
<tr>
<th>Q1 2016/17</th>
<th>Q4 2016/17</th>
<th>Q1 2017/18</th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q4 2018/19</th>
<th>Q1 2019/19</th>
<th>Q4 2019/19</th>
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## Annex 5   Glossary of terms

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<tr>
<th>Acronym</th>
<th>Meaning</th>
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<tr>
<td>ACO</td>
<td>Accountable Care Organisation</td>
</tr>
<tr>
<td>AEC</td>
<td>Ambulatory emergency care</td>
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<tr>
<td>AECU</td>
<td>Ambulatory emergency care unit</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and emergency</td>
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GOVERNING BODY MEETING  
31 JANUARY 2017

Report Title: Safeguarding Children Improvement Progress

Purpose of report

To provide an update to the Governing Body on safeguarding children improvement activity and progress against the recommendations reported in the report to the governing body in January 2016

Key points, risks and assurances

Key Points:
- To provide background information on the recommendations made by Ofsted following their inspection into the Local Authority arrangements for safeguarding children and the effectiveness of the Local Safeguarding Children Board (published July 2015)
- To provide a progress update on the Learning and Improvement Plan – Appendix 1
- To provide a progress update on the Sunderland Safeguarding Children Board (SSCB) Ofsted Improvement Plan – Appendix 2
- To provide a progress update on the support and leadership of health professionals to improvement activity.

Risks for decision making: none - report is for information only.

Assurances:
Ongoing monitoring and governance via the Safeguarding Children Improvement Board with reporting to Sunderland Safeguarding Children Board.

Recommendation/Action Required

The Governing Body is asked to note the assurance provided by the report.

Sponsor/approving director

Ann Fox  
Director of Nursing, Quality and Safety

Report author

Deanna Lagun  
Head of Safeguarding/Designated Nurse  
Safeguarding Children.
## Link to CCG corporate objectives  (please tick all that apply)

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<tr>
<td>CO2: Maintain financial control and performance targets</td>
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<tr>
<td>CO3: Maintain and improve the quality and safety of CCG commissioned services</td>
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<tr>
<td>CO4: Ensure the CCG involves patients and the public in commissioning and reforming services</td>
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<td>CO5: Identify and deliver the CCG’s strategic priorities</td>
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<td>CO7: Integrating health and social care services, including the Better Care Fund</td>
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<tr>
<td>CO8: Develop and deliver primary medical care commissioning</td>
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## Any relevant legal/statutory issues

- S11 CA 2004 – Statutory Safeguarding Responsibilities
- The Prevent Duty 2015
- FGM Duty to Report 2015

## Are the identified risks on the risk register?

N/A

## If issue/report has been previously reviewed please specify meeting and date

N/A

## Equality analysis completed  (please tick)

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## Key implications

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<td>Are additional resources required?</td>
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<td>Has there been appropriate clinical engagement?</td>
<td>Yes via multi agency arrangements</td>
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<tr>
<td>Any current or expected impact on patient outcomes/experience?</td>
<td>Improved safety for children in Sunderland</td>
</tr>
<tr>
<td>Have there been member practice and/or other stakeholder engagement if needed?</td>
<td>Multi agency engagement</td>
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1.0 INTRODUCTION

1.1 The Ofsted inspection of Sunderland’s services for children in need of help and protection, children looked-after and care leavers was carried out between 11 May and 4 June 2015. The report was published on 20 July 2015. The inspection team found children’s services in Sunderland to be inadequate. They reported that there were widespread and serious failures that left children unsafe and which meant that the welfare of children looked-after was not adequately safeguarded or promoted.

1.2 In January 2016 the governing body was advised of the Learning and Improvement Plan developed in response to the Ofsted inspection report which required the Local Authority to respond to 27 areas for improvement. Since this time the Children’s Safeguarding Improvement Board has met regularly. This is attended by senior representatives from across the children’s safeguarding partnership and continues to be chaired by a Children’s Commissioner from the Department for Education (DfE). Representatives from the DfE regularly attend this Board to ensure pace and progression of the improvement plan; reporting back to the department.

1.3 The governing body was also advised that the Ofsted inspection found that Sunderland Safeguarding Children Board (SSCB) could not demonstrate that it had effective arrangements in place and the required skills to discharge its statutory functions and made 7 recommendations to the SSCB. The governing body was informed of an action plan to implement these recommendations.

1.4 There were key improvements to the children’s safeguarding arrangements that necessitated changes to partnership arrangements and an action plan was shared with the governing body of those specifically dependent on the leadership and support of Named and Designated Health Professionals.

1.5 This paper provides an update on the progress of all safeguarding children improvement activity. Appendix one provides a position statement on the Improvement Plan as reported to SSCB in January 2017. Appendix 2 provides an update on SSCB progress against the recommendations made by Ofsted and Appendix 3 outlines the specific activity from health partners in supporting improvements.

2.0 Children’s Services – Safeguarding Improvement Journey

2.1 Further to the formal inspection there has been significant activity within the Local Authority in reviewing safeguarding children arrangements and implementing immediate changes where necessary. The council recognised
that it needed to do something fundamentally different to ensure the best possible future for children and young people in the city and a new organisation to deliver fully integrated children's services covering education, children's social care and early help services has been commissioned, called “Together for Children – Sunderland” and it is expected that the company will operate independently by April 2017. Partners have been involved in recruiting to the senior management team, led by the Chief Executive Alex Hopkins.

2.2 In August 2016 Ofsted started a programme of formal monitoring visits to inspect progress against the inspection findings. The monitoring visits are a reduced version of the full inspection which is likely to happen in 2017. The monitoring visits will be held quarterly and findings are published.

2.3 The first visit, in early August, focused on the progress in improving services for care leavers. During their visit inspectors spoke to care leavers and staff, including social workers, managers and housing providers. They also examined a range of evidence including electronic case records, supervision records, observation of social work practice, performance data and young people's case file audit findings. In the Ofsted letter following this visit the lead inspector reported "The local authority is making significant progress to improve services for care leavers."

2.4 Sunderland's second monitoring visit took place on 8th and 9th November and the focus of the visit was the Integrated Contact and Referral and Assessment Team (previously known as the MASH - Multi-agency Safeguarding Hub). This included initial responses to children in need of help and protection, information sharing, the voice of the child, management decision making, oversight and supervision, arrangements in place to respond to children at risk of sexual exploitation and the provision of early help. The lead inspector reported: "The evidence gathered during the monitoring visit demonstrated steady progress and improvement from a very low baseline, although considerable work is still required in many areas of practice to ensure that children in Sunderland receive the right services at the right time". During this visit partner agencies also met with the lead inspector who reported on their increasing confidence in the senior management team, following a period of substantial upheaval following the inspection in 2015. The staff within Children’s Services endorsed this finding.

2.5 The next monitoring visit will see the inspection team reviewing the arrangements for our Looked After Children (LAC) and will take place on February 2\textsuperscript{nd} and 3\textsuperscript{rd} 2017.

2.6 Appendix 1 outlines progress on the Improvement and Learning Plan as reported to the SSCB on January 16th 2017. This plan is currently being reviewed and refreshed by the Children’s Services Senior Team in conjunction with the Improvement Board. It is likely that significant activity will focus on ensuring a robust early help service and recruitment of social workers; whilst embedding much of the more recent improvements.
3.0 SSCB - Safeguarding Improvement Journey

3.1 Appendix 2 provides a progress update on the 7 key areas highlighted as needing improvement by Ofsted. Whilst most areas show that the work has been completed significant changes and improvements continue to be made by the SSCB, agreed and monitored by the SSCB Executive Group. The red/outstanding actions relate to training activity which was not prioritised due to the pressures within the SSCB Business Unit in co-ordinating an unprecedented number of SCRs. The remaining red/outstanding action pertains to early help data flows which has proved difficult. As reported at 2.6 the early help arrangements will be reviewed along with how performance information will be reported.

3.2 In March 2016 the Independent Chair of the SSCB resigned and an Interim Independent Chair was appointed who has continued to lead the improvement activity. This has included:

- A review and refresh of Missing, Sexually Exploited and Trafficked arrangements
- The development of a multi-agency Performance Scorecard
- The implementation of a Quality Assurance Framework
- Re-establishing multi-agency audits
- Commissioning an independent thematic review of learning from Serious Case Reviews (SCRs)
- Completion and publication of a number of SCRs
- Commissioning 4 SCRs utilising new, more streamlined methodologies
- Commissioning an independent review of the SSCB governance arrangements
- Undertaking a Chair’s diagnostic exercise of multi-agency safeguarding children arrangements.

3.3 The findings from the latter 2 activities have informed the Independent Chair’s proposals to “make a real difference” which have been agreed by Board partners. These changes (to the constitution, governance and accountability arrangements) will enable the SSCB to focus on its key regulatory responsibilities. The changes will be fully introduced from April 2017. These arrangements will ensure the SSCB is compliant with the Wood Report published in 2016

3.4 SSCB partners have recently agreed the job description and person specification for a permanent Independent Chair and the post has now been advertised.

3.5 The SSCB Annual Report 2015/16, due to be published in early 2017, will provide additional detail on the work of the Board
4.0 **Named and Designated Professionals support to the Improvement and Learning Plan**

4.1 Appendix 3 provides assurance to the governing body that the CCG Named and Designated Safeguarding Professionals, alongside others, have supported the Improvement and Learning Plan.

4.2 In addition they have provided stability and leadership to the SSCB and across the health economy during a time of significant change.

5.0 **Recommendations**

5.1 The governing body is asked to note the considerable improvement activity, particularly within the Local Authority, and the acknowledgement by Ofsted that progress has been demonstrated during the last two monitoring visits.

5.2 The governing body is asked to note the ongoing support of the Chief Officer, Executive Lead for Safeguarding (Director of Nursing Quality & Safety) and the CCG Designated and Named Professionals in safeguarding improvement activity.

Deanna Lagun
Head of Safeguarding Sunderland NHS Clinical Commissioning Group

19 January 2017
Sunderland Safeguarding Children’s Board

Overview of Progress against the Learning and Improvement Plan

Purpose

The Ofsted inspection of Sunderland Services for Children in Need of Help and Protection, Children Looked After and Care Leavers took place between 11th May and 4th June 2015 and the final report was published on 20th July 2015. Following the inspection, a Learning and Improvement Plan was developed in response to the Ofsted inspection report. The plan identified seven priority areas, encompassing the 27 recommendations made by Ofsted together with other improvement areas identified in the narrative of the report. Progress against the Improvement Plan is overseen by the Improvement Board.

This report provides an overview of progress made against the priority areas.

Table 1: RAG Ratings Assigned to Actions by Priority

The table below shows the current RAG ratings for all the actions within each of the seven priority areas. The details of the eight Amber actions are detailed in Appendix A.

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<tr>
<th>Priority</th>
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<th>Dark Green</th>
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<td>1. Recruiting, retaining and developing a skilled and confident social care workforce.</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
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<td>2. Providing coherent and coordinated early help services to children and their families.</td>
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<td>1</td>
<td>0</td>
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<td>3</td>
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<td>4. Ensuring high quality support and services for looked-after children</td>
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<td>3</td>
<td>2</td>
<td>4</td>
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and effective permanency planning.

<table>
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<td>5. Putting the voice of the child at the centre of social care practice.</td>
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<td>6. Supporting young people leaving care to have a positive and successful transition to adulthood and independence.</td>
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<td>2</td>
<td>0</td>
<td>2</td>
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<tr>
<td>7. Embedding strong quality assurance and governance mechanisms to drive continual improvement in services.</td>
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<td>1</td>
<td>3</td>
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**RAG RATING DEFINITIONS**

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<td>RED</td>
<td>The action has not yet started or there is significant delay in implementation. The action must be prioritised to bring it back on track to deliver improvement.</td>
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<tr>
<td>AMBER</td>
<td>The action has started but there is some delay in implementation. The action must be monitored to ensure the required improvement is delivered.</td>
</tr>
<tr>
<td>LIGHT GREEN</td>
<td>The action is on track to be completed by the agreed date. Evidence is required to show that the improvement has been sustained.</td>
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<tr>
<td>GREEN</td>
<td>The action has been completed and there is evidence that the improvement has been sustained. The action remains in the plan for monitoring.</td>
</tr>
<tr>
<td>COMPLETED</td>
<td>The action has been completed and there is evidence that the improvement has been sustained. The action can safely be removed from the plan.</td>
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Priority 1: Recruiting, retaining and developing a skilled and confident social care workforce

1.1. A permanent senior management structure is in place to support the delivery of safe and effective services. Recruitment and retention targets are in place and monitored by the Council’s HR service.

1.2. Practice Standards have been implemented across the service. We have received positive feedback from our team managers and social workers who are finding the standards beneficial. The development of a model of social work to support the delivery of best practice is to be considered now that a permanent senior management structure is in place and practice is improving.

1.3. There is an agreed profile for our social care workforce to ensure we have sufficient capacity to deliver the current levels of activity. At the time of the inspection in June 2015, 269 cases were unallocated. At the end of November 2016, 21 cases were unallocated of which 12 had been unallocated for less than 1 working day. 4 of the cases were open referrals that did not progress and the remainder of cases have since been allocated. Also in November 2016, the average caseload across all teams was 17 or less.

1.4. A Workforce Development Strategy has been approved which is focused on improving the recruitment and retention of social workers. Currently the recruitment of social workers is progressing but it remains a challenging area. In the region, demand for recruiting social care posts is high with other neighbouring local authorities also recruiting for the same positions. Joanne Parkinson (from HR) has been identified to support the development of a recruitment and retention strategy. In terms of achieving recruitment targets going forward consideration needs to be given to the employment offer for attracting potential applicants as well as innovative recruitment practices.

1.5. A career progressions framework was implemented in December 2015 for social workers that is in line with the Professional Capabilities Framework and other regional schemes. We have developed a Learning and Development plan which is based on our practice standards and required competencies. In preparation for moving to a company, we intend to complete a further skills audit to baseline the current competencies of the workforce and to inform our learning and development offer.

1.6. A revised supervision policy is operational. Although the frequency of supervision has improved, recent audits show the quality and recording of
supervision remains variable. Additional training is scheduled for January 2017 with a view to improving the quality and recording of management oversight. A programme of further audits is scheduled for March 2017 to see if training and practice standards have been effective.

2. **Priority 2: Providing coherent and coordinated early help services to children and their families**

2.1. Following the inspection in 2015 our Early Help service engaged with partner agencies to develop an early help strategy and operational framework which set out the early help offer and referral pathways. Training, guidance and information to support the framework were also developed. In October 2016 the service reported that 70% of early help assessments were closed with one or more outcomes achieved which meets the target set in the improvement plan. Although the framework has been revised we acknowledge that further improvement is required to provide a coherent and coordinated early help offer. The new Director of Early Help, Karen Davison starts with the Authority on 1 February 2017 and will initiate a further review of the service with an aim to provide targeted early help interventions that are effective at preventing the escalation of children’s needs.
3. **Priority 3: Improving the quality and timeliness of assessment and care planning**

3.1. From the 1 September 2016 the MASH changed its name to the Integrated Contact and Referral Team. It was recognised that the ‘front door’ did not follow a MASH model however it was a multi-agency setting. The work within this team has been refocused. Decision-making has been improved together with the prompt allocation of cases for assessment or section 47 investigations. In November 2016, 75% of contacts within the ICRT had decisions made on outcomes within 24 hours.

3.2. Work is continuing to improve the Duty and Advice arrangements. The Service Manager is working comprehensively with Team Managers, utilising performance data to assess any cases out of timescale. Team managers from the Assessment Teams are meeting with their social workers at agreed review points in the assessment process to ensure they remain on track and to advise on issues around the expected duration of the assessment.

3.3. We operate a PLO tracker to provide management oversight and to improve the timeliness of actions. The PLO tracker provides management oversight and has improved the timeliness of actions. PLO Panel meetings are chaired by our Strategic Managers and dedicated business support personnel record and review actions. The meetings provide greater management oversight and enable decision making on cases entering care proceedings. In November 2016, 94% of cases were reviewed within the last 12 weeks.

3.4. Processes have been reviewed to ensure assessments, care plans and decisions to initiate S47 investigations are approved and clearly recorded by a manager. All decisions to initiate Section 47 investigations are made in strategy meetings, chaired by Team Managers or Advanced practitioners. New templates have been designed for child in need and child protection plans. A single assessment framework was implemented in December 2015 which is helping to improve the quality of assessments. Progress continues to be made on improving the timeliness of single assessments.

3.5. We have developed and implemented a case transfer protocol which sets out the pathways, minimum expectations and decisions-making for transferring cases between teams and services. Our step up-step-down processes have also been reviewed.
3.6. Improving the consistency and quality of case chronologies and genograms remains a priority for the service. The format of the chronologies has been improved, standards and guidance have been produced and training delivered. We are expecting to see improvements from our next round of audits taking place in December 2016 and January 2017.

3.7. The quality of assessments for children with disabilities, including the assessments of young people that are due to transition to adult services has improved. In November 2016 a themed audit was carried out on Children with Disabilities cases. 18 audits were completed and 13 were graded ‘Good’. In the main, the audits show evidence that improvements have been made and children do have good plans and assessments in place.

3.8. We have put in place clear arrangements to systematically gather information in relation to children missing from home, children missing from care and children missing from education. Multi-agency MSET meetings are a forum for sharing information, identifying risks and making decisions regarding safety plans for children identified as being at risk. Training has been delivered throughout 2016.

3.9. The completion of return home or return to care interviews has increased since the 2015 inspection however improvement is still required. A new provider has been commissioned to deliver the return home interviews and this contract commenced on 26 August 2016. Our figures are expected to improve in the forthcoming months.

3.10. We have embedded a risk assessment tool for child sexual exploitation with the aim of improving referrals and responses. Team Sanctuary was created in April 2016. The team provide a multi-agency role in identifying and tackling CSE and SE. The team provide victims with a targeted support response and aim to identify and provide a strategic view of the patterns of abuse across the Northumbria Police, to inform Local Safeguarding Children’s boards (LSCB) and Safeguarding Adult Boards (SAB) responses.

3.11. In February 2016 we redefined our out-of-hours service. It operates as the ‘Children’s Emergency Duty Team’ (EDT) with a core purpose of meeting the emergency needs of children and young people.
4. **Priority 4: Ensuring high quality support and services for looked-after children and effective permanency planning**

4.1. Following the 2015 inspection, a review was conducted of all cases where children are looked-after under voluntary care arrangements (S20) to establish whether this legal basis is sufficient to ensure their safety and emotional security. Immediate actions were taken to address the identified issues. Section 20s continue to be reviewed regularly.

4.2. A permanence tracker has been developed to provide assurance that every child with a plan for long-term care has a robust plan for permanence. A life story tracker has also been developed to ensure effective life story work is progressing. Performance relating to the percentage of CLA with an up-to-date care plan (within 6 months) has remained consistently high over the last year. Life story work is progressing in accordance with the age and circumstances of each child but remains a priority for the service.

4.3. Our Placement Sufficiency and Commissioning Strategy have been updated to increase the placement choice for children looked after but requires further review. The number of CLA with unplanned placement moves and the percentage of CLA who have experienced 3+ placement moves in the last 12 months continue to perform well and are below the latest reported statistical neighbour and national average.

4.4. A review of the arrangements for supervised contact has been concluded and changes are being implemented. Plans are being considered to relocate the team to more suitable accommodation. It is envisaged that the new arrangements will be more appropriate to meet children’s needs.

4.5. Progress is being made to strengthen the Virtual School but improvements are still needed. We have implemented mechanisms to track the progress of all looked-after children and care leavers however the service needs to continue to seek ways to reduce the gap between CLA and other children at all stages.

4.6. Following our Ofsted Monitoring Visit of Care Leavers in August 2016, Inspectors concluded that although young people were receiving appropriate support to access education and college, personal education plans are not consistently provided or updated. Since the monitoring visit a new template has been provided for PEPs and a self-assessment sheet has been shared with schools to allow them to monitor their own PEP quality before submitting them to the Virtual School. Improving the quality of the plans remains a priority.
5. **Priority 5: Putting the voice of the child at the centre of social care practice**

5.1. To ensure the views, wishes and feelings of children and young people are fully considered we have improved our capacity and monitoring processes. This has allowed children to be seen more regularly in line with agreed timescales. In November 2016, 97% of CLA had had a statutory visit within the last 6 weeks compared to 70% in June 2015.

5.2. The support arrangements for Change Council have been further developed to enable Children to engage, support and represent the views of all children and young people who are looked-after. A Mind Of My Own (MOMO) app has been launched to improve communication between young people, their social workers and IRO’s and to increase participation with their care planning. Young people are invited to attend the Looked After Senior Management Team and do so on a quarterly basis. We have six pledges for looked after children and have adopted the Care Leaver’s Charter. Each pledge is owned by a young person and is linked with a member of Corporate Parenting Board and a senior manager. Regular meetings take place with the young people to monitor progress and to feed back to the corporate parenting board.

6. **Priority 6: Supporting young people leaving care to have a positive and successful transition to adulthood and independence**

6.1. In August 2016 Ofsted conducted our first Monitoring Visit which reviewed the progress made in respect of the experiences and progress of care leavers. The report concluded that the local authority is making significant progress to improve services for care leavers.

6.2. We have a clear policy that informs care leavers about their rights and entitlements. The Next Steps Team moved into new premises in June 2016 to allow care leavers to have drop-in access to the service. Young people were part of the decision making process for the relocation to the city centre. The new premises support social workers and personal advisors to keep in touch with care leavers. In November 2016, 75.8% of care leavers had a contact within the last 8 weeks compared with 30% in June 2015.

6.3. Pathway planning has been a priority for the Next Steps service to ensure that care leavers’ needs are identified and action is taken to provide support. The pathway plan template has been revised in consultation with Care Council. In November 2016, 80% of care leavers had a pathway plan compared with 69% in November 2015. Whilst the number of pathway plans has improved, a recent
sampling exercise has shown that the quality of plans is not consistently good. This was noted as an area for improvement in the recent Ofsted Monitoring Visit and is a priority for the service.

6.4. Arrangements to monitor the education, employment and training status of care leavers have been strengthened. A team has been created with staff from Next Steps, Sunderland Virtual School and Connexions to support care leavers into EET (ELEET Team). This team works with Young People who are currently NEET to provide them with a number of Education/Employment opportunities, including apprenticeships. The number of care leavers who are NEET has improved from the time of inspection from 85% to 54.5% in November 2016, however progress is slower than expected and performance is still outside of national and statistical neighbour averages.

6.5. Following a review of housing commissioning arrangements, care leavers have a greater choice of accommodation options. During our recent monitoring visit, Ofsted inspectors recognised how our increased use and promotion of staying put arrangements and supported lodgings has helped to ensure that care leavers have a better range of options. In May 2015 only 44% of care leavers were living in suitable accommodation compared with 69% in November 2016.

6.6. The health needs of care leavers are addressed within the pathway planning process. However, care leavers do not always receive their medical histories or health passports. The lack of health passports is an issue and we are working with the CCG to obtain these for care leavers at their final health assessment. Immediate improvements are to be expected following the appointment of the LAC nurse at the end of 2016.

7. Priority 7 Embedding strong quality assurance and governance mechanisms to drive continual improvement in services

7.1. The Children’s Strategic Partnership (CSP) was established in January 2016. Partners decided that before agreeing their priorities, a Joint Strategic Needs Assessment for children and young people was an essential evidence base. This has been carried out and the findings were presented to the Board. In October 2016, a workshop took place to decide the priorities of the partnership and how they will be delivered. Work is progressing to finalise the multi-agency strategic plan.

7.2. Strategic and operational datasets are in place. Performance information is used at all levels of the service to monitor performance and inform practice and service development. The Scrutiny Committee has been strengthened. The
Committee has new terms of reference, meets regularly and focuses on actions contained within its Children’s work plan. Our Corporate parenting group also has clear terms of reference, appropriate membership and a work plan in place. Children in Care Council now attend the Corporate Parenting Board and we have published our pledge to CLA.

7.3. Policies and operating procedures are updated regularly and all staff has access via the social care online hub. Standards of social work practice are in operation. Early Help and manager practice standards are in development. Audit programmes are determining compliance and identifying any necessary changes to policies and procedures or training requirements.

7.4. Slow progress has made against the implementation of a new electronic social care recording system. The IT contact has been awarded but implementation will take 12 months with an expected completion date between July and September 2016. In the meantime steps are being taken to improve the current system in order to support social workers and managers.

7.5. An electronic recording case management system for allegations made against the children’s workforce and reported to the LADO has been implemented.

8. Summary

8.1. Whilst much progress has been made since the 2015 inspection, there is more to do to ensure we continue to learn, improve and make the required progress.

8.2. Following each Ofsted Monitoring Visit, actions are being identified to address any weaknesses reported by Inspectors. Those actions are contained in a post-monitoring visit action plan and any significant areas of improvement are reported to the Improvement Board with a request for inclusion into the Learning and Development Plan. We are recommending to the Improvement Board in January 2017, the inclusion of eight new actions to the plan.
Appendix A: Current Actions Rated Amber

- (2.1 - Ofsted 18) Engage with partner agencies to implement an early help strategy and operational framework which clearly sets out the early help offer and referral pathways. Although the Early Help Strategy and Framework has been reviewed since the 2015 inspection, a further review is required to ensure we have targeted early help interventions that are effective at preventing the escalation of children’s needs.

- (3.10) Continue to improve the consistency and quality of case chronologies and genograms and ensure these are consistently used to inform assessment and care planning. A new template and guidance has been implemented and training has been delivered with a view to improving the consistency and quality of chronologies. The Quality Assurance team are conducting a themed audit on chronologies and genograms throughout December 2016 and January 2017, the results of which may alter the RAG rating.

- (4.3 - Ofsted 14) Update the Placement Sufficiency and Commissioning Strategy to ensure the local authority has sufficient breadth and quality of placements to meet the needs of children looked-after. The strategy has been updated to increase the placement choice for CLA but requires a further update. Performance relating to placement stability (included in the Improvement Board dataset) continues to perform well.

- (4.4 - Ofsted 20) Review the arrangements for supervised contact to ensure these are driven by children's needs. The review has been concluded and changes have been implemented. Practice standards have been amended. There is a proposal to relocate the team to Lambton House but this is still to be finalised. It is envisaged that the new arrangements will be more appropriate to meet children’s needs. We envisage this action will move to a Light Green status before the end of January 2017.

- (4.6 - Ofsted 22) Improve the quality and monitoring of all personal education plans with clear targets and action plans to achieve those targets. Following our Ofsted Monitoring Visit of Care Leavers in August 2016, Inspectors concluded that although young people were receiving appropriate support to access education and college, personal education plans are not consistently provided or updated. Since the monitoring visit a new template has been provided for PEPs and a self-assessment sheet has been shared with schools to allow them to monitor their own PEP quality before submitting them to the Virtual School. Increased monitoring of the plans is also taking place. The results of a themed audit taking place throughout December 2016 and January 2017 may alter the RAG rating.

- (6.3 - Ofsted 26) Improve pathway plans so that they reflect the needs and aspirations of young people and which involves them in the planning process. Following the August 2016 monitoring visit, Ofsted concluded that although pathway planning has been a priority for the service, the quality of pathway plans is not yet good enough. Inspectors identified that needs assessments are not always undertaken, chronologies are not used consistently or effectively, plans are not specific with regard to actions required and are not always updated to reflect changes in circumstances. A themed audit is currently being undertaken which will show if the quality of plans has improved since the monitoring visit.
• **(6.6) Implement a health passport or equivalent for each care leaver to record their health history.** The health needs of care leavers are addressed within the pathway planning process. However, care leavers do not always receive their medical histories or health passports. The CCG has recruited a dedicated CLA Nurse who is working with young people to develop the health passports. Immediate improvements are to be expected following the appointment of the LAC nurse at the end of 2016. The proposed new performance measure will also monitor the percentage of CLA with an annual health assessment.

• **(7.9) Procure and implement a new electronic social care recording system which enables effective case recording and data sharing and provides appropriate management information.** The IT contract has been awarded to Liquid Logic. This will be RAG rated as green once the implementation is complete and the system is embedded.
**SSCB Ofsted Action Plan**

This is the SSCB Ofsted Action Plan based on the findings of the Inspection of the SSCB in May 2015

<table>
<thead>
<tr>
<th>Ofsted Recommendation</th>
<th>Action</th>
<th>Lead</th>
<th>Progress</th>
<th>Deadline</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure full board approval of agreed priorities and action planning</td>
<td>Ensure governance arrangements for SSCB are agreed and attendance at SSCB and sub-committees is monitored</td>
<td>Independent Chair Business Manager</td>
<td>New governance arrangements and ToR for SSCB and all sub-committees agreed April 2015. Attendance being monitored at every meeting and reviewed by SSCB executive group</td>
<td>September 2015</td>
<td>Green</td>
</tr>
<tr>
<td>Agree business plan and priority areas</td>
<td></td>
<td>Independent Chair Business Manager</td>
<td>Business plan agreed by SSCB and key priorities agreed: Neglect – lead Kerry Mehta (SCC) Toxic Trio – Deanna Lagun (SCCG) Risk Taking Behaviours – Peter Storey (Northumbria Police)</td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td>Ensure all leads report progress on business plan and sub-committee activity to SSCB</td>
<td>Sub-Committee Chairs</td>
<td></td>
<td>New reporting templates introduced to ensure business plan is updated and exception reporting to SSCB</td>
<td></td>
<td>Green</td>
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<tr>
<td>Ofsted Recommendation</td>
<td>Action</td>
<td>Lead</td>
<td>Progress</td>
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<tr>
<td>Ensure that the board is able to effectively monitor the quality and impact of services for children across the partnership.</td>
<td>Embed the SSCB Quality Assurance and Performance Framework and agree dashboard/RAG Rating on key performance indicators</td>
<td>SSCB Quality Assurance Sub Committee Chair</td>
<td>QA and Performance Frameworks agreed.</td>
<td>January 2016 (amended from October 2015)</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Agree 12 Key Performance Indicators to report to SSCB</td>
<td></td>
<td>This action was reviewed and the Interim Chair requested a focus on &quot;obsessions&quot; which resulted in a change to the agreed multi-agency framework.</td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Report to SSCB to propose method/tools to support SSCB to effectively monitor quality and impact of services</td>
<td></td>
<td>QA framework agreed and a multi-agency audit cycle agreed.</td>
<td>January 2016 (amended from October 2015)</td>
<td>Green</td>
</tr>
<tr>
<td>Accelerate implementation of an early help strategy, ensuring that it is consistent with the 'multi-agency threshold guidance'</td>
<td>Launch and implement Early Help</td>
<td>Head of Community and Family Wellbeing</td>
<td>Implementation plan presented to SSCB Executive Group on 14.09.15 and agreed</td>
<td>January 2016 (amended from October 2015)</td>
<td>Amber</td>
</tr>
<tr>
<td></td>
<td>SSCB to raise awareness of thresholds for intervention as outlined in SSCB Early Help</td>
<td>SSCB/SSAB Training and Workforce Development</td>
<td>All training programmes reviewed. Application of thresholds included in the multi-agency early help launch sessions &amp; other SSCB</td>
<td></td>
<td>Amber</td>
</tr>
<tr>
<td>Ofsted Recommendation</td>
<td>Action</td>
<td>Lead</td>
<td>Progress</td>
<td>Deadline</td>
<td>RAG Rating</td>
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<tr>
<td>document and then monitor its effectiveness.</td>
<td>Strategy and Threshold Guidance</td>
<td>/Communication and engagement sub committee</td>
<td>training. Threshold guidance reviewed and updated.</td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td>Develop and deliver a programme of mandatory multi-agency workshops/training to ensure there is a comprehensive understanding of Early Help across partners</td>
<td>Develop and deliver a programme of mandatory multi-agency workshops/training to ensure there is a comprehensive understanding of Early Help across partners</td>
<td>SSCB/SSAB training and workforce development sub committee</td>
<td>Launch dates planned from November 2015.</td>
<td></td>
<td>Amber</td>
</tr>
<tr>
<td>Ensure dataset and quality assurance framework reflects activity and effectiveness of early help services</td>
<td>Ensure dataset and quality assurance framework reflects activity and effectiveness of early help services</td>
<td>SSCB Quality assurance sub-committee chair</td>
<td>Some data included in performance information to SSCB – this needs to be further developed. Early Help offer for Sunderland being reviewed and a new Director has been appointed – to commence Feb 2017.</td>
<td></td>
<td>RED</td>
</tr>
<tr>
<td>Review multi-agency training to ensure it supports and promotes frontline practice and is able to respond to demand following the imminent publication of a high number of Serious Case Reviews (SCRs); then ensure lessons are</td>
<td>Review multi-agency training to ensure it supports and promotes frontline practice and is able to respond to demand following the imminent publication of a high number of Serious Case Reviews (SCRs); then ensure lessons are</td>
<td>SSCB/SSAB training and workforce development sub-committee chair</td>
<td>SSCB trainers group meet bi-monthly and consider evaluations and content. Training is then updated as required.</td>
<td>December 2015 (amended from September 2015)</td>
<td>Green</td>
</tr>
</tbody>
</table>

Identify the multi-agency training needs from serious case reviews in Sunderland and externally where appropriate | Identify the multi-agency training needs from serious case reviews in Sunderland and externally where appropriate | SSCB learning and improvement in practice sub-committee chair | National learning outcomes are circulated to trainers i.e. NSPCC. All trainers receive a copy of SCRs when published. Learning outcomes are incorporated into training programmes. Vulnerable Baby training included | November 2015 (amended from September 2015) | Green      |
<table>
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<tr>
<th>Ofsted Recommendation</th>
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<tbody>
<tr>
<td>learnt and improvements embedded</td>
<td>Update SSCB training strategy and training programme based on the needs identified</td>
<td></td>
<td>in SSCB training programme and delivered within health settings.</td>
<td></td>
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<tr>
<td></td>
<td>LIIP sub-committee to oversee implementation of recommendations from SCRs and link with other sub-committees regarding training, policy change, assurance of action plans and communication and engagement.</td>
<td></td>
<td>Training programme reviewed training strategy needs refreshing</td>
<td>November 2015 (amended from September 2015)</td>
<td>RED</td>
</tr>
<tr>
<td></td>
<td>Undertake audit to measure the impact the training has made</td>
<td>SSCB development and training officer</td>
<td>Agreed process in place and outlined in the SSCB learning and improvement in practice framework</td>
<td>December 2015</td>
<td>Green</td>
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<tr>
<td></td>
<td>Agree with partner local authorities on child death overview panel (CDOP), a coordinated</td>
<td></td>
<td></td>
<td>October 2015 (amended from September 2015)</td>
<td>Red</td>
</tr>
<tr>
<td></td>
<td>Review and update the SOTW CDOP business plan</td>
<td>SSCB local child death review panel chair</td>
<td>Ofsted recommendation discussed at CDOP; and any improvement recommendations from inspections across the 3 localities to be included in CDOP business plan</td>
<td>January 2016 (amended from September 2015)</td>
<td>Green</td>
</tr>
<tr>
<td>Ofsted Recommendation</td>
<td>Action</td>
<td>Lead</td>
<td>Progress</td>
<td>Deadline</td>
<td>RAG Rating</td>
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<tr>
<td>response to the high number of SCRs awaiting publication</td>
<td>Planned review of CDOP and local panel arrangements to be undertaken to ensure robust arrangements are in place for the child death review process</td>
<td></td>
<td>Review to commence December 2015. Local and sub-regional arrangements to continue.</td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td>Ensure that multi-agency arrangements for the oversight of children missing and at risk of sexual exploitation or trafficking are driven by effective information sharing, performance monitoring, action planning and are strategically coordinated and monitored by the board.</td>
<td>Complete a multi-agency Child Sexual Exploitation (CSE) data mapping exercise</td>
<td>SSCB Chair</td>
<td>Section 11 Review completed Dataset/scorecard agreed MSET arrangements reviewed strategic CSE co-ordinator appointed.</td>
<td>February 2016 (amended from September 2015)</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Complete a CSE needs assessment to inform a developing action plan</td>
<td>SSCB MSET sub-committee chair</td>
<td>Section 11 Review completed Dataset/scorecard agreed MSET arrangements reviewed strategic CSE co-ordinator appointed. MSET delivery plan monitored by SSCB MSET sub-committee</td>
<td>February 2016 (amended from September 2015)</td>
<td>Green</td>
</tr>
</tbody>
</table>
| Agree and implement MSET Subcommittee arrangements to ensure robust attendance and engagement and CSE reporting arrangements to ensure SSCB has an up to date and informed view of current levels of risk, | Agree and implement MSET Subcommittee arrangements to ensure robust attendance and engagement and CSE reporting arrangements to ensure SSCB has an up to date and informed view of current levels of risk, | SSCB MSET sub-committee chair | • New ToR agreed for sub-committee  
• New ToR agreed for Operational MSET group  
• CSE Strategy approved at Joint SSCB/SSAB meeting on 12.10.15  
• MSET Performance reporting agreed | September 2015 | Green      |
<table>
<thead>
<tr>
<th>Ofsted Recommendation</th>
<th>Action</th>
<th>Lead</th>
<th>Progress</th>
<th>Deadline</th>
<th>RAG Rating</th>
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<tr>
<td></td>
<td>alongside intervention and disruption activity</td>
<td></td>
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<td></td>
<td>SSCB to commit to working in partnership to raise awareness of CSE</td>
<td>SSCB Chair</td>
<td>CSE Conference held 20.10.15 – led by Northumbria Police, Sunderland, South Tyneside and Gateshead LSCB. Press release made by Northumbria Police</td>
<td>September 2015</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>SSCB to contribute to the planning of team sanctuary south</td>
<td>SSCB MSET sub-committee chair</td>
<td>SSCB representation at briefing sessions Negotiations with LA ongoing re SW representation £97k non-recurrent monies available for health resources from April 2016 to support victim team across the 3 localities South of Tyne – unable to secure health secondment therefore clear health pathways established.</td>
<td>February 2016</td>
<td>Green</td>
</tr>
<tr>
<td>148</td>
<td>Review the resources available to undertake the governance of Multi-Agency Looked After Partnership (MALAP) to ensure a sufficient focus</td>
<td>MALAP to sit with LA and SSCB to hold it to account.</td>
<td>•Agreed at Development Session (20.09.15) and Executive Group Meeting (17.08.15) that MALAP to revert to Local Authority arrangements.</td>
<td>August 2015</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Brief report to go to SSCB</td>
<td>Interim Head of Looked After Children, Children's Services</td>
<td>MALAP report came to Joint SSCB/SSAB Meeting on 12.10.15 Reporting arrangements agreed.</td>
<td>October 2015</td>
<td>Green</td>
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</table>
## Appendix 3

### Specific Actions for Health Safeguarding Children Leads (extracted from the Local Authority’s Learning and Improvement Plan 2015 – 2016)

<table>
<thead>
<tr>
<th>PRIORITY</th>
<th>OUTCOME</th>
<th>ACTION</th>
<th>SUCCESS MEASURES</th>
<th>LEAD</th>
<th>TIMESCALE</th>
<th>PROGRESS UPDATE</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>Providing coherent and coordinated early help services to children and their families.</td>
<td>2.1 - Ofsted 18 Engage with partner agencies to implement an early help strategy and operational framework which clearly sets out the early help offer and referral pathways.</td>
<td>Early Help Strategic Group established; Early Help Strategy and operational framework developed; Training, guidance and information to support framework developed Early Help Strategy and operational framework implemented; There is a coherent and coordinated early help offer available to children and families and which meets their needs. Targeted early help interventions are effective at preventing</td>
<td>Acting Head Community &amp; Family Well-being SSCB</td>
<td>June 2016</td>
<td>Early Help Strategy agreed by SSCB Sept 2015</td>
<td>Green*</td>
</tr>
</tbody>
</table>
### 3.0 Improving the quality and timeliness of assessment and care planning.

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<thead>
<tr>
<th>Assessments and plans are timely and analytical with clear identification of needs and risks and a focus on measurable goals and outcomes for children and young people, including planning for permanency where this is appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.11 Implement the CAADA DASH tool to identify and assess the risk of domestic abuse and determine which cases should be referred to the MARAC and what other support should be provided.</td>
</tr>
<tr>
<td>There is an effective tool in place to identify and assess the risk of domestic abuse on children and young people which ensures that appropriate support is provided and appropriate cases are referred to the MARAC. Information provided informs the development of strategy and services for families affected by domestic violence. To be evidenced through compliance reporting and casework audits and service development.</td>
</tr>
<tr>
<td>Director Children’s Services &amp; Partners SSCB</td>
</tr>
<tr>
<td>All Health Providers are currently using the SafeLives (formerly CAADA) DASH tool to inform MARAC referrals. Designated Professionals have worked with SSP to develop the DA Resource Pack which has been endorsed by the SSCB and which supports all frontline practitioners working with victims and perpetrators of DA; this pack has informed the content of bespoke DA commissioned by the CCG for GPs.</td>
</tr>
<tr>
<td>6.0 Supporting young people leaving care to have a positive and successful transition to adulthood and independence</td>
</tr>
</tbody>
</table>

Further to the Leaving Care monitoring visit the health passport has been reviewed and the quarterly rates are improving – Q3 16/17 = 88%. A range of activities are in place to ensure those young people who do not attend their final appointment with the LAC health team have access to their health passport. This action is included in the LAC Health Green.
| 7.0 | Embedding strong quality assurance and governance mechanisms to drive continual improvement in services. | Services and outcomes for children and young people are continually improving because there are effective management and governance systems in place. | 7.1 - Ofsted 9 Develop and implement a multi-agency strategic plan with agreed priorities to shape services for children and young people in Sunderland based on a clear understanding of local need. | Children’s Strategic Planning Group Established; Information on local need gathered and analysed. Priorities agreed; Strategic plan is in place which informs the work of multi-agency partners and the local commissioning of services in line with need. To be evidenced through compliance reporting. | Director of Children’s Services | SSCB | 11/15 | 01/15 | 02/16 | 03/16 | Improvement Plan being monitored within the CCG. | Senior CCG representatives attend the newly established Children’s Strategic Partnership. Designated Professionals have supported the SSCB in the review of its strategic plan. SSCB Performance Framework agreed; led by CCG Executive Lead for Safeguarding (Director of Nursing, Quality & Safety). | As above; there are clear governance arrangements between the 3 statutory safeguarding partnerships, the Children’s Strategic Partnership and the | Green |
closely with the LSCB and improvement board. Health and Wellbeing Board.

* The green depicts the activity in 2015/16 in supporting the SSCB Early Help Strategy. The Sunderland offer regarding early help/early intervention is currently under review and health partners will support the Local Authority and Together for Children – Sunderland in establishing robust arrangements to ensure families receive the right help at the right time.

** SCCG have benchmarked health arrangements locally against the Joint Targeted Area Inspection Framework for Children living with domestic abuse and are currently working with the Local Authority to bid for funding to improve the recognition and management of domestic abuse within primary and secondary care settings.
GOVERNING BODY MEETING
31 JANUARY 2017

Report Title: Sunderland Cancer Plan

Purpose of report
The purpose of this report is to:

- update the governing body regarding the development and implementation of the Sunderland Cancer Plan
- seek sign off from the governing body for the dissemination and implementation of the Sunderland Cancer Plan across Sunderland

Key points, risks and assurances
The key points, risk and assurances:

- In response to the Five Year Forward View (2014) ambition to improve outcomes across the Cancer Pathway NHS England established the Independent Cancer Taskforce which published its report - Achieving World-Class Cancer Outcomes A Strategy for England 2015-2020 in July 2015. It set out a vision for modern, patient centred services listing 96 recommendations that when achieved should ensure that fewer people get preventable cancers; more people survive longer after diagnosis with a better quality of life and have better experiences of cancer services.

- In response to this and other significant national and local drivers, Sunderland CCG agreed that the development of a local cancer plan, to implement the national strategic aims was a strategic priority in 2016/17

- Assigning management and executive resource to this priority, the CCG developed a task and finish group, representative of the key stakeholders to agree the contents of the local plan. Other stakeholders were engaged separately to ensure that their views were considered.

- Following a prioritisation exercise of all 96 recommendations, the key priorities for Sunderland were identified and stakeholders assigned to lead on the implementation of these priorities over the next five years.

- The local plan, attached, sets out to improve cancer outcomes by reducing smoking, increasing screening uptake, early diagnosis and improving the patient cancer pathway experience including survivorship and end of life care.

- The Sunderland cancer plan will be launched at TITO on the 7th December and each stakeholder will ensure their organisation is aware of and bought into the implementation of the plan. The Health and Wellbeing Board will be cited on the plan in January 2017. The communication and engagement plan can be seen at Appendix 2.

- The implementation of the plan will be monitored via the task and finish group on a monthly basis to provide assurance to the CCG.
### Recommendation/Action Required

The governing body is asked to:

- Consider and discuss the contents of the plan
- Agree formal sign off of the Sunderland Cancer Plan

### Sponsor/approving director

<table>
<thead>
<tr>
<th>Claire Bradford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
</tr>
</tbody>
</table>

### Report author

<table>
<thead>
<tr>
<th>Laura Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality Commissioning Manager</td>
</tr>
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</table>

### Governance and Assurance

#### Link to CCG corporate objectives

(please tick all that apply)

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<tr>
<th>Corporate Objective</th>
<th>Item Ticked</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO1: Ensure the CCG meets its public accountability duties</td>
<td>X</td>
</tr>
<tr>
<td>CO2: Maintain financial control and performance targets</td>
<td></td>
</tr>
<tr>
<td>CO3: Maintain and improve the quality and safety of CCG commissioned services</td>
<td>X</td>
</tr>
<tr>
<td>CO4: Ensure the CCG involves patients and the public in commissioning and reforming services</td>
<td></td>
</tr>
<tr>
<td>CO5: Identify and deliver the CCG's strategic priorities</td>
<td>X</td>
</tr>
<tr>
<td>CO6: Develop the CCG localities</td>
<td></td>
</tr>
<tr>
<td>CO7: Integrating health and social care services, including the Better Care Fund</td>
<td></td>
</tr>
<tr>
<td>CO8: Develop and deliver primary medical care commissioning</td>
<td></td>
</tr>
</tbody>
</table>

#### Any relevant legal/statutory issues

None.

#### Are the identified risks on the risk register?

No

#### If issue/report has been previously reviewed please specify meeting and date

N/A

#### Equality analysis completed

(please tick)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

#### Key implications

Are additional resources required?

No
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has there been appropriate clinical engagement?</td>
<td>Engagement undertaken via GP Executive</td>
</tr>
<tr>
<td>Has there been/or does there need to be any patient and public involvement?</td>
<td>Healthwatch and the CHS patient group were engaged in the development of the plan</td>
</tr>
<tr>
<td>Any current or expected impact on patient outcomes/experience?</td>
<td>Yes. It is hoped that by implementing the local plan fewer people in Sunderland will get preventable cancers; more people in Sunderland will survive longer after diagnosis with a better quality of life and have better experiences of cancer services.</td>
</tr>
<tr>
<td>Has there been member practice and/or other stakeholder engagement if needed?</td>
<td>Yes via the task and finish group</td>
</tr>
</tbody>
</table>
Sunderland Cancer Plan
2016 - 2020
Document Control

Status

Current Status: Draft

Version History

<table>
<thead>
<tr>
<th>Number of this Version</th>
<th>Date of this version</th>
</tr>
</thead>
<tbody>
<tr>
<td>002</td>
<td>18.11.16</td>
</tr>
</tbody>
</table>

Previous Version Number | Previous version Date | Summary of Changes
---|---|---
001 | 06.10.16 | Action plan update; Addition to local context

Owner

Person responsible for this document: Laura Hope, Locality Commissioning Manager, 0191 5128271

Document Location

Electronic Version is located: X:\Localities\CANCER

Distribution List

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Responsibility</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Claire Bradford</td>
<td>Medical Director</td>
<td>Laura Hope</td>
<td></td>
</tr>
<tr>
<td>Dr Raj Bethapudi</td>
<td>GP Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Henry Choi</td>
<td>GP Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Task and Finish Group Members</td>
<td>Various</td>
<td></td>
<td></td>
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Associated Documents

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SUNDERLAND CANCER PLAN

Introduction

The Sunderland cancer plan has been developed by Sunderland Clinical Commissioning Group, with its key stakeholders, to ensure delivery of the cancer strategy for England 2015-2020 Achieving World Class Cancer Outcomes. This plan outlines how Sunderland CCG, in partnership with local health and care organisations, will implement the recommendations from the five year strategy, to improve outcomes for people affected by cancer in Sunderland.

1. Background

1.1 National context

Cancer is the biggest cause of death from illness in every age group in England with 130,000 deaths per year. Mortality is significantly higher in males than females. 280,000 people are diagnosed with cancer each year in England, increasing by 2% per annum with the expectation that new diagnoses will reach 3.4 million a year in 2030. Survival rates are lower than the best in Europe, quality of care is variable and the needs of people living with and beyond cancer are not always met.


The strategy lists 96 recommendations to be achieved which should ensure that fewer people get preventable cancers; more people survive longer after diagnosis with a better quality of life and have better experiences of cancer services. It focuses on six key priority areas:

- Prevention and public health;
- Early diagnosis;
- Patient experience;
- Living with and beyond cancer;

• Investment in a high-quality, modern service; and  
• Commissioning, accountability and provision.

The NHS England operational planning guidance requires that the health and care system must deliver on the recommendations of the independent cancer taskforce, including:

- significantly improving one-year survival to achieve 75% by 2020 for all cancers combined in England (up from 69% currently);
- delivery of the NHS Constitution 62 day cancer standard
- ensure patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP;
- ensuring all breast cancer patients have access to stratified follow up pathways of care and prepare to roll out for prostate and colorectal cancer patients;
- ensuring all elements of the recovery package are commissioned;

The NHS Constitution sets a statutory responsibility on CCGs to ensure delivery of the National Cancer Standards:

• 62-day wait from urgent referral for suspected cancer to first treatment for all cancers
• Patients are seen by a cancer specialist within two weeks from GP referral where cancer is suspected
• 31 day cancer from diagnosis to first definitive treatment for all cancers
• To make progress in improving one-year survival rates by delivering a year-on-year improvement in:

  - the proportion of cancers diagnosed at stage 1 and stage 2
  - reducing the proportion of cancers diagnosed following an emergency admission

NHS RightCare: Commissioning for Value 2016 identified significant variation in cancer diagnosis and care for the population of Sunderland. It identified potential opportunities to improve patient outcomes and drive efficiencies across pathways for people living with cancer in Sunderland. Through service re-design and implementing best practice examples NHS RightCare identified the potential to save 45 lives per year in under 75’s who have been diagnosed with cancer.
1.2 Local Context

Cancer is a strategic priority for Sunderland CCG in 2016/17. The Sustainability and Transformation Plan (STPs) has set out how the core recommendations of the national cancer strategy will be translated into local action.

For those recommendations which require footprints larger than STPs, Cancer Alliances will ensure their delivery. Sunderland CCG is a member of the emerging Northern Cancer Alliance and part of the STP delivery plans for the North East in achieving the future state / ambition for 2020/21:

- Fewer people getting preventable cancers improvements in screening including lung;
- More people surviving for longer after a diagnosis, with 57% of patients surviving ten years or more;
- More people having a positive experience of care and support; and,
- More people having a better long-term quality of life including use of third sector in regard to survivorship and in particular benefits advice
- More radical focus on delivering public health improvements at a population scale.
- Commissioning at scale i.e. a n STP level.
- Freeing capacity by stratification of patients in treatment with regard to follow ups starting with breast.
- Viewing cancer as we do long term conditions with key link workers and support

The Quality Premium for 17/18 and 18/19 set a national indicator for CCGs to improve the proportion of cancers diagnosed at stage 1 and 2.

In Sunderland cancer is the most common cause of mortality accounting for 30% of all deaths. This is slightly above the national average of 29%. Collectively cancers account for 17.9% of the gap between the Sunderland and England average for male life expectancy and 29.1% of the gap in female life expectancy. The four most common cancers in Sunderland are lung, prostate, breast and colorectal, accounting for 50% of all cancer deaths in Sunderland, compared to 46% across England.

Age standardised registration rates from all cancers, excluding non-melanoma skin cancer, has increased over the last 20 years in Sunderland from 526 per 100,000 population in 1995 to 637 per 100,000 in 2013. This was significantly higher than the England cancer registration rates which rose from 532 per 100,000 population in 1995 to 601 per 100,000 population in the same period.
In Sunderland the rate of premature deaths, (people aged under 75 years of age) is 171.89 per 100,000 population which is significantly higher than the national average of 141.9 per 100,000. Cancer prevalence in Sunderland is 2.64% slightly lower than the regional average of 2.75%, however prevalence was higher in males aged 60-64 years and females aged between 35 -39 years. This is mainly due to lung cancer deaths.

Cancer survival rates in Sunderland are similar to the England average for all tumour sites, except in colorectal cancer where the survival rate after one year is lower at 75.1% compared to the national average of 77.3%.

2. Vision

The vision for Sunderland CCG is the same as the national strategy - to prevent as many people from ever having to experience cancer in the first place. However, where cancer is suspected, there should be early diagnosis to ensure the best outcomes for treatment are available and enable people to live for as long and as well as is possible.

3. Sunderland Plan

The Sunderland plan reflects the priorities and ambitions of the national strategy. Through a strict process of prioritisation, by a number of stakeholders, 28 local priorities have been identified, across the six themes. These will be the focus for action to meet the requirements of the national strategy by 2020.

The main areas for action are described below. The full plan with associated actions can be seen at Appendix 1.

3.1 Prevention

Sunderland population experiences a higher level of social and economic disadvantage than the England with 38% living in areas that are among the 20% most disadvantaged across England. There were 1,676 cancer registrations in Sunderland in 2013. Lung cancer, prostate cancer, breast cancer and colorectal cancer account for 52% of these registrations in Sunderland compared to 54% of these registrations across England.
Levels of deprivation have a significant impact on cancer incidence. In England there would be around 15,300 fewer cases and 19,200 fewer deaths per year across all cancers combined if socio-economically deprived groups had the same incidence rates as the least deprived.²

More than half of the inequality in overall life expectancy between social classes is linked to higher smoking rates among poorer people. Approximately 60% of premature mortality from cancers is considered preventable through broad public health activities and 42% of cancers are linked to a range of major lifestyle factors e.g. smoking. In Sunderland 23% of adults smoke compared to 18% across England and the smoking rate is much higher in routine and manual groups.³

In 2014 in Sunderland the rate of premature deaths, (people aged under 75 years of age) was 171.89 per 100,000 population which is significantly higher than the national average of 141.9 per 100,000.⁴ 50% of all cancer deaths were deemed premature compared to 46% of all cancer deaths across England.

The rate of premature deaths due to lung cancer in Sunderland is significantly higher than the national average at 49.4 per 100,000 population. In 2014, 53% of lung cancer deaths in Sunderland were premature compared to 51% of lung cancer deaths across England⁵

Preventing premature deaths due to lifestyle factors is a key priority for health partners in Sunderland. The CCG strategic plan has a focus on prevention. Working with Sunderland City Council and voluntary and community groups we will implement effective evidence based interventions to reduce the age-standardised cancer incidence.

³ All Together Sunderland (2016) Cancer Needs Assessment: Sunderland City Council
⁴All Together Sunderland (2016) Cancer Needs Assessment: Sunderland City Council
⁵ Indicator Portal. Health and Social Care Information Centre.
National Strategic Priority:

Spearhead a radical upgrade in prevention and public health to significantly reduce the 40% of cancers caused by behavioural, lifestyle and environmental factors.

National Ambition 1:
To reduce adult smoking prevalence to less than 13% by 2020 and less than 5% by 2035, and reduce smoking among routine and manual workers to 21% by 2020.

We are committed to achieving our Quality Premium target to improve the smoking quit rate by 4% to 57% by 2017.

National Ambition 2:
To significantly reduce the 40% of cancers caused by behavioural, lifestyle and environmental factors.

We will work with Sunderland City Council to implement the national Tobacco Control Plan.

National Ambition 3:
To ensure all patients treated for cancer are provided with lifestyle advice which is tailored to their individual circumstances.

We will support Sunderland City Council to implement the local Obesity plan.

We will continue to support the Live Life Well service to deliver “integrated wellness”.

3.2 Screening and early diagnosis

Population-based cancer screening programmes currently detect approximately 5% of all cancers. However, uptake of screening is varied across the country which impacts on the detection rate. In Sunderland screening rates were above average for breast screening, however coverage ranged from 59% in some practices to 84%.

Bowel screening rates are slightly below the England average and significantly below the regional average. For Sunderland to achieve the England bowel screening average in 16/17, practices would need to encourage 200 more registered patients to undertake and return the FoBT kits by March 2017.

Fig. 1 Screening Coverage in Sunderland 2016

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>CCG Average</th>
<th>Regional Average</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Type</td>
<td>Cervical screening coverage by GP practice - (females aged 25-64 screened for cervical cancer in last 42/66 months) (2016)</td>
<td>75.33%</td>
<td>76.0%</td>
<td>73.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Range: 61.13 – 86.45%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast screening coverage by GP Practice - (females aged 50-70 screened for breast cancer in last 36 months) (2016)</td>
<td>78.13%</td>
<td>75.2%</td>
<td>72.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Range: 59.93 – 84.72%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bowel screening coverage by GP Practice - (Persons aged 60-69 screened for bowel cancer in last 30 months) (2016)</td>
<td>57.48%</td>
<td>60.2%</td>
<td>57.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Range: 38.71 – 66.90%</td>
<td></td>
</tr>
</tbody>
</table>

The national strategy sets out an ambition of 75% uptake for Faecal Immunochemical Test in the bowel screening programme by 2020 which will be a challenge for Sunderland to achieve. The test is more sensitive and easier to use than the current testing kit and when piloted improved uptake in the cohort who used it.

Sunderland CCG will work with NHS England commissioners to utilise evidence based systems to increase uptake of bowel screening. This is being assisted by the work that Cancer Research UK are doing in visiting practices to identify areas of good practice and reduce clinical variation.
The national strategy estimates that through earlier diagnosis 11,000 patients can survive cancer for ten years or more by 2020. Earlier diagnosis makes it more likely that patients will receive treatment quicker which contributes to more positive outcomes. When lung cancer is diagnosed at the earliest stage, more than 8 in 10 people survive for at least a year, but less than 2 in 10 people are diagnosed at the earliest stage\textsuperscript{6}.

In Sunderland 26.7\% of lung cancers were diagnosed at stage 1 and 2, significantly higher than the national average of 20.8\% and some of the best performing CCGs. Increasing the proportion of cancers diagnosed at stage 1 and 2 will result in fewer cancers diagnosed as an emergency, and an increase in one and five-year survival rates.

The CCG improvement and assessment framework assessment of new cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed at 53.4\% in Sunderland. This is higher than the national average of 48.2\%.

Greater use of the 2 week wait pathway has shown to be linked with reduced mortality\textsuperscript{7}. However, nationally only 27\% of cancers are diagnosed through this route.

In quarter one of 2016/17 Sunderland met the 2 week wait and 32 day targets but missed the 62 day target with a performance of 81\%. Direct access testing and improving routes to referral are areas for improvement to ensure these are achieved.

In Sunderland 22\% of cancers were diagnosed through emergency presentation higher at the England average of 20\%. Lung cancer emergency presentations were worse than the England average with 20.1 per 100,000. However the most significant variation from the England average is seen in colorectal cancers where 51.5 per 100,000 were diagnosed through emergency presentation in 14/15\textsuperscript{8}.

The national strategy sets out an ambition that by 2020, 95\% of patients referred by a GP with a suspected cancer should receive a definitive diagnosis within 28 days. This is reflected in the STP priorities. It is hoped that by increasing provision of GP direct access to key investigative tests for suspected cancer and implementing new diagnostics such as flexi sigmoidoscopy there will be improved outcomes for patients once diagnosed.

\textsuperscript{8} Public Health England, 2016, NHS Right Care Commissioning for Value Focus Pack - Cancer and tumours
National Strategic Priority:

Drive a national ambition to achieve earlier diagnosis through improved screening uptake and rapid access to diagnostics;

National Ambition 1:
To improve bowel screening uptake in Sunderland

Support NHS England to roll out the Faecal Immunochemical Test (FIT) in 2018

National Ambition 2:
To improve one year survival rates to 75% by 2020 compared to 69% currently and reduce variation

Support Cancer Research UK to advise practices on best practice and guidance to improve screening rates

Roll out direct access CT and MRI scanning where clinically appropriate in 16/17

National Ambition 3:
Patients are given a definitive cancer diagnosis, or the all clear, within 28 days of being referred by their GP.

The CCG have commissioned a breast assessment one stop shop to see and diagnose on the same day.
3.3 Patient Experience

The national Cancer Patient Experience Survey (CPES) 2015, commissioned and run by NHS England annually, is a sample survey of all adult NHS patients, with a confirmed primary diagnosis of cancer and were discharged after cancer related treatment between April and June 2015.

Nationally the CPES results have been positive overall however, the national strategy states that this masks considerable variability. Poor communication is the aspect of care most identified by patients. They have identified improvement in information given about diagnosis and treatment options, and in the level of compassion and empathy received.

391 patients in Sunderland responded to the survey in 2015, a 65% response rate. Overall these patients gave their overall care an average rating of 8.8, using a scale of zero (very poor) to 10 (very good). This was slightly above the national average of 8.7%.

There were 50 questions of which the key patient experience domains: provision of information; involvement in decisions; care transition; interpersonal relations, respect and dignity, are shown below:

Fig. 2 Extracts from the CPES survey 2015

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Indicators</th>
<th>No. of Respondents</th>
<th>Sunderland Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Respondents were definitely involved as much as they want to be in decisions about their care and treatment</td>
<td>389</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>17</td>
<td>Were given the name of a Clinical Nurse Specialist who would support them through their treatment</td>
<td>386</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>18</td>
<td>Respondents found it easy or very easy to contact their clinical nurse specialist</td>
<td>333</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td>37</td>
<td>Respondents that felt overall they were always treated with respect and dignity in hospital</td>
<td>251</td>
<td>87%</td>
<td>87%</td>
</tr>
</tbody>
</table>
Respondents stated that hospital staff told them who to contact if they were worried about their treatment or condition after leaving hospital.

<table>
<thead>
<tr>
<th>39</th>
<th>242</th>
<th>97%</th>
<th>94</th>
</tr>
</thead>
</table>

This shows that Sunderland is performing either above or on par with the national average in terms of patient experience, however there is a need to maintain or continuously improve. This will ensure that the national strategy’s vision, for what cancer patients can expect from health services, is met.

One area highlighted through NHS RightCare, where Sunderland were an outlier in relation to its peers and nationally, was in the provision of patient information. Only 66% of patients received information about their operation compared to 75% nationally.

The national strategy seeks to enhance access to the digital technology to address these needs as well as roll out more cancer nurse specialists and the recovery package to give patients more support following diagnosis. The CCG have a focused IT strategy to implement the Digital Roadmap in Sunderland. Online patient access to cancer diagnosis and treatment will be part of this.
National Strategic Priority

Establish patient experience on a par with clinical effectiveness and safety by harnessing digital technologies and ensuring clinical nurse specialists are available to offer support;

National Ambition 1:
To achieve access to all test results and other communications involving secondary / tertiary care providers online, for all patients by 2020

The CCG are progressing with the digital roadmap and currently patients have access to notes and online booking in general practice

National Ambition 2:
Encourage providers to ensure that patients have access to a Cancer Nurse Specialist or key worker from diagnosis through to treatment options

Sunderland City Hospitals are reviewing their current CNS roles to inform future provision

National Ambition 3:
All providers should have a directory of service available both on paper and electronically

Sunderland City Hospitals have a paper directory and will look to put this online by March 2017
3.4 Living with and beyond cancer

The Sunderland one-year survival rate for all cancers, excluding non-melanoma skin cancer and prostate cancer, diagnosed in 2012 was 68.6%. This is statistically significantly lower than the England one-year survival index of 69.3%. This is most apparent in colorectal cancers where the Sunderland survival rate is 75.1%, statistically significantly lower than the England one-year survival rate of 77.3%.

An increasing number of patients survive their primary cancers. However this cohort of patients is more likely to develop a second cancer or to have a recurrence. Exercise has shown to reduce the risk of a number of different types of secondary cancer by 10-50% and also to reduce the risk of cancer-specific death. The role of the GP is also key to ensure that patients who have been previously treated for cancer are quickly investigated if they present again with symptoms which could be cancer.

The use of stratified follow-up pathways – which comprise needs assessment, support for patients to self-manage, remote monitoring and re-entry pathways can offer a more effective approach to aftercare than traditional medical models of follow-up. Implementing these, firstly in breast cancer should enable people to feel in control of their care and regain a good quality of life.

One in four people who have been treated for cancer live with ill health or disability as a consequence of their treatment. Better support for people after treatment can deliver significant benefits in terms of improved quality of life. Everyone who gets cancer is different and the care and support they will need to live with a cancer diagnosis will be different. The national strategy states that the recovery package is a combination of different interventions, which when delivered together, can greatly improve the outcomes and coordination of care, fully supporting the patient's individual needs.

Cancer does not discriminate, it affects people of all ages and backgrounds therefore recovery from and management of cancer is an individual experience. Research has shown that people who have had cancer would like more information about how to approach lifestyle changes. They would also welcome support tailored to their individual needs. Many of the interventions needed for

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12 NCSI, Living with and Beyond Cancer: Taking Action to Improve Outcomes. 2013, National Cancer Survivorship Initiative.
people affected by cancer are the same as those living with other long term conditions and should follow the principles of person centred care as laid out in the NHS England Long Term Conditions Framework.

Sunderland CCG are currently reviewing their long term conditions management services and proposing a new model of provision. This would incorporate rehabilitation and support services for people with a range of long term conditions, including those with cancer. As this is in the developmental stages it offers an opportunity to influence service design to incorporate the national strategy recommendation.

Cancer patients at the end of their lives are often not experiencing the care that they would have chosen. Nationally around three in four people with cancer would prefer to die at home with the right support, rather than in a hospital or hospice. However, nationally less than a third are able to exercise that choice at present.

Evidence shows that early referral to palliative care leads to better quality of life, reduced symptom burden, less exhaustive care, and lower costs. NHS RightCare highlighted the opportunities for improvement in Sunderland’s palliative care services.

Sunderland CCG have identified end of life care as a strategic priority and developed a work plan which includes training and guidelines for providers and implementation of an Electronic Palliative Care Coordination System to enable access to shared records. A service review is underway to ensure the provision of response 24/7 palliative care services for Sunderland.

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13 NHS England (2016) Cancer Taskforce Recommendations: Commissioning Person Care For People Affected by Cancer; LONDON


National Strategic Priority
Transform the approach to support people living with and beyond cancer

National Ambition 1:
Patients living with and beyond cancer have access to elements of the recovery package by 2020.

National Ambition 2:
CCGs commission integrated services for palliative and end of life care, in line with the NICE Quality Standard (2011)

National Ambition 3:
Increase in 5 and 10 year survival rates to 57% by 2020 and reduce variation

CHS will review the elements of the recovery package and plan for implementation of the NHSE service specification

The CCG are currently reviewing palliative care services in Sunderland and will ensure 24/7 access

Sunderland CCG and HWB will work together to identify and promote best practice to support people living with and beyond cancer.
3.5 High Quality Modern Services

Through research we have begun to understand more about the highly diverse nature of some cancers and the short and long term impacts of diagnosis. This coupled with the opportunities offered by new therapies and digital technologies have to potential to improve communication as well as improve outcomes for people diagnosed with cancer.

All cancers develop because something has gone wrong with one or more of the genes in our cells. Our knowledge of these genetic faults is now advanced enough to offer the potential to implement active surveillance for individuals at high risk.

Genetic testing is available to identify hereditary non-polyposis colorectal cancer (HNPCC), also known as Lynch Syndrome and the mutated BRCA1 or BRCA2 gene instrumental in the development of breast, ovarian and prostate cancer. Identification of these faulty genes, in families of patients currently diagnosed with these conditions, can enable preventative action to be taken for those at high risk, such as regular screening or the use of chemo-preventive agents.

Harnessing new technology to improve patient safety and provide speedy access to medication for patients is key. Electronic prescribing of all cancer medicines has been mandatory for providers since 2006, however, the latest national Peer Review report identified that 59% of clinical teams still do not comply fully. City Hospitals Sunderland are currently implement cancer e-prescribing which should be completed in 2017. New sanctions will be introduced in 2016/17 to encourage e-prescribing.

Ensuring this is realised in Sunderland is part of the CCGs work with general practices to implement the digital roadmap. Supporting practices to achieve patient online access to prescribing, access and test results. This is a contractual requirement and should be fully functional by 2020.

It is estimated that there are more than 150,000 people living with advanced and incurable bowel, breast and prostate cancer across the UK. Patients with metastatic cancer, have unique needs which need to be recognised as distinct by MDTs when planning care. Working as part of the cancer Alliance, Sunderland CCG encourage MDTs to enable swifter decisions and appropriate care planning for this cohort of patients.
National Strategic Priority
Making the necessary investments required to deliver a modern high quality services.

National Ambition 1:
Sanctions should be introduced for any provider not complying with electronic prescribing by March 2016.

National Ambition 2:
NHS commissioners should ensure that appropriately aged cancer patients are offered applicable genetic testing at diagnosis.

National Ambition 3:
Encourage MDTs to consider appropriate pathways of care for metastatic cancer patients.

CHS are implementing electronic prescribing in 2016/17. The CCG are supporting practices to implement patient online access by 2020.

Sunderland CCG will work as part of the Cancer Alliance to progress a standardised approach for applying genetic testing by 2020.

Sunderland CCG will work as part of the Cancer Alliance to encourage MDTs to use standardised pathways for this cohort of patients by 2020.
3.6 Commissioning

The cancer pathway is complex. The many types of cancer, an evolving evidence base, and the involvement of a number of services from primary through to tertiary care makes commissioning for cancer care multifaceted and prone to fragmentation.

The national strategy recognised the need for greater strategic coherence in commissioning cancer care and stated that integrated Cancer Alliances should be established at a sub-regional level to address variation and ensure a standardised approach to commissioning. Bringing together leaders from different health and care settings to look at whole pathways and agree shared ambitions will enable improved cancer outcomes for populations based on their local outcome.

Sunderland CCG is engaged with and will be part of the emerging Northern Cancer Alliance which covers the North East and north Cumbria – a population of 3 million and 12 CCGs, ensuring a standardised approach to commissioning across the patch.

This plan adheres to the set of principles that guide the commissioning of different services at different levels set out in the national strategy:

- **Expertise of commissioners** –
- **Improved outcomes for patients** –
- The need to get best value for money.
- The need for adequate volumes of patients to

The learning from the cancer Vanguards and Alliances will be important as we look to roll out transformational change and will influence the plan as this becomes clear.

Commissioning for patients with metastatic disease to improve survival rates is also a key area for commissioning. Bisphosphonates have shown through randomised control trials to help some post-menopausal women treated for early breast cancer reduce the risk of spreading to the bone by 28% and of dying from breast cancer by 18% after ten years. Following the production of NICE guidance on prescribing Sunderland CCG will look to ensure standardised prescribing.

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National Strategic Priority

Ensuring commissioning, provision and accountability processes are fit for purpose

National Ambition 1:
Ensure GPs are prescribing chemo preventive agents to reduce the risk of invasive breast cancer in line with NICE guidelines.

National Ambition 2:
NHS England should encourage providers to streamline MDTs and audit patients who have died within 30 days of treatment

National Ambition 3:
Cancer surgery where volumes are between 2500 and 7500 per year should be commissioned by a lead CCG for populations of 1 to 2 million

Sunderland CCG medicines Optimisation team will support and roll out NICE guidelines once NHS England provide guidance

NHS England are looking at developing collaborative commissioning for upper GI patients following MDT

This work will be driven by the Cancer Alliance and take the learning from the Cancer Vanguard pilots
4. Implementation of the Plan

The plan outlines the key priorities for Sunderland CCG and its key stakeholders to improve cancer outcomes by 2020. The plan has been developed and will be implemented through the following mechanisms:

- **Plan on A Page**
  Cancer is a strategic priority for Sunderland CCG. Executive, clinical and management leads have been aligned to progress the development and implementation of this plan at all levels within the health and care system in Sunderland. They will champion and oversee the implementation of the plan over the next five years.

- **Clinical Leadership**
  Sunderland CCG has two dedicated clinical leads for cancer who have been heavily involved in the development of this strategy. They will be key to implementing it and championing the actions and initiatives within general practice.

- **Cancer Task and Finish Group**
  The implementation of this plan will be overseen by the Cancer Task and Finish group, chaired by Sunderland CCG’s Medical Director. This is a multi-stakeholder group which developed the plan, identified the areas for action which they will lead on and will now feedback and monitor on implementation of the plan.

  This group feeds directly and reports into the CCG Executive Committee on a monthly basis to provide assurance that the implementation of the plan is having a positive effect on patient outcomes.

- **Working with Stakeholders**
  Sunderland CCG will not be able to realise this plan without working closely with other key stakeholders including local provider organisations (City Hospitals Sunderland NHS FT, general practice), Sunderland City Council, Northern England Strategic Cancer Network (NESCN) NHS England, and patients, carers and others who are affected by cancer.

  Through the task and finish group we will implement and monitor progress of the plan to ensure the successful delivery of the actions.
# SUNDERLAND CANCER PLAN PRIORITIES & ACTIONS

<table>
<thead>
<tr>
<th>Priority</th>
<th>Recommendation No.</th>
<th>Ambition</th>
<th>Action</th>
<th>Lead Organisation</th>
<th>Milestones and Targets</th>
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<tbody>
<tr>
<td>Spearhead a radical upgrade in prevention and public health</td>
<td>2 of 96</td>
<td>To reduce adult smoking prevalence to less than 13% by 2020 and less than 5% by 2035, and reduce smoking among routine and manual workers to 21% by 2020.</td>
<td>Work with partners across the city to implement the outcomes of the national Tobacco Control Plan, taking a whole systems approach to identify and treat tobacco dependence.</td>
<td>Sunderland City Council – Public Health (SCC)</td>
<td>To reduce adult smoking prevalence to less than 13% by 2020 and targets by 2025.</td>
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<td></td>
<td>STP Aide Memoire ambition to prevent cancer and take steps to reduce national rate by 2020.</td>
<td>Sunderland Tobacco Alliance continues to work on the priorities of the national Tobacco Control Plan: • stopping the promotion of tobacco; • reducing affordability; • regulation of tobacco products; • helping tobacco users to quit; • reducing exposure to second hand smoke; and • effective communications for tobacco control.</td>
<td></td>
<td>Local ambition signed off by the Health and Wellbeing Board to go further faster to reduce adult smoking prevalence to 5% by 2025</td>
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<td>Based on the findings of the engagement work, Sunderland City Council will produce and consult on a draft Cumulative Impact policy will be agreed by the end of 2016/17 and rolled out in</td>
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<td>Cumulative Impact policy will be agreed by the end of 2016/17 and rolled out in</td>
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### Impact Policy

The CCG have identified prevention as an area on their Plan on a Page and will support the approach by Sunderland City Council and live life well to “make every contact count” across the health and care system. An action plan is being developed to be implemented.

The System Resilience and Transformation Board have agreed to develop and roll out training for clinical staff in brief interventions for smoking and alcohol across all Trusts. Non clinical staff can access the Sunderland Health Champions training.

We are committed to achieving our Quality Premium target to improve the smoking quit rate by 4% to 57% by March 2017 and are strengthening current measures to reduce smoking rates.

Take a co-ordinated approach to implementing the Be Clear on smoking quit rate by 4% to 57% by March 2017.
| 3 | To significantly reduce the 40% of cancers caused by behavioural, lifestyle and environmental factors and support implementation of a Sunderland obesity strategy | The CCG have identified prevention as an area on their Plan on a Page and will support the approach by Sunderland City Council to “make every contact count” across the health and care system.  
We will continue to support the Live Life Well service to deliver “integrated wellness” and a holistic approach to public health interventions which improve healthy lifestyles.  
We will redesign the NHS Health Checks programme to provide a systematic and holistic approach to assessing lifestyle risk factors and promoting self-care - by giving information, providing or signposting to relevant services.  
As part of its work to reduce the | Sunderland City Council – Public Health (SCC) | Action plan developed by March 2017 and implemented 17/18 | April 2017 |  
To reduce the rate of binge drinking adults from 30% to |
|   | To ensure all patients treated for cancer are provided with lifestyle advice which is tailored to their individual circumstances | Providers to agree standardised patient leaflet which is rolled out to patients as part of an integrated approach. To explore what lifestyle advice is available in the community; work with the CCG re smoking cessation, dietary advice, exercise etc. Scope what available, Sunderland City Hospital Foundation Trust (CHSFT) & Newcastle upon Tyne Hospitals Foundation Trust (NUTHFT) | To produce a leaflet by 2017 | national average 20%  
To reduce the rate of obesity in Sunderland by 2020  
To increase the number of healthy eating adults from 53% to 54%  
To increase the % of adults who are physically active from 49% to 57%  

harm associated with alcohol use, Sunderland City Council is currently undertaking engagement work to inform development of a Cumulative Impact Policy (CIP) within the Statement of Licencing Policy by the end of March

Sunderland City Council are developing an approach to promoting healthy weight environments, evaluating the implementation of the Live Life Well services, working to develop and/or promote a range of self-care tools.

The CCG are reviewing the tier 2 and tier 3 services/ pathway to inform commissioning of a full range of services including weight ‘maintenance’ programmes |
<table>
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<tr>
<th>Drive a national ambition to achieve earlier diagnosis</th>
<th>10</th>
<th>To improve bowel screening uptake to 75% by 2020</th>
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<tr>
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<td>To support NHSE to roll out the Faecal Immunochemical Test (FIT) into the Bowel Cancer Screening Programme</td>
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<td>To support GPs to take responsibility for driving increased uptake of FIT and bowel scope in their populations when it is introduced in 2017/18</td>
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<td>To work with CRUK to review practice profiles with GP practices and share best practice in screening. Action plans will be developed for each practice which the CCG will support to implement.</td>
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<td>To explore the use of texting and birthday cards to recall patients in General Practice for screening appointments.</td>
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<td>In 16/17 SCCG implemented an incentive scheme with its member practices to improve screening</td>
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<td>Cancer Alliance (CNE)</td>
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<tr>
<td></td>
<td></td>
<td>To improve bowel screening uptake by 2018 from 57.4% to national average 57.9%</td>
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<tr>
<td>NHSE Public Health Commissioning Team (NHSEPH)</td>
<td>To implement action plans by March 2017</td>
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<td>To feed results into development of QP by March 2017</td>
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<tr>
<td>11</td>
<td>To enable access to HPV testing by 2020</td>
<td>CCG to support NHS England to drive the roll-out of primary HPV testing into the cervical screening programme via TITO / locality communications</td>
</tr>
</tbody>
</table>

rates in people with learning disabilities. The results and methods used to improve uptake will be reviewed and considered for the Quality Premium in 2017/18.
|   | To support Public Health England “Be Clear on Cancer” campaigns including focus on lung and breast  
STP Aide Memoire ambition diagnosing more cancers early | To take a co-ordinated approach to supporting the local campaign roll out in general practice and monitor any impact in hospitals on demand and impact on stage at diagnosis. | SCC and SCCG | December 2017 and annually until 2020 |
|---|---|---|---|---|
| 16 | To improve one year survival rates to 75% by 2020 compared to 69% currently and reduce variation | To support dissemination of NICE referral guidelines and ensure implementation in general practice via existing communication methods.  
To support the use of Map of Medicine to make cancer referrals and monitor the impact on reducing variation through the use of standardised pathways.  
To roll out and embed the urology 2ww referral guidance via Map of Medicine in September 2016 with Lower GI, Upper GI/HPB, CNS and cancer of unknown primary to follow. | Sunderland CCG & Northern England Strategic Cancer Network (NESCN) | To improve one year survival rates year on year to 75% by 2020 |
| 17 | NHS England should mandate that GPs have direct access to key investigative tests for suspected cancers | SCCG and CHS are developing clear protocols for direct access to CT and MRI scanning to be rolled out into General Practice | NHSE, Sunderland CCG | December 2016 |
| 18 | The Quality Premium indicator of 60% to improve the proportion of all cancers diagnosed at stage 1 and 2. Currently at 53.4% 62% of cancers should be diagnosed at stage 1 or 2 by 2020. |
| 24 | A direct access model for practice contact with a consultant for advice in cases of children with suspected cancer is to be launched and evaluated. Flexi sigmoidoscopy is to be used from April 2017 for screening which should improve access to diagnostics for patients and identify polyps and masses earlier. |

A direct access model for practice contact with a consultant for advice in cases of children with suspected cancer is to be launched and evaluated. Flexi sigmoidoscopy is to be used from April 2017 for screening which should improve access to diagnostics for patients and identify polyps and masses earlier.

| 18 | NHS England should incentivise the establishment of processes by GP practices to ensure ‘safety-netting’ |
| 24 | SCCG and CRUK are visiting practices to encourage and support implementation of safety netting’ as part of the SEA process. This will be supported through the proposed cancer improvement scheme for general practice. SCCG will monitor its impact and the learning will inform future service delivery. |

SCCG and CRUK are visiting practices to encourage and support implementation of safety netting’ as part of the SEA process. This will be supported through the proposed cancer improvement scheme for general practice. SCCG will monitor its impact and the learning will inform future service delivery.

| 24 | Patients referred for testing by a GP, should either be definitively diagnosed with cancer or cancer excluded and this result communicated to the patient within four weeks result to be communicated to 95% of |
| 24 | SCCG and CHS are exploring new diagnostics such as ambulatory lung biopsy and direct access CT scanning for patients with unexplained symptoms as ways of reducing referral time to diagnosis. The CCG have commissioned a |

SCCG and CHS are exploring new diagnostics such as ambulatory lung biopsy and direct access CT scanning for patients with unexplained symptoms as ways of reducing referral time to diagnosis. The CCG have commissioned a

| 18 | To implement October 2016 |
| 24 | Implementation by March 2017 |

NHSE, Sunderland CCG CHSFT & NUTHFT

| 18 | NHSE, Sunderland CCG & Cancer Research UK (CRUK) |
| 24 | Implementation at |

March 2017
| 25 | All GPs should undertake a Significant Event Analysis for any patient diagnosed with cancer as a result of an emergency admission. **NHS Constitutional standard to reduce the proportion of cancers diagnosed through** | SCCG and CRUK are visiting practices to encourage the use of SEAs and provide support. **Practices will be supported to undertake SEA’s through the proposed cancer improvement scheme for general practice.** | Sunderland CCG & CRUK | March 2017 | To reduce no. of diagnoses made |
| Establish patient experience on a par with clinical effectiveness and safety | 57 | To achieve access to all test results and other communications involving secondary / tertiary care providers online, for all patients by 2020, to include all GP records thereafter. | Sunderland CCG is working with practices to support patient online access as this is a contractual requirement and part of the digital roadmap. This should be fully functional by 2020. | Sunderland CCG, NHSE & CHSFT | 2020 | March 2017 |
|---|---|---|---|---|---|
| | 61 | • NHS England should encourage providers to ensure that patients have access to a cancer nurse specialist or key worker from diagnosis onwards, to guide them through treatment options  
• Priority in STP aide memoire to improve cancer treatment and care, | Lead nurse (CHS) to do mapping exercise and determine current position, further actions pending following review. The implications will need to be considered for general practice. | NHSE, Sunderland CCG, CHSFT & NESCN | March 2017 |
<table>
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<tr>
<th>Transform the approach to support people living with and beyond cancer</th>
<th>62</th>
<th>NHS England should encourage all hospital providers to provide a directory of services (electronic and on paper) and facilitate local cancer support groups (e.g. by providing free space)</th>
<th>CHS have developed a directory of services which is currently available on paper. This will be made available electronically in 16/17</th>
<th>SCCG &amp; CHSFT</th>
<th>March 2017</th>
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<tr>
<td></td>
<td>41</td>
<td>NHS England should pilot a comprehensive care pathway for older patients (over 75s) incorporating an electronic health needs assessment.</td>
<td>A baseline assessment of use of health needs assessment and electronic health needs assessment will be undertaken. The Cancer Alliance will lead this pathway after the NHSE pilot</td>
<td>NHSE &amp; NESCN</td>
<td>March 2018</td>
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</table>
| | 63 | The NHS and partners should drive forward a programme of work to ensure that people living with and beyond cancer are fully supported and their needs are met.  
  - To develop a secondary prevention model in conjunction with commissioners and providers.  
  - To identify where interventions and referrals to community health and wellbeing services can be incorporated into pathways | The Cancer Alliance clinical lead will work with local commissioners to advise on pathways  
CHS will host discussions to define what services should look like to meet requirements with the Cancer Network. | CHSFT and NESCN | March 2018 |
<table>
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<th>Page</th>
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| 65   | • NHS England should ensure that patients living with and beyond cancer have access to elements of the recovery package by 2020.  
  • NHS Operational Planning Guidance and STP aide memoire ambition to develop enhanced support for cancer sufferers |
|      | A review of what is available in Trusts will be undertaken and the implications for General Practice highlighted.  
  CHS will host discussions to define what services should look like to meet requirements. |
|      | NHSE, Sunderland CCG & CHSFT  
  | March 2018 |
| 66   | • NHS England should with NICE develop a guideline, by mid 2016, for a minimum service specification for the Recovery Package which will be commissioned locally for all patients and performance. Roll out all aspects of the recovery package. |
|      | A review of what is available in Trusts currently and the implications of this for General Practice will be undertaken. CHS will host discussions to define what services should look like to meet requirements. |
|      | NHSE, CHSFT & NESCN  
  | March 2017 |
| 67   | • The Trust Development Authority and NHS England should ensure all providers are incentivised to start implementing stratified follow-up pathways of care for patients treated for breast cancer |
|      | To await guidance and assess ability to implement |
|      | NHS E  
<p>| 2020 |</p>
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<tr>
<th></th>
<th>NHS Operational Planning</th>
<th>Guidance must do</th>
<th>CCGs and HWBs should work to identify and promote best practice in approaches to support people living with and beyond cancer which is communicated to stakeholders.</th>
<th>SCCG, SCC &amp; CHSFT</th>
<th>March 2018</th>
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<tbody>
<tr>
<td>73</td>
<td>Increase in 5 and 10 year survival rates to 57% by 2020 and reduce variation</td>
<td>NHS England should ensure that CCGs commission appropriate integrated services for palliative and end of life care, in line with the NICE Quality Standard (2011)</td>
<td>Sunderland CCG have identified a management and clinical lead on this area and a work plan has been agreed to ensure:  - Training and guidelines for providers on End of Life care  - Implement Electronic Palliative Care Coordination System to ensure all providers can access shared records for patients on the pathway  - Continue to embed Deciding Right in practice  - Ensure the provision of 24/7 palliative care services</td>
<td>NHSE, Sunderland CCG &amp; CHSFT</td>
<td>March 2019</td>
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<p>|   | Making the necessary investments required to deliver a modern high quality service | NHSI and NHS England should introduce sanctions for any provider not complying with electronic prescribing by March 2016  - E prescribing for CTYA needs to be implemented by Sept 17. | CHS are implementing e-prescribing for all cancer drugs in 2016/17  - Sunderland CCG is working with practices to support patient online access as this is a contractual requirement and part of the digital roadmap. This | NHSE &amp; Sunderland CCG | 2020 |</p>
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<th></th>
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<th>should be fully functional by 2020.</th>
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<tbody>
<tr>
<td>36</td>
<td>NHS commissioners should ensure that appropriately aged cancer patients are offered applicable genetic testing at diagnosis.</td>
<td>Cancer Network / Alliance to advise on next steps to take this forward</td>
<td>NHSE, NESCN</td>
</tr>
<tr>
<td>46</td>
<td>NHS England should encourage MDTs to consider appropriate pathways of care for metastatic cancer patients.</td>
<td>The Cancer Alliance will lead on local delivery with partners</td>
<td>NHSE and NESCN</td>
</tr>
<tr>
<td></td>
<td>Ensuring commissioning, provision and accountability processes are fit for purpose</td>
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</table>
| 6 | • NHS England, through CCGs should ensure that GPs are appropriately prescribing chemo preventive agents to reduce the risk of invasive breast cancer in line with NICE guidelines.  
• Five Year Forward view and STP priorities to improve cancer treatment | Sunderland CCG Medicines Optimisation team will support and rollout once NHS England provide guidance | Sunderland CCG Medicines Optimisation Team and NHSE | 2020 |
| 38 | NHS England should encourage providers to streamline MDTs | NHSE looking at developing collaborative commissioning for upper GI patients following MDT | NHSE & Sunderland CCG |   |
| 39 | NHS England should require MDTs to review a monthly audit report of patients who have died within 30 days of active treatment | The Cancer Alliance will develop a regional response to enable this to be undertaken in a standardised way | NHSE & Sunderland CCG |   |
| 47 | NHS England should commission NICE to develop updated guidelines for adjuvant treatment for breast cancer which CCGs must ensure are used by GPs to appropriately prescribe. | Sunderland CCG Medicines Optimisation team will support and roll out once NHS England provide guidance. Adjuvant bisphosphonates are to be considered by the Joint Formulary group. Discussions with CHS to implement this in secondary care ongoing. | NHSE & Sunderland CCG Meds Op team | March 2017 |
| 76 | - All commissioners should commission to NICE guidelines and CRG approved service specifications as a minimum.  
- Cancer surgery where national volumes are between 2500 and 7500 per year should be commissioned by a lead CCG commissioner for populations of 1-2 million or more. | This work will be driven by the Cancer Alliance however the CCG MO team will audit the use of the NICE guidelines. | NHSE & Sunderland CCG | March 2018 |
Stakeholder Analysis and Communication Plan

Version: 1.0
Stakeholder Management and Communication Strategy

Document Control

Status

Current Status Draft

Version History

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<th>Name</th>
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<tr>
<td>Dr Claire Bradford</td>
<td>Medical Director</td>
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<tr>
<td>Dr Raj Bethapudi</td>
<td>GP Executive</td>
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<td>Dr Henry Choi</td>
<td>GP Lead</td>
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</tr>
</tbody>
</table>

If appropriate insert detail
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Appendix A: Stakeholder Analysis Chart (based on the nature of stakeholder interest)
Appendix B: Stakeholder Influence and Interest Matrix
Appendix C: Communication Management Log
1 Purpose

The purpose of this Stakeholder Management and Communication Strategy is:

- To identify all stakeholders who have an interest in the project and set out the purpose, means and frequency of communication between the project and the stakeholders and to validate its effectiveness;
- To provide an overarching framework within which the project will proactively engage and communicate with its stakeholders;
- To enable and ensure leadership and ownership of each project, without which it could fail to generate the changes required to enable all benefits accruing from the work to be realised;
- To ensure that there is consistency in communication quality and approach across projects;
- To ensure messages issued by all projects are regular and consistent;
- To ensure, where timing of communication is business sensitive, there is a defined process to ensure that timings are agreed and adhered to.

Each project will produce its own stakeholder management and communications plan.

2 Principles of Communication

2.1 Core Principles

Successful communication is based on five core principles:

- Message clarity: to ensure relevance and recognition;
- Stakeholder identification and analysis: to send the right message to the right audience;
- A system of collection: to obtain feedback and assess the effectiveness of the communications process;
- A system of delivery: to bring it all together;
- Messages must be consistent: they should be few in number, simple, and brief, and derived from the project’s objectives.

2.2 General Principles

The following communication principles should be adhered to by all parties responsible for initiating and delivering communications:

- All significant activities in the project will have an associated communication activity;
- Communication channels will be used to ensure the timely delivery of accurate messages to the appropriate audience;
- Pre-existing communication channels will be used wherever practicable;
- Where appropriate, multiple channels will be used to ensure the widest possible distribution of the message;
- Communication materials will follow the approved style guidelines for the CCG.
The internal project communications plans will be a living documents that will be used to support the communications during the various stages of each programme / project.

**Critical Success Factors**

In order to assess whether the communications exercise has been successful the following criteria need to be assessed:

- All key stakeholders, as defined in each Communication Plan are aware of the project and how it will impact them;
- The information given to the stakeholders has met their requirements;
- The information received from the stakeholders has met the project owner’s requirements;
- All necessary information has been disseminated and assimilated by stakeholders;
- The roles and responsibilities of those involved in the communication strategy have been understood by them, and these individuals have carried out their roles satisfactorily.

At key points during each project, the success of the communications will be assessed. The results will inform iterative changes in the evolving stakeholder management communications strategy and plans.

**Responsibilities**

The Project Lead is responsible for ensuring that:

- The Stakeholder Management and Communication Strategy is implemented effectively;
- There is a single point of contact for all communications and communications issues within the project;
- Ensuring all messages communicated from the project are: checked for consistency; in plain language, unambiguous and adhere to the objective;
- All episodes of communication, its contents, channel, style and language is ‘safe’ and complies with any CCG Communication Policies and Procedures;
- Where necessary, authority to distribute messages must be obtained from the Project’s Senior Responsible Owner;
- The contents of all communication episodes are filed in an appropriate and safe location.

If the project warrants it, a Communications Lead will be appointed who will work in partnership with the Project Lead to ensure an efficient and effective two-way approach to communications.

**Stakeholder Analysis and Communication Plan**

The nature and degree of stakeholder interest in a programme or project varies considerably, as does their ability to influence its progress and direction. One single
communication programme would fail to meet the needs of many of the stakeholders whilst it would be impractical and unproductive to operate a communication programme tailored for each individual stakeholder.

There are four main components of the Stakeholder Analysis and Communication Plan i.e.

- The Stakeholder Analysis Chart
- The Influence and Interest Matrix
- The Communications Channels
- The Communications Management Log

Each component is explained below:

5.1 Stakeholder Analysis Chart
The Stakeholder Analysis Chart (Appendix A) is used to identify and list the stakeholders by group and identify the nature of their interest in the project. (The application of a group identifier (e.g. a letter – A, B, C etc) will aid the construction of the Influence and Interest Matrix – as described below)

5.2 Influence and Interest Matrix
The Influence and Interest Matrix (Appendix B) looks at the stakeholders by nature of their interest and influence in relation to graded levels i.e. Low, Medium or High. This process results in the matrix being divided into nine cells into which the stakeholders can be placed in accordance with their levels, resulting in e.g. a stakeholder / group with high interest and high influence being placed to the top right of the matrix. (The suggested use of the group identifier (letter) will help map the stakeholders – as shown in Appendix B)

The matrix also suggests an appropriate method and level of communication ranging from ‘Keep stakeholder informed’ via written reports (for stakeholders assessed to be of low influence and low interest) to ‘Face to face’ communication (for stakeholders assessed as be of high influence and high interest).

It should be noted that stakeholder levels of influence and interest may change depending on the stage of the project; therefore it is advisable to revisit the matrix occasionally to ensure that the communication efforts are being directed appropriately.

5.3 Communication Channels
There are a variety of Communication Channels which can be used to inform the stakeholders with different channels being used to inform different stakeholders. Examples of channels are listed below:
- A schedule of briefings reporting of the aims, approach and current status of the project;
- Regular written progress reports to stakeholders;
- Formal written reports in line with the adopted project management framework;
- Newsletters;
- Face to face discussions;
- A web site bringing together all non-sensitive and relevant information related to the project including its progress;
- An internet site summarising the project and its progress;
- Production and distribution of information materials such as flyers and information sheets;
- Consultation programmes (for key issues).

This is a suggested list, other channels of communication may be applied, the prime objective is to ensure that stakeholders are informed of the key elements relating to the programme / project in an efficient and effective manner.

5.4 Communication Management Log

The Communication Management Log (Appendix C) assists to manage the communication effort by identifying following:

- The timing of communication releases;
- Each group of stakeholders as identified in the Stakeholder Analysis Chart (Appendix A);
- Contact details
- The contents of the information to be provided;
- The channel through which the communication requirements will be met;
- The capture of any responses to the messages communicated;
- Any follow-up actions.
## Appendix A: Stakeholder Analysis Chart (based on the nature of stakeholder interest)

<table>
<thead>
<tr>
<th>Stakeholder Group / Individual</th>
<th>Nature of Interest</th>
<th>Organisation</th>
<th>Group Identification Letter</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Hospitals Sunderland</td>
<td>High Interest and Impact</td>
<td>City Hospitals Sunderland</td>
<td>A</td>
</tr>
<tr>
<td>50 GP Practices in Sunderland</td>
<td>Medium interest and high impact</td>
<td>GP Practices</td>
<td>B</td>
</tr>
<tr>
<td>Specialised Commissioning</td>
<td>Medium interest and high impact</td>
<td>NHS England Area Team</td>
<td>C</td>
</tr>
<tr>
<td>North East Cancer Clinical Network</td>
<td>High interest and impact</td>
<td></td>
<td>D</td>
</tr>
<tr>
<td>Public Health</td>
<td>Medium interest and impact</td>
<td>Sunderland City Council</td>
<td>E</td>
</tr>
<tr>
<td>Sunderland Cancer Patient and Carer Group</td>
<td>High interest and low impact</td>
<td>Hosted by Macmillan</td>
<td>F</td>
</tr>
<tr>
<td>Cancer Research UK</td>
<td>Medium interest and low impact</td>
<td></td>
<td>G</td>
</tr>
<tr>
<td>NHS Screening Hubs</td>
<td>Medium interest and low impact</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>Low interest and low impact</td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>GP Alliance</td>
<td>Low interest and low impact</td>
<td></td>
<td>J</td>
</tr>
</tbody>
</table>
Appendix B: Stakeholder Influence and Interest Matrix

**Influence**
- High
- Medium
- Low

**Interest**
- Low
- Medium
- High

**Key players – need strong buy-in**
- A

**Actively consult**
- F

**Maintain interest**
- H

**Keep informed**
- I

**Written**
- J

**Face to Face**
- E

- C
- B
- D
### Appendix C: Communication Management Log

<table>
<thead>
<tr>
<th>Date / timing*</th>
<th>Stakeholder group</th>
<th>Contact details</th>
<th>Communication contents</th>
<th>Communication channel(s)</th>
<th>Response</th>
<th>Follow-up action</th>
</tr>
</thead>
<tbody>
<tr>
<td>18&lt;sup&gt;th&lt;/sup&gt; October</td>
<td>GP Locality Practice Managers</td>
<td>Via Jackie Spencer - SCCG</td>
<td>Presentation of strategy</td>
<td>Localities Working Together Meeting</td>
<td>No formal response</td>
<td></td>
</tr>
<tr>
<td>October and November</td>
<td>City Hospitals Sunderland</td>
<td>Denise Inskip Melanie Robertson</td>
<td>Presentation of strategy</td>
<td>Via Task and Finish Group representatives</td>
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<td></td>
</tr>
<tr>
<td>7&lt;sup&gt;th&lt;/sup&gt; December 2016</td>
<td>50 GP Practices in Sunderland – GPs, PMs, PNs</td>
<td>Dr Raj Bethapudi Dr Henry Choi Claire Bradford Laura Hope</td>
<td>Presentation of strategy</td>
<td>TITO presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laura Hope / NECS Comms</td>
<td>Communication of strategy within the organisation</td>
<td>Newsletter</td>
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<td>Communication of strategy within the organisation</td>
<td>Television screens</td>
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<td></td>
</tr>
<tr>
<td>Date/Group</td>
<td>Communication Method</td>
<td>Communication Action</td>
<td>Place/Type</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>----------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>October and November</td>
<td>Specialised Commissioning</td>
<td>Lisa Jordan</td>
<td>Communication of strategy within the organisation</td>
<td>Via Task and Finish group representative</td>
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<tr>
<td>October and November</td>
<td>North East Cancer Clinical Network</td>
<td>Alison Featherstone</td>
<td>Communication of strategy within the organisation and regionally</td>
<td>Via Task and Finish group representative</td>
<td></td>
<td></td>
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<tr>
<td>October and November</td>
<td>Public Health</td>
<td>Kath Bailey</td>
<td>Communication of strategy within the organisation</td>
<td>Via Task and Finish group representative</td>
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<tr>
<td>28th September 2016</td>
<td>Sunderland Cancer Patient and Carer Group</td>
<td>Laura Hope</td>
<td>Presentation of draft strategy</td>
<td>Management lead to attend Patient Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>October and November</td>
<td>Cancer Research UK</td>
<td>Sarah Kuckumentin</td>
<td>Communication of strategy within the organisation</td>
<td>Via Task and Finish group representative</td>
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<td></td>
</tr>
<tr>
<td>October and November</td>
<td>NHS Screening Hubs</td>
<td></td>
<td>Communication of strategy within the organisation</td>
<td>Via Task and Finish group representative</td>
<td></td>
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</tr>
<tr>
<td>November 2016</td>
<td>Healthwatch</td>
<td>Laura Hope</td>
<td>Given copy of draft strategy</td>
<td>Email</td>
<td></td>
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</tr>
<tr>
<td>December 2016</td>
<td>GP Alliance</td>
<td>Laura Hope</td>
<td>Given copy of draft strategy</td>
<td>Email</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Date / timing: If a regular schedule has been arranged e.g. for Newsletter releases, the timing may be noted as e.g. Bi-weekly commencing 01.06.14*
GOVERNING BODY

31 JANUARY 2017

Report Title: Information Governance Strategy 2016/17 Update

Purpose of report
To provide the Governing Body with an updated information governance strategy for 2016/17.

Key points, risks and assurances
Information governance (IG) is the framework for handling information in a confidential and secure manner to appropriate ethical and quality standards in modern health services. It brings together within a singular cohesive framework the interdependent requirements and standards of practice. It is defined by the requirements within the IG toolkit against which the CCG is required to publish an annual self-assessment of compliance.

Key points
As part of the CCG’s IG framework and to ensure the continued robust management of information, the CCG has an IG strategy in place which sets out its approach to ensuring there is a robust IG framework in place which supports the delivery of the CCG’s objectives. Information governance requirements ensure that best practice is implemented and ongoing awareness is evident across the CCG. The strategy sets out the roles and responsibilities within the CCG to ensure all records and information are dealt with legally, securely, efficiently and effectively.

The strategy is reviewed on an annual basis as part of the IG toolkit requirements and the main change for this year relates to the roles and responsibilities in section 4, particularly the change to the CCG’s senior information risk owner. This is now the responsibility of the director of contracting and informatics.

Assurances
The CCG has a service line agreement in place with NECS to deliver the information governance agenda. The strategy has been reviewed by the IG team within NECS to ensure it meets current legislative requirements and best practice.

The strategy had been reviewed by the Executive Committee at its meeting on 1 November and the committee recommended it for submission to the Governing Body for formal ratification.

Recommendation/Action Required
The Governing Body is asked to formally ratify the updated strategy for 2016/17.

Sponsor/approving director
D Gallagher, Chief Officer

Report author
J Appleby, Senior Governance officer, NECS
D Cornell, Head of Corporate Affairs, SCCG

Governance and Assurance
## Link to CCG corporate objectives
(please tick all that apply)

<table>
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<td>✓</td>
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<tr>
<td>CO2: Maintain financial control and performance targets</td>
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<tr>
<td>CO3: Maintain and improve the quality and safety of CCG commissioned services</td>
<td>✓</td>
</tr>
<tr>
<td>CO4: Ensure the CCG involves patients and the public in commissioning and reforming services</td>
<td></td>
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<tr>
<td>CO5: Identify and deliver the CCG’s strategic priorities</td>
<td>✓</td>
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<tr>
<td>CO6: Develop the CCG localities</td>
<td></td>
</tr>
<tr>
<td>CO7: Integrating health and social care services, including the Better Care Fund</td>
<td></td>
</tr>
<tr>
<td>CO8: Develop and deliver primary medical care commissioning</td>
<td></td>
</tr>
</tbody>
</table>

## Any relevant legal/statutory issues
- Caldicott
- NHS Confidentiality Code of Practice
- Data Protection Act 1998
- Freedom of Information Act 2000
- Health and Social Care Act 2012
- Human Rights Act 1998
- Care Act 2014
- HSCIC IG Toolkit requirements
- Records management (Health, Business & Corporate)
- Information security
- Information quality
- Confidentiality and openness
- Legal compliance
- Information Risk

## Are the identified risks on the risk register?
None identified

## If issue/report has been previously reviewed please specify meeting and date
Executive Committee at its meeting on 1 November 2016

<table>
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<tr>
<th>Equality analysis completed (please tick)</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>✓</th>
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</thead>
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## Key implications

### Are additional resources required?
None

### Has there been appropriate clinical engagement?
N/A

### Has there been/or does there need to be any patient and
N/A
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<th>public involvement?</th>
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<tr>
<td>Any current or expected impact on patient outcomes/experience?</td>
<td>N/A</td>
</tr>
<tr>
<td>Has there been member practice and/or other stakeholder engagement if needed?</td>
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</tr>
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Information Governance Strategy 2016-17

Sunderland
Clinical Commissioning Group

Information Governance Strategy 2016-17
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Document status

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<tr>
<td>Document ratified/approved by</td>
<td>Executive Committee – 1 November 2016</td>
</tr>
<tr>
<td>Date issued</td>
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<td>Review date</td>
<td>November 2017</td>
</tr>
<tr>
<td>Distribution</td>
<td>All staff</td>
</tr>
<tr>
<td>Version</td>
<td>2016-17 Final Draft</td>
</tr>
<tr>
<td>Reference number</td>
<td>SCCG_Strat.CG02</td>
</tr>
<tr>
<td>Location on intranet</td>
<td>Corporate Affairs</td>
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1. **Introduction**

1.1 Information is a vital asset within NHS Sunderland CCG (the CCG), in terms of the effective commissioning and management of services and resources. It plays a key part in clinical governance, service planning and performance management. It is important that information is managed within a framework that ensures it is appropriately managed and that policies, procedures, management accountability and structures are in place.

1.2 This strategy sets out the approach to be taken within the CCG to provide a robust information governance (IG) framework and to fulfil its overall objectives. Information governance requirements ensure that best practice is implemented and on-going awareness is evident across the CCG. The CCG is committed to ensuring that all records and information are dealt with legally, securely, efficiently and effectively.

1.3 Information governance is ‘a framework for handling information in a confidential and secure manner to appropriate ethical and quality standards in modern health services’. It brings together within a singular cohesive framework the interdependent requirements and standards of practice. It is defined by the requirements within the IG toolkit against which the CCG is required to publish an annual self-assessment of compliance. This strategy is supported by a detailed IG toolkit action plan.

1.4 The IG agenda encompasses the following areas:

- Caldicott
- NHS Confidentiality Code of Practice
- Data Protection Act 1998
- Freedom of Information Act 2000
- Health and Social Care Act 2012
- Human Rights Act 1998
- Care Act 2014
- Records management (Health, Business & Corporate)
- Information security
- Information quality
- Confidentiality
- Openness
- Legal compliance
- Information Risk
1.5 Within this agenda the CCG will handle and protect many classes of information:

- Some information is confidential because it contains personal details. The CCG must comply with regulation which regulates the holding and sharing of confidential personal information. Changes to the way in which patient confidential data can be processed came about as a result of the Health and Social Care Act 2012. It is important that relevant, timely and accurate information is available to those who are involved in the care of service users, but it is also important that personal information is not shared more widely than is necessary.

- Some information is non-confidential and is for the benefit of the CCG and the general public. The CCG and its employees share responsibility for ensuring that this type of information is accurate, up to date and easily accessible to the public.

- The majority of information about the CCG and its business should be open to public scrutiny although some, which is commercially sensitive, may need to be safeguarded.

1.6 Information can be in many forms, including (but not limited to):

- Structured record systems – paper and electronic
- Transmission of information – e-mail, post and telephone; and
- All information systems purchased, developed and managed by/or on behalf of the organisation

2. Purpose

2.1 The IG arrangements will underpin the CCG’s strategic goals and ensure that the information needed to support and deliver their implementation is readily available, accurate and understandable. Information governance has 4 fundamental aims:

- To support the provision of high quality care by promoting the effective and appropriate use of information
- To encourage responsible staff to work closely together, preventing duplication of effort and enabling efficient use of resources
- To develop support arrangements and provide staff with appropriate tools and support to enable them to carry out their responsibilities to consistently high standards
- To enable the CCG to understand its own performance and manage improvement in a systematic and effective manner
3. Strategic Aims

3.1 The strategic aims will be achieved by ensuring the effective management of IG by:

- Establishing, implementing and maintaining policies for the effective management of information.
- Ensuring that IG is a cohesive element of the internal control systems within the CCG.
- Recognising the need for an appropriate balance between openness and confidentiality in the management of information.
- Ensuring that IG is an integral part of the CCG culture and its operating systems.
- Ensuring maintenance of year on year improvement within the IG toolkit self-assessment.
- Reducing duplication and looking at new ways of working effectively and efficiently.
- Minimising the risk of breaches of personal data.
- Minimising inappropriate uses of personal data.
- Ensuring that service level agreements, information sharing agreements and data processing agreements between the CCG and other organisations are managed and developed in accordance with IG principles.
- Ensuring that contracted bodies are monitored against IG standards.
- Protecting the services, staff, reputation and finances of the CCG through the process of early identification of information risks and where these risks are identified ensuring sufficient risk assessment, risk control and elimination are undertaken.
- Ensuring there is provision of sufficient training, instruction, supervision and information to enable all employees to operate within IG requirements.
- Ensuring that IG is embedded within the CCG and monitored via regular checks.
4. Roles and Responsibilities

4.1 Executive Committee

The CCG has developed clear lines of accountability with defined responsibilities and objectives. The executive committee is chaired by the chief officer and has responsibility for overseeing the implementation of this strategy.

4.2 The executive committee is accountable to the governing body and has responsibility for overseeing and providing assurance to the governing body on the IG agenda. The executive committee also provides assurance on health and safety, research governance and equality and diversity issues.

4.2 Chief Officer

The chief officer has overall accountability and responsibility for IG across the CCG and is required to provide assurance, through the annual governance statement, that all risks to the CCG are mitigated as far as possible.

4.3 Senior Information Risk Owner

The director of contracting and informatics is the CCG’s senior information risk owner (SIRO) and has the responsibility for ensuring that information is processed and held securely throughout the CCG. The role covers all the aspects of information risk, the confidentiality of patient and service user information and information sharing. The IG toolkit sets out clear responsibilities of the SIRO in relation to risks surrounding information and information systems, which also extend to business continuity and the role of information asset owners.

4.4 Caldicott Guardian

The medical director is the CCG’s Caldicott Guardian and has an advisory role and is responsible for ensuring that the principles of confidentiality and data protection set out in the Caldicott Guidelines and the Data Protection Act are implemented systematically.

4.5 Specialist Expertise

The CCG has a service line agreement in place with the North of England Commissioning Support Services (NECS) to provide IG expertise to the CCG. The service line is managed by the head of corporate affairs.
5. **Equality and Diversity Statement**

5.1 The CCG is committed to promoting human rights and providing equality of opportunity; not only in employment practices, but also in the way services are commissioned. The CCG also values and respects the diversity of its employees and the communities it serves. In applying this policy, the organisation will have due regard for the need to:

- Promote human rights
- Eliminate unlawful discrimination
- Promote equality of opportunity
- Provide for good relations between people of diverse groups

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

5.3 Throughout the development of this strategy, the CCG has sought to promote equality, human rights and tackling health inequalities by considering these implications when writing and reviewing the strategy. The impact of this strategy is subject to a detailed process of review which is undertaken via a formal equality impact assessment when the strategy is reviewed.

5.4 In accordance with equality duties an equality impact assessment has been carried out on this strategy. There is no evidence to suggest that the strategy would have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights.

6. **Training and Awareness**

6.1 Training and education are key to the successful implementation of this strategy and embedding a culture of information governance management in the organisation. Staff will have the opportunity to develop more detailed knowledge and appreciation of the role of information governance through:

- Policy/strategy
- Induction
- Line manager
Information Governance Strategy 2016-17

- Specific training courses

6.2 Mandatory training sessions are delivered online by the Health and Social Care Information Centre (formerly Connecting for Health) IG training tool. The sessions are mandatory and must be updated every year.

6.3 Awareness will be monitored via regular checks and gaps in knowledge will be addressed via further bespoke training materials and/or targeted training sessions provided by the information governance service.

7. Monitoring

7.1 Information Governance Toolkit

7.1.1 The annual release of a new version of the toolkit generally takes place in June. An updated action plan for improving and implementing the requirements of the toolkit will be submitted to the executive committee.

7.1.2 Monitoring reports will be routinely submitted to the Executive Committee as part of the quarterly corporate affairs assurance report. The CCG’s progress will be reported to the governing body via the executive committee minutes or by exception by the chief officer or SIRO as appropriate. The action plan and monitoring will be maintained by NECS on behalf of the CCG.

7.1.3 The CCG will comply with the Health and Social Care Information Centre’s deadlines for submission of updates and final assessment.

7.1.4 Annual IG performance will be summarised in the IG annual report which will be presented to the Executive Committee.

7.1.5 An internal audit of the IG toolkit will also take place in quarter 4 as part of the CCG’s internal audit plan.

8. Performance Indicators

8.1 The IG toolkit submission is a mandatory annual return and the criteria for compliance is set out within the toolkit. The successful implementation of IG across the organisation will be reflected in the achievement level produced from the annual toolkit submission.
9. Associated Documents

9.1 This strategy should be read in conjunction with the following IG policies:

- Information Governance and Information Risk Policy
- Confidentiality and Data Protection Policy
- Information Security Policy
- Information Access Policy
- Data Quality Policy
- Records Management Policy and Strategy

10. Review

10.1 This strategy will be updated at least annually and in accordance with the following as and when required:

- legislative changes
- as dictated by the IG Toolkit
- good practice guidance;
- case law;
- significant incidents reported;
- new vulnerabilities; and
- changes to organisational infrastructure.

10.2 This strategy will be reviewed by the Executive Committee prior to its submission to the Governing Body for formal ratification.

Date reviewed and approved by Executive Committee: 1 November 2016

Date formally ratified by the Governing Body: tbc
<table>
<thead>
<tr>
<th>CATEGORY OF PAPER</th>
<th>Proposes specific action</th>
<th>Provides assurance</th>
</tr>
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**GOVERNING BODY**

31 JANUARY 2017

**Report Title:**
Updated Equality Strategy 2016-2020

**Purpose of report**
To provide the Governing Body with an updated equality strategy to ensure the CCG meets its statutory duties in relation to equality and diversity.

**Key points, risks and assurances**

**Key points**
The CCG is committed to ensuring that equality and human rights are taken into account in everything it does, whether that is commissioning services, employing people, developing policies or involving people in its work. This strategy has been developed to ensure it reflects the Equality Act 2010 which provides a legislative framework to protect the rights of individuals and advance equality of opportunity for all.

It outlines the significant targets the CCG has set in relation to equality and human rights and demonstrates the long-term commitment needed to ensure it meets the legislation and the needs and wishes of the local population and staff.

The CCG is required to publish its equality information to demonstrate compliance with the general equality duty, as specified in the Equality Act. The strategy outlines the CCG’s strategic direction to ensure compliance both with the general and specific Public Sector Equality Duties and highlights the national and local drivers that will shape and influence the CCG’s approach. In addition, the CCG must also prepare and publish the objectives needed to meet the aims of the general equality duty at least every four years. The objectives should be publicly accessible to the public.

**Assurances**
The CCG has a service line agreement in place with NECS to support the delivery of the equality and diversity agenda. The strategy has been drafted by the E&D team on behalf of the CCG and developed in line with current legislation and best practice.

The CCG has also developed its equality objectives as part of the Equality Delivery System 2 (EDS2) self-assessment process. These objectives were approved by the Executive Committee at in July 2016 and the committee receives six-monthly updates on progress. The objectives have also been published on the CCG’s public website.

The Executive Committee reviewed and approved the strategy at its meeting in December 2016 and recommended its submission to the Governing Body for formal ratification.
**Recommendation/Action Required**

The Governing Body is asked to formally ratify the strategy.

<table>
<thead>
<tr>
<th>Sponsor/approving director</th>
<th>D Gallagher, Chief Officer</th>
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</thead>
</table>
| Report author             | H Pearson, Senior Governance Officer, NECS  
                           D Cornell, Head of Corporate Affairs, SCCG |

**Governance and Assurance**

**Link to CCG corporate objectives** (please tick all that apply)

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<thead>
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<th>CCG corporate objectives</th>
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<tbody>
<tr>
<td>CO1: Ensure the CCG meets its public accountability duties</td>
<td>✓</td>
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<tr>
<td>CO2: Maintain financial control and performance targets</td>
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<tr>
<td>CO3: Maintain and improve the quality and safety of CCG commissioned services</td>
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<td>CO4: Ensure the CCG involves patients and the public in commissioning and reforming services</td>
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</tr>
<tr>
<td>CO5: Identify and deliver the CCG’s strategic priorities</td>
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</tr>
<tr>
<td>CO6: Develop the CCG localities</td>
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</tr>
<tr>
<td>CO7: Integrating health and social care services, including the Better Care Fund</td>
<td></td>
</tr>
<tr>
<td>CO8: Develop and deliver primary medical care commissioning</td>
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**Any relevant legal/statutory issues**


**Are the identified risks on the risk register?**

None identified

**If issue/report has been previously reviewed please specify meeting and date**

Executive Committee at its meeting on 6 December 2016.

<table>
<thead>
<tr>
<th>Equality analysis completed (please tick)</th>
<th>Yes ✓</th>
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**Key implications**

<table>
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<tr>
<td>Has there been appropriate clinical engagement?</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Has there been/or does there need to be any patient and public involvement?</td>
<td>Strategy has been developed in line with current legislation for engagement.</td>
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<tr>
<td>Any current or expected impact on patient outcomes/experience?</td>
<td>Strategy will help to ensure equality of opportunity/access for all CCG commissioned services.</td>
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<tr>
<td>Has there been member practice and/or other stakeholder engagement if needed?</td>
<td>Yes – Public Health (health profiles)</td>
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Equality Strategy
2016-2020
**Document Status**

<table>
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<td>No impact</td>
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<td>Approved By</td>
<td></td>
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<tr>
<td>Date Issued</td>
<td></td>
</tr>
<tr>
<td>Date To be Reviewed</td>
<td>December 2020</td>
</tr>
<tr>
<td>Distribution</td>
<td>All Staff</td>
</tr>
<tr>
<td>Author</td>
<td>H Pearson, Senior Governance (Equality &amp; Diversity) NECS D Cornell, Head of Corporate Affairs, SCCG</td>
</tr>
<tr>
<td>Reference No</td>
<td>SCCG_Strat.CG03</td>
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**Version Control**

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<td>Version 1</td>
<td>June 14</td>
<td>Drafted by G Stanger - NECS Reviewed by D Cornell – SCCG</td>
</tr>
<tr>
<td>Version 2</td>
<td>November 2016</td>
<td>Drafted by: H Pearson, Senior Governance Officer (E&amp;D), NECS Reviewed by: D Cornell, Head of Corporate Affairs, SCCG</td>
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1. Foreword

At NHS Sunderland CCG, we are committed to ensuring that equality and human rights are taken into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work.

This strategy reflects the Equality Act 2010 which provides a legislative framework to:

- protect the rights of individuals and advance equality of opportunity for all
- update, simplify and strengthen the previous legislation; and
- deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The strategy describes a clear picture of the significant targets we have set in relation to equality and human rights. It is a long-term commitment driven by both equalities legislation and by the needs and wishes of our local people and staff. For that reason much of the work will be on-going over the next few years.

We look forward to the work ahead, facing the challenges, and meeting the targets we have set ourselves.

Dr Ian Pattison
Clinical Chair

David Gallagher
Chief Officer
2. **Introduction**

NHS Sunderland CCG (the CCG) was established in April 2013 and operates as a collaborative, open and transparent, caring and accountable organisation, which seeks to maximise the value added in clinician involvement with commissioning decisions.

As a public sector organisation, the CCG is required to publish its equality information to demonstrate compliance with the general equality duty, as specified in the Equality Act 2010, which states in summary:

‘Those (organisations) subject to the general equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.’

The Act brings together and replaces the previous anti-discrimination laws with a single Act, which aims to simplify and strengthen the law, removing inconsistencies and making it easier for people to understand and comply with it.

The Act covers the following protected characteristics:

![Protected Characteristics Diagram](image)

For further information on the protected characteristics please see appendix 1.
Additionally, the CCG must:

- Prepare and publish one or more objectives they think they should achieve to do any of the things mentioned in the aims of the general equality duty, and at least every four years thereafter.
- Ensure that those objectives are specific and measurable.
- Publish those objectives in such a manner that they are accessible to the public.

For further information on the general and specific public sector equality duties (PSED) please refer to appendix 2.

3. **Meeting our equality duties**

This strategy outlines our strategic direction to ensure compliance with the PSED and highlights the national and local drivers that will shape and influence our approach.

**Our vision**

Our vision is to achieve **Better Health for Sunderland**. The CCG uses the following seven core values to support the delivery of our vision:
Leadership and governance

The CCG’s member practices are committed to ensuring that the organisation values diversity and promotes equality, inclusivity in all aspects of its business. The Governing Body is accountable for equality and diversity issues on behalf of the CCG members and responsibility to deliver this function has been delegated to the chief officer. The head of corporate affairs is also the designated lead for equality and diversity.

The Executive Committee has delegated authority from the Governing Body to monitor the CCGs equality objectives on its behalf.

Our leadership approach ensures that there is fairness in our commissioning decisions and that business is planned and conducted to meet our equality duties.

The CCG has developed governance arrangements to ensure the structures are in place to develop and maintain the organisation’s capacity to deliver on all statutory duties and responsibilities.

Our Governing Body members are committed to ensuring that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.

Our staff

The CCG directly employs 87 staff, which means we are not required by law to publish staff equality data. However, we are committed to attracting, retaining and developing a diverse and skilled workforce that is representative of our local population.

We actively work to remove any discriminatory practices in our work, eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance management and development practices. We have policies and processes in place to support this.

From 1 July 2016 we have been monitoring our staff data in relation to the Workforce Race Equality Standard (WRES) as set by NHS England.

We routinely provide equality, diversity and human rights training which is mandatory for all our staff and Governing Body members. Enhanced training is available, as appropriate to individual roles.
Our population and their health needs

Sunderland has a population of approximately 281,000 people. Over the next 10 years this is expected to rise by at least 2,179 (0.8%).

Large increases in the elderly population, and particularly the very elderly, have significant implications for healthcare over the next 5, 10 and 20 years.

Sunderland’s community is also affected by lifestyle factors such as obesity, smoking and alcohol abuse which pose a major risk to health and wellbeing.

Major health challenges are consistent across our 5 localities. They include:

- A growing ageing population with escalating health needs
- Poor health compared to the rest of the UK
- Excess deaths, particularly from heart disease, cancer and respiratory problems
- An over-reliance on hospital care
- Disintegrated healthcare service
- Health inequalities across the city

The health of people in Sunderland is varied compared with the England average. Sunderland is one of the 20% most deprived districts/unitary authorities in England and about 24% (11,500) of children live in low income families.

Life expectancy for both men and women is lower than the England average with it being 9.9 years lower for men and 7.6 years lower for women in the most deprived areas of Sunderland than in the least deprived areas.

The Sunderland community health profiles for the CCG are detailed in the diagram on the following page:
The 2016 health profiles outline the following areas of focus for the CCG:

- Giving children the best start in life
- Reducing tobacco use,
- Tackling alcohol harm
- Child obesity
- Promoting healthy weight in general

Further information detailing the health profiles for Sunderland can be found at: [www.healthprofiles.info](http://www.healthprofiles.info)
4. Communications and engagement

Public and patient involvement (PPI) is an integral part of the work that the CCG carries out, and we have a clear commitment to working with the public, patients, carers and communities and their representatives, to ensure health and social care services are shaped around what the people of Sunderland need.

Our PPI strategy aims to:

- Ensure appropriate and effective mechanisms are in place so people can be involved in the commissioning process at all stages
- As part of ‘All Together Sunderland’, identify further opportunities for joint engagement and involvement activities with our partners
- Use our asset based approach with key community, voluntary and interest groups, recognising their ability to reach further into communities
- Ensure we meet our legal duties to engage and consult, for equality delivery, and relevant NHS policy for engagement including the NHS Constitution and case law for consultation.

Through inclusive communication and engagement the CCG will continue to focus on engaging people from minority, marginalised and disadvantaged groups and communities.

5. Equality Analysis

Equality Analysis (EA) is a legal requirement under the Equality Act 2010 and the public sector equality duty and is a process of systematically analysing a new or existing policy or strategy to identify what effect or likely effect will follow as a result of its implementation for different groups within the community. It can also be used as a mechanism for analysing the impact of a whole service or one aspect of the service.

Essentially, EA is about asking a few simple questions:

- Can everyone who needs to, use the service, no matter who they are, no matter what their background?
- And when they do, have we done everything possible to make sure it’s a positive experience for them?

To be able to answer yes to these, we ensure that our decision making is robust and does not discriminate we need to undertake an equality analysis.
We have developed and implemented a tool and guidance for use by staff to help identify likely equality implications of any of our policies, projects or functions.

Training has been provided to staff and the Governing Body will consider the results of any analysis undertaken during the decision-making process.

EA is published, either as part of a policy document or separately on our website.

6. Equality Delivery System

The Equality Delivery System 2 (EDS2) is a tool that has been designed by the NHS to enable organisations to analyse equality performance with the assistance of local stakeholders, prepare equality objectives and embed equality into mainstream commissioning activities.

It includes a set of 18 outcomes grouped into 4 objectives and focus on the issues of most concern to patients, carers, communities, NHS staff and governing body/boards. It is against these outcomes that performance is analysed and graded and action determined.

The EDS2 objectives are:

1. Better health outcomes.
2. Improved patient access and experience.
3. A representative and supported workforce.
4. Inclusive leadership.

For each EDS2 outcome, there are four grades to choose from:

- Excelling (all protected groups) – purple
- Achieving (for most (6-8) protected groups) – green
- Developing (for some (3-5 protected groups) – amber
- Undeveloped (no evidence at all, few or no protected groups) – red

These grades are intended to help organisations clearly identify equality progress and any challenges they may have.

The CCG has adopted the EDS2 and we continue to use the EDS2 framework as an opportunity to raise equality in service commissioning and performance for the community, patients, carers and staff. The most recent objectives that were developed as part of the EDS2 framework can be found in appendix 3.
7. **Workforce Race Equality Standard**

The Workforce Race Equality Standard (WRES) is a mandatory part of the 2016/17 NHS standard contract. It requires CCGs to have ‘due regard’ to the WRES in helping to improve workplace experiences and representation at all levels for their own BME staff.

The WRES has 9 metrics, 4 specifically focusing on workforce data, 4 from the NHS staff survey, and 1 requiring organisations to ensure that their governing bodies/boards are broadly representative of the communities they serve.

From 1 July 2016 onwards, CCGs will be expected to produce an annual WRES report, accompanied by an action plan.

The CCG will ensure that WRES data is compiled and reported in line with NHS England’s requirements and those actions are identified to increase Workforce Race Equality across all nine indicators of the standard.

8. **Accessible Information Standard**

The Accessible Information Standard (AIS) asks organisations to make sure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Commissioners of NHS and publicly-funded adult social care must have regard to this standard, in so much as they must ensure that they enable and support compliance through their relationships with provider bodies.

The CCG will ensure they are compliant with the standard by taking the following actions:

- Ensuring that their commissioning and procurement processes, including contracts, tariffs, frameworks and performance-management arrangements (including incentivisation and penalisation), with providers of health and / or adult social care reflect, enable and support implementation and compliance with this standard.

- Seeking assurance from provider organisations of their compliance with this standard, including evidence of identifying, recording, flagging, sharing and meeting of needs.
9. Conclusion

The CCG has developed detailed constitutional and governance arrangements to ensure the structures are in place to develop and maintain the organisation’s capacity to deliver on all statutory duties and responsibilities.

Through this strategy, the CCG will endeavour to work with and gain the support of, people with the right skills, competencies and capacity to ensure it can carry out all corporate and commissioning responsibilities, including the delivery of statutory functions including equality, diversity and protecting people’s human rights.

The CCG will incorporate equality, diversity and human rights into all aspects of its business plans, such as its commissioning and organisational development plans, developing an organisational culture which is diverse in its makeup, uphold equality of opportunity and fairness for all.
Appendix 1- Protected Characteristics

This equality strategy outlines our commitment to take the following categories into account, which are the specific groups listed in the Equality Act 2010, and are referred to as the nine protected characteristics:

- **Age** - Where this is referred to, it refers to a person belonging to a particular age

- **Disability** - A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

- **Gender reassignment** - A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. Transgender is an inclusive, umbrella term used to describe the diversity of gender identity and expression for all people who do not conform to common ideas of gender roles

- **Marriage and civil Partnership** - In the Equality Act marriage and civil partnership means someone who is legally married or in a civil partnership. Marriage can either be between a man and a woman, or between partners of the same sex. Civil partnership is between partners of the same sex

- **Pregnancy and maternity** - Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding

- **Race** - Refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins

- **Religion and belief** - Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

- **Sex** - A man or a woman

- **Sexual orientation** - Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
## Appendix 2 - Equality Act 2010 Section 149 General / Specific Duties

### Equality Act 2010 Section 149 General / Specific Duties (1-3)

<table>
<thead>
<tr>
<th>General Duties</th>
<th>Due Regard</th>
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| **1** Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 | Remove or minimise disadvantages connected with a relevant protected characteristic (e.g. address the problems that women have in accessing senior positions in the workplace)  
Take steps to meet the different needs of persons who share a relevant protected characteristic (e.g. ensure the particular needs of BME women fleeing domestic violence are met)  
Encourage persons who share a relevant protected characteristic to participate in public life or any other activity in which they are under-represented (e.g. take steps to encourage more disabled people to apply for senior posts). |
| **2** Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it | Tackle prejudice (e.g. tackle hate crime for people with protected characteristics)                                                         |
| **3** Foster good relations between persons who share a relevant protected characteristic and persons who do not share it | Promote understanding (e.g. promote an understanding of different faiths).                                                                |
| **NB** Organisations that are not public authorities are also required to have due regard to the needs listed above whenever they carry out public functions. This could include, for example, a private company with a contract to provide certain public services. |                                                                                                                                               |

### Specific Duties

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<th>Specific Duties</th>
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| **4** Publication of information  
Each public authority must publish information to show that it is complying with the s.149 duty by 31st January 2012 and at least on an annual basis after that. Authorities must include information about persons who share a protected characteristic who are its employees (if it has 150 or more employees) and its service users. |
| **5** Equality objectives  
Each public authority must prepare and publish one or more objectives it thinks it should achieve to have due regard to the need to eliminate discrimination and harassment, to advance equality of opportunity or to foster good relations. Any objective must be specific and measurable. Authorities must publish their first objectives no later than 6 April 2012 and at least every four years after that. |
6 Health Inequalities - The NHS Constitution states that the NHS has a duty to “...pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population”.

The Health and Social Care Act 2012 introduced the first legal duties on health inequalities, with specific duties on NHS England and CCGs.

CCGs have duties to:

Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved;

Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved;

Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities;

Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities.
Appendix 3 – NHS Sunderland CCG Equality Objectives

The following objectives were agreed by the Executive Committee (on behalf of the Governing Body) in July 2016 following the EDS2 self-assessment process.

The CCG’s equality objectives are:

- **Objective 1** - Continuously improve engagement, ensure that services are commissioned and designed to meet the needs of patients from at least six protected groups.

- **Objective 2** – Improve and simplify the complaints process ensuring that complaints are handled efficiently and effectively for at least six protected groups.

- **Objective 3** – Continuously monitor and review staff satisfaction to ensure they are engaged, supported and have the tools to carry out their roles effectively.

- **Objective 4** – Ensure that the Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

**Process**

A detailed action plan will be developed to ensure the CCG achieves deliver of these objectives and progress is monitored by the Executive Committee. Updates will be submitted to the Executive Committee on six-monthly basis.
Executive Committee

Minutes of the meeting held at 12.30pm on Tuesday 1 November 2016
In the Joseph Swan Room, Pemberton House

Minutes

Present: David Gallagher (DG) Chair
Dr Raj Bethapudi (RB)
David Chandler (DCh)
Ann Fox (AFo)
Dr I Pattison (IP)
Dr Karthik Gellia (KG)
Dr Jackie Gillespie (JG)
Dr Fadi Khalil (FK)
Dr Tracey Lucas (TLu)
Gillian Gibson (GG)
Florence Gunn (FG)
Eric Harrison (EH)

In Attendance: Daisy Barnetson (DBa) for item 7.2
Debbie Burnicle (DBu)
Deborah Cornell (DCo)
Angela Farrell (AFa) for item 7.3
Dr Roger Ford (RF)
Patrick Garner (PG) for item 7.1
Clare Nesbitt (CN)
Helen Riding (HR) for item 7.6
Matt Thubron (for Scott Watson)
Jan Thwaites (minutes)

2016/87 Welcome and Introduction

Mr Gallagher welcomed everyone and confirmed that the meeting was quorate.
To allow members of the committee to attend other meetings the order of the agenda
was changed.

2016/88 Apologies for Absence

Apologies were received from Dr Claire Bradford and Scott Watson
2016/89 Declarations of Interest

There were no declarations of interest.

2016/90 Urgent Care Strategy

The purpose of the report was to present the proposed urgent care strategy for review and approval. DBa outlined the key points, risks and assurances.

AFo noted that having had the timeline for the development and implementation of the urgent care strategy approved in October this was now at the stage of needing to articulate the vision and how the project would be taken forward.

DBa described the national and regional guidance around drivers for change including strategic objectives. In terms of engagement prior to writing the report the team had worked extensively with the urgent care board, out of hospital board and taken into account previous public consultations. NECS had also undertaken a “pre, pre engagement” piece of work, speaking to the people of Sunderland. The draft strategy pulled all that information together; key to the vision were the 5 design principles that will inform the way forward. The timeline was set out in the report.

TLu noted that this report was very different to the 2012 version and met a very different set of needs due to the current landscape and the national drivers. The executive summary described a whole system approach.

JG liked the diagram on a patient with urgent care needs and asked if this would be used in the engagement. AFo explained that the diagram would be a large feature of the engagement process.

DCh asked a question around tariffs around ambulatory care and MT noted there were no national tariffs for ambulatory care; there are no data sets just a number of pathways that had been published. In Sunderland work was progressing with City Hospitals Sunderland (CHS) to understand the activity and to standardise the pathways.

TLu noted the importance of making it as easy as possible for a patient to navigate through the system, which may be directly through 111 but until the engagement work is carried out with all partners this was a complex area to understand.

The clinical hub was being progressed quite quickly through NEAS.

The executive committee REVIEWED and APPROVED the proposed SCCG urgent care strategy.

DBa left the meeting at 12.45pm

2016/91 Items of Any Other Business

There were no items of any other business
2016/92 Minutes of the previous meeting held on 4 October 2016

TLa to be noted as present as deputising for DCh.

2016/64 Locality innovations funding evaluations – the 1st sentence to be amended to read east and west not north.

2016/75 SCCG Assurance Report – 6th paragraph to add the word “not” into the final sentence.

2016/76 CHC update – item 1 to read £60 per patient, per week.

The minutes were ACCEPTED as an accurate record subject to the above amendments.

2016/93 Matters arising from the minutes and action log

Items 2016/64 and 2016/86 were complete and would be removed from the action log.

2016/44 Stroke Review – the item was in hand and would be left on the action log

2016/79 Anti-fraud, bribery and corruption policy – DCo to chase a response from Paul Bevan, this item to be left on the action log

2016/81 Localities report – a discussion would be held to discuss how this report would be taken forward. The locality teams would be asked in the first instance what form the report should take then this would be shared with the GP Executives for comment, this item to be left on the action log

2016/86 Sunderland Breast Services – MT explained that the roll out would commence with patients from the Coalfields then some Durham practices as there were pressures from the QE main service and then the focus would be on all others following this. This would be discussed at locality meetings to ensure they are aware of what was planned.

2016/86(1) NHS Property Services – KG still to write to DG, this item to be kept on the action log.

2016/86 (2) an updated letter to be sent to practices by DCh. Further key information was still required from practices. A report to be brought to the executive committee once the work had been completed in December/January. This should also be shared with the localities.

2016/94 Finance Report month 6

DCh confirmed that the CCG was on track to meet all its financial duties. In terms of the year to date position there were minor changes in relation to acute contracts mainly due to overseas visitors.
The performance data around CHS activity both emergency and elective are under against plan.
In relation to the forecast out turn, acute services was forecast to breakeven on the block contracts, children’s packages have not changed and were down to £340k which was as predicted. In regard to prescribing Sunderland has achieved a lower cost for astro-pu than Gateshead, Newcastle and South Tyneside. GP budgets had an under spend of approximately £845k forecast; the assumption is that this will be utilised before the year end.

The Better Care Fund (BCF) has the largest pressure of £3.8m over due almost entirely to packages of care. A workshop has been arranged to look at the finance and processes around continuing care around adults and children.

In relation to QIPP SCCG is the only CCG to report that they will achieve this target.

The CCG is holding a risk of £3m until the end of year with a contingency of £2.5m offsetting those risks. Use of the nationally directed contingency of 1% is still on hold from the treasury.

In regard to CHC restitution cases the back log has been completed and there are no outstanding cases to be assessed.

The introduction of HRG4+ will mean a reduction in the CCG’s purchasing power of around £4-5m, these numbers are awaiting verification.

In relation to market rent there will be an allocation for changes of around £2.5m in 2016/17, DCh raised concerns around recurrent pressures around the changes to the system.

The CCG is looking at a significant 2 year QIPP plan of over £25m with a gap in 2017/18. DCh has written to NHSE to request £6m drawdown in 17/18 and £6m for the year after, so far they have offered £3.5m and £3m.

**Action:** Draft financial plan to be taken to the Governing Body in November 2016 not March 2017 as part of the planning process.

*Tlu left the meeting at 1.00pm*

DB explained that in relation to the GP underspend so far ideas that have come in of around £520k would be spent on veterans, cancer and workforce tools.

JG asked about the need for a reserve and what happens when it is all spent; DCh explained that CCGs are required to have 1% in reserve (approximately £5m in Sunderland)

FK asked if there were any levers in relation to the issues around PropCo as this was a significant increase for GP practices to bear. DCh explained that one of the issues was the move to cost rent and cost service charges. In relation to service charges Gurmeet Singh was working on this issue. In relation to market rent this would push up service charges and rent, DCh was writing to NHSE concerning the
£2.5m as there is a need for an allocation each year to allow the money in the system to flow. It was reconfirmed that a paper would be brought to the executive committee in December/January on these issues.

FK asked if elective costs had gone down, MT confirmed that the CCG was spending less than planned.

RF noted that he had heard that the 1% contingency reserve had dropped to 0.5%; DG confirmed that this would occur next year. Also in relation to the PropCo issues RF stated that the LMC advice was very clear around this, if anyone had any concerns to contact him and he would assist where he could.

The executive committee NOTED the financial position of the CCG as at 30 September 2016, NOTED the update provided on CHC restitution and NOTED the update provided on CCG allocations.

PG and IP joined the meeting 1.10pm

2016/95 Obstetrics & Gynaecology Service Review

PG presented the clinical review across South Tyneside and Sunderland healthcare group, outlining the potential solutions intended to be included for public consultation as part one of the review programme.

The review was being carried out due to workforce sustainability issues and the availability of senior medical staff. By combining services it was intended to moves towards better births and better outcomes for maternity services which is in the five year forward view for maternity care. When looking at joining the services 4 potential configurations were considered but 2 were discounted: to do nothing and to discontinue to provide these services across both localities (South Tyneside and Sunderland).

The 2 remaining solutions were to:

Solution 1: Retain a medically led obstetric unit at City Hospitals Sunderland (CHS) to deliver high risk intrapartum care and continue to provide some midwifery care, develop a free standing midwife led birth centre at South Tyneside NHS Foundation Trust (STFT).

Solution 2: To move all high and low risk care to CHS, this efficiency rationalises the most expensive part of the service to a smaller footprint, there were concerns over capacity and would restrict choice for patients.

It was noted that both solutions would improve clinical quality by bringing the 2 consultant teams together and therefore improving workforce sustainability.

PG noted that solution 1 was expressed as a preferred option but with concerns around timelines of transfer of patients from one site to the other from STFT.
From a Sunderland perspective there were no great changes for patients other than if they chose to access the midwife stand-alone unit. Staffing would be increased to ensure the increase in capacity would be covered.

The main change for gynaecology services would be that the majority were delivered from STFT with some day case provision left in Sunderland. Concerns were raised around transferring high risk births from STFT to CHS.

PG noted that the CCG had been represented in the review through the clinical review steering group.

A listening exercise with the public is underway and would inform the case for change and form part of a public consultation exercise. The governing body would make a decision on the service changes next year following the public consultation.

**GG attends the meeting 1.20pm**

DB explained that at the time of the first clinical review group meeting the CCG had received the report on the assessment framework and the 6 clinical priority areas one of which was maternity which required improvement. Patient experience this was rated as good, patient choice was just below average, still births below average which was a concern although with small numbers. Smoking was significantly below average. In order to move from "requiring improvement" to "good" the CCG would have to concentrate on the smoking issues.

FK raised concerns over North East Ambulance Services (NEAS) transfer times. PG noted that STFT were using a proxy clinical standard which was that the time from recognising the need for a caesarean section and having one was 30 minutes taken from NICE guidance. PG also noted they have tried to meet with NEAS to discuss these issues on 2 separate occasions.

KG noted that ultimately all the pros and cons of the proposed service change needed to be shared with patients. Concerns were raised over the stand-alone unit as other similar units across the country were now being closed due to low usage rates. DG clarified that the CCG would make the decision following public consultation.

AFo noted that the NEAS issue was not driven by quality and safety concerns and there is not in her view a safe option for patients to use a midwifery led unit. The CCG does not commission a specific service for transfers only the national requirements which NEAS are not currently achieving. Concerns were raised that at the moment we cannot assure the process.

DG noted the need for clarity around the issues with NEAS; assurance was needed before any public consultation could commence.

AFo questioned whether thought had been given to moving teams where they were needed instead of moving patients. PG noted that in the majority of cases it would be the patient that would be transported.
DG noted that the recommendations today would feed into the consultation and would refine the report.

IP raised concerns in relation to sustainability issues, expected numbers and other units being closed. KG confirmed that when the stand-alone unit in STFT was looked at it had approximately 300 births per year; this may not be sustainable in the future.

DCo asked if the guidance on planning, assuring and delivering service change for patients had been taken into consideration in the document as discussion had been around preferred options and this could be presumed to be classed as predetermination. PG confirmed that advice had been taken from NHS England and NECS who were delivering the consultation and engagement. There is a paragraph in the executive summary noting this was a preferred option to be considered.

GG highlighted that smoking is one of the biggest health issues in the city and needs embedding in the review work. Another concern is the growth options for the city, capacity issues and new families coming into the city.

**Action:** GG to share this information with the CCG.

JG asked about the rationale behind maintaining some gynaecology day cases in Sunderland and not moving them all to South Tyneside was. PG confirmed that this was due to feedback from the review group.

RB enquired about medical obstetric clinics, PG explained that both anti and postnatal would stay the same in both areas, there had been a small consolidation of clinics.

RF added his concerns over length and timing of journeys and asked if there was any evidence of clinical outcomes, PG noted this would be understood once the meeting with NEAS had taken place.

KG noted the national information in analysing transfers to ensure the outcomes are not any worse.

The executive committee **CONSIDERED** the contents of the review and **ENDORSED** the solutions contained in the report for inclusion in the formal public consultation planned to start in January 2017.

**2016/96 SCCG Assurance Report**

DB pulled out the key changes in the report since the last executive committee meeting:

- **IAPT:** the CCG had received June data for access and recovery, this was above target.
- **MRSA** is increasing. The number of cases with CDiff below target.
- Feedback had been received in relation to the integrated early adopter expression of interest and The CCG had been accept onto the programme. This would be integrated with the 5 locality teams. The IAPT workers would
be part of the MDTs. This would build on current work and the enhancements would be around cancer and obesity.

- The CCG had also been identified as a potential early adopter of employment advisors but have been informed that as it is part of a North East mental health trailblazer it has not been accepted onto that programme and would have to wait for wave 3.
- In relation to the clinical priorities work, 6 clinical areas are being considered and the 4 that require improvement will be looked at in a development session on 20th December.
- Activity – the BI team had completed a lot of work around the tracking of the 1,200 patients that had been the focus of the integrated teams and recovery at home work. 25 practices had signed up to share their data with us enable tracking of the patients. Currently 41 practices have agreed to share their data. MT noted it was down to engaging with the localities to share this information.
- DB raised a concern on behalf of SW that the information about paediatric services had not been forgotten following the executive development session on sustainability areas.

JG noted that discussion had taken place in the sustainability and delivery group meeting. There seemed to be a huge overlap and duplication of work with paediatric staff in various areas and suggested that the CCG need to know who is providing what service and their roles and responsibilities.

IP noted this could be an opportunity to triangulate across the Sunderland/South Tyneside alliance.

- The CCG had unsuccessfully applied to join the national diabetes prevention programme wave; there had been a lot of national interest.
- A workshop had been held with partners from the Transformation Board on 11 October to align the 2 year operational plans. Five big ticket items were agreed from the session for progression.

DB made a plea for all executive committee members to attend an exceptional meeting on 8 November which would focus on the quality premium for general practice. This would also provide an opportunity to discuss how to conclude the finances and contracts for the next 2 years.

FK asked where the information on urological pathways was, MT responded that this would be picked up as part of contract negotiations.

IP noted the issue around ambulance response times which seemed to be an ongoing issue nationally; NEAS response times were still very poor and should not be accepted.

DG explained that there was an opportunity to highlight this information as NEAS quality summit following their CQC visit which would give the opportunity to get information and to keep the pressure on for them to continue to improve.

AFO added that 3 out of 4 attendances in 8 minutes was the nationally commissioned standard. The expected standard was 75%, commissioners need to know what the other 25% looks like.
RF observed that adding in new work such as the obstetrics review would put even more pressure on NEAS.

IP gave his perspective from a general practice point of view where calls for ambulances for patients were delayed as the calls were getting re-prioritised and also that the clinical priority baseline performance graph was disappointing in that dementia and LD we were needing improvement.

DG confirmed that discussions were underway on how to commission NEAS more effectively.

The executive committee NOTED the position and progress against each indicator in the 2016/17 improvement and assessment framework including mitigating actions to improve performance, NOTED the baseline position for each of the six clinical priority areas, NOTED the predicted CCG quality premium payment relating to 2016/17 and NOTED the progress on delivery of the 2016/17 plan on a page transformation programmes.

AFa joined the meeting 2.15pm

2016/97 Integrated self-care and rehabilitation model

The report confirmed the endorsement of the decision to extend the scope and delivery timescale for the project and support for the requirement to serve notice to providers of the existing affected services in order to allow further development of the model.

MT gave some background to the report previously presented to the executive committee in September 2016 via the assurance report and that the sustainability delivery group had endorsed to extend the scope of the productivity project relating to the healthy eating and lifestyle programme and the move to improve team. The purpose of the report was to confirm endorsement of the decision to extend the scope and delivery timescale and to serve notice to providers of the existing services to enable further development of the model.

Legal advice had been sought and had highlighted that there is a need to follow a form of procurement exercise.

JG enquired if notice was to be given on specialist nurses would it be for all the services they provide. MT responded that it was for diabetes nurses, those responsible for pulmonary rehabilitation and cardiology rehabilitation which was not a consultant led service.

AFa noted that the principle of the model was that services were providing a combination of education and exercise and the education was largely the same for all. Patients have more than one condition so the reconfiguration was around making it more patient centred.
FK noted the document reflects the direction of travel and there should be one single point of access.

JG enquired if this was to go to procurement was it hoped that the services would go to a combined bid and MT noted that this would be a combined model.

FK noted that the CCG was trying to fit everything around MCP and the procurement and was conscious of the different timescales. IP highlighted the need to map out these processes.

DB noted a link through the out of hospitals board where work around falls led to challenging what the system was doing about falls as all the national evidence showed this made a big impact on a number of areas. DB also noted that there was overview from a falls consultant and from the services. It was agreed there was a need to sense check if the services in right place. The CCG funded a falls co-ordinator.

DB asked if notice has to be given there was an understanding of the impact on providers. It had been agreed to commission one integrated new out of hospital provider for as much out of hospital care as possible, potentially this could cost £280m and DB raised concerns over serving notice and what it would achieve.

DG clarified that the committee agreed that this was the right thing to do in terms of scope and it needed fine tuning and to be kept legal. There was a need to, work in partnership and work on how to give out the serving notice message.

FK asked why a different approach is being taken rather than the previous approach used for integrated care. MT confirmed it was 3 different providers with a similar service with a large workforce. DB confirmed it would be the same staff groups that would be providing the service.

DG suggested that this be mapped out and then have a conversation with partners to understand what legally has to be done and if it legally has to be done there can be a conversation with partners with some context of why the approach is being taken.

IP asked if legal advice had been sought this must provide a clear path if we were to be challenged.

The executive committee CONFIRMED support for the change in scope of the project and the consequential extension to timescales for delivery and NOTED the content of section four and to APPROVE the formal termination of these services by way of contract notification to the providers.

ACTION: Process to be mapped out and legal advice sought - AFa

*The chair called for a 5 minute break 2.40-2.45pm*
2016/98 LD Employment pledge paper

The purpose of the paper was to inform the executive committee of the learning disabilities employment pledge and to ask for agreement to sign up to the pledge. The national learning disability transforming care board were currently reviewing the position of NHS organisations with regards to the signing up to the learning disabilities employment pledge. As part of this the CCG had been asked to consider signing up to the pledge.

CN explained that if the CCG sign up there are 3 steps to commit to the pledge and to sign up organisations must agree to all 3 steps.

The 1st step is to sign up,
The 2nd step is to create an action plan, to employ more people with learning disabilities – there are resource implications to this step
The 3rd step the CCG needs to confirm they are employing more people with learning disabilities and to share their success stories.

The paper outlined the benefits and CN highlighted that there was a significant commitment of resources from an organisational perspective. The employed person would require 1:1 support from a member of staff, the pledge was aimed at employing permanent fulltime staff.

The CCG would provide funding to employ a member of staff but there would be support from Project Choice to help think about the environment, the workplace and tasks that would be given for example repetitive and paper based tasks.

This is a voluntary scheme and as yet no other CCG has signed up to this.

AFo noted it looks a positive thing to do but there is a need to think of what type of role might be needed and staff would need to be asked as this is a big commitment. DG noted staff would be spoken to if this is something we think we could pursue.

JG asked if there was a timescale from commitment to success, CN explained there was not a definitive timescale but the guide required review of the action plan on an annual basis including actively looking to put employment measures in place.

DB asked if this would be a new post, if this was the case we are currently not recruiting to permanent posts as we are looking at non-recurrent funding. DG explained that it could be a new post or an existing vacancy but it would have to be the right vacancy.

RB asked could this be a pilot for apprenticeships and was there any scope around this. CN explained that we could explore this but it was in the pledge that we employed permanent staff, it would be whether this was acceptable as part of our action planning.

DCh noted that as JG had explained there was a wide spectrum of people and jobs, there were issues around creating a post as we were at full establishment.
DG clarified that there would need to be further discussion with Project Choice and if a vacancy came up and it was the right one this could be explored. However, from the discussion it was agreed that this was unlikely to be something the CCG would be able to sign up to at this point.

**2016/99 Business Continuity Plan**

The report provided the executive committee with an updated business continuity plan. CCGs are a category 2 responder which means that there needs to be a plan in place to deliver its functions in case of an emergency. The plan has been reviewed and updated in line with the revised guidance published by NHS England (NHSE). The guidance included a revised format and updated impact analysis templates.

A template had been received from NHS England (NHSE) which had been produced from the Emergency Preparedness, Resilience and Response (EPRR) assessment. The template was more detailed and robust than the previous version with a few annexes including a key contacts list, action cards which specify roles and responsibilities for key individuals and a NECS disaster recovery plan.

The CCG undertook an internal audit review in 2015 for which we received significant assurance although there were some improvements we were asked to make. We also completed a desktop exercise with the directors and senior team in April 2016.

This will now be broken down into a “battle box” which will pull out key action cards if an incident should take place.

Following a question around the teams listed in the scope section of the report it was agreed to amend the header to read: *The following functions are covered by this plan:*

**Action:** DCo to change the sentence in section 3 and to amend the page numbering.

The executive committee APPROVED the revised business continuity plan subject to the amendments above.

**2016/100 Information Governance update**

DCo presented the information governance annual report for 2015/16, information governance strategy for 2016/17 and the training needs analysis for 2016/17. The 3 reports included in the update were:

Information Governance annual report for 2015/16 - this was recommended as best practice from the IG toolkit, reviewing activity over the year and highlight any areas of improvement that required focus.

The Information Governance Strategy 2016/17 – this had been updated following the annual report setting out the IG framework and how to manage IG issues. This also
sets out the roles and responsibilities taking into any feedback coming from the annual report.

Information Training needs analysis 2016/17 – to ensure compliance with the guidelines and statutory training CCG staff needs to undertake. DCo explained that the analysis gave a breakdown of who should be completing what training and for specific individual training needs.

The analysis would be shared with staff once the paper had been approved by the executive committee.

AFO noted a typographical error in the report in section 5, all staff to complete their annual training by the end of January 2016 – this should be 2017 Action: DCo to amend section 5 of the report to read 2017.

The executive committee RECEIVED the information governance annual report for assurance purposes, APPROVED the information governance strategy and NOTED the training needs analysis for 2016/17.

2016/101 Corporate Affairs Assurance Report quarter 2

The report provided the executive committee with an update and assurance on corporate affairs activity during the period 1 July to 30 September 2016.

This was the usual report covering health and safety, equality and diversity etc. In appendix 1 the equality objectives action plan to give assurance the CCG are working towards the objectives and making progress on the actions.

Appendix 3 related to non-clinical corporate incidents. An issue with the incidents was that the actions were not being closed on the system very quickly. NECS will close once all actions have been taken.

DCo noted a potential issue around subject access requests, going forward this may impact on the CHC requests.

In relation to policy management, the CCG had received limited assurance from an internal audit but, this had now been addressed and all policies are either in date or in the process of being reviewed and brought to the relevant committee for approval.

The executive committee RECEIVED the report for assurance purposes.

2016/102 R&D report quarter 2

Helen Riding, Research Manager, NECS presented the report on the latest activity for research and development.

HR noted that the report helps support the CCGs statutory duty in relation to supporting and promoting research and to use research evidence in commissioning. The figures in quarter 1 for activity were up from 18 in quarter 1 to 66 in this period which shows that research is increasing.
The CCG has recently appointed a research clinical lead, Dr Manchineni whose role would be to raise the profile of R&D and engage member practices. The R&D team could support the CCG in a number of ways with an evaluation event being arranged in 2017 which would share other projects being carried out in other CCGs. The R&D team were currently developing training on how to access and assess evidence.

AFo asked what the acronym PIC stood for; HR explained that it stood for patient identification studies relating to patients consenting within a GP practice. PIC activity is when a patient is referred to a research study within a hospital. AFo asked if there were none sent from primary care there may have been patients from Sunderland in the studies included in the numbers in the report. In relation to CHS it wasn’t clear what the proportion of Sunderland residents were in the study and AFo, asked if this information could be shared. HR noted this may be difficult as the information would be held by the study teams. AFo asked if this could be explored.

HR noted that this data was received from the clinical research network.

**Action:** HR to feedback the CCG request for information on Sunderland patients on the study to the clinical research network.

**Action:** HR to add Dr Manchineni to the list of appointed clinical engagement leads for the next report.

FK asked if the training for evaluation research was for the CCG or member practices and HR noted they were keen to roll out to CCGs then practices.

The executive committee RECEIVED the report for assurance purposes and would continue to promote practice engagement in research across member practices enabling the practice population the opportunity to take part in research and would provide feedback to Dr Shona Haining on any concerns or areas of clarification.

**2016/103 Localities (exception reporting)**

**Coalfields locality** - JG informed the committee that there was not anything specific to report back from her locality apart from Jon Twelves from Sunderland GP Alliance had asked to attend for the whole of the their locality meeting not just the 10 minute slot he had been allocated, she asked the GP executive members if this request had been made to the other localities.

FK noted that providers from all areas attended the meetings and that attendance may be to engage with practices. The Alliance covered the biggest current service in the city; integrated teams.

RF gave an independent view that if outside providers had been invited in the past and had stayed for the whole meeting then the Alliance should be treated no differently.
It was suggested that the group take a consensus over whether they were a member or not and if not to give them a specific slot on the agenda.

FK explained that they were planning to hold an education event in all localities on gastro new pathways. FK was trying to get commitment from a gastro consultant in secondary care to provide a session failing this it may be a fellow GP.

**Washington locality** - RB noted that concerns had been raised around MSK waiting times and had arranged for providers to give a presentation on how things had improved. RB noted that the practices were happy with the engagement process.

**North locality** - KG expressed concern that the north locality extended access was not yet up and running and that there may have been some communication breakdown. From a patient point of view it seemed unfair that the whole locality was not full established.
FK had been involved through the GP Strategy group and he explained that the scheme had been running for the past year although with capacity issues, the infrastructure was there with information sharing and reporting mechanisms with the CCG. The deficiency in the scheme was the capacity; extra capacity had been identified to cover some of the days and weekends going forward.

RB noted that he was conflicted as he was a GP in the North locality and the chair agreed that this was not material to the discussion.

He noted that his practice had offered to cover 3 out of 4 Saturdays with 1 day covering with 1 GP and 1 nurse from 8.00-1.00pm. In regard to weekdays it was understood that Wendy Page, Practice Manager had a plan for this cover.

AF noted the CCG has agreed a model then the proposal model was a different one. There had been some miscommunication across the board. FK had attempted to engage with everyone. This should now sit with the Primary Care strategy group, from where the work would be taken forward.

DG clarified that as soon as a proposal that meets the executive committee expectation sit needs to be expedited as soon as possible through the primary care strategy group. This should be mobilised and brought back to the next executive retrospectively.

**2016/104 Communications and Engagement Steering group minutes from 9 September 2016**

The executive committee RECEIVED the report for information.

**2016/105 Any other business**

There being no other business the meeting closed at 3.35pm.

**Date and time of next meeting**
The next meeting would be held on Tuesday 6 December 2016 at 12.30pm in the Joseph Swan Room, Pemberton House.
Signed

Dated 12/1/7
Executive Committee

Minutes of the meeting held at 12.30pm on Tuesday 6 December 2016
In the Joseph Swan Room, Pemberton House

Minutes

Present:  Debbie Burnicle (DBu) (in the Chair for David Gallagher)
          Dr Raj Bethapudi (RB)
          David Chandler (DCh)
          Ann Fox (AFo)
          Dr I Pattison (IP)
          Dr Karthik Gellia (KG)
          Dr Fadi Khalil (FK)
          Dr Tracey Lucas (TL)
          Gillian Gibson (GG)
          Florence Gunn (FG)
          Eric Harrison (EH)

In Attendance:  Dr Claire Bradford (CB)
                Deborah Cornell (DCo)
                Rebecca Crowe (RC) for item
                Laura Hope (LH) for item
                Gill Lambert (GL) for item
                Clare Nesbitt (CN)
                Helen Steadman (HS)
                Matt Thubron (MT) for item
                Scott Watson
                Jan Thwaites (minutes)

2016/106 Welcome and Introduction

Mrs Burnicle welcomed everyone to the meeting and confirmed that she was
deputising for Mr Gallagher (DG) and confirmed that the meeting was quorate.
To allow members of the committee to attend other meetings the order of the agenda
was changed.
2016/107 Apologies for Absence

Apologies were received from David Gallagher, Dr Jackie Gillespie and Dr Roger Ford.

2016/108 Declarations of Interest

Interests were declared from all GP executives in relation to item 2016/124 Extended hours in primary care during 2016/17. The Chair confirmed that the executives could be part of the discussion but not the decision making, this would be made by the non-conflicted executive members.

2016/109 Items of any other business

Care of dying document update, FG

2016/110 Minutes of the meeting held on 1 November 2016

Following a few typographical amendments the minutes were ACCEPTED as an accurate record.

2016/111 Matters arising from the minutes and action log

There were no matters arising from the minutes.

Action log


2016/44 Stroke Review (TL to check costings in regard to improvement and quality)

This item would be brought to the executive committee in January 2017

2016/86 any other business NHS Property Services – the item would be brought to the executive committee in January 2017

2016/112 Equality and Diversity Strategy

DCo presented the executive committee with an updated equality strategy which ensures the CCG meets its statutory duties in relation to equality and diversity.

DCo confirmed that the equality objectives had been agreed as part of the self-assessment process, these objectives were approved by the executive committee at its meeting on 5 July 2016.

CB asked when the self-assessment against the EDS2 toolkit had been carried out, DCo confirmed this had been in July 2016 and the next would be in January 2017.

DCo explained that an equality and diversity group had been established whose membership included the voluntary sector.
The executive committee **REVIEWED** the updated strategy and **RECOMMENDED** its submission to the governing body for formal ratification.

**2016/113 Assurance Report**

The purpose of the report was to provide the executive committee with the current position against the CCG assessment and improvement framework requirements and delivery against the CCG operational plan for 2016/17.

HS highlighted the following key points, risks and assurances:

The operational plan project toolkit was an excellent way to monitor the milestones and activities; more work was needed to monitor the impact of the change the projects were expected to deliver. Work had begun on this to demonstrate changes with the PMO, business intelligence and the management leads working to develop the key performance measures in relation to ambulatory/emergency care, cancer and CVD.

The sustainability delivery programme projects and South Tyneside Foundation Trust community contract review had been flagged as going from amber to red due to £1m being removed from the contract. They are flagging the need for an additional £1m which would give us a £2m gap.

It was noted that CVD has become a programme of work. HS described the constituent parts of the programme and noted that this is the only area where we have a red risk. There was a potential to not achieve the savings.

The urgent care strategy is in the listening period until 23 December. An email had been sent out to inform the governing body members that the development session to be held on 20 December would focus on starting to develop the clinical model.

MT highlighted the following from the report: –

There had been 1 further case of MRSA at City Hospitals Sunderland (CHS) bringing the total to 5 for the year; this latest occurrence was a Durham resident and the issue of rising numbers was to be a key focus at the next HCAI improvement group.

Referral to treatment (RTT) on page 4 of the report RTT was an emerging pressure particularly in ENT at CHS with a slight deterioration overall in figures. MT had received indicative figures for October and November where overall performance was beginning to improve. This was exacerbated on the whole by ENT around admin and staffing issues. There was an action plan in place and by the end of January they should be compliant again.

There were further issues around the admin around close down of clinics, close down of letters and ensuring the correct outcomes where on the system – this had been addressed due to short term staffing issues.
A&E at CHS was a continuing pressure whilst CHS were delivering their STF trajectory for November, there would be increased activity levels throughout some of the reporting. October A&E attendance was 1,000 patients higher than the same period last year; this was down to a change in reporting due to streaming between Pallion and ED although there was an underlying growth in activity of 4-5%.

CN asked if we had seen any reduction in referrals from the map of medicine work, MT responded that the data would be reported next month as it was received in arrears. Information was going to be brought in from the GP Alliance re map of medicine at a practice level to triangulate information around referrals.

IP raised the treatment room issues in general practice which appears to be around change in service provision and the £300k extra funding request. There appears to be a reduction in work especially around children under 16.
AF relayed the conversation she had had with the Director of Nursing where concerns were raised around the children’s issues, the future of treatment rooms, and what the processes may be. In the meantime there was a need to keep stability. There were issues around the assurance of staff competencies. AF requested work on a collaborative managed plan to minimise the impact on the whole system but would have to have some communications to staff and practices, this would need to be managed.

DCh joined the meeting 1.00pm

FK noted that there had been a loss of a lot of organisational memory with the restructure that had happened in STFT as a result of the need to make efficiencies. There was a need to not destabilise the system any further.

EH noted this was open to a wider debate around the expectations of practices, he highlighted the difference in service provision of treatment rooms across the city and suspected this would need to be addressed in the contracting negotiations.

In discussion MT confirmed that there was no service specification for treatment rooms. AF noted that she was not clear what we were planning to do re treatment rooms.

DB highlighted that we need to understand what was being proposed by STFT before we respond and to look at a way forward. In terms of the priorities for general practice over the coming months there were a number and this issue was not currently one of them, and further info on the issues and a discussion about the way forward would be needed to determine if Treatment rooms do now need to be a priority moving forward and what this may mean for other priorities.

AF noted also that STFT were proposing to establish a task and finish group and wanted CCG engagement.

CB noted that regardless, the contract has not changed and the service should continue via STFT.
IP noted in relation to areas for improvement re the national 6 clinical areas he was not clear what we have to do to improve.
MT was doing more work to understand where there was more than 1 indicator the weighting and hence where we need to be focussed to make the improvements. This work was almost complete and would be shared at the next executive committee as part of the assurance report.

The executive committee NOTED the position and progress against each indicator in the 2016/17 improvement and assessment framework including mitigating actions to improve performance, NOTED the baseline position for each of the six clinical priority areas. NOTED the predicted CCQ quality premium payment relating to 2016/17 and the progress on delivery of the 2016/17 plan on a page.

2016/114 NHS Operational Planning and contracting guidance 2017/19

The purpose of the report is to provide the executive committee with an overview of the recently published NHS planning guidance and describes the process to date to develop the CCGs operational plan in accordance with national guidance and timeline.

HS confirmed that we had submitted our first draft plan and have been advised by NHS England that feedback should be received by Wednesday with a teleconference on Friday to go through the feedback. Also circulated today was a high level summary covering a whole range of areas including the narrative, finance and productivity plans.

The final submission would be on 23 December, this will be finalised at the governing body development session on 20 December 2016.

The executive committee RECEIVED the report and NOTED the contents and comments on the plan on a page.

*MT left the meeting 1.10pm*

2016/115 Finance Report – month 7

The purpose of the report was to present the executive committee with a summary of the financial position of the CCG as at month 7 for the period ending 1 October 2016.

Key messages were relayed which included the following;

The CCG was on track to deliver our financial targets, In terms of forecast outturn the main area highlighted was the CCG premises costs adverse variance of £1.3m from PropCo charging for voids and bookable space, no bills had yet received. The CCG had put in a prudent forecast figure. A number of credit notes may be received at the end of the year.

GP budgets showed a favourable variance, information on what this was to be utilised for was discussed.
In relation to QIPP Sunderland was noted as the only CCG to deliver all targets.

Risks reported on £2.3m on acute and prescribing, £2.5m contingency had been allowed. 
No news on contingency of 1% yet but we could hear by the end of the financial year.

There was one virement to approve in relation to vanguard.

A number of CHC invoices were still to be processed and patients could still put in a claim. NHS England have confirmed that they hold the money this year for claims and are putting money aside for next year.

Progress was being made with the annual financial plan. Progress has been made on managing the additional 4m gap and information would be circulated on the plan at the next non-agenda executive session.

HRG+ in terms of the allocation this is different to the impact the CCG have modelled through. For Sunderland this is in the region of £4m, we have to notify whether we are in agreement of the new set prices. DCh asked the executive committee's support to the consultation process by rejecting the tariff on the basis that CCG estimates show that the funding allocation reduction of £4.1m is out of kilter with the real impact by approximately £3.8m.

TL asked about the impact on funding nursing care (FNC) prices and when this would be done by.

DCh noted that FNC prices were agreed as part of a national Mazars paper and the prices went up by 40% which was up 12% in total, this feeds into the CHC rates. Sunderland providers noted this was not enough to cover the cost of CHC. The CCG agreed that we would progress this work locally and Ian Holliday was working with the local authority.

**Action:** DC to ask IH to circulate an update to the executive committee.

FK questioned the figure of £417 relating to primary care on page 6 of the report; DCh explained there had been a shift in forecast out turn variance; this was the movement from one month to another.

An update on transfers of care was requested and SW responded that there had been a meeting arranged for 6 January to extend the clinical scope. In terms of the CHS work on the transfer of follow ups, the CCG with CHS had agreed that it is done in a staged and managed way and they are aware that we are developing an outpatient programme which they are happy to work with us on.

IP asked how the 1% reserve was accounted for and in response DCh noted it was required for CCGs to increase their surplus and was accepted that this is CCG money.

The executive committee **NOTED** the financial position of the CCG as at 1 October 2016, **APPROVED** the budget virements for month6, **NOTED** the update provided on CHC restitution, **APPROVED** the reject response to the tariff consultation and
CONSIDERED and SUPPORTED the regional QIPP productivity scheme proposals in principle

2016/116 Sunderland Cancer Plan

The purpose of the report was to update the executive committee regarding the development and implementation of the Sunderland cancer plan and to seek sign off from the committee for the dissemination and implementation of the Sunderland cancer plan across Sunderland.

CB confirmed the Sunderland cancer plan was being launched at the TiTO on 7 December and appendix 1 shows who was responsible for the priorities and actions. DB noted the incentive scheme for practices which was funded from the under spend on general practice budget.

R Crowe joined the meeting at 1.30pm
FK noted that 28 recommendations were extremely ambitious and asked if there was the infrastructure to support them, he raised concerns over work load on general practice. CB accepted this concern but noted that it was not all for the CCG to do as it included other organisations such as the local authority. CB noted there were timescales and milestones which should be in the next iteration.
FK also alluded to point 41 comprehensive care pathways for the elderly, and asked where this fitted with the out of hospital (OOH) model. CB noted the CCG had focussed on areas that we felt were deliverable. In relation to freeing capacity for breast cancer patients, CB noted the CCG would be working with the alliance on this.

GG noted alcohol and tobacco were the HWBB priorities anyway and there was a focus on those but not on obesity.

Action: It was agreed to take the Sunderland cancer plan to HWBB and to the Governing Body in January to assist in progressing this agenda.

The executive committee CONSIDERED and discussed the contents of the plan and AGREED the formal sign off of the Sunderland cancer plan.

2016/117 Map of Medicine

The purpose of the report was to provide the executive committee with six further Map of Medicine pathways for sign off.

CB confirmed that there had been some usage data included in the report.

TLu asked that at the TiTO session it be raised that the 2 week referral forms were on map of medicine. FK noted that Dr Bell would be highlighting the new pathways.

Action: FK to check out information on the 2 lipid pathways.
IP noted that it was helpful that the guidance was all in one place and helped with discussions with patients. He questioned that in future should all pathways be brought through the executive committee or be delegated. CB explained that it had been considered to go through the medicines optimisation and guidelines group (MOGG), a summary of which comes through the executive committee. FK explained that for clinical governance it needed the CCG sign off, this should be reviewed.

**Action:** FK, CB and JG to discuss outside of the meeting whether there was sufficient assurance using the MOGG meeting to agree future pathways.

The executive committee **APPROVED** the pathways to be included in the Map of Medicine subject to the check on the 2 lipid pathways noted above.

**2016/118 Renal dialysis patient transport service re procurement business case**

The purpose of the report was to procure a replacement renal dialysis patient transport service (PTS) as the current contract for the existing service ends on 30 June 2017 with no option to extend. The business case was presented to validate the need to procure this service and to present the CCG with the various options it has to proceed.

There was a well-established market for this service and the CCG could be challenged by other PTS providers and if nothing is done there could be no service from 30 June 2016.

In terms of key assurances the contract was currently valued at £287k, based upon a reduction in journeys our share of the future contract would be £191k with a saving of around £100k on the current spend.

DCh asked if the activity had reduced and RC noted that there had been a shift to more home dialysis.

RB asked if the type of transport the patients used was triaged; RC noted it was triaged at the point of booking. SW noted that the eligibility criteria for PTS were different for renal patients. Under the national service framework it was stated that renal patients should have access to regular comfortable transport to improve patient outcomes.

CB asked about modelling for service requirements and if there would be increased demand in future. SW confirmed this had been taken into account as part of the block contract.

**Action:** It was agreed to bring the final specification to the January/February executive committee.

The executive committee **AGREED** to procure the service jointly as part of the wider group of CCGs and achieve economies of scale across those CCGs.
RL joined the meeting at 1.50pm

2016/119 Special Education Needs and Disability (SEND) update

The purpose of the report was to provide a progress update on the implementation of SEND code of practice for 0-25 year olds following the September 2016 executive committee report.

RL highlighted the information from a recent Ofsted update around SEND regarding the 5 day notice period and the requirement and observation that would follow on how well we consult and recruit families to participate. The CCG had asked NECS to develop a joint communications plan with the local authority.

In regard to risks RL highlighted the current changes in local authority and in particular the finances around the new children’s company. Assurance had been received since the writing of the report, although clarity was still required around the full service provision. In terms of transformation work clarification was still required around the Child and adolescent mental health service (CAMHS) transformation work.

Following work on the service review for Speech and Language Therapy (SALT) services there was a possible £500k saving with a move to a prevention model.

DB suggested that we could not approve the request to implement a new SALT service specification from 1 April 2017 as we do not have a specification and do not know the outcome of the review.

GG disputed the comment in that the report stated that obesity levels in Sunderland remained high but that strategic intentions and priorities were unclear. A paper had been to cabinet on commissioning intentions. RL noted that further work was still required on the local offer in particular around children with learning disabilities.

FK asked if the report could include figures for example on level of need, figures of savings etc.

IP asked that clarity around the children’s services be included in the next report.

The executive committee NOTED the content of the report including the joint commissioning challenges and actions which are being taken to support effective service delivery of SEND, continuing care and external placements for LAC, ASD and ADHD. Also noted the committee would receive the outcome of the review of the new specification for agreement at the February meeting.

The Chair called for a 5 minute break 2.05-2.10pm.

LH joined the meeting 2.10pm.
2016/120 Extended access

The Chair noted the conflict of interest by all GP Executive members for this item and declared that they could be part of the discussion but could not take part in the decision making. This would be undertaken by the remaining voting executive members. It was also decided that EH would also be conflicted and a perception that FG could be conflicted as she is employed by a member practice.
The purpose of the report was to update the executive committee regarding the national requirements of the extended access in general practice scheme set out by the general practice five year forward view and national planning guidance. To consider and agree the additional local requirements suggested by the CCG and the supporting draft specification, to consider the options and agree the recommended option in relation to securing the extended access to be in place not later than September 2017 and to agree the use of the £400k pump priming monies.

DB noted that by 23 December when the CCG operational plan is submitted it needs to describe how we will deliver our general practice forward view and GP extended access within that.

DB drew out the following issues:

- The CCG had sought legal advice around the options in the report (confirmation of this was still awaited)
- The core requirement of extended access was from 6.30-8.00pm (Sunderland and Durham are in a unique position as they close from 6pm) this needed clarification. There was an issue from 6.00-6.30pm which was now covered by out of hours cover.
- We are not the only CCG in the NTW area as a transformation area to have the opportunity and the funding for this. All other CCGs in NTW have to conclude extended access by April 2017 and access the £6 per head and despite asking all other CCGs in NTW for info about how they were progressing very little had been received and what had said they were still considering the issue.
- We have access to £1.50 a head pump priming money (£400k this year), using some of this money (100k) to fund Washington and the North developments, this decision had been delegated to get this underway.
- A suggestion had been given from the urgent care out of hospital board for an additional local requirement to enable A&E to access pre-bookable appointments across the system.

LH had set out the issues one of which was capacity in the system to carry out the requirements in 2017/18 it would be harder in 2018/19 when it increases.

DB highlighted that the procurement of the contract could be delayed if the CCG had a good strategic reason to do this. It was recommended that in light of the work on the urgent care strategy we delay on a decision on extended access, this would be part of the out of hospital MCP and how we commission all these services longer term.
One of the other risks would be a division across the general practice community as well as the issues around access to patient data limiting providers.

DB highlighted the options available with advantages and disadvantages:
Option 1 - Formal Procurement
Option 2 - Tender waiver for 2 years and GPA to serve as an integrator working with practices and localities
Option 3 – as option 2 but GPA to provide the service

Discussions highlighted the following points:

- Leadership would be required as some of the options challenged how GPs had traditionally worked.
- One of the differences between options 2 and 3 in terms of the GPA being a provider was service specification they would find it difficult to demonstrate their ability to manage for example quality or safeguarding.
- This would be a test of joint working in localities.
- The test would be scale ability and the demands of an integrator.
- What was the likelihood of challenge if take options 2 or 3?
- Could have 4 localities working at scale and 1 other wanting to work in isolation.
- There may be a challenge around the legalities under procurement law – DB clarified that the CCG are going to procure we are simply delaying the procurement.
- The benefits of local GPs working together.
- The core requirement of the extended access was working across the city regardless of federations.
- Whether to have direct delivery or integrated service.
- When going through procurement you have clear detail on how it will be delivered but don’t have the assurance if don’t go through this process.
- Issues around practices lack of engagement and the need to involve the GPs.
- The need for OD support which could be funded from the pump priming to be included.
- There needs to be full access to extended general practice and not just access to a GP appointment without all supports for example bloods.
- As a point of clarity the GPA would be calling on all practices to engage across the city not just its membership.
- It was confirmed that the CCG would eventually procure but need to ensure clarity on what is procured.

DB asked that for those members who were not conflicted for clarity she confirmed that in relation to the 3 options:

Option 1 would not be supported.
Option 2 it was about support from OD and how to use this to work with practices and build on existing developments by practices in localities and the alliance was best placed to do this.
Option 3 the alliance should be responsible for the delivery, but the specification would require them to work with all practices and set up locality hubs and utilise any lessons learned/experience from these developments.
FK asked that we support the direction of travel but whatever the final decision it needs to be facilitated through discussion with practices with OD support.

IP noted that we should be aware of where this decision came from pilots developed from innovation funding.

IP noted neither Option 2 or 3 are right or wrong, they just reflect a point in the development of general practice and delaying the procurement allows the proof of concept/further testing to be clear what is needed in the future and option 2 allows the CCG to build on the work that practices have progressed to date.

The non-conflicted voting members AF, DCh and DB supported option 2 proposed tender waiver for 2 years with the proviso of the addition of OD support.

2016/121 Value based clinical commissioning policy

The purpose of the report was to highlight the key changes to the regional value based clinical commissioning policy, to ratify the proposed changes and to advise on introduction of the policies in Sunderland CCG.

Following a conversation the following areas were noted;

- Concerns over timing due to increased GP workload,
- the document was secondary care focussed and does not add any value for clinicians
- the referral of regular items was too time consuming for GPs
- the time taken to refer patients using the prior approval ticket
- to improve the quality and variation in care

CB added that this was a clinical policy that the CCG as commissioners could sign up to and noted the issue of how it was implemented could be addressed separately. CB took on board the issues highlighted but stated that this was about approving the extension of the list of the policy with the proviso that we have to be very careful on its implementation.

SW agreed with the demand on GPs but confirmed that primary care was funded £2 per head last year to do this work. SW questioned how this could not be agreed when there is a policy in primary care that formed part of map of medicine.

DB summed up that there was agreement to sign up to the policy, agreed the clinical thresholds but further work was required on implementation.

KG asked for assurance in the future the CCG would not ask the GPs to start implementing the policy without further work/discussion. DB gave that assurance as this is not what we have agreed at this meeting.

The executive committee RATIFIED the revised value based clinical commissioning policy with the codicil that further work was to be carried out on implementation.
2016/122 Localities (exception reporting)

This item was not discussed as a written update would be presented at the next meeting.

2016/123 Business Case Process

The purpose of the report was to seek approval from the executive committee to endorse the proposed process to manage the application of business case requests to and within the CCG.

GL described that the process was in 3 different stages:
1. A business template
2. Who makes the decision to support the business case
3. The output and arrangements put in place to monitor and evaluate the investment

Resource was available across the PMO and finance teams to assist in the completion of the business case template.

The sustainability and delivery group could provide information between stages 1 and 2. Where a shorter decision making process was required the executive committee were asked to approve a waiver process so the Chief Officer could approve cases as required. DB suggested that section 5 of the template mentions the current operational plan and health and social care strategy, could this be changed to utilise the new 2 year operational plan.

CB asked that when the assessment criteria was used that the process recorded what it was and that the evidence would be included. DC noted the risk assessment needed to be updated.

**Action: GL to ensure** the correct risk assessment to be added to the report.

It was confirmed that it was proposed that only a Director could instigate a fast track business case, an additional step to be included around approval between appendix 2 and 3.

**TLu left the meeting 3.40pm**

IP noted that clinicians should be included in any discussions; a question was asked if any fast tracked cases should come through the executive committee to enable this.

AF asked that in relation to fast track this should be a Director and clinical lead to approve, this was agreed.

The executive committee **APPROVED** the proposed process flows in appendices 1, 2, 3 and 4 to become the accepted business case process for the CCG with effect from 6 December 2016, **APPROVED** the business case template at appendix 6,
RATIFIED the role of SDG as the CCG group to quality check and assure business case content to ensure decision maker(s) have the requisite information to make informed investment decisions and APPROVED the fast track waiver process at appendix 5 when extenuating circumstance apply. All to be effective from 6 December 2016 subject to involving the relevant clinical lead.

2016/124 Extended hours in primary care during 2016/17

The purpose of the report was to share information on a delegated decision taken by the Deputy Chief Officer under the scheme of delegation.

The executive committee NOTED the report for information.

2016/125 Communications and engagement steering group minutes from 7 October 2016

The executive committee RECEIVED the report for information.

2016/126 TiTO event evaluation report

The executive committee RECEIVED the report for information.

2016/127 TiTO steering group action grid – November 2016

The executive committee RECEIVED the report for information.

2016/128 Sustainability delivery group minutes from 18 October 2016

The executive committee RECEIVED the report for information.

2016/129 Any other business

FG raised the issue of the care of the dying document and the discussion on how to implement it across the city. It was confirmed that the trainers from the hospice would prefer that it was discussed at the locality workshop days rather than TiTO. FK noted that we may create our own document that fits with our local needs.

FK updated the committee on workflow optimisation training which was raised at the GP strategy group and the incentives for general practice to engage in this optimisation via the training offer. DB suggested that if this was what was needed that a proposal be worked up.

There being no other business the meeting closed at 4.00pm.

Date and time of next meeting

The next meeting would be held on Tuesday 10 January 2017 at 12.30pm in the Joseph Swan Room, Pemberton House.

Signed

Dated
Primary Care Commissioning Committee

Minutes of the meeting held on

Tuesday 27 September 2016

Bede Tower, Burdon Road, Sunderland SR2 7EA.

Present: Mr Chris Macklin, lay member primary care commissioning (chair)

Mr David Gallagher, chief officer

Mrs Aileen Sullivan, lay member patient and public involvement

Dr Ian Pattison, clinical chair

Mr David Chandler, chief finance officer

In Attendance: Ms Deborah Cornell, head of corporate affairs

Mr Kevin Morris, chair of Healthwatch

Mrs Jackie Spencer, senior commissioning manager

Mrs Wendy Stephens, primary care contracts manager, NHS England

Mrs Jacquie Lambie, primary care workforce lead

Miss Alison Greener, minutes

2016/58 Welcome and Introductions

Mr Macklin welcomed everyone to the meeting of the primary care commissioning committee.
2016/59 Apologies for Absence

Apologies for absence were received from Mrs Burnicle, deputy chief officer, Dr Stephenson, primary care adviser, Dr Gellia, executive GP, Mrs Johnstone, head of primary care NHS England and Mrs Brown, director of people services, Sunderland City Council.

2016/60 Declarations of Interest

None received at this point of the meeting.

2016/61 Minutes of the previous meeting held on 26 July, 2016

The minutes of the meeting held on 26 July were agreed as a true record.

2016/62 Matters Arising from the Minutes and action log

2016/49b Update on GP Forward View Finances

Mrs Lake advised that the £171m (£3 per head) allocated to the CCG for transformation support had not yet been received and this was being investigated. Mr Chandler stated that an update on this was expected soon. There was the possibility of further additional funding being made available for 2017/18 or 2018/19 which would be outlined in the forthcoming planning guidance.

2016/63 Primary Care Commissioning Finance Report

Mr Chandler presented a summary of the financial position of the delegated general practice budgets as at month five for the period ending 31 August 2016.

There was a forecasted underspend of £666k on delegated general practice budgets for 2016/17.

Work was currently underway with practices and NHS England on the increase in building charges by NHS Property Services. Mr Chandler advised he would continue to work with NHS England to support the affected practices wherever possible. A further update on this would be brought back to this committee.

Action: Mr Chandler to provide an update on the increased building charges from NHS Property Services and the impact on the affected practices.
Dr Pattison highlighted the current underspend for primary care and suggested that this could possibly be invested in property services. Dr Pattison felt that the impact of this was quite significant for practices and potentially destabilising as there were 30 practices affected which was considerable for Sunderland.

Dr Pattison declared a conflict of interest at this point as he noted that his practice was one of those affected by the increased charges. Mr Macklin acknowledged the conflict, however given its nature, was comfortable for Dr Pattison to continue to take part in the discussion as his views helped outline the problem at a practice level. The item was also for debate and no decisions were required. Dr Pattison advised that his practice had identified contingencies to address the increase but he was aware that other practices were not able to do this. He expressed concerns regarding these practices and the impact this could have if they did have to pay the additional charges as it could cause some practices to file for bankruptcy. He thanked Mr Chandler for the work that was currently underway and noted the future risk and how this could be destabilising.

Mr Macklin highlighted that work was underway in Northumberland, to review the accuracy of the charges and it may be useful for Mr Chandler to link in with the lead for this Mr Naylor. Mr Chandler advised a full time accountant had been employed by the CCG who was focusing on this issue and was linking in with Mr Naylor.

Mr Chandler advised that common issues were coming to light such as the floor areas not being accurately calculated and issues relating to planned maintenance. Mr Macklin suggested informing the GPs that this was being investigated would be helpful. Mr Chandler advised the outcome of this work would be shared with colleagues across North East and Cumbria but expressed concern that practices were not identifying contingencies just in case. Mrs Spencer was also aware of this and shared this concern. Dr Pattison added that the Local Medical Committee for Sunderland were advising practices they should pay what they were previously billed for.

Mr Macklin requested regular updates at this committee on this issue.

Mr Macklin also suggested that plans should be put in place to utilise the underspend in the primary care budget. Mr Gallagher advised this was on hold at present until the planning guidance was released as this would clarify what funding was available and how this could be utilised based on the CCG’s general practice strategy.

The committee NOTED the declaration of interest made by Dr Pattison and NOTED the financial position of delegated practice budgets as at 31 August 2016.
Mrs Spencer presented the report and explained that the general practice resilience programme was designed to support practices in the medium term with regards to sustainability and resilience. Work had been ongoing with practices to assure them that this was about support and not because there were problems within the practice. Following a presentation at the TITO, a number of practices had made enquiries about the programme but to date only 2-3 applications had been submitted. Mrs Bradbury, locality commissioning manager for the CCG, had discussed this with some of the practices, with those practices in Victoria Road who were working together as a group.

The deadline for applications was 26 September and a panel had been set up to review the applications. The short deadline was noted as Mr Macklin advised that the panel were due to meet on Thursday 29 September. NHS England were leading on the process and an update would be provided for the next meeting. Mrs Stephens advised that the deadline had been extended to 7 October for practices to submit their applications. The panel would be stood down following the deadline extension.

Dr Pattison noted that as the CCG had delegated authority with regards to primary care commissioning, any available funding relating to this should be managed by the CCG rather than NHS England. He also stated that there would be a substantial amount of money becoming available and it would be more prudent for the CCG to decide where this could be best used. Mr Gallagher noted a similar discussion had taken place with Durham CCG and that the management of delegated authority monies was a national issue. Dr Pattison also asked if there was an underspend on this funding, where would it go. Mr Chandler responded that the sum was £40k recurrently for each CCG and agreed that transparency was needed to see how it was being allocated to other CCGs. £40k was not a sufficient amount of money and it could be utilised in a better way if it was joined up with other CCGs. Mrs Stephens advised she would feed these concerns and notes back to NHS England.

**Action:** Mrs Stephens to feedback the CCG’s concerns in relation to the practice resilience funding and how this is being managed.

### 2016/65 Practitioner Health Programme North East

Mrs Lambie presented a summary of the practitioner health programme North East. The paper outlined a proposal to extend and develop the programme for a further twelve months.

This had been recommended by the GP workforce steering group following a review of first nine months in which the programme had
overachieved. Six GPs had gone through programme and managed to continue in work.

A national programme and local programme would be put in place but it was not yet known when or what the remit or scope would be. The recommendation was for the programme to continue for further twelve months and, once the national programme has been established, a gap analysis to be undertaken. The cost of this programme was £14k for twelve months and recurrent funding had been identified.

Mr Macklin noted the success of the programme and the fact that it had sustained individuals in work was achieving merits. Mrs Sullivan noted that the evaluation demonstrated it was clinically and cost effective.

Mrs Stephens noted that Cumbria and the North East were starting a procurement exercise for 1 April 2017 and advised she would obtain further detail for this.

Dr Pattison suggested a presentation be made at the TITO to highlight that this programme was available. Mrs Lambie confirmed there would be a relaunch via the TITO, as well as via the general practice strategy implementation group. Dr Pattison also suggested it could be linked in with the appraisal process.

Under their delegated limit as per the CCG’s scheme of delegation, the chief finance officer and chief officer APPROVED the funding to extend the programme for a further twelve months.

### 2016/66 For Information

#### 2016/66a Healthcare Assistant and Practice Nurse Careerstart Procurement Outcome

The healthcare assistant (HCA) and practice nurse (PN) careerstart programme report was received for information. Mrs Sullivan queried whether the programme was resulting in the HCA’s progressing to pre-registered nursing. Mrs Lambie stated that it took them from apprenticeship status to nursing entry level 4 by upskilling them. Mrs Sullivan suggested an additional conversation was needed in relation to the adult nursing programme and securing nursing staff for the acute sector.

The committee RECEIVED the recommended report for information.

#### 2016/66b General Practice Forward View – Position Statement

The general practice forward view position statement was RECEIVED for information.
2016/66c Managing Conflicts of Interest

The paper gave an overview of the revised statutory guidance recently published by NHS England, an outline of the CCG’s process to manage conflicts of interest and the updated standards of business conduct and declarations of interest policy. Ms Cornell advised she had recently attended a session in Leeds where new guidance had been received and gave assurance to the committee that some of the revised processes had already been implemented. The policy had been approved by the executive committee and was scheduled to be formally ratified by the governing body at its meeting later that day.

The managing conflicts of interest paper including the documents described above was RECEIVED for information.

2016/66d GP Strategy and Implementation Group – minutes from last meeting

The notes of the general practice strategy and implementation group meeting held on 10 August 2016 were RECEIVED for information.

2016/66e Workforce Update – minutes from last meeting

The notes of the general practice workforce steering group meeting held on 20 July 2016 were RECEIVED for information.

2016/67 Any Other Business

None was received.

2016/68 Date and time of next meeting

The next meeting will be held on Tuesday 29 November, 2016 at 17:05.
SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 23 September 2016

MINUTES

Present: -

Councillor Mel Speding (in the Chair) - Sunderland City Council
Councillor Louise Farthing - Sunderland City Council
Councillor Shirley Leadbitter - Sunderland City Council
Councillor Graeme Miller - Sunderland City Council
Gillian Gibson - Director of Public Health
Dr Ian Pattison - Sunderland CCG
Ken Bremner - Sunderland Partnership
Kevin Morris - Healthwatch Sunderland
Ben Clark - NHS England

In Attendance:

Ian Cuskin - Tyne and Wear Fire and Rescue Service
Liz Highmore - DIAG
Donna Bradbury - Locality Commissioning Manager, Sunderland CCG
Kath Bailey - Consultant in Public Health
Julie Parker-Walton - Acting Consultant in Public Health
Victoria French - People Services, Sunderland City Council
Jane Hibberd - Head of Strategy and Policy for People and Neighbourhoods, Sunderland City Council
Richard Elliott - Integrated Commissioning, Sunderland City Council
Lorraine Hughes - Public Health Lead, Sunderland City Council
Stuart Cuthbertson - Office of the Chief Executive, Sunderland City Council
Karen Graham - Office of the Chief Executive, Sunderland City Council
Gillian Kelly - Governance Services, Sunderland City Council

HW28. Apologies

Apologies for absence were received from Councillor Watson, Dave Gallagher and Fiona Brown.
HW29. Declarations of Interest

There were no declarations of interest.

HW30. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 22 July 2016 were agreed as a correct record subject to an amendment to show that Ken Bremner had submitted his apologies to the meeting.


The Director of Public Health submitted a report providing the background to the presentation of the key findings from the review of the Joint Strategic Needs Assessment (JSNA) in 2016.

Board Members were aware that the JSNA process had been reviewed to provide a more focused set of profiles based on agreed Health and Wellbeing Board priorities for 2016/2017 alongside an overall high level review of the health of the city. The JSNA originally developed in 2012 included a set of 27 profiles, however this process had been labour intensive and the profiles had proved difficult to update. It was agreed that focus should be narrowed to ensure that updated profiles were completed for all of the Health and Wellbeing Board’s eight priorities with a deadline of September 2016.

Full written profiles had been developed for all except one of the priorities and these would be subject to a quality assurance process during November with a view to publishing all updated profiles by the end of 2016. The Falls Prevention JSNA had not been completed by the due date but a Falls Prevention Coordinator was due to come into post in October would be asked to complete the needs assessment as one of their first anticipated milestones.

Kath Bailey presented a high level summary of the story of the JSNA so far. It was the general consensus that the wider determinants of health and health behaviours were more important than healthcare in ensuring a healthy population. She outlined the key facts and challenges which existed throughout the city in relation to health and its determinants. The data was being analysed in order to develop the context for the JSNA.

Councillor Miller stated that he would like to see a direction of travel for the city to provide more context about where Sunderland was and where it was going. Councillor Farthing referred to the statistical gap between Sunderland and the England average and commented that it was unlikely that this gap would be closed but it would be useful to see how Sunderland compared to authorities with similar characteristics.

Councillor Farthing also highlighted the low levels of breastfeeding initiation and queried if there was a record of when breastfeeding began to be promoted more by
Public Health and if the health impacts of this could be identified. Kath Bailey stated that the information would be available and that breastfeeding remained a priority for the city, however it was now measured differently and unless Public Health were supporting the mother, then initiation could not be claimed.

Kevin Morris requested that with regard to engagement, lead officers were explicit about the messages coming through to ensure that these were being shared.

Alan Patchett presented the Social Isolation and Loneliness JSNA Profile and advised that there were over 25,000 people over the age of 65 in Sunderland and this issue particularly affected them. 36% of over 65s felt out of touch with society and 12% never spent time with family and friends. Loneliness had a major negative impact on health and led to poor lifestyle, being overweight, increased levels of smoking and low levels of exercise.

Alan highlighted that Age UK day services and befriending schemes which worked to prevent social isolation were under threat and requested that the Council help the organisation to continue to provide support to vulnerable older people. Age UK were committed to forming a task force to take this work forward.

Councillor Miller noted that this position was part of a paradigm shift and that if 25,000 city residents were over 65 then this was putting more pressure on services. He commented that not doing the relevant work to address social isolation was a false economy and it was part of the role of the Health and Wellbeing Board to address this issue. The Chair made reference to the Council’s budget setting process and that the Board should be a consultee going forward.

It was also highlighted that extending the age range of the group to those aged 50 and over may reveal as many problems with social isolation and that loneliness could lead not just to weight gain but to malnutrition.

With regard to levels of activity, Councillor Farthing noted that she met a lot of people in the older age group who were active and felt that there was a need to have a greater understanding of what else was going on. She expressed concern about the 12% of over 65s who did not see their friends or family and suggested that it was necessary to prick people’s consciences in relation to this.

Julie Parker-Walton presented the Tobacco JSNA Profile setting out the key facts and a number of recommendations around the theme.

Councillor Farthing raised the issue of large numbers of young people smoking outside the new college building in the city centre and whether it was necessary to do some work with the college. Julie advised that discussions had taken place and the relevant materials at the college would be updated.

Gillian Gibson commented that in terms of smoke-free places, there was evidence that this had had a massive impact on smoking levels and had been mainly self-policing without the need for a great deal of enforcement. Julie added that the introduction of plain packaging later in the year would also have an impact on this.
The use of e-cigarettes to reduce smoking was highlighted and it was noted that there were a number of new shops opening in the city to sell the product. It was confirmed that there were no licensing requirements for establishments which were selling e-cigarettes.

Julie Parker-Walton presented the Alcohol JSNA Profile setting out the key facts and a number of recommendations around the theme.

Councillor Miller referred to the recommendation to ensure that alcohol was not the norm and commented that he felt that overindulgence was the issue. He noted that in Europe alcohol was the norm but excessive consumption seemed to be a British problem. Julie highlighted that alcohol harm was becoming an issue in France and that they were starting to experience the same type of problems as Britain.

It was queried if there were any plans to work with the University on alcohol issues, particularly around fresher’s week. Julie advised that there had been some discussions but the University did not think that there was a significant problem.

Councillor Leadbitter asked if there was an increase being seen in Foetal Alcohol Syndrome and Julie said that she was unable to provide any figures but could say that a survey carried out by Balance in 2014 found that 36% of women were unaware of the condition.

Kevin Morris raised the link between alcohol and domestic violence and the impacts on children in these families. Julie advised that this issue was addressed within the detailed JSNA Profile.

Lorraine Hughes presented the Best Start in Life JSNA Profile and highlighted that it was vital to ensure that Public Health was systemised and embedded in the CCG’s maternity review and to ensure that there was a skilled workforce to work across the six early years high impact areas.

Kath Bailey commented that being clear on the issues was one thing but there also the matter of funding and staff recruitment with some areas such as speech and language therapy being very difficult to recruit into. Unless organisations were able to start converting people’s focus then there would not be the required volumes of key staff. Lorraine noted that this was where early intervention played a part and if early attachment and communication was effective then this would prevent the need for some speech and language services and workforces needed to be up-skilled to deal with this.

Dr Pattison expressed concern that there were still issues around teenage conception and stated that it would be helpful to increase access to long acting reversible contraception (LARC); however the training and certification requirements in order to prescribe these were intensive.

Councillor Farthing commented that this situation reinforced her views on parenting programmes and that the focus should be brought back to what parenting would actually mean for young people. Councillor Speding said that it was important to look
at the reasons why teenage conceptions were rising and Councillor Farthing suggested that high alcohol consumption may be linked to unplanned pregnancies.

Gillian Gibson agreed that there were some links which could be seen and noted that there were a number of things which Public Health were no longer doing and there had been a sharp downward trend in registrations of the C card. Councillor Farthing added that sex and relationships education in schools was very patchy and this could also be linked to attainment in Key Stage 4 if young people were struggling with issues such as self-image.

Victoria French presented the Physical Inactivity JSNA Profile and in doing so set out the current position and key issues moving forward.

Councillor Farthing asked if there was any link between the wards in the city which were least active and levels of car ownership. Victoria undertook to check this but noted that there was link between inactivity and health indicators. Gillian Gibson commented that one of the key ways to address this would be through active travel and ensuring that the design of the city maximised physical activity.

It was queried if it was clear what was happening in schools in relation to activity and particularly the noticeable drop off in participation after the age of 14. Victoria advised that schools had tried to address this with a broader offer during PE lessons and through after school clubs, however there were issues with regard to uniform and also body consciousness for young people.

Stuart Cuthbertson presented the Sunderland as a Healthy Place JSNA Profile outlining key statistics and recommendations for commissioning.

The Chair noted that this covered the whole of the JSNA as an overarching item and Gillian Gibson suggested that it was pertinent to be looking at this in the context of the development of the Core Strategy and Local Plan. The Chair commented that the Local Plan was currently out for consultation and could potentially be discussed at the next Health and Wellbeing Board meeting.

Jane Hibberd presented the Child and Family Poverty JSNA Profile and advised that there was a current JSNA Profile for the theme which would be refreshed over the next few months. There were just over 13,000 children in the city in low income families and almost 11,000 families claiming Job Seekers Allowance and income support, of which 8,670 were lone parent families. The commissioning intentions for this profile include Best Start in Life, Early Help, Education and Skills and Poverty Proofing.

Richard Elliott presented the Welfare Reform JSNA Profile and reported that as a result of welfare reforms over recent years there were now 10,000 fewer tax credit claims in the city and 5,000 pension credit claims. There was more data and intelligence needed to identify impacts and inform activity over a wide range of areas.

Karen Graham advised that the full profiles would now be submitted for quality assurance and then reported back to the Health and Wellbeing Board at a future meeting, setting out commissioning intentions for each area.
RESOLVED that the report and presentations be received and noted and that a further report be received on commissioning intentions.

HW32. GP Five Year Forward View


The Five Year Forward View published in October 2014 required every CCG to produce a Sustainability and Transformation Plan which would include plans to secure and support general practice. The General Practice Forward View included a number of statements in relation to Investment, Workforce, Workload, Practice Infrastructure and Care Redesign.

Dr Pattison outlined the headlines relating to investment including a further £2.4 billion a year to be invested into general practice by 2020/2021. There was also capital investment amounting to £900m and a new funding formula which was intended to better reflect practice workload including deprivation and rurality. The Forward View also pointed to an expansion of the GP workforce and a £16m additional investment in specialist mental health services to support GPs.

Donna Bradbury highlighted that Sunderland CCG would be building on a strong position with regard to the Better Care Fund and the Vanguard programme. In terms of practice infrastructure, the CCG was working with GP practices to manage increased pressures and also using estates management funding and the Local Digital Roadmap.

Extended access to services was already in place and as part of the Vanguard, Sunderland had been awarded an additional £1.50 per registered patient to support rolling out access. There was to be a £171m one off investment beginning in 2017/2018 for practice transformational support and Sunderland CCG had preempted this through the plans for the use of £500,000 underspend in 2016/2017. Improvement management techniques being employed by the CCG meant that Sunderland was already working towards the vision set out in the Forward View.

Dr Pattison highlighted that the CCG had delegated authority for their budget but this new funding would not be delegated and the lengthy application process was not helpful. Ben Clark advised that a technical guidance document had been published the previous day and this might provide the CCG with more clarity about funding.

Kevin Morris noted that the CCG was quite supportive of requests to merge practices but it was necessary to be aware of the impacts of this.

Councillor Speding commented that mergers were being driven by the economics of the situation and Dr Pattison stated that no practice particularly wanted to merge but it was down to issues of sustainability. There was a national shortage of GPS and the North East was at the head of this problem.
Donna Bradbury said that some of the funding included a resilience programme intended to support practices before they reached the emergency stage. Gillian Gibson highlighted that the Council had just consulted on the growth options for the Local Plan and this would have impacts on local primary care which was another pressure to be considered.

Having considered the report, the Board RESOLVED that:-

(i) the direction of travel for General Practice be noted;

(ii) it be noted that Sunderland CCG had already progressed with many of the initiatives described;

(iii) it be noted that Sunderland CCG was well placed to make the most of opportunities in the General Practice Forward View as further information on funding for both pilots and any recurrent investment becomes available; and

(iv) the key messages from a recent NHSE NE event on the GP Forward View, attached as Appendix A, be noted.

HW33. Skin Cancer Policy

The Director of Public Health submitted a report informing the Board of a request from Cancer Research UK for the Council to sign the skin cancer prevention pledge.

It was acknowledged that skin cancer was the most common form of cancer but mortality rates associated with it were low. The Board had identified a number of priorities which it considered were most likely to improve the health of the population in order that resources could be focused in those areas. It was suggested that this request should be considered by the Board when it reviewed its priorities in February 2017.

The Chair commented that this was just a pledge and the Board should be able to sign up to support the general principle without prioritising the issue above others. Councillor Miller stated that it was a valid point for the Board to consider whether is should stick to its priorities or try to do everything which was presented to them as an issue.

Councillor Farthing suggested that this could feed into some wider messages about people taking care of themselves and the Chair queried if there was already a voluntary policy on skin cancer which would meet the requirements of the pledge. It was highlighted that there had been a scrutiny review of the issue in the past.

Kevin Morris noted that Liverpool had signed up to the pledge and that it might be useful to have a discussion with them about what they were doing.

The Board RESOLVED that:
(i) consideration be given to whether to prioritise the prevention of skin cancer when priorities were reviewed in February 2017 or whether this could be addressed in an alternative way;

(ii) the Clinical Commissioning Group’s cancer task and finish group be asked to consider the impact of focusing resources on the prevention of cancer compared with other risk factors for cancer.

HW34. Feedback from Advisory Boards

Adults Partnership Board

Councillor Miller informed the Board that the Adults Partnership Board had met on 6 September 2016 and the main issues considered had been: -

- Sunderland Eye Health Needs Assessment
- Priorities Performance Framework – Update
- Welfare Reform Update

It was clarified that the commissioning of optometry services was within the remit of NHS England and they were jointly working with the CCG on this issue.

RESOLVED that the update report be noted.

Children’s Strategic Partnership

Jane Hibberd advised that the Children’s Strategic Partnership had been meeting on a quarterly basis and, at their meeting in July, had agreed to hold a workshop to inform the refresh of the Children and Young People’s Plan. The workshop had taken place the previous week and had been well attended with the focus being how partnership working could add value and how the Strategic Partnership could drive delivery of the Children and Young People’s Plan.

Those present at the workshop had looked at key data and facts and identified three main areas to prioritise: -

- Building capacity on hearing the voice of and being influenced by children. The existing Children’s Trust Advisory Network was cited as a vehicle for developing this and all partners expressed a willingness to contribute financially.
- Improving achievement and closing educational gaps. It was suggested that a microsite be developed for Sunderland to share job opportunities where there were gaps.
- Developing and implementing the early help offer.

The next meeting of the Strategic Partnership was scheduled for 6 October 2016 and it was intended to present a draft plan on a page to members of the Partnership for refinement and prioritisation.

RESOLVED that the update report be noted.
HW35. Health and Wellbeing Forward Plan and Board Timetable

The Head of Strategy and Performance submitted a report presenting the Board forward plan for 2015/2016.

Following discussions earlier in the meeting it was noted that Teenage Pregnancy and the Core Strategy were to be added to the Forward Plan for future meetings.

The next closed Board session was due to be held on 28 October 2016 and would focus on the role of the Health and Wellbeing Board in system planning. It was intended that the subject of the session scheduled for 15 December would be an update of the Suicide Audit and Board priority setting would take place on 17 February 2017.

The Board RESOLVED that:

(i) consideration be given to topics for in depth closed partnership sessions for 2016/2017; and

(ii) the forward plan be noted and requests for any additional topics be passed to Karen Graham.

HW36. Date and Time of Next Meeting

The next meeting would be held on Friday 25 November 2016 at 12.00noon.

(Signed) M SPEDING
   Chair