SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 2) on Tuesday 31 July 2012 at 10.00am

A buffet lunch will be available at the close of the meeting.

Contact: **Gillian Warnes, Principal Governance Services Officer** **Tel: 0191 561 1041**
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Information contained within this agenda can be made available in other languages and formats.

7.	**Health and Social Care Systems Diagnostic** Report of the Executive Director of Health, Housing and Adults Services (attached).	37
8.	**Health and Wellbeing Strategy Update** Report of the Executive Director of Health, Housing and Adult Services and the Head of Strategy, Policy and Performance Management (attached).	41
9.	**National Learning Sets** Report of the Executive Director of Health, Housing and Adult Services (attached).	47
10.	**Board Development Session** Report attached.	59
11.	**Public Health England** Presentation	-
12.	**'Caring for our Future: Reforming Care and Support' White Paper** Report of the Executive Director of Health, Housing and Adult Services (attached).	61
13.	**Any Other Business**	
14.	**Dates and Times of Future Meetings** The next meeting will be held on Friday 14 September 2012 at 12.00noon.	

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

23 July 2012

Item No. 2

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

Held in Committee Room 1, Sunderland Civic Centre on Friday 18 May 2012

MINUTES

Present: -

Councillor Paul Watson (Chair)	-	Sunderland City Council
Councillor Graeme Miller	-	Sunderland City Council
Councillor Pat Smith	-	Sunderland City Council
Councillor John Wiper	-	Sunderland City Council
Neil Revely	-	Executive Director, Health, Housing and Adult Services
Keith Moore	-	Executive Director, Children's Services, Sunderland City Council
Nonnie Crawford	-	Director of Public Health
Sue Winfield	-	Chair of Sunderland TPCT
Dr Ian Pattison	-	Sunderland Clinical Commissioning Group

In Attendance:

Councillor Dave Allan	-	Sunderland City Council
Gillian Gibson	-	Sunderland TPCT
Martin Rutter	-	North East Ambulance Service
Alan Patchett	-	Age UK
Ailsa Martin	-	Carers' Association
Sarah Reed	-	Office of the Chief Executive, Sunderland City Council
Vince Taylor	-	Office of the Chief Executive, Sunderland City Council
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Warnes	-	Governance Services, Sunderland City Council

HW1. Apologies

Apologies for absence were received from Councillor Speding, Dr McBride and Ron Odunaiya.

HW2. Minutes

The minutes of the meeting held on 30 March 2012 were agreed as a correct record.

HW3. Clinical Commissioning Group Update

Dr Pattison advised that the Clinical Commissioning Group (CCG) continued to make progress, locality structures were maturing and a launch event had been held at the Stadium of Light.

The CCG had applied to the Government for wave one authorisation, however as the business methodology was not yet developed in relation to CCGs who were intending to provide substantial commissioning support themselves, Sunderland had been asked to go into wave two.

The CCG Executive had been disappointed that they were unable to be considered within the first wave and they were concerned that the criteria relating to commissioning support could be applied in the same way as for Commissioning Support Organisations (CSOs). This would be inappropriate for a CCG with its own structure. The CCG had been told that their authorisation process would be seen as a pilot in this regard. Neil Revely suggested that the Council could be involved in the process as the proposed joint working around commissioning support should provide string assurance.

As part of the authorisation process, there would be a survey of stakeholders and partners were asked for their support in contributing to this survey.

Keith Moore commented that the Council had offered support in relation to the CCG's area arrangements and that Children's Services were due to meet with the group to discuss how they could link into the new structure.

RESOLVED that the Clinical Commissioning Group update be noted.

HW4. Feedback from Advisory Boards

Adults Partnership Board

Neil Revely reported that the main agenda items considered by the Adults Partnership Board at its meeting on 1 May 2012 had been: -

- Adults Partnership Board Forward Plan
- Health and Wellbeing Scrutiny Committee
- Health and Wellbeing Board – Agenda
- Older People Mental Health Strategy Group – Update
- Alcohol prevention and treatment
- WHO Healthy Cities Network.

As part of the discussion on the Forward Plan, the Adults Partnership Board had discussed how they could continue to develop their role as an advisory board to the Health and Wellbeing Board and recognised that they had begun to take on some work from the Board.

The Health and Wellbeing Scrutiny Committee had provided feedback from the policy review of hospital discharge arrangements. The Adults Partnership Board had been keen to engage with the implementation process of any recommendations arising from the review.

The Partnership Board had received the CCG Commissioning Plan and although recognising the timescales which had to be met, they felt that they could have been involved in the process at an earlier stage.

Following the update from the Older People Mental Health Strategy Group, the Partnership Board had requested an update on the Memory Protection Service and raised the possibility of including the topic of dementia in the Health Champion Programme. The Partnership Board also agreed to invite a representative from the Safer Sunderland Partnership to sit on the group in order to take forward any issues raised around alcohol prevention and treatment.

The Chair noted the Partnership Board's comments on the CCG report and was informed that these issues should not arise in the future as the meeting schedules of the Health and Wellbeing Board and its advisory boards were now better co-ordinated.

Children's Trust

Councillor Smith reported that the Children's Trust had received a presentation outlining the outcomes from the recent Inspection of Safeguarding and Looked After Children's Services. From a total of 22 judgements, 21 had been scored as good and one as adequate. The 'adequate' judgement related to the inconsistent quality of assessments and plans. This had already been highlighted as a priority and further work had taken place to support improvement in this area.

The Trust had then gone on to consider the progress on priorities within the Children and Young People's Plan as part of its ongoing programme of confirm and challenge. The priority outcomes considered related to increasing the proportion of young people who were in education, employment and training and reducing substance misuse, including smoking.

Keith Moore advised that the Trust had agreed to establish a task group to take forward the work on the future of the Health Visiting Service and Sandra Mitchell would be the project lead.

A group of young people from across the city attended the Trust meeting to provide feedback on the Young People's State of the City debate which had

taken place on 25 November 2011. The main areas which were highlighted were:

- Careers
- Health
- Sex education
- Student rights
- Discrimination

The Trust were also provided with a copy of the Sunderland Youth Parliament's action plan and agreed that the relationship between the Trust and the Youth Parliament should be formalised through termly meetings.

Sue Winfield informed the Heath and Wellbeing Board that the Sunderland Youth Parliament were actively engaged with a number of groups across the city and were an asset that should be nurtured. She suggested that the Board may engage with the Youth Parliament at some point as they were an excellent, ready made resource representing the youth of the city.

RESOLVED that the information be noted.

HW5. CCG Commissioning Plan

Dr Pattison presented the latest version of the Clinical Commissioning Group (CCG) Commissioning Plan. The plan incorporated a number of amendments to reflect stakeholder feedback following engagement sessions. The improvements include: -

- Further strengthening of how the NHS Consultation requirements will be delivered;
- Identification of high level Commissioning Outcomes; and
- Impact of the CCG strategy on the market.

At the present time, the Commissioning Plan did not reflect structures, but a locality based health needs assessment had been produced for each area and had been discussed with those who would be leading area boards.

Dr Pattison acknowledged that the plan was lengthy and may be trimmed down in some places. The vision, values and Chair's introduction were now in place but there needed to be more information on what the CCG was doing and how it was going to be measured. The Plan clearly showed how the common high level goals were coming together but still required some simplification to make it more patient friendly. Neil Revely added that Commissioning Plan had been considered by the Learning Disabilities Partnership and the CCG had commissioned an easy read version of the plan.

The Commissioning Plan was available electronically and would be on the Council's website when it was finalised. It was suggested that it would useful to provide a search facility for ease of use for visitors to the website.

There had been discussions during the Health and Wellbeing Strategy engagement sessions about using the same strapline for both the strategy and the Commissioning Plan. Within the Board, there were differing views. While most agreed that simplicity was key, the strategy needed to encompass the wider area of 'wellbeing'. Vince Taylor had met with members of the CCG to look at this and it was something which could be considered again.

With regard to comments made by the Adults Partnership Board, that prevention was not linked to the social model, this had been picked up and referred to Debbie Burnicle at the PCT.

RESOLVED that the revised Clear and Credible Plan be noted.

HW6. CCG Authorisation Process

Dr Pattison delivered a presentation on the process for Clinical Commissioning Group authorisation. The authorisation would be based on six domains: -

1. A strong clinical and multi-professional focus which brings real added value
2. Meaningful engagement with patients, carers and their communities
3. Clear and credible plans
4. Proper constitutional and governance arrangements
5. Collaborative arrangements for commissioning
6. Great leaders who individually and collectively can make a real difference.

It was hoped that the Sunderland Clinical Commissioning Group, as a second wave application, would be authorised by NHS Commissioning Board Special Health Authority (NHSCBA) by the end of November. The 360° Stakeholder Review would take place in July and would seek to assess whether CCGs had been developing strong foundations for successful relationships with all key stakeholders and examine the potential for these relationships to evolve.

There were three potential outcomes from the process: full authorisation; authorised with conditions or established but not authorised. The authorisation process would also look at a number of facets of the CCG and local authority relationship, including the arrangements in place for the delivery of public health advice, evidence of participation in the Health and Wellbeing Board and in the development of the draft Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy and that CCG plans were aligned with the strategy and that opportunities had been identified to integrate commissioning and reduce health inequalities.

It was queried if there was anything which the Board could do to support the CCG in its views around not being able to go forward in the first wave of authorisation. It was felt that it would be more appropriate to confirm the

support of the Health and Wellbeing Board for the second wave application and engage in the discussions around the criteria for authorisation.

RESOLVED that the presentation be noted.

HW7. Transition to Shadow Board

Sarah Reed informed the Board that with its transition from an 'Early Implementer' to a 'Shadow Board' status, a report would be taken to the Council's Cabinet to confirm the arrangements and to reflect the work which had been carried out during the Early Implementer year.

The report would also discuss the role of the advisory boards and how they had reviewed their terms of reference and membership to assist their role in respect of the Heath and Wellbeing Board. The development sessions taking place in 2012/2013 would be very important in the move towards formal Board status in 2013.

Members were referred to a document from the Good Governance Institute which showed a maturity matrix against which the effectiveness of the Health and Wellbeing Board could be measured. A major piece of work to be developed was an understanding of the governance of the Board as it was an unusual type of local authority committee. It was suggested that the Board could work with the Good Governance Institute on this.

RESOLVED that the update be noted.

HW8. Health and Social Care Systems Diagnostic

The Sunderland Health and Wellbeing Board had commissioned the NHS Institute for Innovation and Improvement to carry out a diagnostic tool which focused on ensuring that Health and Wellbeing Boards could grow into their role of leading the strategic development of health and wellbeing policy and commissioning.

The diagnostic tool had been carried out between January and March 2012 and had involved:

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

A draft report was about to be circulated to organisations which had taken part. The report would contain a series of recommendations to support debate and discussion among partners and it was suggested that the next step should be a workshop to bring together those who contributed to the research to consider the findings, share learning and develop a way forward.

The next Health and Wellbeing Board development session would take place on Thursday 21 June and it was suggested that this be used as the workshop session with the NHS Institute.

RESOLVED that: -

(i) the next Board development session on 21 June 2012 focus on the Heath and Social Care System Support findings and the agreed next steps; and

(ii) partners involved in the research be invited to attend the event.

HW9. Health and Community Resilience

Transforming Health and Wellbeing: the Role of Resilience

Gillian Gibson, Sunderland TPCT, delivered a presentation and submitted a report on the role of resilience in transforming health and wellbeing.

The Board was told of the background to public health services in the city and the complex system approach to health and wellbeing, which recognises that multiple factors affect people's health and choices and that these were guided by their values and the system in which they operate. Working with people in a way which takes account of these values builds up resilience and the ability to deal with change.

There was no single definition of community resilience, but there were examples of initiatives such as the cervical screening collaborative which had benefits for the whole system, the practices involved and the volunteers. The Health Champion Programme develops some themes from the cervical screening programme and focused on issues such as emotional resilience and the advantages for volunteers who take part.

The Council was in a strong position to take this forward and the development of the Community Resilience Plan and the strengthening families work would tie in with the transformation of health and wellbeing. It was suggested that a future development session might look at the work which was going on and how it might be pulled together.

It was commented that the theme of community resilience resonated in a number of other areas of work concerned with how and why people would want to change. Organisations were trying to look at the customer, patient and service user point of view at the initial stage of redesigning services.

The Community Resilience Plan

Vince Taylor, Head of Strategy and Performance, Sunderland City Council, delivered a presentation and submitted a report providing an overview of the Council's emerging approach to community resilience.

Prompted by the economic downturn and the current challenges facing communities, the Council had been looking at the complex system model of community resilience which took the individual and household as the starting point and showed it surrounded by the community elements. The key factors which could limit resilience within communities were highlighted as: -

- Number of people dependent on benefits
- High unemployment and low skills base
- High prevalence of individual and household debt
- Poor physical and mental health amongst segments of the population
- High levels of child and family poverty

From the Council's perspective there were also a number of key strengths and assets including the community leadership role of elected Members, responsive local services and area based working. There were also opportunities in the changing public health responsibilities, the potential for economic growth and volunteering and social action. The strengthening families approach was an area of significant opportunity as this was looking at families as the bedrock of communities and viewing them as having strengths and assets but sometimes needing help, support and intervention. This approach would involve working with families at the earliest stage possible and developing a way of working with families across partner organisations.

The emerging Community Resilience Plan was intended to enable and support communities in making the transition to greater strength and independence, with less reliance on the public sector in the long term. There would be eight core aims within the plan. These aims related to areas where it was believed that the Council and partners could make the greatest contribution to community resilience and would have defined actions over the short to medium term. The core aims were: -

Aim 1: Maximise and stabilise the **disposable income** of households
Aim 2: Ensure people have **a place to live** that meets the needs and entitlements of their households
Aim 3: Increase the ability of residents to **influence and own change** that affects them and the community they live in
Aim 4: Create a strong and inclusive **sense of community** and local pride
Aim 5: Support people to manage their **health and wellbeing** and the health and wellbeing of others
Aim 6: Create a community environment where people are, and feel **safe and secure**
Aim 7: Ensure people have **access to appropriate services** and facilities that enable them to meet their changing needs

Aim 8: Maintain a physical environment that is **clean and attractive**.

The approach was founded on the principles of early intervention and prevention, building capacity and reducing dependency, creating connections, responsive local services, community leadership, an asset based approach and delivering publicly valued outcomes.

A number of workshops would be held to consider the outline plan and Council officers had offered to present the plan to the management teams of partner organisations.

Councillor Miller commented that 'troubled families' could be added to the challenges facing communities and that there needed to be assurances that there was enough focus and resource being concentrated on this element. Keith Moore advised that part of the work under the 'Strengthening Families' approach was to use the existing resource base more effectively. A successful multi-agency workshop had been held on this theme and it would shortly be the subject of a presentation to the Council's Joint Leadership Team. It was noted that the Adults Partnership Board had said they would welcome being part of this work and that the Children's Trust would also be involved.

RESOLVED that the presentations and reports be noted.

HW10. Public Health Transition Update

Nonnie Crawford updated the Board on the current position with regard to the transition of public health responsibilities from the PCT to the local authority.

Progress continued to be made and work was being undertaken around commissioning some significant services to serve as a model for Council processes in the future. The latest version of the transition plan had been submitted to the Strategic Health Authority, although approval of the plan had not yet been confirmed.

Guidance on HR issues was still awaited and it was hoped that there would be a more detailed report for the next Board meeting which would address some of the HR implications.

There was also a need to have discussions around the splitting of services for Sunderland, Gateshead and South Tyneside, particularly around evidence based health care. This information had been provided by a small team for all three areas which was now being broken up and it needed to be determined how this would be provided in the future and how resilience would be built into the system. An options analysis was being carried out and would be presented to a meeting of the Public Health Transition Group on 21 May. Details of the options and the discussions which took place at the Transition Group would be brought to the Health and Wellbeing Board so that the Board could give a view on the option which would operate most effectively.

RESOLVED that the update be noted.

HW11. Development Session – Thursday 21 June 2012

It was confirmed that, as discussed earlier in the meeting, the next Board development session would focus on the NHS Institute report into the Health and Wellbeing Board. Full details would be confirmed to Members by email.

HW12. Other Business

Nonnie Crawford advised that the consultation on plain packaging for tobacco based products closed at the end of July and that the Board had the opportunity to support this.

RESOLVED that Nonnie Crawford, assisted by Karen Graham, draft a response to the consultation on behalf of the Board and submit it to the Department for Health, subject to comments from the Chair of the Board.

HW13. Date and Time of Next Meeting

The next meeting will be held on Tuesday 31 July 2012 at 10.00am in Committee Room 2, Sunderland Civic Centre.

Item No. 3

NHS Sunderland CCG

360° Stakeholder Survey Update for the Health and Wellbeing Board

As you will be aware, NHS Sunderland Clinical Commissioning Group is progressing on its journey towards authorisation, through which the NHS Commissioning Board will assess our readiness to take on our new statutory responsibilities under the Health and Social Care Act 2012, from April 2013.

We wrote to key stakeholders last month, including Council Members, to inform them about the forthcoming CCG authorisation 360 degree stakeholder survey. Indentified stakeholders will receive an email in July/August from Ipsos MORI and your support in this survey will be vital in establishing NHS Sunderland CCG as an authorised statutory body.

The stakeholders were identified for Sunderland CCG in conversation with Neil Revely supported by the criteria for the survey which was;

Members of the Health and Wellbeing board - Chair of the board and two other board members and Council Chief Executive, Director of Adult Services, Director of Children's Services, Chair Overview and Scrutiny Committee and two elected members nominated by the local authority

HWBB stakeholders
Cllr Paul Watson
Cllr Melville Speding
Ms Maureen Crawford

Local Authority stakeholders
Dr Dave Smith
Mr Neil Revely
Mr Keith Moore
Cllr Christine Shattock
Cllr Peter Walker
Cllr John Wiper

In order to support you to complete the survey, below is the evidence that the CCG will be tested on.

Evidence for Authorisation
Local Authority Views
Arrangements in place between local authority (ties) and CCG specifying how public health advice to CCGs will be delivered. CCG had engaged local authority/ties in establishing its geographic area. Where the need for integrated commissioning has been identified by the health and wellbeing board and in the JHWS, CCGs are collaborating with the local authority to develop shared plans. Clear lines of accountability for safeguarding are reflected in the CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children's Board and the Safeguarding Adults.
Health and wellbeing board member views
CCG can demonstrate it has taken steps to communicate its vision and priorities to partners via its clinical leadership through the local health and wellbeing board

To test the evidence stakeholders will be asked to answer certain questions. From a pilot carried out previously we understand these questions may include:

Engagement and relationships (overview)

Overall, to what extent, it at all, do you feel you have been engaged by (CCG)?

And how satisfied or dissatisfied are you with the way in which (CCG) has engaged with you so far?

To what extent do you agree or disagree that (CCG) has listened to your views where you have provided them?

To what extent do you agree or disagree that (CCG) has acted on your suggestions?
Overall, how would you rate your working relationship with (CCG)?

Please provide any further comments you would like to make on how (CCG) has engaged with you, and your working relationship with them.

To what extent do you agree or disagree about the leadership of (CCG)…?

Have you been involved in the development of any of the following activities, or not?

Overall, how inclusive, if at all, do you feel the process has been for developing (CCG's) plans and priorities?

Overall, how transparent, if at all, do you feel the process has been for developing (CCG's) plans and priorities?

Overall, how involved, do you feel you have been in developing (CCG's) plans and priorities?

Are you aware of any of the following activities, or not?

Have you been involved in any of the following activities, or not?

To what extent, if at all, are you aware of (CCG's) QIPP plans and priorities?

Overall, how clear, if at all, would you say (CCG's) QIPP plans and priorities are?

How confident are you, if at all, that (CCG's) QIPP plans will deliver continuous improvement in quality within the available resources?

How satisfied or dissatisfied are you with the steps that (CCG) has taken to communicate its vision and priorities to you?

Local authority views

Do you have arrangements in place with (CCG) that specify how your local authority will deliver public health advice to the CCG, or not?

How confident are you, if at all, that these arrangements will enable your local authority to deliver public health advice to (CCG)?

How involved were you, if at all, in discussions about the geographic area that (CCG) would cover?

How satisfied or dissatisfied are you with (CCG) boundaries?

Has a need for integrated commissioning between (CCG) and your local authority been identified by the health and wellbeing board and in the JHWS, or not?

How well, if at all, would you say (CCG) and your local authority are working together to develop shared plans for integrated commissioning?

Does (CCG) have arrangements in place with your local authority to co-operate in the operation of the Local Safeguarding Children Board, or not?

How appropriate, it at all, would you say the arrangements are for (CCG) and your local authority to co-operate in the operation of the Local Safeguarding Children Board?

Do you know who will be accountable for safeguarding children within (CCG), or not?

Does (CCG) have arrangements in place with your local authority to co-operate in the operation of the Safeguarding Adults Board, or not?

How appropriate, if at all, would you say the arrangements are for (CCG) and your local authority to co-operate in the operation of the Safeguarding Adults Board?

Do you know who will be accountable for safeguarding adults with (CCG), or not?

Health and wellbeing board members' views

To what extent do you agree or disagree with the following statements about the clinical leadership of (CCG)…?

How active, if at all, would you say the clinical leaders of (CCG) are as members of your health and wellbeing board?

How well, if at all, would you say the clinical leaders of (CCG) have communications its vision and priorities to the health and wellbeing board?

How satisfied or dissatisfied are you that the vision that (CCG) clinical leaders have communicated is consistent with the health and wellbeing board's priorities?

Has a need for integrated commissioning between (CCG) and the local authority been identified by your health and wellbeing board and in the JHWS, or not?

How well, if at all, would you say (CCG) and the local authority are working together to develop shared plans for integrated commissioning?

Thanks for your support in this matter; if you have any further questions please don't hesitate to contact me.

Dr Ian Pattison (NHS Sunderland Chair)
David Robinson (Commissioning Development Manager)

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CCG Authorisation

Developing good working relationships between Health and Wellbeing Boards and Clinical Commissioning Groups

"The creation of health and wellbeing boards is one aspect of the NHS reforms that enjoys overwhelming support. The Boards offer new and exiting opportunities to join up local services, create new partnerships with GPs, and deliver greater democratic accountability" Kings Fund, 2012

Origins and purpose of this framework

The London Health and Wellbeing Board (HWB) Partnership Support Programme initiated this piece of work on behalf of the London Health and Wellbeing Board Network. Following a discussion on the Clinical Commissioning Group (CCG) Authorisation process at a Network meeting, it was decided that we should develop a framework to support HWBs and CCGs through the Authorisation process. This framework has been created by the London Health and Wellbeing Board Partnership Support Programme, in conjunction with London HWB support officers, the Londonwide Clinical Commissioning Council, Public Health Professionals, NHS London and a London CCG Chair.

The Authorisation process is not just about compliance, but also about helping to realise the potential of the CCGs. Authorisation is not the end in itself, but is part of the journey. This is an opportunity for the HWB to work in partnership with the CCG to drive local improvement in health, care and reduce inequalities.

The purpose of this paper is to:

1. ***Support both a CCG and HWB to develop a common understanding of the quality of their working relationship***
2. ***Outline how a HWB can support their CCG through the Authorisation process***
3. ***Provide an aid for the HWB to reflect upon when completing the 360 degree review of their CCG as part of the Authorisation process***

This framework intends to help support HWBs and CCGs **'build the basics'** to develop effective partnership working as well as where they can build upon their current working arrangements to **'develop together for the future'.**

This framework explores the domains of Authorisation, what it means for HWBs and how a HWB can support its CCG throughout the Authorisation process and beyond. It pulls together the thinking and examples of how HWBs and CCGs are already working together in London and suggests areas that could enhance their relationship and partnership working.

The framework is not intended to be prescriptive and should not be interpreted as policy or as an exhaustive list of what a CCG / HWB should be doing throughout the Authorisation process or how they should work together. This document was written to work now as the first wave of Authorisation

progresses. This framework will be reviewed as the Authorisation process advances and when further information evolves to support the role of HWBs in the annual CCG Assurance process.

Clinical Commissioning Group (CCG) Authorisation Process

During 2012-13, general practices across England will be preparing to take on responsibility for commissioning the majority of healthcare for their local population by forming CCGs. By April 2013, the whole of England will be covered by established CCGs and the present system of NHS commissioning organisations will be abolished.

To become an established CCG, each must go through an authorisation process. CCGs are new, clinically-led organisations coming into being for the first time and they must demonstrate that they meet nationally determined thresholds to assume their full statutory responsibilities.

CCGs will be assessed against six domains to provide assurance that CCGs can safely discharge their statutory responsibilities for commissioning healthcare services and are also intended to encourage CCGs to be organisations that are clinically led and driven by clinical added value.

What are the roles of the Health and Wellbeing Board in the authorisation process?

Each of the authorisation Domains have implications and considerations for how the CCG works with its partners through the HWB. During the Authorisation process, each HWB will have a role supporting preparation of evidence, i.e. Joint Health and Wellbeing Strategy (JHWS), against the domains for authorisation, as well as clarifying with CCGs; the roles, responsibilities and expectations of their partnerships with their Local Authority and the public.

HWBs and CCG will want to consider how they work together to deliver the three main functions of a HWB to:

- Assess the needs of their local population through the joint strategic needs assessment (JSNA) process
- Produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant
- Promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate

Health and Wellbeing Boards are listed as a stakeholder to participate in the 360 degree review of the CCGs carried out by the NHS Commissioning Board. Each stakeholder will be invited to be involved in a short web based survey that will be based on the domains so HWBs will need to develop a view of how the CCG is working in partnership now and how they would wish the partnership to develop in the future.

Authorisation Domain 1: A strong clinical and multi-professional focus which brings real added value

This domain is concerned with developing a systematic approach to monitoring quality and outcomes, demonstrate evidence-based decision making, democratically engaging with constituent practices and involving a range of other health professionals.

The evidence to support this domain is the CCG Constitution, 2012-13 Integrated Plan and Draft Commissioning Intentions 2013-14, JSNA, JHWS and HWB meeting minutes

Key Points to consider:

- CCG and HWB are working towards both a shared vision and shared commissioning intention utilising the JSNA / JHWS
- The CCG uses the HWB as a resource to improve health and health related services
- The CCG uses the HWB to engage with patients and the public

The following actions' proposes where CCGs and HWBs can **Build the Basics** to enable effective partnership working	Building on current working arrangements, the below proposes ways that CCGs and HWBs can **develop together for the future**
- The CCG and HWB have a complementary vision, covering population, partnerships and an approach to improving health and wellbeing and reducing health inequalities - The CCG should demonstrate in their constitution how constituent practices can influence the decisions of the CCG, HWB and vice versa which can be related back to decisions and discussions in the HWB - The CCG can evidence the use of JSNA and JHWS throughout development of their plans - The CCG can identify where conflicts may exist in decisions and have an agreement in place which includes how they will manage these when it is working as part of the HWB - The CCG can demonstrate it understands the role and benefits of working together with Public Health and other LA colleagues, to inform, advise and influence the work of the CCG - The CCG has developed a communications and engagement strategy that extends beyond Health Watch to articulate its vision to stakeholders, patients and the public and how this will influence decision making	- The CCGs constitution could make reference to the Health and Wellbeing Boards priorities when outlining its shared vision - The CCG can indentify how advice from the HWB/LA professionals has impacted on their work. Arrangements to seek advice go beyond the use of the HWB - The CCG can outline clear linkages between the CCGs vision and that of their partners and how their commissioning intentions will specifically support joint workings to improve equalities of health - The CCG can evidence effective and ongoing engagement with patients and the public outside of the HWB to articulate it's shared vision - LINks / Health Watch / other patient groups could be involved in governance arrangements of CCG and/or vice versa, supported through the function of the lay member

Authorisation Domain 2: Meaningful engagement with patients, carers and their communities

This domain is concerned with establishing clear processes to gather patient views and to receive patient feedback, constructing mechanisms for gathering these views into meaningful data, demonstrate how these views are fed into the decision-making process and to seek public health expertise to aid understanding of patient populations and their needs.

The evidence to support this domain is the 2012/13 Integrated Plan and Draft Commissioning Intentions for 2012/13, Configuration agreement, CCG Constitution, HWB Minutes and reports, JSNA, and JHWS

Key Points for consideration:

- The CCG should use the JSNA as an aid to map their communities which should be reflected in their commissioning plans
- The CCG plays an active role in the development of the HWB, the JSNA and the JHWS
- The HWB and CCG ensure systems are in place to engage with patients and public and convert their insights into commissioning plans

The following actions' proposes where CCGs and HWBs can **Build the Basics** to enable effective partnership working	Building on current working arrangements, the below proposes ways that CCGs and HWBs can **develop together for the future**
- CCGs meets in public, and their notes, minutes and documents are readily accessible - The CCG could consider developing the role of the lay member for PPE to champion work to ensure inclusion of diverse groups served by the CCG i.e. ensure PPE at the heart of CCGs, good links with Health Watch, voluntary organisations, views of public and patient groups views are heard, their expectations understood and met as appropriate - The CCG can evidence how patients, carers and their representatives' involvement has led to service improvement and indicate how they have fed this back to the local community - Demonstration of public engagement activity in partnership with other agencies (e.g. local authority or third sector groups), particularly to reach groups with specific needs - The CCG will have built an effective relationship with local Health Watch and draw on existing PPE and involvement expertise - LA and CCG should have co-terminus boundaries, if it doesn't, it should evidence	- The CCG, HWB and Health Watch could take a joint approach to PPE to engage with seldom heard groups - The CCGs constituent practices bring added knowledge and are actively involved in the production of the JSNA and mapping / analysis - The CCG have developed with the HWB an agreement about how the development of the JSNA and JHWS will be resourced - The CCG could develop champions within constituent practices to lead on and follow through the work of the Health and Wellbeing Board at a practice level - There are examples of where CCGs and LAs are currently joint resourcing the establishment and continual development of the HWB - The HWB has agreed a transparent and systematic process to developing joint commissioning

how the LA was consulted when the CCG was establishing its organisational boundaries and an assessment of the impact where boundaries differ - CCG should have an active role in the development of the HWB, by attending meetings and participating in developmental activities - The HWB / LA is used as a resource by the CCG to better understand the development of the local services i.e. Housing - The production of a JSNA and JHWS is seen as a joint responsibility of all statutory members of the HWB, and the CCG should evidence how it has been involved in its development beyond sign off of final documents - The CCG can demonstrate understanding of difference within its population and how engagement and commissioning plans will address these different needs - The CCG can demonstrate how it will engage and address the needs of people who are not registered with a GP, who are transient, or who are registered with a constituent practices but living outside LA boundaries - The CCG has appropriate arrangements in place to secure PPE and to capture feedback from patients, carers and the public, e.g. investment, time, explicit ask requested of commissioning support organisations, patient forums, role development of lay member - The CCG has built an effective and productive relationship with Health Watch in regards to how will be used to actively monitor and improve quality of services - The CCG has developed an explicit statement and approach to shared decision making and patient choice principles and how this will be developed to enable data and outcomes to be captured at an individual patient level to influencing the commissioning process. This could be developed with Health Watch and the HWB. - The CCG can demonstrate clear safeguarding policies and procedures with leads working towards agreements how it will support the work of the local adults and childrens' safeguarding board particularly where the CCG crosses borough boundaries - The CCG attend LINks / Health Watch / other patient groups' stakeholder meetings or support patient representative groups to enhance engagement with patients and the public	- The CCGs engagement strategy can be crossed referenced against communities of interest and geography to demonstrate the CCG understand and has plans in place to engage with hard to reach groups - The CCG could establish a sub-committee for quality assurance to focus on monitoring and acting on patient feedback - CCG contracts with providers have a requirement for providers to demonstrate continual improvement through PPE, patient reported outcomes measures and fedback into commissioning cycle work of the commissioning support organisation - The CCG understands the personalisation agenda and has mechanisms in place to enable commissioning at an individual level (personal health budgets) as well as strategic level - Contact with LINks / Health Watch / other patient groups could go beyond just meeting with the Chair i.e. the CCG could have in-depth engagement throughout the organisation - There CCG can show how it has influenced commissioning intentions that affect the wider determinants of health, beyond social care and public health

Authorisation Domain 3: Clear and credible plan which continues to deliver the Quality, Innovation Productivity and Prevention (QIPP) challenge within financial resources

This domain concerns developing robust financial management arrangements (including risk sharing), developing comprehensive commissioning plans that include the QIPP objectives and how achievement of these will be measured, and ensuring that all commissioning plans are backed by a coherent Joint Health and Wellbeing Strategy.

The evidence to support this domain is the 2012/13 Integrated Plan, Draft Commissioning Intentions 2013/14, JHWS, and the CCG Constitution

Key Points to consider:

- The CCG works with the HWB and other stakeholders throughout stages of integrated planning, plans are evidenced based using JSNA and JHWS and relate to the QIPP challenge
- Opportunities to integrate commissioning and provision are identified, including where joint commissioning will assist in delivery of QIPP agenda

The following actions' proposes where CCGs and HWBs can **Build the Basics** to enable effective partnership working	Building on current working arrangements, the below proposes ways that CCGs and HWBs can **develop together for the future**
- The CCG and HWB have worked together to develop the JSNA, stakeholder engagement, understand evidence / data and develop priorities outlined in the JHWS - All commissioning plans / strategies tie in and align to each other across health, public health and the local authority, directly linking to the JHWS. Partners can demonstrate how they have been involved and influenced each others commissioning plans - There is a shared understanding of resources available and how they are aligned to the priorities set out in the JHWS - Opportunities to integrate commissioning is systemically approached across all ages and services, including an opportunity to incorporate health improvement and prevention in pathway redesign - The CCG has shared high level risks with the HWB, with regard to any inherited risks from transferring contracts from the PCT - The HWB / CCG have developed a 'statement of intent' describing how and when major risks or changes to commissioning plans will be communicated to avoid unilateral decisions that may unduly affect a partner or joint arrangements	- Plans at a sub-borough level / locality level could be put in place to tackle inequalities and the wider determinants of health - The increasing use of Health Act flexibilities to share and align the use of resources can be evidence, i.e. Section 75 pooled commissioning budgets - If the CCG is not meeting QIPP objectives, the HWB should be informed at the earliest opportunity of what the resolution path is, what the reporting mechanisms are, what the implications are for not meeting them and who is accountable

Authorisation Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities

This domain is concerned with engaging with constituent practices and involving all GPs locally; implementing democratic structures to ensure accountability to the local profession; securing effective commissioning support to ensure good financial management and demonstrating good governance arrangements.

The evidence to support this domain is CCG Constitution, CCG Organisational Development Plan, Integrated risk framework / register and, JSNA, JHWS, 2012/13, Integrated plan and draft commissioning intentions for 2013/14

Key points to consider:

- In order to deliver all their statutory functions, the CCG could utilise the expertise in the HWB to inform on health, social Care and public health
- The CCG will need to work closely with the HWB / LA to plan how integrated commissioning will be carried out and to also determine how their commissioning support plans will support commissioning arrangements within the LA

The following actions' proposes where CCGs and HWBs can **Build the Basics** to enable effective partnership working	Building on current working arrangements, the below proposes ways that CCGs and HWBs can **develop together for the future**
- The lay member for PPE should ensure public and patients' views are heard and their expectations understood and met as appropriate - The HWB could be used as a sounding board for discussing / monitoring significant issues of quality and the CCG could share learning of any serious untoward incidents and never events to the HWB, influencing future commissioning decisions - The CCG can evidence they understand their duties to safeguard children and vulnerable adults and have established systems to ensure regard is given to safeguarding in their own operations and in commissioning safe pathways of care from providers - The CCG could outline to the HWB who the responsible officer is for reducing Health Inequalities and attend Board meetings if not already a member - The CCG has considered and developed its approach to how public health expertise will be embedded within the CCG beyond the interface with commissioning support - The CCG's commissioning plans should outline how it aims to tackle health inequalities, having regard for the JSNA	- HWB and CCG could annually / quarterly review risk of integrated working arrangements - Implications and learning for equality impact assessments can be tracked to changes in commissioning planning and implementation of service redesign

- The CCG can directly demonstrate how the JHWS / JSNA has shaped development of commissioning intentions and how it has influenced use of resources (both commissioning and decommissioning services) - The CCG will have involved the HWB in planning how it will arrange commissioning support services, including what it plans to have in house, externally contracted, share with other CCGs or the LA - The CCG should have detailed planning with the LA how integrated commissioning will be carried out - The CCG can articulate how their commissioning support arrangements will enable joint commissioning arrangements with LA	

Authorisation Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support

This domains concerns developing positive relationships with neighbouring CCGs, the Health and Wellbeing Board and local authorities; adopting a proactive approach to joint commissioning, with a view to achieving economies of scale and commissioning services that pose particular challenges and to ensure there is access to comprehensive commissioning support.

The evidence to support this domain is Constitution and geographical area assessment. HWB meeting minutes, JHWS, 2012/13 Integrated Plan and Draft Commissioning Intentions for 2013/14, HWB Minutes and the JHWS, Joint Commissioning Agreements, inc, pooled budgets, joint appointments, s75 Agreements etc

Key points to consider:

- Strong Partnerships with Local Authorities to develop JHWS and improve outcomes
- Strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care is vital

The following actions' proposes where CCGs and HWBs can **Build the Basics** to enable effective partnership working	Building on current working arrangements, the below proposes ways that CCGs and HWBs can **develop together for the future**
- The CCG can outline where and why it will work with other CCGs to the HWB, and clearly define how commissioning plans at borough, sub-borough and cross-borough level will relate to the local JSNA / JHWS and processes are in place where plans may effect local decision making / priorities or services available - The CCG is able to articulate when and how it will involve the HWB in preparing commissioning plans and when need arises to revise commissioning plans - The CCG can demonstrate its ability to engage with the develop of the JSNA / JHWS by attending HWB Meetings, involved in sub-groups and designating clinicians from practices to lead, taking responsibility for leading on elements of design and content, and demonstrating knowledge how information and evidence of need from constituent practices influences the JSNA process - The CCGs could outline decision making processes and accountability to the HWB, which could be documented in the CCGs constitution - There is an agreed definition of integration used locally to inform CCG and LA commissioning arrangements. Effective governance arrangements for joint	- The CCG could involve the HWB in discussions on how well commissioning support is performing -The CCG could demonstrate its engagement to the Health and Wellbeing Board by becoming its vice-Chair

commissioning are in place to oversee the planning, design, procurement and management of contracts and performance against shared measures and outcomes. Existing joint arrangements have been reviewed and affirmed - The JHWS should include a system wide overview of commissioning intentions across health and social care with attention to opportunities for integrated commissioning and service provision, requiring collaborative arrangements between CCGs and HWB partners and identifying where existing joint commissioning plans have been maintained - The CCG can demonstrate an understanding about 'Any Qualified Provider' and how choice can be enabled in a way that still enables integrated provision - CCG should outline to the HWB its proposed working arrangements with large acute trusts (especially where reconfiguration is taking place) describing mechanisms for including interests of local residents	

Authorisation Domain 6: Great leaders who individually and collectively can make a real difference

This domains concerns setting up democratic structures and appointment processes designed to facilitate the appointment of skilled leaders with the support of their constituents and ensuring clear lines of accountability from the CCG leadership to constituent practices, including processes by which practices can access information about the decisions taken on their behalf

The evidence to support this domain is CCG Organisational Development Plan

Key points to consider:

- CCG leaders work collaboratively with HWB

The following actions' proposes where CCGs and HWBs can **Build the Basics** to enable effective partnership working	Building on current working arrangements, the below proposes ways that CCGs and HWBs can **develop together for the future**
- Clearly identified roles and responsibilities in the CCG includes defining where the key roles to link in with the HWB and any subgroups - Regular engagement by CCG leadership team and LA / HWB members - Engaged in organisational development together e.g. induction process - Demonstrates understanding and commitment to working collaboratively with partners	- The CCG could ensure that their plans for organisational and leadership developments have links to the HWB organisational development plan - The HWB and CCG are committed to continually enhancing knowledge to ensure specific skills and awareness of health and social care leaders enable effective collaboration, communication and leadership - The HWB is involved in annual reviews of the effectiveness of the CCG board and visa versa

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

SUNDERLAND ADULTS PARTNERSHIP BOARD – 10th July 2012

ITEM

Cllr G. Miller approved as a chair for the Board. Nominations for the vice chair to be put forward from the broad Partnership membership and agreed at the next meeting.

4 Sunderland Initial Response Team

NTW Mental Health presented on the revisions to the service for initial referrals for people with mental health issues, recognising that in Sunderland there had been issues in accessing services. They highlighted a single phone number for self referral or agency referral which was positively received and well used highlighting that waiting time for referrals have been consistently reduced to under 1 hour.

03031231145

5 Suicide Action Plan

This piece of work initiated by the New Horizons Partnership was introduced, showing a multi agency approach to suicide prevention for the City. Stats highlighting a shift in suicides from younger men to men aged 36 – 45

The group highlighted the need to engage acute trust in the new horizons partnership.

6 Personalisation – Update

HHAS presented an update on the personalisation agenda within adult social care – provides good outcomes for people as well as providing value for money. Carers will be depended on more as people are staying at home for longer.

7 Health and Wellbeing Board

Agenda

CCG Update – Karen to follow up with the CCG re: list of the organisations that are on the stakeholder list/ they engaged with – there do not seem to be many partner organisations on the current list

Public Health Transition – we are still awaiting the guidance; Draft indicative budgets based on the new formula show the potential for having the budget reduced by 30%

Strengthening Families – it was commented that the definitions/ criteria of the troubled families seem contradictory and may prevent the families from voluntarily and positively engaging with the programme

Health and Social Care Systems Diagnostic – the Board suggested that the title of the report should be changed as this one does not reflect what the report is about.

Health and Wellbeing Strategy

Information about the next engagement event to forwarded to the Board

8 50+ Strategy & Age Friendly City

Need for the establishment of a baseline position. Support from the council in the self-assessment process. Set up a working group to progress. Importance of partners' involvement in the process was underlined.

9 Autism Strategy – Verbal update

Regional strategy will be developed and Sunderland will feed into it. Currently Autism needs assessment is being produced – looking at numbers/ where and who is accessing what/ perceptions and views of service users gathered – via focus groups/ parent and carers groups and online consultation live to early August.

10 Local Accounts

The draft of Local Accounts will be out for comments in September. There will be a traditional report and a multimedia version– the Board will be asked to sign it off.

11 AOB

Tobacco's plain packaging – Gillian Gibson informed about the national consultation on the plain packaging for tobacco.
http://consultations.dh.gov.uk/tobacco/standardised-packaging-of-tobacco-products/consult_view

The Board were asked whether they support it. The Board were encouraged to respond to the consultation as the deadline for responses has been extended to 10th August. The Board was asked to pass information to other organisation to respond to the consultation.

Flower pot gang – gardening programme with the involvement of young carers in Sunderland will be broadcast on BBC1 on 22nd August

Item No. 4b

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

SUNDERLAND CHILDREN TRUST BOARD – 12 JULY 2012

Cllr P Smith welcomed Jan van Wagtendonk (Independent Chair of the Sunderland Safeguarding Children Board (SSCB)), who would now be a member of the Trust Board as an observer.

Health and Wellbeing Board Update

KM provided an update from the meeting of the Health and Well-being Board held on 18 May 2012.

Following the meeting of the Children's Trust Health and Well-being Sub Group, the following items were put forward to the Children's Trust for discussion.

Health and Wellbeing Strategy: it was agreed that the strategy would be circulated electronically and Children's Trust members were asked to provide comments/ amendments to Jane Hibberd (Head of Strategy and Policy: People and Neighbourhoods).

S Winfield noted that it would be helpful if something could be included under Assets in relation to Partnerships.

CCG 360° Stakeholder Survey: Cllr G Miller requested that the membership of the HWBB and Local Authority Stakeholders be updated to reflect recent changes in roles of Elected Members.

Plain Packaging for Cigarettes: the Children's Trust supported and endorsed the campaign calling for plain, standardised tobacco packing.

The Board asked if there is someway to highlight this campaign through the Council's intranet to get staff involved. J Hibberd will raise this issue.

Consultation on Revised Safeguarding Guidance

M Boustead presented the recently published Draft Revised Guidance – Working Together to Safeguard Children. The trust agreed that they support a joint response on behalf of both the SSCB and the Children's Trust.

Sunderland Safeguarding Children Board

J van Wagtendonk presented the report on behalf of the SSCB which highlighted the current work programmes and achievements.

S Winfield raised the issue of Child Sexual Exploitation and it was agreed that a formal report of the sub regional group be presented to the September Trust Board.

YOS Plan

L Hill (YOS Manager) and M Elsy (SPPM) presented the report and Draft Sunderland Youth Justice Plan 2012/13 for comment. The Trust Board endorsed the Plan.

Cllr P Smith and Partners congratulated the YOS team for the good work that they carry out and continuing high performance.

Health Visitor Review

B Scanlon (Head of Commissioning and Change Management) updated the Trust Board on the work that has been commissioned by the Health and Well-being Board in relation to the Health Visitor service. A report will be presented to the Trust Board in September which will include options for future service delivery.

Item No. 6

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

STRENGTHENING FAMILIES

Report of the Executive Director of Children's Services

1.0 Purpose of the Report

1.1 To provide the Board with an update on the development of a strategic approach to Strengthening Families in Sunderland and its links to the government's 'Troubled Families' initiative, which has been renamed locally in Sunderland as the Family Focus Project.

2.0 Background

2.1 In December 2011, the Prime Minister launched a new three-year payment by results scheme aimed at reducing the problems presented by "troubled families" in England. specifically those who are involved in crime and anti-social behaviour, where children are frequently truant or excluded from school, and at least one adult is out of work and claiming benefits.

2.2 In Sunderland, the 'Troubled Families' initiative has been renamed the Family Focus Project (see Appendix 1). The Council (like other participating local authorities) will receive funding based on their success in achieving an identified set of outcomes defined by the Department for Communities and Local Government (DCLG). However, the programme is being viewed as an opportunity to review and improve the way partners work with the most challenging and vulnerable families across the city, adopting a more systematic and strategic approach with a greater focus on early intervention and prevention, as well more asset based ways of working and thinking.

3.0 A Strategy for Strengthening Families in Sunderland

3.1 The Family Focus Project operates within a wider strategic context in the city, one which is concerned with strengthening families and building their capacity to achieve positive outcomes for themselves and their community, with less dependence on the public sector. The primary aim of the Family Focus Project is to improve behaviours amongst an identified subset of families in the city. More fundamentally, however, in the longer term we are seeking to transform the way services are delivered to achieve a wider set of outcomes for a wider set of families in Sunderland.

3.2 A multi-agency Strengthening Families Board is leading the development of an integrated strategy for supporting and strengthening families in Sunderland. The 'Strengthening Families' Strategy and its associated delivery mechanisms (including the Family Focus Project) will seek to ensure that families in Sunderland can easily access the right support, at the right time

and in the right way to enable them to meet their needs and achieve their goals. It will outline our commitment to safeguarding and promoting the welfare of those who are vulnerable by working with them at the earliest opportunity and making the best use of all resources available. This will include identifying and building on families' strengths, helping them to recognise and fulfil their potential and make a positive contribution to their community.

3.3 **An inclusive definition of family**

The term ‘family’ in this context is used to refer to the bond between people brought together through birth, legally recognised relationships, or kinship with other people through a close connection. The City Council and its partners recognise and celebrate the wide diversity of family structures in Sunderland, and we are seeking to support and strengthen all families in the city, whatever their shape or size. The definition of a family is intended to be broad and inclusive, recognising families of all ages, those with or without children, and those with connections across more than one household, in more than one community.

3.4 **Strategic Principles**

The strategic principles underpinning our approach cut across a number of different local agendas, including the emerging Health and Wellbeing Strategy and Community Resilience Plan:

- Early intervention and prevention
- Building capacity and reducing dependence
- Asset based approach
- Whole systems thinking – whole family, whole life, whole community
- Responsive local services and publicly valued outcomes
- Multi agency and integrated working

3.5 **Developing a Vision**

The intention is to produce the Strengthening Families Strategy through a partnership approach. It will therefore represent the way in which a wide range of organisations – from across the public, private and voluntary and community sectors – will work together to support families in Sunderland, from the development of the strategy through to delivery in localities.

4.0 The Family Focus Project and Emerging Service Delivery Model

4.1 The Family Focus Project will serve as a precursor to the development of a wider delivery model for the Strengthening Families Strategy. Work is already underway and in some cases has been completed to identify: the Family Focus families in Sunderland; national and international best practice in relation to engaging with such families; and what is already working well in Sunderland. Families are also currently being consulted on their views as to how services can be developed to best meet their needs.

4.2 A well attended partnership workshop was held on 9 May 2012 where the basic design principles for the Family Focus Project were discussed. The

broad aspects of the service delivery model have now been agreed by the Strengthening Families Board and consist of:

- Integrated Multi-Disciplinary Teams – one based in each locality which will be the single point of identification and the initial triage point.

- A multi-agency Information Desk to pool information from different agencies and provide a family profile showing which agencies are currently working with the family, what interventions they are involved with etc.

- A single point of contact with the family through a key worker chosen by them (within guidelines).

- A single assessment/family snapshot using a single tool that takes an asset based approach.

- A single Family Support Plan which details what is needed to meet the identified outcomes for the family which will have been developed with input from the family. This will include what families need to do alongside professionals. It will be a two way pledge detailing the role and responsibilities of all parties.

- Flexible packages of support for each family based on the Family Plan.

- Regular progress review and monitoring with the family and information passed to the Information Desk.

4.3 Key work packages have been created to develop the detail underpinning the model and determine how it will work in practice. Lead Officers from each of the work packages will present their initial products to a Strengthening Families Working Group at the end of July 2012. If agreed, these will then be submitted to the Strengthening Families Board for consideration before the model is implemented.

4.4 The Family Focus Project will apply to a specific cohort of families in the city (i.e. those with multiple and complex needs) as defined by guidance from the Department for Communities and Local Government. However, the intention is that the initiative will act as a springboard for transformation across the board, dramatically improving the way all services work with all families in Sunderland to achieve better outcomes as well as efficiency savings in the longer term.

5.0 Recommendations

5.1 The Health and Wellbeing Board is recommended to note the contents of this report.

Appendix 1

FAMILY FOCUS PROJECT

In December 2011, the Prime Minister launched a new programme designed to 'turn around' the lives of 120,000 'troubled families' in England by the end of this Parliament. The announcement followed the release of new government figures which suggested that the country's 120,000 most troubled families are costing central and local government an estimated £9bn per year in terms of extra spending on the NHS, the police and social services. This was based on previous indicative research which defined a 'troubled family' as one who met five out of the seven following criteria:

- No on in the family is in work
- Living in poor or overcrowded housing
- No parent has any qualification
- Mother has mental health problems
- At least one parent has a longstanding illness, disability or infirmity
- A low income
- An inability to afford a number of food, clothing items

In Sunderland, the Department for Communities and Local Government (DCLG) estimates that there are 805 such families with an estimated cost to the taxpayer of £60,375,000. It is estimated that up to 28 public services might engage with the members of one family, often uncoordinated, with separate interactions, assessments and funding streams. Each agency addresses a separate symptom but do not tackle the root causes of the problem.

The 'Troubled Families' programme in Sunderland has been renamed the **Family Focus Project** and is overseen by the Strengthening Families Board.

Identifying the Family Focus Families in Sunderland

The criteria for drawing up the local list of families to be targeted by the Troubled Families programme has been set out by the DCLG. Any family that meets the following first three criteria below will automatically be expected to be part of the scheme:

1. Young people involved in crime and families involved in anti-social behaviour.
2. Households affected by truancy or exclusion from school.
3. Households which have an adult on out of work benefits.

Local areas then have local discretion to include other families who meet any 2 of these 3 criteria and are a cause for concern. In Sunderland partners have agreed the local discretion criteria as: domestic violence; substance misuse (both adults and young people); and child protection issues.

How will the programme work?

This programme will run on a **payment-by-results basis.** The Government will pay up to 40% of the cost of interventions designed to turn around the lives of these families. It is estimated that the average unit cost of intensive interventions known to work with such families is around £10,000. Therefore DCLG will make available up to £4,000 for each identified family that has demonstrated achievement of the following outcomes in order to receive payment:

Each child in the family has had fewer than 3 fixed exclusions and less than 15% unauthorised absences in the last 3 terms;

60% reduction in ASB across the family in the last 6 months; and

33% reduction in offending by all minors in the family in the last 6 months = £3,900.

Plus

If one adult has achieved 'progress to work' (has volunteered for the Work Programme or attached to the ESF provision in the last 6 months) = £100

Or

One adult in the family has moved off out-of work benefits into continuous employment in the last 6 months = £4,000

Upfront attachment fees are also being paid for eligible families annually.

The Family Focus Project will apply to a specific cohort of families in the city as defined by the guidance from the DCLG. However, the intention is that the initiative will act as a springboard for transformation across the board, dramatically improving the way services are delivered to achieve a wider set of outcomes for *all* families in Sunderland as well as efficiency savings in the longer term.

Item No. 7

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

HEALTH AND SOCIAL CARE SYSTEMS DIAGNOSTIC – NHS INSTITUTE

Report of the Executive Director of Health Housing and Adult Services

Background

The NHS Institute for Innovation and Improvement (the NHS Institute) have been tasked nationally with offering support to health and social care systems through a support programme. In the North East, the Strategic Health Authority have provided funding for the Institute to work with all of the regions PCT clusters to assist in the change that is required to meet the emerging Health agenda with a particular focus on ensuring that Health and Wellbeing Boards can grow into their role of leading the strategic development of health and wellbeing policy and commissioning.

Sunderland Health an Wellbeing Board commissioned the NHS Institute to start the diagnostic tool in Sunderland in late 2011 with reports dues back in time to inform the development of the Shadow Health and Wellbeing Board.

Current Situation

The NHS Institute have carried out the diagnostic tool which involved

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

The report was release in early June and copies circulated to the Health and Wellbeing Board alongside partners who were involved in the review and survey stages.

A session was called by the NHS Institute to launch the report and to discuss how to develop a way forward with the recommendations that were outlined. The session was held on the 21st June at the Stadium of Light and saw 12 participants attend from the City Council, NTW, City Hospitals Sunderland, Age UK, The Carers Centre, the PCT, the Clinical Commissioning Group.

A copy of the presentation from the day is included as Appendix 1.

A number of organisations were unable to attend, and notably South Tyneside Foundation Trust was not included by the NHS Institute on the invitation list. As such it was highlighted at the event that there was a need to bring together a further meeting of the group to discuss the recommendations and way forward with a fuller attendance.

The Diagnostic Report

The report was broadly accepted by those present at the session, however, it was recognised that the report represents a snapshot of the system at a point in time which was 3-6 months ago. A lot in terms of development, relationship building and strategic planning has moved on since the research was undertaken and limitations to this effect were noted.

The report makes in total 24 recommendations to the Health and Wellbeing Board about determining a way forward. It is proposed that these recommendations be discussed in greater detail at the proposed second meeting of the working group. They include specific recommendations for the CCG, NTW, the Ambulance Service and SOTW in respect of community services.

Recommendations that pay specific attention to the Health and Wellbeing Baord, are detailed below and the Board is recommended to review them and agree a common course of action:

Recommendation 4 & 7: The Health and Wellbeing Board should assure that its local authority contributors (councillors and officers) have sufficient advice and support to enable them to understand the new NHS Commissioning process, business models, working practices, drivers and accountabilities of primary and secondary care providers. Similarly, partners, and particularly the CCG and its advisors, should have sufficient advice to enable them to understand the business models, working practices, drivers and accountabilities of the local authority and other potential partners and providers in the health system locally.

Proposed Action: Previous Board meetings have focused on the priorities of Board members including presentations on the Council directorate plans, the Childrens and Young Peoples plan and regular updates on the CCG plans and priorities. Future Boards could also include opportunities for members of the broader system including providers to feed enhance understanding.

Recommendation 5: The Health and Wellbeing Board should lead a piece of work to determine the best way of engaging all staff and volunteers in the health and social care sector to embrace the spirit of the health and social care reforms, and to work as integrated teams and become individual health and wellbeing champions.

Proposed Action: As part of the public health transition project, the HR and OD workstream is looking at ways of engaging staff shaping the reforms and keeping them informed of the changes that will affect them. The engagement sessions being put forward as part of the Health and Wellbeing Strategy are opening up the debates on what changes are needed to respond to the health and social care reforms. This process is ongoing.

Recommendations 8 & 9: There is an opportunity to review the role and function of Public Health as it transfers across South of Tyne and Wear and how it integrates with the current Sunderland way of working.

Proposed Action: The Public Health Transition Board and the workstreams underneath this are ensuring close working between the PCT and local authority to ensure transition is as smooth as possible, but also that the opportunity offered by the transition is maximised.

Recommendations 17: As the development of integrated care is a broadly shared objective in Sunderland a common vision of what this will look like and will deliver in 3-5 years' time needs to be articulated. The vision needs to be framed in a way that connects with staff, motivates them to pursue the objectives and gives them scope to develop how they work together to deliver these at a local level. The Health and Wellbeing Board is well-placed to co-ordinate this work.

Proposed Action: The emerging Health and Wellbeing Strategy and the Clinical Commissioning Group Clear and Credible Plan have a clearly articulated vision which has been developed in consultation with individuals and organisations throughout Sunderland. Additional work needs to be undertaken in particular with organisations active in the Health and Social care system but not currently actively involved in the strategy development process. In particular the engagement of providers needs to be improved.

Recommendation 19: The methodology for delivering change at scale and pace needs to be considered within Sunderland, including:

- the style of leadership required
- the capability to deliver service change
- the capacity within the system to deliver change and how this is used across organisations
- how organisations will work together whilst retaining separate corporate entities
- how objectives are set that reflect the joint nature of the change required
- how people are held to account for delivery
- how risk will be managed.

Proposed Action: Forthcoming Board development sessions will be developed to incorporate change management into the programme.

Recommendations 23: That a comprehensive community engagement plan is created under the auspices of the Health and Wellbeing Board to build up capacity and support the community to engage with the delivery of health and social care services, and provide customer insight.

Proposed Action: Individual engagement plans have been drawn up under the auspices of the Health and Wellbeing Board, specifically around the development of HealthWatch, the JSNA redevelopment, Public Health

Transition and the Health and Wellbeing Strategy. Work needs to be done to bring these individual components together into a comprehensive plan which is monitored and reviewed as part of ongoing development.

Recommendation 24: That, under the auspices of the Health and Wellbeing Board, the voluntary sector is facilitated to fully engage in respect of potential changes and to capture their input to redesign on a community and locality basis.

Proposed Action: Representatives from individual organisations within the voluntary sector are included as core members of the advisory groups of the Childrens Trust and Adults Partnership Board and as standing invitees to the Health and Wellbeing Strategy engagement events. Further work needs to be undertaken to capture input in terms of service redesign and in terms of including a broader range of VCS partners in the process.

Recommendations

The Board is therefore recommended to:

- Agree to calling together a second session to look at the way forward for implementing the recommendations in the Diagnostic Report
- Agree the proposed actions for the Health and Wellbeing Board as detailed above

Item No. 8

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

SUNDERLAND HEALTH & WELLBEING STRATEGY

Report of the Executive Director of Health Housing and Adult Services & Head of Strategy, Policy and Performance Management

1. Purpose of Report

To update the Board on the process and timetable for the development of the Health and Wellbeing Strategy.

2. Background

The Health and Social Care Act gives the local authority the responsibility for five key areas of development –

- To establish a Health and Wellbeing Board
- To complete a Joint Strategic Needs Assessment
- To produce a Joint Health and Wellbeing Strategy
- To set up a local Health Watch
- To transition public health responsibilities.

The Health and Wellbeing Strategy is to be completed by October 2012 and must be a joint high-level strategy that spans the NHS, social care, public health and the wider health determinants of health such as housing and child and community poverty.

Similarly mandated by the Health and Social Care Act, as part of their authorisation process, the Clinical Commissioning Group have produced their Clear and Credible Plan and where appropriate the plans are aligned to ensure clarity of vision across the system, recognising that the two plans have distinct places in the picture.

Faced with reducing public resources and increasing demand and expectations many current delivery methods are recognised as no longer appropriate. The development of the Health and Wellbeing Strategy also comes in the context of large scale change to the way public services are being delivered and in an environment of reducing resources. Although a challenge, the changing environment also offers an opportunity to fundamentally review and improve the way agencies work with residents and communities in the future. At the same time, there is also growing recognition of existing but often untapped assets and potential within communities that can enhance and complement the public sector's offering.

Consideration will need to be given to our relationship with communities and how services can be delivered in the future to make best use of all resources in order to achieve better outcomes. Ultimately we want to enable and support

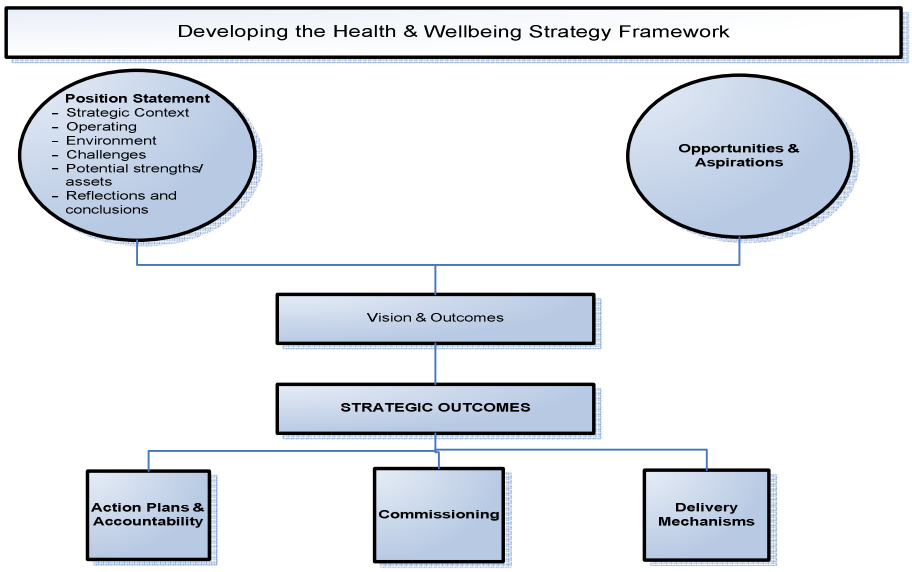
individuals, families and communities in Sunderland to make the transition to greater strength and independence, with less reliance on the public sector in the longer term. This involves being responsive not only to local needs but also to community strengths and exploring how these can be better harnessed to help address local needs. By building on and utilising the resources and energy of our communities, we can support people to take greater control of their lives and enable outcomes that matter to them, their families and communities.

The Health and Wellbeing Strategy, Community Resilience Plan and the Strengthening Families approach are together aiming to achieve the transition to a new way of working and at the same time achieve improved outcomes for the people of Sunderland.

3. Current Situation

The broad process for developing the Health and Wellbeing Strategy is highlighted in Figure 1 below.

Figure 1



Since the last Board update, two broad engagement sessions have taken place. Both the events were held at the Stadium of Light and in total over 70 attendees gave views on: the vision, aims and priorities and how to use assets to change service delivery and empower communities.

These views have been incorporated into the latest version of the outline strategy as detailed in Annex 1:

4. Recommendations

The Board is requested to:

- Note the Strategy development process and progress made
- Review the outline strategy as detailed.

Annex 1

Sunderland's Joint Heath and Wellbeing Strategy

Vision

Better Health and Wellbeing for Sunderland

….by which we mean a City where everyone is as healthy as they can be, people live longer, enjoy a good standard of wellbeing and we see a reduction in health inequalities.

Design Principles

Proposed strategic principles that underpin the delivery of the Health and Wellbeing Strategy are:

- **Strengthening community assets – Empowering communities, increasing their capacity and involving them in co-producing services, thereby enabling them to build on their existing strengths and their potential to help people address their own, family and community's needs.**
- **Prevention – seeking to prevent people developing problems**
- **Early intervention – actively seeking to identify and tackle issues**
- **Equity – provide access to excellent services dependent on need and preferences, and that are based on evaluated models and quality standards**
- **Promoting independence and self care – enabling individuals to make effective choices for themselves and their families**
- **Joint Working – shaping and managing cost effective interventions through integrated services**
- **Address the factors that have a wider impact on health – education, housing, employment, environment, and address these proportionately across the social gradient**
- **Lifecourse – ensuring appropriate action throughout an individuals life with a focus on early years and families**

Assets

- **Strong and stable family and community relationships**
- **The coast and countryside and a passion for sport and activity**
- **Potential for large employers to offer swift access to a large proportion of the workforce and understanding of different communities**
- **A vast number of contacts with residents through daily provision of a wide range of services**
- **At the leading edge of putting new technology to work in the public interest**
- **A huge variety of local organisations and networks with a strong track record of effective delivery**

Strategic Objectives

Notes on strategic objectives:

- **The numbers are for ease of reference and not a priority**
- **Each strategic objective utilises one or more of the assets and applies the design principles.**

1. Mutual understanding between communities and organisations

- **Communities understanding what they can expect of service providers and what other organisations can offer**
- **Making best use of local intelligence to identify emerging risks to health and wellbeing**
- **Harnessing individuals, communities and service providers views to inform and challenge provision**
- **Understanding the strengths and diversity in our communities and reflecting this in our commissioning**

2. Ensure that children and young people have the best start in life:

- **Encouraging parents and carers of children to access early years opportunities**
- **Acknowledging the whole of a child's journey, including the transition into adulthood**

3. Supporting and motivating everyone to take responsibility for their health and that of others:

- **Encouraging people to take the first steps towards healthy lifestyles**
- **Making healthy lifestyle choices easy**

- **Promoting and sustaining interest in healthy lifestyle options**
- **Raising self-esteem, confidence and emotional health and wellbeing**

4. **Supporting everyone to contribute**
    - **Work together to get people fit for work**
    - **Understanding the health barriers to employment and training, and supporting people to overcome them**
    - **Actively working with local businesses to ensure a healthy workforce**
    - **Supporting those who don't work to contribute in other ways**

5. **Supporting people with long-term conditions and their carers:**
    - **Supporting self-management of long-term conditions**
    - **Providing excellent integrated services to support those with long-term conditions and their carers**
    - **Support a good death for everyone**

6. **Supporting individuals and their families to recover from ill-health and crisis:**
    - **Supporting individuals and families to have emotional resilience and control over their life**
    - **Providing excellent integrated services to support people to recover from ill health and crisis**
    - **Building trust and relationships with individuals and families who require support**

Item No. 9

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

NATIONAL LEARNING SETS FOR HEALTH & WELL BEING BOARDS

Report of the Executive Director of Health, Housing and Adult Services

Purpose of the Report

1. To update the Board on the publication of the findings of the National Learning Sets for Health and Wellbeing Boards.

Background

2. As previously reported, Sunderland have been participating throughout its Early Implementer stage into a national learning set focussing on how Health and Wellbeing Boards can make best use of collective resources. The representative from Sunderland was the Executive Director of Health, Housing and Adult Services.

3. This is part of a series of seven national learning sets which have focussed on themes that early implementers have said are of most interest and importance to Health and Wellbeing Board members, namely:

   - Improving the health of the population
   - Bringing collaborative leadership to major service reconfiguration
   - Creating effective governance arrangements
   - How do we “hard wire” public engagement into the work of the board?
   - Raising the bar on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
   - Making the best use of collective resources.
   - Improving services through more effective joint working

4. The intention of the sets was to gather and share learning from the Early Implementer phase to support Boards as they make their transition to Shadow status and subsequently take up the full statutory role. More than 90 out of 152 emerging Health and Wellbeing Boards from across England have been represented in the learning sets.

5. Each learning set comprised members from local government and NHS organisations, with a nominated policy lead from the Department of Health. The peer-to-peer learning approach encouraged senior people to share solutions that are already working, shape new solutions and influence national policy makers in the areas that matter to emerging boards and their constituent members.

National Learning Set Findings

6. The findings of the learning sets have been condensed into a series of products designed to support health and wellbeing boards. These were launched at the NHS Confederation conference in June. The products summarise each learning set's key points of learning and are designed to provide useful points of reference for shadow health and wellbeing boards as they move towards statutory form in April 2013.

7. The eight products include:
    1. A guide to governance for health and wellbeing boards
    2. Public and patient engagement: resources for health and wellbeing boards
    3. Health Impact Assessment: a useful tool for health and wellbeing boards
    4. Case studies relating to the health and wellbeing of children and young people
    5. Poster relating to the health and wellbeing of children and young people
    6. Making the best use of collective resources: An introduction for health and wellbeing boards
    7. Making the best use of collective resources: Examples in practice
    8. A review of policy documents on children and young people's health and wellbeing

Copies of these resources can be downloaded from the NHS Confederation website - http://www.nhsconfed.org/Publications/Pages/lresources-health-wellbeing-boards.aspx .

Making Best Use of Collective Resources Learning Set

8. Membership of the set was drawn from across the country and includes a mix of Board level members from Local Government, PCTs and CCGs. It met four times virtually and at one London based learning event.

9. The final report of the learning set is attached as Appendix 1 and includes
    - a set of questions for Boards to prompt consideration of key issues,
    - a series of 'tips' for Boards as they consider the use of collective resources,
    - a list of the range of resources that may be available, and
    - an explanation of terms regularly used by the various partner organisations.

10. The Five 'top tips' from the collective resources learning set were:
    Top tip 1: Benchmark use of resources
    Top tip 2: Use evidence to support the board's decision-making
    Top tip 3: Plan for areas of tension
    Top tip 4: Establish the scope of each member's responsibilities
    Top tip 5: Clarify how financial decisions are taken in member organisations

11. It is proposed that the report be considered alongside those of the other learning sets and recommendations for action be integrated in to the recommendations from the NHS Institute diagnostic tool. It is then proposed that an action plan be developed with responsibilities shared between the Health and Wellbeing Board and the advisory groups of the Adults Partnership Board and Children's Trust.

Recommendations

12. The Health & Wellbeing Board is recommended to

    (a) Note the content of the report.

    (b) Agree to the development of an action plan bringing together actions from the learning sets and the NHS Institute report.

Making the best use of collective resources

An introduction for health and wellbeing boards

June 2012

Key points

- Taking a systematic, planned approach to joint working is more likely to produce success.
- There are a variety of ways that resources can be shared – with different degrees of formality.
- Collaborative use of resource types such as finances can help local agencies get more from the same.
- A focus on building trust and a genuinely shared vision and strategy should be a first-order priority for emerging health and wellbeing boards.
- A longer version of this summary guide is available on the LGA knowledge hub.

This summary guide is meant to help health and wellbeing boards understand how to collectively use the resources available in their local area. Money is one part of this, but the guide also highlights how other kinds of resources can be used collaboratively to greater effect. This summary guide was produced by the health and wellbeing board learning set for the use of collective resources.

Health and wellbeing boards have been created to enable leadership of local health and social care systems and encourage partnership working between these services. A key component of this role will be the ability to join-up the resources available to each of the organisations that make up the board – sharing, reducing duplication and getting more from the same.

The current context of financial pressure on public services and need for savings makes the lessons contained in this guide all the more valuable. As money gets tighter, it is vital that local organisations resist the temptation to retrench or become inward-focused and instead pursue the opportunities that using their limited resources collaboratively can bring.

At a glance

Audience: This summary guide is aimed at all health and wellbeing board (HWB) members and supporting officers.

Purpose: To provide HWBs with some top tips and suggested questions to use when considering how to make the most of the resources available to each member.

Background: This guide was developed by a HWB learning set, which is part of the National Learning Network (see back cover) and is supported by the Department of Health, NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement.

Supported by

DH Department of Health

Local Government Association

NHS CONFEDERATION

NHS Institute for Innovation and Improvement

Integrated commissioning: Duties and Directions

Different areas will be in different positions regarding levels of joint working. Some localities will already have well-developed integrated teams whereas others will operate a model of collaborative commissioning without formal integration. It is important to understand the differences between **integrated commissioning** and **joint commissioning** in planning how local partnerships will operate under the health and wellbeing board.

Integrated commissioning is the process where organisations come together to consider their respective strategic commissioning responsibilities in their entirety. This may include aspects of work where joint arrangements do/do not materialize, but where there is an agreement to be open and transparent about all commissioning activity.

Where agreements to undertake pieces of commissioning work together are reached, this can be said to be joint commissioning: where organisations combine their resources (formally or informally) for a particular service or pathway.

The following boxes describe some of the mechanisms that exist to help health and wellbeing boards achieve more joined-up local services.

Encouraging integrated working

A key duty on health and wellbeing boards is to promote integrated working to improve services, reduce inequalities and make the best use of collective resources – something that clinical commissioning groups, the NHS Commissioning Board and the health regulator Monitor are also required to do. There are various levels at which health and wellbeing board members can coordinate their commissioning processes and decisions to achieve joint working. At the most basic level, boards can agree to an integrated commissioning approach, meaning that commissioning members use the board as a forum to keep each other informed and involved as they make important commissioning decisions.

Joint commissioning

For services or pathways that may benefit from a closer level of cooperation, organisations can agree to joint commissioning. Joint financing arrangements can be formal, such as when NHS and local authority bodies 'pool' their budgets, or take more informal configurations that retain each party's independence – so called 'aligned' budgets. Health and wellbeing boards will have a duty to consider how joint financing arrangements could better meet the needs in the Joint Strategic Needs Assessment (JSNA), and a further duty to provide advice, assistance and other support to encourage commissioners to take advantage of pooled budgets.

For more information see: Audit Commission (2009), *Means to an end: Joint financing across health and social care.*

JSNA/Joint health and wellbeing strategy

Regardless of degrees of formal integration, clinical commissioning groups, the NHS Commissioning Board and local authorities will need to have regard to the relevant JSNA and joint health and wellbeing strategy when carrying out their functions. Specifically, CCGs must involve health and wellbeing boards when preparing their commissioning plans or making revisions that CCG's consider to be significant.

For more information see *JSNA and joint health and wellbeing strategies draft guidance:* **www.dh.gov.uk**

Relationships

Research and experience show that where successful service transformation has been achieved, no amount of duties, mechanisms or intelligence has been able to replace close, positive relationships between local system leaders. Focusing on building trust and a genuinely shared vision and strategy should be a first-order priority for emerging health and wellbeing boards.

Commissioning support

Strategic commissioners will require support to collate and interpret the range of information into intelligence that can be used to inform their decisions, and then to implement and monitor these. As there is considerable overlap between the commissioning functions performed by different health and wellbeing board members – particularly local authorities and CCGs, boards should consider whether some of the support arrangements they need could be joined up.

For more information see: NHS Commissioning Board (2012), *Developing Commissioning Support: Towards excellent service.*

Funding for collaborative working

A portion of NHS funding – £1 billion per year by 2014/15 – has been set aside to be spent on social care and reablement services. Local authorities must work together with NHS commissioners to identify ways to allocate this money to support vital services or invest in preventative approaches.

For more information see page 50, paragraph 5.24 of the *Operating framework for the NHS in England 2011/2012:* **www.dh.gov.uk**

Personal budgets

Integrating personal budgets (social care) with new personal health budgets (NHS) could allow for greater service integration at the level of the individual. Many people who receive services from both the NHS and local authority could benefit from a single joint budget that brings together the two funding streams and helps partnership working between professionals.

For more information see forthcoming publication from the Department of Health and NHS Confederation: *Integrating personal budgets for health and social care.*

Ten questions every health and wellbeing board should ask itself

Below are some questions for boards to discuss that may help them to think through different ways of deploying resources and agree an approach that is right for their own local circumstances.

1. Is there a consensus over what the board wishes to achieve through the sharing of resources?
2. Are the right people on the board to commit to and mandate any decisions to commit resources?
3. Do the board's members have a clear understanding of what types of fixed and variable resources (finance, people, buildings, information) they need information on, and what the totals of these are?
4. Has the approach to utilising resources collaboratively been agreed by the relevant agencies (for some ideas of different approaches, see the 'examples in practice' that accompany this guide)?
5. Has the board considered where formal joint commissioning arrangements, or other forms of integrated commissioning, might work best?
6. Is there an understanding of the different governance requirements of each organisation involved in using resources collaboratively?
7. Is there scope for flexibility and innovation in the deployment of resources, especially those that appear to be already committed or fixed?
8. What other agencies might the board engage in order to bring other resources to bear (for example, from the private or voluntary sectors)?
9. Do the board's members share a commitment to, and definition of, openness and transparency in their decisions about the use of resources?
10. Is there an agreement on how the benefits will be shared? Are there risk sharing protocols if success is not achieved?

Five top tips from early implementers

All boards should learn from the endeavours of each other. The following pieces of advice on making the best use of collective resources are based on the experience of early implementer sites and examples of what has worked well for those within the learning set. The five top tips were taken from a list of 10 that can be found in the longer version of this guide, which is available on the LGA knowledge hub.

Top tip 1: Benchmark use of resources

Boards and their members should consider benchmarking their allocation of resources against similar or comparable areas (for example, statistical neighbours) that are achieving good outcomes. Comparing variations in different areas' programme budgets to their improvements in outcomes can be a useful way of analysing investment levels for a particular community's need. A useful resource (particularly for clinical commissioning groups) when doing this work is the NHS Benchmarking Club (**www.nhsbenchmarking.nhs.uk**), and particularly the National Audit of Intermediate Care (**www.nhsbenchmarking.nhs.uk/icsurvey.aspx**) due in autumn 2012.

Why? Benchmarking approaches are a helpful way of understanding levels of return on investment that boards might aspire to achieve. They also give a useful perspective on what can be done to address inequalities in populations across a defined area.

Top tip 2: Use evidence to support the board's decision-making

Health and wellbeing boards should ensure they have access to and use regional and national evidence on the most effective ways of improving health and wellbeing, as well as information of what has worked well in their own locality. Different board members and partners

will also hold a plethora of data and intelligence that, when brought together, may provide a more comprehensive understanding of what solutions will meet their population's needs.

Why? Boards will have access to intelligence on how to make the best use of resources, however this information, held by different organisations, is not always brought together. Using these knowledge resources collaboratively will help boards to learn from the successes and failures of others in the locality, region and country.

Top tip 3: Plan for areas of tension

Not all organisations want the same thing, so it will be useful to set out processes for areas of disagreement. Although time invested early on in understanding the pressures and positions of each board member will be well spent, in the long term it may also be useful to ensure that the board's discussions are not solely focused on the agreed priorities, and that some time is given to understanding issues that are not shared and could cause tension if they are not openly discussed.

Why? Boards will benefit from taking account of how successful partnerships operate. This includes understanding that there will be common areas of interest but also areas outside the scope of the board that member organisations will be influenced by. Understanding which of these could impact on the successful work of the board could reduce the build up of tensions and improve how the board deals with them – this is especially important where organisations have put financial resources at risk.

Top tip 4: Establish the scope of each member's responsibilities

Since few health and wellbeing boards will be directly commissioning services, a key part of their role will be to oversee the governance and delivery of locally agreed plans (such as the joint health and wellbeing strategy). Coordinating perspectives and actions across the NHS, public health, social care and the whole of local government will be easier if it follows from a shared understanding of what the board exists to do and what each member's contribution to this is.

Why? Different board members and organisations may have differing levels of understanding of the role and responsibilities of the board. Exploring these to reach a common position will make it easier to agree new ways of working.

Top tip 5: Clarify how financial decisions are taken in member organisations

As well as calculating the totality of resources within the scope and influence of the health and wellbeing board, it would be beneficial to understand how financial decisions are taken in each of the member organisations. This may include required timescales for returns on investment, current financial pressures and the processes for commissioning or decommissioning a service. Members will need to be able to challenge investment decisions, especially where these may have an unforeseen impact in other parts of the local health economy. Reaching a consensus will help avoid adding to financial constraints and cost pressures, cost shunting and short-term decision making.

Why? Reaching agreement on how to use resources collectively will be easier if board members understand each other's decision-making style and procedures.

Scoping resources: what to ask for and in how much detail

Across the NHS and local government there are myriad funding streams, financial regimes, accountability arrangements and governance procedures. This makes bringing ambitions and resources together difficult. An important initial stage for health and wellbeing boards who do this is to scope the extent and nature of what resources are available to members. It is important to get this process right, as gathering information of sufficient depth and quality often involves significant effort by people that support the board.

Below are some important considerations to hold in mind when gathering resource information for use by the health and wellbeing board, including a suggestion as to the level of detail that boards are likely to consider appropriate and other questions that it may be important to ask.

Agree which organisations are to be scoped

Resources that the board may consider as potentially under its influence may belong to a broad range of organisations that need to be engaged, including:

- statutory organisations
- voluntary sector organisations
- carers and informal support networks
- major local employers.

Agree what should be considered as a resource

Resources that the board may wish to consider worth scoping include finances, people, assets, skills, networks and information.

Of these, some important areas to think about gathering data on are:

Finances:

- total budget of the stakeholder organisation
- unit cost data, such as total cost per head of population
- price charged for a range of common services
- saving and efficiency targets
- budget setting timetables.

People:

- employed workforce
- non-employed human resources, for example, volunteers, carers and expert patients
- anticipated requirements for the future (for example, integrated workforce, generalists vs specialists).

Infrastructure:

- list of all property assets held
- extent of under/over utilisation of assets
- any asset strategies currently in place.

Boards may also wish to calculate some of the individual assets of citizens, as this links to the levels of deprivation, government funding and impact of changes to means tests. Information to consider collecting might include the rates of unclaimed benefits/entitlements and the number of self-funders.

Resources consumed by the board

Since health and wellbeing boards will consider system resources and the efficacy of their usage, they should also be aware of their own costs of operation. This includes a breakdown of the board's annual operating costs against its budget, who the named budget holder and group accountant is, and what ancillary expenses are being consumed by board members to support its work.

Initiating joint work

Sharing resources can release significant additional capacity in local systems and reduce duplication. Such arrangements need to be managed carefully, however, as close joint working needs to be done with a clear understanding between all parties involved of any agreement.

Before entering into a joint working arrangement, it is essential that the health and wellbeing board has a scoping template completed to set out some of the core details of any proposed arrangement. At a minimum, this should include the following:

- a definition of the scope of the project, i.e. what is inside/outside its range
- an agreement from all members to the defined scope
- a description of what kinds of resources are included from each member, for example:
    - if finances, analysis should be included between capital, revenue and time period of payments
    - if personnel, the names of posts being seconded or, in the case of new posts, who is the employing organisation and what are the terms
    - if assets, these should be individually listed and stated as to whether they are to be loaned or acquired, with the terms on which either of these has been agreed stated
- the sources of any funds used and how these have been made available
- approval arrangements/procedures for each organisation involved
- whether the project will be marketed under a single participating organisation or all
- who the legal entry for contracting purposes will be
- a risk assessment and risk management plan
- a list of the key staff in each participating organisation who are responsible for the oversight or day-to-day running of the project.

This document was developed as part of the National Learning Network for health and wellbeing boards, a programme funded by the Department of Health and supported by the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement. Each health and wellbeing board learning set has focused on a theme that early implementers have said is of most interest and importance.

It aims to provide health and wellbeing board members with an accessible and helpful resource and does not necessarily showcase best practice but represents key learning on the issues. For further information, or to comment, please email hwb@nhsconfed.org.

The health and wellbeing board learning set for the use of collective resources that developed this publication included:

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Further information

Email: hwb@nhsconfed.org
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Item No. 10

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

BOARD DEVELOPMENT SESSION – INFLUENCE AND RELATIONSHIPS AND DECISION MAKING

1.0 PURPOSE OF THE REPORT

To inform the Board of the date and scope of the next development session.

1.1 INFLUENCE AND RELATIONSHIPS AND DECISION MAKING

The Shadow Health and Wellbeing Board does not operate in isolation – it works in parallel to Boards throughout the City that lead on topics which in turn impact on the health and wellbeing of residents – including crime and community safety, jobs, employment and training, children and adults.

The importance of developing a system which ensures that all partnerships are working towards the same goals and that joint goals and asks of each partnership are clearly articulated is key.

To facilitate this, the development session on **Thursday 30 August 2012, 10.00am - 12.00noon in Committee Room 1** and representatives from the parallel partnerships are to be invited.

The Aims and Objectives of the session are as follows.

Development Aims	Objectives/Outcomes
Establish methods that will enable a clear communication, influencing and decision making process with Sunderland other key strategic groups e.g. The Sunderland Partnership Board & SIIG, Economic Leadership Board, Education Leadership Board (One Education Board), Safer Sunderland Partnership, Children's Trust, Adults Partnership Board, Clinical Commissioning Group	○ Agree a process to ensure that other Strategic Boards are informed, and can influence the decisions being made by the Health & Wellbeing Board ○ Feed into strategy development process ○ Establish the 'one big task' for each group

The session will be facilitated by the council's development and training team.

3.0 RECOMMENDATIONS

The Board is recommended to note the session.

Item No. 12

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **31 July 2012**

INITIAL BRIEFING ON WHITE PAPER 'CARING FOR OUR FUTURE: REFORMING CARE AND SUPPORT'

REPORT OF THE EXECUTIVE DIRECTOR OF HEALTH HOUSING AND ADULT SERVICES

1. PURPOSE OF THE REPORT

To provide the Board with an initial briefing on the White Paper 'Caring for our future: reforming care and support'.

2. BACKGROUND

The coalition's Programme for Government highlighted in May 2010 the "urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face". Andrew Dilnot's Commission on the Funding of Long-Term Care reported in July 2011, and the Law Commission completed its review of social care legislation in May 2011. In response, the Government launched an engagement exercise, 'Caring for our future', from September to December 2011 with a number of strands including integration with health, information and insurance. During 2011/12, the Health Select Committee published reports on funding social care and integration. A white paper and an update on funding reform were originally promised in April but came out on 11th July 2012 under the title Caring for our future: reforming care and support'

3. OVERVIEW

The White Paper 'Caring for our future: reforming care and support' sets out the vision for a reformed care and support system.

The White Paper was released together with the draft Care and Support Bill and a progress report on funding reform. The Care and Support Bill aims to create a single law for adult care and support, replacing more than a dozen different pieces of legislation. It provides the legal framework for putting into action some of the main principles of the White Paper and also includes some health measures. The progress report sets out that the government agrees the principles of the Dilnot Commission's model – financial protection through capped costs and an extended means test – would be the right basis for any new funding model.

There are two core principles underpinning the vision of social care and support presented in the White Paper:

1) focus of care and support will be **on promoting people's wellbeing and independence** instead of waiting for people to reach a crisis point

The Government wants to support active communities that will reach out to those around them. Families and individuals will have better information to plan and prepare for their future, and people will have more options to keep them well and independent the simple notion of promoting people's independence and wellbeing.

2) **People should be in control of their own care and support**

Personal budgets and direct payments, backed by clear, comparable information and advice, will empower individuals and their carers to make the choices that are right for them. This will encourage providers to improve and to provide high-quality, integrated services built around the needs of individuals. Local authorities will also have a more significant leadership role to play, shaping the local market and working with the NHS and others to integrate local services.

4. OUTLINE OF THE MAIN THEMES

Strengthening support within communities
The White Paper underlines that strong communities can improve our health and well-being and reduce health inequalities. The Government is encouraging a number of projects to help develop supportive networks of volunteers within communities including among others time banking. Social Impact Bonds will be used to stimulate investment in new innovative services.

Early intervention and prevention
The Government will introduce a duty on local authorities to commission and provide preventative and early intervention services. Joint Strategic Needs Assessment will play a role in identifying how the skills and networks in a community can contribute to the health and wellbeing of local people

Housing
New duties will be put on local authorities to ensure social care and housing departments work together. A new care and support housing fund will provide £200 million of funding over five years to encourage housing providers to develop new accommodation options for older people and disabled adults. Further details about the fund will be published in October 2012.

Moreover, incentives and support will be given to encourage widespread adoption of assistive technology, such as Telecare, as it is recognised to help people to live independently, have greater control over their health and well-being, improving the quality of life for both users and their carers.

Better information and advice
The Government will legislate for local authorities to provide a comprehensive information and advice service and providing £32.5 million over two years from 2014/15 to support local authorities in improving their online information

and support services. Getting access to information about services and entitlement is a huge problem for those in need of care and carers.

To address the need for better national information, the Government is creating a single portal for health and social care bringing together national information on the NHS, social care and public health. The NHS 111 urgent care telephone service will also help to signpost callers with social care needs to their local authority.

Assessment, eligibility and portability for people who use care services
From 2015 the Government will introduce a national minimum eligibility threshold. Local authorities will be able to set their eligibility threshold to be more generous but will not be able to tighten them beyond the minimum.

The Government will legislate to require local authorities to continue to meet the assessed needs of people who have moved into their area. People should also be able to request an assessment before they move home.

Legislating for the 'portability' of care will help to allay the fears of carers and their families that leaving their local authority could result in them losing their care package. Having this flexibility will help people make the most appropriate choices about where they and their families live. These measures are being taken forward in the draft Care and Support Bill.

Carers' support
The Government plans to extend the right to a carer's assessment and provide an entitlement to services for carers for the first time. Eligibility will be set by a national minimum eligibility threshold for support for carers. By 2013, everyone needing state-funded care should be offered a personal budget as part of their care and support plan, preferably as a direct payment.

In order to improve the early identification of carers, the Government will establish, in the Secretary of State's Mandate, responsibilities on the NHS Commissioning Board and clinical commissioning groups to identify and support carers.

Defining high-quality care and improving quality
The Government sets out plans to improve the quality of the social care provided. Every social care provider will have a quality profile on the NHS and social care information website. The first stage will go live on the NHS and Social Care Information website in July 2012.

To move towards quality ratings for social care provides, the Government will support the growth of care comparison websites and support websites which allow service users and carers to feed back about good or poor quality practice.

In April 2013, the Government will add improved information to the provider quality profile and make data available to organisations developing a quality rating.

Working with the Association of Directors of Adult Social Services, the Government seeks to improve the quality of commissioning and in particular end the practice of contracting by the minute.

The Government will also provide training for new local Healthwatch organisation to take on the responsibilities in relation to care and support.

Keeping people safe
The Government intends to legislate to give local authorities responsibility for convening a Safeguarding Adults Board in their areas, which will have the responsibility to carry put safeguarding adults reviews.

The Government will launch a consultation on whether local authorities should have a new power to access and see a person who may be at risk of abuse or neglect, in cases where the local authority may not otherwise be able to carry out a safeguarding enquiry.

Expanding the care market
The Government will put a duty on local authorities to stimulate a diverse and high quality care market and the White Paper highlights their position as market shapers with responsibility for self funders as well as publicly funded care.

Workforce
Dignity and respect will be at the heart of new code of conduct and national minimum training standards for care workers. Personal assistants (Pas) and their employers will be offered greater support and training to improve recruitment, retention and the quality of the care and support they deliver. The Government aim to double the number of apprentices in social care over the next 5 years.

Personalised care and support
The Government will create a legal entitlement to a personal budget for everyone and will continue with the push to maximise of uptake direct payments. The Government will invite expression of interest from local authorities to pilot direct payments in residential care in summer 2012.

Integration
The NHS Commissioning Board, Clinical Commissioning Groups, Monitor and health and wellbeing boards will all have duties to promote and enable integration of services. The NHS will transfer an extra £100 million in 2013/14 and £200 million in 2014/15 to improve joined-up working with social care.

In order to promote local transparency and decision making, the Government has developed Outcomes Frameworks for the NHS, public health and adult social care. The Government will publish the 2013/14 Adult Social Care Outcomes Framework in October 2012.

An integration plan, which sets out how the modernisation of the NHS can be built upon to provide a more joined-up experience for people, will be published in winter 2012.

5. SUNDERLAND CONTEXT

5.1. Promoting people's wellbeing and independence

- **Prevention and early intervention**

Focus on prevention and overall wellbeing is already being promoted in Sunderland. Innovative services such as Telecare and prevention teams reduce or delay the need for high cost crisis interventions and expensive residential care, potentially reducing the number of cases in which the Council would be required to intervene and provide financial assistance above the cap. This preventative approach has already seen a rapid decline in annual admission rates of older people to residential/nursing care in recent years, and the Council remains committed to investment in upstream preventative measures despite the need for immediate efficiency savings.

- **Strengthening support within communities**

Supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, is central to our vision for care and support. The same (asset) approach based on empowering the communities, increasing their capacity, involving them in producing services and therefore enabling them to build on their existing strengths and their potential to help people to address their own, family need and community needs underpins Sunderland's Joint Health and Wellbeing Strategy that is currently being developed. The approach in the work around Community Resilience and Strengthening Families is also framed around recognition that all communities have strengths and assets. Assets and opportunities log that is currently being undertaken should help with identifying skills and assets existing within the communities, which can help individuals and communities by mobilising and building on their existing strengths and potential.

- **Housing**

The Supporting People programme helps a wide range of people to live independently in the community by providing a range of support and assistance. The programme aims to provide a high quality of support that meets individual needs on both a long and a short term basis. Furthermore, Extra Care housing provides independent living for people over the age of 55.

- **Carers**

Nationally carers' have welcomed many of the provisions outlined in the paper. In Sunderland it is recognised that the resources available to support carers are vital to the success of personalisation, to enable people to maintain their caring role and to help the individuals they care for to stay in their own homes and communities for as long as possible. The Carers Breaks and Opportunities Fund, administered by the Carers' Centre offers a flexible and

creative way to provide acceptable help to carers with things or services that they value.

5.2. People should be in control of their own care and support

- **Personalisation**

The Health, Housing and Adult Services Vision for 2025 and the current three year delivery plan focus on six key aims: Choice and Control, Independent Life, Equal Access for All, Improving Health and Wellbeing, Better Commissioning and Increasing the Number and Quality of Homes.
The service aims at maximising and maintaining people's independence through: Prevention, Reablement and Personalised responses, all of which are in line with what is proposed in the White Paper.

The new Contributions Policy has been approved by the council in February 2012, enabling people to contribute to their annual personal budget based on their ability to pay, instead of being charged for units of service. This allows people to use their personal budgets more creatively and promotes more flexible and cost effective solutions to meet their needs. It will help to promote the take up of Direct Payments, which is understood to be critical to achieving true and authentic personalisation. The new policy also reduces bureaucracy and cuts down the number of transactions between the council and the individual.

Integration
The integration of service is already on Health and Wellbeing agenda in Sunderland. The duties that are planned to be imposed on The NHS Commissioning Board, CCGs, Monitor and health and wellbeing boards should assist with the aspiration.

6. NEXT STEPS

Proposals to legislate will be taken forward in the draft Care and Support Bill which will be scrutinised by Parliament before a final Bill is introduced.

To take forward other provisions in the White Paper, two new leadership groups will be established; a new Care and Support Transformation Group made up of local authorities, care providers, the voluntary sector and service users and carers; and the Care and Support Implementation Board made up of those leading streams in the Caring for our Future consultation.

The timetable for the key actions which will transform care and support over the coming months and years is included in appendix A.

The Government has committed to work with its partners on further publications over the coming months, which will provide more details of the reform plans.

In the meantime there are some imminent actions coming out from the White Paper that Sunderland may wan to consider. For example:

- participation in the groups that are to be established (Care and Support Transformation Group)
- participation in pilots projects that are to be launched shortly (direct payments in residential care)
- response to consultations that are shortly to be released by the Government

In a longer term, once details are released, Sunderland will need to consider implications of the changes to social care and support delivery. For instance, what will be the implications of the introduction of the national minimum eligibility thresholds or minimum training standards for care workers or impact carers resulting from further development of personalisation agenda.

7. RECOMMENDATIONS

The Board is recommended to note the content of the report and is invited to make comments.

Further updates in relation to the White Paper will be provided to the Board as appropriate.

APPENDIX 1

This White Paper sets out a range of actions which the Government and its partners will take forward straight away, in order to reform care and support.

The table below sets out the timetable for the key actions which will transform care and support over the coming months and years.

June 2012	**2012/13 Health and Social Care Volunteering Fund (local scheme) invites bids to support community-based support, including time-banking schemes.**
July 2012	**First stage of the provider quality profile goes live on the NHS and Social Care Information website.**
July 2012	**Publication of the draft Care and Support Bill, setting out how we plan to reform care and support law. The draft Bill will be subject to pre-legislative scrutiny.**
Summer 2012	**Expressions of interest invited to pilot direct payments in residential care.**
Autumn 2012	**Consultation on oversight of the care market published. This will provide more details on how people will be protected should a care provider run into financial difficulties.**
Autumn 2012	**Further details about the process for establishing Social Impact Bond trailblazers published.**
September 2012	**Code of conduct and minimum training standards for care workers published.**
October 2012	**Further details about the £200 million capital fund for older and disabled people's housing published.**
October 2012	**2013/14 Adult Social Care Outcomes Framework published.**
Winter 2012	**Publication of an integration plan, setting out how the modernisation of the NHS can be built upon to provide a more joined-up experience for people.**
Winter 2012	**Chief Social Worker appointed.**
Winter 2012	**2013/14 Health and Social Volunteering Fund (national scheme) invites bids to support community-based support, including time-banking schemes.**
March 2013	**Working group established to develop and test options for a new assessment and eligibility framework for people who use services and for carers.**
March 2013	**Launch of the Leadership Development Forum.**
Spring 2013	**Social Impact Bond trailblazers launched, to encourage investment in innovative support to keep people independent at home.**
April 2013	**NHS Commissioning Board, clinical commissioning groups, Public Health England, health and wellbeing boards, and local authorities take on their new statutory responsibilities as set out in the Health and Social Care Act 2012.**
April 2013	**Additional funding for integrated care and support made available to local authorities through the NHS Commissioning Board.**
April 2013	**Improved information added to the provider quality profile, and the data made available to organisations to develop a quality rating.**
April 2013	**NICE begins the development of a library of quality standards for care and support, including standards for the quality of home care.**
April 2013	**Residential care charging rules changed, so that the income that people earn in employment is exempt from charges.**
Winter 2013	**Care and support sector compact published.**
April 2015	**Introduction of new funding system for end-of-life care.**
April 2015	**National minimum eligibility threshold for adult social care introduced.**