NHS
South Tyneside
Clinical Commissioning Group

Operational Plan

2017/18 – 2018/19

27.04.2018

CONTENTS

Separate annexes • Technical annex (STP and CCG technical narrative) • Plan on a page/delivery plan • MOAR	Submitted separately

1. Introduction

NHS South Tyneside Clinical Commissioning Group (CCG), as a membership organisation, is made up of 22 GP practices from across the borough and has been operating since April 2013 commissioning services with an overall budget of c.£250m.

We continue to strengthen our partnerships in the borough working closely with many organisations such as South Tyneside FT, South Tyneside Council, NHS England and organisations that provide community, voluntary and primary care services.

This approach gives us a very real chance of achieving our key objectives and building an NHS fit for the 21st century, one which provides high quality, innovative, safe and efficient healthcare for the people of South Tyneside.

This plan illustrates how we set out to address the key challenges facing us in the coming years and illustrates our progress to date in terms of implementing the Five Year Forward View, as well as the journey ahead.

This plan also demonstrates tangibly the links between our work locally and the Sustainability and Transformation Plan at Northumberland, Tyne and Wear, and North Durham level (NTWD).

Additionally, through our work as an Integration Pioneer, we are working closely with the New Zealand Canterbury Health Board, who are front-runners in the delivery of integrated care, to learn from their experience and to implement international best practice here in the borough.

In delivering this plan we will continue to work with our communities, patients, partners and stakeholders locally and at NTWD level, to implement initiatives which will help to ensure we have safe and sustainable NHS services for our residents across not only the next 2 years, but also in the years beyond.

2. Our vision

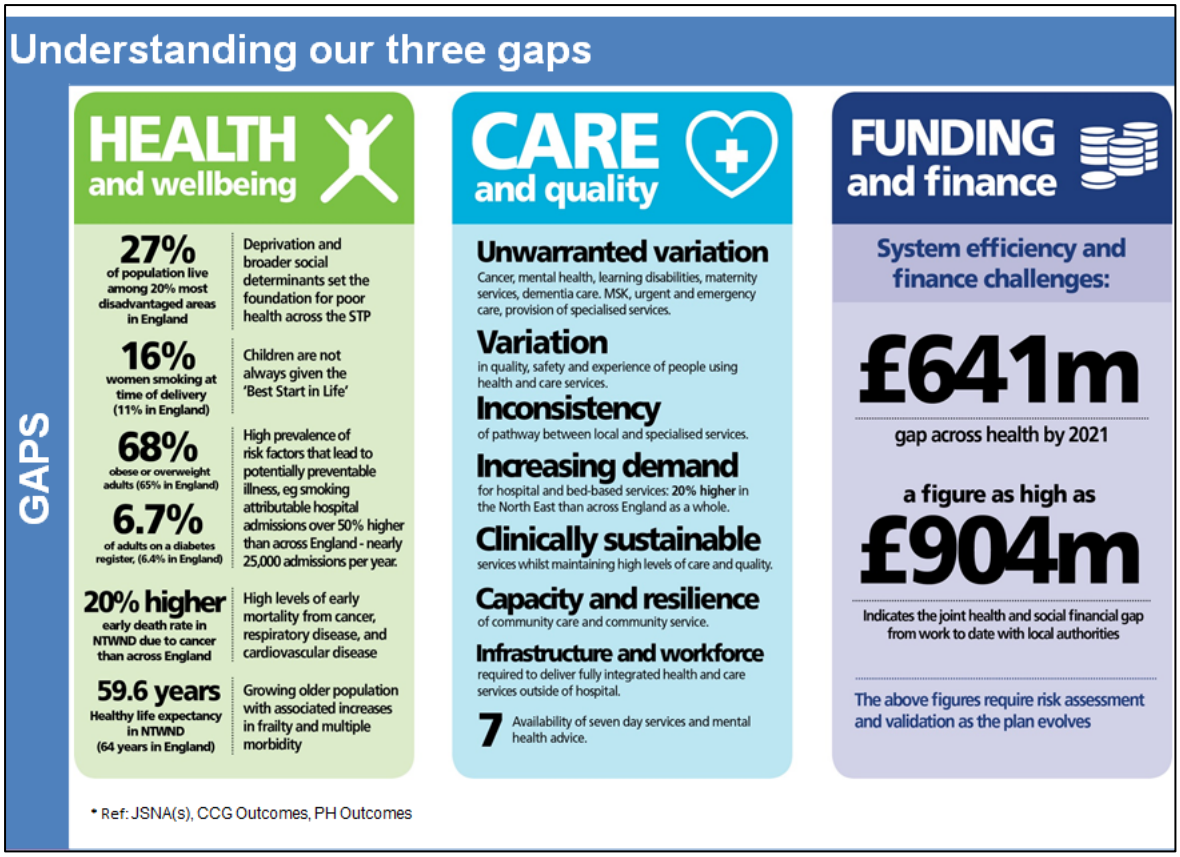
The CCG's vision is to work collaboratively across South Tyneside to improve health and commission excellent health care and is supported by three high level goals which describe the changes we aim to make.

These are to ensure that:

- **People are able to be able to take greater responsibility for their own health**
- **People are able to say well in their own homes and communities**
- **People receive timely and appropriate complex care**

3. The challenges

Our understanding of the current position against the three gaps set out within the NHS Five Year Forward View has been developed through a process of robust analysis and modelling utilising for example JSNAs, scrutiny of clinical quality and safety data, patient and carer feedback, evaluations and organisational financial information



Balancing the books: the NHS financial position is the most challenging it has ever encountered. By 2020/21, the estimated deficit in South Tyneside and Sunderland could be as high as £270m if we continue as we are. Doing nothing is not an option.

Given the financial pressures facing STFT, CHSFT and local commissioners there is a recognition and acceptance that the traditional approach to costs savings, will not deliver the savings required over the coming years.

The local healthcare partners (STFT, CHSFT, Sunderland CCG and South Tyneside CCG) with support from local authority colleagues have committed to, and are working together to develop a sustainable financial recovery plan.

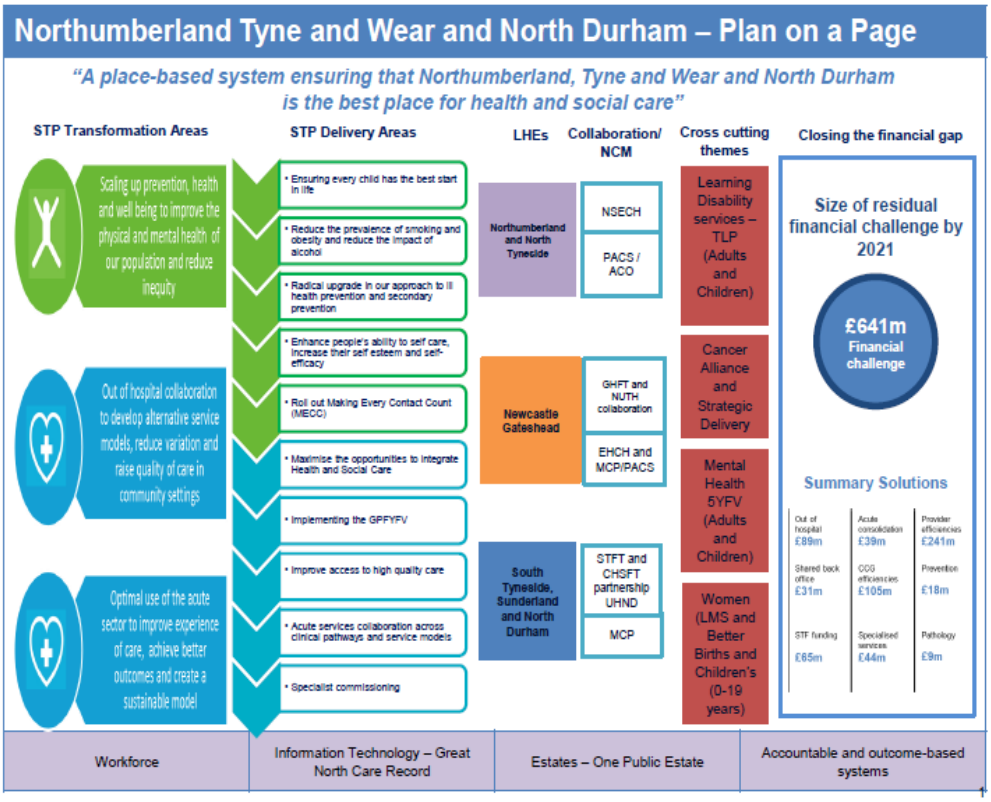
This overall plan will cover the geographies of South Tyneside and Sunderland, both in and out of hospital.

A series of system wide clinical engagement events have been held to discuss how the system can be transformed to deliver better outcomes, whilst using our resources more effectively. The outputs from these events are helping to shape and develop new ways of working and a new governance framework is being produced to oversee the delivery of the plan. This will build on the work that the local health system has been developing, individually and collectively and covers existing transformation programmes such as the 'Path to Excellence' across both Trusts, the MCP work led by Sunderland CCG and Alliancing approach led by South Tyneside CCG, and brings this work together into a common governance structure across all partners.

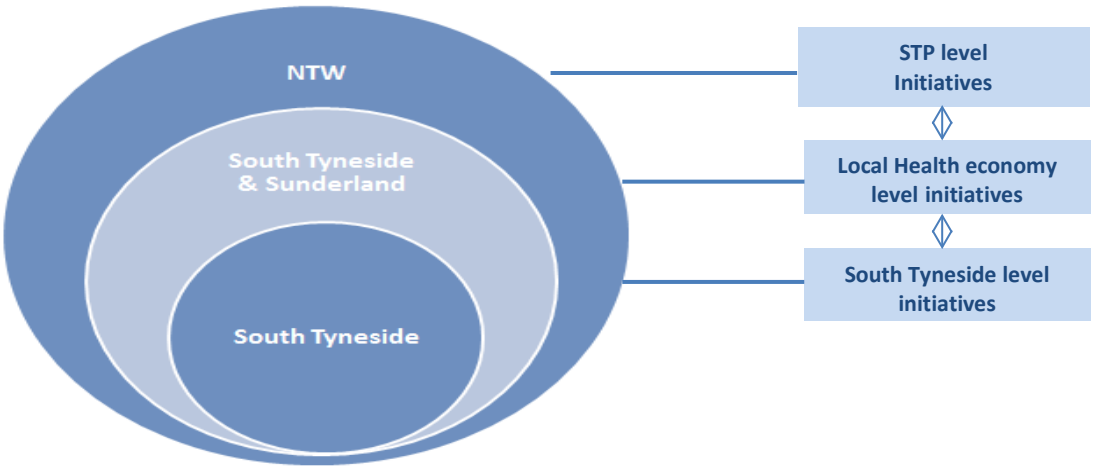
It is expected that this plan and the associated programmes of work covering all organisations will be in place by the end of Q1 2018/19.

4 The STP and our local plans

The CCG will continue to work closely with partners across the Northumberland, Tyne and Wear, North Durham footprint, as well as with colleagues in Sunderland to deliver a range of joint initiatives across the LHE. Our LHE and CCG level plans will tangibly link with the priorities set out in the STP:



The CCG will therefore be working across the levels shown below:



Further, as part of the NTWND STP, the CCG is committed to the **collective vision** to:

- **Build upon Health and Well Being Strategies** in each of our Local Authority areas
- **Ensure safe and sustainable health and care services t**hat are joined up, closer to home and economically viable
- **Empower and support people** to play a role in improving their own health and well being

The CCG's journey, as part of the STP, will incorporate the following key components:

As a system we will be moving:

From	To
Fragmented Payment	Unified Budgets
Hospitals at the centre	Home as the hub
Excellent soloists	High performing teams
Moving people	Moving knowledge
'What is the matter with you?'	'What matters to you?'
A sense of scarcity	A sense of abundance

	South Tyneside, Sunderland and North Durham LHE Plans for 2016/17 -2017/18 (South Tyneside, Sunderland)	Plans for 2018/19
Scaling up prevention, health and well being	• Strong focus on the best start in life – through reviewing maternity services and 0-19 services • Self care and prevention programme, "making every contact count" and "A Better U" • Embedding an asset based approach to self care – including developing resources to support prevention and self care • Enhancing support to workplaces to promote a healthy and active workforce – through development of the Workplace Health Alliance • Exploring locality-based approaches to tobacco control, alcohol and healthy weight • NHS Rightcare - pathway transformation for respiratory disease, cancer and CVD – from prevention (including Change4Life), secondary prevention & self care to end of life • To enhance long term condition management, through proactive self care (secondary prevention)	• Embed locality based approaches to tobacco control, alcohol and healthy weight • To continue NHS Rightcare pathway transformation
Out of hospital collaboration	• Continuation of out hospital and integrated care models including sharing of learning and exploring model alignment • Deliver the GPFV with a focus on addressing the resilience of general practice including workforce developments; developing general practice at scale and improving access to general practice. • Redesign pathways across primary and secondary care in light of learning from Right Care and productivity opportunities	• Take the best for the 2 models to develop a "blended" out of hospital model • Review progress and continue to implement the GPFV to support the sustainability and transformation of general practice. • Review and further implement the new pathways across primary and secondary care
Optimal use of the acute sector	• Single Clinical operating model created • Full service reviews completed across a number of pathways including Stroke • Options for service delivery consultation	• Full service reviews completed across every service across the two hospital sites • Options for service delivery consultation • To share assets and workforce
Mental Health	• Community Mental health service - easier access to low level interventions for adults and children • Mental health reconfiguration programme largely complete DRAFT Official - Sensitive: Commercial 8	• Sustain improvements to Mental Health Services at all tiers taking account of the MH 5YFV

To underpin all of this we've set out a range of strategic initiatives as shown which we will work on locally, at LHE and at STP level:

Aligning STP to LHE and CCG level initiatives	
STP theme: Scaling up prevention, health and well being to improve the physical health of our population • Embedding asset based approaches to Self Care across the borough – "A Better U" • Continuing to embed prevention **through "Making every contact count"** programme • Ensuring stop smoking initiatives are priority features in key work programmes, including Stop Before Your Op • Ensuring healthy lifestyle choices are embedded into **HealthPathways** • Exploring locality-based approaches to **tobacco control, alcohol and healthy weight** • Enhancing support to workplaces to promote **a healthy and active workforce** – through development of the Workplace Health Alliance	**Outcomes** • Better population health and well being • A healthier place to live, eg smoke free health and care sites • Reducing over reliance on statutory services
STP theme: Develop the out of hospital model to help keep people safe, well and cared for at home or as close to home as possible and to reduce variation in primary and community services Develop and implement South Tyneside **Out of Hospital model, the Community Model** working closely with Sunderland Vanguard • Developing and implementing our local **GPFV** • **NHS Rightcare** - pathway transformation **for respiratory disease, cancer and CVD** and to enhance long term condition managem • Urgent and Emergency Care as part of the **North East Vanguard** • Choice and control through implementing **Personal Health Budgets** • Implementing **HealthPathways** to improve quality and reduce variation • Implementing the **Mental Health F**V including easier and earlier access to lower level interventions for children and adults • Transforming Care for people with **Learning Disabilities** • Transforming **NHS Continuing Healthcare** to ensure high quality and value for money packages of care designed to meet current need	**Outcomes** • Increasing volumes of proactive care delivered at home/ community setting • Reducing spend on non electives • Reducing variation in general practice and more equitably higher standards of care • Better management of mental health conditions with faster recovery
STP theme: Optimal use of the acute sector • Phase 1 service reviews implemented for **stroke, obstetrics & gynaecology and paediatrics**. Phase 2 to follow. • Ensuring linkages with **North Durham** and other local trusts to make best use of specialist workforce • Ensuring high quality, sustainable **maternity services** in line with national guidance and standards • Implementation of **7 day working** across our local hospital services in line with national requirement • Sustaining the recovery of the **4 hour A&E standard**	**Outcomes** • Safe and sustainable services across LHE • An improved position in against a range of national quality and performance indicators
STP Theme: Addressing the care and quality challenge • Improving care and quality will be underlying themes across **all work programmes** • HealthPathways will standardise the way in which care is delivered across general practice and will **reduce variation** across primary • We will continue **to reduce variation** through robust **clinical incident reporting** and management including the increased uptake of through primary care • Continued implementation around integrated commissioning arrangements for individual level packages of care for **people with learn disabilities, children, older people, those at end of life**, as well as those in **S117** arrangements, ensuring locally delivered high qu value for money care packages tailored to current, individual needs.	**Outcomes** • A CQC rating of at least "Good" for South Tyneside Hospital • An improved position against a range of national quality and performance indicators • Person centred, tailored packages of care which meet current need • A stabilized position in terms of CHC spend

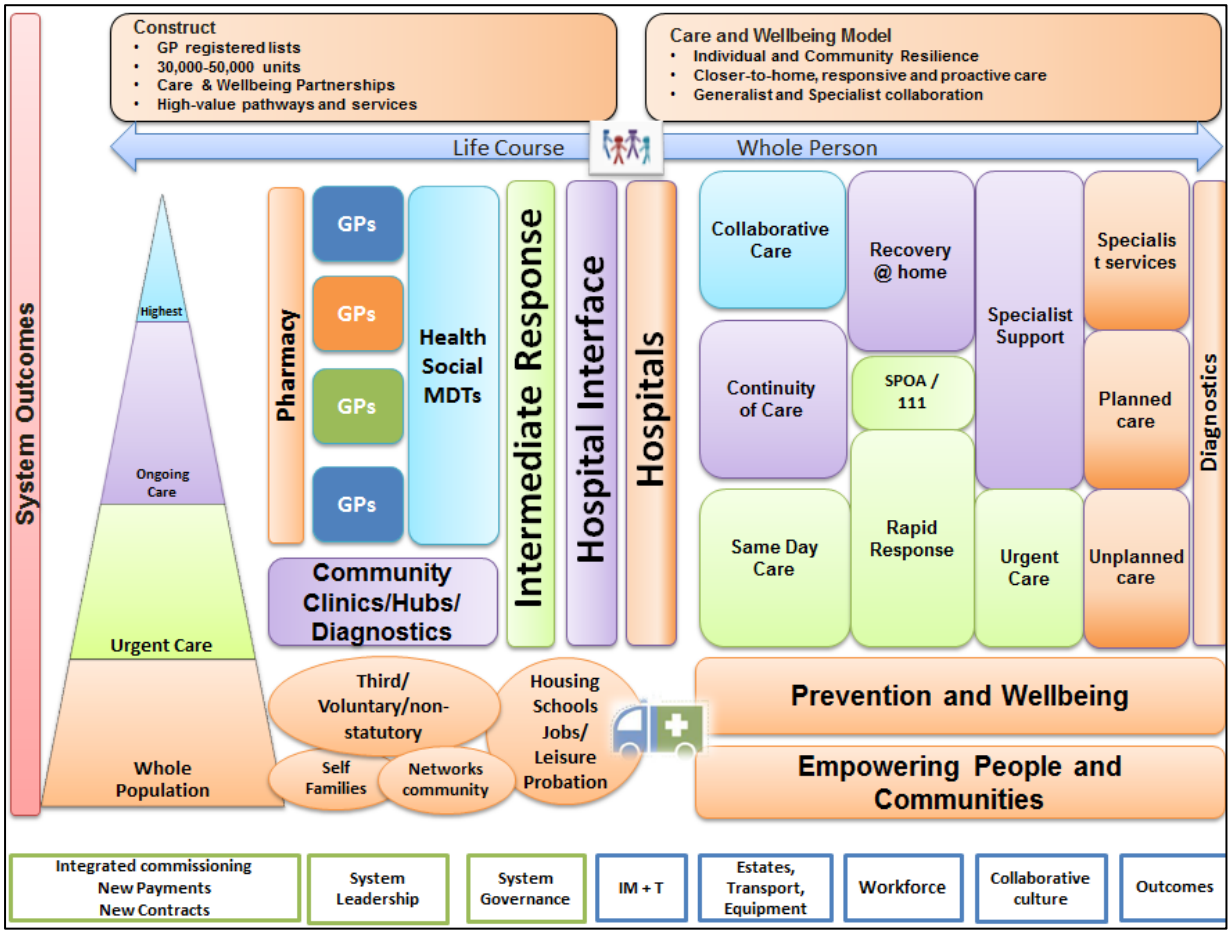
5. Plan on a Page

The above, embedded below, sets out our local schemes, which triangulate to the STP . A number of these will be delivered working in partnership with colleagues in Sunderland CCG and others jointly with South Tyneside Council. The following illustrates our schemes and their anticipated levels of impact.

South Tyneside CCG
Delivery Plan on a Pa

6. New model of care and GPFV

To address the challenges we have established an NTWND STP wide framework for a future health and care model. This work is based on an assessment of current re-design programmes within each LHE including the North East Wide Vanguard Programmes. Our framework provides a 'blue-print' for the spread of population based new models of care.



The South Tyneside Out of Hospital model is being developed in alignment with the above, with our GPs, and also through close working with Sunderland CCG as a Vanguard.

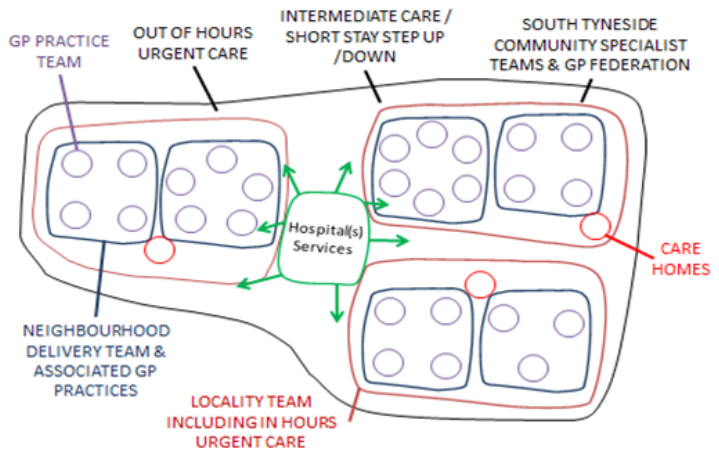
6.1 Out of hospital model

Our out of hospital model has been branded our "**community model**" and aligns a broad range of community based work programmes, all with the shared aim of preventing hospital admission and providing more care in the primary and community setting. There are critical links with the **GPFV** in the primary care aspects of the community model.

Information on our community model, progress and plans is shown as follows:

Our community model

South Tyneside Partnership



Prevention and self care principles embedded into care models and service delivery

7 day services to avoid out of hours issues

Maximising our assets via third sector, with navigator roles embedded in locality teams

System enablers

South Tyneside Partnership

Workforce

- Ensuring workforce is fit for the future
- Considering the different skills and roles needed

Early help and prevention

- Developing the role of the third sector and communities in providing early help and preventing needs from increasing

Commissioning

- Joint commissioning arrangements with pooled budgets and coordinated governance arrangements
- Commissioning with a focus on improving health and social care outcomes

Information sharing and digital solutions

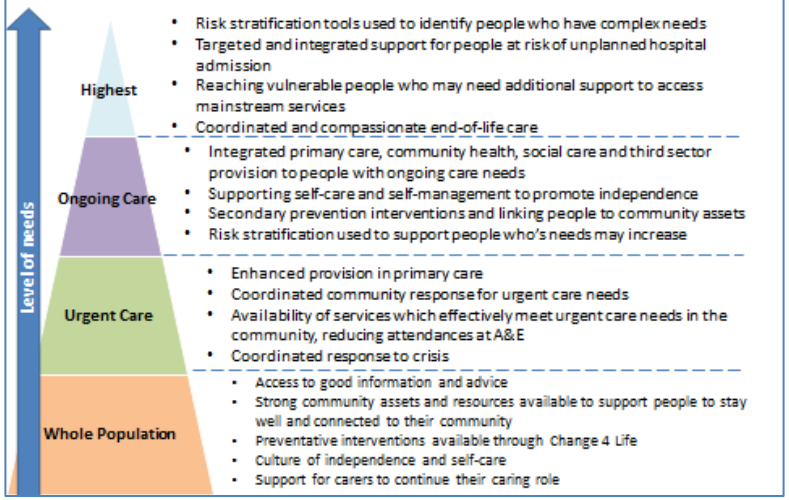
- Giving health an social care professionals access to an information sharing portal
- Exploring digital solutions to keep people well in the community

South Tyneside Partnership

Community model – key features

Principles of care

South Tyneside Partnership



South Tyneside Partnership

Community model – work programmes

Primary care

- Mixed economy **of general practices** working individually - and also where they choose - together and at scale, to ensure high quality care services for the registered list population, with reduced unwarranted variation
- More accessible care available through general practice and community pharmacies, right professional, right time – and new underpinning **workforce** model
- Commissioned to be provided at scale, enhanced primary care services on a wider population basis including eg ***Specialist community clinics*** to offer a greater range of investigations/treatment in the community and hub-style approached to deliver ***enhanced primary care access***

Care Homes

- GP practices ***aligned*** with 'link' Care Homes for ***all care homes*** *(res and nursing)*
- Practices offer pro-active co-ordinated care via ***'ward round'*** and ***enhanced care offer***
- Better management of patients through ***shared care plans*** which results in reduced avoidable admissions
- Care home staff are a key part of the system and ***trained in new approaches*** with timely refreshers
- Commissioning processes ensuring high quality care

Integrated community services

Planned/ ongoing care	Unplanned/ short-term care
• Community nurses, social workers and allied health professionals aligned to the registered lists of GP practices, providing planned care to people to complex needs • ***3 localities: 30,000 – 50,000 pop. each*** • 3rd sector navigation, linking people to community support Regular ***MDTs*** with practices to discuss people who may be at risk of hospital admission or residential care • Named ***care co-ordination*** for risk stratified list • Alignment to community mental health teams • Development of joint care plans for people with complex needs	• Joined-up rapid response to meet urgent care needs in the community and support timely discharge from hospital • Integrated reablement and intermediate care services, delivering effective short-term interventions • Effective step-up and step-down pathways and services to prevent hospital admissions, support discharge and reduce residential admissions • Rapid access to reablement, community equipment and telecare • Supporting discharge to assess approaches to prevent prolonged hospital stays

End of life care

- ***End of life care*** is systematically of high quality regardless of setting, including the availability of hospice at home model
- Supporting people to die in the place of their choosing

Carers

- Effective support for carers which enables them to continue their caring role
- Recognising the invaluable contribution of local carers

Wrap around, specialist care

- Specialist teams wrap around integrated teams, eg frailty, to help people with particular conditions stay safe and well at home, may include consultant outreach and rapid response

Long-term conditions management

- Recognition of the mental and emotional wellbeing of people with long-term health conditions
- Use of the Patient Activation Measure to segment the population based on their readiness to take a greater role in self-management
- Availability of self-management support such as peer groups, education courses and coaching

Vulnerable adults

- Identifying vulnerable groups such as socially isolated older people and substance users
- Ensuing groups have equal access to health and care services including prevention interventions

Mental Health

- Availability of effective Talking Therapies services to prevent or reduce the development of future mental health issues
- Integrated mental health service provision including community nursing, psychology and social care for people with more severe mental health needs
- Alignment of mental health services to the integrated teams providing care to older people and adults with physical disabilities
- Joint focus on the recovery model

Learning Disabilities

- An alliance approach between health and social care, with an integrated team and pooled budget, supporting people to remain independent
- Responding rapidly to changes in need
- Supporting access to universal services
- Ensuring effective use of the voluntary sector
- Coordinated health and care services including a crisis response
- Greater focus on outcomes including pathways to employment, volunteering or meaningful activity
- Embedding a Progression Model for people with a learning disability

Vignettes … Our progress on the community model

An **alliancing approach** to system leadership is being developed to ensure partners can effectively transform the local health and care system by putting the needs of people first. This approach includes empowering our clinicians and front-line professionals to drive change

Integrated health and social care community teams covering three localities providing more person centred care, delivered via smaller community teams, with alignment to the general practice list, linked with 3rd sector and mental health services (planned/in hours)

Adult Social Care

- A review of the initial point of contact is underway to ensure people receive effective information, advice and signposting
- A Draft Adult Social Care Strategy has been developed and is out for public consultation
- Improvement Plans have been developed across the whole service
- A focus on asset-based social work is being embedded across the service
- Better use of short-term interventions including reablement
- A new operating model has been designed
- Remodeling key provider services

Learning Disabilities:

- Fully pooled health and social care budget in place, removing perverse incentives and ensuring appropriate commissioning of high quality care
- Reduced number of inappropriate hospital admissions via a care a treatment review process
- Alliance between health, social care and community sector

Think Pharmacy First minor ailments scheme, available at all 39 community pharmacies, delivering around 400 consultations weekly

Implementation of hundreds of standardised **Health Pathways**, agreed between primary and secondary care, which standardise care in general practice and reduce variation

An innovative **self-care model**, A Better U, aiming for a culture shift where people are supported to self-care or manage their health condition or personal circumstances, raising their independence and wellbeing, and reducing demand on statutory services

Carers

- Improved Carer's Service based on outcomes
- Better recognition and support for Carers in Hospital through training and awareness raising for staff
- Carer's Passport being planned to provide Carers with an ID card to access concessions
- Review of Carer's Assessment process to speed up access to support

Mental Health

- Lifecycle service for adults, young people and families – improves access to evidence based interventions, supports young people and schools, provides employment support.
- Improved access to urgent MH care via 24/7 Initial Response service and Police Street Triage service
- Achieved two week target from referral to treatment for first episode psychosis

6.2 Delivery of the GPFV In South Tyneside

Co-ordination of local initiatives and delivery of national initiatives in primary care services are significant areas of focus for the CCG.

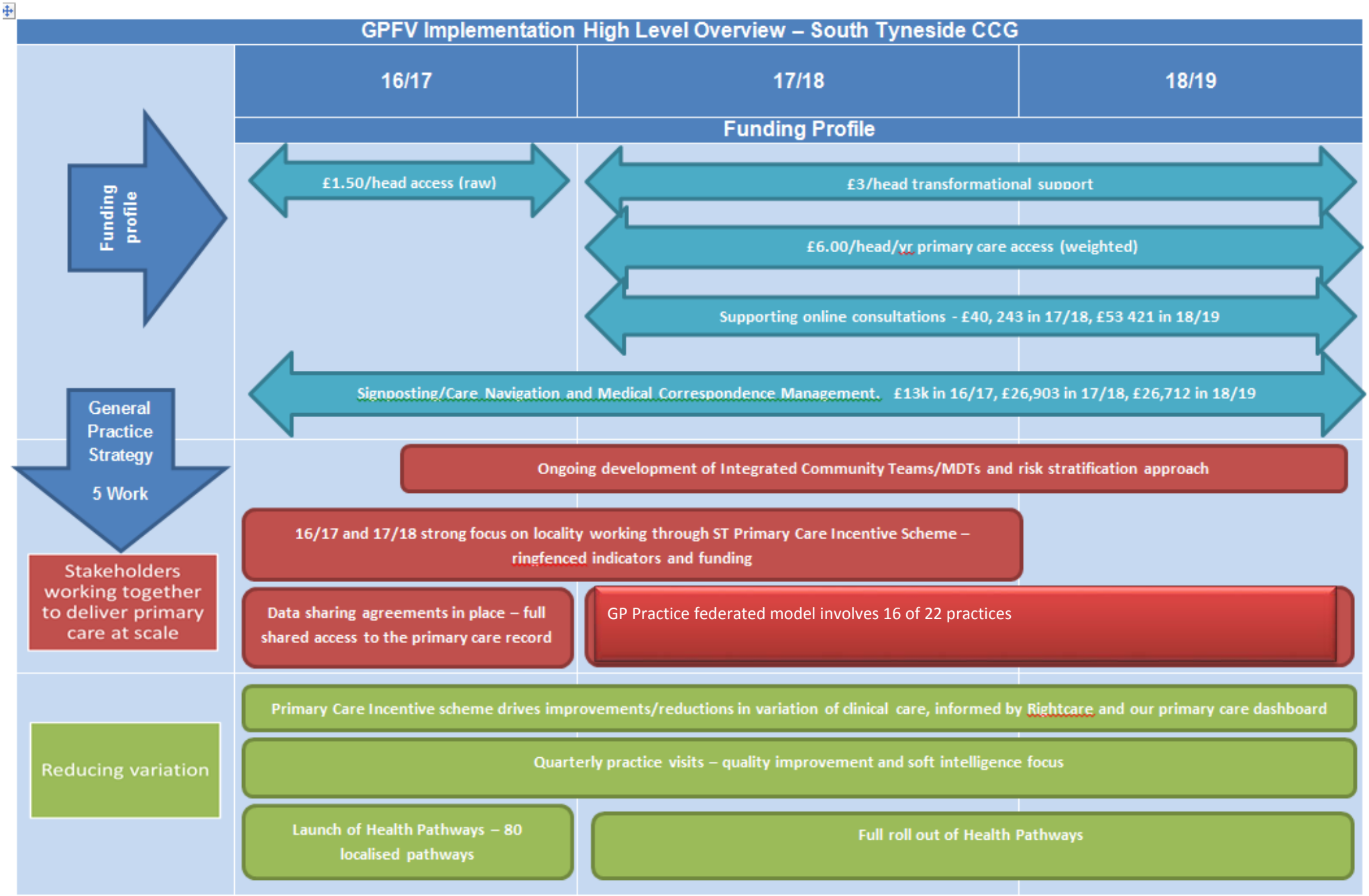
We know that the landscape will need to look different in the medium to long term[1], the GPFV alongside the CCG's local plans to transform out of hospital care provide the building blocks to support primary care (in particular general practices), to deliver services in different ways. Supporting practices to transform and to deliver wider services to the population on an 'at scale' basis is at the heart of the CCG's general practice strategy.

Our strategy has five key workstreams:

1. Delivery of Primary Care at Scale
2. Reducing Variation
3. Changing the Focus of Primary Care
4. Improving Access to Primary Care
5. Workforce Planning

The 'GPFV High Level Overview', below, sets out how our key initiatives against known funding streams will be delivered across 17/18 and 18/19. In addition, we are able to give further narrative on how our strategy will contribute to delivering the GPFV which is included at ***Appendix 1.***

[1] NTWND STP wide framework for a future health and care model, P11 STCCG Draft Operational Plan 17/18 – 18-19


GPFV Implementation High Level Overview – South Tyneside CCG
16/17
17/18
18/19
Funding Profile
Funding profile
£1.50/head access (raw)
£3/head transformational support
£6.00/head/yr primary care access (weighted)
Supporting online consultations - £40, 243 in 17/18, £53 421 in 18/19
Signposting/Care Navigation and Medical Correspondence Management. £13k in 16/17, £26,903 in 17/18, £26,712 in 18/19
General Practice Strategy
5 Work
Stakeholders working together to deliver primary care at scale
Ongoing development of Integrated Community Teams/MDTs and risk stratification approach
16/17 and 17/18 strong focus on locality working through ST Primary Care Incentive Scheme – ringfenced indicators and funding
Data sharing agreements in place – full shared access to the primary care record
GP Practice federated model involves 16 of 22 practices
Reducing variation
Primary Care Incentive scheme drives improvements/reductions in variation of clinical care, informed by Rightcare and our primary care dashboard
Quarterly practice visits – quality improvement and soft intelligence focus
Launch of Health Pathways – 80 localised pathways
Full roll out of Health Pathways

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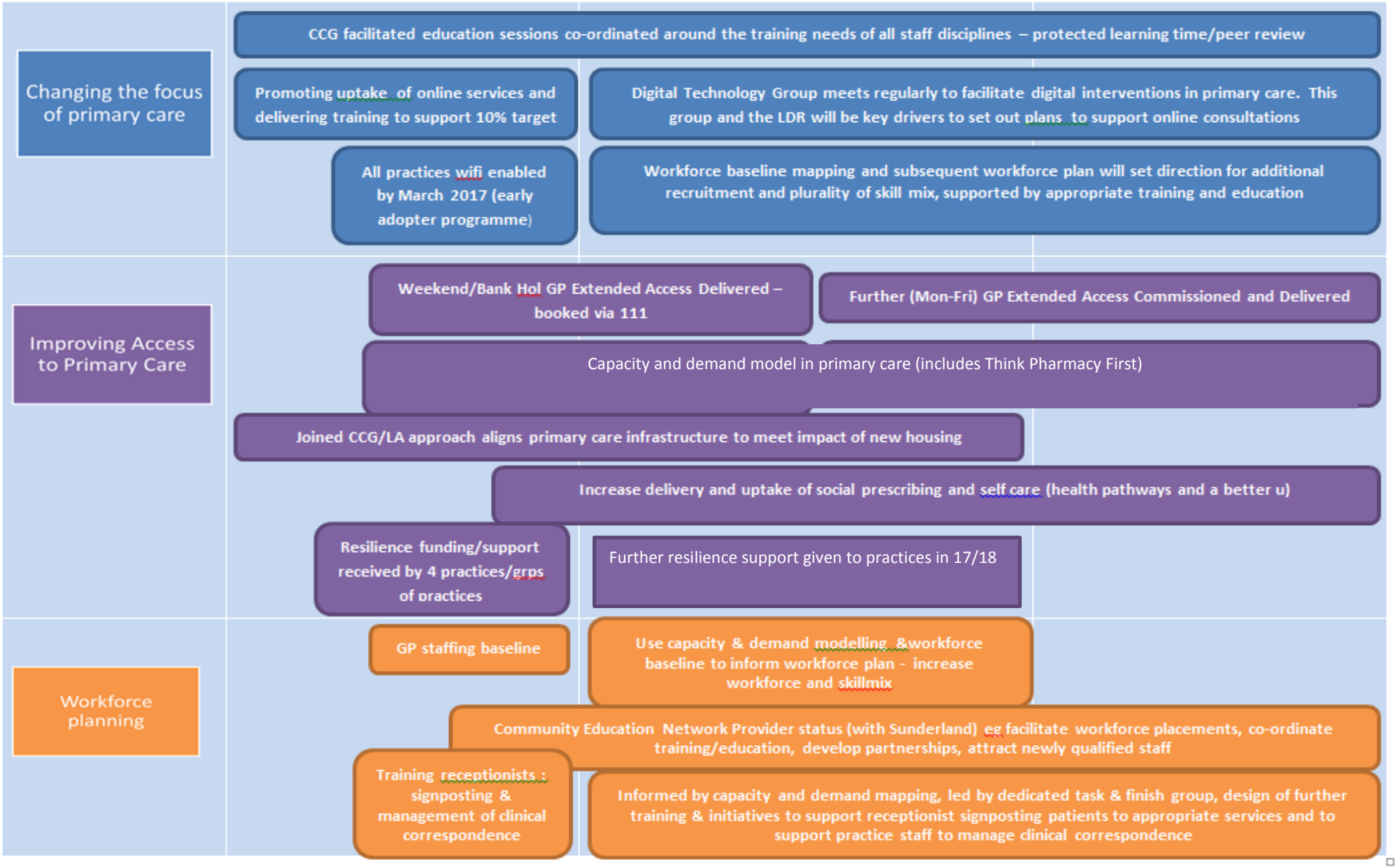
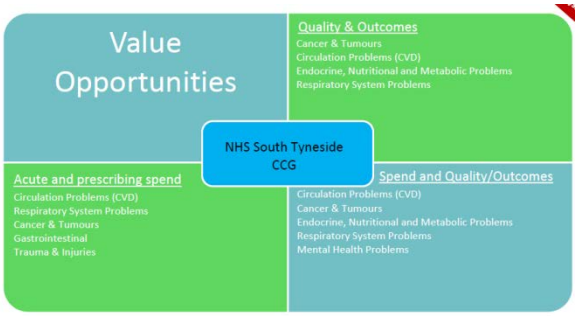

Changing the focus of primary care
CCG facilitated education sessions co-ordinated around the training needs of all staff disciplines – protected learning time/peer review
Promoting uptake of online services and delivering training to support 10% target
Digital Technology Group meets regularly to facilitate digital interventions in primary care. This group and the LDR will be key drivers to set out plans to support online consultations
All practices wifi enabled by March 2017 (early adopter programme)
Workforce baseline mapping and subsequent workforce plan will set direction for additional recruitment and plurality of skill mix, supported by appropriate training and education
Improving Access to Primary Care
Weekend/Bank Hol GP Extended Access Delivered – booked via 111
Further (Mon-Fri) GP Extended Access Commissioned and Delivered
Capacity and demand model in primary care (includes Think Pharmacy First)
Joined CCG/LA approach aligns primary care infrastructure to meet impact of new housing
Increase delivery and uptake of social prescribing and self care (health pathways and a better u)
Resilience funding/support received by 4 practices/grps of practices
Further resilience support given to practices in 17/18
Workforce planning
GP staffing baseline
Use capacity & demand modelling &workforce baseline to inform workforce plan - increase workforce and skillmix
Community Education Network Provider status (with Sunderland) eg facilitate workforce placements, co-ordinate training/education, develop partnerships, attract newly qualified staff
Training receptionists : signposting & management of clinical correspondence
Informed by capacity and demand mapping, led by dedicated task & finish group, design of further training & initiatives to support receptionist signposting patients to appropriate services and to support practice staff to manage clinical correspondence

7. NHS Right Care

During 2016/17 STCCG was identified as a wave one implementer of the RightCare programme. Involvement within the programme enabled the CCG to compare it's spend and outcome data against 'comparator' national CCGs. This benchmarking exercise highlighted where there was variation in terms of spend and outcomes which could not be explained by a difference in population demographics/needs. In turn this enabled the CCG to direct the focus of their transformational change towards those areas presenting the greatest challenge/opportunity.

Through utilising this methodology three priority areas were identified for focus within 2016/17 with a further 3 areas identified in 2017/18;

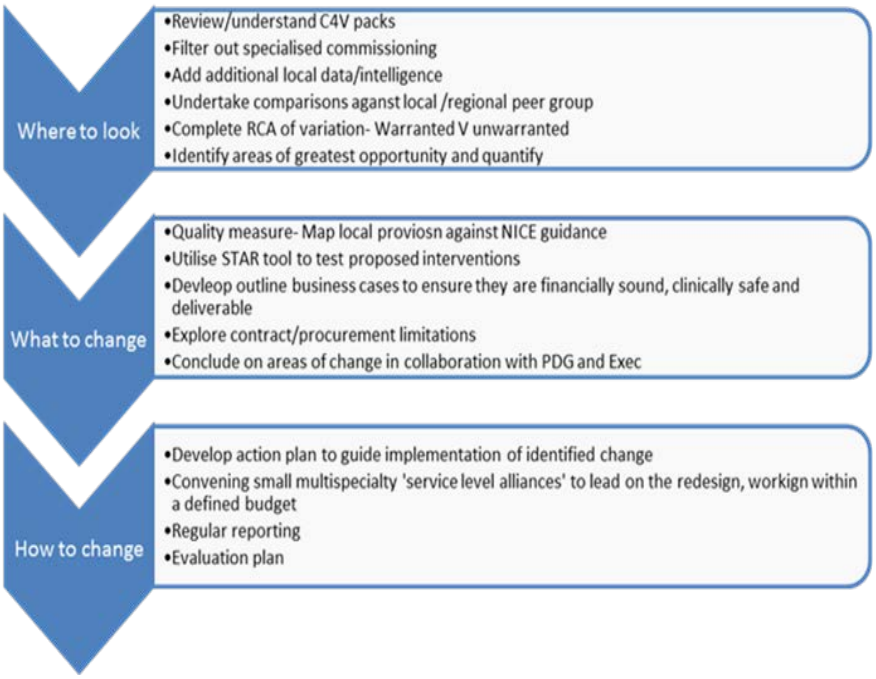
- **Cycle 1 –**
  - **Cancer**
  - **Respiratory**
  - **Cardiovascular disease**
- **Cycle 2 –**
  - **Endocrine**
  - **Gastrointestinal**
  - **MSK**



The above areas represented those with the greatest variation from comparator CCGs which in turn represented the greatest opportunity in terms of scope for improvement.

Our way of working for NHS Right Care is illustrated to the right.

Significant progress has been made within each of the priority areas during 2017/18 and all six will continue to be priority areas moving into 2018/19.



8. Canterbury

In 2016/17 STCCG entered into a formal partnership arrangement with Streamliners LTD, a strategic partner of the Canterbury District Health Board (CDHB) in New Zealand. The agreement contained two core elements; Consultancy support to implement an alliancing way of working across health and social care and the implementation of HealthPathways (HP).

The Alliancing element is based on a model successfully implemented in Canterbury which supports a collaborative approach to joint decision making and governance structures across both provider and commissioner organisations in order to maximise the outcome of the local 'dollar/pound'. The aim being to create a 'one system' approach whereby decisions are made on the basis of 'what is best for the patient, what is best for the system' not what's best for individual organisations.

Significant progress has been made in 17/18 with the adoption and adaption of this approach with South Tyneside. We have established an Alliance Leadership Team which oversees some of the key work programmes within the borough. This operates within parameters of high-trust and low-bureaucracy and tries to move the points of decision making as close to the patient as possible, encouraging front-line staff to develop their own solutions. In turn, the senior system leaders are encouraged to 'say yes' to these ideas and to find ways of making the money work to support these.

To this end, we have already formed a number of Service Level Alliances to drive particular priority areas, including End of Life care, Frailty, Respiratory disease and Cancer.

The already-existing Local Leadership of Health group, which consists of the Chief Executives of the statutory and voluntary sector, is there to both lead and support this new way of working.

In 2018/19 we will seek to develop this emerging way of working even further to ensure best use of the 'South Tyneside pound'

The second element within the agreement related to the introduction of HealthPathways (HP) into the local health economy. HP is an online resource for GPs to access live within clinical consultations. The site contains hundreds of condition specific pathways of care which have been agreed by a local GP and a subject matter expert for the particular condition. The aim of the pathways being to provide a consistent approach to the management of conditions, with all GPs working to the same protocols and guidelines ensuring a reduction in variation in referrals into specialist services.

In addition the develop process, in which GPs and secondary care consultant come together to discuss shared pathways is having a significant positive impact on blurring the boundaries between primary and secondary care.

The local site was launched in August 2016 and now contains over 150 localised pathways and numerous associated request pages. The site is developing into the one stop shop for system information and is the central portal for sharing across the South Tyneside system.

Monthly utilisation demonstrates an ever increasing site usage with additional users accessing the site on an ongoing basis.

The site will continue to be developed throughout 18/19 including an expansion in its content. In addition we will work with our LHE partners in sharing our learning to support the implementation of their HP site.

9. Achieving financial balance

To enable South Tyneside CCG to achieve a balanced financial position the CCG has developed an indicative QIPP programme comprising schemes totalling £5.7m which is 2% of the CCG's allocation. Of this £1.9m relates to schemes put in place to reduce activity levels.

The remaining elements the QIPP plan comprise expected savings from the on-going redesign of local community service provision, prescribing initiatives and a number of small schemes.

The activity implications of the QIPP plan are reflected in the activity return and finance plan consistently. Each scheme has been worked through using 16/17 baseline data and 17/18 updated positions. The impact has been calculated by understanding the impact of existing schemes from 17/18 and the understanding of similar schemes implemented elsewhere. The profiling of the schemes has been calculated individually and the CCG has considered the impact of elective and outpatient schemes and alignment with investment.

At each step we have triangulated the activity and finance to ensure there is consistency between the two datasets; although not using the commissioned dataset (SLAM) has meant there will be reconciliation differences where local arrangements have been agreed between the Commissioners and Providers.

The CCG recognises that the QIPP programme for 2018/19 is challenging and is to continue enhanced arrangements for reporting and monitoring delivery which will be overseen by the CCGs dedicated Financial Sustainability Group with escalation to the Audit and Risk Committee and/or Governing Body where required. Please refer to the section on risk, below, which sets out our risk management approach.

10. Embedding quality in all we do

10.1 Quality Framework and quality risk management

Our approach to **quality risk management** comprises the following key features: Risk registers in place with appropriate mitigations in place and action plans as necessary:

- Service specifications in place which include quality requirements and reporting arrangements
- Quality impact assessments to be undertaken for each service development/scheme
- Local quality requirements aligned to schemes which will provide details of quality indicators at a local level
- National CQUIN schemes in place for all providers.
- Patients safety monitoring which includes:
    - Use of appropriate incident monitoring systems
    - Serious Incidents reports and lessons learned; action plans
    - Mortality and morbidity ratios and pathway developments to support improvements in key areas for example the early identification and treatment of Sepsis
    - 104 days breaches and SI monitoring in accordance with cancer backstop policy
    - Supporting quality assurance across pathways covering primary, secondary and community services
    - Care home assurance and monitoring in liaison with Local Authority colleagues

The CCG has a Quality Strategy which **supports the implementation of the Operational Plan,** which includes:

- Monitoring of national and local quality indicators and which are reported into quality and patient safety committees by exception including HCAI; mortality and patient experience indicators.
- CQUIN schemes to support service developments, aligned to national schemes
- Service specifications include quality requirements, including NICE standards, monitored in collaboration with contract management processes, includes monitoring of safeguarding to ensure that the most vulnerable patients are protected
- Procurement processes underpinned by quality appraisal assessment of tenders and responses and safeguarding
- Regular forum for Clinical Quality Review with discussion of performance issues including quality held with the provider on a monthly basis. This gives the provider the opportunity to share actions; provide assurance and share good practice
- Commissioner assurance visits are undertaken to triangulate information and provide assurance to the commissioners. For example; themes and trends from serious incidents and/or CQC inspection reports may provide focus for commissioner visits
- Serious incident monitoring including analysis of themes and trends and lessons learnt. Any issue with compliance against the national guidance would be challenged and managed with the providers
- Complaints about providers are monitored for themes and trends via the quality framework described and CCG complaints are reviewed regularly by the Governing Body
- CCG representation at CNE QSG

Patient experience and other quality intelligence is used to drive service improvements , as follows:

- Use of patient stories at QPSC, these will shared with relevant providers to request follow up/investigation and feedback to committee and service user/carer. Provider expected to demonstrate what improvements have been made as a result of patient stories.
- Emerging themes from complaints/incidents would be used to inform commissioners of areas for development
- Areas of poor performance giving rise to quality concerns would provide a focus for improvement
- Working collaboratively with other multi agencies such as Local Authorities to support providers in developments as required such as Care Home developments and quality issues
- Informing commission intentions through triangulation of quality information
- Engagement with patients, service users and communities via our annual PPI action plan, the outcomes of which are used to inform service planning including the Path to Excellence work across South Tyneside and Sunderland NHS Foundation Trusts
- Formal public consultation, as required by regulation, is carried out according to robust plans and designed in a way which will ensure excellence in consultation process

Quality Premium

The CCG will be using the Quality Premium Scheme to continue to improve the quality of services commissioned and work to improve outcomes and reduce inequalities in health outcomes.

Local measures for the CCG have also been drawn from the Right Care data, for 2018/19 which will focus on mental health and stroke.

In addition, we will be guided by national indicators which include:

- Early Cancer diagnosis
- GP access and Experience
- Continuing Health Care
- Mental Health
- Bloodstream infections

11. Workforce

The integration that the new models of care calls for requires a flexible workforce, with new roles and changes in skill mix to ensure delivery across seven days. Changes and the willingness to embrace new roles and responsibilities and develop knowledge of other sectors will become more important along with geographical mobility.

It is important that in 18/19 we build upon previous development of the workforce, but also begin to plan for future requirements. Robust approaches to workforce development will be essential, including assessment of current workforce to inform planning. Implications of any future structural changes likely to emerge from new models of care need to be understood with early work anticipated re: changes to terms and conditions, professional regulation and indemnity issues, along with any TUPE transfers.

The CCG will ensure a dialogue is maintained between HENE, in terms of feeding up future commissioning plans and also accessing support in developing the workforce moving forward. As part of this, all practices in South Tyneside have participated in the HEE Workforce tool gathering baseline and ongoing information on the demographics of the local workforce and their knowledge and skills with a view to using this to shape the workforce strategy.

We are active participants in the Community Education Provider Network (CEPN) with Sunderland CCG and in 2017/18 have been able to use this partnership to support undergraduate placements in general practice. This has offered the opportunity for a more diverse learning environment and raised awareness of roles outside the hospital setting.

Further information on our workforce plans can be found in the sections of this plan which relation to the implementation of the GPFV.

12. Triangulation to the 9 “must do’s”

The 9 “must do’s”		
Area	**Our response (Note: many of these are covered in our articulation of key work programmes for 17/18 and 18/19)**	
Primary care	✓	• See GPFV section of this Operational Plan and GPFV appendix for the detail of our plans
Mental Health	✓	• The articulation of our key schemes throughout this plan includes requirements of mental health forward view • Our newly commissioned life course mental health service for children and adults will ensure quicker and easier access - via a Single Point of Contact – to lower level health interventions. • Our dementia diagnosis rate is one of the best in the country and we will continue to improve on this position. • Work programme is in situ to deliver a reduction in OOA placements
Urgent Emergency Care	✓	• Detailed system wide A&E improvement plan in place to cover 5 high impact areas, with the aim to continue with improved performance of the A&E Standard and address winter challenges. • Work focused on ACS pathways including the introduction of a range of new pathways. Schemes in situ to monitor and improve hospital flow, DTOC, discharge to asses, as well as a range of schemes to avoid admission. • The GP out of hours service has been procured in line with national standards and is available to 100% of the population • We are committed to continuing to work with colleagues in the Urgent Care Network and in the UEC vanguard We are working closely with NTW FT around liaison and crisis services for mental health.
RTT and elective care	✓	• The CCG has a good track record on delivery of the constitutional standards. • All trajectories continue to be on track. • The CCG is engaged in regional work around the implementation of Better Births in addition to the clinical service review of Maternity and Obstetrics as part of the optimal use of the acute work.
Cancer .	✓	• Smoking - Multi-agency approach to delivering the tobacco control agenda, CCG being part of work to meet ambitious targets 2020-2025. • 1 –year cancer survivorship. Work underway to identify practice variation including screening. Work programmes monitored for year on year improvements in offering/uptake of screening programmes. • Review outcomes of pilot “increasing early detection of lung cancer” through low dose CT screening of COPD patients. • Work with the Northern Cancer Alliance to review the Breast Cancer Services. • Stratification approaches extended to colorectal cancer by 2018/9. Review existing prostate stratification to follow.

People with Learning Disabilities	✓	• We have developed and implemented an innovative, integrated learning disability team with pooled budget. This gives greater flexibility to meet individual needs, more focus on prevention/ early intervention/ increasing independence/outcomes. • Continue to work with colleagues across the NE Transforming Care agenda; STCCG is on track in terms of this work.
Improving quality in organisations	✓	• Through our Quality Committee routes we will robustly continue to monitor the standards of care being delivered in our commissioned organisations and we will work closely with STFT as it seeks to move from a position of "requires improvement" to "good". We continue to monitor mortality information and work closely with our Governing Body and FT around this,

13. Risk

The CCG faces a number of risks during this period, which that have been considered when drawing up the operation plan.

13.1 Financial risks

The level of ambition associated with our QIPP schemes is considerable but manageable, schemes have been subject to robust workup with realistic deliverability expectations attached to each scheme. The schemes are subject to regular monitoring and scrutiny via the Programme Board.

The profiling of the schemes has been calculated individually and the CCG has considered the impact of elective and outpatient schemes and alignment with investment.

In 2017/18 we implemented a new architecture in the CCG associated with Financial Sustainability, with associated governance structures. This will continue in 2018/19 to ensure robustness in approach as well as oversight and challenge from governing body members.

The CCG continues to bid for additional funding to assist with pump priming and/or scaling up of projects to support delivery of our plans.

13.2 Performance risks

A&E 4 hour standard

After significant improvement and excellent performance during 2017/18 the system has experienced challenges in the sustained achievement of the A&E four hour standard during the winter. There is continued focus via Local A&E delivery board and operations group with an intention to reflect on the winter 2017/2018 challenges during the spring of 2018.

The A&E delivery board has an A&E improvement action plan to support delivery of the standard which takes into account A&E performance and patient flow, from admission through to hospital discharge.

The improvement plan includes the development of services in the community to support resilience and help prevent readmission such as the GP winter weekends pilot scheme.

This standard continues to receive the highest level of scrutiny and action plans and additional assurances have been provided to NHS England on a monthly basis. As a result, definitive timescales are not included within this narrative to prevent duplication.

Additionally, as part of the Urgent and Emergency and Care Vanguard we will be testing out, locally, particular initiatives which in turn should support delivery of this standard such as direct GP appointments being bookable via NHS 111 and the extraction of information from GP systems to help us understand when pressures occur in primary care and thus to react proactively to this as far as possible.

Delayed Transfers of Care (DTOC)

DTOC has been highlighted in the past as an area of concern due to growth in days delayed from an acute setting, which had significant oversight via the SRG. There has been an exceptional improvement in this standard with South Tyneside consistently performing substantially below the target 3.5% of occupied bed days.

Actions to address the delays included:

- Discussion of delays on a weekly basis with acute, social care and mental health to identify barriers to discharge/opportunities for improvement.
- Specific task and finish group on discharge processes to residential step down facilities
- Pilot of 'home first: discharge to assess' pathway
- Use of standard operating procedure for supporting patients' choice at discharge

Ambulance response times

The ambulance response times trajectories for 2018/19 have been prepared by NEAS with support from NECS. These trajectories have been revised to ensure that they meet NHS Constitutional standards over the year. Key actions planned across the health economy to improve the current ambulance response times in order to achieve the NHS Constitutional standards, have been shared with NHS England.

In addition improvements in performance are not exclusively dependent upon the ambulance provider. Changes in the ways of working by other providers within the health economy are required and this area receives continued local focus at our A&E Delivery Board, of which the ambulance service provider is a member. NEAS has been a key partner in the Path to Excellence programme.

Appendix 1 : Delivery of the GPFV In South Tyneside

Co-ordination of local initiatives and delivery of national initiatives in primary care services are significant areas of focus for the CCG. We know that the landscape will need to look different in the medium to long term[2], the GPFV alongside the CCG's local plans to transform out of hospital care provide the building blocks to support primary care (in particular general practices), to deliver services in different ways. Supporting practices to transform and to deliver wider services to the population on an 'at scale' basis is at the heart of the CCG's general practice strategy. Our strategy has five key workstreams:

6. Delivery of Primary Care at Scale
7. Reducing Variation
8. Changing the Focus of Primary Care
9. Improving Access to Primary Care
10. Workforce Planning

The 'GPFV High Level Overview' (detailed within the body of our operational narrative) sets out how our key initiatives against known funding streams will be delivered across 17/18 and 18/19. The CCG has defined an investment profile, but this has not yet been broken down across our initiatives, however spend will be tightly focused on the developments and initiatives we describe.

We are also able to give further narrative on how our strategy will contribute to delivering the GPFV below:

1. Delivery of Primary Care at Scale

South Tyneside has a blueprint for 'out of hospital' services known as our 'community' model[3] and delivery of primary care at scale is a key component to support the redesign of care provision which is unconstrained by organisational barriers and maximises economies of scale.

Our Enablers

- We have well established **integrated community teams** covering populations of between 30,000 and 50,000 (clustered around 'localities' of practices) which combine community nursing, social care, GP practices and third sector to concentrate on effective multi-disciplinary management of at risk patients. Further development work will continue to enhance the functionality of the teams to take in both planned and unplanned work, and to expand the cohort of patients, through risk stratification, who will benefit from this approach. A review of the skills and competencies required to deliver integrated services has taken place and an ongoing development and education programme has been put in place.

- Our local **primary care incentive scheme** in 17/18 and 18/19 sets out the need for practices to work collaboratively on plans to deliver services on an at scale basis. Further focus is being placed on practices working together to deliver services that have traditionally been provided in hospitals so that care is provided closer to home where appropriate, and only services that need to be delivered within an acute setting are delivered in hospital. The 17/18 and 18/19 scheme has deliberately been

[2] NTWND STP wide framework for a future health and care model, STCCG Draft Operational Plan 17/18 – 18-19
[3] Out of Hospital Model, see section 5.1 of main document

designed to offer practices flexibility in choosing development areas that are pertinent to their own development needs, but which are also complementary to the CCG's target areas.

- 16 South Tyneside GP practices have joined together under a **federated/collaborated model** (from 1/4/17). Whilst respecting the need for an appropriate commissioner/provider split (and the management of conflicts of interest), the CCG meets regularly with key members of the collaboration to discuss the overall strategic development of primary care and the development of a shared understanding of the workplan going forward for the borough.

- Data sharing is in place between our practices to allow the **full primary care patient record** to be viewed of any South Tyneside patient. This both supports the delivery of enhanced primary care at scale and provides the ability for primary care extended access to be delivered at scale (likely to be via a hub based arrangement).

2. Reducing Variation

Supporting practices and wider teams to provide **high quality and evidence based care** within safe and efficient systems is central to all that the CCG does. Reducing variation is therefore a key focus within our general practice strategy.

Our enablers:

- South Tyneside is using **NHS Rightcare** data to inform our approach to better management of patients in the community and to avoid inappropriate admissions to hospital. Rightcare data is therefore able to direct the focus of both the CCG and wider stakeholders in designing services and radical new approaches to service provision in the community.

- South Tyneside CCG also uses Rightcare data to inform our **primary care incentive scheme f**or general practices. This therefore is acting as a further lever to drive change, particularly supporting a reduction in variation and the provision of primary care services at scale.

- South Tyneside CCG has recently developed a **quality dashboard** of local and national indicators which we use as a tool to help guide care delivery within general practices. Although this links to quality assurance of primary care, it primarily exists as a lever and enabler to support improvement and development. Practices can use this tool to baseline themselves against their peers and to identify areas where changing working practises or identifying enhanced services in primary care can contribute to the overall health and care challenges within the borough to deliver improved patient outcomes.

- The CCG carries out **practice visits** regularly. Visits are focused on improvement and development and the practice's relative position on the primary care dashboard is discussed. The visits are also a good source of other intelligence that helps build a picture of how things are in general practice such as current or anticipated pressures, or upcoming contractual or infrastructure issues etc. This gives good opportunity for the CCG to discuss pertinent issues with practices in a timely manner and often affords the time to plan for and/or discuss significant practice issues such as merger intentions etc

- South Tyneside CCG has commissioned the '**Health Pathways'** system which standardises care pathways and puts them on the desktop of front line staff. This both reduces variation in care pathways and also helps staff to have the most up to date information at their fingertips. Dual screens have been purchased for all practice staff so that EMIS can run on one screen and Health Pathways the other. Pathways will be developed to ensure that the management of acute conditions in the community is supported.

3. Changing the Focus of Primary Care

Transformation of primary medical care will rely heavily on:

- Pro-active **patients in control** of their own health (embedded approaches to patient activation)
- Using **online and digital technology** to support primary care provision (it is widely viewed that practices who actively promote online and digital services benefit from reduced administrative workload and increased patient satisfaction)
- A focus on the **skillmix and competencies** of staff with the delivery of interventions that match need

Our Enablers:

- The CCG has developed a **Local Digital Roadmap** (LDR) in conjunction with Sunderland CCG. Two of the ten 'universal capabilities' in the roadmaps are related to GP Online (patients accessing their GP record and being able to book appointments and order repeat prescriptions from their GP practice). The CCG has delivered a training session for all admin staff (October 2016) and has communicated extra support offers to all practices. We get regular position statements in regard to transactional monitoring from practices in line with the national target of at least 10% of patients registered for online services in every practice by 31st March 2017.

- The CCG has successfully applied to become an early adopter of **wifi enabled** General Practices. All of our practices will therefore be wifi enabled by March 2017.

- The CCG convenes a **Digital Technology Group** for practices which acts as a project group to facilitate implementation of online and digital technology

- Our local **primary care incentive scheme** supports an evolving and changing focus to population outcomes

- The CCG has **protected learning time** (Education Session) monthly for all practice staff. An education plan is forward mapped to align with training requirements and strategic priorities. Delivery of training is tailored to staff discipline which allows multiple education to take place simultaneously at different venues

- The CCG champions an agreed patient activation approach as part of the '**a better u' self care programme.** General practice staff are invited to attend the training to support this initiative. Good uptake has been observed in the Jarrow and Hebburn localities and we now aim to promote this further across wider South Tyneside practice

- Part of the CCG's workforce plan (see section below) will focus on the potential demand for contacts by **allied professionsals, pharmacists** and **other complementary disciplines** to create an active recruitment and retention plan

- We have supported our practices to bid into the N**HS England Estates and Technology Transformation Fund,** as required and several practices have received support on individual or pan CCG wide (technology) schemes

4. Improving Access to Primary Care

Access to primary care is a foundation of the provision of proactive, high quality and timely care. The national GP Patient Survey tells us at regular intervals our patients' perception of access to general practice. Although South Tyneside in general performs well compared to the national position, we know through our regular discussions with patients, councillors and other stakeholders that there can be pockets of 'access hotspots'. Our general practice strategy therefore focusses on **defining and delivering good access to services**, coupled with ensuring the right professional with the right skills sees the patient at the right time. The ringfenced additional monies for delivery of **extended primary care** are welcomed and the CCG has now commissioned extended access services in the early mornings, evenings and weekends. The total additional capacity commissioned is 78 hours/312 additional appointments per week

Other Enablers to support improving access:

- South Tyneside is working in partnership with South Tyneside Local Authority on integrating our **primary care estates plan** with planned and pending housing planning permissions. Joined up workshops have taken place to triangulate existing primary care estate, primary care access challenges and planned housing developments. Particular focus has been placed on Hebburn due to the large numbers of houses being built there. Dialogue with local authority town planners has afforded conversations with developers and potential contributions to primary care infrastructure being built into future planning permissions. In addition, nearly all of our practice premises have now been surveyed. This information will be useful to inform future service delivery approaches and models.

- The CCG has established pathways of care that integrate with community pharmacy via our highly successful **Think Pharmacy First** service. This provides consultations for over 45 minor ailments with a formulary of over 90 items. This has been in operation for nearly 2 years now and the metrics collected are showing clear evidence of a shift in activity from GP practices to community pharmacies - 900 patients using the Think Pharmacy First service per month have stated they would have attended their own GP as an alternative. This equates to broadly 35 appointments per practice per month which have been directly diverted to this scheme (ie, the patients told us that they would have gone to the GP practice if the scheme was not in place).

- We will be using **capacity and demand mapping** data to inform and develop skill mix in primary care

- We have promoted the **role of the receptionist** to help navigate patients. Signposting training has now been completed on a pan CCG wide basis at levels 1 and 2.

- We take a keen interest in the **resilience of our practices**. To support this we have quarterly individual practice meetings where practices can discuss issues freely with

the CCG. These are vital sources of soft intelligence and can often facilitate 'early warning' conversations where actions can be taken to mitigate against the risks or issues identified. A local primary care resilience workshop took place in 2017 to help us plan resilient services and to help us identify practices who may be vulnerable

- We have supported our practices to bid into the NHS England resilience fund against 16/17 and 17/18 monies , and several practices have received support, including our GP collaboration

- We have supported our practices to be involved in the **Productive General Practice Quick Start Programme** (PGP – QS) and a cohort of 8 practices are currently taking part in the programme. The programme takes place over 14 weeks (4 group based sessions and 6 in practice half days with individual improvement facilitators working with the practice on their issues). All participating practices complete the mandatory module of 'failure demand' and choose from 5 optional modules:

    - Minimum job requirements
    - Consistency of approach
    - Workplace organisation
    - Chasing the tail
    - Workforce planning

  These modules closely align with reducing workload pressures in general practice (how to use the 10 high impact changes to improve practice efficiency).

  We were successful in running a second cohort from March 2017. 62% of our practices (focussing on the most vulnerable), therefore had the opportunity to participate in this specialist programme.

5. Workforce Planning

The primary care workforce, in terms of raw numbers of staff disciplines and also in developing the primary care skill mix is a key focus area. The CCG has not had absolute visibility over the primary care workforce as level 2 co-commissioners, however, as we became level 3 commissioners from 1st April 2018 we recognise the need to map the existing workforce alongside our emerging out of hospital model to profile in the first instance what the gap is. Once this information is established, the CCG can then work with stakeholders to increase the workforce and importantly, the skill mix, as appropriate. All of of our practices has now completed the HENE primary care workforce tool to give us a baseline assessment. A key component of our vision is to create a workforce that reduces pressure on GP time whilst supporting career development in medical, nursing, allied health, professional, administration and managerial roles. Our intentions are that an emerging workforce plan will set out the current position, greatest areas of pressure, the desired end state and the planned future model and actions to get there.

Our Enablers:

- Establishing a **baseline of general practice staff**, by discipline and by practice

- Undertaking a **capacity and demand analysis** within general practice which includes both demand for appointments and appropriateness of clinician. The

appropriateness of clinician field will provide evidence to support our desired end state regarding best skillmix

- Part of a **Community Education Provider Network**, in partnership with Sunderland CCG and GP Alliance, which aims to support our work through delivering:
    - Facilitating primary and community based providers to come together in a collaborative manner to produce the primary care workforce of the future by, amongst other activities, facilitating primary care placements of students of all professions allied to primary care
    - Coordinating the development of training and education needs of the current workforce, working with the continuing workforce team at HEE NE
    - Developing partnerships with all stakeholders including federations, CCGs, LMCs, Higher Education Institutes (HEIs) and secondary care providers
    - Helping to develop a system of locally managed but centrally assured educational governance eventually encompassing all training and education in primary care

    Although this work is at an early stage, it is hoped that this will offer significant scope for increasing a skilled primary care workforce and there are also aspirations to attract new staff to our area once their training has been completed.

- **Training reception and clerical staff** to undertake enhanced roles in active signposting and management of clinical correspondence has allow us to support practices to direct patients to the most appropriate service or clinician within the practice. Managing medical correspondence training has enabled practices to free up GP time through the introduction of better administrative processes for letters and other administration relating to clinical care.