Item No. 2

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

Held in Committee Room 2, Sunderland Civic Centre on Friday 25 November 2011

MINUTES

Present:

Councillor Paul Watson (Chair)	-	Sunderland City Council
Councillor Dave Allan	-	Sunderland City Council
Councillor Pat Smith	-	Sunderland City Council
Councillor Mel Speding	-	Sunderland City Council
Councillor John Wiper	-	Sunderland City Council
Keith Moore	-	Executive Director, Children's Services, Sunderland City Council
Nonnie Crawford	-	Director of Public Health, Sunderland TPCT
Sue Winfield	-	Chair of Sunderland TPCT
Dr Ian Pattison	-	Chair of Sunderland Clinical Commissioning Group
Dr Gerry McBride	-	Sunderland Clinical Commissioning Group

In Attendance:

Councillor Harry Trueman	-	Sunderland City Council
Councillor Christine Shattock	-	Sunderland City Council
Sarah Reed	-	Office of the Chief Executive, Sunderland City Council
Jean Carter	-	Health, Housing and Adult Services, Sunderland City Council
Mike Poulter	-	City Services, Sunderland City Council
Nichola Fairless	-	North East Ambulance Service
Alan Patchett	-	Age UK (Observing)
Mike Lowthian	-	Sunderland LINk
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Warnes	-	Governance Services, Sunderland City Council

HW16. Apologies

Apologies for absence were received from Neil Revely, Ron Odunaiya and David Hambleton.

HW17. Minutes

The minutes of the meeting held on 16 September 2011 were agreed as a correct record.

Karen Graham reported that the workshop event for partners would take place in January 2012.

HW18. Clinical Commissioning Group Update and CCG/PCT Interim Joint Commissioning Intentions

Dr Pattison provided the Early Implementer Board with an update on the Clinical Commissioning Group's journey towards becoming a statutory body.

The Clinical Commissioning Group (CCG) was continuing to evolve and develop and there was excellent engagement from practices. The first stage was to review the configuration of the emerging CCG and the Strategic Health Authority had also requested a trajectory to the point of authorisation for the CCG which set out key milestones and timeframes. The progress made had meant that Sunderland was ahead of where it needed to be on the trajectory line and was on track for receiving authorisation status in October 2012.

The next milestone would be the development of a Clear and Credible Plan (CCP) by the end of December. The CCP would be the Commissioning Group's three year Strategic Plan which would continue to deliver the quality, innovation, productivity and prevention challenge within financial resources in line with national requirements and the local joint health and wellbeing strategy. The Sunderland CCG felt that this plan was more important than being ahead of the curve as regards the journey towards authorisation and a draft would be prepared by the end of December. There would then be the opportunity to refine the CCP and engage with key stakeholders prior to finalising the Plan for March 2012.

The CCG also had to engage with the development of commissioning intentions and was working with the PCT to identify what it would be involved in and where it could add most value. The CCG would also be required to lead the contracting round for 2012/2013 and Sunderland had agreed a position with the other two CCGs in the South of Tyne and Wear area and would be leading on mental health and acute contracts.

Dr McBride explained that the CCG had started to do some practical as well as theoretical work and this had already had an impact in reducing the stacking of ambulances at the Accident and Emergency department of Sunderland Royal Hospital.

Nonnie Crawford advised that the clinical commissioning intentions were still in a draft form and had originally been generated from the PCT Strategic Plan. The NHS Operating Framework had just been received by PCTs and it would be mid January before the intentions were fully formulated. The following six months would be spent tightening the intentions and aligning them with the Operating Framework and what

the PCT and local authorities were doing. By next year, the National Commissioning Board would also be in place.

The Chair commented that once the statutory duty of the CCG was known, then the possibility for any innovation could be assessed. Dr McBride noted that this was why the CCG had focused on key areas at the outset and would follow on with these if the Bill went through as planned.

Following discussion, it was: -

RESOLVED: - (i) that the update be received for information; and

(ii) that the draft Clear and Credible Plan be presented to the Early Implementer Health and Wellbeing Board at its meeting on 3 February 2012.

HW19. Feedback from Advisory Boards

Adult Partnership Board

Councillor Allan reported that the main agenda items considered by the Adult Partnership Board at its meeting on 8 November 2011 had been: -

- Caring for futures and the better integration of health and social care and better quality of services.
- The long term relationship between the Adult Partnership Board and the Health and Wellbeing Board. A sub group was to consider this and provide a report back to the Partnership Board.
- The refresh of the Carers Strategy.
- The progress of the JSNA was noted and a long debate ensued about the level of consultation.
- The agenda for the Early Implementer Health and Wellbeing Board was considered and this led to further discussion about the relationship with the Children's Trust as well as the Health and Wellbeing Board.
- Annual Complaints Report – this had been a positive report which showed complaints had reduced and 80% were being dealt with within two weeks. It was suggested that the Health and Wellbeing Board might like to think about the performance information they would like from the Adult Partnership Board in the future.

With regard to the Carers Strategy it was noted that a number of members of the Early Implementer Board would have officers involved in the refresh of the strategy, so it would not be necessary for it to come to the Health and Wellbeing Board. There was some involvement from the GP side and Nonnie Crawford highlighted that this would usually be brought back to the GP Executive Committee and the Pathfinder Committee.

As the Early Implementer Health and Wellbeing Board had said that they did not want to see all 23 JSNA profiles, it was agreed that the comments of the Adult

Partnership Board on the JSNA would be provided for the Health and Wellbeing Board's information.

It was noted that the way that the Adult Partnership Board and the Children's Trust would interact to ensure that the course of life and families were covered was a separate issue to how each advisory board would interact with the Health and Wellbeing Board. It was envisaged that the Health and Wellbeing Board would consider the big issues and hot topics and would ask the advisory boards to look at certain matters and in turn, the advisory boards could refer issues to the Health and Wellbeing Board.

Children's Trust

Keith Moore reported that at the Children's Trust had met on 18 October 2011 and had a detailed discussion on the relationship between the Trust and the Health and Wellbeing Board. The Trust had agreed to change meeting arrangements to ensure these fitted with the governance arrangements for the Health and Wellbeing Board. A task and finish group was being established to look at the Trust's relationship with the Board and the Board's work plan would also be a standing item on the Trust agenda.

The Children's Trust had also received detailed information from Jan van Wagtendonk, the Chair of the Sunderland Safeguarding Children Board (SSCB), on SSCB operational issues, the SSCB Annual Report and business plan. Jan provided an update at each Trust meeting and on this occasion, the implementation of recommendations from the Serious Case Review was brought to the fore.

The Trust received two presentations, on the 'Whole Family Approach' and the review of acute paediatric services.

The Trust appreciated the opportunity to report back to the Health and Wellbeing Board and could establish a more formal reporting arrangement once the task group had completed its work.

RESOLVED that the information be noted.

HW20. NHS Institute for Innovation and Improvement – Health and Social Care System Support Diagnostic

The NHS Institute for Innovation and Improvement had been tasked nationally with offering support to health and social care systems and in the North East, the Strategic Health Authority had provided funding for the Institute to work with PCT clusters to assist in the change which was required to meet the emerging health agenda.

The Health and Wellbeing Executive group had received a presentation from the Institute on the support available, which would involve a number of key stages including: -

- A review of key organisational and system documents
- A chief executives listening exercise
- A stratified staff survey

This was seen as positive support for the Board and the Institute would be free to commence work in January. Board members and partners may be invited for interviews, but the Institute had confirmed that these would take no longer than one hour. Reports would be produced in February/March and the data could then be used as the Board transferred from Early Implementer to shadow status.

Upon consideration of the report, it was: -

RESOLVED that: - (i) the summary of the Institute's support service be noted;

(ii) it be agreed that the Institute start work in Sunderland in January 2012;

(iii) partners agree to be available for interviews during weeks commencing either 16 or 23 January 2012; and

(iv) the reports on the recommendations of the Institute be received on completion.

HW21. Development and Evaluation of the Health and Wellbeing Board

Karen Graham presented a paper which set out the outcome of a Board member training audit and the current opportunities for development. She highlighted that as part of being granted Early Implementer status, there was an obligation to review and evaluate the structure, membership and operation of the Health and Wellbeing Board.

Following an audit of Board member training, it was recognised that there was a desire for development activities to be undertaken as a Board and on an individual or small group basis. The Board needed to establish the following: -

- Values: what are the shared values that all members of the Health and Wellbeing Board bring to the table?
- Goals: what is our vision and what are our key objectives and goals? How do we tackle long-standing issues that have proved hard to address? and
- Tasks: What do we need to do to achieve our objectives and who will do this?

It would be necessary to clarify these issues, to consider the relationships between the Board and other groups and to determine roles and responsibilities, media relations and understanding of timelines and deadlines.

The importance of making all elected Members aware of their new responsibilities had been identified and a training programme was being developed to carry out this work. On a regional basis, the ANEC Improving Health Task and Finish Group

intended to bring together the Chairs of all 12 Health and Wellbeing Boards in the region with the aim of taking forward the health agenda.

It was proposed that a series of sessions be developed between now and March 2013 to cover issues highlighted by the training audit and to continue board development. The first session would be for the whole Board and be followed up by a series of thematic briefings and workshops.

Turning to the evaluation of the Early Implementer Health and Wellbeing Board, members of the Board had been informed about the support to be provided by the NHS Institute and that their recommendations for Shadow and Full Board status would be fed back into the Board in March 2012.

At the first meeting of the Early Implementer Board in July 2011, members agreed what success would look like, however it was proposed to seek the views of advisory groups and other interested parties in order to establish a wider set of success criteria. The responses from partners would be collated together with the factors agreed by the Health and Wellbeing Board and be brought back to the Board early next year. It was noted that the Board and advisory group structure had only been in place for a short time and that full evaluation should be delayed for six months in order to accurately measure improvement and distance travelled.

It was highlighted that a number of Members had completed, or were in the process of completing, accredited training as part of the Health Champion programme and this was very much aligned with what the Health and Wellbeing Board would seek to achieve.

It was confirmed that a briefing was to be arranged on key heath issues in the city for all Members of the Council.

Upon consideration of the report, the Board: -

RESOLVED that: -

(i) a whole Board values, goals and tasks session be held;

(ii) an ongoing training plan running to March 2013 be established;

(iii) advisory groups and broader partners be involved in setting success criteria; and

(iv) the NHS Institute for Innovation and Improvement be engaged to undertake the Health and Social Care Support System diagnostic.

HW22. JSNA and the Health and Wellbeing Strategy

Nonnie Crawford provided an update on the progress of the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy.

The process of refreshing the JSNA which had begun in June/July continued and a list of 23 priority areas had been established for which to develop health profiles. The profile leads had been engaging in a number of ways through the process and the second set of draft profiles would be available on the Sunderland Partnership website in the next week.

Through the development of the profiles, consideration would be given to the plans for 2012 and the future and what would be statutory, mandatory and aspirational. An alignment should be seen with the priorities of the CCG and the local authority. A summary of the JSNA profiles would be brought to the next meeting of the Early Implementer Board.

The JSNA work was underpinning the development of the Health and Wellbeing Strategy and the first draft of this would be ready in January. It was intended to take the draft to a range of health groups during February and March and by July and August it would be going through the approval processes of a range of bodies. Details of this process and the associated delivery plans would be presented in a report to the next meeting of the Board.

The Chair highlighted that the Board would have both an overarching vision for the City and a statutory duty and the Health and Wellbeing Strategy would underpin these areas of work.

RESOLVED that the information be noted.

HW23. Public Health Transition Plan

Sarah Reed presented a report providing an update on the proposed process for the transition of the Public Health Service from Sunderland Teaching Primary Care Trust to Sunderland City Council.

There were a number of elements which were still unknown but planning was being done around these known variables. The transition was to take place from April 2013 and there was a requirement for each area to have a transition plan in place which was then to be submitted to the Department of Health by the end of March 2012.

The Director of Public Health would transfer to the local authority but it was uncertain how many staff in total would transfer from the PCT to the Council and there was potential for a sharing of responsibilities between Sunderland, Gateshead and South Tyneside councils. There was an exercise being carried out to assess the amount of time spent by officers doing particular tasks and it had been identified that approximately £28million was spent annually on public health. Again it was unclear how much of this would be transferred to the local authority, however it would be the intention to align the new areas of work with the council's operating model.

There was a need for clarity about how the public health function would work in practice, how intelligence and information could be transferred and how communication and consultation would be managed. Further information would be brought to the Board as it was published.

It was noted that the Council would be employing on their terms but this may not be straightforward for employees transferring from the PCT which operated a range of different contracts. A paper was due to be released on 14 December which would give more detail about the local authority's role in taking on Public Health and also further information on ring fenced budgets. It was envisaged that those papers would fundamentally shape the process.

Sarah Reed was leading the transition for Sunderland and was working closely with Neil Revely and Nonnie Crawford on the development of the transition plan and the first cut of the plan would go to the council's Executive Management Team in January.

It was queried if the JSNA would pick up the analysis of current public health work and future priorities and Nonnie Crawford flagged up that the JSNA was about improving health outcomes and its priority areas covered the issues which were related to public health. The JSNA was also far more detailed than it had been in the past, however there were still gaps in relation to equalities impact assessments but the current content would offer more support to officers in decision making.

Having considered the report, the Board: -

RESOLVED that the outlined processes be supported and agreed and that they would direct and facilitate solutions to the key issues which would enable Public Health in its transition to Local Authority responsibility and management.

HW24. Health Watch Update

Sue Winfield presented a report updating the Board on national and local progress with the HealthWatch transition.

The Board were informed that the outcomes of the 'Listening Exercise' in relation to HealthWatch had strengthened the principles of patient and public involvement at all levels including shared decision making. The commencement date for Healthwatch was October 2012 with the NHS Complaints Advocacy delivery beginning in 2013.

The development of HealthWatch England was progressing and it was intended that a Chair would be appointed and take up post in April 2012. The national body would then disseminate information and briefings for local HealthWatch by June 2012.

Pathfinder status had been awarded to 75 areas and the North East Local HealthWatch Pathfinders were Gateshead, Hartlepool and Northumberland. The Chair of Sunderland LINKs was a member of the national HealthWatch advisory group and he had reported that Action Learning sets for LINKs had not yet commenced.

Details of potential funding were highlighted in the report and there had been some initial discussions around transferring the PCT PALS funding for signposting services to the local authority. The amounts of money involved were not huge and HealthWatch would have to develop creative ways to engage with as many people

as possible. Further information about national funding would be released in mid December.

An engagement event had been held to look at the service specification for Local HealthWatch in Sunderland and this had been very well attended. Strong messages came through about the need for information and the importance of personal contact. The main issue continued to be how to make the service effective with only a small resource.

A procurement exercise for Local HealthWatch was to be carried out once a final service specification was developed and agreed. The procurement would be carried out by the Council and overseen by the project group. This would mean that the Health and Wellbeing Board would need to consider Patient and Public representation on the Shadow Board from April 2012 until October 2012 when HealthWatch was in place.

There was less knowledge about how the advocacy element would be progressed as this was currently being carried by another organisation. The Government had issued a contract for advocacy services but there was provision for HealthWatch to provide that service or to sub contract to another body. The issue of advocacy had been flagged up as a major area of concern, however Joan Carter advised that work was underway to establish what was known and what support would be needed.

The report detailed the next steps for the HealthWatch transition as follows: -

- Engage in national and regional pathfinder learning events
- Complete the engagement activities to inform the service specification for Sunderland HealthWatch
- Initiate a formal procurement process once the service specification is greed.
- Develop financial planning for national and local PCT PALS funding transfer to include consideration of any TUPE requirements
- Engage in regional discussions regarding provision of NHS Complaints Advocacy
- Seek advice on the interim arrangement for Patient and Public representation on the Shadow Health and Wellbeing Board

Following discussion the Board: -

RESOLVED that: - (i) the report be received for information;

(ii) the next steps be agreed; and

(iii) Sue Winfield continue as Patient and Public representative on the Shadow Health and Wellbeing Board from April to October 2012.

HW25. Briefing on the Association of North East Councils – Improving Health Task and Finish Group

Karen Graham presented a briefing on the report of the Association of North East Councils (ANEC) Improving Health Task and Finish Group.

The task and finish group was set up as a means to engage with elected Members across the region and the focus of the group was to look at NHS reforms, other relevant evidence and make recommendations.

Sunderland was represented on the group by Councillors Speding and Anderson and the group had set out a number of key recommendations including that ANEC should ensure there was early discussion by both Chief Executives and Leaders and Elected Mayors about how to work differently to address critical issues and achieve better values.

The full report was provided for the information of the Board Members.

RESOLVED that the report be noted.

HW26. Other Business

North East Ambulance Service

Nichola Fairless advised that the North East Ambulance Service (NEAS) was keeping a watching brief on Health and Wellbeing Boards in the region. Whereas they would not intend to send a representative to every meeting, they would be happy to attend to input from NEAS was required.

Improving Health through Health and Wellbeing Boards

Karen Graham advised that ANEC were holding an event aimed at Board Members, Local Authority Leaders and Chief Executives, Cabinet Members with a Health portfolio and senior officers in local government, the NHS and Public Health. The theme for the event would be ‘Improving Health through Health and Wellbeing Boards’ and would take place on 31 January at The Durham Centre, Belmont Industrial Estate. Full details would be circulated by email.

(Signed) P WATSON
Chair

Item No. 3

Sunderland Clinical Commissioning Group

NHS South of Tyne and Wear

Development of Strategic and Operational Plans for 2012/13 – 2016/17

Progress Update for Sunderland Early Implementer Health and Wellbeing Board January 2012

Purpose of the Report

This paper describes the process and timetable for developing Sunderland Clinical Commissioning Group (CCG) and Primary Care Trust (PCT) plans for 2012 to 2017.

It includes an initial draft / work in progress version of the Clinical Commissioning Group Commissioning Plan, together with the initial list of PCT detailed changes planned for 2012/13.

The Health and Wellbeing Board is asked to consider the draft plan and provide input and feedback, as part of the plan development process.

Background

2012/13 is a year of transition for the commissioning of health services in Sunderland. Although the PCT is still formally accountable for the NHS commissioning budget, responsibility is increasingly being delegated to the CCG for the commissioning of those services which will transfer to them, while it is expected that the public health budget and responsibilities will transfer to the Local Authority, potentially by October 2012.

Planning for spend in 2012/13 is formally the responsibility of the PCT which must produce an Integrated Strategic and Operational Plan (ISOP) to address the recommendations in the Sunderland Joint Strategic Needs Assessment and meet the national requirements set out in the National Operating Framework for the NHS. However, the impact of those plans will fall on Sunderland CCG and Sunderland Council and so the CCG part of the PCT ISOP has been developed with and will be signed off by the CCG, while the Public Health part of the ISOP is still the subject of discussions with the Council.

Sunderland Clinical Commissioning Group Commissioning Plan 2012- 2017

Department of Health guidance on the development of Clinical Commissioning Groups requires them to develop a 5 year strategic plan which sets out their vision; the challenges they face; their strategy for tackling those challenges; and arrangements for delivering the changes. The Sunderland CCG Pathfinder Committee has worked since October 2011 to articulate this plan and at the end of December 2011 produced a first

draft / work in progress to share with partners at the earliest possible stage to ensure that the plan develops in harmony with the local authority and other local partner plans.

Appendix A sets out that initial draft plan. It is very much a work in progress for early sharing. The Plan is also being shared with patients, carers and the public and offers have been made to visit these groups and discuss the plan where requested. The Plan will also be shared with other stakeholders and the Executive Committee are considering options such as holding an event for key stakeholders as well as presenting to this Board and Scrutiny Committee in order to discuss the Plan.

Sunderland PCT Commissioning Intentions 2012/13

Planning guidance and allocations for PCTs were issued in December and a first draft ISOP will be submitted to the Strategic Health Authority on 20th January. This document will be shared with partners (including the Health and Wellbeing Board) when it is written, but the detailed changes planned for 2012/13 have been developed using a detailed process over the past three months. CCG changes have been jointly developed and agreed with the CCG while Public Health service changes have been discussed between PCT and Council officers.

Appendix B sets out the lists of detailed changes proposed for 2012/13 – these commissioning intentions have been shared as an earlier draft with the Health and Wellbeing Board at their last meeting for comment.

The intentions will be notified to potential providers during week of the 16th January 2012 and contract negotiations will commence to agree final contracts by mid March.

The proposed Public Health changes will be taken forward as part of the public health transition arrangements.

Recommendations:

The Health and Wellbeing Board are recommended to:

1. Note the draft SCCG Clear and Credible Plan and final Sunderland Commissioning Intentions
2. Discuss and feedback and comments on the SCCG Clear and Credible Plan.

Author: Fiona McDonald Head of Business Strategy and Debbie Burnicle Head of Commissioning Development (Sunderland CCG)

Date: 16.1.12

Sunderland Clinical Commissioning Group

Commissioning Plan

2012-2017

Sunderland Commissioning Plan 2012 - 2017

Contents

Clinical Commissioning Group Chair Foreword

To follow

Section 1 – Executive Summary

Sunderland Clinical Commmissioning Group – Who are we?

54 Practices in Sunderland make up the single Clinical Commissioning Group, bringing together what were 3 separate PBC consortia. Facilitated by the LMC the Practices agreed to form one CCG and elected 6 GPs to form the Executive Committee. The Committee then agreed a Chair and Vice Chair and lead roles for each GP member. Since the group was formed in March 2011, A Practice Manager has been appointed to the Committee and work is underway to appoint a Nurse member.

The move from 3 PBC groups which existed for a number of years, to one CCG represents a major achievement in Sunderland and remains fully supported by all Practices. The Executive has devoted a lot of time to ensuring continual communication with its member Practices and not long after forming consulted on a locality sub structure which resulted in the development of 5 Localities along Local Authority regeneration areas. Regularly meetings with all Practices take place throughout the year, along with a monthly Newsletter and monthly Locality meetings. Locality Practice Managers have been appointed and the appointment of Locality Practice Nurses will follow shortly- all designed to ensure continual engagement of member Practices.

An example of the interest generated was the number of expressions of interest in taking Clinical lead roles – with over 50 expressions of interest. Attendance at CCG events usually has 52 of 54 practices with over 200 people each time.

As a Leadership team, the Executive have dedicated substantial time and energy to developing themselves as a corporate body. Each week has involved at least one full afternoon on our executive business meetings, pathfinder committees or development sessions. The latter also include Locality representatives. We have embraced learning opportunities, membership of the Health and Wellbeing Board' engagement with the PCT Commissioning Directors and other CCG s through a fortnightly collaborative team meeting; attend deep dive performance meetings; quality meetings; PCT Board meetings as well as lead pathfinder priority areas.

Our elected Leadership team is also enhanced by the Director of Public Health and the LMC secretary, with support from the PCT including the aligned Director (Director of Finance) and both the Director of Commissioning Development and a Non Executive along with the aligned Director sit on the Pathfinder Committee.

Whilst as individuals we are all on a development journey as Commissioners, and each have strengths and areas for development, as a leadership team we benefit from each other and our commitment to acting corporately for the benefit of our members and the public we serve.

Section 2 - Vision

2.1 Vision

Our vision is to achieve **'better health for Sunderland'** and was agreed by the Executive Committee in November 2011.

Our vision is supported by three high level goals which describe the changes we aim to make in the medium to longer term, which are to:

- **Improve the health and well being of all local people**; to live longer, with a better quality of life and a reduction in health inequalities across the locality;
- **Integrate services better across health and social care**;
- Underpinned by **more effective clinical decision making.**

We will do this by working closely with **patients**, the **public**, **carers**, **providers** and **partners**.

2.2 What will health, health services and social care look like in Sunderland in five years time ?

The following section describes how we want health, health services and social care to look and feel once the changes set out in this Plan have been implemented.

2.2.1 Improve the health and well being of local people

Our aim is for every individual to live longer, with a better quality of life and a reduction in health inequalities across the locality

The future health of our local people will be characterised by:

Addressing inequalities

Targeting of resources to address the needs of disadvantaged and vulnerable people in the most deprived communities of Sunderland to reduce health inequalities;

Increased resilence of individuals and communities to address inequalities in coping strategies;

Prevention

A reduction in lifestyle behaviours which pose major risks to health (including smoking, alcohol abuse and obesity);

Increased identification of people with risk factors or in the early stages of disease;

Identification integration and navigation

Every contact with a health professional to be a health improvement contact;

Comprehensive care and treatment for people with identified risks or established illness;

Engagement

Improvements in the wider determinants of health through our participation in the Sunderland Health and Well Being Board and collaborative working with partners;

Improved engagement with communities of greatest need through locality working;

Choice and control

Individuals having a greater awareness and ownership of their own health and well being and that of their families;

Individuals feeling empowered and supported to adopt healthier choices and lifestyles.

By 2017 there will be: (quantified outcomes to be developed)

.....

2.2.2 Integrate services better across health and social care

Our future services will demonstrate:

Integration

Seamless integration across primary, community, secondary and social care resulting in improved health outcomes for patients;

Optimum treatment pathways with standardised care consistently provided by all GP practices thereby reducing clinical variation;

A multi disciplinary approach where appropriate (i.e. Long Term Conditions) to enable a holistic approach to care planning;

Increased synergies resulting from streamlining and integrating pathways;

Patients receiving the right care in the right place, first time thereby reducing waste and demonstrating value for money in everything that we do;

Quality

Safe, high quality care which is consistently delivered and routinely evidenced through commissioning mechanisms;

A patient-centred approach based on the needs and wishes of patients to ensure excellent patient experience;

Access and choice

More care available closer to patients' homes; with routine treatment increasingly provided in primary and community settings (e.g. more GPs with a Special Interest) and complex treatments commissioned from specialist centres;

Greater choice of services for patients, with convenient and timely access at all stages, so that patients can make informed decisions about where and from whom they receive their care.

By 2017 there will be: (quantified outcomes to be developed)

.....

2.2.3 More effective clinical decision making

By 2017 effective clinical decision making will be evidenced by:

Communication

Increased collaborative working across organisations (primary, community, secondary care, social care) to enhance knowledge and the sharing of expertise, including timely access to opinions;

Strong and mature clinical relationships between organisations so that clinical input adds value to the pathway resulting in improved outcomes and patient experience;

Evidence based

All care based on best clinical evidence available, including compliance with standards;

Application of best practice and outcome information where available complemented by local evaluation and research reflecting a commitment to continuous learning and development;

Promoting use of research in an evidence- based approach to decision making;

Using both nationally agreed and local guidance

Standardisation of provision

Consistent standard application of optimum pathways in primary care resulting in a reduction in clinical variation.

By 2017 there will be: (quantified outcomes to be developed)

.....

In summary by 2017, our patients will:

Feel empowered and supported to look after themselves and take control over their treatment regime, particularly those patients with long term conditions;

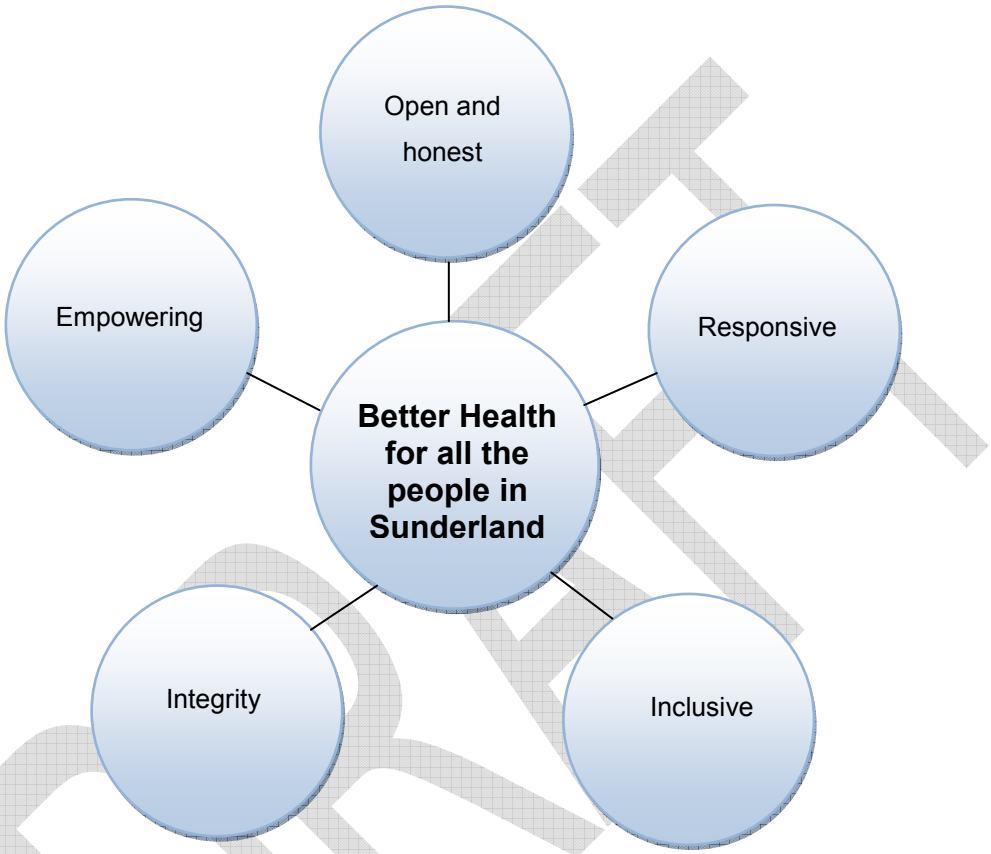
Have input into the processes for making decisions about their healthcare;

Be actively engaged in shaping the planning and delivery of services to ensure their needs are met and views taken into account;

Have confidence in the services we commission.

2.3 Core Values

We have identified a set of core values which will shape and underpin all of the work we undertake to deliver our vision, including all aspects of decision making and governance, as illustrated on the following chart:



2.4 Commissioning for Quality

Commissioning for quality is an integral part of our vision and encompasses the three key components of quality: patient safety, clinical effectiveness and patient experience. We will drive improvements in quality through provider management and pathway reform and this is a key development area for the Executive Committee in the short term.

Section 3 – The Big Challenges for Sunderland

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

Excess deaths, particularly from heart disease, cancer and respiratory;

Health which is generally worse than the rest of England;

A growing population of elderly people with increased care needs and increasing prevalence of disease;

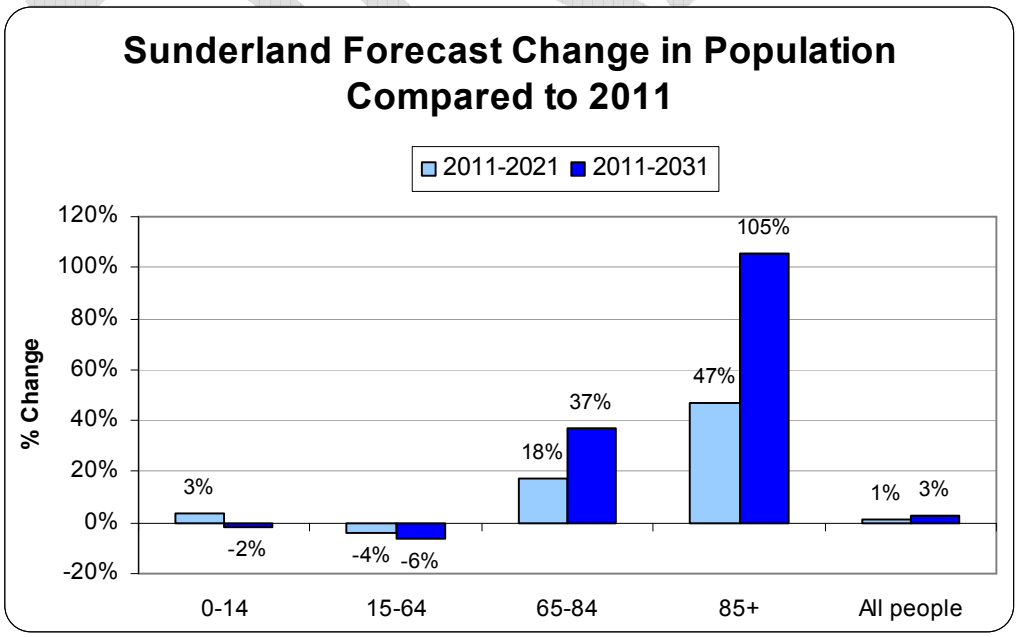
An over-reliance on hospital care;

Services which are fragmented and lack integration.

This section gives a general overview of the Sunderland population we serve, describing the age structure, general health and income of our people. It then summarises the analyses which we have used to identify the major challenges facing the NHS in Sunderland.

3.1 Overview of the Sunderland population

There are around 281,500 people in Sunderland, with an increase of 8,100 (3%) forecast over the next 20 years. The age structure of our population is forecast to change significantly, as follows:



Office for National Statistics, 2008-based Subnational Population Projections, available at www.statistics.gov.uk

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five, ten and twenty years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group, particularly as older people use services more often, have more complex needs and stay longer in hospital. Our modelling shows that in ten years, if we do nothing differently, we will need over 150 extra beds which our hospitals don't have, at a cost of over £18m which we cannot afford.

3.1.1 Overview of health in Sunderland

Sunderland has overall levels of deprivation significantly higher than the England average (we are in the 10% of local authority areas with the highest deprivation). Levels of health and underlying risk factors in the area are amongst some of the worst in the country.

The 2011 Community Health Profiles, prepared by the Association of Public Health Observatories compare health in Sunderland to England averages, highlighting in red those measures which are significantly worse and in green those which are significantly better. It is clear that on most health measures, Sunderland is significantly worse than the rest of England.

Health summary for Sunderland

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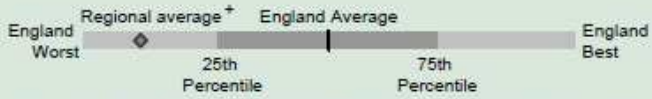
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



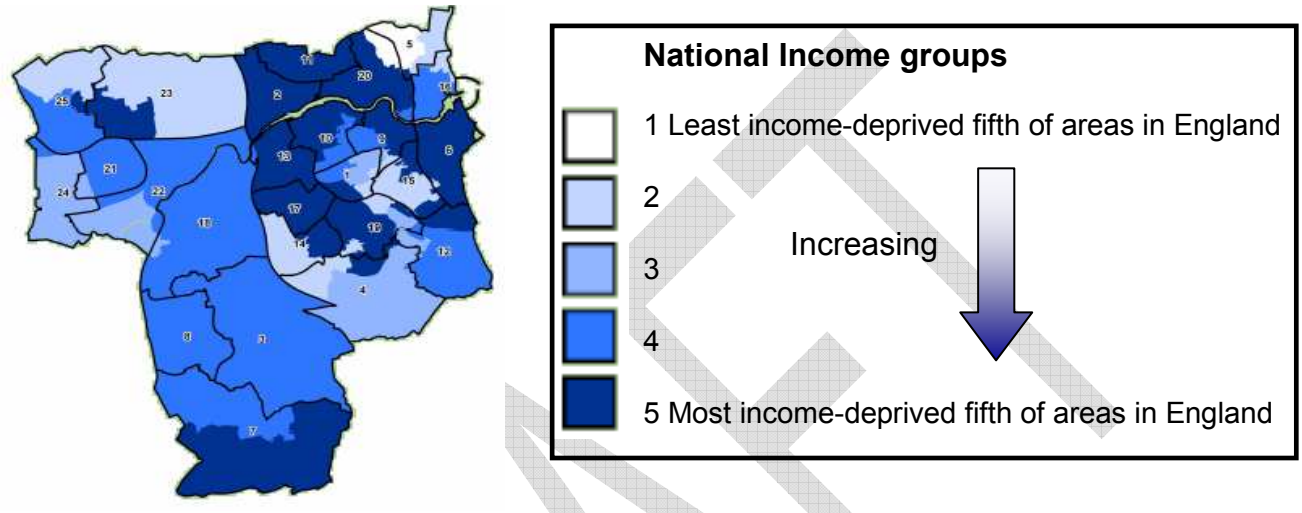
+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	119430	42.5	19.9	89.2		0.0
	2	Proportion of children in poverty	14760	25.0	20.9	57.0		5.7
	3	Statutory homelessness	166	1.37	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1812	52.6	55.3	38.0		78.6
	5	Violent crime	4027	14.3	15.8	35.9		4.6
	6	Long term unemployment	1408	7.6	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	665	22.3	14.0	31.4		4.5
	8	Breast feeding initiation	1476	51.1	73.6	39.9		95.2
	9	Physically active children	20141	57.5	55.1	26.7		80.3
	10	Obese children (Year 6)	556	21.1	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	1.1	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	302	54.9	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	29.8	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	26.6	23.6	39.4		11.5
	15	Healthy eating adults	n/a	19.4	28.7	19.3		47.8
	16	Physically active adults	n/a	12.3	11.5	5.8		19.5
	17	Obese adults	n/a	28.6	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	27	9.4	13.1	27.2		3.1
	19	Hospital stays for self-harm	1059	382.2	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	6310	2581	1743	3114		849
	21	Drug misuse	1444	7.7	9.4	23.8		1.8
	22	People diagnosed with diabetes	12788	5.63	5.40	7.87		3.28
	23	New cases of tuberculosis	20	7	15	120		0
	24	Hip fracture in 65s and over	304	517.1	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	142	15.4	18.1	32.1		5.4
	26	Life expectancy - male	n/a	75.9	78.3	73.7		84.4
	27	Life expectancy - female	n/a	80.7	82.3	79.1		89.0
	28	Infant deaths	11	3.52	4.71	10.63		0.68
	29	Smoking related deaths	636	308.1	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	260	81.5	70.5	122.1		37.9
	31	Early deaths: cancer	459	143.9	112.1	159.1		76.1
	32	Road injuries and deaths	104	37.1	48.1	155.2		13.7

Source: Association of Public Health Observatories

3.1.2. Income inequalities

Income levels are directly related to both life expectancy and health inequalities. The map below shows the variation in income levels across Sunderland compared to the whole of England. There are significant variations in income levels between wards within the area, therefore specific strategies are required to minimise the health gap between the affluent and less affluent members of our population.



3.2 Challenges identified in the Joint Strategic Needs Assessment

Joint Strategic Needs Assessment (JSNA) is a continuous process by which the Sunderland Director of Public Health works with partners including the third sector and patient/public groups to identify the health and well-being needs of local people. It sets out key priorities for commissioners and provides the basis for Sunderland plans.

The Sunderland JSNA is undergoing a major refresh to broaden the coverage of wider determinants of health; take account of Marmot priorities; update the analysis of health and well being information; give greater insight into expressed needs of local people; identify where effective interventions to address needs are available but not taking place.; and include equality impact assessments as they are developed.

The JSNA refresh has used a structured process with clear criteria, which continues to involve partners and the public. Further prioritisation will be carried out before the JSNA is considered by the Health and Wellbeing Board in February 2012, because we are in a time of economic turmoil and major system change which make it crucial that JSNA recommendations are clear about priorities based on a one Sunderland strategy; what

needs can be met and how we can mitigate against unintended consequences from changes in funding and organisational arrangements over the next 3-5 years.

3.2.1 Summary of JSNA messages

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

Increasing life expectancy and reducing health inequalities;

A tiered approach to prevention and risk management;

Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;

Identifying those who would benefit from services and improving navigation through those services;

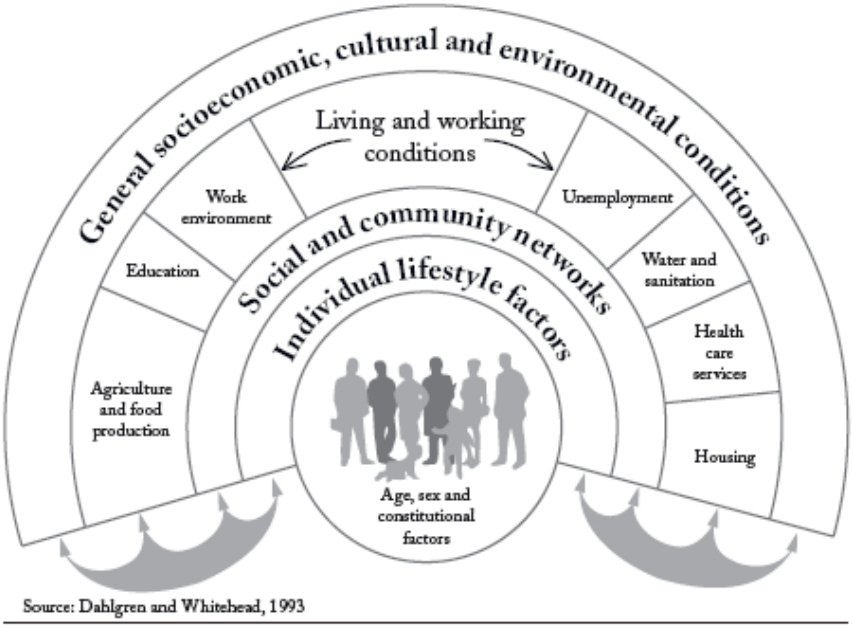
Integration of services, whether NHS, social care or other services which affect health (eg spatial planning, housing, transport, enhancing wellness and wellbeing thorugh libraries, wellness services etc);

Reducing health inequalities by focussing on the wider determinants of health, including deprivation, employment, education, housing, environment and by identifying neighbourhoods to target;

Commissioners and providers engaging with individuals, families, neighbourhoods, and communities in order to deliver on all the above.

We have traditionally focused on treating illness but to improve health, we need to move, as represented in the diagram below, out into the concentric circles working with a broader range of partners.

Figure 1. The Main Determinants of Health



Source: Dahlgren and Whitehead, 1993

In considering this model the top ten priorities to improve health in Sunderland are to:

1. Tackle worklessness;
2. Improve educational attainment;
3. Reduce overall smoking prevalence (all ages) and numbers of young people starting to smoke;
4. Reduce levels of obesity;
5. Reduce overall alcohol consumption and increase treatment services for those with problem drinking;
6. Commission excellent services for cardiovascular disease;
7. Commission excellent services for cancer;
8. Commission excellent services for diabetes;
9. Commission excellent services for mental health problems;
10. Raise the expectation of being healthy for all individuals, families and communities and promote health seeking behaviours.

As a Clinical Commissioning Group, we are directly responsible for commissioning the hospital, community and mental health services associated with these priorities, but we also have a significant role to play in all of these areas, both through our work with partners in

the Health and Wellbeing Board, but also through the mobilisation of all our member GP practices to play a full part in this agenda

3.2.3 Life expectancy challenge

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

	England Average Life Expectancy	Sunderland Life Expectancy	Gap (%) *
Males Females	77.9 82.0	75.4 80.4	-3.2% -2.0%

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

Over 60% of the gap is caused by CVD, cancer and respiratory diseases and to address this the Health Inequalities National Support Team has identified five supporting strategies (tobacco control, community engagement, measuring impact, maintaining momentum and working with the Local Authority) and 8 "High Impact Interventions" which our commissioning and work with partners and our GPs will contribute to:

Use of Health Checks to identify asymptomatic hypertensives age 40–74 & start them on treatment;

Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;

Systematic cardiac rehabilitation;

Systematic COPD treatment with appropriate local targets;

Develop & extend diabetes best practice with appropriate local targets;

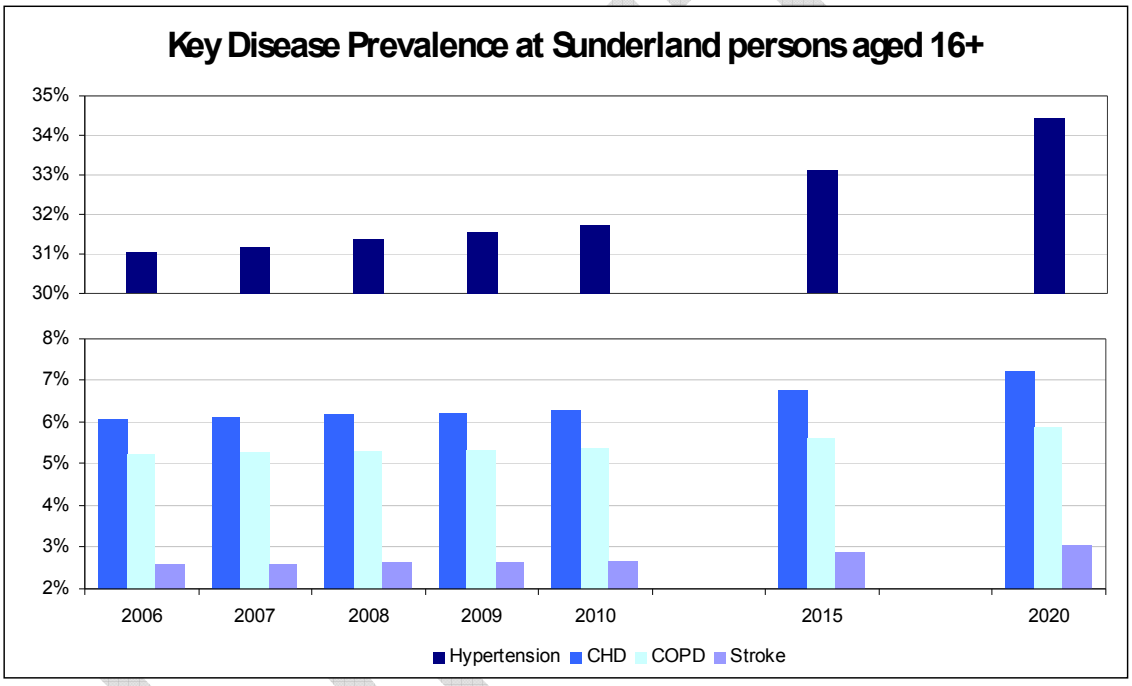
Best practice access to TIA clinics for stroke across South of Tyne and Wear;

Cancer early awareness and detection;

Identification and management of Atrial Fibrillation.

3.2.4 Expected disease prevalence

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



3.3 Challenges identified by patients, public, clinicians and partners

3.3.1 Patients and the public

Development of the JSNA includes extensive public involvement and takes into account both patient and public views. In addition there has been significant work done in Sunderland to gather the views and experiences of local people and use them to identify areas of service where we need to do better.

Further detail to follow…

3.3.2 Clinicians (including practices)

Clinicians have expressed concern in relation to the fragmentation and lack of integration of current services

Further detail to follow…

3.3.3 Partners and Stakeholders

To follow

3.4 Challenges set out in national policy

In addition to our local challenges, there are also a range of national priorities, targets and standards which we must deliver in Sunderland. These are described each year in the NHS Operating Framework.

3.4.1. Current performance challenges

The current 2011/12 PCT performance against national priorities is monitored and managed carefully but there are a few areas where the PCT are not expecting to reach the year-end targets and standards. These are shown in the table below, split between those for which we will have a direct commissioning responsibility in the future (and some are in our current Pathfinder) and those we will help our partners to deliver through their commissioning:

Clinical Commissioning Group Commissioning responsibility	§ % patients spending 4 hours or less in an accident and emergency department § Emergency admissions to hospital § Unplanned re-attendance at an accident and emergency department § Hospital outpatient attendances § Outpatient referrals from GPs § Patients waiting more than 6 weeks for diagnostic tests § Elective admissions to hospital § Patients treated in mixed sex hospital accommodation § Clostridium difficile infections § % first outpatients made via Choose and Book system
Partner commissioining responsibility	§ Deaths from cardiovascular disease per 100,000 population § Deaths from Cancer per 100,000 population § All age all cause mortality for both males and females § Chlamydia screening § % of pregnant women who smoke § Rate of hospital admissions for alcohol related harm § Teenage conceptions § Childhood Immunisations § % women totally or partially breastfeeding at 6-8 week check

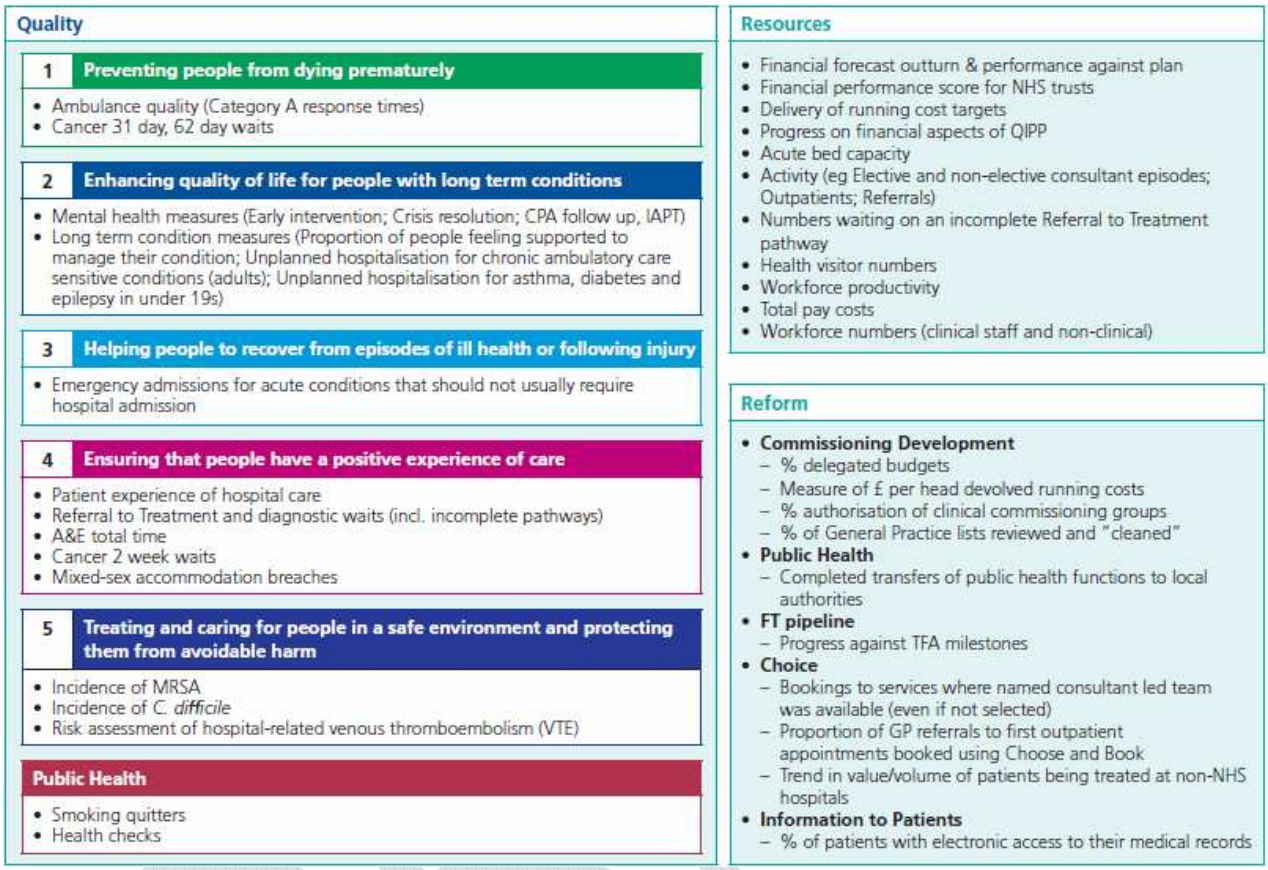
3.4.2 Additional challenges in the NHS Operating Framework 2012/13

The NHS Operating Framework 2012/13 requires us to continue to meet existing standards and targets, and also details the following areas in which we must make specific improvements in 2012/13

- Delivery of the QIPP Challenge
- Dementia and care of older people
- Carers
- Military and Veterans' health
- Health Visitors and Family Nurse Partnerships
- An outcomes approach
- Public Health

- Emergency Preparedness

The Framework emphasises that the experience of patients, service users and their carers should drive everything the NHS has to do. It sets out the key performance measures which will be subject to national assessment:



3.5 Challenges posed by existing provider landscape

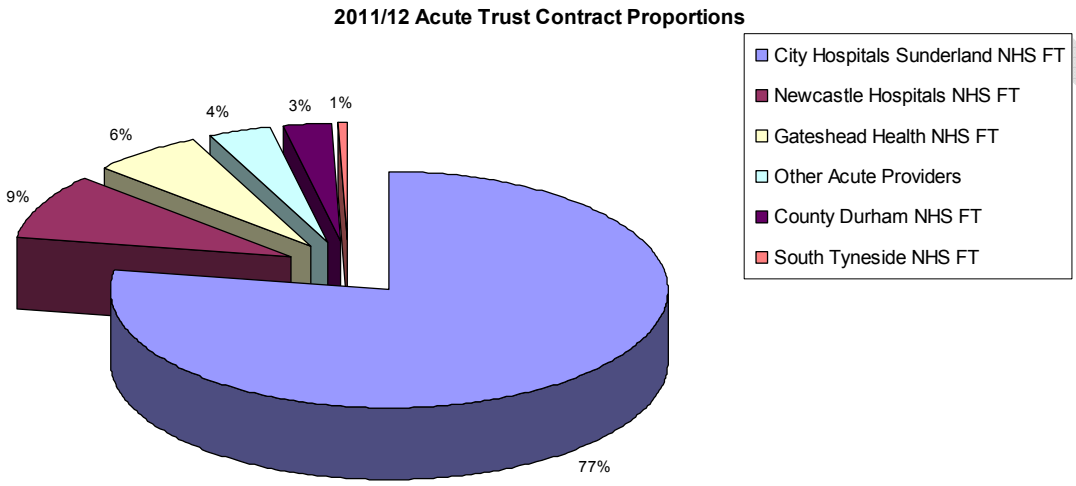
As well as the health and service challenges described in this chapter, the services which we are able to commission are constrained in the short term by the current shape and availability of local services and the major challenges involved in any significant change to this configuration and pattern of service use.

This does not mean that in the longer term we will not be looking for major changes in the shape of local service supply, but it does place limitations on the speed with which change can be achieved and this has been taken into account in the development of detailed initiatives for 2012/13.

3.5.1. Current pattern of acute hospital use

The people of Sunderland receive most of their acute hospital care from City Hospitals Sunderland NHS FT where the annual contract is around £169 million. City Hospitals provides Accident and Emergency; surgical and medical specialties; therapy services; maternity and paediatric care; an increasing range of more specialised services; and a substantial range of community based services, particularly family care and therapy services.

Sunderland people also use services at Newcastle Hospitals and Gateshead Health NHS FT, with annual contract values of £19 million and £14 million respectively.



3.5.2. Current pattern of Community Service use

There are lots of different types of community services such as Community Nursing, Allied Health Professionals and Therapies which are currently commissioned from a range of different providers, including the community services arm of South Tyneside NHSFT, the voluntary sector and the independent sector (including care home providers). A number of these services are jointly commissioned with Local Authorities. The annual value of community services contracts in Sunderland including Continuing Healthcare and Funded Nursing Care, is £xmm:

3.5.3 Current pattern of Mental Health Service use

The majority but not all of mental health and learning disability services are commissioned from Northumberland, Tyne and Wear Mental Health Foundation Trust which provides a wide range of mental health, learning disability and neuro rehabilitation service to a population of 1.4 million people working from over 160 sites covering 2,200 square miles in the North East. Other services include urgent care mental health, Planned care services, Specialist care services and Forensic services.

3.6 Challenges likely in the future

As well as the challenges we have identified from the analyses and insights into current health and services, we have used a set of predictive models developed by NHS South of Tyne and wear to identify further challenges we will be facing in the future.

The modelling also allows us to ensure that:

1. Contracted hospital and community activity levels reflect our forecasts of demand changes and impacts of planned disinvestment initiatives;
2. The investment and disinvestment plans which underpin our balanced financial position fully reflect the financial consequences of these planned changes in activity levels;
3. We have a shared understanding with our local providers of the likely workforce implications of both our planned changes in activity levels and the impact of tariff and

tariff equivalent efficiencies, with a high level view of how these implications will be managed.

3.6.1 Hospital Activity Model

The PCT use an established predictive model to predict likely changes in hospital and community activity levels. The annual update of the model continues to confirm that if we do not take effective action, the increasing elderly population with their high use of health services, coupled with the inevitable developments in clinical practice, technology and patient expectations would result, in less than ten years, in hospital capacity shortages equivalent to a small general hospital and a financial cost which could not be met.

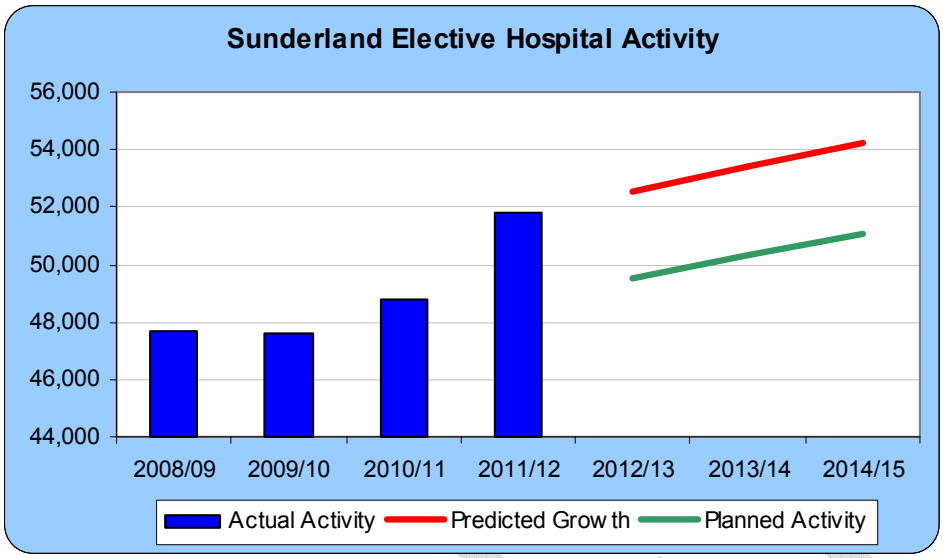
In the shorter term, if we do not change the way in which our services are provided, we would expect to see the following growth in hospital activity levels over the next three years.

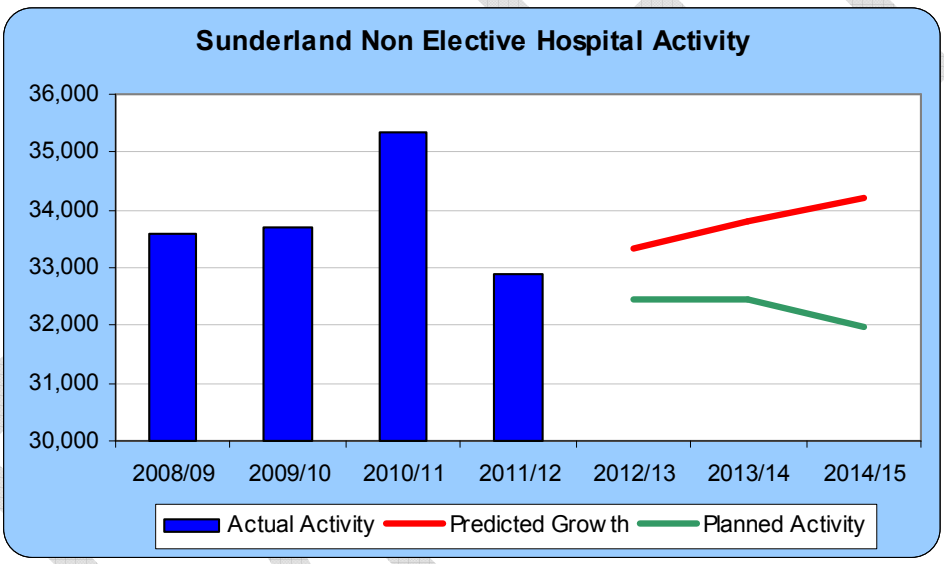
	2012/13	2013/14	2014/15
Elective Hospital Spells	1.49%	1.65%	1.48%
Non Elective Hospital Spells	1.32%	1.43%	1.14%
First outpatient attendances	1.53%	1.82%	1.69%

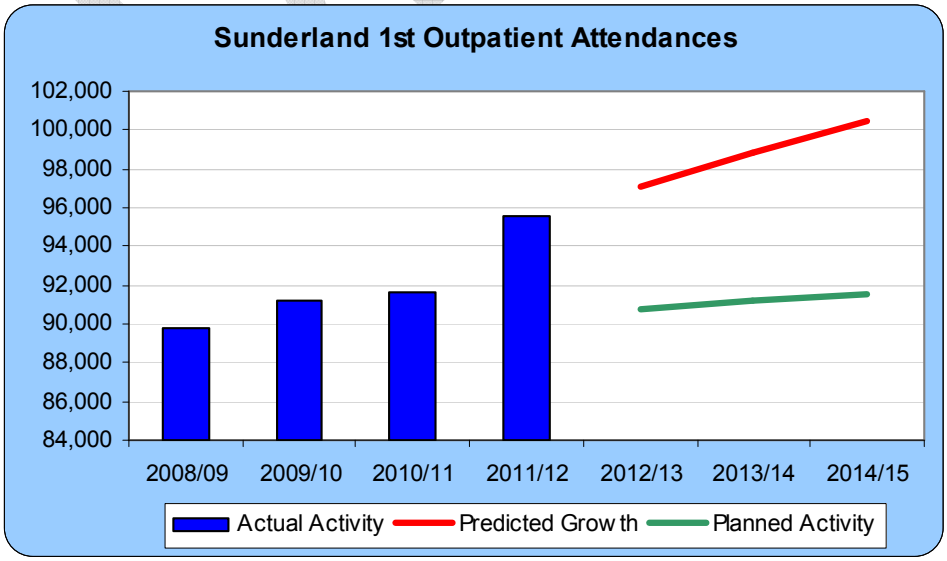
Similar increases in accident and emergency attendances are also expected, if we do not change how these services are provided.

However, as detailed in the strategy part (section xxx) of this plan, we have a range of initiatives in place to reduce hospital activity (elective, non-elective and outpatient) through redesign of services, better care of people with long term conditions and more streamlining of urgent care services.

The following charts illustrate the expected impact of our initaitives. The red lines represent the predicted growth in activity over the next three years, while the green lines show how the plans for activity reductions mitigate this growth.







Hospital activity reductions are planned throughout 2012-15 with particular emphasis on elective and emergency admissions. Achieving the planned reductions in hospital activity will require additional primary and community care contacts; a separate modelling exercise estimates an additional 13,000 primary and / or community contacts.

3.7 Financial Challenges including QIPP

Financial allocations are not expected until late January / Early February. Until share of finance is known we are unable to detail a balanced financial plan.

However we do know that the levels of hospital activity being seen in 2011/12 exceed current contracts significantly. Until we know our likely share of the current PCT budget we cannot identify the extent of financial pressure on us in future years but we are expecting that we will have to deliver at least the current QIPP programme and are likely to have to identify further initiatives to release resources to allow us to fund the costs of healthcare in the coming years.

Section 4 – Strategy

4.1 Our Success so far

Our pathfinder application set out the following priority areas:

- Urgent Care
- COPD
- Prescribing
- Clinical Effectiveness.

Our achievements to date against these priorities are highlighted below:

Urgent Care

- We have ensured strong links between the Urgent Care and COPD agenda in work areas we have responsibility for.

- Following a review of pathway information and meetings with Community Team manager and Community Health Services at South Tyneside Foundation Trust, we have developed a project plan to address fragmentation issues with Primary and Community Teams to ensure seamless care. Recently we have agreed with the Trust to pilot a single point of access to currently 2 separate teams to minimmise the current confusion about which team to access in what circumstances.

- We have introduced a standard Emergency Assessment Proforma for all Sunderland GPs to use before sending a patient to secondary care for assessment or admission which incorporates an Early Warning Score (EWS) increasing GP awareness of any alternative services which could be used to manage the patient in the community (depending on the EWS and clinical judgment).

- We have provided all GPs with proforma pads to use on home visits for patients in need of assessment or admission to hospital and have electronic versions available within practice which pre-populate key information.

- We are currently developing a community based cellulitis pathway to allow suitable patients who require intravenous (IV) antibiotics to be treated in the community instead of triggering a hospital admission with a short length of stay and have developed a protocol using a specific IV antibiotic drug.

- We have prioritised funding to implement a community based Anticoagulation Initiation and Monitoring Service in 2012/13 and have rolled out the software tool (GRASP-AF) which identifies patients with Atrial Fibrillation who are suitable for anticoagulation to all practices providing appropriate training to ensure patients are indentified and treatment commenced for those at risk of stroke.

- We are currently developing a community based service for DVT with a clinical lead appointed to develop the pathway.

- We have discussed and agreed options for the newly built Houghton Primary Care Centre in terms of most appropriate Urgent Care facilities to best suit the local population as part of developing our short, medium and long term strategy for urgent care in Sunderland.

COPD

- We have taken leadership of improving the quality of care for people with COPD across the whole health care system and have developed the Sunderland COPD Improvement Group (SCIG) specifically to take forward these actions. We have signed a joint working agreement with the Pharmaceutical Company GSK to support some parts of the project plan. All practices are developing individual action plans, with the aim of reducing variation in the quality of care provided across Sunderland. Practices have made early progress in improving the percentage of patients on the COPD register who have disease severity coded, in quarter 1 2011/12, 70% of COPD patients had severity coded and by quarter 2 this had risen to 81%.

- We have undertaken a training needs analysis to ensure primary care staff receive appropriate training in the care of COPD patients.

- Spirometry interpretation sessions have been organised and most practices have sent along at least one GP/practice nurse and there is a waiting list for future sessions.

- All practices have reviewed their palliative care registers and completed an audit for these patients. An education session has been delivered for all practices focusing on the prognostic indicator guidance and when COPD should be considered for the palliative register.

- We have developed a standardised patient information pack for distribution to patients attending for annual reviews. A self-management plan has been agreed and is being discussed with patients as appropriate.

Prescribing

- We have appointed a Prescribing lead to take forward the prescribing agenda including cost effective prescribing. Working closely with the Medicines Management Team, a Prescribing Incentive Scheme has been developed to encourage practices to be proactive in driving down prescribing spend whilst improving the quality.

- The Prescribing group is currently developing educational materials to aid practices to increase repeat prescribing within Primary Care, as it has been proven to improve patient care whilst reducing medicines waste. This follows engagement in a week long Rapid Process Improvement Workshop with all key stakeholders on the subject. The initial data has shown a 2.2% increase in repeat prescribing from April 2011 to August 2011.

- We are currently rolling out a project to allow pharmacists to undertake Medicines Reviews within Sunderland Care Home to reduce prescribing errors.

- We have introduced a prescribing incentive scheme, setting a target of 80% for practices to achieve in relation to patients on all 4 drugs post-MI. All practices have received baseline data with regard to the 4 drugs post MI and have been given guidance on how to review patients. From Quarter 1 2011 to Quarter 2 2011, there has been a 1.5% improvement.

Clinical Effectiveness

- We have appointed a lead to address clinical effectiveness in primary care and a programme has been devised which is split into three areas: informing, changing and monitoring.

- We have identified early priorities which include raising awareness of lung cancer among patients attending COPD, CVD and smoking cessation clinics.

- The clinical lead has developed detailed guidance in the Local Incentive Scheme and “Be Clear on Cancer” leaflets have been distributed to all practices.

- We have organised an educational event in January 2012 to raise awareness of early diagnosis and practices have been asked to follow NICE guidance when referring coughs.

- We have been heavily involved with the work around QOF QP indicators for Emergency Admissions and Outpatient Appointments. Practices have been given data on both areas and have reviewed this information within their practices. The practices have taken part in an External Peer Review Process to look at pathway issues and ideas on how to reform and improve pathways. These ideas will be fed in to the Commissioning Intentions process for the next year and influence the development of alternative pathways. This work has also to an agreement for all practices to follow 6 key pathways in 2011/12 in order to have a positive eimpact on the overperformance in planned care this year and next year.

Other work Areas

- We have taken a lead on the review of the District Nursing service provided by Community Health Services at South Tyneside Foundation Trust. All practices within Sunderland have received a questionnaire in relation to current service provision and we have held a development session to ensure the service specification meets the needs of Sunderland patients.

- We have added value to the service specification and participated in the procurement of the new Houghton Intermediate Care service.
- We have added value and supported the business case for the development of the new build Hospice planned for Sunderland.
- We have assured the recovery plans for the dermatology service currently contracted from County Durham Hospitals following staffing changes to the service and will be leading the review of the model for dermatology services next year.
- We have engaged in and supported a pilot for counselling services as part of a spectrum of support for people with common mental health problems and prior to AQP developments
- We have engaged in and influenced the selection of the 3 AQP pathways for the next year.

4.2 Overview of our Strategic Objectives and initiatives

In order to achieve our Vision by 2017, we have identified three key **strategies** for moving from our current position to our desired future state:

Prevention, empowerment and resilience;

Seamless integrated pathways

Mature Clinical relationships which add value and increased standardisation

We have identified the 9 Overarching Outcome Measures detailed within the NHS Outcomes Framework for 2012/13 as key outcomes to quantify our five year ambitions and will use national and international benchmarks to identify challenging but achievable aspirations.

In order to achieve the 9 Overaching Outcome Measures we have identified 8 Strategic Objectives.

Active role in Delivery of the Health and Wellbeing strategy
Screening and early identification
Mental Health- integrated and tiered approach
Integrated Urgent Care - responseive and easily accessible
Long Term Conditions – Improving the quality of Care across the whole system

Providing More Planned care closer to home

Systematically improving the quality of prescribing in Practices

Standardisation in Primary Care – every Practice operating to agreed standards and pathways, working collaboratively with partners

The following diagram shows a “map” of our strategy:

From challenges (where are we now?);

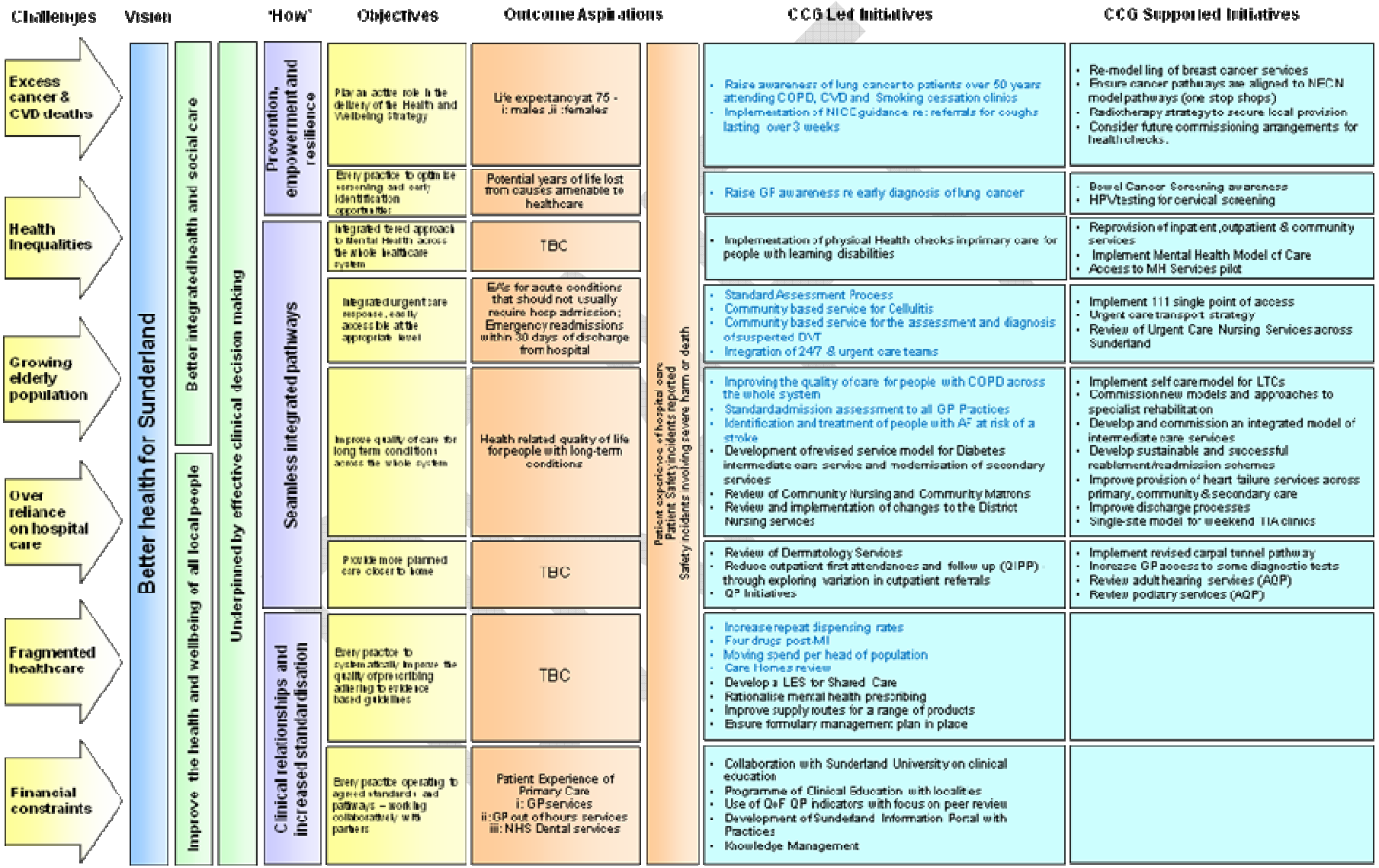
Through vision (where do we want to be?);

‘The How’ and Objectives (how will we get there?);

Outcomes (how will we know when we get there?);

To initiatives (what actions do we need to take?).

Future provision of health and social care in Sunderland - 'Plan on a Page'



4.2 Initiatives to deliver changes

As part of the development of the Clear and Credible (CCG) five year plan, we have played a key role in shaping the detailed changes planned for the NHS in Sunderland in 2012/13 (known as Commissioning Intentions).

These detailed changes need to be well developed and agreed by the end of December 2011 so that they can be included in 2012/13 contracts (for which negotiation takes place from January to March 2012). This timescale means that our longer term strategy, which is just taking shape now as the Board develops its five year plan, has influenced and shaped the detail for 2012/13 rather than determined it, as will be the case for 2013/14 onwards. The initial list of changes was generated from the PCT legacy strategy but has been the subject of scrutiny and change from ourselves as our own longer term strategy emerges.

2012/13 is a year of transition, as commissioning transfers from PCT to CCG. We have already agreed delegated responsibility in 2011/12 for the priorities set out in our Pathfinder application. We have agreed that we wish to extend our lead delivery role to a number of other priorities in 2012/13, on a path to accountability for the full agenda from April 2013. Taking on increasing responsibilities on a phased basis will both assist with our rapid development as an effective decision making body and provide the evidence of delivery which is needed for CCG authorisation.

A process has been used to enable us to:

- become familiar with the full agenda to help in determining our 5 year plan;
- influence, shape and change the commissioning intentions or detailed changes planned for 2012/13;
- decide which areas we wish to lead in 2012/13, in addition to our Pathfinder commitments.

Over two extended Executive Committee development sessions, the PCT lead officers for each programme within the existing PCT Integrated Strategic and Operational Plan (ISOP) have described in detail the proposed changes for 2012/13, with detailed discussion and challenge by ourselves. The sessions also included the Locality Practice Manager Lead

and a Local Authority representative. The Practice Manager Leads in particular to help consider how to share the intentions with Localities.

At the end of each programme discussion we agreed a “long list” of the changes which we considered suitable to lead in 2012/13.

We then agreed a set of standard criteria against which the long listed changes would be judged and used a simple scoring system, shown below, to score each change, in a facilitated Executive discussion. The simplicity of the scoring helped the discussion but also meant some subtleties of impact and do-ability needed to be reflected in addition to the scores and this is reflected in the outcome of the process.

	CRITERIA											
	Impact of change						Do-ability of change					£
LONG LISTED 2012/13 CHANGES	Improves health	Reduces inequalities	Safer / more effective	Improves access / choice	Improves productivity	**Total Impact Score**	Has local GP support	Has other local support	Infrastructure is in place	CCG clinical lead in place	**Total do-ability score**	Short term £ impact Cost(+) Saves(-) neutral(0)
Reduce outpatient first attendances and follow up (QIPP) 'Exploring variation in outpatient referrals'				✓	✓	**2**					**0**	**-**
Where appropriate, transfer some diagnostic test activity out of secondary care. Consider opening up CT and MRI access to primary care to reduce unnecessary referrals		✓		✓		**2**	✓	✓			**2**	**+**
Review Dermatology Services with a view to aligning the service model with services commissioned for Gateshead and Sunderland (QIPP)		✓		✓	✓	**3**	✓				**1**	**-**
Review nurse led clinics and where appropriate decommission (QIPP)			✓		✓	**2**	✓		✓		**2**	**-**
Review role and effectiveness of Community Nursing and Community Matrons	✓	✓	✓	✓	✓	**5**	✓		✓	✓	**3**	**-**
Complete the review and implementation of the changes to the District Nursing services whilst retaining the option to procure alternatives depending on the outcomes.	✓	✓	✓	✓	✓	**5**	✓		✓	✓	**3**	**-**
Further review of Heart failure service	✓	✓	✓	✓	✓	**5**		✓	✓		**2**	**-**
Develop a revised service model for a Diabetes intermediate care service and modernise current secondary services to reduce unnecessary admission and length of stay	✓	✓	✓	✓	✓	**5**	✓	✓		✓	**3**	**0**
Implement physical Health checks in primary care for people with learning disabilities	✓	✓	✓	✓		**4**	✓	✓	✓		**3**	**+**

Following the outcome of this process, we have agreed that in addition to our Pathfinder priorities we will also lead the following initiatives in 2012/13:

- Reduce outpatient first attendances through 'Exploring variation in outpatient referrals'
- Review role and effectiveness of community matrons and community nursing
- District nursing review
- Diabetes intermediate care
- Health checks for people with learning disabilities
- Dermatology

4.3 Strategic Programmes

Context, Vision, Strategy, Initiatives, Outcomes, Measures

We are currently developing strategic programmes in order to demonstrate clear links from our initiatives to our Strategic Objectives. The following section shows an example of how we will demonstrate the link across our Vision map. It describes for each:

Why is change needed?

How do we want the future to look?

What are we doing about it?

What impact will these actions have?

How much will this cost or save?

What capacity and capability is needed to deliver the planned changes?

What is distinctive about the planned approach?

How do planned initiatives improve quality, prevention and productivity through innovation?

How will we know we are doing what we planned and that our actions have the desired impact?

MEDICINES MANAGEMENT

Why is change needed?

Medicines are associated with significant cost to the NHS in terms of mortality, morbidity and financial impact. Effective management of medicines can improve patient outcomes and yield cost efficiencies through a reduction in expenditure and hospital admissions due to inappropriate prescribing that needs to ensure priority is given to the safe, legal and effective use of medicines and medicines management is actively integrated into new commissioning structures

Objective

To ensure safe, legal and effective use of medicines within commissioned services

How do we want the future to look and what are the transitional issues?

- Ensure statutory obligations with respect to medicines use continue to be met
- Ensure development of appropriate governance infrastructure to effectively manage the medicines agenda
- Ensure prescribing costs are managed within the agreed budgetary envelope and identified cost efficiencies are achieved

What are we doing about it?

Project Gantt Chart	2012/13 Q1	Q2	Q3	Q4
To have an action plan in place to improve the quality of prescribing, optimise medicines usage in patients with long term conditions and deliver disinvestment opportunities in Primary care prescribing.				
To manage prescribing expenditure within prescribing envelop, to move closer to the North East average to release resources to invest in better quality service. (Astro PU)				
Work with both secondary, community and primary care to develop a health economy approach to prescribing of medicines across pathways of care.				
Through the contracting process to develop plans for a consistent and collaborative approach for the transfer of prescribing responsibility, including improving the effectiveness of communication, provision of shared care medicines and outpatient prescribing				
Develop a LES for Shared Care				
Explore options to develop services to improve medicines management in care homes in order to reduce the number of emergency admissions and reduce medicines wastage.				
Explore options for collaborative working across primary and secondary care in relation to the provision of oral nutritional products				
Explore options for collaborative working across primary and secondary care in relation to the provision of stoma and incontinence				
Explore options for collaborative working across primary care and communality in relation to the provision of wound management products, including encouraging appropriate use of the wound management formulary				
Improve the systems for high impact / cost drug exclusions to include a consistent approach across the locality / region and effective implementation of the decisions.				
Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including . Improving rates of repeat dispensing, (implementation of the actions of the repeat dispensing RPIW) . New medicines service . Targeted use of medicines usage reviews . review of the use of MDS				
Ensure there are robust local mechanisms for decision making around medicines.				
Review the contract for provision of medicines management support to individual practices				
All secondary care and primary care providers to ensure patients post MI benefit from 4 drugs - aspirin, beta-blocker, statin and ACEI				

How much will this cost or save?

What KPIs will we use to monitor progress?

Headline Measures

Supporting Measures

Local Measures

- Prescribing Cost growth
- Prescribing cost per Astro-Pu
- Individual Practice performance versus budget
- Percentage of prescribed items as repeat dispensing
- 4 Drugs post MI

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of engagement from GPs and secondary care clinicians	Develop effective communication strategies via the formal groups including the 5 localities Utilise formal communication channels with secondary care
Drug tariff fluctuations	Monitor prescribing and prescribing costs Develop medicines management action plans that include the ability to respond to change and to evolve to meet ongoing needs
New drugs / drugs approved by NICE / high cost drugs	Carry out horizon scanning exercise Monitor prescribing and prescribing costs
Lack of support / procurement expertise	Utilisation of regional procurement expertise
Challenge to new supply models from community pharmacy representatives	Engage with LPC formally and include them in the consultation process
Lack of medicines management resource	Review areas of work and priorities
Lack of regional engagement	Heads of Medicines Management to liaise with Chief Pharmacists and those employed within current regional structures
Lag time between initial drug investment (prescribing) and long term therapeutic outcomes	Identify quick wins from prescribing savings to compensate initial investments that will deliver longer term improvements in patient care and release resources
Lack of resources within secondary care pharmacy and associated disciplines to support transfer of prescribing responsibilities	Lease with secondary care leads to ensure that priority areas are addressed
Lack of engagement of community pharmacy in the NMS	Engage with LPC formally and include them in the consultation process Appointment of community pharmacy mentor (time limited to support the roll out of the service locally)
Lack of engagement of community pharmacy in targeted MURs	Engage with LPC formally and include them in the consultation process Appointment of community pharmacy mentor (time limited to support the roll out of the service locally)
Challenge from community pharmacy representatives relating to provision MDS	Engage with LPC formally and include them in the consultation process

Communications Implications

- Communication strategy required with all key stakeholders

Informatics Implications

- Monitoring of action plans

Estates Implications

- Minimal

Workforce Implications

- Limited medicines management resource to deliver objectives
- Additional resource required to provide new services

4.4 Prioritisation and financial strategy

To follow

4.5 Impact of our strategy on the market

To follow

Section 5 – Delivery and Transition

5.1 Overview

to follow

5.2 Organisational Development

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people; it is often termed as the "oil that keeps the engine going". We fully embrace this philosophy and concept of Organisational Development. The Executive Committee agree that this strategic approach to development is critical at a time when we, and the wider NHS, is undergoing such extensive and wide ranging transition.

An Organisational Development Plan has been developed in order to:

- Support the delivery of this Commissioning Plan including the delivery of our vision, high level goals and objectives in order to improve health outcomes;
- Enable the Executive Board to mature and expand its knowledge and expertise on its journey towards authorisation and beyond;
- Achieve authorisation by October 2012;
- Ensures that the actions we take in the shorter term support delivery of our longer term objectives;
- Ensures that the organisational enablers for delivery are in place and being progressed; and
- Be refreshed regularly as different needs are identified within the Executive Committee and as national requirements change.

As a clinically led organisation, we will add value and build upon the current NHS South of Tyne and Wear Integrated and Strategic Operational Plan (ISOP). We are working closely with the PCT to ensure effective knowledge transfer prior to and beyond April 2013.

5.2.1 Internal Leadership

5.2.1.1 Executive Committee

A key milestone in the development of the Executive Committee is to achieve authorisation by ideally October 2012. The national self assessment diagnostic tool was utilised to initially assess our current baseline position against the six domains for effective clinically led commissioning organisations; the diagram below notes the six domains:

Each individual member of the Executive completed the Price Waterhouse Cooper diagnostic tool, followed by a Board dialogue to test assumptions, challenge perceptions and agree the current state of our organisational health and the key areas for development. From this, a composite report was produced which the Board agreed was a true picture of the current state.

This baseline position therefore formed the basis of the Organisational Development Plan; twelve high level objectives were identified for development incorporating the areas for improvement in relation to each of the six domains required to achieve authorisation. The objectives were prioritised and milestones with agreed timelines agreed for implementation.

As a result a critical path for development has now been established with nominated Board leads.

The table below highlights our twelve development objectives mapped to the six domain areas (each objective supports delivery of at least two domains thereby adding value); the detail actions are identified within the Organisational Development Plan.

Priority	Objective	Delivery will support Domain	Board Lead	Timeframe
1.	Complete Vision and values and engage/ share with Practices	Domain 1, 3 & 5 *Main Domain 1*	I Pattison G McBride J Gillespie	December 2011
2.	To develop the Commissioning Plan utilising the current JSNA and ISOP	Domain 3	I Pattison	December 2011
3.	Develop a strategic approach to engaging patients, public and communities	Domain 4 & 6 *Main Domain 4*	G McBride	December 2011 Review quarterly
4.	Review their expected statutory responsibilities and agree the functions to deliver them. Determine the Commissioning Management Team/capacity required (both employed, shared and procured). e.g. finance, contracting, governance and business intelligence .	Domain 2, 3 & 5 *Main Domain 2*	I Pattison	Review December –conclude March 2012 and then revisit quarterly
5	Identify and lead the development of commissioning intentions for 2012/13	Domain 1 & 6 *Main Domain 6*	I Pattison I Gilmour	December 2011 - January 2012
6	Develop a Communication and engagement strategy which should also incorporate the approach to public engagement. This strategy should include as a first priority the completion of a stakeholder mapping; analysis and agreement on the way to manage the various stakeholders	Domain 4, 5 & 6 *Main Domain 5*	G McBride	Stakeholder mapping by November 2011 and Strategy by February 2012 Review quarterly
7	Review the Governance arrangements - conclude the constitution and the revised scheme of delegation with ongoing review of governance arrangements	Domain 2 & 5 *Main Domain 5*	G McBride	November 2011 Constitution and Delegation by December 2011 - Ongoing
8	Agree & appoint Clinical Leads to support the delivery of the objectives.	Domain 1, 3 & 5 *Main Domain 1*	H Choi	Fully operational by February 2012

9	Complete and review Locality work – including Practice Manager leads	Domain 1, 3 & 5 *Main Domain 1*	H Choi	March 2012
10	Complete Board appointments including appointing Practice Manager and Practice Nurse	Domain 1, 3 & 5 *Main Domain 1*	I Pattison I Gilmour	P Manager – December 2011 P Nurse – January 2012
11	Ensure effective Clinical Leadership - agree personal development plans and appraisals for all Board members	Domain 1, 2 & 5 *Main Domain 5*	I Pattison J Gillespie	Ongoing appraisals by March 2012 with 6 monthly reviews
12	Build an effective relationship with the Health and Well Being Board	Domain 1, 4 & 6 *Main Domains 1 & 6*	I Pattison B Arnott	Dec – March 2012 - Ongoing

5.3 Primary Care involvement

Harnessing the added value of clinical input from primary care is key to delivering our vision in terms of improving quality, stimulating innovation and ensuring value for money. We need to encourage awareness, engagement and ultimately ownership of commissioning decisions and in the delivery of our objectives and initiatives.

To enhance communication between the Executive Committee and constituent practices, five Board Locality Links have been established (reflecting the five regeneration areas in Sunderland). A structured approach to engagement has been agreed via 'Time In Time Out' events and locality meetings: the remit of the Locality Groups is to provide a:

- Two-way communication between practices and the Board;
- Robust mechanism for practice involvement in commissioning;
- Mechanism for the delivery of the Commissioning Plan objectives and initiatives i.e. clinical variation, prescribing;
- Forum to consider local developments e.g. Primary Care Centres;
- Support delivery of the Local Incentive Scheme (LIS) and QoF QP indicators;
- Forum to share good practice and encourage innovation;
- Effective Public and Patient Involvement mechanisms are in place within the locality;
- Develop and implement an educational programme as part of 'Time In Time Out' programme.

5.4 External Leadership

To follow

5.5 Working with partners and stakeholders

We are proactively engaging with the wide range of local partners including local authorities, business community and voluntary sector, clinicians and patients/carers to ensure our plans reflect local need and that partners play a key role in change for local people. The strength of partnership activity and collaboration is critical to delivery of the transformation we have described in this Plan and is a key strand of our ongoing OD activity.

We recognize that there are many stakeholders and partners with whom we need to engage over time and in a variety of ways. We agreed a draft Communication and Engagement Strategy in November 2011 which sets out key objectives to support effective engagement, including reputation management. The first key action being a development session planned for early January 2012 to undertake a formal and systemic stakeholder mapping exercise together with a review regarding how best to effectively manage communications with the various stakeholders (acknowledging that we will need to utilise a range of communication mechanisms).

Furthermore, a communication programme is being developed to support the effective engagement of this Commissioning Plan with partners and stakeholders between January and March 2012. This will complement the engagement plan for the public, patients and practices; activities of which include:

Executive Committee members meeting key stakeholders to update on the development of the Plan (initial 2012/13 Commissioning Intentions have already been shared with providers and the Local Authority);
Draft Plan being available on the website;
Opportunity for discussion at Local Engagement Board meetings with the public and also at Local Overview and Scrutiny Committee;
Accessing LINK and utilising the Voluntary Sector and Local Authority mechanisms to share information with the public;

Use of social media and interactive technology to develop interactive and responsive engagement mechanisms that can be public led (particularly useful with younger age groups).

5.6 Health and Well Being Boards

The Sunderland Health and Well Being Board was established as an early implementer site in April 2011. We are represented at the Board by our Chair and Governance Leads. We have established clear communications between the Board and the CCG Executive and Pathfinder Committee.

As part of the work programme of the Health and Well Being Board, we are participating and updating on a number of developments including:

Delivery of the refreshed JSNA which includes a broad range of health determinants (members of the CCG have input into specific aspects of the JSNA including tobacco, alcohol, long term conditions, cancer); the next phase will be to engage with local practices regarding the emerging implications;

Development of the Sunderland Health and Wellbeing Strategy;

Development of the 2012/13 NHS South of Tyne and Wear Commissioning Intentions;

Regular updates regarding the development of the CCG including development of this Plan, the CCG authorisation process and alignment with Sunderland Regeneration areas;

A review of all current joint commissioning arrangements (including Alcohol, Drugs, Mental Health, linked health and social care commissioning for adults and children)

We acknowledge the importance of joint working with the Health and Well Being Board and recognise the synergies to be gained in enhanced health outcomes through both the alignment and integration of commissioning plans.

5.7 Patients and the Public

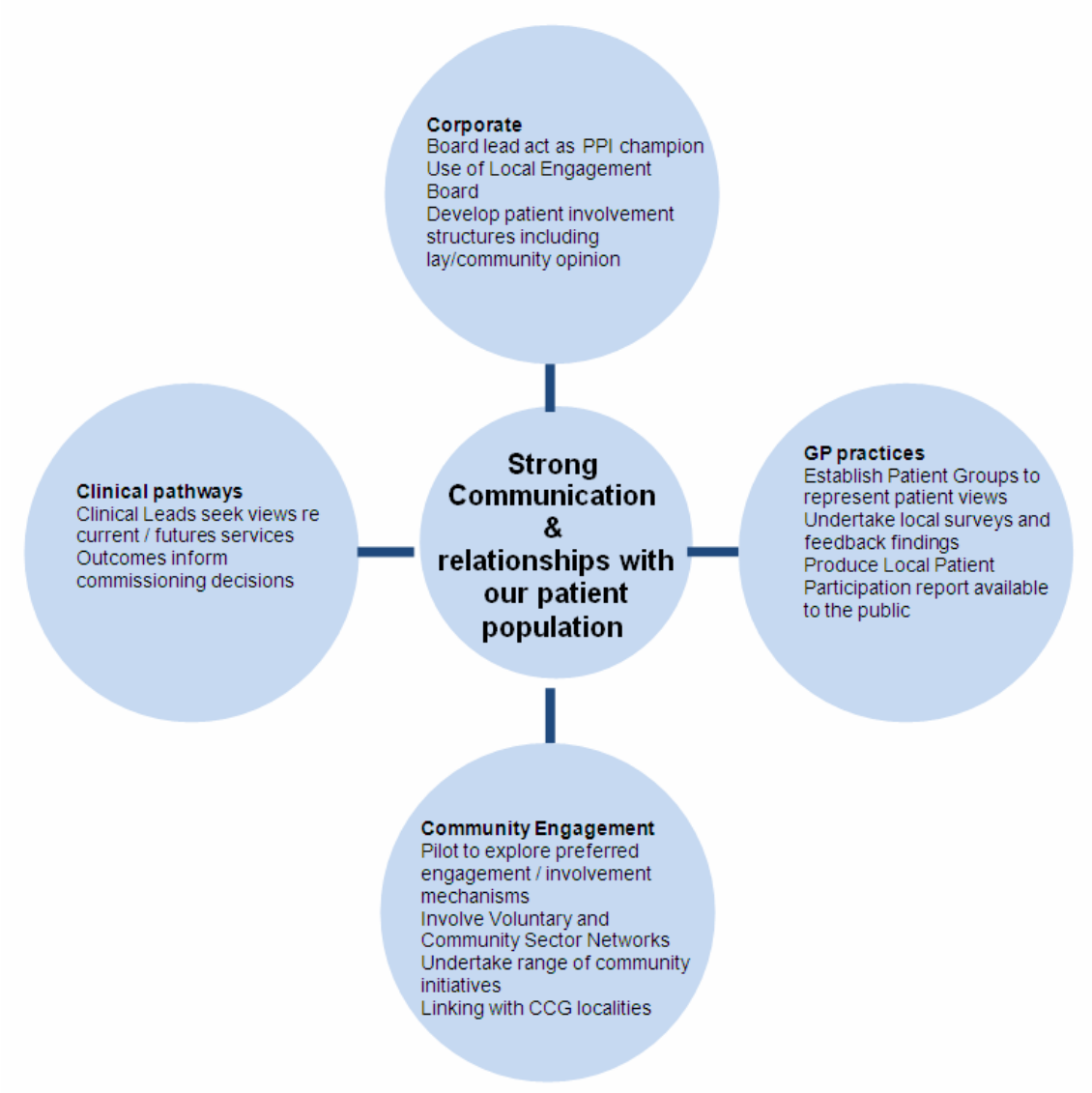
We are committed to excellent patient care and it is essential that strong communication and relationships are developed with our patient population in order that local people are meaningfully involved in the development and implementation of our Commissioning Plan. It is vital that patients are actively engaged in shaping the planning and delivery of local

services in order to ensure that their needs and wants are met, and that healthcare is accessible and responsive to their views and experiences. We have a unique position in that we communicate with patients on a daily basis and welcome the opportunity to harness this experience in order to develop strong and effective ties with the community.

The following diagram illustrates how effective community engagement will inform all aspects of our commissioning, from detailed planning (identifying health needs and identifying priorities) to commissioning services (service redesign and identifying outcomes in specification) through to managing performance.

To drive this agenda forward, we have appointed two Executive Leads who will actively develop a range of patient and public involvement mechanisms, working closely with a dedicated public involvement officer with experience in developing effective communication methods.

Our patient and public involvement strategy and engagement strategy sets out the mechanisms we will use to continue to strengthen and co-ordinate this core process including communications, social marketing, community engagement, patient involvement and Local Involvement Networks. The planned engagement and involvement activities are illustrated in the following diagram:



5.8 Commissioning Support

5.8.1 Current support from the PCT

to follow

5.8.2 Commissioning Support Organisation

The shared operating model for PCTs has made clear that Clinical Commissioning Groups should be centrally involved in the development of the commissioning support that will help them to achieve their objectives. Commissioning support will need to help CCGs to achieve their objectives and give the CCGs the information and support they need to take effective commissioning decisions and then make them into a reality. We are currently considering the issue of Do; Buy or Share ie: how much support we want to provide ourselves; how mych we want to share with other CCG's and how much we want to buy from a Commissioning Support Organisation.

We will continue to help shape the commissioning support through ongoing local discussion and as part of regional discussions on the plans to develop one commissioning support organisation for the North East but with a local presence in South of Tyne and Wear.

We will look to the commissioning support to fully support our roles, responsibilities and statutory duties. Commissioning support will need to be customer focused and designed around our needs and requirements. We will require a high quality, responsive and flexible business support solution that will enable the Executive Committee to take responsibility for commissioning local healthcare successfully.

Commissioning support across a number of key service lines is envisaged including commissioning and business support services as outlined in the table below:

Commissioning support services	Business support services
• Planning and health needs Assessment • Service redesign • Provider Management • Procurement and Market Management • Performance • Quality and safety	• Business Intelligence • Assurance • Information Technology Services • Estates and Facilities management • Corporate Support Services • Medicines Management • Communications and Engagement

• Continuing Healthcare • Financial Management	

In developing our vision for local healthcare, we will require a flexible menu of services that can be tailored to meet our specific local requirements depending on the outcome of our considerations of the model of support that best suits our needs eg: provided directly; share; purchased or a hybrid of all of these options.

We will seek to be actively involved in shaping the development of commissioning support arrangements including responding to the initial offer outlined in the Prospectus from the North East CSO in December and informing the preparation of its Outline Business Plan in January and Final Business Plan in June 2012.

5.9 Delivery of safe high quality care

To follow

5.10 Workforce

To follow

5.11 Estates

To follow

5.12 Informatics

To follow

5.13 Proactive Management of Risks

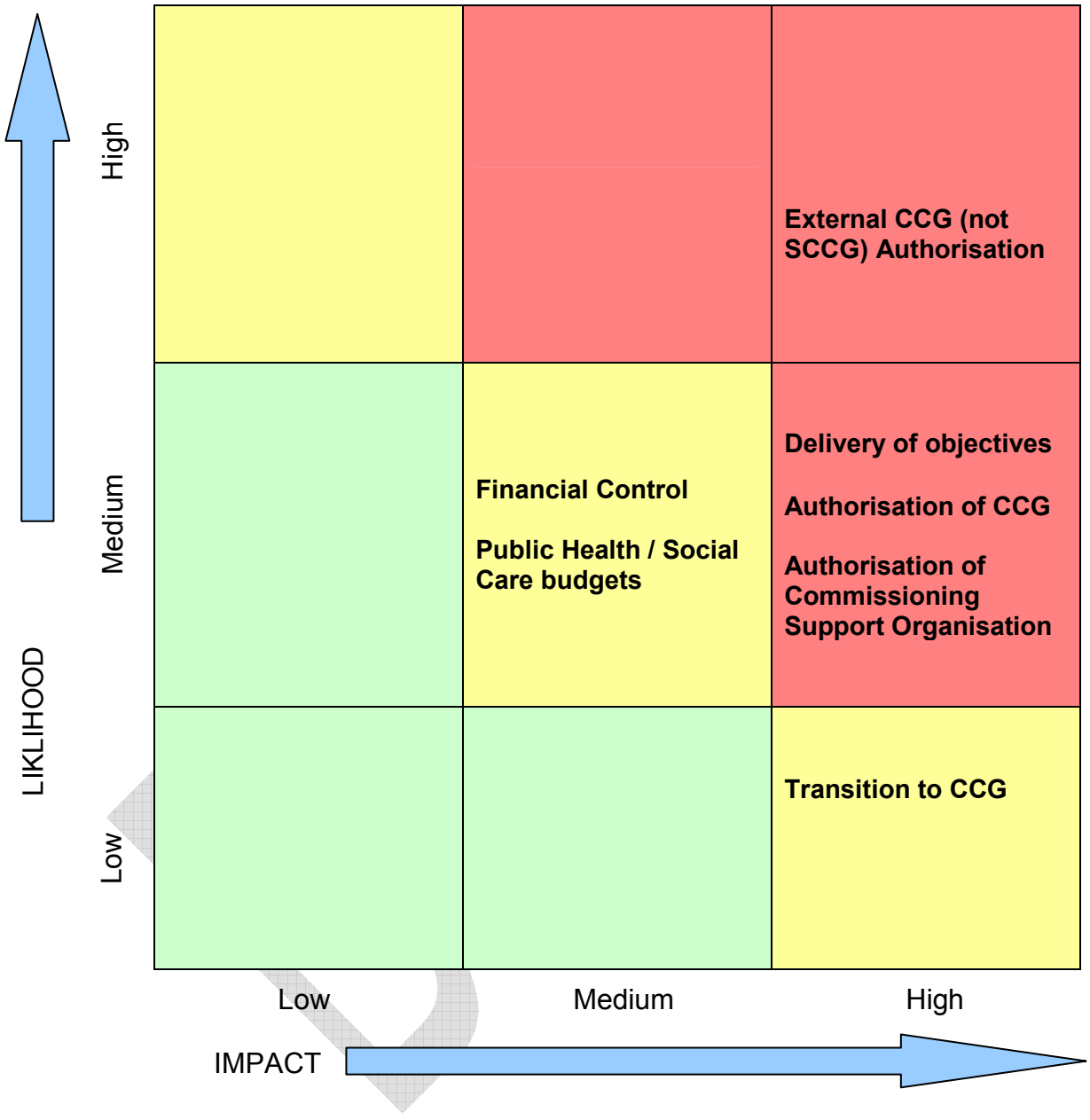
5.13.1System Risks

The risks to delivery of the Plan have been systematically identified and quantified for all of the investment and disinvestment initiatives as part of the planning process, using an assessment of likelihood and impact. A moderation exercise then reviewed the risks to ensure comparability and validity. This is an ongoing and evolving process which will be regularly reviewed and updated as both sets of initiatives are implemented and evaluated and also as new evidence becomes available.

From the detailed analysis underpinning these high level risks, a number of cross-cutting risks to delivery have been identified, which predominately reflect the impact of undertaking

system wide transformational change in the short to medium term. These have been assessed for impact and likelihood and are plotted on the following chart.

Assessment of cross cutting risks



The risk log below outlines mitigating actions to reduce impact and likelihood for each of the cross cutting risks and is ranked by severity.

RISK LOG

Failure to meet control total and deliver financial balance and QIPP savings as part of the of pathfinder delegated authority ***Impact – Medium Likelihood – Medium***	
Delivery risks § Comprehensive Spending Review (CSR) confirms NHS funding through to 2014/15 with allocations only for 2012/13, consequently future plans based on assumptions derived from CSR § 40% management cost reduction over three years § Tight control totals reduce flexibility § Ability to manage/control secondary care demand and financial impact § Reduced level of resource arising from penalties within new tariff regime ? § PCT target saving includes £x.xm from xx resource releasing initiatives and £x.xm from prescribing efficiencies - CCG pathfinder bids include an element of the RRI programme relating to urgent care and prescribing – delegated accountability for delivery	**Mitigating actions** § Clear and Credible Plans incorporate financial plans based upon an agreed funding scenario for the period 2012/13 – 2014/15 § Detailed financial planning identifies range of risks and contingencies § Legally binding contracts include levers to manage activity § Additional funding for reablement services to help prevent admission and speed up discharge § Extend QIPP initiatives to generate further schemes to release efficiencies § 201 2/1 3 Integrated plans for each strategic programme include the RRI initiatives with savings to be delivered - signed off by either each Programme Board / Director § Progress against the financial savings is tracked through the integrated performance and planning system, reported to each CCG Pathfinder Committee ; note recent internal audit report on internal control confirmed that significant assurance could be given § Grip on delivery is managed via a number of internal forums including individual Programme Boards, Accelerated Bigger Picture Board (includes Chief Executives from NHS SoTW and Foundation Trusts), Collaborative Commissioning Team (involves CCG Pathfinder Committee Chair)

Failure to deliver strategic objectives and associated performance targets as part of pathfinder delegated authority *Impact – High, Likelihood – Medium*	
Delivery risk	**Mitigating action**
§ Underperformance against specific objectives during 2012/13 where CCG is the identified agreed lead § Unable to control demand for activity § Lack of clinical capacity within CCG to support deliver objectives § Lack of sufficient dedicated management capacity to support delivery	§ Integrated plans identified for delivery of specific initiatives supported by robust performance management framework including assessment of risks and mitigating actions § 2011/12 Integrated plans for each strategic programme include all the health improvement and performance requirements together with milestones, risks and mitigation actions - signed off by either each Programme Board or Director § Locally as part of Pathfinder Bid, undertaking review of outpatient referrals as part of the reduction in clinical variation and also considering alternatives to contribute to the on-going work to reduce activity levels § Menu of actions agreed with practices for better identification and management of high risk patients, referral standard and work with nursing homes § Progress against planned milestones is reported directly via Performance Update Report to Clinical Commissioning Pathfinder Committees § Activity overperformance is in escalation across all 4 PCT clusters with recovery actions and rigorous review of impact § Grip on delivery is reviewed via a number of internal forums including monthly review of performance by Clinical Commissioning Pathfi nder Committee, update at individual Programme Boards, visibility wall updates, specific escalation meetings, review at Collaborative Commissioning Team which involves CCG Pathfinder Committee Chairs § Alignment of staff Phase 2

Transition to Clinical Commissioning Arrangements *Impact – High, Likelihood - Low*	
Delivery risk	**Mitigating action**
§ Lack of clarity, capacity and capability to enable CCG Board to undertake commissioning role § PCT capacity to support transitional arrangements § Engagement of practices § Appointment of Clinical Leads	§ Production of Organisational Development Plan includes timeline of actions to enhance CCG commissioning knowledge, skills and expertise including joint working with practices, stakeholders, patients and the public § Terms of Reference, Ways of Working and Scheme of Delegation agreed with Constitution for CCG in development § CCG supported by Commissioning Development Unit with Head of Commissioning Development. PCT Executive Director aligned to each CCG § Detailed Transition Plan and Programme for Commissioning Development mapped to DoH Shared Operating Model for PCT Cluster, with supporting risk register § Locality sub structure and appointment of Locality PMs and PN's and link GP Executive Lead; TITO's Newsletter. § Lots of interest expressed and ability to flex offer to meet needs and use Executive Member and Locality Leads influence.
Failure to achieve Authorisation by local agreed date October 2012 ***Impact – High, Likelihood – Medium***	
Delivery risk	**Mitigating action**
§ Clear and credible plan is not signed off by North of England SHA § Capability and capability gaps within the CCG Board § Lack of support by partners including local Health and Well Being Board § Failure by Commissioning Support Organisation to achieve Authorisation within timescales § Failure to resolve the Do;Buy:Share option for commissioning support	§ Project plan in place to develop Plan including dedicated CCG Board development sessions § Ensure alignment of PCT 's ISOPs with Clear and credible Plan with regard to Finance, Performance and QIPP § Re-aligned capacity with PCT to support development of the Plan § Production of Organisational Development Plan includes timeline of actions to enhance CCG commissioning knowledge, skills and expertise § Proactive input in the development and implementation of the Health and Well Being Board – key link being DPH who is joint PCT / LA appointment on Health and Well Being Board and is also a member of CCG Board and the Chair and Governance Lead on the CCg Executive Committee are members of the Health and WellBeing Board. § Developing a comprehensive communication and engagement strategy including stakeholders, patients and the public § Development of CSO build upon identification of CCG customer requirements with engagement in the production of the business plan § Work on Do;Buy; Share model is underway and support from SHA and independent advice and

	§ appointment of AO and DoF,

Failure of authorisation of neighbouring CCG's ***Impact – High, Likelihood – High***	
Delivery risks §	**Mitigating actions** § Relationships between 3 SOTW CCG Chairs and support from LMC's

Public Health and social care budgets prove insufficient to deliver required outcomes ***Impact – Medium Likelihood – Medium***	
Delivery risks §	**Mitigating actions** §

Failure of Commissioning Support Organisation to achieve authorisation ***Impact – High, Likelihood – Medium***	
Delivery risks §	**Mitigating actions** §

5.14 Governance

We are mindful of the need to have in place the proper constitutional and governance arrangements (as set out in the draft guidance issued by the Department of Health "Towards establishment: Creating responsive and accountable Clinical Commissioning Groups"). A significant amount of work has already been undertaken to ensure that we have effective and robust governance arrangements in place, pending finalisation of the national guidance. These arrangements address our "internal" working arrangements and delegated authority from the PCT Board to the Clinical Commissioning Pathfinder Committee during the transition period, in the lead up to the CCG authorisation as a statutory body in its own right.

As part of our "internal" governance arrangements, we are preparing a Constitution which regulates the relationship between the Member Practices within the CCG and the elected members. The structure of the Constitution includes:

- Membership of Member Practices;
- Nominated representatives of Practices and their role;
- Arrangements for meetings of members such as through a “council of members”;
- Establishment of an Executive Committee consisting of Member leads – to have delegated powers from Member Practices for the overall management and Strategic direction of the CCG;
- Enabling the CCG through its Executive Committee’s representatives on the Clinical Commissioning Pathfinder Committee to have delegated responsibility for delivery of a key part of the PCT’s commissioning function and undertake the preparatory work for establishment as a statutory organisation;
- Matters that should be considered through the “council of members” in that we recognise the importance of engaging with member practices on a ongoing basis regarding commissioning decision making.

Whilst the PCT Board continues to be accountable for ensuring that it discharges its statutory duties for the commissioning of healthcare, governance arrangements have been put in place between the CCG and the PCT which provide for an accountability framework under which the Clinical Commissioning Pathfinder Committee operates as a sub-committee of the PCT Board under delegated authority during the transition period and until such time as the CCG is authorised and becomes a statutory organisation. Specifically, detailed terms of reference are in place governing the CCG’s role as a sub-committee of the PCT Board together with a detailed Scheme of Delegation with timescales setting out details of the functions for commissioning of healthcare, for which over time, the CCG will assume responsibility. Underpinning all of this work is the our commitment to the Nolan principles of openness, accountability and transparency; with these principles in mind, we have adopted a Conflicts of Interest policy which all Clinical Commissioning Pathfinder Committee members have signed up to.

As part of our journey towards authorisation, we are developing, in parallel with our Organisational Development Plan, a Governance Development Plan which takes into account the work of the National Leadership Council and the draft national Governance Framework for CCGs in supporting them with the development of their governance arrangements. Using this framework, we are developing effective governance and assurance arrangements which will be necessary in the short and longer term to meet our statutory responsibilities.

Section 6 – Declaration of Approval from Pathfinder Committee

To Follow

Sunderland Commissioning Intentions 2012/13 **APPENDIX B**

Attached below are the Sunderland Commissioning Intentions 2012/13 split by likely future Commissioning Responsibilities: with specific colour coding for those which the CCG will lead in 2012/13.

Please note that this is a provisional split based on information known to date and may be subject to change.

Orange: anticipated these will fall within the CCG remit once a statutory body, and currently the CCG support/ influence where appropriate, but led by PCT.
Purple: anticipated these will move to the Local Authority
Blue: is anticipated these will move to NHS Commissioning Board
Green: will be led by the CCG in 2012/13

NB: Table updated January 2012

PCT /CCG Responsibility

Strategic Priority	Action
Cancer Services	Remodel Breast Cancer Services across NHS SoTW (excluding screening services) in order to implement a sustainable service model. Developments include; 5 year follow up clinics to be nurse led. The remodelled service is expected to be operational during 2012/13.
	Ensure cancer pathways for Foundation Trusts are in line with North East Cancer Network model pathways. Awaiting standards for Brain and Sarcoma services
	Work with Foundation Trusts to ensure processes are in place to recoup funding through Patient Access Schemes for High Cost Cancer Drugs.
	Increase the uptake of Radiotherapy Services by implementing a strategy to secure local provision.
	To identify sufficient endoscopy capacity to meet demand
	Deliver outcomes of teenager and young adult cancer standards in collaboration with NECN
	Increase the early detection and identification of cancer and increase uptake by reducing variation in GP profiles.
Learning disabilities	Ensure that physical health care checks in primary care for people with learning disabilities are implemented.
	Develop an Autism Spectrum Disorder assessment and diagnostic service across Sunderland from April 2012.

Primary Care Mental Health
Primary Care Mental Health Services - increase input into long-term conditions in terms of identification of mental health problems and treating them – through other specialist staff already dealing with LTC (see LTCs Commissioning Intentions)
Continue the process of repatriating high cost out of area placements to locally provided services.
Develop and agree an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service.
Implement mental health specific actions within the Suicide strategy.
Specialist / Secondary Care
Continue to work with NTW to realise efficiencies in relation to QIPP & ensure continued engagement in the delivery of resource releasing initiatives. Use quality initiatives to support service development.
Work with NTW to support the implementation of the business case for re-provision of in-patient, outpatient & community services regarding new facilities at Ryhope & Monkwearmouth during 2012/13
Continue implementation of the Mental Health Model of Care § Secondary care re-modelling including liaison and services for veterans § Further development of mental health in primary care (Primary Care Mental Health Service)including a review of access to practice based counselling § Further development of the dementia strategy including anti psychotic prescribing plan (Links with medicines management) § Moving to tariff § Potential move towards AQP
Contracts / QIPP
Lead the implementation of CPPP (PbR for mental health) in shadow form across contracts
Consider existing commissioning arrangements moving to Any Qualified Provider for psychological therapies in Primary Care

Children's Services	Implement the recommendations from the review of Speech, Language and Communications needs. Working in partnership Local Authority and Community provider/ other key partners to ensure the new model of provision is embedded and sustainable.
	Review Children's Community Nurses (CCNs) and palliative care for children in line with requirements set out in Aiming High for Disabled Children.
	Review occupational therapy and physiotherapy services for children and young people and consider future commissioning intentions.
	Review the implications for new national tariff for children's diabetes
Urgent Care	Implement the 111 single point of access for urgent care to signpost patients with an urgent care requirement to the most appropriate service to meet their needs. The contract to provide the 111 service will be awarded in November 2011; between November 2011 and September 2012 urgent care services will need to be aligned to the 111 operational model (including GP out of hours) which will include a range of re-procurements where necessary or variation of current contracts.
	Develop an urgent care transport strategy to support the implementation of 111.
	Arrange an annual 'Choose Well' public information campaign to publicise the range of services, points of access, hours of operation and areas of exclusion by targeting focus groups in SoTW in order to help reduce demand for secondary care services.
	Following the evaluation of the current models of minor injury and illness units across SoTW, a standard model of GP integrated working will be implemented across all MIUs. Modelling work will also look at the number of services required, the most appropriate locations and associated commissioning actions. • Houghton MIU options to be agreed • The exploration of an urgent care hub in CHS is underway.

	Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted.
	Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality.
	Review Urgent Care Nursing services across Sunderland to understand the impact to develop a future state.
	Expected impact of the introduction of Trauma Centres and locally the potential re-classification of our local FTs as Trauma Units.
	Develop a community based cellulitis model and service.
	Develop a community based DVT model and service.
Long Term Conditions	**Develop a commissioning model for Long Term Conditions** **Self Care** Implement self care model for LTCs, including reviewing current provision of self management education and support, improving access to a menu of options, systematic delivery within pathways, and workforce development to increase capacity and capability. To review the future commissioning arrangements of self care services To embed self care opportunities into health care core services
	Develop a commissioning model for Long Term Conditions <u>Specialist Rehabilitation</u> Consider the findings of the review and Commission new models and approaches to specialist rehabilitation which provides increased access from primary care, a menu based approach to service delivery and ensure synergies and joint working between specialist professionals

Develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with LTCs and frail elderly within each PCT locality, including care within individuals own homes.
Develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with LTCs and frail elderly within each PCT locality, including community based 'step up' facilities.
To review the existing rapid access community nursing teams and consider opportunities for improved access and clarity of role. In particular to develop integrated teams including a joint urgent care and 24/7 team.(linked to intermediate care, see above)
Review provision, role and effectiveness of Specialist Community Nursing and Community Matrons to develop appropriate models of case management that support proactive and anticipatory primary care. This may require decommissioning elements subject to the review.
Complete the review and implementation of changes to the district nursing service whilst retaining the option to procure alternatives depending on the outcomes
Having completed the review of the impact of the additional reablement/readmission investment in 2011/12 we will work with stakeholders to develop sustainable and successful schemes for 2012/13.
Improve provision of heart failure services across primary community and secondary care
Review the COPD pathway and identify improvements that could be made to improve patient care.
Improve discharge processes (including documentation) and opportunities for early supported discharge.
Implement single-site model for weekend TIA clinics.
Develop a revised service model for the provision of diabetes services across primary community and acute.

	Develop recommendations for future commissioning following the pilot of the community arrhythmia service. .
	Implement an AQP procurement for community based INR services
	Improve the management and provision of AF services across Primary, Community and Secondary care including developing a community model and service.
	Commission a home oxygen assessment service.
	Diabetic Retinal Screening - Vary service specifications to reflect the new national commissioning pathway
Planned Care	Reduce the number of procedures of limited clinical value for varicose veins.
	Implement the revised pathway for patients with carpal tunnel syndrome
	Explore further alternative surgical pathways including Trigger Finger and Dyputrens contracture
	Explore variation in outpatient referrals in order to reduce outpatient first and follow up attendances where appropriate
	Explore feasibility of increased GP access to diagnostic tests for non obstentric ultrasound and MRI for dementia
	Review dermatology services and consider aligning the new service model if appropriate with the model commissioned for Gateshead and South Tyneside.
	Following scoping of nurse led clinics in terms of continued viability and cost, agree clinics to “decommission” or change to ensure added value to patient pathways
	Review Adult Hearing Services with an aim to improving access, choice and quality of care (AQP).
	Review podiatry services with an aim to improving access, choice and quality of care (AQP).
	Potential procurement of Primary care based orthodontic services.
End of Life Care	To ensure end of life care packages are co-ordinated and available 24/7

	To have advanced care plans and DNAR in place for all appropriate patients
	Re-provide St Benedict's Hospice.
Medicines Management	To have an action plan in place to improve the quality of prescribing, optimise medicines usage in patients with long term conditions and deliver disinvestment opportunities in Primary care prescribing.
	To manage prescribing expenditure within prescribing envelope, to move closer to the North East average to release resources to invest in better quality service. (Astro PU)
	Work with both secondary and primary care to develop a health economy approach to prescribing of medicines across pathways of care.
	Through the contracting process to develop plans for a consistent and collaborative approach for the transfer of prescribing responsibility, including improving the effectiveness of communication, provision of shared care medicines and outpatient prescribing,
	Work with Primary Care to develop a LES for Shared Care
	Explore options to develop services to improve medicines management in care homes in order to reduce the number of emergency admissions and reduce medicines wastage.
	Explore options for collaborative working across primary and secondary care in relation to the provision of stoma and incontinence
	Explore options for collaborative working across primary care and communality in relation to the provision of wound management products, including encouraging appropriate use of the wound management formulary
	Improve the systems for high impact / cost drug exclusions to include a consistent approach across the locality / region and effective implementation of the decisions.
	Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including . Improving rates of repeat dispensing, (implementation of the actions of the repeat dispensing RPIW) . New medicines service . Targeted use of medicines usage reviews . review of the use of MDS

	Ensure there are robust local mechanisms for decision making around medicines.
	Review the contract for provision of medicines management support to individual practices within the SCCG to ensure a Sunderland wide approach to priorities.
	All secondary care and primary care providers to ensure patients post MI benefit from 4 drugs – aspirin, beta-blocker, stain and ACEI
Childrens Acute	Enhance services provided by CCNTs to include care of acutely sick and injured children and with extended hours (evenings and weekend working). Evaluate the ongoing testing of the revised CCNT model in Sunderland and use the evaluation to inform future development of services.
	Subject to public consultation, implement the agreed paediatric emergency pathway; including children's assessment and short stay services.
	Implement a contract variation to extend the role of Walk-in-centres and Minor Injury Units to include assessment and treatment of children under two years of age.

Public Health England/Local Authority Responsibilities

Strategic Priority	Action
Cancer Services	Increase uptake of Bowel Cancer Screening by raising awareness. Whilst ensuring contract volumes reflect anticipated increases in demand.
	Introduction of HPV testing for Cervical Screening.
	Implement urgent lower GI investigation by adopting the Hamilton Risk Assessment Tool into 2WW time frame.
	Enhance engagement and uptake of services following HEA of Breast Screening Service.
Joint commissioning	Implementation of robust joint strategic function arrangements with Sunderland LA through the use of Health Act flexibilities.

	Implement current preferred option from the outcome of the review of the assessment and commissioning processes around CHC, FNC(Free Nursing Care) & s117 (Section 117) and consider future commissioning intentions
	Continue to implement the Carers strategy and local action plans in each locality.
	Enhancement of governance & quality arrangements with independent sector providers. Building on stock take around contracting to ensure all provider relationships are underpinned with provider contracts.
	Work collaboratively to bring together plans for development of physical health, mental health, medicines management and end of life care for Sunderland care homes. (Links with Urgent care and frailty Team in Sunderland.)
Mental Health	**Emotional Health & Well Being**
	Implement the emotional health & wellbeing plan.
	Implement mental health specific actions within the Suicide strategy.
	Re-provide BME and LGBT wellbeing programmes.
	Re-provide workplace health programme with improved service offer for organisations not pursuing NE Better Health at Work Award.
Children's Services	Review school nursing services for provision and capacity to ensure all key elements of the Healthy Child Programme 5-19 years are delivered and key outcomes are achieved.

	Develop an early intervention and prevention strategy with local partners and consider future commissioning intentions to ensure effective evidence based interventions are delivered and monitored in accordance with need to reduce health inequalities and narrow the gap in outcomes.
	Review children's overweight and obesity services (across all the tiers) to meet the requirements of a life course approach and ensure children and young people have access to timely, appropriate and accessible support to meet their needs, and consider future commissioning intensions. (Links with Prevention and Staying Healthy)
	Implement a model to minimise risk taking behaviours and build resilience. To build associated workforce capacity, a risk and resilience training package will be developed in partnership with the Local Authority. Review workforce skills and competencies against the core standards of the model.
	Develop a phased approach to the implementation of 'You're Welcome' quality standards. Ensure service providers deliver in accordance with 'You're Welcome' quality standards.
	Ensure all appropriate providers are signed up to the new electronic C Card and are using it appropriately and develop on basis of need.
	Ensure compliance with NHS SOTW strategy, policies and procedures for Safeguarding Adults and Children.
	Implement recommendations from the CQC and Ofsted joint inspections.
	Review drug and alcohol services for children and young people in Sunderland and implement recommendations in line with the risk and resilience model.
	Ensure increased focus on short breaks for young carers and parents of children with disabilities
	Review stop smoking services for young people in line with NICE guidelines. (As part of the Stop Smoking Services review).
Prevention/Staying Healthy	Following completion of evaluation of Healthcheck Programme, consider future commissioning arrangements.
	Following completion of evaluation, consider future commissioning intentions for prevention and treatment of Obesity and exercise on referral services
	Following completion of review & HEA, amend/ re-provide Stop Smoking services.

	Re-commission alcohol & drugs services in line with the National Drugs Strategy with a focus on recovery and outcomes from treatment.
	To re-commission the Chlamydia programme across SOTW when clarification on 2012/13 targets received.
	Implement the sexual health locality action plan which is informed by the findings of the sexual health review with a focus on: - • Governance arrangements • Access to Contraception • Reducing the prevalence of STIs • Improving, protecting and promoting the sexual health and wellbeing of the population.
	Review the input of providers into the Multi Agency risk assessment Conference (MARAC) process relating to incidents of domestic violence
	Re-align pathway of care for offenders on release of prison as necessary.
	Review the commissioning arrangements of FRESH and Balance.
	Ensure that substance misuse service continue to develop accessibility for ex-service personnel and that pathways are adapted to support their needs.
	Consider future commissioning arrangements of Health Trainer Service following publication of future shadow budget arrangements.
	Review provision and coordination of training & capacity building across lifestyle services and re-align services accordingly.
	Utilise findings of the Lifestyle survey (due March 2012) to inform in year variations in lifestyle services and inform commissioning intentions 2012/13 utilising a social marketing approach
	Review and consider future commissioning arrangements of the Health Champion training.
	Implement recommendations arising from report on outcomes of physical health improvement programme for people with severe mental illness (SMI)
Child and Adolescent Mental Health Services and	Development of Tier 2 CAMH service provision including improved access to talking therapies in line with evidence base.
	To increase the capacity of universal service providers to promote mental health for children and young people,

Learning Disabilities	recognise problems early in their development, intervene and refer as appropriate Provide direct services to Children, young people and their families with moderate mental health needs, including grouping work and talking therapies
	Establishment of new model of specialist community CAMH / LD service provision with a particular focus of integrated pathways of care for children, young people and their families: • with complex, severe or persistent mental health needs • with learning difficulties and disabilities • in special circumstances • with complex behavioural mental health and social care needs • who require access to intensive home treatment service
	Re-alignment of resources/ changes in service provision for children and young people with ASD based on outcomes of the review that will take into account: • Change regional service provision • Changes in specialist community service provision (newly awarded CAMHS/ LDD contract) • Newly published NICE Guidance in line with the outcome of the review of 2011/12
	In partnership with LA, development of services for Children and Young people with Disabilities: • implementation of continuing care guidance • implementation outcomes of review community equipment service (including children's wheelchair services) • Implementation of short break guidance • implementation of SEN guidance • personalised planning outcomes • implement recommendations of CQC / OFSTED inspections • improve transition between Children's and Adult Services
	Working in partnership with Local Authority support the review of SEN assessment and statement framework. This will explore the potential for changing / revising the existing systems with an assessment process, a single, joined up ‘Education, Health and Care Plan’. Explore opportunities to implement personal health budgets for children as part of this overall review (links with LA).

	Implementation of the review of services for Looked After Children
	Implementation of result of review of Child protection service specification
	Implementation of outcomes of review of services for children and young people involved in youth justice system.

NHS Commissioning Board Commissioning responsibilities

Strategic Priority	Action
Children's Services	Continue to implement the expansion programme for Family Nurse Partnership (FNP) and Health Visiting Services. Ensure the Health Visitor service meets the requirements of the new national model and service specification which will come into effect from 1 April 2012 (as per requirements of Early Implementer Site status). Continue to review the impact of the new model working in partnership with early years providers to ensure the best start in life is achieved. Review skill mix within the Health visiting service and explore opportunities nationally to expand the FNP offer.
Maternity Services	Carry out social marketing exercise across Sunderland using a regional model to increase the number of women breastfeeding.
	Review performance across the breastfeeding pathway looking at rates and peer support programmes (Quality Service Review).
	Support acute hospitals to achieve Baby Friendly Status.
	Review pathways for families with additional needs with a view for develop an integrated pathway with Children's services.
	To explore the options available to deliver a community based rapid response service to reduce the numbers of unplanned admissions during pregnancy.
	Evidenced based commissioning; Develop a review programme of services specifications for community based children services and maternity against existing evidence base. Identify opportunities to develop innovative practice.
	Review newborn screening pathways including assessment of AQP impact on audiology

Item No. 4b

SUNDERLAND CHILDREN TRUST BOARD – 10 JANUARY 2012

BRIEFING FROM MEETING

Safeguarding Children Peer Challenge – December 2011

M Boustead (Head of Safeguarding) presented to the board an update on the outcomes from the Peer Review Challenge which took place during December 2011.

The Peer Challenge had been commissioned by the Executive Director of Children's Services, supported fully by the Sunderland Safeguarding Children Board (SSCB). The Peer Challenge provided a valuable learning to take forward in preparation for the anticipated Announced Inspection during the first half of 2012.

The Peer Challenge team were asked to focus on the following key areas:

- Common Assessment Framework/Early Intervention interface
- Sunderland Safeguarding Children Board/partner roles and responsibilities
- Corporate/service priorities – outcome framework
- Commissioning – areas for development
- 'Whole Family Approach', ie what people understand by the term.

During the visit a cross section of staff were interviewed, as well as elected members, young people and partners, to help to consider how well local services are working to meet the safeguarding needs of children.

Following the inspection, the Executive Director of Children's Services received a draft letter which set out the main areas identified for consideration by the Peer Challenge team:

- Urgently reviewing CAF and thresholds so that early help effectively meets children's needs and diverts families from statutory interventions
- Communicating the next stages of change
- Increasing the pace of the improvement journey and building sustainability
- Demonstrating improved outcomes for children and families
- Making partnership working 'real'
- Developing member engagement and scrutiny

Next Steps

- Comments invited from partners regarding the draft letter, prior to Children's Services feedback to Peer Challenge Team.
- Sharing key messages with partners.
- Further development of the improvement plan with partners, taking into account the Peer Challenge Team's observations.

- Report to SSCB in February with progress in relation to actions identified.
- Using the learning from the Peer Challenge to plan for the Announced inspection.

Early Intervention Offer

The report was presented to provide an overview and gather comments on the proposed Early Intervention Core Offer and the next steps in developing and promoting the Offer.

Children's Services has adopted the following approach to early intervention, namely "to ensure that in every local areas there is a continuum of support for the many families whose needs vary over time, with children's centres and schools at its heart".

Integrated working is particularly important when a child or young person has needs additional to those usually met through universal services. The Common Assessment Framework (CAF) is used as the key assessment tool to identify and support integrated working. With the agreement that "early intervention is everybody's business" a wide range of practitioners have been trained to identify emerging need and work with parents to complete the assessment.

There are currently five locality based integrated teams which form the core of the Early Intervention and Locality Service, and include practitioners from Attendance, Children's Centres, Information, Advice and Guidance, Educational Psychology, Risk and Resilience, and Youth Development.

Children's Services have produced a Continuum of Support chart, which identifies for practitioners, which services are available for which age group, whether that be at universal, specialist or targeted level.

Further consultation on the offer will take place with the Children, Young People and Learning Scrutiny Committee and with Head Teachers, with the intention to formally relaunching via Locality Steering groups during January and February 2012.

Relationship with Schools

M Foster (Deputy Executive Director of Children's Services) provided a brief overview of the continuing work to develop the one.education@sunderland Partnership Board and the impact of the Education Act 2011.

The first formal meeting of the Partnership Board will take place on 23 January 2012 and a detailed presentation outlining the work of the group and also the implications of the Education Act 2011 will be provided at the next Trust meeting in March 2012.

Friends and Family Care Policy

M Boustead (Head of Safeguarding) and S Robson (Carer) gave a presentation to inform the Trust of the development of the Family and Friends Carer Policy.

The definition given of a friends or family carer was “those who are providing care and accommodation to a child or children of a friend or family member, mostly as a result of traumatic circumstances within the child’s family.”

S Robson set out the background to the research undertaken, and supported by the Sunderland Carers Centre and funded by the Sunderland Drug Action and Alcohol Team (DAT). The research sought to answer the following questions:

- What is the extent of grandparent caring for their grand-children full time as a result of birth parents substance misuse in Sunderland?
- What barriers and difficulties are these grandparents facing in the course of their everyday lives?
- What types of support and services are needed to overcome the barriers, difficult and conflicts?
- What support services already exist and where are the gaps?
- What examples of support for kinship carers exist elsewhere in the North East?

The following conclusions/recommendations were identified from the research and consultation to better support kinship carers in Sunderland:

- Awareness-raising
- Enabling informed choices
- Ensure family and friends carers can influence policy and approaches
- Support and training for family and friends carers
- Cross boundary approaches/policies
- Understanding numbers of family and friends carers.

The Coalition Government required all local authorities to have published by 30 September 2011, a Family and Friends Carer Policy, and the research and recommendations noted above were considered and incorporated into this policy.

Sunderland Safeguarding Children Board Update

The SSCB provide a regular update on their activities to the Trust. The report includes updates under the following headings (a full copy of the report can be provided on request):

- Business Plan and Bi-Annual Report
- Business Planning Sub Group Update
- Child Death Review Panel

- Communication and Workforce Development
- Case Review Sub Committee
- Quality Assurance
- Munro and Threshold Task and Finish Group
- Family Law Review
- First Annual Independent Chairs Conference
- Peer Challenge (see first item on briefing)

Munro and Thresholds Task and Finish Group

This group held its first meeting on 6 December, with the following terms of reference:

- To consider the Munro Review of Child Protection and the implications of the recommendations for the SSCB. This group will identify the work the SSCB needs to undertake to be in a position to operate in a 'post-Munro world' and make appropriate proposals.
- To consider the Thresholds for Child Protection Referrals and review what guidance is available and determine whether this is sufficient or if there is a better model of best practice available and make appropriate recommendations to the SSCB.

It has been identified through the Peer Challenge and also through the recent Unannounced Inspection of Contact, Referral and Assessment Arrangements, that there needs to be a greater understanding of the thresholds by practitioners and managers in every agency who work with or are involved with children, young people and families. As noted in bullet 2, the Task and Finish Group will work to revise the Thresholds guide and a draft copy was presented to the Trust for their consideration and comment.

It is anticipated that the Thresholds Guide is finalised by 22 February and Trust members were asked to provide any comments to M Boustead/L Thomas for consideration and inclusion.

Health Improvement – An Overview of Current and Projected Performance

The report was presented to provide a current position in relation to performance of the health improvement indicators of teenage conception, breastfeeding, childhood obesity and childhood immunisation. It also provided an overview of the latest position regarding the transition of public health responsibilities to the Local Authority, including comprehensive access to sexual health services and the National Child Measurement Programme

Teenage Conceptions

It was noted that rates of teenage conception have reduced from 63.1 per 1,000 to 52.9 (288) per 1,000 between 1998 and 2009, a decrease of 16.2%, with the overall downward trend continuing. During the same period rates decreased by 17% in the North East and 18.1% in England.

Teenage conception rates are reported based on live births and terminations, meaning that local data will always be at least 10 months behind. Indicative data available locally would suggest rates of teenage conception will increase in the next quarter and are at risk of increasing until May 2012, when it is expected the positive impact of the new C-Card Scheme, SRE offer and the expansion of provision for Long Acting Reversible Contraception and Emergency Hormonal Contraception will start to be seen.

Breastfeeding

Breastfeeding prevalence is measured at 6-8 weeks; rates in Sunderland and the North East are consistently lower than that of England. Following an improvement in breastfeeding prevalence in 2009/10 there has been a marked decline since quarter 2 of 2010/11, with prevalence reducing from 27% to 20.7% for the same period in 2011/12, a decline of 23.3%. Whilst latest data suggests performance is improving it is unlikely the end of year target of 28.8% will be achieved.

Childhood Obesity

Levels of childhood obesity are measured annually through the National Child Measurement Programme. The programme allows us to monitor the percentage of children who are underweight, a healthy weight, overweight and obese at reception and year 6. The NCMP is to be mandated to local authorities from April 2013.

Provisional figures for levels of obesity show that in reception rates have reduced from 11% in 2008/09 to 10.2% in 2010/11. For children in year 6 there has been an increase from 20.2% in 2008/09 to 21.9% in 2010/11. These trends are reflected nationally.

As the NCMP commenced in 2005/06 the first cohort of children measured at reception will be measured again at year 6 within the 11/12 cohort. Whilst this data will not be reported until December 2012 early indications show a significant increase for year 6 compared to 2010/11, from 21.9% to 24.3%. This would mean that nearly 1 in 4 children are classified as obese at age 10-11. At reception in 2005/06 13% of this cohort were classified obese, although it should be noted that the uptake in 2005/06 was much less than now, meaning the sample was less representative.

Childhood Immunisations

Whilst coverage of childhood immunisations is improving overall there is a need to improve uptake of the pneumococcal infection booster (PCV) and MMR for children aged 2 and the pre-school immunisations as it is not reaching the required thresholds of 95% and 90% coverage respectively.

Review of Children's Trust Governance Arrangements

The Trust have received a number of papers over the last 12 months setting out changes to Trust arrangements and the establishment of the Early Implementer Health and Well-being Board.

At the Trust meeting on 10 January 2012, a report was received and the following recommendations were agreed:

- Partnership Arrangements Task and Finish Group to be convened to revisit the current partnership agreement to determine the future shape and scope of the Trust, including the Aligned Partnerships to ensure that it is fit for purpose and can continue to support the improvement of outcomes for children and young people in Sunderland, as well as contributing to the development of the Health and Well-Being agenda.
- A Health and Well-being Sub Group will be established with the following remit:

    - To consider the agenda and papers of the Health and Well-being Board and provide comment back to the Trust for consideration.
    - A member of the Trust, who also sits on the Health and Well-being Board, will act as Chair of the sub-group.
    - The sub group will be commissioned to undertake appropriate pieces of work on behalf of the Trust and Health and Well-being Board.
    - The sub group will act as a consultative group to represent the views of the Trust.
    - Trust members were asked to nominate appropriate officers to form this group. *It should be noted, that the sub-group have already been tasked to undertake a piece of work on behalf of the Trust, to consider the Health Impacts of the Welfare Reforms: Guidance to Health and Well-being Boards. This meeting is scheduled to take place on 26 January 2012.*

Keith Moore
Executive Director Children's Services

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **3 FEBRUARY 2012**

HEALTH AND WELLBEING BOARD DEVELOPMENT PLAN

Joint Report of the Chief Executive and Director of Human Resources and Organisational Development

1 The membership of the board is diverse in terms of knowledge, understanding, and experience in Health and Wellbeing locally, regionally and nationally. As part of the Boards duties, members will be expected to make key decisions that will directly impact in supporting, delivering and improving the Health and Wellbeing of residents of Sunderland.

2 An audit of Board members development needs was carried out in November 2011 following on from which, Members of the board agreed to take part in a programme of development sessions aimed at informing and developing members in a number of health related topics, to better equip members to make informed decisions of behalf of city residents.

3 A proposed development plan (included as Appendix 1) has been established that identifies areas of development that the Board felt would benefit its members and as identified trough the Board member development needs audit that was carried out in November 2011.

4 It is proposed that the sessions will be delivered in Thematic or Problem Solving workshops using a number of development tools and techniques to support the required outcomes/objectives. The thematic sessions are largely developmental in nature and will be limited to Board members and facilitator. For Thematic and problem solving sessions it is proposed that invitations me made to additional partners and experts in order to maximise the value of the sessions for service improvement in the City as a whole.

5 To enable the workshops to be neutral, (in terms of agency representation and outcomes), it is proposed that independent specialist facilitators will lead on the majority of sessions. Internal specialist facilitators will be used where relevant to support the sessions.

6 Following the first two development sessions, it is proposed that the approach, timing and success of the development sessions be evaluated and the forward plan for development throughout March 2012 – 2013 be brought back to the Board for agreement.

RECOMMENDATIONS

The Board are requested to:

- Agree the thematic/problem solving topics identified in the plan
- Agree to the providers identifies in the plan
- Establish supplementary health related topics that the Board feel will benefit understanding and involvement.

Appendix 1

Session	Date	Provider	Development Aims	Objectives / Outcomes
1. Establishing the Board	24.01.12	Vince Taylor (Head of Strategy, Policy & Performance Management)	○ **Values:** Establishing shared values ○ **Goals:** Establish a shared vision and identify the key goals that the board will work toward in its current format, shadow and statutory Health and Wellbeing Board status. how do we Tackle long-standing issues that have proved hard to address	○ Agree values for the Board that will be used when making decision on the Health and Wellbeing of the city and the actions of the Board. ○ Establish the objectives, tasks and responsibilities required to meet the vision and goals of the Board
2. Thematic Workshop	21.02.12	External Facilitator (Sunderland university tbc)	**Priority Setting** ○ To give the Board the opportunity and understanding of what the health priorities are for the city (taking evidence from the Joint Strategic Need Assessments and other relevant quantitative and qualitative evidence). ○ Establish a mutual understanding of what the competing and/or joint priorities of the city are from Board members ○ Identify an agreed criteria for priority setting from the Health & Wellbeing Strategy	○ Have a consensus decision on what the health priorities for the city and how these are prioritised. ○ Agree a criteria for health priority setting in Sunderland
3. Thematic Workshop	TBE	Specialist Facilitator	**Influence, relationships and decision making**. Establish methods that will enable a clear communication, influencing and decision making process with Sunderland other key strategic groups e.g. The Sunderland Partnership, Children's Trust, Adult Social Care Partnership, Clinical Commissioning Group and Council	○ Agree a process to ensure that other Strategic Boards are informed, and can influence the decisions being made by the Health & Wellbeing Board

Session	Date	Provider	Development Aims	Objectives / Outcomes
			Commissioning Board."	
4. Thematic Workshop	TBE	Lee Stoddart /Democratic Services	**Governance and decision making protocol.** To explore levels of authority to ensure the Board can carry out its roles in decision making on behalf of the city.	○ Understand and agree the level of delegated decision they can undertake in both shadow status and in its constituted statutory full board status
5. Thematic Workshop	TBE	Specialist external facilitator	**Joint commissioning** To develop an understanding of joint commissioning to include: ○ Current commissioning practice/models ○ Challenges ○ Benefits ○ Risks (Initially between the Clinical Commissioning Group and the LA). ○ Explore implications of wider commissioning, e.g. SOTW	○ Understand joint commissioning and identify some joint commissioning opportunities ○ Understand joint commissioning models/practice ○ Commit to establishing a joint commissioning model for Sunderland between CCG & LA ○ Identify opportunities for investigation on wider commissioning prospects
6. Thematic Workshop	TBE	Vince Taylor/ Karen Graham	**Health & Wellbeing Strategy** ○ To develop an understanding of the Health & wellbeing Strategy ○ To establish the outcomes	
7.Thematic Workshop	TBE	Specialist external facilitator	**Engagement – Public Sector/VCS/ Residents** ○ To define what engagement means to the Board, (e.g. level of engagement-awareness , active involvement) ○ To identify all the stakeholders that the board feel should be engaged. ○ Identify method of engagement that the board want to see.	○ Definition of what engagement is ○ Identified stakeholders/access routes ○ Established method/levels of engagement
8. Problem Solving	TBE	Specialist external	**Wider determinants of health** ○ To identify the wider determinants of	

Session	Date	Provider	Development Aims	Objectives / Outcomes
		facilitator- Mike Grady	health and how they impact on health in the city o To establish how the group can impact and support decisions on wider determinants in supporting health, (e.g. social housing, planning and physical development, environment) o To identify local organisations/stakeholders that should understand wider determinants of health and how it can influence the city's health	o Understand wider determinants of health and how they are/can impact on health in the city. o Establish a strategy on how the group can start to influence and support decision in wider arena
9. Problem Solving	TBE	Specialist external facilitator	**Personal Health Budgets/Personalisation budgets** o To understand personal health budgets o To understand personalisation budgets o To identify opportunities for aligning budgets o Participate in a scenario sessions to support thinking on options of dealing with any issues and problems presented	o Understand Health Budgets/Personalisation budgets o Understand impact on the residents/city o Establish a way forward for dealing with potential Health budget issues
10. Problem Solving	TBE	Specialist external facilitator	**Urgent Care** o To understand urgent care o To establish uses and challenged in urgent care being faced by the City o To agree a way forward in jointly dealing with urgent care o Participate in a scenario sessions to support thinking on options of dealing with any issues and problems	o Understand urgent care in the city o Establish a joint view on dealing with urgent care in the city o Establish a way forward for dealing with urgent care issues

Session	Date	Provider	Development Aims	Objectives / Outcomes
			presented	
11. Problem Solving	TBE	Specialist external facilitator	**Service Redesign** ○ Confirm and Challenge identified health services ○ Identify services for redesign ○ Prioritise redesign services ○ Participate in a scenario sessions to support thinking on options of dealing with any issues and problems presented	○ Agree list of priority services in need of redesign ○ Agree how service redesigns will be taken forward ○ Establish a way forward for dealing with services that are in need of redesign.

Item No. 6

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **3 FEBRUARY 2012**

UPDATE ON THE JOINT STRATEGIC NEEDS ASSESSMENT PROCESS AND NEXT STEPS OF THE HEALTH AND WELLBEING STRATEGY

Report of Director of Public Health

1 PURPOSE OF THE REPORT

To provide board members with an update on the Joint Strategic Needs Assessment (JSNA) process currently underway

To set out the proposed next steps including outlining the development of the Health and Wellbeing Strategy.

2 BACKGROUND

Equity and Excellence: Liberating the NHS (July 2010) set out a vision of a new health and care system, shifting away from centrally driven targets, and focussing on putting patients and public first, delivering the outcomes that matter most to people, and strengthening accountability and local democratic legitimacy. These legislative changes set out the government's ambition for an enhanced role for the JSNA. This has been followed up by *Public Health in Local Government* (December 2011) which reiterates that the Government is returning responsibility for improving public health to local government for several reasons , namely their:

- Population focus
- Ability to shape services to meet local needs
- Ability to influence wider social determinants of health
- Ability to tackle health inequalities

The strengthened role of JSNA and joint Health and Wellbeing Strategy will enable democratically accountable Councillors, Clinical Commissioning Group General Practitioners and Directors of Public Health, Adult and Children's services to work with their communities in leading a more effective and responsive local health and care system. They will sit at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community. As such, they are key to the success of Health and Wellbeing Boards and individual commissioner's in the future local health and care system.

Although new statutory duties will not take effect until April 2013, activity in the next year of transition will be crucial for the development of the reformed health and care system. It is an opportunity to develop strong relationships, embed new ways of working, build on good practice, and agree priorities for the future before taking full responsibility for the day-to-day running of the system.

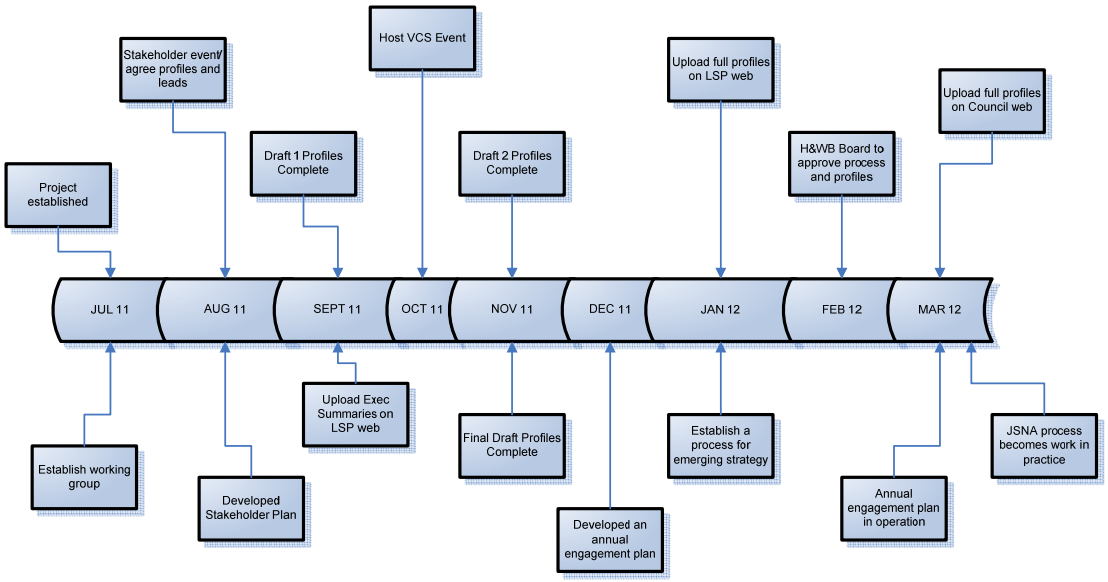
3 SUNDERLAND'S JSNA

During 2011 Sunderland TPCT and Sunderland City Council began the coproduction of a significantly refreshed JSNA using information from a variety of sources to establish the

needs of the Sunderland population in a single, ongoing process. This included quantitative data e.g. health care and local government statistics; information on current service provision, outcomes and value for money (where available), and qualitative data from a range of sources including patients, service users, carers, the public and service commissioners. This information is being analysed to identify:

- priority issues to be addressed to improve overall health and well-being
- areas to be addressed if we are to reduce inequalities locally, and
- priority actions that local agencies and partners need to address through commissioning decisions

The JSNA is delivering an enhanced version of profiles for Sunderland, more rounded and engaging of local people and services than the two previous iterations. The process was project managed by the Programme & Project Office which enabled the timeline (demonstrated below) for engagement and profile completion to be monitored more coherently.



The stages of the JSNA process for Sunderland included:

- review of all current (completed within last five years) needs assessments
- review of citizen and public engagement work by Council and TPCT
- stakeholder involvement
- engaging with communities
- linking with other strategic plans
- establishing a core set of profiles (linked to Sunderland Outcomes Framework)

4 STAKEHOLDER INVOLVEMENT

An initiation event was held in August predominantly for health and local authority staff to explain the new JSNA completion process (note: representatives from Sunderland Community Network, the Carers Centre and LINKs were also present). The event helped to identify the profiles and leads, identified from significant strands of our business for at

least the last 3-5 years, although recognising change in emphasis in some areas changed due to local performance and changing Policy Frameworks. The JSNA process has been identified as an iterative process which will change as the process and the profiles develop. The currently agreed profiles have been cross checked into the Sunderland Priority areas of People, Place and Economy across the life course and Lead Officers have been identified:

	Profiles	Leads
PEOPLE	Start in life (incl. parenting, breastfeeding, readiness for school)	Deanna Lagun
	Quality of life and emotional wellbeing	Gillian Gibson/Jackie Nixon
	Sexual health (including teenage pregnancy)	Lorraine Hughes
	Safeguarding Children & Adults	Meg Boustead
	Literacy and educational attainment	Sandra Mitchell
	Mental Health including dementia, including suicides, and improving support and recovery for people with mental illness	Jean Carter
	Social isolation & exclusion	Graham King
	Physical activity	Victoria French
	Supporting People to Live Independently including supported accommodation for socially disadvantaged individuals	Graham King
	Cancer, COPD, CVD	Nonnie Crawford, Gillian Gibson, Mark Overton
	Reducing/ preventing Substance Misuse	Ben Seale
	Obesity/Healthy Weight	Victoria French
	Tobacco	Julie Parker
	Preventing hospital admissions and Care Closer To Home	Jean Carter
	Life Expectancy	Gillian Gibson
PLACE	Access to services which impact on health/Healthy urban planning	Mike Poulter
	Homelessness, Hostels, Rough Sleeping and Migration	Alan Caddick
	Housing (Physical Condition)	Alan Caddick
	Accidents	Lorraine Hughes
	Low carbon	Janet Snaith
	Crime/perception of safety	Stuart Douglass
ECONOMY	Family, financial & household resilience	Vince Taylor
	Access to good quality work	Keith Moore
	Digital Inclusion	Tom Baker

The process also supports the review and alignment of Commissioning Plans and Service Plans for 2012/13 onwards as well as providing the underpinning for the development of the Health & Wellbeing Strategy. A stakeholder plan has been developed and is underway along with an annual engagement plan illustrating the planned ongoing work to keep the JSNA a 'live' document whilst recognising the balance required between needs assessment and action on prioritisation.

5 BROADER ENGAGEMENT

An event was held in October specifically for the Voluntary & Community Sector (VCS) with the main message being to raise awareness of the JSNA. Whilst the JSNA process has been in place since 2008, this was the first time a formal event was arranged to engage the VCS. The format of the event was planned with Sunderland Community Network and the 5 VCS Area Network Co-ordinators. Attendees were asked to share knowledge and information about health and wellbeing issues and the impact on people

within the community and to let us know what they, as organisations, do to support people across the City to have healthy and happy lifestyles and inform us over what barriers they face. A number of attendees requested more detailed discussions on specific JSNA profiles and this was followed up by policy officers from within the Council and the feedback passed to profile leads for inclusion in the profiles.

A workshop took place in November to specifically look at the demonstration of addressing requirements under the Equality Act and delivering Equality Impact Assessments which will underpin future decisions around commissioning and decommissioning of services. Profile leads have been asked to take this work forward with the support of the Equality Forums (previously the Equality Advisory Groups). This area of work is a major challenge for all and these have not been coherently delivered currently (3rd January 2012), but work will continue over the coming months to ensure that any profile area potentially under change will have an up to date assessment in place..

As well as attending the Sunderland Community Network to extend the process into the third and independent sectors all leads understood the need to consider how stakeholder views (user, carer, public) are included within their profiles - either by using what was already available from the significant range of engagement work carried out continuously by the Council, the LSP and Sunderland Partners, or by identifying where an enhanced approach was needed. The iterative nature of the JSNA process requires ongoing engagement work not just with communities of interest (eg VCS) but also across neighbourhoods and geopolitical communities (ie Area based).

In the new health and care system, Local Authorities will have the responsibility for undertaking the JSNA (and joint Health and Wellbeing Strategy, JHWBS) with challenge delivered through the Health and Wellbeing Board. Elected councillors, directors of public health, adult and childrens services and commissioning general practitioners will have critical roles to play. The JSNA will be a vital tool to support the Board to understand the needs of their whole community, and support collective commissioning action by local Partners to address those needs. By bringing together insights from communities with a range of high quality evidence and information, which could include other local assessments and non-health data, the Health and Wellbeing Board can make decisions on how best to meet those needs, through commissioning of joined up, integrated and appropriate services and by tackling the wider determinants of health. The JSNA process will also enable service users and the public to understand the factors that influence services in their area. Through the local political processes local people will be able to influence future decision making by their democratically accountable councillors

This will not be the only opportunity for the public to shape their services, as Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board will also be required to involve the public and service users in the planning of services or service change in the same way as current NHS commissioners are mandated. Health and wellbeing boards may wish to consider how other local Partners (e.g. Police, Foundation Trust, University) engage with the public and identify opportunities for alignment and rationalisation.

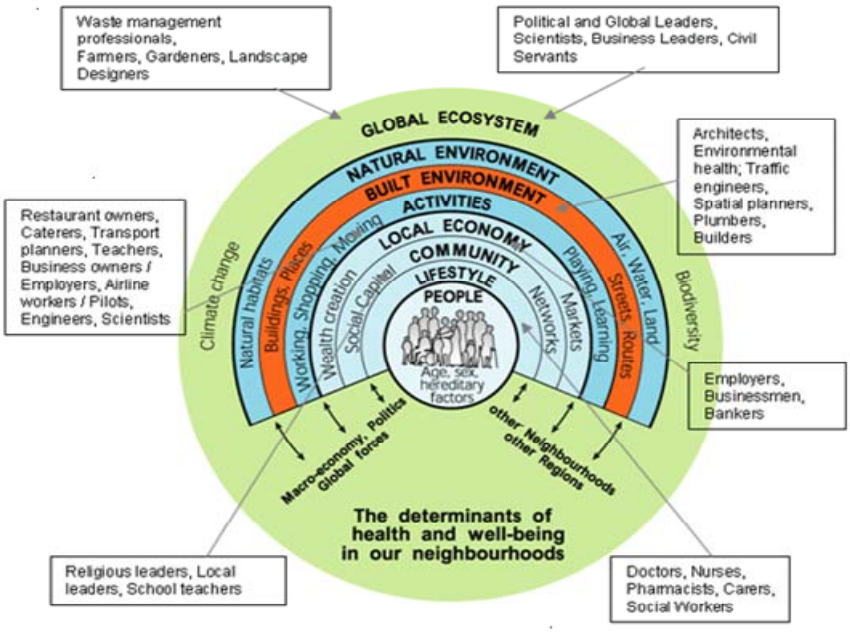
The Health and Wellbeing Board will have a continued duty to involve users and the public in the development of both the JSNA and the joint health and wellbeing strategy, and pay due regard to the Public Sector Equality Duty. This will strengthen local accountability, enabling health and wellbeing boards to work with the local community and partners to identify needs and assets, and to jointly decide and agree actions to address them and utilise their potential.

6 LINKING WITH OTHER STRATEGIC PLANS

In assessing needs and priorities, the Health and Wellbeing Board is likely to adopt an 'outcomes-based approach', considering how their influence will focus on improving the outcomes that matter most to and for their populations. It is also clear from the work currently underway in developing the JSNA that there are significant issues for people and communities which impact on how they interact with the services and systems we commission and it the balance of these impacts which then leads to the outcomes. Early assessment suggests that key issues are:

- personal experience of inequalities
- individuals level of choice & control over service delivery
- service integration & individuals navigation through pathways
- prevention and risk management across the lifecourse
- community and individuals engagement

The circular diagram below shows a depiction of the wider determinants of health and the annotated boxes describe some examples of how local players' actions in the areas integrate with Sunderland's Framework of People, Place and Economy.



This model will be built on for the development of the Health and Wellbeing Strategy, a timeline and process plan for which are included as Appendix 1.

7 ESTABLISHING A CORE DATASET

The Intelligence Hub within Sunderland City Council took responsibility for establishing a core dataset which complements the NHS dataset mandated by DH. Further analysis of the profiles is now identifying emerging themes including:

7.1 Inequalities

Recognition of life inequalities between Sunderland and England and within Sunderland wards remains a significant challenge

Most of the Profiles recognise as an underlying strand there are substantial inequalities, at least partly generated by the city's socio-economic demographics, across a range of outcomes for different communities (either geographical or communities of interest), including health and illness, causes of mortality, children's life chances, worklessness and economic prosperity between Sunderland and England, and within the city itself. The degree to which the gaps between Sunderland and England and within the city itself have closed is mixed: whilst outcomes, such as mortality rates for specific diseases have generally improved in the city, this is true of England as a whole and the 'gap' has not yet reduced. The need to reduce these inequalities and "close the gap" was highlighted in many Profiles as an area for improvement.

It should be noted, however, the city has several advantages that help it perform better than the England position in a number of areas, e.g. the city is rated as one of the safest in Northern England; and the higher degree of residents' satisfaction with local services. However, many of the Profiles report there may be future pressures in terms of the city's ability to continue to "close the gap" between Sunderland and England (see Significant Challenges).

7.2 Engagement

Recognition that some groups are particularly and multiply disadvantaged due to their life circumstances and their voice needs need to be heard
Most of the Profiles reflected the need to provide advice, information and support to specific groups of individuals and communities in a more meaningful and tailored way, more consistently (see Choice & Control). This is partly linked to tackling inequalities in Sunderland, e.g. one might expect a greater proportion of people from more deprived areas to make greater use of health and social care services, but there are communities of interest (e.g. those with disabilities) or geographical communities in which this is not demonstrably the case, or in which this services don't fully reflect the diversity of Sunderland's population. Some groups appear to be particularly at risk, and this includes families with children, with low incomes; children looked after and care leavers; people with life-limiting illness (including older people); and carers with significant caring burdens, all at risk of a range of poor life outcomes; older men at risk of chronic diseases due to their life circumstances.

There is a need to better reflect on how the needs identified in most of the Profiles fully reflects those all Sunderland's diverse population and what this means for equitable access to, and outcomes from, solutions, interventions and facilities. Furthermore, the process of completing the Profiles suggests the city needs to build on, and then maintain, its engagement mechanisms with residents and representative groups to become more inclusive in needs analysis and subsequent decision-making about commissioning and service improvement.

7.3 Prevention

Recognition of need to focus on greater level of prevention for individuals
Most of the Profiles in the People framework recognised there was a need for more preventative solutions to improve the life-chances of the population and vulnerable groups at risk. Some of the Profiles identified the need to encourage people to make personal changes in their or their families' lifestyles as part of a preventative agenda (see Choice & Control). Sometimes these preventative measures were associated with improving public-sector or Third Sector interventions to facilitate changes, e.g. provision of meaningful information, advice, practical support and/or facilities to help people make informed choices, e.g. in terms of welfare rights & advice, sex & relationships education

and self-directed choices about social care and support options for adults. Most of the evidence suggests that preventative strategies implemented earlier not only improve individuals' outcomes but are also more cost-effective than later, more complex interventions (e.g. admission to hospital or residential/nursing care).

Evidence from the Profiles suggests the city as a whole has a mixed record in successfully promoting a more preventative approach that best fits the underlying socio-economic demographics in the city as a whole.

7.4 Choice & Control

Recognition of the need for people to exercise greater responsibility in their and their family's lifestyles, but also individuals' desire to exercise greater choice & control over solutions available to them

Some of the Profiles identified the need to encourage people to make personal changes in their or their families' lifestyles, e.g. reducing alcohol consumption, taking more exercise, ensuring a healthier start in life etc. Several of the Profiles discuss the opportunities for people and communities to take a greater degree of control over the choices for their lives, acknowledging the critical role of the family and carers in continuing to provide practical and emotional support for children and vulnerable adults.

A common issue identified in many of the Profiles was the need to improve meaningful information and advice at the right time (through access channels shaped around individuals' preferences, which might include through a trusted source) to help people make informed choices about their lives, and to provide more consistent messages from professionals about the choices available to individuals, e.g. in terms of health/social care solutions; access to services etc. Several of the profiles commented on the relationship between improved choice and control over available solutions and resulting satisfaction with outcomes, e.g. in supporting people to live independently. These Profiles also commented on the challenges and opportunities greater control over solutions presents to commissioners and providers in terms of developing care markets to provide a greater range of diverse solutions to meet needs and preferences, e.g. need for availability of high-quality Personal Assistants in the city to meet demand; and resulting opportunities this brings in terms of supporting entrepreneurialism in the city.

7.5 Integration & Navigation

Recognition of need to better target interventions, often in closer collaboration with a range of partners, most consistently and make better use of existing assets in the community

The findings within the Profiles suggests there's a need to better target advice, information and practical support and interventions at specific individuals, including at a more preventative stage, with communication messages tailored around preferred access channels of these individuals. The degree to which specific issues captured in (predominantly People) Profiles are targeted at specific individuals is mixed; as a generalisation, there seems a need for better intelligence to support this targeting and better use of these results in terms of access, front-line operations and commissioning, e.g. targeting groups for smoking cessation; people at risk of hospital admission or falls; social exclusion etc., building on successes elsewhere.

Furthermore, evidence from most of the Profiles re-affirms the need for closer collaboration between a range of public, private and Third Sector partners to better deliver improved population outcomes (and potentially provide efficiencies) from a strategic, front-line and customer perspective. Examples include the need for improved

collaboration in terms of children's best start in life; safeguarding; care closer to home; social exclusion; and risk of homelessness.

7.6 Wider Life Determinants

Recognition of need to facilitate a preventative approach through improving outcomes of wider life determinants for individuals
Most of the Profiles across the People-Place-Economy framework recognised there was a greater need to improve wider life determinants for individuals and families. As with Choice & Control, the Profiles identified the need to encourage people to make personal changes, e.g. in terms of their aspirations for themselves and their families in terms of employment, reducing their carbon foot-prints or taking part in the life of the community.

However, there was recognition of the role of statutory agencies in facilitating or influencing partners to deliver these changes, e.g. providing accessible green spaces and health facilities locally, improving access to high quality housing, education and employment opportunities or perceptions of safety. The Profiles suggest the city has a generally good track record in facilitating such opportunities (most recently in terms of digital connectivity), but further consideration is needed about the extent to which all groups are able to benefit from these opportunities.

7.7 Future Challenges & Opportunities in the City

Recognition that there are significant challenges facing the city and its population over the years ahead
Most of the Profiles across the People-Place-Economy framework reflect on the challenges – but also the opportunities – facing the city over the next 5 years and beyond. Significant issues are associated with:

- *Impact of Economic Downturn and resulting uncertainty:* This is reflected in the future needs of the Profiles in terms of what it means for individuals, communities and organisations. For example, national research suggests the impact of Welfare Reform may disproportionately affect Sunderland more than many other England authorities. This, in turn, will affect a range of issues discussed in the Profiles, and could increase demand on services at a time of reduced funding for the public-sector (with a resulting impact on private and Third Sectors), e.g. mental health services; advice services; individuals' and families' at risk of homelessness, youth unemployment. However, it is important to reflect there will be different (and more positive) economic and employment opportunities in the city with some sectors projected to grow over time as part of the city's Economic Masterplan.
- *Technological Opportunities:* Several of the Profiles identify the improvements that might be brought about through technological development, both to improve individuals' health & well-being (e.g. Tele-Health and Tele-care) and to improve wider People-Place-Economy opportunities in the city, e.g. digital connectivity in the city; improving access channels.
- *Socio-Demographic Changes:* There are key demographic changes that will impact on the city in the longer-term. This includes the impact of the ageing population in the city, with an increased proportion of people aged 50+ in the city over the next 15 years. This is partly because people are generally living longer and are, at any given age, are healthier than previous generations, which is to be welcomed. However, the increase in the overall number of older people in the population has important consequences for the city (e.g. demands on health/social care provided; probably burden on carers; designing place around

the needs of this older population). Other social changes are likely to occur, e.g. reducing household sizes – and more people living alone – is likely to meet increased demands on different forms of housing; people wanting increasing choice over their care and support. Some of these changes are clearly gradual and long-term, though others impact more quickly, e.g. rising youth unemployment.

8 NEXT STEPS

In previous years and during 2011/12, Partners' processes for making commissioning decisions were not completely aligned (although the outcomes did align to the current Sunderland Strategy and to Partners strategic plans) Examples here are the TPCT Integrated Strategic and Operational Plan which links to key Council Work strands and the Safer Partnership's Strategic Information Assessment where we sought for a coherent approach to a limited number of priority areas within the five Responsible Authorities work programmes. During 2012/13 we will seek to strengthen the Sunderland Way of Working approach and deliver a comprehensive Sunderland Strategy refresh encompassing the priority areas for local Partners.

We have seen early progress in that the work undertaken to develop the JSNA in 2012 has already significantly influenced the development of the Sunderland Clinical Commissioning Group's Clear and Credible Plan, a fundamental requirement as part of their forward assurance process. This plan will come to the Board in early 2013

The coming years will see the continuation of a period of challenge for the City and all public, private, independent and voluntary sector partners in commissioning to achieve the desired Sunderland Outcomes Framework against a deteriorating financial and resource backdrop.

The Health and Wellbeing Board will wish to see alongside the JSNA, and underpinning the Health and Wellbeing Strategy, a clear prioritisation framework. This will allow them to consider and review partners' commissioning and decommissioning decisions and the impact they are likely to have on driving improved health and wellbeing outcomes and reduced inequalities. It will be essential that there are completed Equality Impact Assessments available for all areas where significant service change is deemed likely.

Members of the Board may wish to consider the prioritisation processes undertaken by the Safer Sunderland Partnership and is constituent members as a fundamental part of targeting the work programme for 2013 forwards. Consideration should be given to its inclusion within the Board Development Programme.

9 RECOMMENDATIONS

That the Health and Wellbeing Board

- approve the JSNA process undertaken
- approve publication of the profiles on Sunderland City Council website
- note the Health and Wellbeing Strategy development process and timeline
- Give consideration to the Safer Sunderland Partnership's Prioritisation processes within the Board Development Programme
- Review further work on prioritisation and equality impact assessment to underpin commissioning decision making during 2012 with particular reference to budgetary realignments which become unavoidable.

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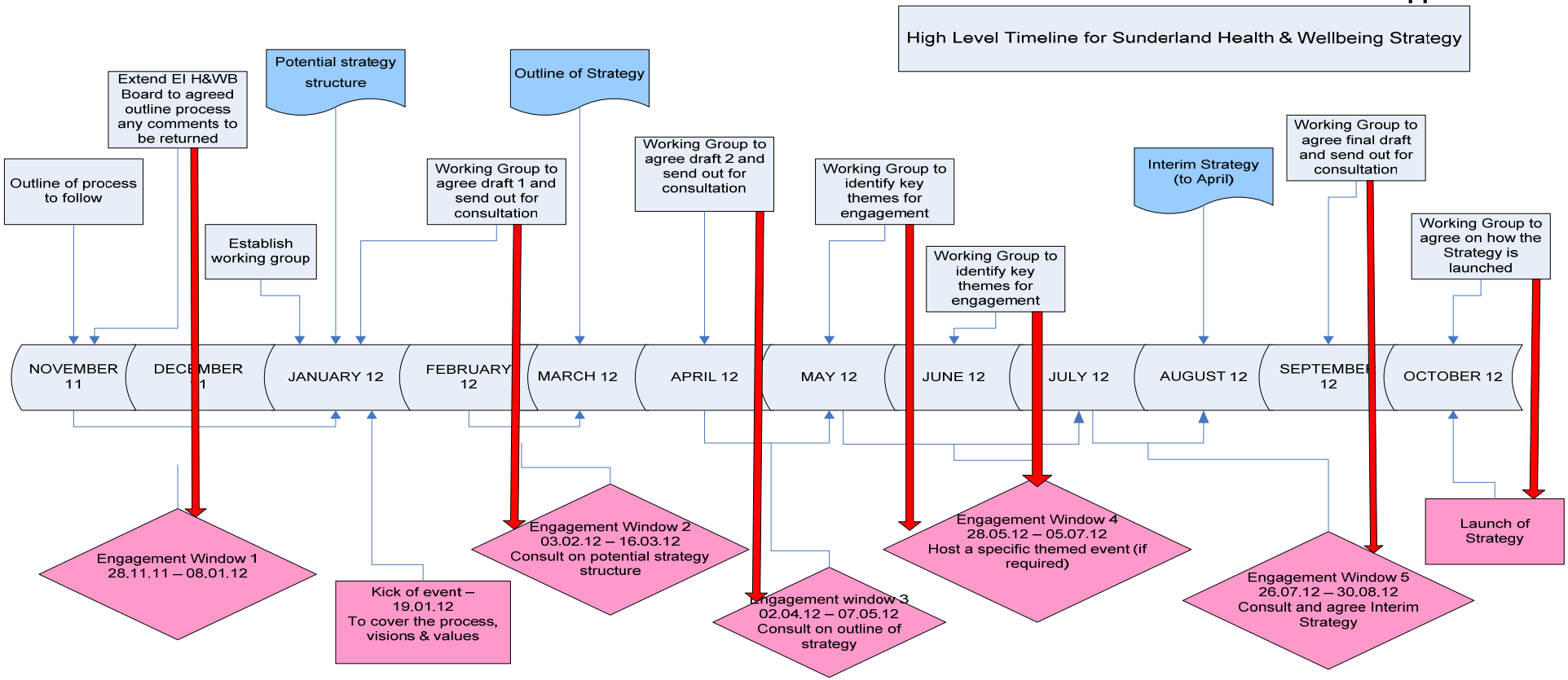
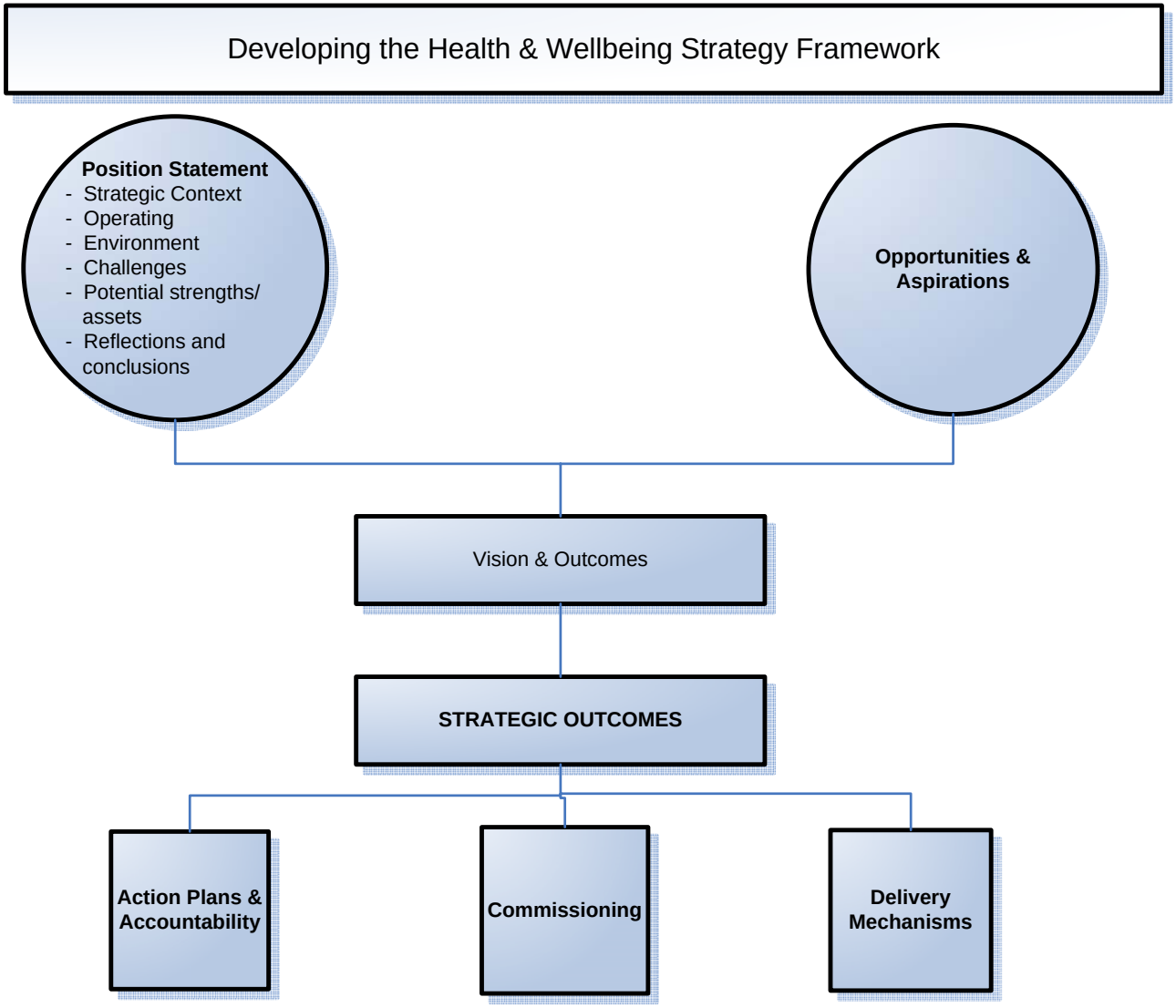
Appendix 1



Key:
Engagement Windows consist of the following :
- Meetings
- Events
- Emails
- Phonecalls
- Newsletters etc
- Ladder of engagement
- Community Spirit

The following Groups/Boards need to include the Strategy on their agenda throughout the process to give feedback and approval:

HWB Strategy Working Group	Officer Group
Voluntary/Community Sector Providers	Children's Trust
Adult Partnership Board	Transitional Executive Group
Sunderland Improvement Innovation Group (SIIG)	
Clinical Commissioning Group Board	Early Implementer HWB Board
EMT	Cabinet
Integrated Board	Scrutiny


Developing the Health & Wellbeing Strategy Framework
Position Statement
- Strategic Context
- Operating
- Environment
- Challenges
- Potential strengths/ assets
- Reflections and conclusions
Opportunities & Aspirations
Vision & Outcomes
STRATEGIC OUTCOMES
Action Plans & Accountability
Commissioning
Delivery Mechanisms

Item No. 7

REPORT TO THE EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **3 FEBRUARY 2012**

The Human Impact of Welfare Reform

1 Purpose

To provide the Health and Wellbeing Board and its advisory bodies with an update on the projected 'human impact' in Sunderland of the Governments Welfare Reform Programme, together with details of the Council led response to date

2 Background

The Governments Welfare Reform Programme is the biggest change to the welfare system in at least 60 years. It is intended to save 18 billion pounds per year by 2014-2015 but the main stated aim is to reduce benefit dependency and 'to make work pay' for more people.

The majority of changes therefore will impact on people of working age, with Pensioners being protected from the majority of the reforms. The changes may also be most likely to impact on the sick and the unemployed, especially those that remain sick and / or unemployed.

The programme also involves a major change in responsibilities in relation to administering benefits for those of working age, with councils losing responsibility for the current housing benefit system, but gaining responsibility for developing and implementing localised Council Tax Support and for providing support to vulnerable people in emergency situations (previously met by the Social Fund)

A number of changes have already been implemented with the majority of the rest due for implementation between now and 2013, however the specific detail for many of these is still to be developed, may still be subject to change, and transitional arrangements between the old and the new are expected to be in place in relation to some benefits for a number of years.

As outlined, proposals and impacts continue to be released; a report from the Family and Parenting Institute on 4 January 2012 has advised that the average income of households with children will drop by £1250 per year by 2015.

Work is underway to start to map the potential impact on the city however at this stage it's only possible to offer a snapshot. This picture will become clearer over time as we engage and work with partners and as more information because available from central government.

What is already known however is that whatever our local responses may be we are specifically prohibited from creating council policy and processes that would conflict with government policy.

To put this in context because of the scale and size of the changes, and the clear messages about working within government policy means all of our activity can only serve to mitigate the impact.

3 Projected impacts on individuals / families

People that remain within the revised benefit system are likely to face a number of negative impacts, although the effects of some of these may grow over time. They are likely to;

- Experience lower relative incomes , income growth and increasing relative poverty , when compared to people not receiving benefits (due to changes in how these increase annually (RPI – to CPI) , Benefit Cap and the requirement to meet more of their rent , mortgage and council tax costs from their benefit incomes) . Some may also face absolute poverty indicators – due to increasing benefit sanctions or homelessness
- Face restricted housing choices, be required to move more frequently and be at increased risk of rent arrears and/ or homelessness (due to lowering of private sector Housing Benefit levels, capping rents at the 4 bed roomed rate for larger families, increase in shared room rent age from 25 to 35, size related housing benefit rules being extended to the social housing sector, and help with mortgage interest payments being restricted). In addition extended families living within the same property are likely to face additional financial pressures due to an increase in non dependent deductions – reducing benefit that they would otherwise be paid
- Face additional pressures within their families. Child Care is likely to cost more in practice due to less financial help being provided towards these costs. Members of separated couples may not be able to afford accommodation for their children (for temporary stays due to Housing 'Benefit ' restrictions)
- Experience more financial difficulties / debt. Financial exclusion is reported to have grown against all measurable indicators over the last few years due to the economic downturn. Many people have used up the financial resources that they had – so any prolonged period spent on subsistence level welfare benefits is likely to make these problems worse.
- Require better budgeting skills / other skills in order to manage their benefits effectively. Benefit claims will be managed on line , will be paid monthly , be paid to one claimant in the family only, and include payment for housing costs
- Educational attainment may suffer where the families remain low income families or suffer sudden drops in income. There may be a pressure for some to relocate within the local authority area to cheaper accommodation which may mean their children moving schools more often. Children from poorer families may be less likely / willing to attend college due to more limited funding being available through the replacement for the Educational Maintenance Allowance. In addition the quality of parenting may suffer where the parents are themselves under significant financial pressure
- Be at increased risk of remaining workless. There are already more people chasing jobs than there are jobs available. Any increase in unemployed numbers due to a shrinking public sector, additional recessionary pressures together with more people

currently classed as sick being found fit for some work will make it harder for those already unemployed (or sick) to find suitable employment.

All of these projected impacts are likely to have a knock on effect on council and partner services and relevant joint strategies. Some of these are detailed in the next two sections and are highlighted in Appendix A.

4 Likely Impacts on Health Services

Welfare Reform is likely to exacerbate many people's existing financial pressures and worries. Many people will find their disposable income reducing dramatically due to, for example being found fit for work, losing their Disability Living Allowance or having to make up short falls in rent. For some of those that are unable to leave the benefit system for well paid employment there is likely to be an impact on emotional health and well being. Even those that do not actually lose benefit income may feel threatened by this potential loss of benefits and these threats are likely to last for a number of years.

Some of the impacts are likely to be;

- An increase in referrals to services helping people with mental ill health. There are clear linkages between financial pressures and indebtedness and poor mental health (and vice versa) and benefit changes are likely to add to these. In this area Mind have already reported a major increase in incoming referrals where financial issues have been a recorded factor
- An increase in referrals to GPs and from them to other NHS resources due to links between low income and some morbidity / mortality indicators. While causality is not always clear at best these ongoing changes may prevent some of these indicators improving
- That GPs and consultants also find an increased workload due to the need to provide their patients with supporting information for their claims and to challenge decisions
- That hospitals face increasing admissions due to illnesses with links to poor income, health and diet. Fuel poverty is also on the increase and will increase further in some groups due to welfare reform. It may also prove harder to discharge some people without there being adequate support in place – so bed blocking may increase.

The above are some of the projected impacts. Board Members and their respective organisations are likely to be able to identify more impacts and to support the work being undertaken to establish more accurately the actual impacts across the city.

5 Likely impacts on Social Care Services

Having a given level of income assists people to be more independent and often require less support from other organisations. Conversely reducing peoples incomes may have the opposite effect – especially for those that are unable to work or face limitations on what they can undertake. Some of the projected impacts are as follows;

- People less able to exercise effective choice and control – for example many people with learning disabilities and mental health problems face cuts to their sickness benefits and potentially to Disability Living Allowance (which may in turn prevent them helping to meet their own additional care and mobility needs)

- Carers will be under more pressure, especially where the person they care for loses their own benefits – with a potential knock on effect on Carers Allowance / Carers Premiums
- Crimes such as financial abuse may increase due to additional financial pressures being faced by many, which may make vulnerable people seem an attractive target
- Services that levy charges – even if these are financially assessed, may see numbers that use them reducing – or people that need them not taking them up. This may have a longer term cost in that some of these people may develop more complex needs and require expensive interventions earlier than they would otherwise have needed them
- Income streams that are relied on to help provide the support that some groups need are being reduced – impacting on what services it may be possible to provide in the future. For example the role and level of Housing Benefit payable in types of Supported Accomodation has just been subject to a consultation exercise
- More people will be approaching Voluntary and Community Sector organisations – including advice agencies, for help

Again these are just some of the projected impacts. Board Members and their respective organisations are invited to be able to identify more impacts and to support the work being undertaken to establish more accurately the actual impacts across the city.

This is very much as a city issue and it important to recognise that to maximise the mitigation of negative impacts there will need to be a coordinated approach to information sharing and the development of responses with partners; and work with partners is a high priority within the next phase of the Project Boards work programme

6 Council Welfare Reform Project Board

The Welfare Reform Programme is likely to have a significant and ongoing impact across Sunderland and on specific customer groups. The council is a major provider of services administers current local benefits to approximately 40,000 households and plays a key Community Leadership role by working in conjunction with its partners in order to improve the lives of Sunderland residents.

The council has in response formed a Welfare Reform Project Group chaired by Malcolm Page (Executive Director of Commercial and Corporate Services) to establish the scale of the changes, the likely impacts on residents, localities, services and those of its partners.

The Project principles and individual work streams are intended to result in;

- More accurate and comprehensive intelligence gathering and reporting – both within the council and to / from partners
- Delivery of support and appropriate interventions across the council and across the city (in conjunction with partners)
- Development of new and improved processes – that will also support the delivery of the councils new / changing responsibilities

It is important to understand that given the reasons for, and the scale of the changes being implemented, that the Welfare Reform Project Groups activity will not prevent many people still being worse off financially in future, with the resulting associated negative impacts.

As described earlier, much of the activity that will be undertaken by the board will lead to mitigation only, because of the clear instruction that council policy cannot conflict with government policy for example; localisation of council tax support must lead to making work pay.

7 Welfare Reform Project and Working Board Progress

The project has established a board with 11 initial work streams and leads (as detailed below) that will be reporting to it. The project and a number of individual projects will be influenced by and bring in a range of partner agencies and organisations as they develop over the coming months.

Work Stream	Lead
1. Preparation for the Introduction of Universal Credit	Fiona Brown (supported by Joan Reed)
2. Policy Changes and Impact and Analysis	Jane Hibberd
3. Impact on Council Services Performance and Outcomes	Ray Leonard
4. Working with Landlords	Elaine Bateman
5. Single Financial Assessment and Benefit Take –up	Joan Reed
6. Community Care Grants and Crisis Loans	Fiona Brown
7. Increased Demand for Work	Lee Cranston
8. Independent Living Charging	Richard Elliott
9. Design and Implementation of the Localisation of Council Tax	Howard Middlemiss
10. Housing Policy and Alignment	Alan Caddick
11. Assumed consent for school meals	Raj Singh / Fiona Brown

Progress has already been made against a number of these individual work streams already and the following examples highlight some of the work undertaken to date.

7.1 Update - Work Streams 2 / 3

Initial activity by the councils Strategy, Performance and Policy Team indicates that there will be a net direct income loss in the city of £54 million for the period 2011-2013, due to changes due to Disability Living Allowance, Incapacity Benefit, and Job Seekers Allowance and to Tax Credits. This is an initial finding only and work is ongoing in respect of challenging and improving underpinning assumptions to enable these figures to be validated, and also so that further impacts due to multiple benefit changes, can also be accurately assessed in the future

Work stream 3 also involves consultation and engagement with local, regional and national stakeholders to develop a wider understanding of these impacts across all services and to enable agreed approaches to be developed. This work is likely to include;

- Identifying impacts on the economy, health, social care, community cohesion etc. Developing a communications strategy – and sharing the above information
- Ensuring that partners important roles in supporting residents are understood and supported where possible
- Providing a joined up approach for government lobbying

Together these work streams will help shape the development of the whole welfare reform project by;

- Ensuring that all organisations are able to feed into the information gathering processes and receive relevant project outputs – for example consistent and co-ordinated information being produced
- Adding value to what individual services may be able to achieve in isolation
- Helping services achieve maximum reach

7.2 Work stream 3

Advance intelligence has also enabled a number of services to respond to one of the Housing Benefit Changes. Just over 800 Single residents under 35 in private accommodation face a average £43 drop in Housing Benefit from January 2012 onwards due to a shared room rent being applied to them (instead of to under 25s as previously) .

The council and Job Centre plus worked together to respond to the change with letters being sent out from October onwards to all affected residents ,advising them of the changes , and asking them to contact the Access to Housing Team and /or apply to the Benefit Service for a Discretionary Housing Payment.

7.4 Work Stream 11

Taking forward increased free school meal take up is being delivered in conjunction with the Child and Family Poverty Board. The activity will maximise funding through the Pupil Premium into Sunderland Schools and ensure that all eligible children and young people have the opportunity to access free school meals through an assumed consent arrangement.

To enable this a number of council services have worked together during December 2011 to data match and identify where there were ‘gaps’ in free school claimants. To date this has resulted in over 800 additional children being eligible for free school meals

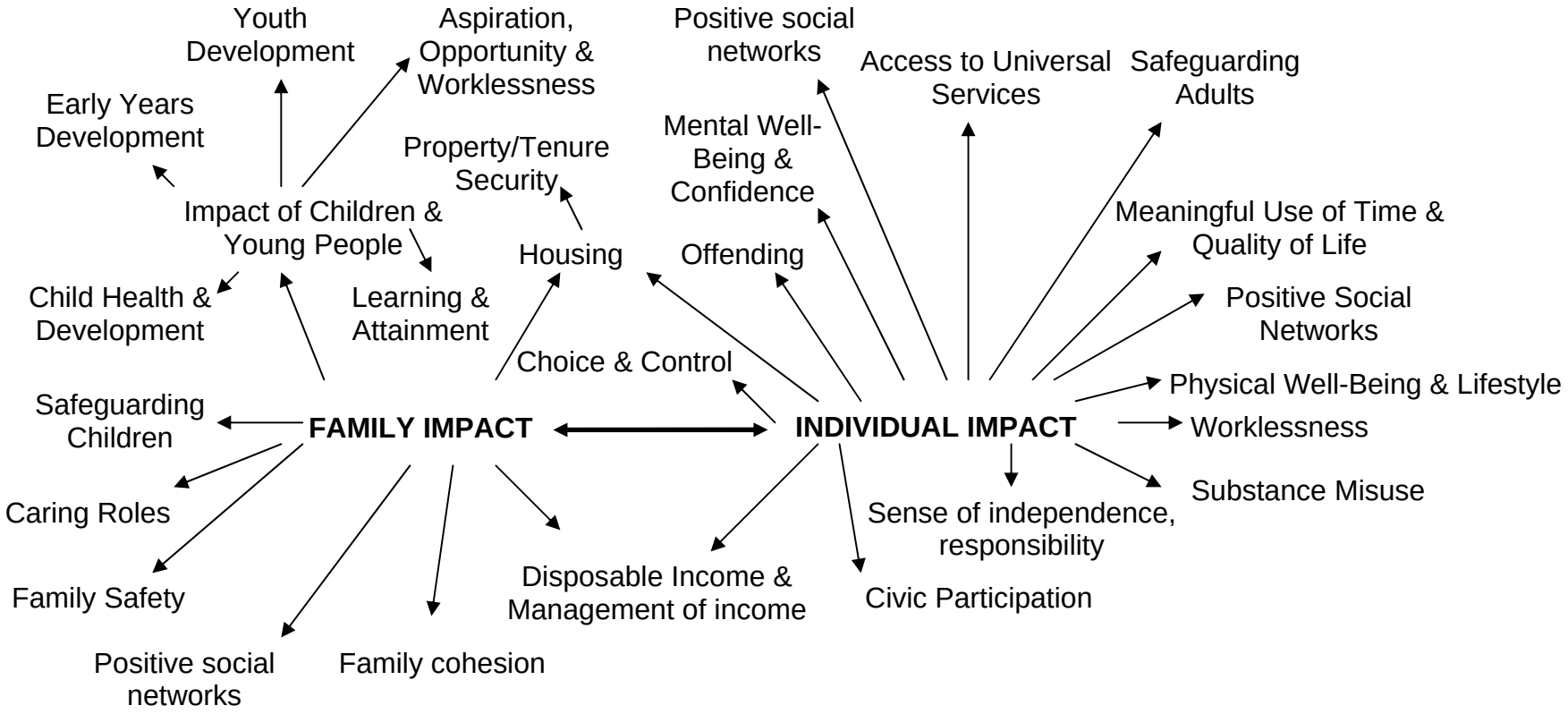
8 Next Steps

The intention is for the Welfare Reform Project Group to involve partners / stakeholders to help influence this ongoing work and city wide responses.

This report is provided for comment and to enable partners to become increasingly involved in the future. This could be for example in relation to;

- Helping to identify impacts of Welfare Reform for their own services / for their own customers
- Informing their individual organisations responses to these changes
- Helping to mitigate impacts by working together on developing / implementing solutions

APPENDIX A


Youth Development
Aspiration, Opportunity & Worklessness
Positive social networks
Access to Universal Services
Safeguarding Adults
Early Years Development
Property/Tenure Security
Mental Well-Being & Confidence
Meaningful Use of Time & Quality of Life
Impact of Children & Young People
Housing
Offending
Positive Social Networks
Child Health & Development
Learning & Attainment
Choice & Control
Physical Well-Being & Lifestyle
Safeguarding Children
FAMILY IMPACT
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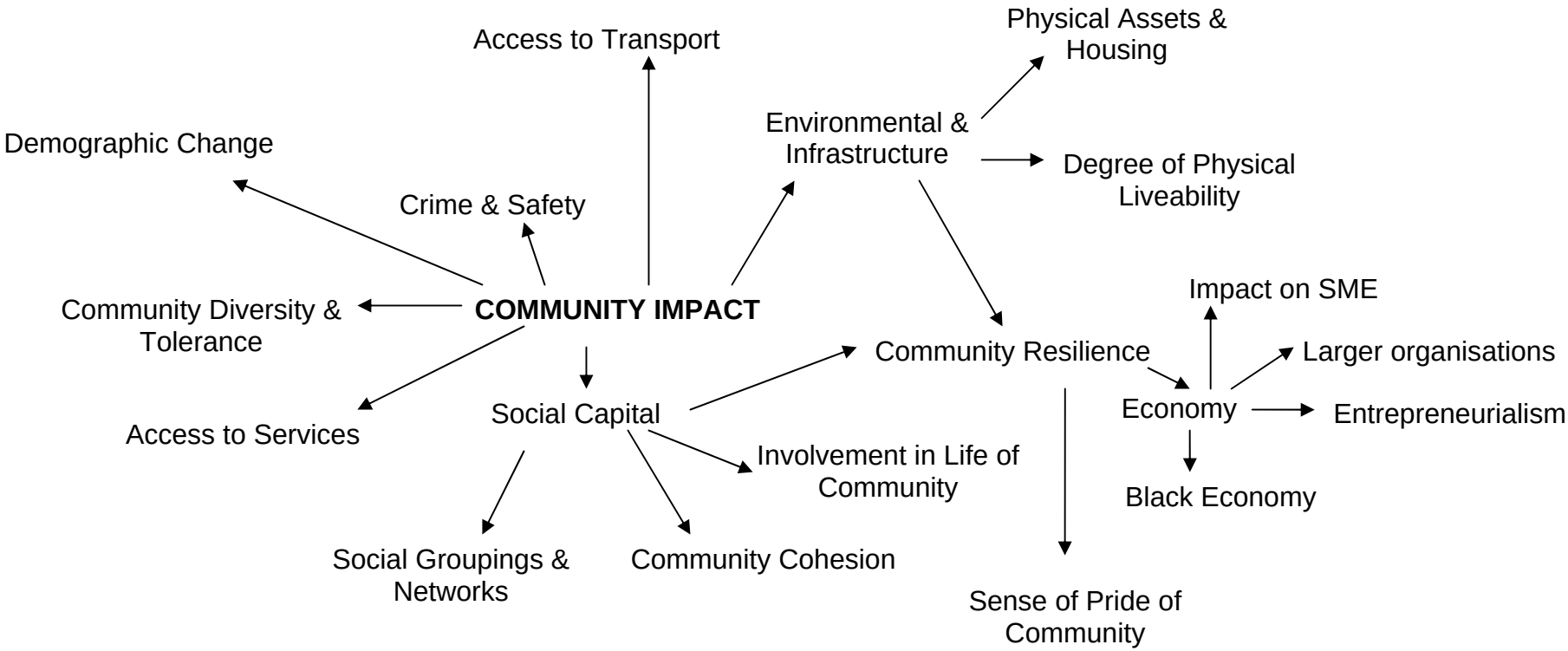
Caring Roles
Sense of independence, responsibility
Family Safety
Disposable Income & Management of income
Civic Participation
Positive social networks
Family cohesion


Access to Transport
Physical Assets & Housing
Demographic Change
Environmental & Infrastructure
Degree of Physical Liveability
Crime & Safety
Impact on SME
Community Diversity & Tolerance
COMMUNITY IMPACT
Community Resilience
Larger organisations
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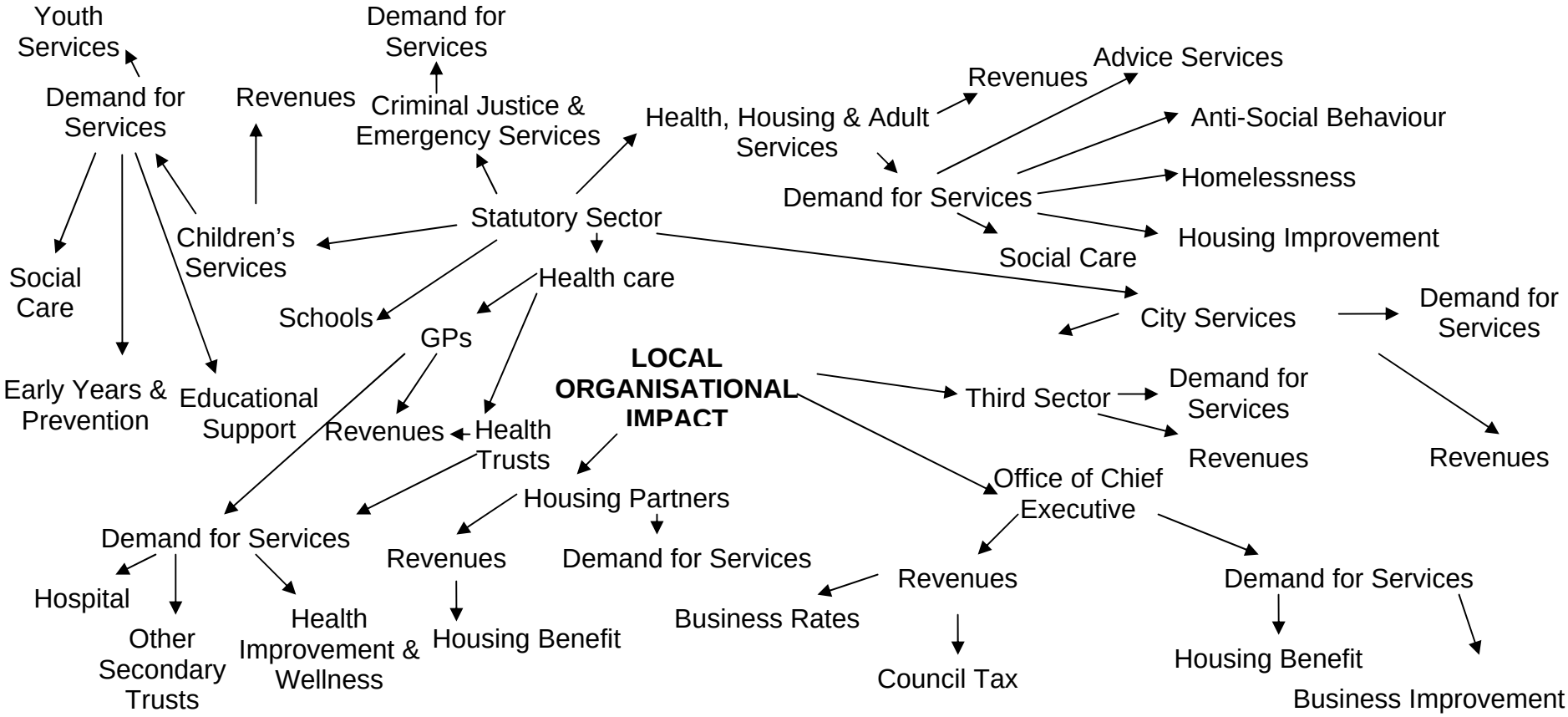
Economy
Entrepreneurialism
Involvement in Life of Community
Black Economy
Social Groupings & Networks
Community Cohesion
Sense of Pride of Community


Youth Services
Demand for Services
Demand for Services
Revenues
Criminal Justice & Emergency Services
Health, Housing & Adult Services
Revenues
Advice Services
Anti-Social Behaviour
Homelessness
Housing Improvement
Social Care
Demand for Services
Children's Services
Statutory Sector
Social Care
Schools
Health care
GPs
City Services
Demand for Services
Early Years & Prevention
Educational Support
LOCAL ORGANISATIONAL IMPACT
Third Sector
Demand for Services
Revenues
Revenues
Revenues
Health Trusts
Office of Chief Executive
Housing Partners
Demand for Services
Revenues
Demand for Services
Revenues
Demand for Services
Hospital
Other Secondary Trusts
Health Improvement & Wellness
Housing Benefit
Business Rates
Council Tax
Housing Benefit
Business Improvement

Item No. 8

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **3 February 2012**

TRANSITION FROM EARLY IMPLEMENTER TO SHADOW BOARD

Report of the Assistant Chief Executive

1.0 Purpose of the Report

1.1 The purpose of the report is to set out the next stages to transition from an Early Implementer Health and Wellbeing Board to a Shadow Board in Sunderland.

2.0 Background Information

2.1 The reform of the public health in terms of statutory changes will take place from 1 April 2013 subject to the passage of the Health and Social Care Bill. The formal transfers of statutory responsibilities to the local authority aligns with this timetable where the lead for improving health and co-ordinating local efforts to protect the public's health and wellbeing and ensuring health services effectively promote population health. Local political leadership will be central to making this work.

2.2 In June 2011 it was agreed through Cabinet that an Early Implementer Health and Wellbeing Board be established. This has allowed Sunderland to trail new working arrangements before transitioning into shadow form in 2012 and then subject to Parliamentary approval, the establishment of a formal Health and Wellbeing board in 2013.

2.3 The existing terms of reference for the Early Implementer Board are:

- To assess the broad health and wellbeing needs of the local population and lead the statutory joint needs assessment (JSNA)
- To develop a new joint high-level health and wellbeing strategy (JHWS) that spans NHS, social care, public health and potentially other wider health determinants such as housing
- To promote integration and partnership across areas through promoting joined up commissioning plans across the NHS, social care, public health and other local partners
- To support/lead commissioning, integrated services and pooled budgets
- To ensure a comprehensive engagement voice is developed as part of the implementation of Health Watch.

2.4 For the ongoing development of the board consideration is also being given to the following:

- The Board will be responsible for overseeing significant improvement in outcomes as a result of joint planning and commissioning of services across agencies.

- The Board brings together the priorities to make change but it is the responsibility of constituent bodies to ensure these priorities are taken through their own governance arrangements.
- To prioritise and monitor the implementation of the themes identified in the Board's strategy and supporting strategies;
- To request regular assessment of needs in the area, identify shared priorities for action and specific outcomes on the basis of those needs and to develop and comply with appropriate information sharing arrangements;
- To recommend the commissioning of services, resource allocation to achieve the outcomes and indicators set out in the aims of the Board through the prioritisation and recommendation of proposals in the constituent partners' budget setting rounds;
- To commission and receive reports from standing sub groups and task groups to take up additional work on research of policies, service improvement and local needs;
- To ensure that there is active user and public involvement in decision-making and developments of services;
- To ensure that all initiatives are carried out in a framework that promotes equalities and celebrates diversity;
- Ensure that activities promote a positive image of the City, the Partnership and the local community;
- To support and influence service developments and change that enhance the general well being of the City;
- Ensure objectives are reflective of the objectives set out by Sunderland Strategy
- Invite appropriate representatives and bodies to give evidence

3.0 Progress Made to Date through the Early Implementer Board

3.1 In relation to the key terms of reference initial work has begun based around the development of the board (including the alignment of the Children's and Adults boards); the assessment of need analysis and the commencement of work both on the Health and Wellbeing Strategy and the development of Health Watch. National guidance is being published on an intermittent basis which is helping to ground many of the initiatives in a wider strategic context.

3.2 The work through the North East Wellbeing and Health Leadership Academy to evaluate progress made in the wider health and wellbeing agenda will also be invaluable to help shape the transition from Early Implementer to Shadow Board status.

3.3 The Development sessions planned for the Board will also help to shape the future role of the Board and enhance the current Terms of Reference as well as assisting to develop the relationships, competencies and structures necessary to operate as an effective shadow board from June 2012. Planned sessions that are relevant include:

- Achieving a shared vision of health and wellbeing and the role of the board (linked to the development of the strategy) – defining role of board moving forward
- Building good governance for health and wellbeing – governance arrangements and clarification of relationships and links to both local and national boards and networks and constitutional position in advance of the formation of a statutory board
- To develop a joint approach to Priority Setting through an understanding of what the health priorities are for the city including what the competing and/or joint priorities of the City are from Board members
- Establish methods that will enable a clear communication, influencing and decision making process with Sunderland other key strategic groups To develop an understanding of joint commissioning to include: Current commissioning practice/models, challenges and benefits and risks
- To explore the engagement of Public Sector/VCS/ Residents/providers and agree methods.

3.4 This is also being complemented with work being done with both the Adults and Children's boards to consider future development and improvement of arrangements.

4.0 Proposals for Transition

4.1 It is proposed that the work undertaken by the North East Wellbeing and Health Leadership Academy and the developmental sessions help shape the format of the Shadow Health and Wellbeing Board and that formalised proposals go to Cabinet in June for approval after the elections processes in May.

4.2 A key element of this transition will be the need for more formalised Terms of Reference which are attached at **Appendix 1** in draft format. It is the intention that these are consulted upon with key stakeholders including the Adults and Children's' boards as well as being discussed at the board's developmental session in March

5.0 Recommendations

5.1 To agree to the proposals in Section 4 and the development of a Cabinet Report for the June 2012 cycle for formal approval.

5.2 To provide nominations onto the working group to finalise the Terms of Reference for the Board and Advisory groups.

Appendix 1

Sunderland Shadow Health and Wellbeing Board –
Draft Terms of Reference

1. **Conduct.** Members of the Board are expected to subscribe to and comply with any Code of Conduct applicable to them.

2. **Frequency of Meetings.** The Board shall meet at least quarterly. The date, hour and place of meetings shall be fixed by the Board.

3. **Meeting Administration.** Board meetings shall be advertised and held in public and be administered by the Council. The Council shall give at least five clear working days' notice in writing to each member for every ordinary meeting of the Board, to include any agenda of the business to be transacted at the meeting. Papers for each Board meeting will be sent out five working days in advance. Late papers will be sent out or tabled only in exceptional circumstances.

The Board shall hold meetings in private session when deemed appropriate in view of the nature of business to be discussed. The Chair's decision on this matter shall be final.

Apart from those meetings held in private session, a period of 15 minutes at the start of each meeting shall be set aside for members of the public to address the Board on matters within the purview of the Board.

4. **Special Meetings.** The Chair may convene special meetings of the Board at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

The Chair will be required to convene a special meeting of the Board if s/he is in receipt of a written requisition to do so signed by no less than [three] of the [Constituent Members/members] of the Board. Such requisition shall specify the business to be transacted and no other business shall be transacted as such meeting. The meeting must be held within seven days of the Chair's receipt of the requisition.

5. **Minutes.** The Board shall cause minutes of all of its meetings to be prepared recording:
a) The names of all members present at a meeting and of those in attendance
b) Apologies
c) Details of all proceedings, decisions and resolutions of the meeting.

These minutes shall be printed and circulated to each member before the next meeting of the Board when they shall be submitted for the approval of the Board. When the minutes of the previous meeting have been approved they shall be signed by the Chair.

6. **Chair.** The Leader of the Council will chair the board without a timeframe attached.

7. **Absence of Members and of the Chair.** If a member is unable to attend a meeting, then the relevant Constituent Member shall, where possible, provide an appropriate alternate member to attend in his/her place.

8. **Voting.** All matters to be decided by the Board shall be decided by a simple majority of the members present, but in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

9. **Quorum.** Five Constituent Members/members shall form a quorum for meetings of the Board. No business requiring a decision shall be transacted at any meeting of the Board which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chair shall either suspend business until a quorum is re-established or declare the meeting at an end.

10. **Adjournments.** By the decision of the Chair of the Board, or by the decision of a majority of those present at a meeting of the Board, meetings of the Board may be adjourned at any time to be reconvened at any other day, hour and place, as the Board shall decide.

11. **Order at Meetings.** At all meetings of the Board it shall be the duty of the Chair to preserve order and to ensure that all members are treated fairly. S/he shall decide all questions of order that may arise.

12. **Suspension/disqualification of Members.** At the discretion of the Board, any Constituent Member may be suspended from the Board or disqualified from taking part in any business of the Board if it:

a) Fails to provide a representative member to attend at least three meetings of the Board in any year, without leave of the Chair;

b) Their representative(s) conducts her/himself in a manner prejudicial to the best interests of the Board and its objectives, and the Constituent Member refuses to appoint an alternate member to attend in her/her place.

13. **Authority.** The Board may seek any information it requires from any employee of a Constituent Member and all Constituent Members and members are directed to co-operate with any reasonable request made by the Board.

The Board may obtain independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The costs, if any, of obtaining such third party advice shall be shared among the constituent organisations as agreed between them.

The Board shall receive written and oral evidence from senior staff, and other partners, as appropriate. The Board shall seek to ensure there is an

acceptable balance between the value of the information it receives and the time and other costs it takes to acquire and process it.

14. **Review.**
There shall be an annual review of these terms of reference and the effective working of the Board.

15. **Duties.**
The following shall be the core duties of the Board:

- To assess the broad health and wellbeing needs of the local population and lead the statutory joint needs assessment (JSNA)
- To develop a new joint high-level health and wellbeing strategy (JHWS) that spans NHS, social care, public health and potentially other wider health determinants such as housing
- To promote integration and partnership across areas through promoting joined up commissioning plans across the NHS, social care, public health and other local partners
- To support lead commissioning, integrated services and pooled
- To ensure a comprehensive engagement voice is developed as part of the implementation of Health Watch.

The following will be the additional responsibilities of the board:

- The Board will be responsible for overseeing significant improvement in outcomes as a result of joint planning and commissioning of services across agencies.
- The Board brings together the priorities to make change but it is the responsibility of constituent bodies to ensure these priorities are taken through their own governance arrangements.
- To prioritise and monitor the implementation of the themes identified in the Board's strategy and supporting strategies;
- To request regular assessment of needs in the area, identify shared priorities for action and specific outcomes on the basis of those needs and to develop and comply with appropriate information sharing arrangements;
- To recommend the commissioning of services, resource allocation to achieve the outcomes and indicators set out in the aims of the Board through the prioritisation and recommendation of proposals in the constituent partners' budget setting rounds;
- To commission and receive reports from standing sub groups and task groups to take up additional work on research of policies, service improvement and local needs;
- To ensure that there is active user and public involvement in decision-making and developments of services;
- To ensure that all initiatives are carried out in a framework that promotes equalities and celebrates diversity;
- To ensure that activities promote a positive image of the City, the Partnership and the local community;
- To support and influence service developments and change that enhance the general well being of the City;

- To eensure that objectives are reflective of the objectives set out by Sunderland Strategy;
- To invite appropriate representatives and bodies to give evidence

Note: The Health and Wellbeing Board will not have a scrutiny function, which will be retained by the Health and Wellbeing Scrutiny Committee.

16. **Draft Membership of the Shadow Health and Wellbeing Board.**

Leader of the Council (Chair)
Cabinet Secretary
Health and Wellbeing Portfolio Holder
Children and Young People Portfolio Holder
Opposition Member
Executive Director of Health, Housing and Adults
Executive Director for Children's Services
Executive Director for City Services
Director of Public Health (Joint Appointment)
Sunderland PCT
Chief Executive or his/her nominee
Clinical Commissioning Forum
Chair Clinical Commissioning Forum
Member Clinical Commissioning Group
LINk /Healthwatch
Chair of Healthwatch Transition project*
Healthwatch from April 2013 – arrangement for shadow board to be agreed

* patient and public voice
HealthWatch will have a statutory place on the Health and Wellbeing Board representing the patient and public voice. The commencement date for HealthWatch has now been deferred from October 2012 to April 2013.
The current arrangement is that the Lead for the HealthWatch Transition project is a co-opted member of the HWBB representing the transition work but not the patient and public voice.
Due to the delay in implementation of HealthWatch consideration is required to establish the patient and public voice on the Shadow HWBB

Note
To add in the Advisory Boards Terms of Reference and Membership too at a later stage

Item No. 9

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **3 February 2012**

UPDATE ON PUBLIC HEALTH TRANSITION

Joint report of the Director of Public Health and Assistant Chief Executive

1.0 Purpose of the Report

The report provides an update on the recent publications by the Department of Health in relation to health reform and the implications for the transition of public health in Sunderland and details of the outline timetable and draft transition planning process.

2.0 Background Information

The public health white paper *Healthy Lives, Healthy People,* published in November 2010*,* set out the context of why change is required: that nationally there are significant challenges to the public's health. Rising levels of obesity, misuse of drugs and alcohol, high levels of sexual transmitted disease and continuing threats from infectious disease have a heavy cost in health, life expectancy and a large economic burden through costs to the NHS and lost productivity. Improving public health and developing sustainable services is viewed as a key contribution to meeting the challenges to the public finances.

The programme of reform for public health centres on the principles of:

- strengthening local action,
- supporting self-esteem and behavioural changes,
- promoting healthy choices and
- Changing the environment to support healthier lives.

In December 2011 the new Public Health scheme was published which sets out at a high level how the whole public health system will operate. This includes:

- Local government taking the lead for improving health, co-ordinating efforts to protect health and ensure health services promote health
- A new executive agency of the Department of Health, Public Health England, to integrate service delivery, provide public health leadership and support development of the specialist and wider public health workforce.
- The NHS continuing to play a full role in public health, providing care, tackling inequalities and ensuring every contact counts.
- The Department of Health will set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities.

2.1 Public health in local government

The Government is returning responsibility for improving public health to local government because of their unique potential to transform outcomes through their:

- population focus
- ability to shape services to meet local needs
- ability to influence wider social determinants of health
- ability to tackle health inequalities.

Local authorities are leading for public health and will have a new duty to improve the health of their population. They will have responsibility for commissioning across 21 defined areas (see Appendix 1), supported by a ring-fenced grant, and five of those areas have been deemed mandatory:

- Commissioning of sexual health services (further consultation underway on whether terminations included)
- Coordination role for DPH in relation to local population health protection plans
- Population healthcare advice to the NHS (commissioners of healthcare services provided by the NHS)
- Commissioning delivery of NHS Healthchecks Programme
- Facilitating delivery of the National Child Measurement Programme

Local authorities will employ directors of public health who will occupy key leadership positions. Directors of public health will have a role across all three domains of public health. Local government will also be responsible for establishing health and wellbeing boards to coordinate Joint Strategic Needs Assessments and plans to address them.

An initially ring-fenced public health grant will support local authorities in carrying out their new public health functions. There will be shadow allocations established for local authorities for 2012/13 to help them plan and prepare for taking on formal responsibility in 2013/14.

2.2 Public Health England's operating model

Public Health England (PHE) will be a new, integrated and expert public health service to support the new public health system. Details are very high level and there is acknowledgment that there is more detailed work to do to design PHE. Its three key functions will be:

- Delivering services including specialist public health services, and information and intelligence service and supporting the commissioning and delivery of health and care services and public health programmes.
- Leading for public health by encouraging transparency and accountability across the system and supporting public health policy development and building the evidence base.
- Developing the workforce by supporting the development of the specialist and wider public health workforce.

2.3 A focus on public health outcomes

In terms of the new Public Health scheme the focus will be on outcomes. A new Public Health Outcomes Framework was published on 23rd January and set out key indicators of public health from the wider determinants of health through to effectiveness in reducing premature mortality. The overall goals will be to increase life and healthy expectancy and reduce health inequalities. The Public Health Outcomes Framework is aligned with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework and identifies future work that will be carried out e.g. to align a broader range of Childrens Outcomes.

2.4 The public health workforce

There is also further information on the importance of the current extended public health workforce and the acknowledgment that delivering health improvement is part of "everyone's business".

The DH has published an HR Concordat and Frequently Asked Questions document establishing key principles to assist people transition. A 'Building the PHE People Transition Policy' will be published in January. The final People Transition Policy will follow formal agreement to the new terms and conditions. The broader workforce strategy will be subject to specific consultation during 2012.

The DoH and Local Government Association published more detailed guidance on workforce transition in January 2011. Within the paper it is clear that PCT clusters will retain statutory responsibilities for their existing functions until formal abolition on 31 March 2013. It is expected that local areas will want to agree arrangements for local authorities to manage health functions during the transition year. Additional elements of the time line include:

- agree arrangements on public health information requirements and information governance by September 2012
- test arrangements for the delivery of specific public health services, in particular screening and immunisation by October 2012
- test arrangements for the role of public health in emergency planning, in particular the role of the Director of Public Health and local authority based public health by October 2012
- ensure an early draft of legacy and handover documents is produced by October 2012
- ensure final legacy and handover documents are produced by January 2013
- agree arrangements for local authorities to take on public health functions – date for local determination.

3.0 Local Authority Transition Planning Process

The Department of Health has developed a single transition process that is applied to each of the Strategic Health Authority (SHA) clusters. Guidance was provided to each SHA. The draft national timetable is set out below:

Date in 2012	Action
Fri 27 Jan	SHA clusters make initial submissions for 2012/13 to David Flory cc Performance Delivery Team contact at DH
Mon 31 Jan – Wed 8 Feb	First cut analysis of data and submissions by DH & internal DH meetings to discuss plans
Thurs 9 Feb – Fri 30 Mar	DH and SHA cluster discussions and feedback on progress of plans
31 Mar	All contracts expected to be signed off
Thurs 5 Apr	SHA clusters make final submissions for 2012/13
Tues 10 Apr – Fri 20 Apr	Analysis of plans by DH & internal DH meetings to discuss plans
Wed 25 Apr – Fri 4 May	David Flory meetings with SHA clusters to sign off plans with formal sign off letters being issued shortly afterwards. Meetings will combine a look back at 2011/12 together with forward look

For the North East (as part of the North of England grouping which now covers the North East, North West and Yorkshire and Humberside) NHS North of England requested that each PCT provided their initial overview of transition planning in advance of the first deadline of the 27th of January. There will have been two days of challenge of high level NHS transition plans on the 19th and 20th of January in order to provide assurance to the Regional Director of Public Health that work programmes which will deliver successful transition are underway and which meet the requirements of NHS Planning Guidance issued in December 2011.

Within Sunderland, the DPH and her senior team have been working closely with the Assistant Chief Executive and an internal PH transition team cover the last three months to progress the necessary workstreams using standard operating policy and design models. An NHS South of Tyne and Wear transition meeting with all three local authorities took place on the 23rd of January where a number of issues and risk areas were discussed.

Attached in **Appendix 1** is the completed Public Health Transition Planning Assurance table for Sunderland which was required for the January deadline.

4.0 Recommendations

To note the progress on the transition of public health in Sunderland and provide any comments to support the more detailed transition planning.

To agree that formal reports on public health transition be taken to the PCT and Council decision-makers and providing any other suggestions for sign off.

Sunderland TPCT/City Council

RAG rating criteria

Criteria not met. No actions identified as to how requirement will be met by April 2012./Guidance awaited

Criteria partially met. Actions identified to fulfill requirement by April 2012.

Criteria Met/Actions completed

Public Health Transition Planning Assurance 2011-13

Objective	Ref no.	Requirement	Evidence of Assurance	Is assu		
				YES	NO	Partially
Ensuring a robust transfer of systems and services	**1.1**	Is there an understood and agreed (PCT cluster/LA) set of arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013?	PHTP 1A and Appendix 1 Sunderland Operating Model-SR			**X**
	1.2	Is there a clear local plan which sets out the main elements of transfer including functions, staff and commissioning contracts for 2013/14 and beyond?	PHTP 1B and Appendices 1-3	**X**		
	1.3	Are there locally agreed transition milestones for the transition year, 2012/13?	PHTP page 5 and throughout			**X**
	1.4	Is there a clear local plan for developing the JSNA in order to support the H&WB strategy?	PHTP 1D Sunderland LSP Website and Minutes of H&WB Meeting December, Agenda for EIH&WB February	**X**		

	1.5	Is there a clearly developed plan for ensuring a smooth transfer of commissioning arrangements for the services described in*Healthy Lives, Healthy People* that Local Authorities will be responsible for commissioning?	Contract Grids available via Mark Overton at NHS SoTW outlining service review work, PHTP 1E, Appendix 1 & 2			**X**

	1.6	Is there a clearly developed plan for ensuring a smooth transfer of those PH functions and commissioning arrangements migrating to NHS CB and PHE?	PHTP 1F		**X**	
	1.7	Is there local agreement on the delivery of a core offer providing LA based public health advice to Clinical Commissioning Groups?	PHTP 1G		**X**	
Delivering public health responsibilities during transition and preparing for 2013/14	**2.1**	Is it clear how future mandated services and steps are to be delivered during transition and in the new local public health services:	Limited evidence but under development in PHTP, Appendices 1-4			
		Appropriate access to sexual health services,	PHTP 2A Contract grids, Minutes of Sexual Health Locality Planning Group, Childrens Trust	**X**		
		Plans in place to protect the health of the population,	PHTP 2B Appendix 2-3, LRF briefing Note (17th January 2013)		**X**	
		Public health advice to NHS commissioners,	PHTP 2A but discussions underway which will develop approach		**X**	
		National Child Measurement Programme,	Limited evidence but under development in PHTP 2A, Appendices 1-4			**X**
		NHS Health check assessment?	Contract grids and other Limited evidence but under development in PHTP 2A, Appendices 1-4	**X**		

	2.2	Is there clarity around the delivery of critical PH services/programmes locally, specifically: screening programmes; immunisation programmes; drugs & alcohol services and infection prevention & control?	Evidence around drugs and alcohol- currently up for recommissioning potentially as a LA procurement exercise but otherwise Limited evidence but under development in PHTP 2B, Appendices 1-4		**X**	
Workforce	**3.1**	Has the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat?	Work programme to be led by VT/JL in association with the LA HR Leads- expect evidence from JL, PHTP 3Aworkstream evidence in Appendix 2	**X**		
Governance	**4.1**	Does the PCT cluster with LA have in place robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate?	PHTP 4A & Appendix 3 Draft MoU under discussion but currently not agreed			**X**

	4.2	Are there robust arrangements in place for key public health functions during transition and have they been tested e.g. new emergency planning response to include:	PHTP 4B and Appendix 2-4 and LRF Briefing (17/01/12) and TC Briefing documents (HPA Consultant for Sunderland)		**X**
		o Accountability and governance,	PHTP 4C & Appendix 3- Draft MoU under discussion		**X**
		o Details of how the DPH, on behalf of LA, assures themselves about the arrangements in place,	PHTP 4C & Appendix 3 and LRF briefing re emergency planning - Draft MoU under discussion in relation to support for other key PH functions		**X**

		○ Lead DPH arrangements for EPRR and how it works across the LRF area?	PHTP and LRF briefing (17/1/12) Tricia Cresswell HPA briefing documents		**X**

	4.3	Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of SUIs/incident reporting and Patient Group Directions?	PHTP 4C, Appendix 2-4			**X**
	4.4	Has the PCT cluster with the LA agreed a risk sharing based approach to transition?	PHTP 4D		**X**	
	4.5	Is there an agreed approach to sector led improvement?	PHTP 4E, Appendix 1,2	**X**		
	4.6	Is the local authority engaged with the planning and supportive of the PCT cluster approach to PH transition?	PHTP 4F and Appendices 1-3	**X**		
Enabling infrastructure	**5.1**	Has the PCT cluster with LA identified sufficient capability and capacity to ensure delivery of their plan?	PHTP and Appendix 2 and MoU		**X**	
	5.2	Has the PCT cluster with LA identified and resolved significant financial issues?	PHTP 5B Discussion underway at High level LA/NHS SoTW meeting		**X**	
	5.3	Has the PCT cluster with LA agreed novation/other arrangements for the handover of all agreed PH contracts?	PHTP 5C		**X**	
	5.4	Are all clinical and non-clinical risk and indemnity issues identified for contracts?	PHTP 5D, Appendix 2-3, Financial risk outstanding re evidence			**X**

	5.5	Are there plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer?	PHTP 5E -During transition will be an issue for MoU post transition		**X**	
	5.6	Have all issues in relation to facilities, estates, asset registers been resolved?	Under development and will be found in PHTP and Appendix 2.		**X**	
	5.7	Is there a plan in place for the development of a legacy handover document during 2012/13?	PHTP 5E and Appendix 2	**X**		
Communication and engagement	**6.1**	Is there a robust communications plan? Does it consider relationships with the Health and Well being Board; clinical commissioning groups and NHSCB; Health Watch; local professional networks?	Under development but will be found in PHTP 6A and Appendix 2 and links to the Rachel Chapman led work for Transition Planning			**X**
	6.2	Is there a robust engagement plan involving stakeholders, patients, public, providers of PH services, contractors and PHE?	Under development but will be found in PHTP6B and Appendix 2 and links to the Rachel Chapman led work for Transition Planning			**X**

rance complete?	
Rag rating	Comments
Amber/Red	Agreement in principle and some detail exists for an operating model during transition. LA have agreed high level and detail required around governance and assurance and financial
	PHTP demonstrates high leve work and LA developed workstream spreadsheet demonstrates separate work streams and timelines. Will
	Significant transition milestones have been agreed e.g. journey through Council
	Work on the refreshed JSNA and embedding it within transformed Council processes has been underwa

	Service reviews have been delivered in all key health improvement commissioned programmes. Finance, outcomes and current performance have been identified for the most up to date year available. The
	Commissioning arrangements for health vising are migrating to NHS CB. Other arrangements for 0-5's include local support for breastfeeding, obesity
	There is current a verbal expression of willingness to share capacity and resource to deliver this by the 3 DsPH but no fomal capture. We are
	Delivery during transition is less of a problem - not forgetting that NHS SoTW will also be in transition in relation to shadow CSSs.Whilst not
	Overall there should be no problem during 12/13 and we are continuing our arrangements to secure
	The statutory duties of NHS bodies and their boards in relation to emergency preparedness, resilience and
	There is no problem during 12/13 and we are continuing our arrangements. There is still a lack of agreement over
	We expect 2012/13 to be managed as previous years but there are issues for post 2013 including who will
	There is no problem during 12/13 and we are continuing our arrangements to secure

	There should be no problem during 12/13 for delivery of the critical PH services/programmes as we are continuing our arrangements. There is still a lack of clarity over some of the critical PH
	The workforce elements have so far been developed in accordance with the PHHRC. However future working requires integrated working across the LA and the One NE HR service and
	Each organsiation has robust internal accountability and performance monitoring. We would not anticipate changing these but we do receommend the adoption of an MoU to cover current arrangements even if staff and function are

	The statutory duties of NHS bodies and their boards in relation to emergency preparedness, resilience and response remain in place until 31 March 2013. • Unless review is required for immediate operational reasons, all NHS plans and response arrangements at local level will remain in place. Plans will only be revised once final structures are understood. • Unless review is required for immediate operational reasons, all HPA plans at local level will remain in place. Plans will only be revised once final structures are understood. • Exercising of current plans will continue in relation to Olympic assurance. • From 3 October 2011, the three NHS Strategic Health Authorities (NHS North East, NHS North West and NHS Yorkshire and the Humber) have operated under a single management framework, NHS North of England.
	. Work is underway and PCT Cluster Transition Plans and possible development of MoU
	. Work is underway and PCT Cluster Transition Plans and possible development of MoU (requested by SCC) will assist in robustness and

	Arrangements have been agreed by NHS players in the NHS emergency planning strategic group and

	During transition we do not anticipate changes to clinical governance arrangements and delivery of the MoU would provide transparency and robustness to verbal agreements but this is an area
	This is an ongoing area for discussion. There are a series of LA Transition Meetings to discuss PH Transition issues
	The Sunderland Way of Working and Operating Model implies that this will not be a 'drag and drop' of PH capacity into the Council but an
	The Assistant Chief Executive and Director of Health Housing and Adult Services have been given the Corporate responsibility for
	Staff in both the LA and TPCT are managing planning without additional capacity at this time. The LA may be able to provide additional capacity via
	Without additional information on the ringfenced budget and the impl,ications going forward, this is difficult to
	There is an ongoing discussion over contracts and commissioning which may well require legal opinions to resolve. One view is that
	This work has been underway clinical risk as currently known is managed by the routine PCT arrangements.

	Arrangements during 2012/13 should maintain as current (to potentiall be agreed in the MoUwith LA and SLA with CSS) but arrangements for 2013 are less clear and require changes in the H&SC
	There are limited issues around facilties and estates and asset registers for PH
	There is a plan in place for the development of a legacy handover document and this is
	The detailed communication plan has not yet been completed but there is currently communication with NHS SoTW Directors, Sunderland CCG, Sunderland EIH&WBB, Sunderland CC
	The detailed engagement plan has not yet been completed but there is currently engagement with a range of