SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 1) on Friday 29 May 2015 at 12.00noon

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

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1.	**Apologies for Absence**	
2.	**Declarations of Interest**	
3.	**Minutes of the Meeting of the Board held on 20 March 2015** (attached).	1
4.	**Feedback from Advisory Boards** • **Adults Partnership Board** (attached). • **NHS Provider Forum** (attached).	 13 15
5.	**Update from the Health and Social Care Integration Board** Report of the Health and Social Care Integration Board (attached).	17
6.	**Children's Safeguarding Peer Review and Framework of Cooperation** Joint report of the Executive Director of People Services, Sunderland City Council and the Independent Chair of Sunderland Safeguarding Children Board and Sunderland Safeguarding Adults Board (copy attached).	25
7.	**Joint Strategic Needs Assessments** Report of the Executive Director of People Services (copy attached).	55

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Information contained within this agenda can be made available in other languages and formats.

8.	**Sunderland CARE Academy** Report of the Chair of Sunderland CARE Academy (copy attached).	63
9.	**CCG Operational Plan Refresh** Report of the Chief Operating Officer, Sunderland Clinical Commissioning Group (copy attached).	85
10.	**NHS Quality Premium 2015/2016** Report of the Chief Operating Officer, Sunderland Clinical Commissioning Group (copy attached).	147
11.	**Health and Wellbeing Board Forward Plan and Board Timetable** Report of the Head of Strategy, Policy and Performance Management (copy attached).	151
12.	**Date and Time of the Next Meeting** The next meeting of the Board will be held on Friday 24 July 2015 at 12noon.	-

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

21 May 2015

Item No. 3

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 20 March 2015

MINUTES

Present: -

Councillor Paul Watson (in the Chair)	-	Sunderland City Council
Councillor Graeme Miller	-	Sunderland City Council
Councillor Pat Smith	-	Sunderland City Council
Councillor Mel Speding	-	Sunderland City Council
Neil Revely	-	Executive Director of People Services
Dave Gallagher	-	Chief Officer, Sunderland CCG
Gillian Gibson	-	Consultant in Public Health
Ken Bremner	-	Sunderland Partnership
Kevin Morris	-	Healthwatch Sunderland

In Attendance:

Councillor Ronny Davison	-	Sunderland City Council
David Tate	-	Hetton Town Council
Liz Highmore	-	DIAG
Nicola Thackray	-	North East Ambulance Service
Sandra Mitchell	-	Head of Community and Family Wellbeing, Sunderland City Council
Graham King	-	Head of Integrated Commissioning, Sunderland City Council
Kath Bailey	-	Locum Consultant in Public Health, Sunderland City Council
Lorraine Hughes	-	Public Health Lead, Sunderland City Council
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

HW50. Apologies

Apologies for absence were received from Councillors Kelly and Leadbitter and Christine Keen, Dr Pattison and Dr McBride.

HW51. Declarations of Interest

There were no declarations of interest.

HW52. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 23 January 2015 were agreed as a correct record subject to an amendment to show that Gillian Gibson was not Acting Director of Public Health until 1 April 2015.

HW53. Feedback from Advisory Boards

Adults Partnership Board

Councillor Miller informed the Board that the Adults Partnership Board had met on 3 March 2015 and the main issues considered had been: -

- Over2You Project
- Smoking Prevalence Update
- New Horizons Project
- Department of Health Autism Self-Assessment

In relation to smoking prevalence, Councillor Miller reported that the Board had felt that the message needed to be more challenging and had asked to have a report brought back which outlined how hardcore smokers would be targeted.

The Chair stated that, as Chair of the Association of North East Councils (ANEC), he was also the Smoking Cessation Champion, and commented that the Government needed to be brave enough to challenge overseas companies responsible for the import of tobacco products. Councillor Miller agreed that more needed to be done in respect of lobbying and highlighted that tremendous work had been done over the last ten years, but this was now plateauing.

Karen Graham advised Members that the Health and Wellbeing Strategy Working Group was looking at behaviour change pilots and one of these was for smoking and pregnancy. The Chair noted that smoking was sometimes associated with relieving stress and tension and felt that more needed to be done before expectant mothers began to experience high levels of stress. Gillian Gibson highlighted that new research had shown that smoking actually increased stress and that there was still a lot that maternity services could do to address smoking during pregnancy.

RESOLVED that the feedback from the Adults Partnership Board be noted.

NHS Provider Forum

Ken Bremner informed the Board that the Provider Forum had met on 3 March 2015 and the main issues discussed had been: -

- Manpower
- Vanguard bid
- Engagement Event provisionally scheduled for 20 April 2015 at the Stadium of Light

Dave Gallagher commented that it was great to have the GP Alliances involved in the forum and that this would be a good test for them moving forward. He noted that the

Vanguard Bid was predicated on integrated care work and a provider board was to oversee delivery which was to include acute providers. He also asked if there would be an opportunity to do more work around workforce issues with a wider group of people as part of the Engagement Event and Ken Bremner stated that the work on this would certainly be highlighted.

Neil Revely reaffirmed the need to have vertical integration in all areas and that a complete and sustainable whole system was the key aim. He asked if housing organisations would be included within the Engagement Event as a national memorandum had just been signed to engage housing providers in health solutions.

Ken advised that the original focus had been aimed at the voluntary sector but the provider definition could cover a wide range of organisations and this would be kept open and flexible.

The Chair wished to reinforce what had been said by other Board members and that health and wellbeing depended on every partner in the city. Sunderland would be unable to have a vibrant economy if there were not healthy people in the city. Partners needed to be able to see a future for themselves in the city and to be a full and inclusive part of all activity which was taking place.

RESOLVED that the feedback from the Provider Forum be noted.

HW54. Update from the Integration and Transformation Board

There had not been a meeting of the Integration and Transformation Board since the last meeting of the Health and Wellbeing Board, however Dave Gallagher highlighted that the success of the Vanguard Bid was a great achievement and was the opportunity to bring something back for the future.

A report was tabled providing the Board with an overview of the key points in the refreshed CCG operational plan for 2015/2016 and the updated Plan on a Page. As part of the refresh of the plan, the CCG had reviewed its priorities, and whilst continuing to work on transformational changes, had identified some further priorities such as: -

- Work with Public Health on a prevention and self-management approach;
- Develop a strategy with Sunderland Council to improve outcomes for children;
- Develop and implement a strategy for General Practice;
- Implement transforming lives for people with learning disabilities; and
- Implement the new model of care for people needing continuing health care.

A review of outcome ambitions had also been carried out and while these remained the same for the most part, it was proposed to increase the ambition of potential years of life lost to a 15% improvement by 2019, which was a further 8% improvement on the original ambition of 7%. The Plan on a Page now also drew in aspects of primary care as the CCG was taking on the delegated responsibility for co-commissioning for general practice in 2015/2016.

Neil Revely advised that with regard to primary care commissioning, the Government has set out a consultation on the ability to use the Section 75 Agreement to move that

budget into the pool. A response had been submitted to Government which also supported the inclusion of pharmaceutical services, optometry and dentistry. Depending on the outcome of the consultation, this would be for a future discussion at the Board.

The Board RESOLVED that the key points of the operational plan refresh and revised CCG Plan on a Page be noted.

HW55. Better Care Fund – Section 75 Agreement

The Chief Officer, Sunderland Clinical Commissioning Group and the Executive Director of People Services submitted a joint report seeking support for the Section 75 agreement in relation to the vision for integration in the City between health and social care through utilising the plans set out within the Better Care Fund.

Sunderland had been fairly ambitious with its Better Care Fund and pooling the Council's adult social care budget with the CCG's out of hospital spend had created an overall fund totalling £150m. This had signalled the intention of partners and in taking this forward, the manifestation of the work would be on the ground, with co-located teams being vertically integrated with hospital services.

Neil Revely informed Members that the Pooled Budget would be divided into a number of mini pools or schemes to be hosted and managed by one or other partner. These were: -

- Community Integrated Teams and Recovery @ Home
- Mental Health Services
- Learning Disabilities
- Packages of Care
- Carers Service
- Community Equipment Services
- Disabled Facilities Grant

The arrangements for the governance of the fund were also set out within the report and it was highlighted that the Integration Board had delegated authority from both partners to manage the Pooled Budget and provide a clear accountability structure. This was a one year initial agreement with the intention to develop a three year agreement from 2016/2017.

The Board were directed to paragraph 5.9 of the report which showed a high level breakdown of the whole scheme and it was noted that the contributions of the Council and the CCG had originally been a 50/50 split but this had changed due to money being transferred straight to the Better Care Fund rather than being passported to the local authority.

Dave Gallagher stated that at its last meeting, the Board had signed off the financing of the adult social care budget at the end of the financial year but this agreement was now putting things on the front foot for 2015/2016 and was positive for local people. The total value of the schemes had fluctuated slightly over the last few months but these were fixed and secure.

The Chair stated that this was clearly a jewel in the crown of the arrangements in Sunderland and this was evidenced by the success of the Vanguard Bid. The most important aspect was better outcomes for people in the city and these were being delivered and would continue to improve as things moved forward. He congratulated and thanked all those involved and reaffirmed the support of the Health and Wellbeing Board for the Better Care Fund work.

RESOLVED that: -

(i) the contents of the report be noted;

(ii) the Section 75 agreement be supported; and

(iii) regular updates be received through the Health and Social Care Integration Board on the progress being made against the Better Care Fund.

HW56. Health and Wellbeing Board Priority Setting

The Board received a report providing an update on the process of establishing short, medium and long term priorities for the progression of the Health and Wellbeing Strategy.

Board members had previously received a full assurance report but had felt that there needed to be a focus on the key issues for improving health in the city and the public health team were requested to lead a piece of work to establish a number of priority outcomes which should be the focus of improvement activities.

A framework had been developed for assessing priorities and this was the basis for discussions at a closed Board session in February 2014 which narrowed down the long list of potential priorities to seven key themes: -

- Alcohol
- Smoking
- Physical Inactivity
- Falls prevention
- Best Start and Resilience
- Economy and Standard of Living
- Sunderland as a healthy place.

Key overall measures for the strategy and measures related to the priorities were attached at appendix 1 to the report. It was proposed that a lead officer be allocated for each theme and that a joint workshop be held to bring together key partners to determine the most appropriate mechanisms for delivery.

Ken Bremner commented that the Board had requested a structure and this was a useful piece of work. He queried if the Board now needed to look at whether the structures being put in place would deliver the identified priorities and would translate the strategy into deliverable outcomes.

Gillian Gibson highlighted that some of the priorities were more outcome focused than others and it would be a lifetime before the impact of 'Best Start' would be felt. It was necessary to look at existing pieces of work as it was not desirable to replace what was already there.

The seven priorities were the big issues that were key to get right for the future and partners needed to be focused on these and travelling in the same direction. Neil Revely noted that there may be an opportunity to take a final and further look at these to consider how Sunderland's money should be spent across the city. With an ever ageing population, the National Health Service was positioned at episodic points of care and bringing quality of life to people with long term conditions was not an area which could be ignored.

Gillian commented that a large element missing from this was 'wellbeing' and improving not only the length but quality of life was central to this. Emotional, physical and mental wellbeing would impact on all of these priorities and it was suggested that 'wellbeing' could be added as an eighth priority.

The Chair noted that it had to be decided whether the priority was handling health issues within certain financial limits or managing conditions and Dave Gallagher added that it was about articulating where the aim was improving 'health' and where it was improving 'health care'.

Karen Graham reminded Board members that paragraph 6 of the report showed the process by which the priorities were identified and commented that 'improvement actions' might be a better way of describing the seven priorities.

Having considered the report, the Board RESOLVED that: -

(i) the seven priority themes as set out in the report, with the addition of 'Wellbeing' as an eighth theme be agreed;

(ii) the establishment of the necessary groups to take forward the priority themes be agreed; and

(iii) further reports be received on progress on a no less than annual basis.

HW57. Sunderland Draft Family Outcomes Plan

The Head of Community and Family Wellbeing submitted a report outlining how Sunderland had developed the Strengthening Families Delivery Model over the last three years to provide relevant, timely and coordinated support to families, some of whom met the criteria for the national Troubled Families Programme.

The current Troubled Families Programme was due to end on 31 March 2015 and the next phase would follow a five year period subject to funding beyond 2015/2016. All local authorities were required to produce a Family Outcomes Plan and this was intended to be a measure of significant and sustained progress in Sunderland and would be signed off locally. The expanded national priorities outlined by DCLG were consistent with the outcomes which the city was trying to achieve and whilst the Plan

should be aspirational, it had to be considered where added value would be achieved in terms of the priorities of the Plan.

The draft Family Outcomes Plan had been developed following discussions with the Strengthening Families Board and Working Group and an event held on 27January 2015 where key workers, operational managers and strategic partners were asked what were the key themes which would make a difference. Outcomes Plans from other local authorities had also been considered as part of the process and there had been consultation with representatives from early help, social care, the Youth Offending Service and the Performance and Intelligence Team to discuss use of assessment to inform the Plan and the availability of data to measure success.

The majority of the outcomes of the plan had been determined locally but the outcomes related to children who were not engaged in education were determined nationally. It was highlighted that the areas related to each outcome were quite broad and Sandra Mitchell referred to the example of crime and anti-social behaviour where an additional identification criteria had been added so that referrals could be made for adults and children whose behaviour was of concern but they did not fulfil the initial criteria.

Feedback from the event in January 2015 had shown that partners and key workers felt that there was no mechanism to report and recognise change in attitudes and willingness to make progress amongst individuals and families. This was felt across the six criteria and when the Strengthening Families Board had approved the draft version of the plan, it had been clear that this would be subject to further consultation and review. Where possible a key worker assessment had been included in response to the issues raised by partners.

The Board were informed that the Family Outcomes Plan had to be in place by 1 April 2015 and work was continuing towards that target.

Gillian Gibson commented that the Intelligence Hub would assist in the measurement of significant and sustained progress and would follow this on to strong outcomes in the longer term. Sandra noted that in terms of payment by results, progress could be demonstrated but as a city, partners might like to consider if they were happy with this.

Ken Bremner stated that he was most interested in the areas which would come under the remit of the Health and Wellbeing Board and suggested that the Board needed to be drawing these out and measuring them as part of the priorities structure. It was noted that there was some synergy between the measures in the plan and the Board's priorities.

Having considered the draft Family Outcomes Plan, it was: -

RESOLVED that the Plan be received and approved.

HW58. The Local Government Alcohol Declaration

The Board received a report providing an overview of the development and purpose of the Local Government Alcohol Declaration.

The declaration was a result of work across the North East and had been initiated at a meeting of the North East Directors of Public Health Group following a BALANCE conference in November 2013.

Partners were aware of the importance of the issue across the city and Gillian Gibson advised that statistics showed that 600 girls and 700 boys in Year 10 in the city consumed alcohol and there were 50 alcohol related hospital admissions each year for under 18 year olds. In addition, it had been identified that 4,000 people over 65 consumed over the recommended level of alcohol.

The harm caused by alcohol was extensive and the personal, social and economic cost had been estimated to be up to £55bn for England, with a total cost for the North East estimated at £1.1bn a year. The goal of the Declaration was not only to demonstrate local authority leadership on tackling alcohol harm but also to make a collective statement about the importance of this issue nationally.

The draft Declaration on Alcohol was set out as an Appendix to the report and the Health and Wellbeing Board was recommended to sign up to the Declaration on behalf of the Council and it was proposed that other partners might also like to do so.

The Chair noted that the Declaration was being presented to the Association of North East Councils and would display the organisation's logo if all partners agreed.

Councillor Miller commented that until the Government gave local authorities some powers then the document was toothless and the Chair acknowledged that point, adding that existing powers were probably not being used enough to shut down premises and revoke licenses.

Dave Gallagher stated that it would be great for the Council and individual partners to sign up to the Declaration as he believed that it was a powerful message which needed to be as widely supported as possible.

RESOLVED that the Health and Wellbeing Board agree to sign up to the Local Government Declaration on Alcohol.

HW59. Department of Health Autism Self-Assessment

The Board received a report informing them of the process followed in completing the Department of Health Autism Self-Assessment and to share the key messages from the exercise.

Graham King, Head of Integrated Commissioning, Sunderland City Council, informed the Board that an annual self-assessment was carried out by local authorities to enable them to report their progress on fulfilling the recommendations of the National Autism Strategy to the Department of Health. Sunderland's multi agency Local Autism Working Group had discussed and agreed the ratings for the self-assessment in February and the document had been signed off by the Adults Partnership Board prior to submission to the Department of Health on 9 March 2015.

Graham highlighted the main points which had come out of the exercise including the need to improve data sharing between agencies and the possibility of including a specific profile within the Joint Strategic Needs Assessment for autism. The Working Group had rated engagement with people with autism as 'red' and an engagement network would be developed to address this issue.

The self-assessment had also found that training could be better co-ordinated and that the waiting time for diagnosis was currently 24 weeks, double the National Institute for Health and Care Excellence (NICE) guideline of 12 weeks. However, there had been additional resource deployed in this area and it was expected that the waiting times would reduce to the guideline level by April 2015. In addition, it was highlighted that the needs of people with autism were not reflected within the Housing Strategy and that there needed to be awareness raising for employers about employing people with learning disabilities and autism.

The Working Group had agreed that it would be replaced by the Sunderland Autism Partnership Board which would report to the Adults Partnership Board three times a year. The Autism Partnership Board would be chaired by the Head of Integrated Commissioning, Councillor Miller had agreed to provide elected member representation and the Board would also include four people with autism, two carers and key representatives from health, social care, education, employment and the criminal justice system.

The Autism Engagement Network would sit alongside the Autism Partnership Board and would be a virtual network of individuals and organisations with a particular interest in autism. A consultation event had taken place on 4 March 2015 and Councillor Miller commented that this had been very well supported and attendees had been pleased to see the local authority taking the condition seriously. He added that he felt that the move towards the Autism Partnership Board was a good one and fully supported the work being developed as a result of the self-assessment.

Liz Highmore queried if, given the width of the autism spectrum, there could be training offered in the same vein as dementia friends. Graham King stated that this was a good idea which he would take back to the Board.

In relation to the responses from the event on 4 March, Kevin Morris asked how these would be publicised. Graham advised that this would be through various networks including Healthwatch, provider forums and user groups and he noted that it had been heartening to see how cohesive the autistic community was.

The Chair made reference to the waiting times for a diagnosis and asked what the current position was. Graham stated that he would check the up to date figures but he did not believe that the waiting times were down to 12 weeks as yet.

RESOLVED that: -

(i) that the report be received and noted; and

(ii) further progress reports be received as the Sunderland Autism Partnership Board becomes established.

HW60. Pharmaceutical Needs Assessment

The Health and Wellbeing Board had considered the draft Pharmaceutical Needs Assessment at its meeting in January 2015 and Kath Bailey, Locum Consultant in Public Health presented a report seeking final approval and sign off for the report, in line with the Board's statutory responsibility to agree and publish an updated pharmaceutical needs assessment (PNA) by 1 April 2015.

The 60 day consultation period had now ended and there had been changes made to the document to reflect more recently published data, to correct any identified errors and to reference updates to policy and regulations. Ongoing discussions with the Health and Wellbeing Board and the CCG Governing Body about the future vision for pharmaceutical provision and debate which had been had about the provision in the Coalfields area was also referenced within the report.

The consultation draft had been well received and the feedback was generally positive and work was being undertaken with Healthwatch to produce a plain English version of the document. Members were directed to the responses to the consultation set out in section 11 of the document and conclusions detailed in section 12. After considering all elements of the Pharmaceutical Needs Assessment, the document stated that the recommendations of the Health and Wellbeing Board were:

- Commissioners take cross border issues into account and consult with relevant stakeholders when they were removing, commissioning or decommissioning services, to avoid or mitigate against creating inequality of provision for the local population.
- Commissioners should consider the opportunities afforded by community enhanced pharmacy enhanced services which focus on the safe and effective use of medicines and support for self-care, within the context of the current financial constraints for the health economy.
- Patterns of provision may need to be reviewed as the NHS moves towards "7 days a week" working.
- With regard to locally commissioned services, the public health team would work with the CCG to ensure that services were commissioned to meet local health needs and that any changes would serve to improve equity, access and choice.

Having considered the report, it was:-

RESOLVED that the Board give final approval and sign off to the Pharmaceutical Needs Assessment for Sunderland April 2015 – March 2018.

HW61. Care Act: Implementation Update

The Executive Director of People Services submitted a report providing the Board with an update on the implementation of the Care Act requirements, regional and national activity and the draft Department of Health proposals for April 2016.

The first part of the Care Act was to be implemented in April 2015 and would be the biggest change in legislation for adult social care since 1948. A Programme

Implementation Board was overseeing work to implement the actions required to meet the 2015 requirements and everything was on track to be delivered by 1 April 2015.

The Council had undertaken an engagement and consultation exercise between 9 February and 2 March 2015 which provided customers with background information about the changes and a Care Act summary which provided more detail about its wide ranging requirements. There had not been a large number of responses but the opportunity to engage had been welcomed. A common question had been when the care regulator Care Cap would begin but this would not come into force until April 2016.

Another issue which had been flagged up was eligibility under the equality impact assessment. A random sample of customers had found that all would still meet the criteria and no great impact was envisaged.

As part of the regional and national response to the Care Act, a combined Programme Management Office had been established to support councils with implementation. A regional Training and Implementation Support Fund had been established to offer support and undertake joint developments and a suite of eLearning courses had also been developed and were being rolled out to council staff.

The Department of Health had launched a consultation exercise, ending on 30 March, in relation to the funding reforms and appeal and challenge mechanisms being implemented in 2016. The Council would be submitting a response to this and would contribute to regional and national responses via organisations such as ANEC and the Association of Directors of Adult Social Services. Neil Revely commented that the real financial issues would become apparent in 2016.

Kevin Morris asked if they had been any indication of why the consultation response was poor and Neil said that there did not appear to be any particular reason for this but the level of response was not out of keeping with other similar processes. He highlighted that he had delivered a presentation at the Carer's Centre, for example, and carried out consultation throughout the process so it was possible that customers already felt engaged. Neil also emphasised that this was why he had sought to have consultation events and had set up a Freephone number for frequently asked questions. He agreed that there was a need to better join up meaningful consultation and as a partnership, work continued to see how this could be done better.

Councillor Miller commented that usually you would not hear from people unless there was a problem and that was why the focus had been on consultation events. Kevin Morris advised that he had been discussing how to use the voluntary and community sector more effectively with Neil Revely and Dave Gallagher. Neil said that he would follow things up with Age UK as they had been provided with a lot of information and he needed to find out how many customers had been engaged with.

Councillor Miller felt that the way ahead was to engage people while they were using the services and made reference to the Over2You scheme operated by Gentoo and using tenant volunteers.

Liz Highmore stated that she had attended the Care Act presentation at Age UK and it had been very well attended, but she felt that some people had missed out on the consultation due to uncertainty about when it would begin.

Upon consideration of the report, it was: -

RESOLVED that: -

(i) the contents of the report be noted; and

(ii) a further update be received when the final regulations for 2016 be published.

HW62. Closed Board Sessions and Forward Plan

The Head of Strategy and Performance submitted a report informing the Board of forthcoming development sessions and the forward plan.

Karen Graham advised that the next development session would be held on Friday 6 February 2015 and would look at setting priorities for action in line with the previous report on the agenda. This session would then set the agenda and format of advisory group meetings for the forthcoming year and provide a focus for the next annual assurance report.

Details of the timetable for the Board and its advisory groups and deadlines for submission of reports were also provided for information.

The Board RESOLVED that: -

(i) consideration be given to topics for in depth closed/partner sessions for 2015;

(ii) the forward plan be noted and requests for any additional topics passed to Karen Graham; and

(iii) the timetable be noted.

HW63. Date and Time of Next Meeting

The next meeting of the Board will be held on Friday 29 May 2015 at 12noon

(Signed) P WATSON
Chair

Item No. 4a

SUNDERLAND HEALTH AND WELLBEING BOARD **29 May 2015**

FEEDBACK FROM THE ADULTS PARTNERSHIP BOARD

Report of the Chair of the Adults Partnership Board

The Adults Partnership Board met on Tuesday 5th May, 2015

The meeting was a single topic meeting looking at the role, function and membership of the group.

It was agreed that the terms of reference of the group need to be revised to better reflect the role of the group as an advisory group to the HWBB.

Similarly the membership of the group could usefully be reviewed to ensure that the right members were invited.

It was agreed that following the HWBB establishing its shortlist of priorities that the Adults Board could focus on ensuring delivery of a number of priorities once agreed by the HWBB.

The group also agreed that a close working relationship needs to be forged between itself and the other advisory groups to ensure that they all avoid working in traditional silos and came together to address cross cutting issues.

Item No. 4b

SUNDERLAND HEALTH AND WELLBEING BOARD **29 May 2015**

FEEDBACK FROM THE NHS PROVIDER FORUM

Report of the Chair of the NHS Provider Forum

There had been no full meeting of the provider forum since the last Health and Wellbeing Board as focus was on delivering the first of the broader provider engagement sessions which was held on Monday 20th April at the Stadium of Light.

Over 40 organisations from a range of public, private and voluntary sector providers attended the event.

The agenda covered:

- An introduction to the forum
- Workforce Issues – how can we better address provider workforce issues
- Health and Social Care Integration – the opportunities and challenges
- The Future Role of the Forum - what key issues would you like the Forum to focus on in 2015?

The session was well received and all participants agreed there was a need for more broad engagement sessions in the future.

There was a feeling that the impacts of big policy changes including the Better Care Fund and the Care Act were not very well understood throughout the provider community especially with smaller providers and it was suggested that a number of focussed sessions be held to brief smaller providers on the implications for their organisations.

Item No. 5

SUNDERLAND HEALTH AND WELLBEING BOARD 29 May 2015

FEEDBACK FROM THE HEALTH AND SOCIAL CARE INTEGRATION BOARD

Report of the Health and Social Care Integration Board

The Health and Social Care integration board has met twice under the new arrangements since the last meeting of the Health and Wellbeing Board.

The minutes of the meeting of 9 April 2015 are attached for information. Issues covered included:

- Appointment of chair and vice chair
- Terms of reference
- Reporting arrangements
- The director of health and social care post
- Support and administrative arrangements

The second meeting of the group was on 14 May 2015. The minutes of this group will be circulated on completion. Discussion centred on a paper outlining the seven pooled budgets, the breakdown of contributions from the Clinical Commissioning Group and the local authority and the key risks for each.

The nature of reporting from each pool was discussed and it was agreed that quarterly reports should be seen by the Integration Board although reports would be submitted to the Better Care Fund Implementation Group on a monthly basis and escalated on a by exception basis whenever appropriate.

The next meeting of the group is scheduled to take place on 25 June and will include discussion of

- A schedule of reporting for all pools
- Clarity on overheads figures
- Broader system and forward planning.

Appendix

Minutes of the Health and Social Care Integration Board
Thursday 9 April 2015

Present: -

Councillor Mel Speding (in the Chair)	-	Cabinet Secretary, Sunderland City Council
Fiona Brown	-	Chief Operating Officer, People Services
Dave Chandler	-	Head of Finance, Sunderland CCG
Dave Gallagher	-	Chief Officer, Sunderland CCG
Karen Graham	-	Associate Policy Lead for Health, Sunderland City Council
Ian Holliday	-	Head of Reform and Joint Commissioning, Sunderland CCG
Sarah Reed	-	Assistant Chief Executive, Sunderland City Council
Neil Revely	-	Executive Director, People Services, Sunderland City Council
Sonia Tognarelli	-	Director of Finance, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Ian Pattison, Debbie Burnicle and Gillian Gibson, Pat Taylor.

2. APPOINTMENT OF CHAIR AND VICE-CHAIR

Neil Revely advised that Dr Ian Pattison had been nominated as Chair of the Integration Board and it had been suggested that Councillor Speding act as Vice-Chair.

It was AGREED that Dr Pattison be appointed as Chair and Councillor Speding as Vice-Chair of the Health and Social Care Integration Board.

3. TERMS OF REFERENCE FOR THE BETTER CARE FUND IMPLEMENTATION GROUP

The terms of reference of the Better Care Fund Implementation Group had been circulated to the Board and it was noted that the membership of the group had now changed from that originally set out. The Director of Commissioning, Planning and Reform and the Head of Finance from the CCG and the Chief Operating Officer from the Council's People Directorate were now to attend the Integration Board and it was queried if additional people needed to join the group to fill these gaps. It had been agreed that Ian Holliday and Graham King would chair the group.

It was suggested that scheme managers and quality assurance officers could be involved in the group and Ian Holliday suggested that he could discuss this and the potential revision of the terms of reference with Graham King at their meeting the following week.

Dave Gallagher suggested that there should be a link between the Implementation Group and the Integration Board through dual membership and Sonia Tognarelli supported this as crucial to knowing how things were being progressed. She commented that the roles and responsibilities section seemed to fall short of including the future year's planning requirements to be reported to the Transformation Board.

Neil Revely suggested that the issue could be looked at as part of the terms of reference for the Integration Board and that this reflected the discussions which had taken place at the Board development session.

Regarding the terms of reference for the Integration Board, Dave Gallagher highlighted that the purpose was clear but the work plan needed to be considered. There had been a change to the voting rights which was aimed at balancing the numbers between organisations. It was also noted that the Chair was to have a casting vote in the unlikely event of there being an impasse.

It was agreed that there should be an additional bullet point in the roles and responsibilities of the Integration Board to reflect something about planning for the future.

ACTION: Sonia Tognarelli to circulate a form of words to add to the roles and responsibilities within the Board terms of reference.

Karen Graham highlighted that the reference to a rotating Chair should be removed if it was intended to elect a Chair and that the title on the document needed to be amended.

ACTION: Terms of reference for the Integration Board to be amended and brought back to the next meeting of the Board.

4. REPORTING ARRANGEMENTS FROM THE BETTER CARE FUND IMPLEMENTATION GROUP

The Board discussed the reporting mechanisms by which the Implementation Group would feed into the Board and it was proposed that at the next Board meeting there should be a draft report presented showing a template of what could be expected to be received in future months and the members of the Board could then take a view on how this would be presented. Neil Revely commented that the funding element was important but he would also want to see how the work was being delivered as part of the report.

Councillor Speding asked if this would be a joint report and it was confirmed that information would be pulled together from both the CCG and the Council and that the reporting arrangements were laid out within the Better Care Fund Agreement.

ACTION: Reporting template from the Better Care Fund Implementation Group to be presented to the next meeting of the Integration Board

It was suggested that one of the joint chairs of the group could be responsible for reporting to the Board on a monthly basis and that this could be reflected within the membership of the Integration Board.

Fiona Brown advised that the group would make recommendations to the Board about the lead against each pool and suggested that this also be brought to the next meeting of the Integration Board.

Neil Revely also highlighted that the Integration Board's terms of reference required regular reporting to the Sunderland Health and Wellbeing Board and a view needed to be taken on this. The Board would report on the progress of the Better Care Fund and this may also prompt discussion on future work.

Dave Chandler highlighted that the guidance was for the Integration Board to report quarterly at a minimum and Karen Graham suggested that the minutes be presented to every meeting of the Health and Wellbeing Board with anything additional being the subject of a special report.

ACTION: Minutes of the Integration Board be placed on the agenda for all Health and Wellbeing Board meetings.

5. DIRECTOR OF HEALTH AND SOCIAL CARE POST

Neil Revely advised that he had had discussions with Dave Gallagher and also the Council's Cabinet about the structure of People Services and the opportunity for joint posts. As part of a review of the Directorate's senior structure, a joint post of Director of Health and Social Care had been advertised however there appeared to be a lack of clarify about the role therefore Neil and David had agreed a communication note would be sent to the CCG Governing Body and to senior staff in the People Directorate aiming to remove any confusion about the advertised posts of Director of Health and Social Care, Head of Children's Services and Chief Social Worker.

Neil circulated a draft note which explained the posts which were being advertised and the reasons behind this. The CCG would be involved in the appointment process and would also monitor delivery.

Councillor Speding asked about the interview process and Neil confirmed that although the senior posts were seen as joint because of the close working with the CCG, the appointment process would follow the Council's procedure with

involvement of the CCG. The posts had been established when the People Directorate was formed but had not been filled at that time.

The final appointments would be the decision of the Council's Human Resources Committee and Neil suggested that, with the permission of the Committee, the CCG could be in attendance at the interviews. The arrangements had not been finalised as yet, however the posts had been advertised on 23 March and the closing date was Friday 10 April 2015. Fiona Brown advised that there had been four applications for each post so far.

Neil commented that he was keen to see how the CCG would like to be involved in the recruitment of the Head of Children's Services and Chief Social Worker posts and noted that the Head of Children's Services would drive integration in the Council and then move this onwards to Health Visitors etc. Dave Gallagher stated that all CCG posts had joint working with the Council in their job description and the clarity on the job description for the People Services posts would hopefully show the internal and external focus. It then had to be determined how these would fit in adult care and integration.

Ian Holliday commented that questions had been asked about what the new posts would mean for current line management, for example for those working in children's commissioning. Neil advised that nothing would change until something new was designed, in consultation with all relevant service areas.

Dave Gallagher asked if an organisational chart would be helpful and Neil advised that this had been circulated as part of the advertisement material.

ACTION: People Services Organisational Chart to be circulated to members of the Integration Board

Neil stated that one reason for roles such as these was to develop where services were going in the future and how roles would evolve and potentially move out of the local authority. He also commented that his preference was to have a set of outcomes rather than a job description for the posts.

6. SUPPORT AND ADMINISTRATIVE ARRANGEMENTS

Karen Graham highlighted that the process for the administration of the Board had not yet been clarified and proposed that there be an item at the end of each agenda where Board members could highlight issues to be considered at the next meeting. This would enable lead officers to be identified and deadlines to be attached to pieces of work.

Dave Gallagher commented that if the Integration Board was to agree a work programme then the agenda for meetings would flow from that and that reports should go to the Chair initially for him to be briefed. It was confirmed that formal notes would be taken at the Better Care Fund Implementation Group and it was proposed that these be placed on the Integration Board agenda with a full report being received by exception if there was any potential over or under spend.

Ian Holliday advised that it was intended to run the Implementation Group as a paperless meeting with access to papers through a SharePoint site and the key points of the discussion would be reported up to the Integration Board.

Sonia Tognarelli suggested that people needed to have a full picture of exactly what was in the fund and how it was planned to be spent and Dave Gallagher noted that this could be provided at the next meeting. It was highlighted that Internal Audit would want to look at the fund because it was new and that the Council's external auditors were also keen to find out more about the Better Care Fund.

The Board went on to discuss planning for the programme over the next three to five years and the medium term financial plan and it was felt that a workshop session might be the best way to identify what was needed. Sonia Tognarelli highlighted that any financial planning needed to start before the summer period or it would be too late for 2015/2016. It was agreed that time would be set aside at the next meeting to design what the Board wanted to do in terms of defining the system and future planning.

The items for the agenda for the next meeting were summarised as: -

- Breakdown of finances and unpacking of the Better Care Fund
- Template for reporting from the Better Care Fund Implementation Group
- Signing off of pool leads
- Design of broader system discussion
- Deadline for Integration Board meetings

ACTION: Karen Graham be informed of any additional agenda items for the next meeting of the Integration Board.

7. ANY OTHER BUSINESS

Efficiency Opportunities through Health and Social Care Integration

Sonia Tognarelli advised the Board that the Local Government Association had written to the Chief Executive in regard to a health and social care integration project aimed at gathering robust evidence of the efficiency opportunities to be gained through integration. The Integration Board were asked to consider if they felt that this would be a useful project to take part in.

It was the general view that more information was needed about whether the work would add value and the level of resource and commitment which would be required to take it forward. It was noted that the findings from this work would be reported in the autumn and that Sunderland may benefit from this in any case. It was agreed that further information should be sought.

ACTION: Sarah Reed to make enquiries with the Programme Manager, advising of Sunderland's position and aiming to identify the potential benefits of the work to partners.

8. DATE AND TIMES OF MEETINGS

The following schedule of meetings was noted: -

Thursday 14 May 2015
Thursday 25 June 2015
Thursday 23 July 2015
Thursday 10 September 2015
Thursday 15 October 2015
Thursday 12 November 2015
Thursday 10 December 2015
Thursday 7 January 2016
Thursday 4 February 2016
Thursday 3 March 2016
Thursday 7 April 2016

All meetings to be held at Sunderland Civic Centre, beginning at 3.00pm.

(Signed) M SPEDING
In the Chair

Item No. 6

SUNDERLAND HEALTH AND WELLBEING BOARD 29 May 2015

CHILDRENS SAFEGUARDING PEER REVIEW & FRAMEWORK OF COOPERATION

Joint Report of the Executive Director of People Service and Independent Chair of the Sunderland Safeguarding Children Board and Sunderland Safeguarding Adults Board

1.0 Purpose of the Report

To highlight to members of the Health and Wellbeing Board, the findings of the November 2014 Peer Review into Childrens Safeguarding and to introduce a new framework of cooperation for review and adoption.

2.0 Background

A team of LGA peers came to Sunderland in November 2014 as the second stage in a review of Childrens Safeguarding following a Core Assets review to examine the nature of the Council's safeguarding service and identify areas in need of improvement which was completed in early 2014.

3.0 Focus of the Review

The safeguarding peer review focused on five key themes:

- Effective practice, service delivery and the voice of the child
- Outcomes, impact and performance management
- Working together (including Health and Wellbeing Board)
- Capacity and managing resources
- Vision, strategy and leadership

Within these overall areas, the team were also asked to explore the following issues to assist in the delivery of the on-going partnership improvement plan:

- Early Intervention, Help, Support
- Sunderland Safeguarding Children Board
- Children's Services improvement activity
- The quality and effectiveness of MASH

The full recommendations from the peer team are included as Appendix 1.

3.1 Framework of Cooperation

A voluntary Improvement Board, with an Independent Chair, has been established to oversee the improvement journey. The Sunderland Safeguarding Children Board (SSCB) has been given fresh impetus via a new Independent Chair, with challenge, refreshed governance and accountability strengthened on the Board and within partners' own organisations.

The peer review recommended that the relationship between the various strategic fora across safeguarding should be reviewed and reconfigured, with the aim of strengthening governance and oversight.

In order to progress this recommendation, a proposed framework of cooperation between the Health and Wellbeing Board, Sunderland Safeguarding Childrens Board and Sunderland Safeguarding Adults Board has been developed and is included as Appendix 2 to this report.

4.0 Recommendations

The Board is recommended to:

- Note the findings of the Safeguarding Children Peer Review
- Review the Framework of cooperation and agree to its adoption
- Recommend to the Sunderland Safeguarding Childrens Board and Sunderland Safeguarding Adults Board to adopt the framework of cooperation

Neil Revely
Executive Director People Services
Colin Morris
Independent Chair
Sunderland Safeguarding Children Board
Sunderland City Council
Civic Centre
Sunderland
SR2 7DN

5th March 2015

Dear Neil and Colin,

RE: CHILDREN'S SAFEGUARDING PEER REVIEW

Thank you for taking part in the Children's Safeguarding Peer Review. It was evident that all those we met, right across the partnership, were interested in learning and continued development.

We agreed to send you a letter confirming our findings.

As you know the safeguarding review focused on five key themes:

- Effective practice, service delivery and the voice of the child
- Outcomes, impact and performance management
- Working together (including Health and Wellbeing Board)
- Capacity and managing resources
- Vision, strategy and leadership

Within these overall areas, you asked the team to explore the following issues to assist in your on-going partnership improvement plan:

- Early Intervention, Help, Support
- Sunderland Safeguarding Children Board
- Children's Services improvement activity
- The quality and effectiveness of MASH

This letter sets out our findings as positive observations and as areas for consideration. The peer team used their experience to reflect on the evidence you presented on safeguarding vulnerable children and young people. The team triangulated the evidence for their findings from a wide range of documents, and

from interviews and focus groups with staff from across the partnership. It is important to stress that this was not an inspection and the documentary and other evidence provided to us was used in our focus on assisting you in your on-going improvement.

You decided to take up the optional element of a Case Records Review which was completed over two days prior to the main review. A separate case records review report is attached as Appendix One and evaluates the quality of casework, care planning and supervision found in the cases that we reviewed. The evidence obtained from the case records review also contributed to the team's overall findings.

Executive Summary

There has been a thorough ongoing review of frontline safeguarding in Sunderland over the course of the past year, driven directly from the top of the City Council. Partners' concerns are being addressed and outside expertise was commissioned through the Core Assets review to examine the nature of the Council's safeguarding service and identify areas in need of improvement. This Peer Review was seen as the second phase of this drive for improvement with a focus on the wider partnership effectiveness. Although the impetus for this initially came from within the council it is now being driven by the wider partnership as the beginnings of a multi-agency approach to systems improvement are put in place.

In the past, partners have felt that the partnership was 'the council and its partners'. Partners acknowledge their respective roles in allowing this situation to develop without challenge. It is important to avoid any legacy of this "us and them" culture being perpetuated, and to actively promote real partnership across all organisations.

A voluntary Improvement Board, with an Independent Chair, has been established to oversee the improvement journey, and it is commendable that this has the highest possible levels of representation and engagement, due in no small part to the efforts of the council Chief Executive in persuading others of the significant return that will come from investing time now in this Board. The Sunderland Safeguarding Children Board (SSCB) has been given fresh impetus via a new Independent Chair, with challenge, refreshed governance and accountability strengthened on the Board and within partners' own organisations. Proposals for further development of the Board are both ambitious and appropriate. The relationship between the various strategic fora across the partnership is being reviewed and reconfigured, again with the aim of strengthening governance and oversight.

In terms of frontline practice, the Children's Social Care workforce is currently under considerable pressure because of high workloads with some turnover issues in relation to agency staff, which are being addressed. The Core Assets findings revealed the need to improve frontline practice and plans to do this have already been put in place. Implementation is in the initial stages and we saw similar inconsistency of social work practice to that which was highlighted in the Core Assets Report. There is a high proportion of interim managers in senior positions in Sunderland City Council Children's Social Care. We recognise the intention is to take time to decide on the right appointments to key positions but this, when combined with the pressures at the frontline, does need to be carefully monitored as it could be a risk to progress.

Organisations out with the Council also reported that their staff are feeling pressured and anxious because of high workloads in child protection and their staff are increasingly feeling the need to manage risk themselves. There is strong political and executive commitment to bring about rapid improvements within Children's Social Care and in this context additional resources have been allocated to this task; and this commitment is being maintained despite financial pressures.

Early Help and the MASH are both evolving.

Early Help provision appeared widespread and good, with the locality teams providing a strong community base. Staff applied lessons learned from other projects to their own practice, though this is individually rather than strategically driven. At the present time, in the absence of a fully defined Early Help Strategy, Early Help is not linked strategically to child protection, and the role of Early Help in reducing demand on child protection services is not yet clearly set out. Early Help has enormous potential which is not yet being fully realised. To realize this potential will require the delivery of your plans around the strategic and operational positioning of Early Help in relation to other aspects of children's services across the whole partnership.

Following on from a recent Kaizen event, the MASH is being reconfigured and we believe the new operating model offers a good base upon which to move forward.

Staff across the partnership reported positively on CAF and Strengthening Families

Data on measures such as reach and throughput is not readily available and data on impact and outcomes even less so. Performance management is largely under developed across the whole of the Children's Services Partnership. Performance monitoring is hampered by poor quality data and we found little evidence of a performance driven culture. Efforts are being made to address this deficit with specialist expertise being brought in, both in the Children's Social Care management team and via secondments from the corporate centre and from health.

The necessary governance structures are being put in place to drive forward improvement. However this is not solely a question of strategic relationships and process. The will to drive improvement is certainly there at the very top, and the desire for things to get better is certainly there at the frontline. However senior managers are not visible enough with staff, and we did not see the performance focused analysis and priority setting that will be needed to bring about the required impact. Senior leaders and managers need to communicate better and explain, in terms that staff will feel addresses their concerns, how the journey to an improved safeguarding system will be taken forward and what it will look like in the future. The management plan needs to be driven to be successful.

We saw some very good front-line practice, and significant engagement everywhere to getting it right now and in the future. There is a real sense that the 'we're all in it together' culture to which everyone aspires can be realised. Across the workforce there is tremendous commitment to local communities and to the children and families of Sunderland. There is also a willingness to go the extra miles it will require in order to bring about the significant changes that are both needed and desired.

The Review Team highlighted key messages from their overall findings in a presentation at the end of the onsite week.

Summary Strengths

- You are working in partnership to provide effective safeguarding services to children and families.
- You are putting in place improvement plans at both an operational and strategic level to drive improvement forward
- Everyone knows that things have to be done differently; as a partnership you recognise the scale of the challenge that you face and there is widespread support to bring about system wide change
- We met committed, competent, passionate and inspiring people across the partnership, at all levels; this energy and loyalty to Sunderland is a good base upon which to build improvement

There is strong political and corporate commitment to resource change and improvement.
The Sunderland Safeguarding Children Board has appointed a strong and well regarded Independent Chair; there is renewed energy and commitment from partners, and the Board is rapidly taking appropriate steps in the guise of a Delivery Plan to fully meet its statutory responsibilities, address gaps and develop stronger and more systematic oversight of safeguarding.
Early Help is currently an untapped strength, but clearly has the potential to play a significant role in reducing demand in child protection

Summary Areas for Consideration

Frontline services are under severe pressure and workloads mean that practitioners across the partnership are anxious about managing risk.
There are a high number of interim managers within Children's Social Care; staff experience this as a rolling programme of new initiatives that are not embedded before another change of personnel and direction.
Improvements to frontline social work practice are being put in place but there remain instances of inconsistent practice, poor quality case recording and reports. The level of posts filled by agency staff may be a contributory factor.
The partnership is hampered in its understanding of how effective services are by a lack of good quality performance data, we saw very little evidence of a performance driven approach.
There is a perception amongst some partners that the partnership has not been an equal one – this is being addressed and the impetus needs to be maintained going forward, with a more equitable basis for the partnership established.
Moving forward, a more visible leadership style is needed and a culture needs to be developed that acknowledges and rewards staff for their hard work and contribution, - and builds upon and learns from their awareness of pressure points and what could be done differently/better. This applies across the children's services partnership.

The review team highlighted the following key messages in relation to your additional lines of enquiry (see above for details of these)

Evidence collected during the peer review endorses the Core Assets findings and the Core Assets recommendations remain very relevant.
We found good evidence of Early Help provision and activity, and were impressed by the range of what was on offer across the city. However Early Help provision is not yet part of a strategic plan for the child's journey.
The potential of Early Help to become a major part of the solution to the high levels of demand for intensive interventions (CP/CiN/ LAC) is not yet fully understood nor is it effectively articulated in a partnership-wide Early Help Strategy. This means that you have yet to see the full benefits that Early Help could bring.
Partner agencies are committed to working together in a reconfigured MASH. Recent quality assurance of the MASH has identified shortcomings which are actively being addressed. We have not seen the new operating model for MASH but there has been considerable learning from the past year and there is now a good base upon which to build.
Recent developments indicate that the Sunderland Safeguarding Children Board is going in the right direction and has the potential to be an effective forum to safeguard children in Sunderland. Partners recognise that they have significant responsibilities to engage far more strategically and proactively, and contribute to the development of a challenging culture of learning and accountability.
You are keen to develop the Improvement Plan as a partnership plan; the current iteration captures most of - and focuses upon – the key findings from Core Assets report relating to Sunderland City Council Children's Social Care. We understand the early focus on getting frontline social work practice right in the light of the recent Core Assets findings. However in order to develop the systemic and partnership approach to which you aspire, in our view, the Improvement Plan needs to have a broader scope and move beyond its current and predominant focus upon frontline social work practice.

The cross cutting enabling themes in the Improvement Plan are appropriate; these now need to be delivered.
Outcomes need to be more SMART and priority needs to be given to how the right kind of leadership and partnership culture is developed to enable improvement to happen.
Our evidence suggests that the pace of delivery on your improvement targets needs to increase. We acknowledge the amount of improvement activity taking place; a refocus on a smaller number of key priorities would better focus your activity on 'doing the right things at the right time'.
You are working hard to address the challenges revealed in the Core Assets report but at the time of the Review Team visit the improvements you are seeking were not consistently identified.
In order for you to gain the level of assurance that services are effectively delivered to children we suggest that your immediate priorities should include the following; a safe front door, good quality performance information, supported and valued staff, enabling leadership and a learning culture

Detailed Findings

The table below highlights good practice noted by the peer review team and areas for consideration by the partnership:

Effective practice, service delivery and the voice of the child	**Positive observations:** • We saw a tremendous commitment to Sunderland at all levels across the partnership • You have put in place positive developments in relation to CSE • The Sunderland Safeguarding Children's Board's safeguarding resources, and the training provided and accessed by the partnership, are highly valued • We saw many innovative ways of working with and engaging children and young people • There was good communication and feedback from the Customer Service Network, within CAF and in the Strengthening Families Panel • There is evident commitment to continue to develop the MASH across the partnership. You have learned much from the first twelve months of operation. On the back of your recent Kaizen event you are developing a new operating model and there is a good base upon which to build • Early Help is developing positively, there is a wide range of locality based Early Help services and proactive multi-agency working is being encouraged. Projects are learning from each other and are continuously refining how they deliver services • There are some early indications that partners are becoming more willing to manage risk themselves without recourse to putting in place Child Protection Plans • Multi- agency meetings (core groups, CAF, TAF) work

	well and staff report that they are extremely helpful in coordinating holistic support to families **Areas for consideration:** • We did not see consistent improvement in social work practice. • Have the needs of the child been maintained as you focus on getting process right? There seemed to be an understandable focus on process as you drive forward improvement. • The loyalty of staff has been drawn on heavily and staff concerns need to be heard and acknowledged; test how far what you have put in place already has had an impact on frontline staff - and explore with them what further support they need to do their jobs well • Referrers spoke of their anxiety that they may need to escalate concerns to child protection levels in order to secure a service; this perception needs to fully investigated and any blockages and/or miscommunication addressed by the partnership • We found a widespread perception amongst Health Visitors and Midwives that they are inappropriately carrying risk because of the workload pressure on frontline social work teams. This perception warrants investigation and if necessary remedial action taken as a matter of priority • Some partners feel they could contribute more to work with children and families but anxieties about data sharing stand in the way. The SSCB might want to consider what action it could take to further clarify or emphasise the responsibility on all partners to share information about children who may be at risk • The threshold document is disseminated but needs to be consistently applied by all partners • Early Help is not a strategic offer. The intended impact on outcomes and the interface with safeguarding is not defined • We saw examples of poor quality case recording and reports, as well as inconsistent social work practice • MASH is improving but it is still in development and the new operating model has not been fully tested • More effective engagement with schools is needed in respect to referrals and case work activity

Outcomes, impact and performance management	**Positive observations** • There have been a number of attempts to improve governance and performance monitoring across the health and social care economy • The Independent Reviewing Officer function has moved service areas and additional capacity is now in place. • The Children's Services Scrutiny Panel is now scrutinising safeguarding. • You have made progress in terms of QA within the MASH. • MARAC receive quarterly benchmarking information • Early Help has a de-escalation system, albeit this is currently a manual system • The use of the Outcomes Wheel in Early Help services is a positive development that could help to incorporate an outcomes focus into your performance management processes. **Areas for consideration** • Performance reporting is hampered by poor quality data • The team saw some evidence that you have begun to address the absence of performance data. The role of the QA manager will be vital in developing robust systems and driving activity; as yet this is at an early stage of development. • Urgent and consistent progress is needed to develop an adequate data set and performance scorecard for the partnership. • Two areas of underdeveloped data (monitoring and tracking children in need cases & recording activity and impact in Early Help) mean you are unable to assure yourselves of, first, effectiveness at these levels of intervention and, second, the way that early help and children in need services can impact on demand for child protection services - reach and throughput data is missing in some cases • Your system of collecting information on contacts makes it difficult for you to track your rates of conversion from contact to referral – an important performance indicator • A useful next stage of development would be to design and implement a detailed multi-agency performance management information system that reflects the child's journey

Working Together (including Health and Wellbeing Board)	**Positive observations:** • Elsewhere we reference a number of good examples of partnership working. We found a real sense of 'we are all in this together' and a positive attitude to developing a partnership approach to improvement • The Sunderland City Council Chief Executive, and the Independent Chair of the Sunderland Safeguarding Children Board, are both highly visible with partners. • The appointment of a new and well regarded Independent Chair has brought a redefined positive direction of travel for the Sunderland Safeguarding Children Board, which brings the promise of the effective future development of the Board's oversight of safeguarding • Planned revisions to the structure and governance arrangements for the Sunderland Safeguarding Children Board are underway • Steps have already been taken by the Sunderland Safeguarding Children Board to address areas of non-compliance against Working Together 2013 statutory requirements (e.g. drafts of the Business Plan, Annual Report and CSE strategy are in place) • There was positive engagement of partners in the Sunderland Safeguarding Children Board development day which identified and endorsed a clear improvement schedule • Dealing with multiple Serious Case Reviews is a testing process and there has been generally high partner engagement, including at learning events • The five themes of the Improvement Board are defined - each has a theme lead and an executive sponsor from different agencies • There are joint case focussed meetings between Health and Children's Social Care managers • The Clinical Commissioning Group has seconded a senior manager to Sunderland City Council to drive specific improvements **Areas for Consideration** A robust look at connectivity between strategic Boards is needed to align multi- agency accountability and governance across Sunderland Safeguarding Adults Board, the Improvement Board, the Health and Wellbeing Board, Sunderland Safeguarding Children Board and the Safer Sunderland Partnership - new arrangements are at the design stage. The continuing role of the Children's Trust is unclear.

	There is a legacy of 'the council and their partners' which needs to be addressed – the language and thinking about partnership working needs to change so you can move on from an 'us and them' partnership to an equitable partnership. There has been good partnership working on the frontline between different agencies that has developed as a result of good working relationships within localities - how can you now use effective strategic leadership to maximise the gain, and focus this activity around key strategic outcomes and targets? Despite a recent increase in capacity for the Sunderland Safeguarding Children Board business unit you have not yet clarified how as a partnership you will ensure that the Board is sufficiently resourced to function effectively, including covering the costs of the many ongoing SCRs You are continuing to develop the Board; key areas for consideration include, the size of Board, how to maximise scrutiny and challenge, how to develop effective information provided for performance management You need to address the fact that there is no multi agency Early Help Strategy, including oversight of its effectiveness by the Sunderland Safeguarding Children Board Health representation in MARAC needs to be broadened beyond the Mental Health Trust who are currently the only health representative To maximise pace and keep a regular eye on progress the Improvement Board needs to consider meeting more frequently Progress the planned implementation of a combined performance management framework across both the Improvement Board and the Sunderland Safeguarding Children Board. Ownership of the delivery of the CSE strategy appears to lie with the Sunderland Safeguarding Children Board. This should be reviewed, to ensure appropriate operational leadership and accountability, including how the Sunderland Safeguarding Children Board will hold partners to account. Ensure that data sharing protocols do not unnecessarily hinder the ability of partner agencies to offer support to families

Capacity and managing resources	**Positive observations** • There is strong political commitment to maintaining the increased investment in Children's Services by Sunderland City Council, enabling extra capacity to drive improvement. • Specific secondments from the corporate centre are used to provide specialist expertise • Management development has been prioritised with a development programme within the council and the Leadership for Change programme funded by the Leadership Academy and Public Health • You have a two phase plan to improve your Integrated Children's System; phase one is remedial action to improve the current ICS system; in phase two (intended to be delivered within the next two years) you will go out to tender for an improved ICS system • The locality teams promote good operational level partnership working and are being extended to include Child Protection • The West Locality pilot points to positive future ways of working but is as yet at a very early stage • CAF is reported to be working effectively and feedback loops are used • A Social Work Academy is to be launched in the near future to help in recruitment and retention of staff • We were impressed by the Customer Service Network manager and staff, there is a commitment to make it work and to deal with problems as they arise • Partners recognise the stress that exists in Child Protection, are sympathetic to the workload pressures experienced by social workers and are working hard in to try to mitigate it as much as possible by 'managing the risk' whenever possible **Areas for consideration:** • Frontline social work staff were very stretched. High case loads and high levels of demand mean some staff feel vulnerable • Multiple IT systems prevent effective reporting • There is an absence of data to evidence work flows and outcomes • Business support arrangements do not effectively support frontline practice, there was a widespread perception that 'the wrong savings' had been made in respect to business support • There remains a reliance on interim appointments in

	the management tiers of Children's Social Care and many agency staff in the social work teams • Your Workforce Strategy remains in draft and is generic; a corporate approach to workforce development does not appear to be meeting the needs of the social work workforce nor providing for effective social worker induction. • We were told that there was a poor record of attendance by Children's Social Care, both managers and social workers, at multi- agency Sunderland Safeguarding Children Board training and at Core Groups
Vision, Strategy & Leadership	**Positive observations** • The incoming Executive Director for People was keen to investigate fully how effective frontline safeguarding actually was when he assumed managerial responsibility. Since then he has driven forward a programme of improvement. He sought the help and support of his corporate and political colleagues in the council, and from partners, as well as bringing in new staff and outside expertise to secure the future effectiveness of his own service and the wider safeguarding partnership • Across the partnership there is a recognition of the need for major improvement - and that this will need to continue to develop for some time to fully embed all the improvements to practice that have been highlighted by external and internal review and audit • Management teams across the partnership are open and honest in terms of what they have to do to improve • The Improvement Board and the Improvement Plan were instigated voluntarily in response to the findings of the Core Assets report; the Improvement Board is attended by Chief Executives of appropriate partner agencies and the Council Chief Executive has worked hard to fully engage all partners at this level • The Council Chief Executive's office is committed to improvement and is actively facilitating additional support to Children's Social Care via specialist secondments • The new Independent Chair is showing strong leadership and vision to the Sunderland Safeguarding Children Board. • The Strengthening Families Framework promotes resilience in families, communities and individuals • There is positive leadership in localities, which promotes staff empowerment and innovation; this is

	increasing the effectiveness of service delivery **Areas for consideration** • The pace of improvement needs to increase • The extensive use of interims across the partnership can carry risk and give out the wrong message. • Promote a stronger 'Team Sunderland' voice to ensure frontline staff are confident in the direction of travel • Senior leaders across the partnership need to take responsibility for developing a culture of openness, accountability without blame, learning and trust • Increased visibility of Children's Social Care senior managers at the frontline is required • The partnership should set out the outcomes expected for children in Sunderland and how these could be measured and monitored • We found that there was no clear expression of a joined up vision across the partnership that tells the story of where you want to be • You need to assure yourselves on performance through effective reporting systems • Collective leadership is needed, the willingness to do that is there, but it needs to be one partnership with equal responsibility and accountability. • There is not as yet a fully-fledged 'we're all in it together' culture – the willingness and intent is there but the reality lags behind the intent; mainly as a result of the 'council and its partners' culture that is said to have prevailed in the past. • You need to ensure the right skill sets and the necessary expertise exists across all management positions to drive improvement • Nurture frontline children's services staff; recognise how they feel and reward their commitment and hard work. • Strategic leaders need to be more visible, listen to concerns and inform frontline staff of how they intend to address those concerns and agendas. • Opportunities seem to be missed to learn from and share good practice across the City. Celebrate the achievements that are happening. • We didn't see any evidence of a reward culture, acknowledging the hard work and contribution of staff. In times of transition this is a vital means to keep staff engaged and working in the right direction. This is equally true on a partnership as well as a single service basis.

We wish you well with taking forward the issues identified by the peer review and we understand that the feedback from our review presentation has been discussed by key stakeholders.

You and your colleagues will want to consider how you incorporate the team's findings into your improvement plans, including taking the opportunity for sector support through your regional arrangements - the LGA's Principal Advisor, Mark Edgell, can be contacted by either email: Mark.Edgell@local.gov.uk or by phone on 0774 763 6910. In addition, you can contact Ann Baxter, LGA Children's Improvement Adviser covering the North East Region for specialist support. Ann can be contacted via baxter.ann@googlemail.com or on 0757 749 5153.

Once again, thank you for agreeing to receive a review and to everyone involved for their participation. In particular, please pass on our thanks to Agnes Rowntree and her team who provided sterling support to the review team during the onsite week.

Peter Rentell
Programme Manager (Children's Safeguarding)
Local Government Association

Appendix One

Case Records Review - summary of key findings

NB findings are aggregated due to the extreme difficulty experienced by the review team in accessing information held within individual electronic case records

- Social workers were not adjusting the date on the system when they input case notes. As a consequence the case records that we reviewed did not have the actual date of the activity correctly assigned.
- ESCR files are dated but often the date doesn't correspond with the document contained within.
- Plans, assessments etc. stored on ESCR appeared to be the dated for the time that the entry was uploaded onto the system rather than the date that the activity took place.
- There is an overuse of the 'terminated' assessment function; this is often seen within Initial Assessments.
- Initial and Core Assessments are not populated on the electronic system, the form is downloaded, completed and then stored on a social worker's personal drive or will be found on ESCR, some assessments could not be found at all.
- Child's status was not inputted on the system so when first accessing the system it was not possible to ascertain whether a child was e.g. CP/CLA etc.
- There is a general over use of, and over reliance on, written agreements with families. This was seen in a number of cases where risk was very obvious and a written agreement was not viewed by the peer reviewer as an appropriate way to manage the case
- Supervision did not appear to be taking place monthly in the cases reviewed, despite the update given on the Improvement Plan suggesting that it was. On those instances where supervision was recorded it often lacked focus and/or direction and in some cases failed to address risk and drift.
- Where there was case direction about fundamental activity, i.e. progress to PLO, significant delay in implementation was noted
- Assessments, including parenting assessments, lacked structure and analysis, some assessments were written on the basis of self-reporting by parents. Revised Parenting/Risk Assessment guidance was written in January 2013 but this was not seen to be used in the cases that were reviewed

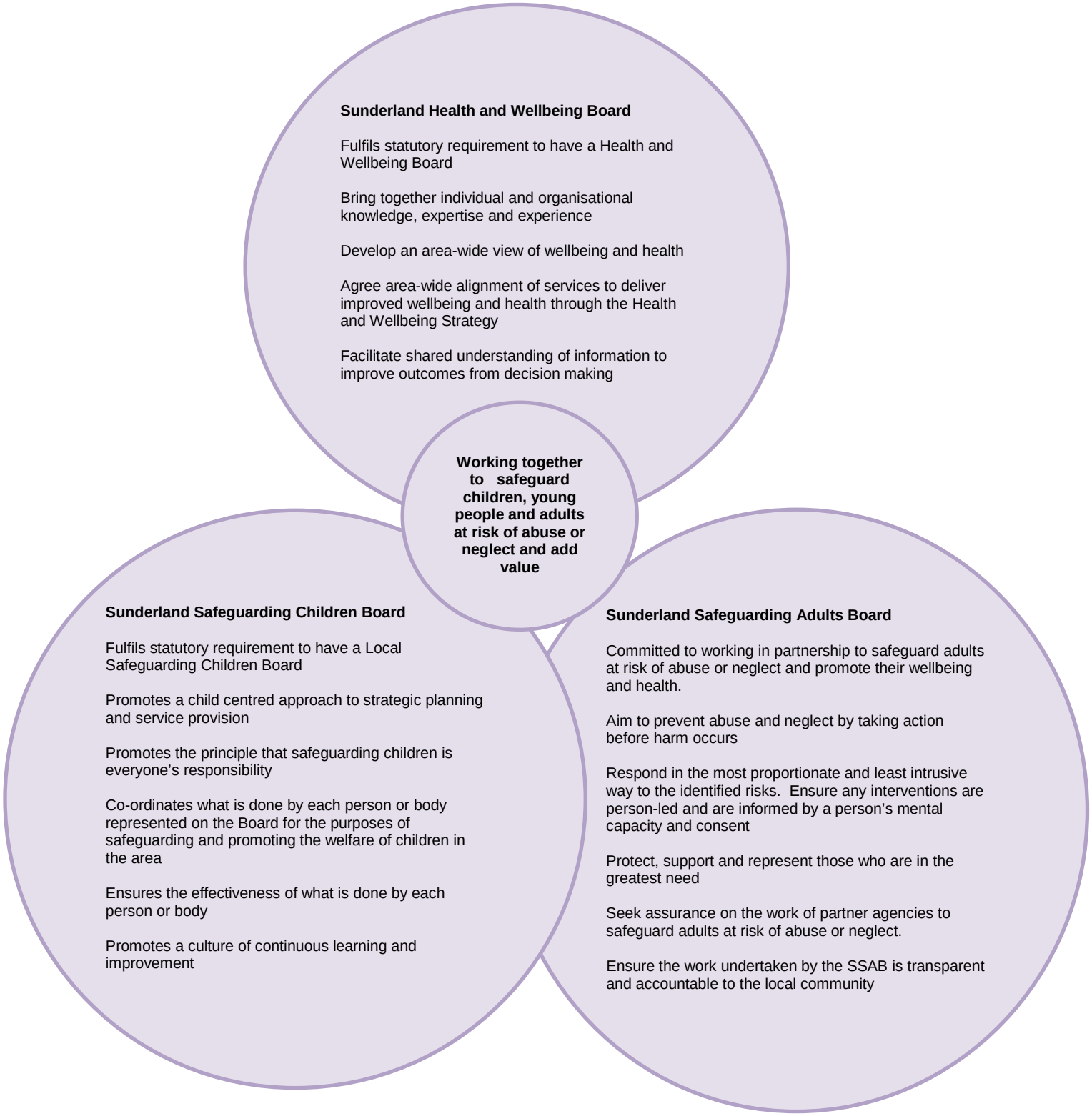
- There was barely any reference to be found in the cases reviewed to the utilisation of Early Help services
- Significant drift and delay was found in many of the cases that were reviewed
- Many of the cases appeared to be 'stuck', with workers unable to identify when a case needed to progress further i.e. to Child Protection or removal.
- Child Protection minutes, and subsequent plans, lacked focus and gave little direction to the multi-agency team in terms of what was expected

Framework of Cooperation between

Sunderland Health and Wellbeing Board (HWBB)

Sunderland Safeguarding Children Board (SSCB)

Sunderland Safeguarding Adults Board (SSAB)


Sunderland Health and Wellbeing Board
Fulfils statutory requirement to have a Health and Wellbeing Board
Bring together individual and organisational knowledge, expertise and experience
Develop an area-wide view of wellbeing and health
Agree area-wide alignment of services to deliver improved wellbeing and health through the Health and Wellbeing Strategy
Facilitate shared understanding of information to improve outcomes from decision making
Working together to safeguard children, young people and adults at risk of abuse or neglect and add value
Sunderland Safeguarding Children Board
Fulfils statutory requirement to have a Local Safeguarding Children Board
Promotes a child centred approach to strategic planning and service provision
Promotes the principle that safeguarding children is everyone's responsibility
Co-ordinates what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area
Ensures the effectiveness of what is done by each person or body
Promotes a culture of continuous learning and improvement
Sunderland Safeguarding Adults Board
Committed to working in partnership to safeguard adults at risk of abuse or neglect and promote their wellbeing and health.
Aim to prevent abuse and neglect by taking action before harm occurs
Respond in the most proportionate and least intrusive way to the identified risks. Ensure any interventions are person-led and are informed by a person's mental capacity and consent
Protect, support and represent those who are in the greatest need
Seek assurance on the work of partner agencies to safeguard adults at risk of abuse or neglect.
Ensure the work undertaken by the SSAB is transparent and accountable to the local community

1. Purpose

1.1 This Framework is intended to clarify the statutory, independent and complementary roles and responsibilities of the Sunderland Safeguarding Children Board (SSCB), Sunderland Safeguarding Adults Board (SSAB) and the Health and Wellbeing Board (HWBB). It sets out the opportunities available to work together and add value to each other's work.

The Framework is taken in the context of:

- The requirement of statutory guidance Working Together 2015 that "the LSCB should work with the Health and Wellbeing Board, informing and drawing on the Joint Strategic Needs Assessment"
- An Ofsted requirement that "governance arrangements enable Local Safeguarding Children Board partners (including the Health and Wellbeing Board …) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people"
- Care Act Guidance states that a copy of the Sunderland Safeguarding Adults Board Annual Report must be sent to the Chair of the Health and Wellbeing Board.
- The Health and Wellbeing Board plays a key role in the assurance and accountability of SSAB and local safeguarding measures, by ensuring strong partnership working and that the needs and views of local communities are represented.

2. Principles

2.1 It is important that the Boards:

- Work together in an environment of mutual respect, courtesy and transparency
- Have a shared understanding of our respective roles, responsibilities, priorities and different perspectives
- Promote and foster an open relationship, where issues of common interest and concern are shared and any challenge is undertaken in a constructive and mutually supportive way
- Share work programmes, intelligence and data to thus reducing duplication of effort and cost

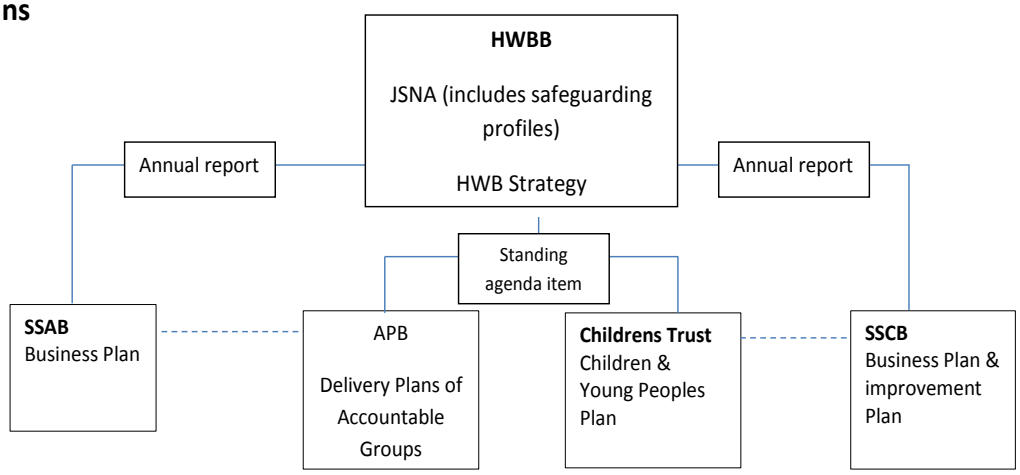
2.2 There are common aims and the need for closer working across the partnerships but it is important to be clear that the SSCB/SSAB and HWBB are independent bodies and have autonomy over their work programmes and methods of working. It is crucial that all bodies hold each other to account for the work undertaken to safeguard and promote the welfare of children, young people and adults at risk of abuse or neglect across Sunderland.

2.3 This Framework does not preclude any of the 3 Boards working with any other local, regional or national organisations to deliver these aims.

3. Overview of Relationships

3.1 The HWBB has the role of a 'Sponsoring Group' and provides system leadership for safeguarding arrangements, providing top-level endorsement of the rationale and objectives of the Safeguarding Boards. This will include receiving annual reports from the two Safeguarding Boards detailing work over the previous year, plans for the forthcoming year and any key issues. Ad hoc reports will also be received as and when issues arise.

Strategies and Plans



3.2 The HWBB has a statutory responsibility for producing two documents – firstly a strategic level assessment of the health and wellbeing needs of the population (the JSNA) and secondly a high level health and wellbeing strategy. In Sunderland, the JSNA is separated into a number of profiles which include both adults and children's safeguarding. It is the responsibility of the profile lead to ensure that the profiles are updated as and when new data becomes available or when there are significant changes to policy, regulations or commissioning intentions in relation to their profile. The profiles are published on the internet and freely available.

3.3 The Sunderland Health and Wellbeing Strategy operates at a very high strategic level establishing the way in which the HWBB expects the system to operate, establishing a vision for the City and outlining a set of design principles and key objectives for the system.

3.4 The HWBB is supported and advised by three advisory groups – the Childrens Trust (title under review), the Adults Partnership Board and the Provider Forum. Their role is to ensure that the views of their respective sectors are fed into the HWBB on a regular basis. It is envisaged that to ensure that there is a clear thread running through the system, that the Adults Partnership Board and Childrens Trust receive regular reports from their respective safeguarding boards.

3.5 The two Safeguarding Boards have the responsibility for reducing the impact of abuse and neglect on children and adults at risk of abuse or neglect. The members of the Safeguarding Boards have overall responsibility for ensuring that the Boards meet their objectives and deliver on their functions. This

includes self-assessment and self-assurance that the work of the partnerships is on track, that relevant practices and procedures are being applied, and that the projects, activities and business rationale remain aligned to the objectives of the partnership. An important step in working together for the whole system is that the SSCB and SSAB have the same Independent Chair.

3.4 As each Board is made up of constituent partners, there is overlapping membership as follows:

- Sunderland City Council
- NHS England
- Sunderland Clinical Commissioning Group

3.5 In addition the Associate Policy Lead for Health and the SSCB and SAB Business Managers will meet regularly to support productive working relationships between the three Boards.

Signatories

Councillor Paul Watson	Colin Morris
Date:	Date:
Chair	Chair
Health and Wellbeing Board	Sunderland Safeguarding Children Board Sunderland Safeguarding Adults Board

Sunderland Safeguarding Children Board (SSCB)

Role and Responsibilities

The SSCB is the statutory multi-agency partnership with responsibility for safeguarding and promoting the welfare of children and young people across Sunderland.

Sunderland Safeguarding Children Board aims to ensure that:

"Every child and young person in Sunderland feels safe and is safe".

To support this aim the Board has published the SSCB vision and Business Plan 2014-17, which outlines how it will be achieved.

The SSCB's key responsibilities are to:

- Develop policies and procedures for safeguarding and promoting the welfare of children in Sunderland, including policies and procedures in relation to the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention, ensuring safe recruitment and working practice, investigating allegations and concerns and training provision
- Monitor and evaluate the effectiveness of what is done by Sunderland Local Authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve
- Communicate and raise awareness of the need to safeguard children and promote the welfare of children to those who work with children including volunteers and members of the public
- Collect and analyse information about child deaths with a view to learning from experience and safeguarding and promoting the welfare of children
- Participate in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account
- Undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern about the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child
- Lead on or contribute to specific safeguarding initiatives e.g. sexual exploitation, e-safety, substance misuse, licensing

Membership

The SSCB is chaired independently and has the following membership:

- Chief Executive, Sunderland Local Authority (representing Public Health and Safer Sunderland Partnership,
- Executive Director People Services, Sunderland Council (Representing Youth Offending Service, Community and Family Wellbeing, Adult Services and Children's Safeguarding)
- Chief Officer Northumbria Police
- Chief Officer National Probation Service
- Chief Executive South Tyneside NHS Foundation Trust
- Chief Executive NHS England
- Chief Officer Northumbria Probation Community Rehabilitation Company

- Chief Executive City Hospitals Sunderland, NHS Foundation Trust
- Chief Executive Northumberland Tyne and Wear Mental Health Foundation Trust
- Chief Executive CAFCASS
- 2 Lay Members
- SSCB Independent Chair
- Chief Officer Clinical Commissioning Group
- Chief Executive North East Ambulance Service
- Chief Executive Gentoo
- Chief Executive Tyne and Wear Fire and Rescue Service
- Chief Executive Sunderland College
- Chief Executive Turning Point
- Chief Executive Sunderland University
- Head of Educational Attainment and Lifelong Learning representing schools and academies
- Portfolio Lead Member Sunderland City Council (Participating Observer)

It should be noted that there will be a requirement from time to time for other officers also to be 'in attendance', but that they should not be considered formal members of the SSCB and do not have voting rights. This will include the, Director of Public Health, Designated Nurse Safeguarding Children and Adults and other designated professionals. The SSCB Business Manager and the SSCB Legal Advisor or their representative will be in attendance at all Board meetings.

The SSCB Financial Adviser (who is appointed by Sunderland City Council) will be in attendance at all Board meetings to report on the SSCB Budget.

Further information about our SSCB is available on the SSCB website atwww.sunderlandscb.com

To support this Framework our SSCB will:

- Lead on the preparation and approval of the Childrens Safeguarding Joint Strategic Needs Assessment (JSNA) profile
- Use the Childrens Safeguarding JSNA profile to inform the work that it does
- Contribute to the HWBB Strategy by agreeing the annual priorities that inform the commitments for shared change
- Lead on and ensure the specific commitments for safeguarding children and young people are met
- Submit details of progress on the commitments for inclusion within the HWBB Annual Report
- Act upon any delegations of responsibility from the HWBB
- Share its Annual Report with the HWBB and advisory groups of the HWBB as appropriate
- Maintain a separate identity and an independent voice for safeguarding children and young people
- Provide expertise to the HWBB to support it in carrying out its functions

In addition, where appropriate the SSCB may:

- Refer matters to the HWBB for investigation and/or comment, where there are particular issues of mutual concern

- Consider recommendations and/or areas of referral submitted by the HWBB, in relation to areas of current and upcoming work of the Board, or priorities of the HWBB Strategy and/or the SSCB Business Plan

Sunderland Safeguarding Adults Board

Role and Responsibilities
The SSAB is the multi-agency partnership with responsibility for safeguarding adults at risk of abuse or neglect.

The SSABs key functions are:

- To develop and deliver a shared vision for safeguarding adults
- To develop and maintain strong links with relevant partnerships and ensure inclusion of safeguarding adults in relevant partnership strategies and business plans
- Promote the active involvement of service users, their carers, their families and their advocates and adopt an inclusive approach to secure wider community understanding, awareness and feedback on safeguarding adults arrangements
- Approve policy and procedural guidance to safeguard and promote the safety and wellbeing of adults at risk of abuse or neglect
- Oversee and monitor operational safeguarding adults activity and ensure the production of timely and accurate performance and safeguarding information
- Secure Citywide consistency in safeguarding and ensure all staff and stakeholders know and use policies and procedures effectively
- Commission and receive reports and consider proposals from other Boards, Partnerships and other work areas, as appropriate
- Secure effective operational engagement and integration of safeguarding adults work within the areas of the safeguarding of children, MAPPA, MARAC, domestic violence, and within the wider arena of community safety including forced marriage and honour-based crime
- Ensure mechanisms are in place to recognise, report and respond to incidents of abuse, including institutional abuse and discrimination
- Identify and maintain relevant strategic links with local, regional and national organisations
- Lead on the preparation and approval of the Adults Safeguarding Joint Strategic Needs Assessment (JSNA) profile
- Use the Adults Safeguarding JSNA profile to inform the work that it does
- The communication of the need to safeguard adults at risk of abuse or neglect, raising awareness of how this can be done and encouraging people to do so
- Provide learning and development opportunities to people who work or volunteer with adults at risk of abuse or neglect
- The production of a strategic annual plan that outlines how the Board will achieve its vision and objectives and what each member will do to implement that strategy
- Monitoring and evaluating the effectiveness of what is done by the Board and its partners individually and collectively to safeguard adults at risk of abuse or neglect, including the publication of an Annual Report

- Participating in service planning and commissioning of services for adults at risk of abuse or neglect
- Undertaking Safeguarding Adult Reviews and advising on lessons that can be learnt.
- The SSAB became statutory in April 2015.

Membership
The SSAB is chaired independently and has the following membership:

- Chief Executive, Sunderland City Council
- Executive Director, People Directorate, Sunderland City Council
- Chief Officer, Northumbria Police
- Chief Officer, Sunderland Clinical Commissioning Group
- Chief Officer, Northumbria Probation Trust
- Chief Officer, Northumbria Community Rehabilitation Company
- Chief Executive, Northumbria, Tyne and Wear NHS Foundation Trust
- Chief Executive, City Hospitals Sunderland NHS Foundation Trust
- Chief Executive, South Tyneside NHS Foundation Trust
- Portfolio Holder for People Directorate
- Lay Member – to be confirmed
- Chair, Healthwatch
- Independent Chair, SSAB
- Deputy Director, Gentoo
- Chief Officer, VCAS
- Business Manager, SSAB (or delegate)
- Care Quality Commission
- Chief Executive Officer, Sunderland Carers' Centre
- Director, Age UK Sunderland

Sunderland Safeguarding Adults Board (SSAB) is committed to ensuring the welfare of adults at risk of abuse or neglect and to safeguard against all forms of abuse.

- Every individual has a right to be protected against harm and exploitation, and a right to dignity and respect;
- It is everyone's responsibility to safeguard adults at risk within our society.

For more information on the work of the SSAB, including its Vision and Priorities, please visit: http://www.sunderland.gov.uk/index.aspx?articleid=7635

To support this Framework SSAB will:

- Use the Sunderland Future Needs Assessment (SFNA) and 'Know Sunderland' to inform the work that it does
- Contribute to the HWBB Strategy by agreeing the annual priorities that inform the commitments for shared change
- Lead on and ensure the specific commitments for safeguarding adults are met

- Submit details of progress on the commitments for inclusion within the HWBB Annual Report
- Act upon any delegations of responsibility from the HWBB
- Share its Annual Report with the HWBB and advisory groups of the HWBB as appropriate
- Publish summary minutes of its meetings that can be accessed publically on the SSAB webpage

In addition the SSAB may:

- Refer matters to the HWBB for investigation and/or comment, where there are particular issues of mutual concern
- Consider recommendations and/or areas of referral submitted by the HWBB, in relation to areas of current and upcoming work of the Board, or priorities of the HWBB Strategy and/or the SSAB Strategic Annual Plan

Sunderland Health and Wellbeing Board

The Sunderland Health and Wellbeing Board ('the Board') will have the following statutory roles and functions under Section 194 of the Health and Social Care Act 2012:

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

The following will be the additional responsibilities of the board:

- To lead in the significant improvement in outcomes as a result of joint planning and commissioning of services across agencies.
- To provide a leadership role in the health and social care system whilst recognising that it is the responsibility of the Board's constituent bodies to ensure priorities are taken through their own governance arrangements.
- To prioritise and monitor implementation against the Objectives identified in the Health and Wellbeing Strategy and refresh as required;
- To request regular assessment of needs in the area, identify shared priorities for action and specific outcomes on the basis of those needs and to develop and comply with appropriate information sharing arrangements;
- To recommend the commissioning of services, resource allocation to achieve the outcomes and indicators the Board requires, through the prioritisation and recommendation of proposals in the constituent partners' budget setting rounds;
- To ensure that there is active user and public involvement in decision-making and developments of services;

- To ensure that all initiatives are carried out in a framework that promotes equalities and celebrates diversity;
- To ensure that activities promote a positive image of the City and the local community;
- To support and influence service developments and change that will enhance the general wellbeing of the City

For more information about the Health and Wellbeing Strategy and JSNA please visit: http://www.sunderlandpartnership.org.uk/healthy.html

Membership
The HWBB had the following membership:
Leader of the Council (Chair)
Cabinet Secretary (Vice Chair)
Health Housing and Adult Services Portfolio Holder
Public Health, Wellness and Culture Portfolio Holder
Children Services Portfolio Holder
Opposition Member
Executive Director, People Directorate
Director of Public Health
CCG Clinical Chair
CCG Additional Member
CCG Chief Officer
Chair of Sunderland LSP
HealthWatch Chair
NHS England Area Team

To support this framework agreement, HWBB will:

- Publish details of current and upcoming work of the Board, recognising that changes will be made on an ongoing basis to reflect emerging priorities
- Receive the Annual Report of the SSCB and provide scrutiny and challenge to the work of the SSCB in improving outcomes for children
- Receive the Annual Report of the SSAB and provide scrutiny and challenge to the work of the SSAB in improving outcomes for adults at risk of abuse or neglect.

In addition the HWBB may:

- Refer matters to the SSCB or the SSAB for investigation and/or comment, where there are particular issues of mutual concern.
- Consider recommendations and/or areas of referral submitted by the SSCB or SSAB, in relation to areas of current and upcoming work of the Board, or priorities of the HWBB Strategy

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD **29 May 2015**

JOINT STRATEGIC NEEDS ASSESSMENTS

Report of the Executive Director of People Services

1. Purpose of the Report

To support the board to develop a framework for the further development of Joint Strategic Needs Assessments.

2. Background

The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to joint strategic needs assessments (JSNAs).

Local authorities and clinical commissioning groups have equal and joint duties to prepare JSNAs. The responsibility falls on the health and wellbeing board as a whole with success bring dependent upon all members working together.

Health and Wellbeing boards can request relevant information to support JSNAs from organisations represented on the board (core members and others) and when asked they have a duty to supply the information if they hold it.

The Act determines that the JSNAs must assess current and future health and social care needs within the health and wellbeing board area, covering the whole population and must be published. This allows transparency and accountability explaining to the local public what the board's assessment of the local needs are and what the proposals are to address these needs.

The Health and Wellbeing Boards have the responsibility to determine when JSNAs should be refreshed or updated, again this process should be transparent with boards being clear with partners and local communities how this will be done.

3. Current Position

A number of JSNAs have been developed and published in PDF format on Sunderland City Council website. These JSNAs have been added to and updated periodically, however, as with any document that includes data these become out of date almost as soon as they are prepared and published. List attached at **Annex 1**.

Given the duties introduced under the Act there is now an opportunity to review the framework for the development, creation and publication of JSNAs.

4. Proposal

To develop and create a Joint Strategic Needs Assessment that will act as the single vehicle for all strategic intelligence, initially covering health and wellbeing and the wider issues that affect health such as employment, crime and disorder and housing. Future opportunities for further development include creating area profiles and expanding the information to incorporate Economy and Place.

The Joint Strategic Needs Assessments will be moved from a static annual publication to a continually evolving on-line “wiki” resource hosted on Sunderland City Council website. Bath and North Somerset Council have implemented such a resource as shown in Annex 2 and following a peer challenge this framework was identified and shared as notable practice.

In practice this means that once the resource is developed, created and published partners can continuously update the JSNA ‘wiki’ resource which includes data as well as intelligence such as patient feedback and service user data.

Officers and members within the Council, the wider health and wellbeing system, the voluntary and community sector and local communities can use the JSNA as a shared resource.

In order for the proposal to be progressed a multi-agency steering group (time-limited task and finish group) would need to be established to progress the development and creation of the resource.

Once the JSNA resource is established core members and partners of the board would need to identify practitioner representatives who would be responsible for the ongoing refresh of the resource online.

Recommendations

1. Consider and note the content of the report.
2. Consider and agree the establishment of a multi-agency task and finish group (representatives) to develop and implement the online resource.

Annex 1

The following JSNA profiles are available in PDF format on the Sunderland City Council website:

Tobacco
Obesity
Homelessness
Accidents
Supported Accommodation
Substance Misuse
Sexual Health
Physical Activity
Mental Health
Life Expectancy
Housing Conditions
Access to Services
Care Closer to Home
Supporting People to Live Independently
COPD
Low Carbon Climate Change
Access to Good Quality Work

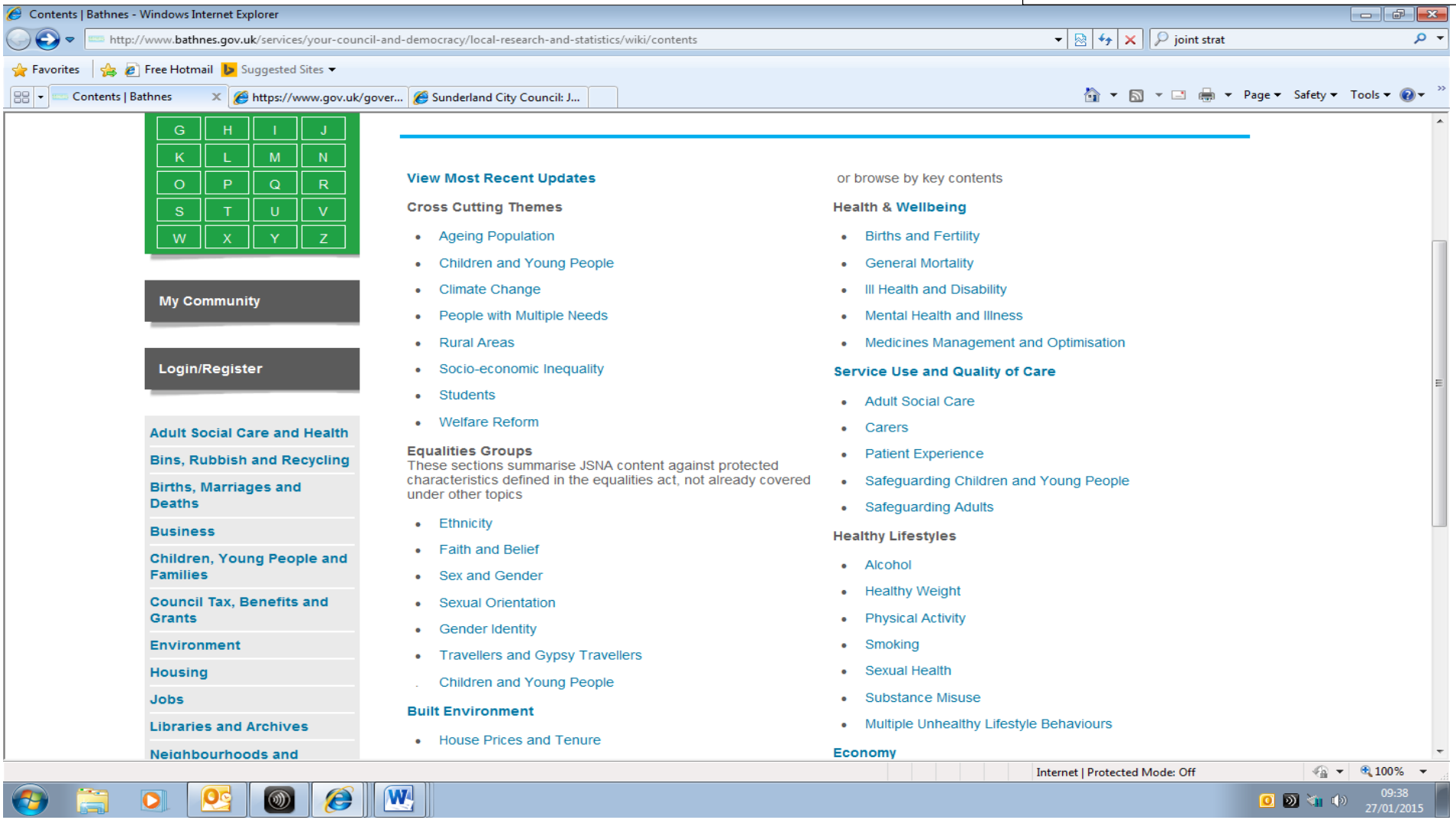
The following JSNA profiles are available internally, all are at varying stages of completion/review. Some are included in the above list but the latest version has not been published on the Council website:

Best Start in Life
Reducing or Preventing Hospital admissions / care closer to home
Chronic Obstructive Pulmonary Disease
Crime and Community Safety
Cardiovascular disease
Family Financial and Household resilience
Homelessness, Hostels, Rough Sleeping & Migration
Learning and attainment
Life Expectancy
Mental Health (Illness and prevention)
Obesity
Quality of Life - emotional wellbeing / Community Resilience
Safeguarding - adults
Safeguarding - children and young people
Sexual Health
Social Isolation
Substance misuse, drugs & alcohol

Supporting people to live independently
Supported accommodation
Tobacco
Increasing and Improving Physical Activity
Access to Services, Urban Planning and Wellbeing
Accidents
Housing Conditions (Physical Conditions)
Low Carbon and Climate Change
Access to good quality work
Digital Inclusion

Annex 2

Contents page that is provided when user types in 'Joint Strategic Needs Assessment'



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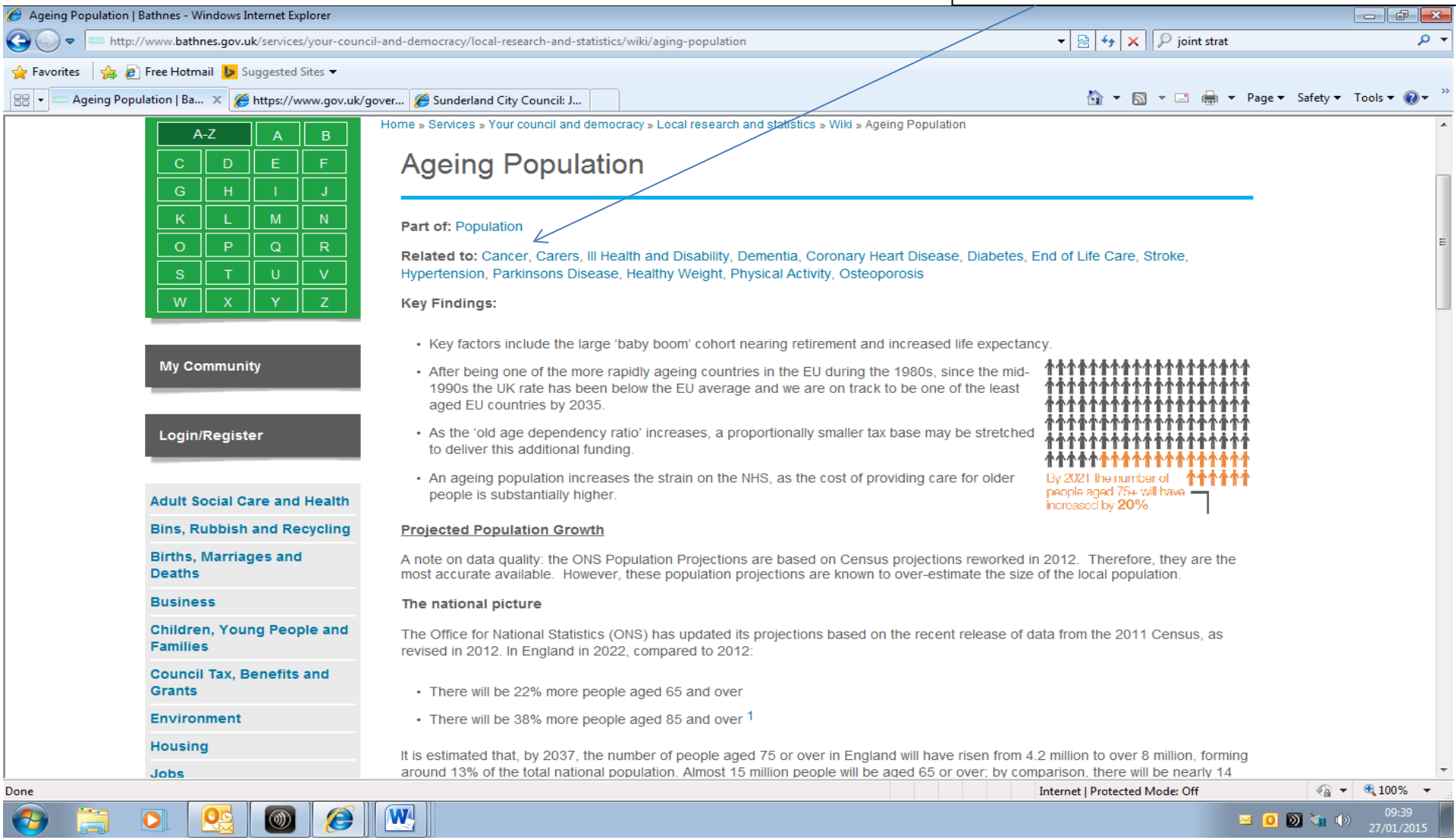

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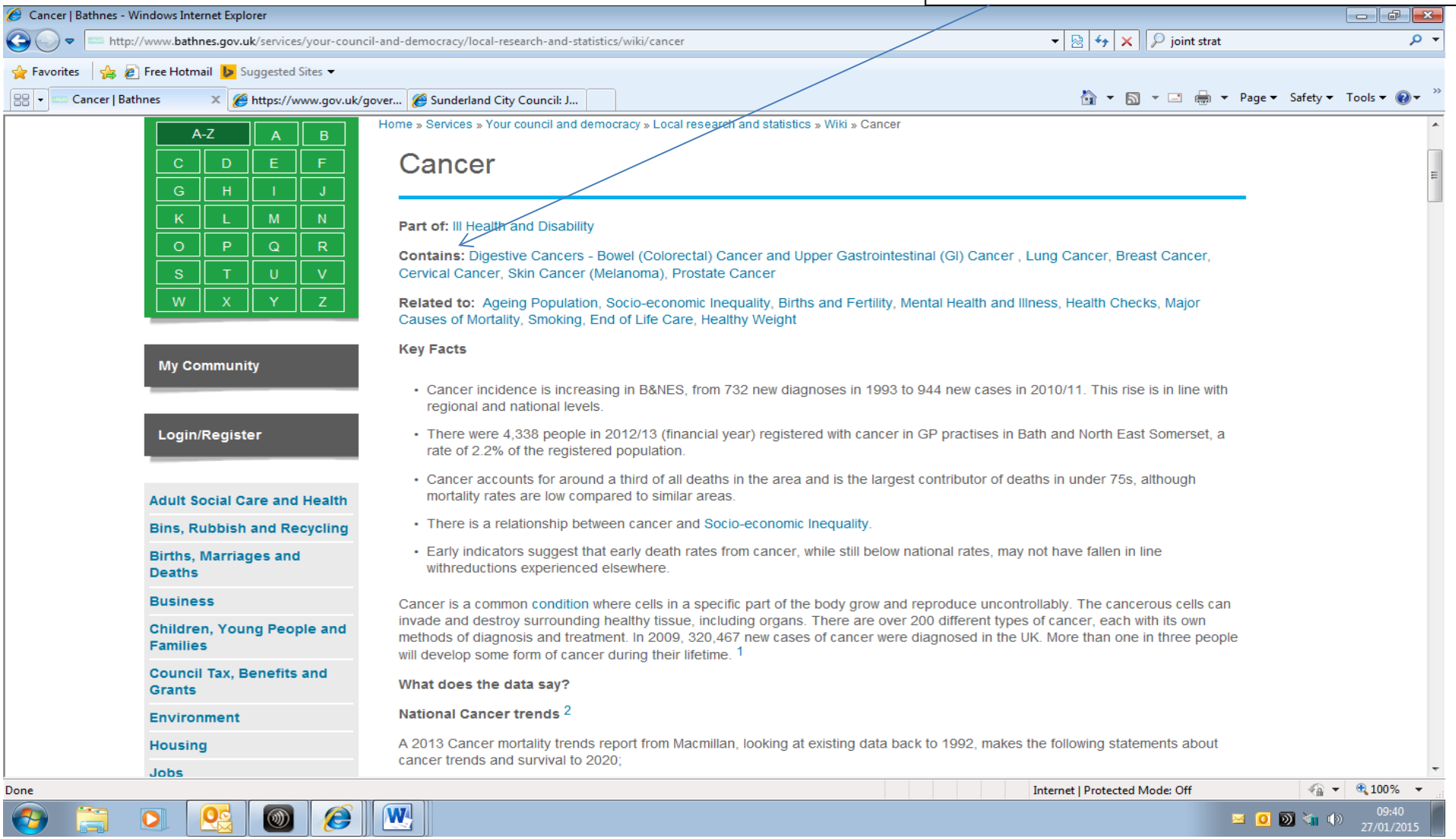

Item No. 8

SUNDERLAND HEALTH AND WELLBEING BOARD **29 May 2015**

SUNDERLAND CARE ACADEMY

Report of the Chair of Sunderland CARE Academy

1.0 Purpose of the Report

The purpose of this paper is to provide the Health and Wellbeing Board with the opportunity to discuss the developments to date of the Sunderland CARE Academy.

2.0 Background

The Sunderland CARE Academy is a collaboration of partners from health, social care, education and the voluntary sector working together to improve the quality of care delivery across the city. Partners include NHS, University of Sunderland, Sunderland Council, Foundation of Light and the Carers' Centre.

3.0 Body of report

The Sunderland CARE Academy's mission is to:

> ***'Improve the overall focus on and quality of care in Sunderland and to bring health and wellbeing benefits and socio-economic benefits to the local population and the city.'***

This aligns intentionally with the role and aims of the following:

- Sunderland Partnership;
- The Health and Wellbeing Board;
- The Education and Skills Leadership Board;
- The Economic Leadership Board; and
- The Sunderland Multiagency Carers Strategy.

The CARE Academy will:

- Develop education and training programmes for the health and care workforce across the city with the aim of supporting high quality care to patients, carers and families;
- Promote research and innovation into health and social care, increasing the quantity and quality of research undertaken in Sunderland;
- Promote participation in local, national and international research; and
- Implement the findings of research into practice.

The CARE Academy title consists of an acronym to describe the four workstreams which partners are working together on which support local strategies, and the

implementation of national policy to improve the quality of care delivery across the city.

C Collaboration
A Achieving High Quality Care
R Research and Innovation
E Engagement

The paper describes the SWOT analysis, governance arrangements and progress to date on the workstreams.

4.0 Recommendations

The Board is recommended

- To note the development of the CARE Academy and progress to date
- To discuss the potential benefits to the city of Sunderland
- To agree next steps

Joy Akehurst
Chair
Sunderland CARE Academy

May 2015

Sunderland CARE Academy

Strategic Document

Version 15.1

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1.0 BACKGROUND

The Sunderland CARE Academy was established in 2014 as a proactive, creative response to recent inquiries into care provision which emphasised the need for:

- New and transformed approaches to care;
- Better quality standards of care provision;
- Clearer organisational governance;
- Better staff training; and
- More patient involvement.

The Sunderland CARE Academy is a 'virtual' academy, formed by local partner organisations with a focus on the provision and support of high quality care collaborating and sharing assets. It aims to address some of the issues highlighted in the following reports:

- Personalized Health and Care 2020 - Using Data and Technology to Transform Outcomes for Patients and Citizens – A Framework for Action[1] (National Information Board, November 2014);
- Developing a flexible workforce that embraces research and innovation – Research and Innovation Strategy[2] (Health Education England, September 2014);
- The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care settings[3] (Department of Health, July 2013);
- Treating Patients and Service Users with Respect, Dignity and Compassion[4] (Department of Health, March 2013);
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - The Francis Report[5] (The Stationery Office, February 2013);
- Impact of Digital Technology in Health and Social Care[6] (Department of Health, January 2013);
- Digital Health -Working in Partnership[7] (Healthcare UK, Department of Health, and UK Trade & Investment, January 2013);
- Compassion in Practice – Nursing, Midwifery and Care Staff Our Vision and Strategy[8] (Department of Health, December 2012);
- Winterbourne View Hospital: Department of Health review and response[9] (Department of Health, December 2012);
- Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery[10] (Department of Health, January 2012);
- A Framework for Technology Enhanced Learning[11](Department of Health, November 2011).

2.0 INTRODUCTION

2.1 What is the CARE academy?

The Sunderland CARE Academy is a collaboration of partners from health, social care, education and the voluntary sector working together to improve the quality of care delivery across the city. To do this, it will:

- Develop education and training programmes for the health and care workforce across the city with the aim of supporting high quality care to patients, carers and families;
- Promote research and innovation into health and social care, increasing the quantity and quality of research undertaken in Sunderland;
- Promote participation in local, national and international research; and
- Implement the findings of research into practice.

The Sunderland CARE Academy's mission is to:

> ***Improve the overall focus on and quality of care in Sunderland and to bring health and wellbeing benefits and socio-economic benefits to the local population and the city.***

The CARE Academy title is an acronym of the titles of the 4 workstreams:

C Collaboration
A Achieving High Quality Care
R Research and Innovation
E Engagement

2.2 What will the CARE Academy do?

The CARE Academy has four main work streams that will support local strategies and the implementation of national policy to improve the quality of care delivery across the city.

These four work streams, whilst distinct, are not mutually exclusive. They will work in tandem to provide the best possible outcomes for the city. More detail of the work streams is provided in Appendix 1.

The work streams are:

2.2.1 Collaboration

This work stream will strengthen links between a range of stakeholders across Sunderland to develop opportunities for health and wealth creation in the city. Initiatives include:

- Developing "Sunderland CARE" a virtual electronic network for sharing practice;
- Aligning work with the vision and priorities set out in the Sunderland Health and Wellbeing Strategy and Sunderland Joint Strategic Needs Assessment;

- Aligning work with other city-wide initiatives such as “All Together Sunderland!” and “Wear One City”;
- Supporting and participating in the work of the Academic Health Sciences Network for the North East and North Cumbria;
- Working with industry providers and using funding opportunities to bring resources into the city.

2.2.3 Research and Innovation

This work stream will increase the quality and quantity of research undertaken across the city. The programme will improve pathways for the dissemination of research which seeks to improve health, wellbeing and quality of care. Initiatives include:

- Developing evidence based care approaches;
- Dissemination of research to inform care pathways;
- Engagement with local, national and international research;
- Promotion of Sunderland as a proactive research site.

2.2.4 Engagement

This work stream will engage the people of Sunderland in improving Sunderland as a healthy and prosperous city. The programme will provide workforce development opportunities across the economy. Initiatives include:

- Patient, public and carer engagement through involvement groups and public events;
- Encouraging and promoting active involvement in improving and maintaining their own health and wellbeing through self-care and self-management;
- A strong focus on engagement with and support for carers, who are twice as likely to suffer ill health as those who do not have a caring role;
- Supporting collaborative and inter-professional working; and
- Support for community wellbeing e.g., by developing volunteering.

3.0 CONTEXT

Partners across Sunderland work well together to meet key strategic objectives for the City. Strategic plans for the city focus on three overlapping themes of:

- Health and wellbeing;
- Education and skills; and
- Economic development.

The Sunderland CARE Academy will be an integral part of these Sunderland-wide partnership arrangements; using the collaborative as the focal point for providing a unified approach to care across the City, the Sunderland CARE Academy will strategically aligning its work with the following:

- Sunderland Partnership;
- The Health and Wellbeing Board;
- The Education and Skills Leadership Board;
- The Economic Leadership Board; and
- The Sunderland Multiagency Carers Strategy.

3.1 Cross City Priorities

"All Together Sunderland!" is an initiative to strengthen working links between communities, public service commissioners and potential partners across the city. Its aim is to understand the priorities of the community in order to help find solutions to the issues identified, mobilise resources, and actively encourage, facilitate and enable communities to make their own contribution.

The "Wear One City" initiative proposes better health for Sunderland through:

- Inclusive patient and community centred involvement;
- Empowerment;
- Integrity;
- Honest and open culture;
- Innovation; and
- Responsiveness.

The Sunderland CARE Academy will align its work with the "All Together Sunderland!" and "Wear One City" initiatives.

3.2 Health and Wellbeing

The Sunderland Health & Wellbeing Board brings together Sunderland City Council and Sunderland Clinical Commissioning Group with a range of partners to promote integrated working between commissioners of health services, public health and social care services to improve the health and wellbeing of local people.

3.2.1 Joint Health and Wellbeing Strategy for Sunderland

Sunderland's joint Health and Wellbeing Strategy[12] sets out our vision to have the:

> ***Best possible 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.***

The priorities in the joint health and wellbeing strategy for Sunderland are as follows:

- Promoting understanding between communities and organisations;
- Ensuring that children and young people have the best start in life;
- Supporting and motivating everyone to take responsibility for their health and that of others;
- Supporting everyone to contribute;
- Supporting people with long-term conditions and their carers; and
- Supporting individuals and their families to recover from ill-health and crisis.

The Sunderland CARE Academy shares the principles underpinning the joint health and wellbeing strategy for Sunderland which will support a proactive, collaborative approach to high quality care. These are as follows:

- Strengthening Community Assets
- Prevention
- Early intervention
- Equity
- Promoting independence and self-care
- Joint working
- Addressing the factors that have a wider influence on heath (social determinants)

3.2.2 Joint Strategic Needs Assessment

The Health & Wellbeing Board produces a joint strategic needs assessment[13] (JSNA) which describes the health and wellbeing of people in Sunderland and how this compares to the rest of England. The JSNA:

- Provides an insight into current and future health, wellbeing and daily living needs of local people;
- Informs the commissioning of services and interventions to improve health and wellbeing outcomes and reduce inequalities; and
- Places a strong emphasis on the issues which may adversely affect people's ability to stay well, and which may adversely impact upon quality of life, and life expectancy.

The Sunderland Care Academy will utilise the findings and direction of the JSNA and promote the integration of services across health, social care and the private and the voluntary sectors.

3.3 Third Sector

The drive for public sector efficiency requires enhanced collaboration between partner organisations in order to deliver high quality care with fewer resources; the utilisation of voluntary and charitable organisations is being encouraged.

The Sunderland CARE Academy includes members from the Sunderland Association Football Club (SAFC) Foundation of Light, and the Sunderland Carers' Centre, both of which are highly respected charities. This reflects the current change in culture of health and care organisations.

3.4 Education commissioners and providers

The Sunderland CARE Academy recognises the potential for collaboration with industry providers, including access to possible future funding opportunities. Sunderland University and Sunderland College are already involved in the work.

The Sunderland CARE Academy recognise the importance of developing strong working relationships with Health Education North East – the local outpost of Health Education England - who are responsible for ensuring that education, training, and workforce development drives the highest quality public health and patient outcomes.

3.5 Academic Links

The Department of Health has established Academic Health Sciences Networks to align education, clinical research, informatics, innovation, training and education and healthcare delivery. They seek to improve patient and population health outcomes by translating research into practice, developing and implementing integrated health care services, supporting knowledge exchange, and building alliances across networks to actively share best practice, and provide for rapid evaluation and early adoption of new innovations.

The Sunderland CARE Academy model aligns well with the current proposals of the regional Academic Health Sciences Network for the North East and North Cumbria. These include:

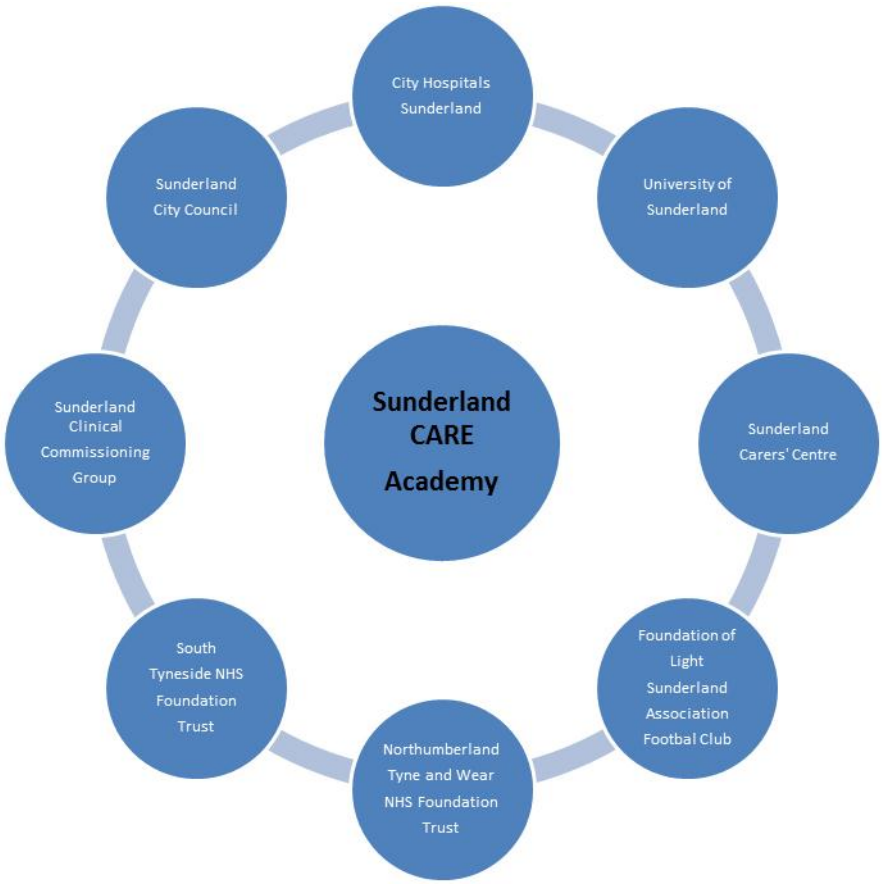
- System-wide integration;
- Partnership working;
- Collegiate approaches to problem solving;
- Wealth creation and
- Health improvement.

The Sunderland CARE Academy will support and participate in the work of the regional Academic Health Sciences Network for the North East and North Cumbria.

4.0 GOVERNANCE

4.1 Collaborating Partners

The diagram below shows the collaborating partners from health, social care, education and the voluntary sector that are working together within the Sunderland CARE Academy.



4.2 Management Board

Local representatives from health, social care, higher education, the city council, and the voluntary sector form a management board (see Table 1, Appendix 2). Each member of the management board has pledged to support the Sunderland CARE Academy initiatives, to contribute to the development of the Sunderland CARE Academy, and to ensure delivery of any actions required on behalf of their organisations, including the dissemination of progress reports. Member organisations will determine their respective reporting and governance arrangements for their specific work stream.

The Management Board Chair and Sunderland CARE Academy Lead, is Joy Akehurst, Executive Director of Nursing and Quality, City Hospitals Sunderland. Management Board meeting minutes will be generated, disseminated and co-ordinated by administrative staff, under the direction of the Executive Director of Nursing and Quality at City Hospitals Sunderland.

Terms of reference will be reviewed annually.

4.3 Work Stream Leads

Each of the four work streams has identified specific areas for development; these have been chosen as they are tactically important to all of the partners, and will facilitate the Sunderland CARE Academy partnership philosophy, whilst providing practical and applicable solutions to improving and enhancing care.

Each work stream has an identified lead, who has been allocated based on their ability to provide the best potential to develop their particular work stream and their opportunity and capacity to network with relevant internal and external agencies.

Each work stream also includes a number of "Members" who are key people from partner organisations, who will assist in driving and support the work stream initiatives. Members will be nominated for inclusion, by the work stream leads.

Each work stream has an action plan which sets out objectives, actions and milestone. Progress against the action plans is reviewed at each Management Board meeting.

4.4 Evaluation and Dissemination

The impact of the CARE Academy will be measured through Key Performance Indicators (KPIs) as part of specific initiatives within the work streams, as well as some overarching impact measures. Initially, these will be developed through discussions with partners, relating to each specific work stream, and may include measures such as: the number of new initiatives, attendance at joint training, the number of public engagement events and attendances, the number of research participants.

Additional evaluation criteria will be set over the course of the first year. An evaluation report will be completed for the year by September 2015.

The CARE Academy model has the potential to be replicated in other areas. Over the course of the year, any opportunities for disseminating best practice will be shared through partner networks such as: NHS, academic networks, and community networks.

There will be a dissemination event, which will be open to regional and national attendees.

5.0 RESOURCES AND ASSETS

5.1 Current Resources

The University of Sunderland has invested £200k in the "Point of Care Testing Facility" as an initial initiative to drive the implementation of, and the impetus for, the Sunderland CARE Academy. This facility, at Sunderland University integrates diagnostic and therapeutic point of care testing with the clinical skills facility, to provide multidisciplinary clinical practice training.

A Senior Academic Nurse/Lecturer was appointed in partnership, to work with the Executive Director of Nursing and Quality at City Hospitals, with a view to supporting the Sunderland CARE Academy initiative.

Other joints posts have also been developed to support the initiative including those in pharmacy and public health. An academic GP post has been developed to build links across primary and secondary care, and Sunderland University. A Health Economist has also been engaged to support the Sunderland CARE Academy.

5.2 Future Resources

The management board is currently considering the submission of bids for funding provision to provide further support for the initiative. There is the potential for funding opportunities via the AHSN.

5.3 Brand and Intellectual property

The Sunderland CARE Academy brand and Sunderland CARE portal will be subject to copyright. It is not anticipated that there will be any Intellectual Property issues in relation to this specific concept, although advice is being sought on this.

Any Intellectual Property rights associated with individual research projects will be agreed as part of each project. The same approach will apply to work that may lead to patent applications.

5.4 Strengths, Weaknesses, Opportunities and Threats

The results of a SWOT analysis on the Sunderland CARE Academy are presented on the following page.

Strengths	**Opportunities**
• Committed management group • Highly experienced group members • Some highly influential members in the group • Common cause/buy in • Linked to National and regional initiatives • Possibility for support funding for the collaborative • Practical work streams have been considered	• Improve aspects of health in Sunderland • Engage the public in improving health and wellbeing in Sunderland • Improve public perception of healthcare in Sunderland • Increase public engagement in research • Increase collaborative working opportunities in Sunderland. • Increase the potential for collaborative working with a geographically wider group of partners • Become a nationally/internationally recognised, renowned collaborative working model for care • Develop specific work streams which can be adapted to other healthcare providers and organisations to benefit: patient, carers and families, staff development • Opportunity to publish academic papers and attend conferences highlighting both the Academy and its collaborative partners
Weaknesses	**Threats**
• Time constraints on members • Financial constraints • Current lack of a working group • Public engagement may be difficult • No additional IT/administrative support	• Individual organisational objectives may conflict/interfere with the collaborative vision.

6.0 PROGRESS SO FAR – CASE STUDIES

6.1 Collaboration

6.1.1 Knowledge and Information

The Sunderland CARE Academy will raise the profile of knowledge about care and those who provide it for the Sunderland community. The development of a "Sunderland CARE" electronic portal, supporting the Sunderland CARE Academy will be one mechanism for the dissemination of knowledge within Sunderland and potentially beyond.

The Sunderland CARE Academy aims to be a provider of expertise, which enhances collaborative working thereby delivering improved health outcomes.

6.1.2 Improving Health and Standards

The Sunderland CARE Academy will harness partner capabilities, and use best practice evidence on quality standards, to inform accreditation processes, commissioning and service improvement.

6.2 Achieving High Quality Care

6.2.1 National Care Certificate

The national "Care Certificate" development is an example of collaborative working to benefit Sunderland. City Hospitals Sunderland has recently been chosen as a national pilot site for developing the "Certificate of Fundamental Care" for Health Care Assistants (HCAs), due to its current provision of an excellent and longstanding development programme for HCAs, which now includes an accredited academic learning programme developed in collaboration with Sunderland University. Sunderland Carers' Centre also helped to develop this programme and provides on-going support by delivering carer awareness training, based on the principle that the greatest number of people giving care in the city are doing so in an unpaid role as carers.

6.2.2 Obesity

Obesity is both a local and national priority. City Hospitals Sunderland has a national media profile in the area of bariatrics, with PhD studies by hospital staff indicating the benefits of outreach work in this area. The CARE Academy will drive the implementation of relevant research findings into practical local service development.

6.2.3 Ageing Well

National and local health strategies identify older people as a key focus. The Sunderland CARE Academy aligns and accelerates local initiatives on 'ageing well', such as the development of joint training programmes between City Hospitals Sunderland, and

Sunderland University, and joint work with the Sunderland Carers' Centre, to ensure that the needs of carers are appropriately reflected in any training development planning.

6.2.4 Integrating Primary and Secondary Care

A key strategic priority for the Sunderland health and care economy is developing "out of hospital" care and integration across patient pathways. To support this, a Primary Care Strategy will be developed and integration of community teams is taking place during 2015/16 involving all key partners across the city.

The City Hospitals Sunderland integrated electronic patient record allows GPs electronic views of the acute care record, to provide a seamless interface between primary and secondary care. This supports research opportunities in care pathways, to improve access to patient records, thereby improving the patient journey. City Hospitals Sunderland also manages a GP practice, which provides a unique opportunity to increase potential research participation across care pathways.

6.3 Research and Innovation

6.3.1 Promoting Research Participation

City Hospitals Sunderland has initiated a series of regular research seminars delivered on site, with the aim of increasing research awareness to staff and increasing participation by patients, and their carers, and their families. City Hospitals Sunderland's Research and Innovation Strategy has increased recruitment to National Institute for Health Research (NIHR) portfolio research studies, and Clinical Research Network (CLRN) research.

The Sunderland CARE Academy also aims to develop research capacity for local care professionals across Sunderland.

6.3.2 Innovation, Industry and Wealth Creation

Sunderland City is actively committed to attracting innovation, industry and wealth into the city. City Hospitals Sunderland is a partner in Quality Health Solutions, a company set up to develop innovative technical solutions to health care service challenges, promote dissemination, and wealth creation.

The University of Sunderland has developed the only Clinical Practice and Point of Care Testing (POCT) Facility in the North East, which provides an infrastructure for the work of the Sunderland CARE Academy, and will attract industry. There are also numerous other opportunities to use the underpinning principle of improving care to generate interest in the city.

6.4 Engagement

6.4.1 Brand Identity

The Sunderland CARE Academy approach will create the environment for accelerated efficient partnership working and provide a visible 'brand' to raise the profile of key health and wellbeing improvement initiatives, with the public.

6.4.2 Outreach into Schools – Caring Careers

Outreach work into schools is supporting young people into caring careers, engaging more volunteers with care work, and connecting the local community with their NHS. Engagement activity has been shown to have a significantly positive impact on health and well-being.

6.4.3 Focus on Carers

The *Carers UK: State of Caring Survey 2014*[14] reported that 75% of carers said it was hard to maintain relationships and social networks because people do not understand the impact of their caring role. Carers become isolated and hard to reach and hard to engage with. Sunderland Carers' Centre runs on-going programmes of carer awareness training to a range of agencies and businesses to combat the invisibility and isolation felt by carers. Engaging carers and supporting them to focus on their own health and wellbeing will also enable them to provide high quality care for longer.

6.4.4 Hard to Reach Population

The Sunderland CARE Academy 'brand' will be used to help engage groups of people who are harder to reach. The Foundation of Light has vast experience in community engagement, and has used the medium of sport to engage hard to reach patient populations. Developing this relationship has provided new learning experiences and opportunities, which have improved lifestyle behaviours, raised self-confidence and employability of people in Sunderland, and promoted self-care and self-management. Through the collaborative approach of the CARE Academy this expertise could usefully support the care economy in Sunderland.

7.0 REFERENCES AND LINKS

7.1 References

1. DEPARTMENT OF HEALTH and NATIONAL INFORMATION BOARD (2014) Personalized Health and Care 2020 - Using Data and Technology to Transform Outcomes for Patients and Citizens – A Framework for Action. London. Crown Copyright.
2. HEALTH EDUCATION ENGLAND (2014) Developing a flexible workforce that embraces research and innovation – Research and Innovation Strategy.
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4. DEPARTMENT OF HEALTH (2013) Treating Patients and Service Users with Respect, Dignity and Compassion. London. Crown Copyright.
5. DEPARTMENT OF HEALTH (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - The Francis Report. London. The Stationery Office. Crown Copyright.
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10. DEPARTMENT OF HEALTH (2012) Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery. London. Crown Copyright
11. DEPARTMENT OF HEALTH (2011) A Framework for Technology Enhanced Learning. London. Crown Copyright
12. SUNDERLAND PARTNERSHIP (2012) Sunderland's Joint Health and Wellbeing Strategy.
13. SUNDERLAND PARTNERSHIP (2012) Sunderland's Joint Strategic Needs Assessment.
14. CARERS UK (2014) State of Caring Survey 2014. London. Carers UK Copyright.

7.2 Useful Website Links

Academic Health Science Network for the North East and North Cumbria
http://ahsn-nenc.org.uk/ (Accessed 22/01/2015)

All Together Sunderland!
https://www.sunderland.gov.uk/index.aspx?articleid=10148 (Accessed 24/04/2015)

Better Health for Sunderland
http://sunderlandccg.nhs.uk/wp-content/uploads/2014/01/CCG-Sunderland-prospectus-final.pdf (Accessed 24/04/2015)

National Institute for Health Research and Clinical Research Network
http://www.crn.nihr.ac.uk/can-help/funders-academics/nihrcrn-portfolio/ (Accessed 22/01/2015)

Point of Care Foundation
http://www.pointofcarefoundation.org.uk/Home/ (Accessed 22/01/2015)

Sunderland Partnership Health and Wellbeing Board
http://www.sunderlandpartnership.org.uk/healthy.html (Accessed 22/01/2015)

Sunderland City Joint Strategic Needs Assessment
http://www.sunderlandpartnership.org.uk/healthy.html (Accessed 22/01/2015)

Technology Enhanced Learning – Health Education England
http://hee.nhs.uk/work-programmes/tel/ (Accessed 26/01/2015)

APPENDIX 2: SUNDERLAND CARE ACADEMY WORKSTREAMS

PRINCIPLES	OBJECTIVES	LEADS	MEMBERS	ACTIONS	MILESTONES	PROGRESS
Collaboration	Strengthen Links with: • Health and Wellbeing Board • Altogether Sunderland • Education and Skills Board	A Fox(lead)	K Bailey G Robinson			
Achieving High Quality Care	Development of: • Care Certificate Quality Standards • Accreditation Training for: • Customer Care • Compassionate Care • Patient Safety/Human Factors	G Robinson (lead)	K Griffin D Little J Akehurst S Brent			
Research and Innovation	• Develop Telemedicine Projects. • Further development of Bariatrics re Public Health agenda. • Improve networks with community pharmacy and secondary care. • Support new innovation in Research.	T Alabaster (lead)	S Wilkes K Hinshaw			

Engaging People	• Improve and develop engagement pathways with:
	  • Carers
	  • School age children and young people
	  • Communities
	• Encourage and promote patient/client self-care management.
	• Communication and marketing.
		K Teears (lead)	E Inglesby
			K Griffin
			D Little			

APPENDIX 2

Table 1: Membership of the Sunderland CARE Academy management board

Title	Name
City Hospitals Sunderland NHS FT	
Executive Director of Nursing & Quality	Joy Akehurst
Director of Human Resources	Kath Griffin
Director of Innovation & Research	Kim Hinshaw
Workforce Development Manager	Dennis Little
University of Sunderland	
Associate Dean	Tony Alabaster
Head of Nursing & Health	Sue Brent
Academic Senior Nurse/Lecturer	Gina Robinson
Professor of Primary Care	Scott Wilkes
Sunderland CCG	
Director of Nursing, Quality & Safety	Ann Fox
Executive GP and Clinical Vice-Chair	Val Taylor
Sunderland City Council	
Director of Public Health	Gillian Gibson (Acting)
Sunderland Carers' Centre	
Partnership & Policy Manager	Eibhlin Inglesby
SAFC Foundation of Light	
Director of Families and Adults	Matt Hill
South Tyneside NHS FT	
Executive Director of Nursing & Patient Safety	Bob Brown
Northumberland Tyne & Wear NHS FT	
TBC	TBC
Sunderland College	
Head of Health and Education	Peter Stafford

Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 29 MAY 2015

CCG OPERATIONAL PLAN REFRESH 2015/16

Report of the Chief Operating Officer of Sunderland Clinical Commissioning Group

1. Purpose

The purpose of this report is to provide an overview of the key points outlined in the refreshed CCG operational plan for 2015/16.

2. Background

In April 2014, Sunderland CCG developed its two year operational plan which lays the foundations to ensure achievement of the Sunderland health & care economy vision of 'Better Health for Sunderland' and the associated ambitions to improve outcomes for the people of Sunderland.

As part of this a number of key transformational changes were identified. These were:

- 7 day access;
- Community Integrated locality teams;
- Extension of Intermediate Care hub in all localities;
- Implementation of end of life deciding right initiatives in practices;
- Mobilise GP urgent care centres, A&E hub and out of hours integration;
- Improved community mental health pathways, access and waiting times for all mental health conditions;
- Development of dementia friendly communities;
- Procure and mobilise the new MSK service;
- Reduce procedures of limited clinical value.

Work has progressed well in year 1, with progress against each outlined below:

- Integrated Community Locality Teams – This has been developed through working in partnership across Sunderland and the model agreed in principle. It is now being mobilised over the next 12 months;
- Care Homes – The pilot in Coalfields is producing very good outcomes and will be rolled out across the city as part of Integrated Community Locality Teams;
- Intermediate Care Hub (Now known as Recovery at Home)– The hub is soon to be operating from Leechmere and is now operating extending hours and additional beds available at Farnborough Court moved towards 24 hour single point of access by September;
- End of Life deciding right - Care Home and GP training is now underway;
- Mental Health – A 5 year programme to develop a model of care for Sunderland is now near the end: Enhanced IAPT services, a new model of

psychological therapy, new hospital environments at Ryhope & Monkwearmouth are now in place. Ongoing implementation of improved community mental health services is underway;

- Urgent Care – GP urgent care centres are now operational, GP Out of hours procurement is currently underway as well as the development of the Sunderland Royal Hospital emergency department urgent care centre;
- MSK – The procurement of the new musculoskeletal (MSK) service is complete and the new provider will be announced shortly;
- Dementia – A dementia friendly community pilot is running well in Houghton. All staff in GP practices across Sunderland will be trained on Dementia Awareness by end of March 2015. The Essence service is now in place and receiving referrals;
- Procedures of Limited Clinical Value - Phase One of the value based commissioning policy was implemented in January 2015, with full implementation by April 2015.

3. Operational Plan Refresh 2015/16

As part of the planning refresh moving forward into 2015/16, a review of priorities was undertaken and, whilst the focus on the transformational changes outlined above continues, some further priorities have been identified including:

- Work with Public Health on a prevention & self management approach;
- Develop a strategy with Sunderland City Council to improve outcomes for children;
- Develop and implement a strategy for General Practice;
- Implement transforming lives for people with learning disabilities;
- Implement the new model of care for people needing continuing healthcare.

The CCG is confident that these initiatives, when delivered alongside existing priorities, will further improve outcomes for the people of Sunderland.

Planning submissions were made to NHS England on 27th February and 7th April 2015 with a final submission required on 14th May 2015.

As part of this refresh the CCG has also undertaken a review of outcome ambitions. In the main the ambitions remain the same, however, it has been proposed to increase the ambition of potential years of life lost to 15% improvement by 2019, which is a further 8% improvement on the original ambition of 7%.

The CCG has also been required to submit trajectories for all of the NHS Constitution measures – and has proposed that all of these will be consistently achieved throughout 2015/16 with the exception of A&E 4 hour waits due to feedback from City Hospitals advising that they will not achieve this measure until Quarter 2 2015/16. However, it is anticipated that this will be achieved from Quarter 2 onwards.

In addition, as the CCG has taken on delegated responsibility from NHS England for the commissioning of primary medical care there was a requirement to provide an ambition for improving the experience in Primary Care in 2015/16: specifically these measures are:

E.D.1 - Satisfaction with the quality of consultation at the GP practice.
E.D.2 - Overall experience of GP surgery (Proportion with good overall experience).
E.D.3 - Overall experience of making an appointment (Proportion with good overall experience).

Given existing priorities in 2015/16, the work on increasing the number of GPs in Sunderland, the work on extended primary care and the development of the Out of Hospital model it was not expected to see some impact on these indicators. However, mindful of the existing primary care workforce issues the most likely scenario in the short term at least could be a further deterioration which is likely to be an ongoing national issue.

Considering all of the above the CCG has agreed that maintaining the current performance for these measures will be an achievement.

The full operational plan for 2015/16 accompanies this report.

4. Recommendations

The Health and Wellbeing Board is asked to:

- Note the key points of the operational plan refresh;
- Note the CCG operational plan for 2015/16.

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Date 15th May 2015

NHS
Sunderland
Clinical Commissioning Group

Operational Plan 2014-2016

Refreshed March 2015
Version 0.6

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1.0 Who are we?

Sunderland CCG (SCCG) are the statutory body responsible for planning, purchasing and monitoring the delivery and quality of most of the local NHS healthcare and health services for the people of Sunderland. We are made up of doctors, nurses and other health professionals with management support.

All 51 GP practices in Sunderland are members of NHS Sunderland CCG - so in the most part we are practising family doctors, although we do have a range of other clinical professionals working with us. The members have elected six GPs to lead the CCG on their behalf, working as part of a wider Governing Body which includes the local authority, lay members, senior managers, a hospital consultant and a senior nurse. The Governing Body and its formal committees are responsible for setting the strategy for health improvement in the city and ensuring the CCG delivers the improvements signalled in the strategy. In doing this we work very closely with other partners as members of Sunderland's Health and Wellbeing Board to improve the overall wellbeing of local people.

2.0 Our Vision and Strategic Objectives

2.1 Our Vision for 2018/19

Our Vision is to achieve **Better Health for Sunderland**

We will deliver this through:

- **Transforming out of hospital care (through integration and 7 day working);**
- **Transforming in hospital care, specifically urgent and emergency care (including 7 day working);**
- **Enabling Self Care and Sustainability.**

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

This operational plan describes the work we have undertaken in year 1 (2014/15) and the further work we will be undertaking in 2015/16 to lay the foundations to ensure the delivery of our vision and strategic objectives.

2.2 Our Strategic Objectives

The following table provides further detail on what our strategic objectives mean in terms of outcomes:

Transforming out of hospital care through integration and 7 day working	Transforming in hospital care, specifically urgent and emergency care and 7 day working	Self Care and Sustainability
▪ Right Care; Right Place; Right Time; Right Skills; ▪ System wide approach with one common vision; ▪ Multi-disciplinary teams in localities working together with people, adults and children with long term conditions / complex needs to ensure person centred co-ordinated care; ▪ Improved overall quality of care for the elderly; ▪ Reduced variation in primary care ▪ Patient centred; ▪ A system which is simple to navigate; ▪ Reduced emergency admissions to hospital as people are cared for effectively in the community.	▪ Equality of access across the City to urgent care; ▪ 24/7 hub; ▪ Reduced handoffs in the system; ▪ Reduction in emergency admissions.	▪ Local people influence and understand the system; ▪ A city that actively supports / enables people to be and stay healthy, well and happy; ▪ Improved public health outcomes; ▪ Managing demand ▪ Using community assets.

2.3 What will the future look and feel like?

The following table outlines what the future will look and feel like by 2019:

<table>
<tr><th colspan="3">Citizens (Adult, Child, Older Person, Carer)</th></tr>
<tr><td colspan="3">

- People are educated to self-manage where possible with the necessary support if required;
- Easily accessible advice;
- Once diagnosed someone co-ordinates the care you require and there is only one record which is shared with those who need it;
- Best use of Information technology to enable this to happen;
- Responsive providers;
- As local as possible.

</td></tr>
<tr><th>Member Practices</th><th>A&E Consultant</th><th>District Nurse</th></tr>
<tr>
<td>

- Feel part of a system which is efficient and joined up;
- Belonging to a community / locality;
- Able to use time effectively to influence change in the system.

</td>
<td>

- Only see accidents and emergencies;
- Have great communications with primary care, social care and the rest of the system;
- Make best use of skills;
- Provide ‘remote’ advice via technology;
- Trust in the system;
- Wait for patients to arrive.

</td>
<td>

- Will be part of a multidisciplinary team (24/7) in the community;
- Have a relationship with GP Practices;
- Make use of all skills;
- Specialist knowledge / advice to call upon;
- Understand how the system works.

</td>
</tr>
</table>

3.0 Values and Principles

3.1 Core Values

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

3.2 System Principles

In order to deliver the transformational change set out in this plan the following system wide principles have been agreed:

- Our approach will be one of a single system for health and social care across Sunderland;
- Mental and physical health will be equally important, recognising both impacts on each other;
- To develop, as a principle, a team based working approach across the city;
- To share learning and approaches around demand management across the health and social care sector, but also wider public sector e.g: Sunderland City Council;
- A single Transformational Programme Board will oversee this work;

We will also work closely with our partners in neighbouring CCGs where our patients use services in these areas.

4.0 Meeting the needs for local people

4.1 Big Challenges for Sunderland

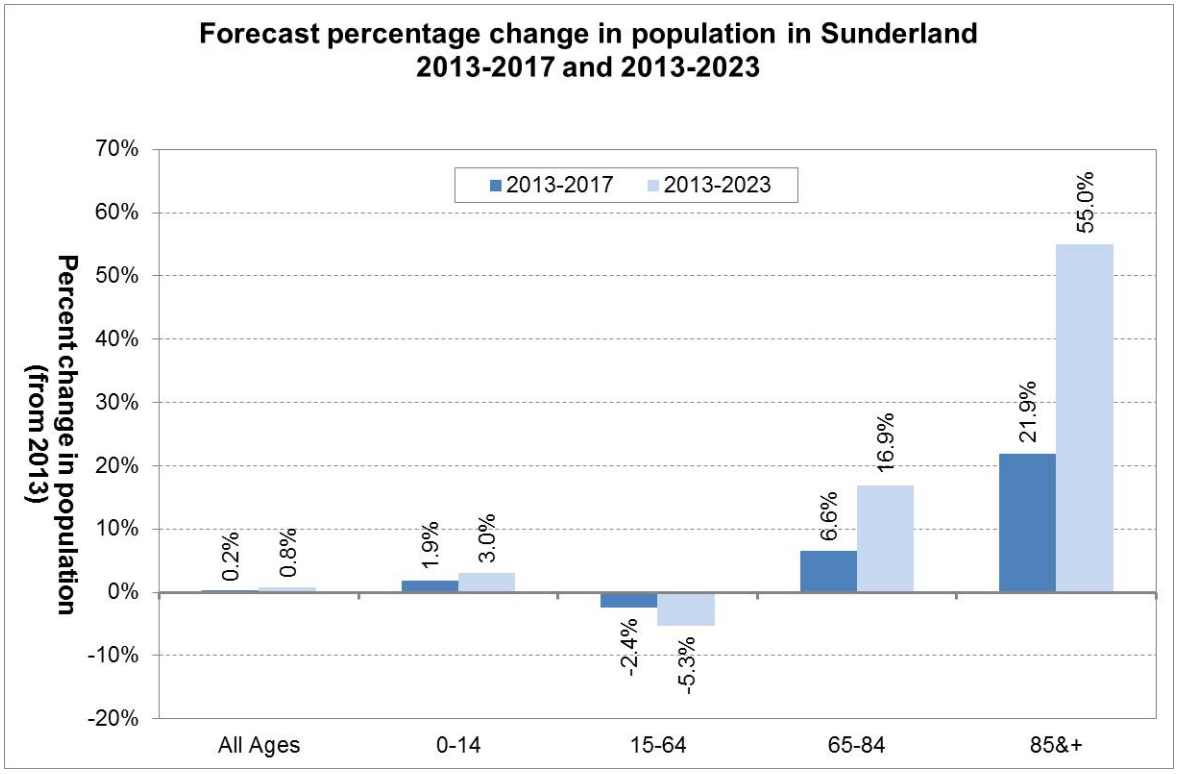
We have used a range of information and analyses to identify the big challenges facing the NHS in Sunderland. The challenges which we need to address through our commissioning and joint work with our practices and partners can be summarised as:

- **Mental Wellness as demonstrated by our poor outcomes in relation to depression and self-harm;**
- **Excess deaths, particularly from cancer, respiratory and circulatory disease;**
- **Health which is generally worse than the rest of England;**
- **A growing population of elderly people with increased care needs and increasing prevalence of disease who need to be supported to live independently;**
- **An over-reliance on hospital care;**
- **Services which are fragmented and lack integration.**

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

4.2 Overview of the Sunderland population

There are approximately 276,080 people in Sunderland, with an increase of 2,179 (0.8%) forecast over the next 10 years. The age structure of our population is forecast to change significantly, as follows:



Source: 2013 mid-year population estimates, ONS; 2012-based subnational population projections, ONS

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five, ten and probably twenty years. Even if the general levels of health in these age groups continues to improve, the shape and structure of health services will need to change to meet the needs of this growing population, particularly as older people use services more often, have more complex needs and stay longer in hospital.

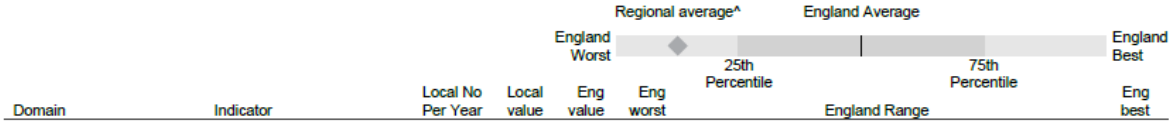
4.2.1 Overview of health in Sunderland

Levels of deprivation remain high within Sunderland. Seventy of Sunderland's 188 Super Output Areas are among the most disadvantaged fifth of all areas across England, and 37% of the Sunderland population lives within these super output areas. Levels of health and underlying risk factors in the area are amongst some of the worst in the country.

The 2014 Community Health Profile, shown overleaf, prepared by the Public Health England compares health in Sunderland to England averages, highlighting in red those measures which are significantly worse and in green those which are significantly better. The Community Health Profile for Sunderland can be seen overleaf. It is clear that on most health measures, Sunderland is significantly worse than the rest of England.

Health Summary for Sunderland

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



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	102,038	37.0	20.4	83.8	0.0
	2	Children in poverty (under 16s)	12,655	25.7	20.6	43.6	6.4
	3	Statutory homelessness	125	1.0	2.4	11.4	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1,945	60.1	60.8	38.1	81.9
	5	Violent crime (violence offences)	1,907	6.9	10.6	27.1	3.3
	6	Long term unemployment	3,058	17.1	9.9	32.6	1.3
Children's and young people's health	7	Smoking status at time of delivery	523	18.5	12.7	30.8	2.3
	8	Breastfeeding initiation	1,705	60.3	73.9	40.8	94.7
	9	Obese children (Year 6)	546	21.3	18.9	27.3	10.1
	10	Alcohol-specific hospital stays (under 18)	47	86.1	44.9	126.7	11.9
	11	Under 18 conceptions	207	43.1	27.7	52.0	8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	23.4	19.5	30.1	8.4
	13	Percentage of physically active adults	n/a	47.8	56.0	43.8	68.5
	14	Obese adults	n/a	26.6	23.0	35.2	11.2
	15	Excess weight in adults	500	68.9	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma	35	12.3	14.8	31.8	3.6
	17	Hospital stays for self-harm	1,084	388.6	188.0	596.0	50.4
	18	Hospital stays for alcohol related harm	2,884	1,071	637	1,121	365
	19	Drug misuse	1,549	8.4	8.6	26.3	0.8
	20	Recorded diabetes	14,616	6.3	6.0	8.7	3.5
	21	Incidence of TB	18	6.5	15.1	112.3	0.0
	22	Acute sexually transmitted infections	2,222	807	804	3,210	162
	23	Hip fractures in people aged 65 and over	321	669	568	828	403
Life expectancy and causes of death	24	Excess winter deaths (three year)	121	13.6	16.5	32.1	-3.0
	25	Life expectancy at birth (Male)	n/a	77.0	79.2	74.0	82.9
	26	Life expectancy at birth (Female)	n/a	80.7	83.0	79.5	86.6
	27	Infant mortality	9	2.8	4.1	7.5	0.7
	28	Smoking related deaths	596	405	292	480	172
	29	Suicide rate	32	11.7	8.5		
	30	Under 75 mortality rate: cardiovascular	236	99.9	81.1	144.7	37.4
	31	Under 75 mortality rate: cancer	412	174	146	213	106
	32	Killed and seriously injured on roads	87	31.5	40.5	116.3	11.3

Indicator Notes

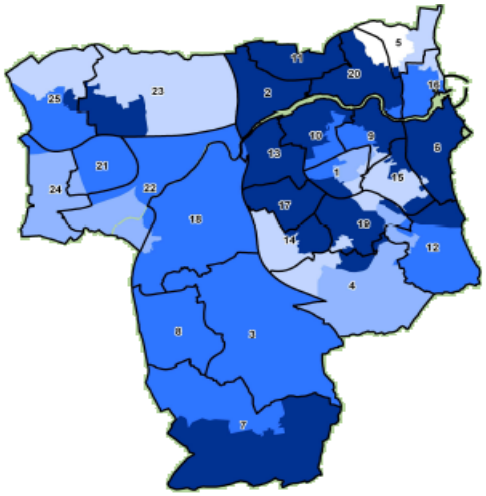
1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

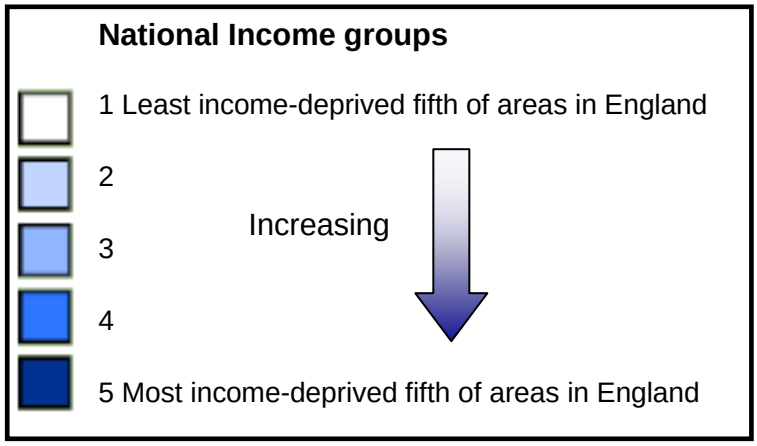
More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Source: Sunderland Health Profile 2014, Public Health England, © Crown Copyright 2014

4.2.2. Income inequalities

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





4.3 Challenges identified in the Joint Strategic Needs Assessment

The JSNA is the process by which Sunderland City Council and Sunderland CCG, working in collaboration with partners and the wider community (including the third sector and patient/public groups), identify the health and wellbeing needs of the local population. It provides an insight into current and future health, wellbeing and daily living needs of local people and informs the commissioning of services and interventions to improve health and wellbeing outcomes and reduce inequalities. It sets out key priorities for commissioners and provides a health baseline for the development of this plan.

The Sunderland JSNA covers the wider determinants of health, takes account of priorities from the Marmot Review, updates the analysis of health and wellbeing information, gives greater insight into the expressed needs of local people, identifies where effective interventions to address needs are available but not taking place, and includes equality impact assessments as they are developed.

The JSNA uses a structured process with clear criteria, and continues to involve partners and the public. The Health and Wellbeing Board periodically reviews its priorities, based on the JSNA. Because we are in a time of economic uncertainty, it is crucial that the JSNA recommendations are clearly prioritised based on a "one Sunderland strategy", and identifies what needs can be met, and how we can mitigate against unintended consequences from changes in funding and organisational arrangements over the next 3-5 years.

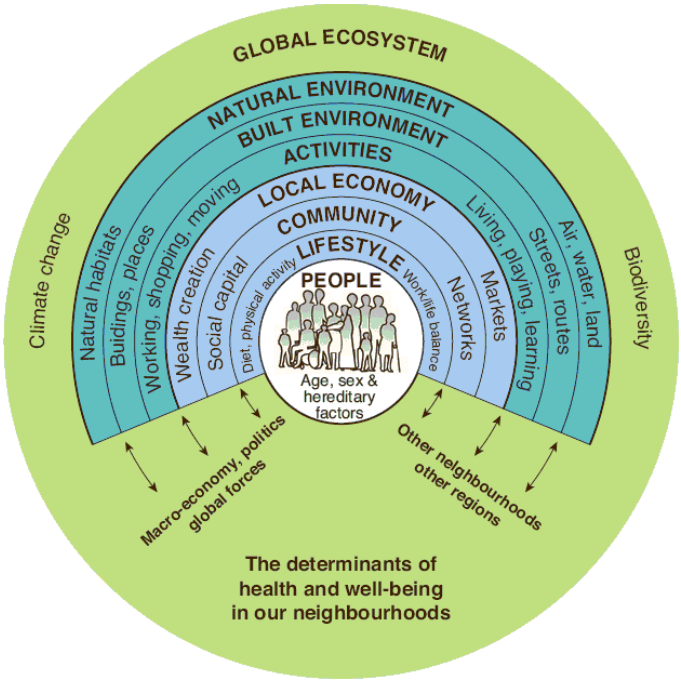
4.3.1 Summary of JSNA messages

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

- Increasing life expectancy and reducing health inequalities through focusing on addressing the causes of premature morbidity and mortality;
- A tiered approach to prevention, risk management and early intervention;
- Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;
- Identifying those who would benefit from wraparound health and social care services;
- Integration of services, whether NHS, social care or other services which affect health (e.g. spatial planning, housing, transport, libraries, wellness services, addressing fuel poverty, mitigating the impacts of welfare reform etc.);
- Reducing health inequalities by focussing on giving children the best start in life and strengthening ill health prevention as well as addressing the wider determinants of health, including deprivation, employment, education, housing, social isolation, environment and by identifying neighbourhoods to target;
- Commissioners and providers engaging with individuals, families, neighbourhoods, and communities in order to deliver on all the above to build resilience at all levels to enable greater levels of self care.

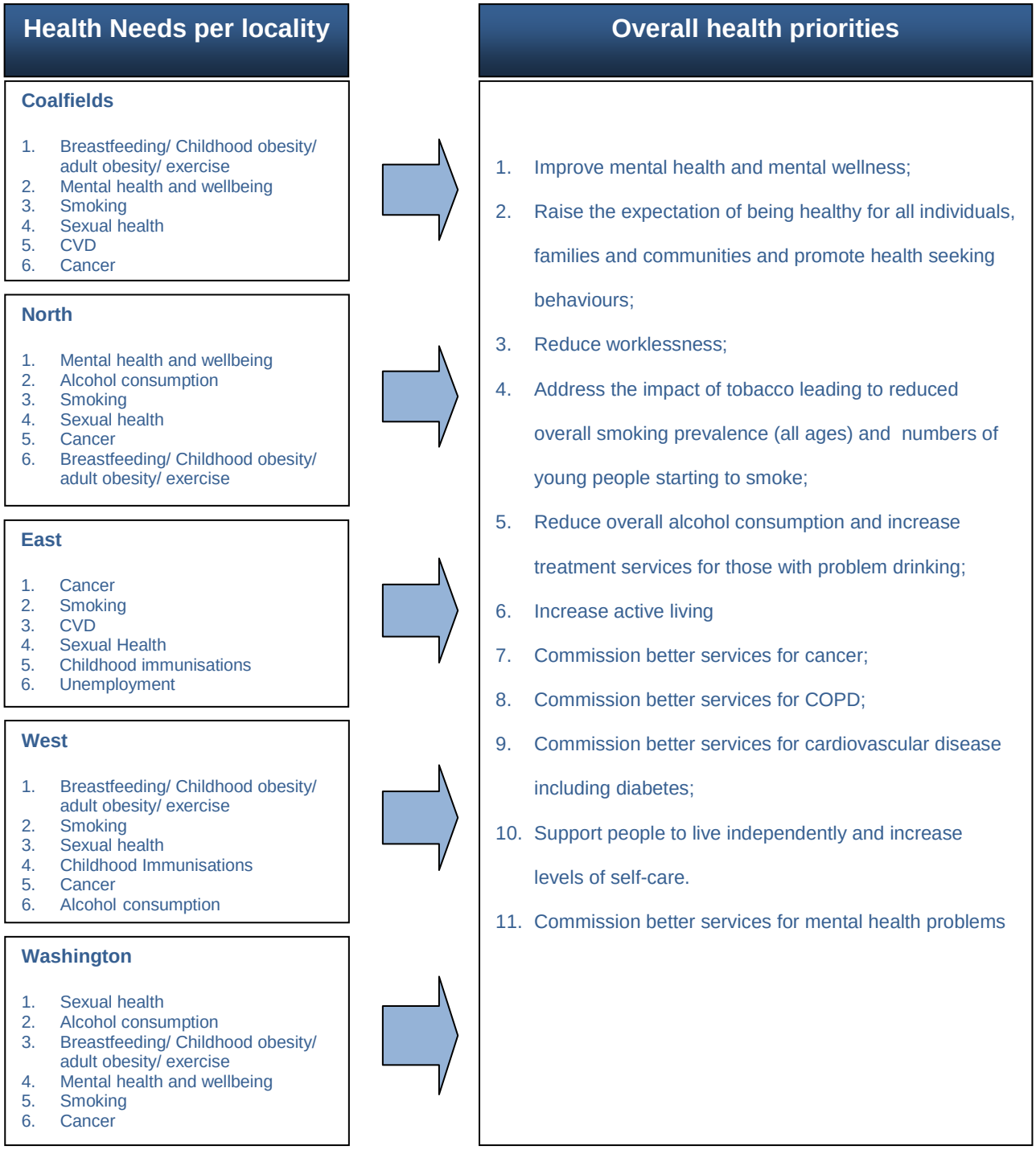
We have traditionally focused on treating illness but to improve health, we need to move, as represented by the following diagram, out into the concentric circles working with a broader range of partners, delivering our direct responsibilities and influencing partners to deliver theirs.

The main determinants of Health and Wellbeing



Ref: Hugh Barton and Marcus Grant (2006), drawing on Whitehead and Dahlgren (1991) and Barton (2005).

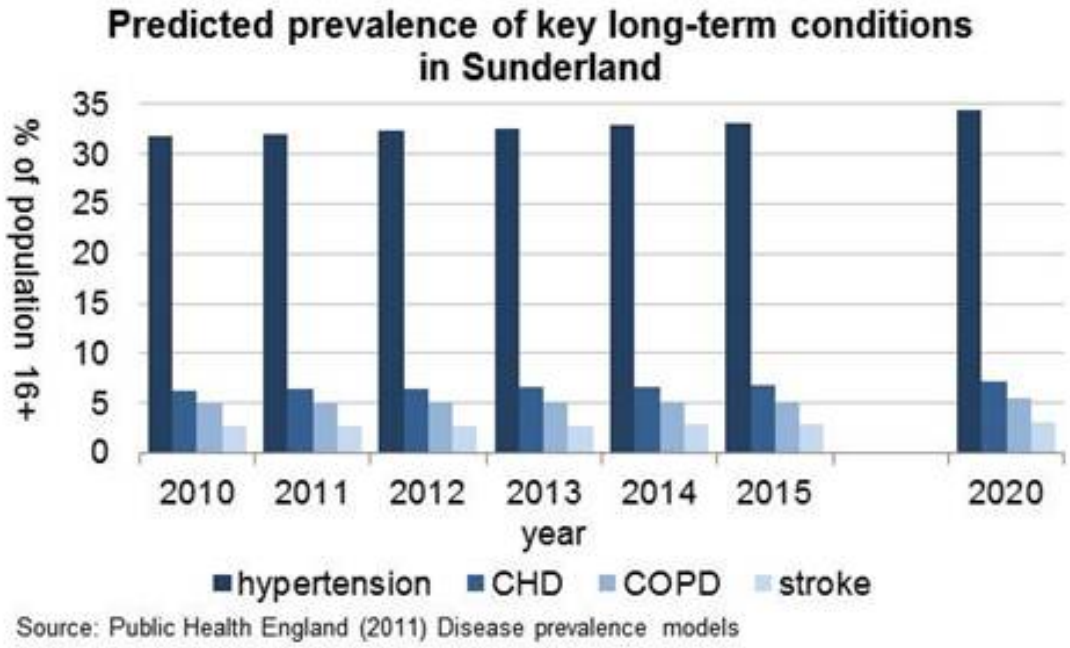
The JSNA is set out using profiles to highlight the needs of individual health groups and community areas; we continue to work closely with public health colleagues to identify health needs. The top 6 health needs per locality are outlined below along with the top ten priorities to improve health in Sunderland.



As a Clinical Commissioning Group, we are directly responsible for commissioning the hospital, community and mental health services associated with these priorities, but we also have a significant role to play in all of these areas, through our participation in the Health and Wellbeing Board through added value that can be delivered from the services we commission and through ensuring that all of our member GP practices play a full part in this agenda. The locality structure, which enables groups of practices in a locality to work together, is a key mechanism through which we will deliver these improvements. From April 2015, we have also taken responsibility for commissioning core primary care general practice services.

4.3.2 Expected disease prevalence

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



Source: Public Health England (2011) Disease prevalence models

4.3.3 Life expectancy challenge

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

	England Average Life Expectancy	Sunderland Life Expectancy	Gap (%) *
Males Females	79.4 83.1	77.3 80.9	-2.7% -2.7%

Source: Life expectancy at birth and at age 65, England and Wales, 2011-13,

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

Just over 70% of the gap is caused by cancer, respiratory diseases and CVD and to address this, we have built on previously identified "High Impact Interventions" to deliver an effective approach to improving health and transforming care which our commissioning and work with partners and our GPs will contribute to:

- Use of Health Checks to identify asymptomatic hypertensives age 40–74 & start them on treatment;
- Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;
- Systematic cardiac rehabilitation;
- Systematic COPD treatment;
- Develop & extend diabetes best practice with appropriate local targets;
- Cancer early awareness and detection;
- Identification and management of Atrial Fibrillation thus avoiding vascular dementia;
- Develop best practice in relation to dementia and falls to support people to live independently;
- Implement new approaches to people living in care homes and extra care facilities;
- Support people to manage their own health conditions where appropriate.

5.0 National drivers and mandated areas

The NHS Five Year Forward View was published by NHS England on 23 October 2014 and sets out a vision for the future of the NHS.

The Five Year Forward View articulates why change is needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

The Forward View outlines that a radical upgrade in prevention and public health is needed and that NHS England will back hard hitting national action on obesity, smoking, alcohol and other major health risks.

The plan also outlines that strong public health related powers for local government and elected mayors will be given to enable local decisions.

Patients will also gain far greater control of their own care and there is a need to break down barriers in how care is provided across the health care economy.

There will be a focus on supporting people with multiple health conditions, rather than single diseases, however, there is recognition that one size will not fit all and so local health economies will be supported to choose from a small number of radical new care delivery options such as:

- Multispecialty Community Providers – Groups of GPs combining with nurses and other community health services, hospital specialist and perhaps mental health and social care to create integrated out-of-hospital care potentially employing hospital consultants, having admitting rights to hospital beds, running community hospitals or taking delegated control of the NHS budget.
- Primary and Acute Care Systems – The integrated hospital and primary care provider.

- Urgent & emergency care networks – Urgent and emergency care units re-designed to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services.
- Viable smaller hospitals - Smaller hospitals having new options to help them remain viable, including forming partnerships with other hospitals further afield and partnering with specialist hospitals to provide more local services.
- Specialised care – Specialised services to develop networks of services over a geography, integrating different organisation and services around patients using innovations such as prime contracting and / or delegated capitated budgets.
- Modern Maternity Services – NHS England will commission a review of future models for maternity services and midwives will have new options to take charge of the maternity services they offer.
- Enhanced care in care homes – new models of in-reach support, including medical reviews, medication reviews and rehabilitation services.

In all cases one of the most important changes will be to expand and strengthen primary and out of hospital care, with a new deal for GPs recognising primary care as the cornerstone of the NHS.

6.0 Vanguard Sites

In January 2015, NHS England invited individual organisations and partnerships, including those within the voluntary sector to apply to become 'vanguard' sites for the New Care Models Programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services.

More than 260 individual organisations and health and social care partnerships expressed an interest in developing a model in four of the areas of care, with the aim of transforming how care is delivered locally.

On 10 March 2015, the first wave of 29 vanguard sites were chosen. This followed a rigorous process, involving workshops and the engagement of key partners and patient representative groups.

Sunderland were successful in being a vanguard site for Multispecialty Community Providers and will take a lead on the development of this new care model which will act as the blue print for the NHS moving forward and share learning with the rest of the health and care system.

Sunderland CCG and Sunderland LA, in partnership with our key providers in the city, believe we are already a Vanguard site because of our work to transform out of hospital care. We believe there will be benefits in being accepted as an area to co-produce the models of care in terms of access to national support to address potential barriers to integration, external challenge/ advice to support our next steps; peer support and funding.

7.0 Better Care Fund

The £3.8billion Better Care Fund has been introduced nationally to ensure transformation in integrated health and social care. This fund is a single pooled budget to support health and social care services to work more closely together to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

Better Care fund plans must deliver on the following national conditions:

- Protecting social care services;
- 7 day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional.

The Better Care Fund has been seen as a real opportunity within Sunderland to drive change through a system wide approach with a pooled budget of £24.8m identified in 2014/15, in comparison to the minimum required value of £12m, and up to £169m identified moving forward into 2015/16.

The fund will facilitate the transformation of our out of hospital model of care across Sunderland, along with vanguard status.

8.0 Our Outcome Ambitions

Through delivery of our transformational programmes we expect to make significant progress against the critical indicators of success outlined by NHS England and have been ambitious in setting outcomes for the future:

Critical Indicator of Success	Outcome Ambition by 2019	RAG Rating *(As at 31/03/2015)*
Securing additional years of life for the people of England with treatable mental and physical health conditions	Reduce years of life lost by 15%	
Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Improve quality of life for those with long term conditions by 8.9%	
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Reduce emergency admissions by14%*	
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Improve patient experience of hospital care by 7.2%	
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the	Improve patient experience of out of hospital care by 8%	
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Healthcare associated infections ▪ MRSA Zero tolerance; ▪ Cdifficile nationally set trajectory	MRSA Cdifficile

**14% reduction is related to the composite measure which does not include all emergency admissions. Overall aim is to reduce emergency admissions by 15%.*

Our operational plan outlines the key transformational changes which we are implementing to lay the foundations to ensure we achieve these outcome ambitions, as well as achievement of the NHS Constitution rights and pledges.

In addition to these outcome measures we will also aim to make improvements against the following mental health measures:

Measure	Ambition by 2016	RAG Rating (As at 31/03/2015)
Improved access to psychological therapies (Access and recovery)	16% access by 2016	
	Maintain 50% recovery rate	
Increase in Dementia diagnosis	68% by 2016	

8.1 Quality Premium

The Quality Premium was introduced in 2013/14 and is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The guidance for 2015/16 sets out both the measures and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards and NHS England local NHS England teams to agree measures to be selected from menus, local measures and levels of improvement in preparation for 2015/16.

The Quality premium will be paid in 2016/17, to reflect the quality of health services commissioned by them in 2015/16 – will be based on the following measures which cover a combination of national and local priorities. These are:

- **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);
- **Urgent and emergency care** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the

quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure;

- **Mental health** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure;

- **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

- **Two local measures** which should be based on local priorities such as those identified in joint health and wellbeing strategies (20 per cent of quality premium-10 per cent for each measure).

However, the total payment for a CCG (based on the performance against the measures outlined above) will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to the following:

- 18 weeks RTT;
- 4 hour waits in A&E;
- Maximum 14 day wait from an urgent GP referral for suspected cancer;
- Maximum 8 minute responses for category A red 1 ambulance calls.

A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money during 2015/16; or
b) ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position; or
c) incurs a qualified audit report in respect of 2015/16.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2015/16.

The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs (285,000 for Sunderland) which equates to a total value of approximately £1,425,000 (This is in addition to a CCG's main financial allocation for 2015/16 and in addition to its running costs allowance.)

Regulations set out that quality premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities.

The Quality Premium measures for Sunderland in 2015/16, agreed by both the CCG Executive Committee and the Health and Wellbeing Board are outlined below:

Area	% of Quality Premium	Proposed Measure
Potential years of life lost	10%	6% improvement from 2013/14 baseline
Urgent & Emergency Care	30%	Avoidable emergency admissions composite measure of: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in children; Emergency admissions for acute conditions that should not usually require hospital admission (adults); Emergency admissions for children with lower respiratory tract infection
		Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays
Mental Health	30%	Reduction in the number of patients attending an A&E department for a mental health related needs who wait more than 4 hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.
Improving antibiotic prescribing in primary and secondary care	10%	Composite measure comprising of three parts: Part a) reduction in the number of antibiotics prescribed in primary care; Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care Part C) secondary care providers validating

		their total antibiotic prescription data.
Locally Selected Measures	20% (10% each)	**Increase in the proportion of patients who have an emergency health care plan coded in EMIS practice systems.** The baseline is 0.12%. The proposed increase is 0.25% which is equivalent to approximately 352 additional care plans. This will help to ensure people feel supported to manage their condition, reduce the time spent in hospital by people with long term conditions and reduce emergency admissions and re-admissions.
		Increase in direct referrals to the new Sunderland Intermediate MSK service, from 40% to 50%. A new intermediary service will be in place from October 2015. Increasing the number of referrals to this service will support in reducing the pressure in elective activity for orthopaedics at City Hospitals.

9.0 Improvement Interventions

9.1 Our Progress so far

In 2014 we identified 10 transformational changes which would lay the foundations to ensuring delivery of our 5 year vision. Work has progressed well against these transformational changes in the first year of our plan:

- **Integrated Community Locality Teams** - Developed partnership working in Sunderland, model and make up of teams agreed in principle, Investment of both non-recurring and recurring funds agreed to enhance medical / nursing input, Looking to mobilise, test and refine over the next 12 months. Each team includes community nurses, social workers, living well workers, carer workers and GPs wrapped around groups of GP Practices to provide enhanced care to our most complex patients.

- **Enhanced Healthcare in Care Homes** – Pilot in Coalfields produced very good outcomes, including 45% reduction in emergency admissions, high patient, carere and staff satisfaction and more people dying in their preferred place. Looking to roll out across the city as part of Integrated Community Locality Teams;
- **Intermediate Care Hub (now known as Recovery at Home)** – Hub and linked nursing and care teams operating from one base and now operating extending hours and investment in additional community beds available at Farnborough Court moving towards 24 hour single point of access to Hub by September. The hub includes a contact centre, nursing and care teams which support people at home ;
- **End of Life deciding right** - Care Home training to enable people to die in their preferred place has progressed well with most homes engaged. Additional resource agreed to support GP Practice Training;
- **Mental Health** – 5 year programme to develop a model of care for Sunderland is now near the end: New model of psychological therapy, new hospital environments at Ryhope & Monkwearmouth, Ongoing implementation of improved community mental health services;

- **Urgent Care** – GP led urgent care centres are now operational, GP Out of hours procurement is currently underway following agreement of the new model that is fit for the future as well as the development of City Hospitals emergency department urgent care centre;
- **MSK** – The procurement of the new MSK service is complete and the new provider will be operational from October 2015;
- **Dementia** – A dementia friendly community pilot is running well in Houghton. All staff in GP practices across Sunderland have been trained on Dementia Awareness with additional Dementia friends training planned. The Essence service is now in place and receiving referrals to support newly diagnosed patients who do not yet require care but need to keep connected with what is important to them.
- **Reducing the use of procedures of limited clinical value** - Phase one of the value based commissioning policy, reflecting national guidance, was implemented in January 2015, focusing on varicous veins and minor skin lesions with full implementation by April 2015.

9.2 CCG Plan on a Page

The CCG plan on a page, shown overleaf, summarises the following:

- CCG Vision;
- Strategic Objectives;
- Outcome ambitions;
- Transformational changes moving into 2015/16;
- Key enablers;
- Governance arrangements;
- How our success will be measured;
- Values & Principles.

Version 1.3

Plan on a Page 2014/15 – 2018/19 (Revised for 2015/16)

NHS Sunderland Clinical Commissioning Group

Better Health for Sunderland

Transforming out of hospital care (through Integration and 7 day working)			Transforming in hospital care, specifically urgent & emergency care (7 day working)			Enabling Self Care and Sustainability		
Improve health related quality of life for people with LTC by 8.9% by 2019	Put in place 352 more Emergency Health Care plans by 2016	Improve patient experience of out of hospital care by 8% by 2019	Reduce Emergency Admissions by 14%* by 2019	Increase direct referrals to the MSK Intermediate service to 50% by 2016	Improve patient experience of hospital care by 7.2% by 2019	Increase no of people receiving treatment for IAPT from 12% to 16% by 2016	Reduce years of life lost by **15%** by 2019	Improve diagnosis of dementia from 62% to 68% by 2016

Transformational Changes 2015-2016	
OUT OF HOSPITAL	Implement the out of hospital model, including locality integrated teams for people at home and in care homes, city wide recovery at home services and the end of life standards in GP Practices
URGENT CARE	Improve timely access to urgent care by concluding the procurement of the GP Out of Hours service & supporting implementation of the whole system Emergency Care Intensive Support Team recommendations.
DEMENTIA	Conclude the implementation of the national dementia strategy in Sunderland e.g. supporting dementia friendly communities by specific focus on Primary Care awareness, development, training and environment
MSK	Mobilise the new integrated musculoskeletal service
MENTAL HEALTH	Continue to support the implementation of the new principal mental health community pathways
PREVENTION	Influence a prevention and self management approach with commissioned health services, working jointly with the local authority / public health
CHILDREN	Develop a joint strategy and joint commissioning approach with Sunderland city council to improve outcomes for children
GENERAL PRACTICE	Develop and implement a strategy for general practice across the city
LEARNING DISABILITIES	Implement the transforming lives programme for people with learning disabilities and / or autism
CONTINUING HEALTHCARE	Implement the new model of care for people needing continuing healthcare

Enabled by	Governed by	Measured by	Values and Principles
Joint Commissioning & Better Care Fund Co-commissioning Primary Care IT infrastructure Telehealth Contract Management (CQUIN) CCG Localities Medicines Optimisation Research & Development Organisational Development Reform Methodology	CCG Governing Body System Wide Transformation Board Health & Wellbeing Board	Achievement of outcome ambitions Delivery of QIPP cost reduction plan 2015/16 – 2018/19 of £16m Delivery of prescribing savings £8m	One system for health and Social Care 7 day services Person centred Prevention focused Development of team based working across Sunderland Mental and Physical health of equal importance Evidence based approach

*14% reduction is related to the composite measure which does not include all emergency admissions. Overall aim is to reduce emergency admissions by 15%

9.3 Transformational Programmes

The impact of the health priorities, outlined within the JSNA, on long term conditions and on the frail and elderly more generally is significant and so much of our focus is on ensuring we have sufficient initiatives in place to address the impact of these.

We have undertaken a 'lite touch' review of our priorities moving forward taking into account our progress to date and recent national guidance including NHS England's 5 year forward view.

We will still be continuing to deliver the priorities we identified in 2014 where not fully complete, however, we have also identified some additional priorities. Some of which are new and others are priorities that we are already addressing which we feel are significant enough to highlight them on our plan.

The additional priorities identified moving forward in to 2015/16 include:

- Influencing a prevention & self management approach
- Developing a strategy with Sunderland Council to improve outcomes for children
- Development and implementation of a strategy for General Practice
- Implementation of the national 'Transforming lives' programme for people with learning disabilities
- Implementation of the new model of care for people needing continuing healthcare

Further detail on each of our transformational changes is outlined in the following pages:

9.3.1 Implementation of the Out of Hospital Model of Care

Principle Changes planned to the delivery of care are set out below:

City wide recovery at home service

- This city wide service currently exists to provide both Step up and Step down health and care which is time limited and rapid response both in peoples own home and in community beds. It is focussed on preventing an emergency admission and supporting timely discharge with a strong re-ablement philosophy.
- This service will be enhanced through 24/7 working; single point of contact; all core health and social care teams including the GP Out of Hours provider being based in the same building along with the assisted technology services; under one management arrangement and a more effective community beds function which will enable an overall reduction in community beds.

Locality Integrated Teams

- These services will be enhanced by being brought together into multi-disciplinary teams which will be wrapped around groups of 10-15 GP Practices in each of 5 Localities (approx. 50,000 patients per locality). Whilst meeting the needs of the whole practice list, they will provide an enhanced level of response to those complex patients, often elderly frail and or with multiple co morbidities both at home and in supported housing including care homes identified via a risk stratification approach. This enhanced level will be proactive, planned, coordinated and case managed based on the outcomes that are important to the patient. The teams will have a single management structure. The teams will also include Living Well workers who will be very familiar with the local voluntary and community resources and connect patients with those resources where needed to improve quality of life for those individuals.

- The teams will be able to access city wide specialist resources where it is not viable to have those resources in each team e.g. Consultant Geriatrician. Wherever possible there will be a named contact for each Locality e.g. 3 older people mental health teams will have a key contact for each of the 5 teams. There will be a key relationship with the city wide Recovery at Home service, when despite a proactive and planned approach, emergencies can occur, although they should be less frequent. The patient groups are likely to be very similar for both services. These patients will have direct access to the Recovery at Home service and have a joined up electronic health record. They will also be able to support the development of personal budgets building on the current joint arrangements with the council to provide personal budgets

to people with continuing health care needs.

General Practice

- 51 practices in the city currently with 42 recently forming a local federation covering 85% of the practice population and all 5 localities. A smaller federation of 5 practices approximately 30,000 practice population has also formed in one part of one of the 5 Localities. This locality sits on the border of Sunderland and Gateshead as the new town of Washington and is geographically a discreet locality. The CCG has supported the development of both federations.

- These services will be enhanced through the ongoing development of the Localities providing peer support as commissioners and through the federations as providers of extended, standardised and proactive primary care particularly for people with long term conditions.

Communities

- Sunderland has a population of c 284,000 with 3 well defined localities (Washington; Coalfields and North) and the rest of the city being divided into the East and West – 5 Localities in total with very similar health and wellbeing status, whilst clear inequalities between wards and within and across localities. There is an active and vibrant voluntary and community sector with some organisations operating across the city and some locality/ward focussed.

- These communities are being enhanced through the development and or recognition and support of Community Connectors. Individuals and groups that enable people to become and stay well connected with others and or access support when they are temporarily or permanently vulnerable. The majority of these connections are provided by voluntary and community organisations of all sizes. The concept of Community Connectors will be further developed, current provision mapped and better supported and gaps considered.

9.3.2 Procurement of the GP Out of Hours service & supporting implementation of the whole system Emergency Care Intensive Support Team recommendations

The proposed GP Out of Hours service model will deliver a comprehensive integrated OOH service across Sunderland.

The aims and objectives of the service are to provide a clinically safe and exceptional GP OOH service providing access to unplanned urgent care, working in partnership with the wider urgent care system across primary, community, secondary health and social care. The service will be an integral part of the Sunderland Recovery at Home (RAH) team providing telephone advice and a home visiting service. Face to face appointments will be delivered via the Sunderland Urgent Care Centres (UCCs). The GP OOH provider will have access to book appointments.

We invited the emergency care intensive support team, which is a national team, to review the whole urgent care system in Sunderland. Following this the following recommendations were identified:

- Early senior review of all patients along all parts of the pathway is required;
- In order to maintain the momentum of care there should be a senior review of every patient's care plan every day;
- To ensure patients are on the right pathways they should be managed in 'flow streams';
- The implementation of internal/ external professional standards across the entire pathway;
- Plan and manage capacity to meet demand;
- Manage variation in discharge planning;
- Avoid unnecessary overnight stays across the entire system through implementation of the ambulatory emergency care/ frailty model.

The CCG will support the urgent care system in Sunderland to implement these recommendations throughout 2015/16

The 4th urgent care centre as part of the new accident and emergency (A&E) build

at Sunderland Royal Hospital will also progress during 2015/16. The centre is currently adjacent to A&E at Pallion Health Centre until the new build is in place. The aim is to have primary care response as the first response to those attending wherever appropriate.

9.3.3 Improved community mental health pathways, access and waiting times for all mental health conditions

The 5 year programme to develop a model of care for Sunderland is now near the end with enhanced IAPT services and new hospital environments at Ryhope & Monkwearmouth,

The Mental Health provider, NTW, will continue to develop and improve community mental health pathways, access and waiting times for Attention deficit hyperactivity disorder, personality disorder, autism and psychosexual disorders.

9.3.4 Conclude the implementation of the national dementia strategy in Sunderland e.g. supporting dementia friendly communities by specific focus on Primary Care awareness, development, training and environment

The dementia friendly communities programme focuses on improving the inclusion and quality of life of people with dementia. In these communities: people will be aware of and understand more about dementia; people with dementia and their carers will be encouraged to seek help and support; and people with dementia will feel included in their community, be more independent and have more choice and control over their lives. This work will complete the intensive pathway reform that has been underway across Sunderland for the last few years e.g. memory protection service already in place; work with practices to increase the dementia diagnosis rate.

9.3.5 Mobilise the integrated musculoskeletal service

The existing musculoskeletal service has been redesigned to offer an integrated service, streamlining patient pathways and reducing handoffs. This will increase patient experience by responding to patient preferred outcomes, reduce waste in the system and improve patient outcomes. The focus for 2015/16 will be to

mobilise the new service, now the procurement has completed.

9.3.6 Influence a prevention and self management approach with commissioned health services, working jointly with the local authority / public health

Across Sunderland, there is significant work underway in relation to prevention. We will continue our focus on cancer in terms of prevention, identification, treatment and survivorship. We will also continue to build on the work we have undertaken in relation to diabetes prevention and management.

The CCG have funded the exercise on referral programme moving forward into 2015/16 which is a weight management programme for adults aged sixteen years and over, who are not taking part in any form of exercise and have a condition that their GP or healthcare professional thinks will be improved with physical activity. We have also implemented a new Tier 3 obesity service to ensure patients are appropriately managed prior to going to Tier 4 (Bariatric Service)

In addition we have implemented a successful LVSD (Left ventricular systolic dysfunction) scheme providing high quality care for people within their familiar place of care as well as an effective atrial fibrillation service in order to identify previously undiagnosed patients who have AF and initiate their investigation and treatment.

Moving into 2015/16, the clinical forum will be working with public health colleagues to develop a robust prevention and self management plan specifically relating to ways in which the CCG and its member practices can support this agenda.

9.3.7 Develop a joint strategy and joint commissioning approach with Sunderland city council to improve outcomes for children

Our aim is to improve Health and well being outcomes for children, young people and families. In 2015/16 we will develop a joint strategy and joint commissioning approach with the local authority to improve outcomes for children. This will include:

- Ensuring clarity in relation to partnership arrangements for children and young people;
- Supporting the development of integrated pathways of care;
- Ensuring the CCG are meeting their statutory requirements in relation to children with complex needs.

9.3.8 Develop and implement a strategy for general practice across the city

By 2019, we aim to have a high quality, safe, sustainable primary care system fully integrated within a whole health and social care system, operating within available resources to improve health and provide timely access to appropriate services for the population of Sunderland.

The CCG has taken on delegated responsibility for the co-commissioning of primary care, specifically general practice in 2015/16. We believe this will help to ensure achievement of our overall vision and strategic objectives.

In 2015/16 we will develop our strategy for general practice across Sunderland taking account of:

- Current state of primary care
- National expectations
- Review of strengths, weaknesses and opportunities
- CCG drivers

We will be engaging with member practices and stakeholders to agree the key strategic priorities for general practice over the next few years.

9.3.9 Implement the transforming lives programme for people with learning disabilities and / or autism

The CCG and our partners across the health and care system in Sunderland are committed to transforming care for people with learning disabilities and/or autism who have a mental illness or whose behaviour challenges services.

Sunderland has a long-standing, comprehensive approach to individual care planning, so that people do not stay longer than necessary in hospital, specialist treatment centres, or in out of area placements. A robust and careful approach is taken with regards to discharge planning. Discharge only takes place when clinicians, family, commissioners, social workers and, where relevant, the courts decide it is safe and best for the individual.

Long-standing relationships with NHS specialised commissioners and between the CCG and the Council mean that a whole-system approach can be taken to all people with learning disabilities and complex needs admitted to hospital from Sunderland. Pooled budgets mean that discussions about responsibility for funding take place up front, rather than on a case-by-case basis. Close working between commissioning and care management functions mean that commissioning decisions are fully informed by individuals' care needs.

The Winterbourne View programme of work has not required to major changes in how Sunderland supports people with learning disabilities and behaviour that challenges, however the focus brought by the programme has meant a number of lessons have been identified to improve the assessment and discharge process.

These include:

- Develop a better understanding of why individuals need to be admitted to hospital and identify any themes or trends that would inform commissioning and/or practice; discussions about themes will take place in care review and planning meetings;
- Ensure that people admitted to hospital have had a physical health check in the past 12 months and if not offer one; this will be built into the hospital protocol and picked up at care review meetings;
- Better information for people admitted to hospital **and** their families; an information pack has been developed which will include letters from the Carers Centre and People First advocacy.

9.3.10 Implement the new model of care for people needing continuing healthcare

NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'… Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness.

The CCG have been working with the council around documentation and raising awareness across the city of personal healthcare budgets (PHBs). There is also an ongoing programme of discussing PHB's at individuals' annual review.

In 2015/16 we will work in partnership with the local authority and South Tyneside FT (provider of the assessment) to implement the new model of care for continuing healthcare. This new model is intended to address the current inefficiencies / duplication in the system which can lead to poor patient experience.

10.0 Enablers

10.1 Telehealth

Telehealth (also referred to as telemedicine) covers the remote monitoring of physiological data e.g. temperature and blood pressure that can be used by health professionals for diagnosis or disease management. Examples of Telehealth devices include blood pressure monitors, pulse oximeters, spirometers, weighing scales and blood glucometers. Telehealth also covers the use of information and communication technology for remote consultation between health professionals or between a health professional and a patient e.g. providing health advice by telephone, videoconferencing to discuss a diagnosis or capturing and sending images for diagnosis. (Telehealth can collect this data via SMS text).

Within Sunderland we have dedicated resource assigned to drive forward the Telehealth agenda and ensure this technology is integrated across all transformational changes. Some of the work we have implemented to date include:

- Smoking cessation supportive tool for smokers hoping to quit
- Smoking in pregnancy supportive tool for pregnant mums
- Hypertension – accurate diagnosis of hypertension and appropriate treatment
- Daily monitoring of blood glucose levels for those with gestational diabetes

Moving forward into 2015/16 we have a number of improvements planned including:

- Weight monitoring – targeting specific at risk groups to assist with weight control including those on the Bariatric pathway prior to surgery.

- Supportive tool for carers – signpost and alert raising to avoid crisis;
- MSK pain management text tool to support self management and control;
- Asthma – text support tool for inhaler reminders, prescription renewals and inhaler techniques.

10.2 Medicines Optimisation

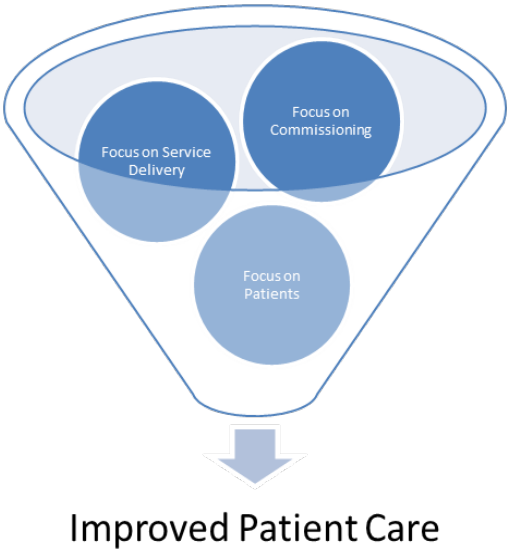
Our medicines optimisation plan will be a key enabler across each of these transformational changes and will aim to deliver savings of £8m by 2018/19.

We have reviewed our medicines optimisation strategy for 2015-6 which will include a focus on the following:

- GP Practice prescribing and a proposed strategy for providing additional medicines optimisation support to practices;
- Optimisation of prescribing of appliances e.g.;Appliances for urinary incontinence, Stoma Appliances and Accessories;
- Care Homes;
- Diabetes Specialist Nurse to support practices with management of patients in primary care;
- Additional measures to support improvements in, and better monitoring of prescribing in SCCG:
    - Locality working and development of locality prescribing reports;
    - Subscription to PresQIPP – Medicines Optimisation Web Resource;
    - High Cost – PbR Excluded Drugs;
    - Formulary and Guideline Development.

10.3 Informatics

Moving forward into 2015/16, we have developed an Informatics strategy. The diagram below illustrates the three key elements of our strategy:



10.3.1 Focus on Commissioning

Securely linking data from different healthcare settings to support commissioning intelligence

We will continue to improve our business intelligence resources to ensure accurate, relevant and timely information to enable the CCG to design and plan services and ensure that they are open, responsive and transparent for patients, carers and members of the public

Communicating with member practices

We will continue to develop robust and efficient digital methods and channels of communication between the CCG Head Quarters and member GP practices with a focus on document management solutions and intranet / extranet development.

10.3.2 Focus on Service Delivery

Supporting integrated care delivery within improved information and technology

We will improve the delivery of care through the introduction and adoption of modern clinical information systems with the ability to:

Share information electronically within and across organisational boundaries supported by adoption of the NHS number as the key patient identifier;

Utilise robust channels of communication for transactional based information flows such as discharge communications, referrals and diagnostic services;

Support health care professionals to deliver services in different care settings such as the patients home or in remote locations;

Provide assurance to patients that their data processes securely and confidentially.

Support care professionals to make the best use of data and technology

We will provide users of information and technology with the skills and support to exploit and realise the benefits of the solutions and services available.

Value for money systems and services

We will ensure the provision of IT systems and support services provide value for money through the use of national and local frameworks along with regular review to ensure waste in service provision and service level agreements are removed and levels of quality match customer expectations

Maintaining Robust Infrastructure

We will ensure the IT infrastructure supporting delivery of GP services is stable, secure and resilient. Refreshing the infrastructure is critical to maintaining this position and making improvements in availability. Our focus will include an upgrade for the local NHS network (COIN), GPIT Hardware Refresh Programme, Virtual Desktop Environment Pilot and Remote Practice Backup Solution.

10.3.3 Focus on Patients

Social Media to facilitate access to personal health information

We will enable access to health information for Patients and Public through the development of excellent communications channels and high quality information resources including the use of social media, apps for specific conditions and healthcare service and advice and digital signage in practices.

Automating routine transactions with patients

We will enable patients to interact with NHS services through digital methods making contact convenient, personal and efficient. We will do this through booking appointments online, electronic prescriptions including EPS R2 and Patient messaging using MJog

Patient and carer access to electronic records

We will enable patients and their carers to access care records and be informed and involved in decision about their own care and treatment.

10.4 Organisational Development

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people; it is often termed as the “oil that keeps the engine going”. In Sunderland we fully embrace this philosophy and the concept of continuous improvement and development. This strategic approach is critical as we continue to develop and grow as an organisation.

As SCCG is still in its infancy we have developed an Organisational Development Plan in order to:

- Support the delivery of the 5 Year Strategic Plan and 2 Year Operational Plan to deliver our vision and transformational changes to improve health outcomes;
- Ensure a system wide approach with partners to organisational learning;
- Ensure the actions we take in the shorter term support delivery of our longer term objectives;
- Ensure that the organisational enablers for delivery are in place and are being progressed;
- Establish a cross-cutting approach by connecting our efforts, skills, experiences and competencies to continually improve our commissioning process.

As a clinically led organisation, the CCG will add value and continue to use appropriate mechanisms to seek feedback on our performance as leaders of the local health economy.

We are working with our partners to address our shared priorities and challenges and ensure our approach to organisational development across the health economy provides a strong platform to deliver our vision.

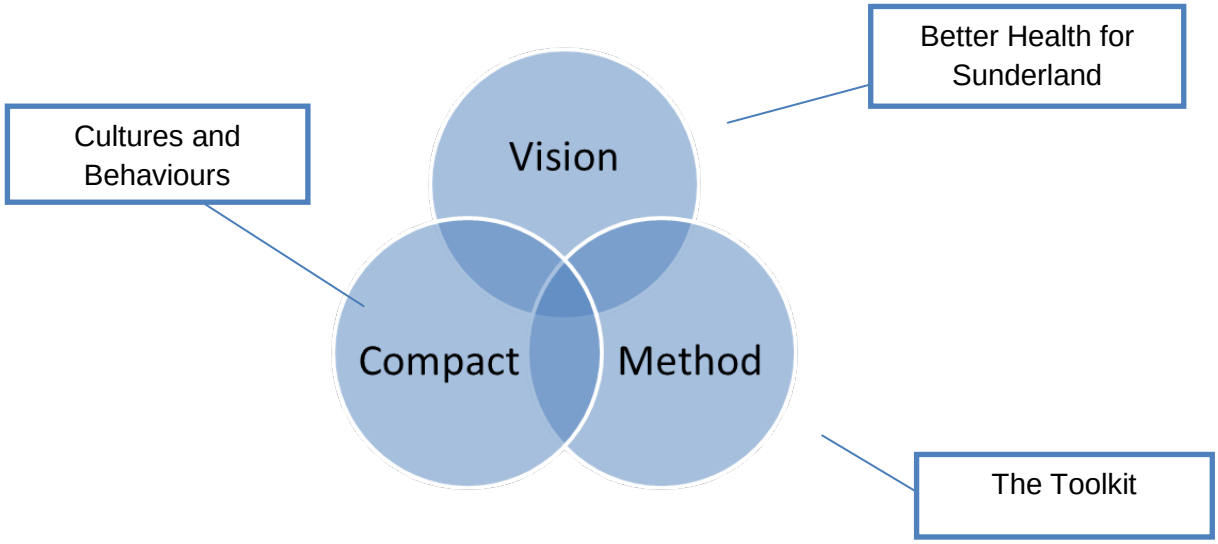
As an organisation we promote organisational learning and are committed to promoting a learning culture to ensure that all staff are developed to ensure safe and effective care and to achieve their full potential.

10.5 Improvement Methodology

We know all organisations involved in the commissioning and delivery of health and social care face the daily challenge of managing change. We recognise the importance of having a clear approach to continuous improvement and as stated by NHS Improving Quality (2013)[1]: "…using an evidence-based improvement methodology ensures that the change will be delivered in a planned, proven way that follows established methods. The improvement methodology is the game plan.

We have adopted the North East Transformation System (NETS) as our reform methodology, which has been identified by NHS IQ as evidence based improvement methodology. However, we will also adopt other complimentary approaches as needed.

The NETS framework, outlined below, comprises of 3 key elements namely, Vision, Compact and Method:



The framework incorporates transformation and change techniques from international exemplars in industry as well as healthcare. Each element of the framework is considered equally important for success and for this reason, the framework is often *referred to as the '3 legged stool'*.

In Sunderland, we have tailored our approach to utilise our resources where they are most needed and ensuring individual providers are clear of their own responsibilities to lead and demonstrate their improvements. Our ambitious transformation programme comprises of 10 programmes many of which will require commissioners to take the role of facilitator due to the complexity and involvement of multiple stakeholders. A continuous improvement approach will prove invaluable in capturing the current issues, encouraging providers to collectively undertake root cause analysis and work collaboratively to commission/provide innovative solutions.

We recognise that we are overfunded by £50m using the national formula with therefore very little financial growth anticipated and an ambitious cost improvement Programme.

This lean approach aims to release capacity within existing resource and we are committed to ensuring quality is maintained in the backdrop of financial austerity, and ensuring savings or resource released are reinvested wisely, for the benefit of the people of Sunderland.

11.0 Impact of our Improvement interventions on activity

We have reviewed activity levels in previous years and forecasted the expected activity levels over the next five years taking into account the anticipated impact of our transformational changes. The table below outlines the forecasted activity levels:

Activity Measure	Position in 5 years
GP referrals	Reduced growth by 3%
Other referrals	Reduced growth by 2%
First outpatient attendances	Reduced growth by 1.5%
Elective daycase admissions	Reduced growth by 2%
Elective ordinary admissions	Reduced growth by 2%
Non elective admissions	15% reduction (already 12% reduction in 13/14)

12.0 Ensuring Quality and improved outcomes

Quality is at the centre of Sunderland CCG's vision and values and we are dedicated to ensuring that the services we commission on behalf of the people of Sunderland are of the highest quality and delivered with respect and compassion. Our Quality Strategy 2014-17, which was approved in August 2014, describes a quality service as being one that recognises the individual needs and circumstances of the patient and ensures services are accessible, appropriate and effective for all and that workplaces support and empower the staff to deliver high quality care.

We are committed to delivering quality improvement across the three areas of quality, namely effectiveness of care, patient experience and patient safety. We have reviewed the recommendations from the key quality and safety reports and strategies i.e., Francis 2, Berwick, Keogh, Clwyd & Hart, Compassion in Care and Hard Truths and whilst we have not identified any specific risks currently, we have developed and made significant progress on the implementation of a robust action plan to ensure continuing improvement from a commissioning and provider perspective. The overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people and patients at the centre of the NHS. As an organisation we are committed to ensuring clinically led commissioning, ensuring safety, quality and outcomes drive everything we do, informed by efficient and effective engagement with patients, carers and the public.

Alongside our overarching quality aims and objectives, Sunderland CCG has always been committed to ensuring and improving quality in primary care in Sunderland, which will be strengthened now that the CCG has taken on delegated responsibility for the co-commissioning of primary care (GP practices).

Examples of the range of actions we continue to take include:

- Quality impact assessments undertaken on all key transformational changes;
- Develop and maintain relationships with all key providers and co commissioners to ensure continuous dialogue on quality of services and quality improvement;

- Secure and use quality assurance data and information from a broad range of sources both external and local;
- Identify areas for improvement and respond to areas of concern in relation to quality quickly and monitor accordingly;
- Maximise use of contractual levers to secure quality improvement e.g. use of quality indicators and Commissioning for Quality and Innovation (CQUIN) schemes;
- Promote the implementation of national best practice guidance and standards with all providers;
- Ensure that systems and processes are in place to fulfil specific duties of co-operation and best practice in relation to the safeguarding of vulnerable adults and children.
- Work with associate/lead commissioners, including the Local Authority, to maximise quality assurance/improvement in commissioned services;
- Summarise quality assurance reports to the CCG Governing Body as the accountable body outlining key areas of assurance, risks and mitigating actions.

13.0 An NHS centred around patients

We have recently reviewed our engagement activity against national priorities, to consider our key local priorities for the future. In particular we are keen to enhance involvement and to further ensure commissioning activity reflects the communities the CCG serves.

We will ensure patient experience is central to service development and that patients, carers, and the public (our citizens) are actively and systematically involved in all aspects of public service design and change. Communities will feel empowered and enabled and will know how they can engage with us on everything to do with their Health and Wellbeing. We will also ensure that patients are fully empowered to make informed choices regarding their own care.

The CCG has recently revised its Patient and Public Engagement Strategy to demonstrate its commitment to working with our partners and the public, patients, carers and communities and their representatives, to ensure health and social care services are shaped around what the people need. As a health and care economy our focus is to ensure we engage collaboratively with the people of Sunderland.

Public Participation

Being patient centred is one of our 7 core values. This really means ‘no decision about me, without me’ for patients and their own care. The same goes for the design of health and social care services. We are making sure we have effective ways to always involve patients and the public when identifying their needs, the plans we develop to meet these needs and evaluating whether services are meeting them.

The majority of GP practices in Sunderland have their own patient groups and localities have explored the most effective ways of bringing these voices together to enhance their knowledge of the patient and public perspective at a local level.

As a health and social care system we have developed an Altogether Sunderland approach, which includes the move from local engagement boards to Sunderland Health Forum which will be led jointly by the CCG and Local Authority.

We will continue to proactively engage with the wide range of local partners including the business community, community and voluntary sector and clinicians to ensure both our short and long term plans reflect local need and that partners play a key role in change for local people.

We will also continue to seek the views and opinions of local people, patients, voluntary and support groups about the services we provide through a wide range of activities including surveys, focus groups, formal consultations and events. ‘My NHS’ is being be proactively populated to represent Sunderland demographics and engagement opportunities related to individual interests actively marketed using this tool.

There is an open invitation for patients and members of the public to attend the Sunderland Health Forum, which is held every 2 to 3 months, to engage with the CCG. These are held in a central location within the city to update the public on key developments and seek views about proposals and meetings are advertised in the local press and via social media.

We have developed a good working relationship with Healthwatch, the local independent body, required by law to ensure the views and experience of people who use health and social care services are heard and taken seriously by statutory bodies such as Sunderland CCG. Healthwatch is a key member of the Health and Wellbeing Board and our Sunderland wide Transformation Board.

We will continue to ensure that appropriate action is taken in response to patient and staff feedback through the Friends and family Test and other patient experience activity.

We review feedback on patient experience from a wide variety of other sources, especially that collected via providers and this forms part of our assessment of the quality of those services and is used in Quality Review Group meetings to ensure a focus on safety, good patient experience and effective services.

We will be using new technologies and communication methods, such as My NHS, Twitter and Facebook, to reach all parts of our society to listen to what is important to them in improving local health services and seek views on plans and proposals.

Individual Participation

Enabling self care and sustainability is one of our three strategic objectives and we are committed to a focus on helping individuals to better manage their own health and heath care needs.

We will continue to invest in empowering local people through effective care navigation, peer support, mentoring and self-management programmes to maximize their independence and wellbeing. We will help identify and combat social isolation as a major influence on overall health and wellbeing.

Through our work in developing locality integrated community teams, we will ensure that every person in Sunderland with a long term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.

We will also ensure that any person who would benefit from it will have access to their own personal health budget.

This work is being overseen by the safety, risk and quality committee – and in particular the following areas have been identified for development

- Accessibility and protected groups;
- Developing community assets through voluntary and community sector engagement;
- Co-ordination of relationships with the wider voluntary and community sector;
- Development of health champions led by public health;
- Make better use of VCS ability to reach further into communities, further meet equality duties;
- Developing community assets through practice participation groups (PPGs);
- Insight and feedback – understanding people's experiences of care – development of patient stories;
- Developing better CCG engagement planning and capacity for delivery;
- Development of a programme for engagement delivery – enhancing staff skills and knowledge base to better commissioning activity;
- Work with reform leads to identify specific engagement needs as part of existing transforming methodology;

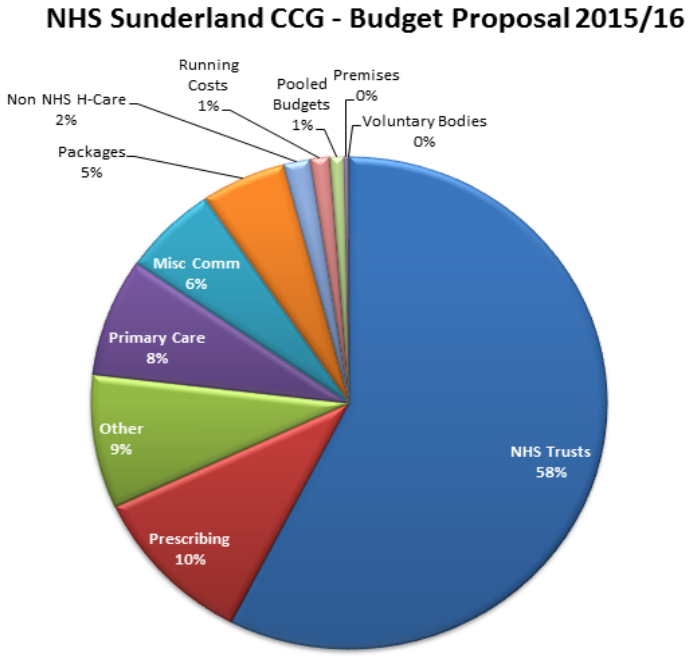
- To become more intelligence-led organisation, using easy ways to share what thematic insight has been gained from engagement activity across the CCG.

14.0 Our Financial Plan and Sustainability

We have been identified as one of a small number of CCG's who are substantially overfunded, according to the latest national formula, and so we recognise the potential for our future financial picture to change if the formula is fully enacted. Our cost improvement programme is therefore based on being prudent, preparing for the future and reducing our recurrent run rate. The Chief Officer of NHS England, Simon Stevens has indicated the desire to move all CCGs to within 5% of their targeted allocation as fast as possible which validates the prudent approach the CCG is taking in their financial plans.

We have undertaken detailed impact assessments to understand the potential impact of our transformational changes on finances over the next four years from 2015/16 to 2018/19, which outline the £16m savings we intend to make. Triangulation of finance with both outcome ambitions and activity trajectories has also been undertaken. There are also a number of transactional savings we plan to make as well as £8m savings through a medicines optimisation plan. The savings help us to invest in improvements. Our financial plan on a page can be found in Appendix 1**.**

For 2015/16 we have been allocated a budget of £501m. The diagram below outlines how we will spend this money in order to improve health outcomes for the people of Sunderland:



15.0 Delivery of our plan

15.1 Performance and Planning Framework

We have set in place a framework and structure to ensure that all of the components of this operational plan are efficiently and effectively implemented including a comprehensive performance management regime and a governance framework to routinely advise the CCG Executive and Governing Body on progress. In addition to this we have agreed the formation of a system wide Transformational Board to drive the delivery of our vision and strategic objectives, supported by a multi-agency Out of Hospital Programme Board, Mental Health Programme Board and the Urgent Care Programme Board.

Performance is reviewed on a monthly basis by the CCG Executive Committee and covers delivery against our operational plan (including national targets and progress of transformational programmes), contracting position at each of our providers and delivery against our cost improvement programme. The report documents, for each of the key performance indicators, the actual position against plan, trend month on month, an assessment of risk to year end delivery and key actions to recover any underperformance. The reporting regime is also supplemented by specific high risk key measures being monitored more frequently e.g. A&E 4 hour standard and healthcare associated infections.

A key part of the performance framework is the systematic review of the risks associated with the delivery of each aspect of performance, and if circumstances change, the risk management plan is amended to reflect the latest context. Where key risks have been identified, routine reporting is supplemented by escalation, exception reporting, development and close tracking of performance time limited recovery plans. These are focused on root causes of the problems and remedial action including, where appropriate, the use of contractual interventions to ensure delivery and sustainability of improvement. Initiatives and targets ranked as high risk are closely scrutinised to ensure performance remains on track, and any deviation from plan is quickly identified so that appropriate action can be taken.

Understanding of provider contributions to overall delivery is critical and commissioned providers have agreed information schedules including both national and local

requirements with required submission dates. Performance targets are detailed in contracts across a broad range of key performance domains such as activity, access, health improvement, safety and quality. Our internal monitoring supports the performance improvement discussions which form a key part of monthly contract review mechanisms.

Building on the success of the North East Transformation System to date, we are continuing to embed the methodology throughout the CCG to drive quality and continuous improvement in our commissioning processes, by undertaking:

- Regular Tier 2 Visibility Wall stand-up meetings to ensure continuous improvement in performance are at the heart of our management method;
- Continued enhancement of the Tier 1 Performance Wall and the Tier 2 Improvement Wall and also improving the linkage between them.

15.2 Governance

In line with our values as a CCG to be open, honest and inclusive, the CCG have developed a planning process to ensure patients, the public, partners and providers are part of developing our plans for the future.

We have developed a gateway process which is a mechanism for providers to share ideas which will support us in delivering our priorities.

Our three programme boards, (Out of Hospital, Urgent Care and Mental Health) are an integral part of our planning process which has membership from the local authority, partners and providers.

We actively engage with the Health and Wellbeing Board (HWBB) and have established a Transformation Board with key partners to oversee the delivery of the Transformation programme. We meet regularly with Healthwatch Sunderland who are also part of the HWBB and our Programme Boards. Our Locality teams meet regularly with their counterparts in the LA e.g. Local Councillors, voluntary sector and partners who form the locality People and Place Boards linked to the local Area Committees.

To ensure that the CCG and its Board are delivering on its strategic objectives, a committee structure has been developed to provide assurance on the key aspects of plans under the Governing Body. This committee structure includes:

- An Audit Committee;
- Remuneration Committee;
- Quality, Safety & Risk Committee
- Primary Care Commissioning Committee

They are supported in their work by an Executive Committee comprising elected GPs together with Directors within the CCG.

Importantly, the Audit Committee will ensure that we have effective internal controls and risk management arrangements in place to ensure that risks to delivery of plans are identified and mitigated through effective action at an early stage.

The Audit Committee will also assist the Board in providing additional scrutiny of the cost improvement programme, implementation of which will be managed by the Executive Committee. The Executive Committee will be supported by the relevant Programme Boards in delivery of operational plans for which they have been assigned lead responsibility. The Quality, Patient Safety & Risk Committee will provide assurance that for those services which we commission as part of the commissioning plan they are of high quality and safe for the patient and that risks are being effectively controlled with mitigation action put in place.

Underpinning all of our work is a commitment to the Nolan principles of openness, accountability and transparency; with these principles in mind we have adopted a Standards of Business Conduct and Declaration of Interests Policy in keeping with the NHS Commissioning Board's guidance. All members of the governing body, its committees, member practices and senior employees are required to adhere to the policy, including registering of their interests and arrangements are set out as to how such conflicts of interest will be managed.

16.0 Equality & Diversity

Following an in depth consultation exercise, the CCG has developed a number of equality objectives:

Objective	Description
1	Work with partners to improve the safety and quality of commissioned services across Sunderland.
2	Ensure all patients and carers can be involved and that patient experience is captured and acted upon to inform service change and delivery where possible.
3	That Sunderland CCG has sufficient organisational data to demonstrate that staff from all protected groups are paid equally and in line with pay levels for the organisation as a whole and that appropriate training has been given on equality and diversity matters.
4	That the Governing Body receives adequate assurance around equality and diversity including the equality objectives, strategy and progress towards achievement.

An action plan has been developed to support the delivery of these objectives and a process established to monitor progress via the Executive Committee, with formal reporting to the Governing Body on a six monthly basis.

Full Equality Impact assessments part of the business case for any transformational change to ensure that the needs of all local communities are fully reflected in the design, planning, implementation and evaluation of services.

17.0 Conclusion

We have outlined in this plan the operational detail of the work we have undertaken in 2014/15 and our focus moving forward into 2015/16 to lay the foundations to ensure the delivery of our five year vision and strategic objectives in Sunderland.

Appendix 1 – 5 year Financial Plan on a Page

PLAN ON PAGE v5 Feb-15

PLANNING ASSUMPTIONS FOR CCG 2/5 YEAR FINANCIAL STRATEGIES

	2015/16 %	2016/17 %	2017/18 %	2018/19 %
CCG Allocation Uplifts	**1.94**	***0.50***	***0.50***	***0.50***
TARIFF				
General Uplift	2.54	4.70	3.70	3.70
CQUIN Increase	0.00	0.00	0.00	0.00
Tariff Efficiency	-3.80	-4.00	-4.00	-4.00
Net Tariff Impact	**-1.26**	**0.70**	**-0.30**	**-0.30**
Prescribing Uplift	6.50	6.00	6.00	6.00
Prescribing Efficiency	-3.00	-4.00	-4.00	-4.00
Net Prescribing Impact	**2.50**	**1.00**	**1.00**	**1.00**
	Within CSR	<----------	------New Gov to Decide---------->	

Growth Allocations by CCG for 2015/16 were announced in December 2014 by NHS England.
Indicative growth figures for the following 3 years have been issued by NHS England within Everyone Counts Guidance (page 45)
Although this document states that Commissioners as a whole should assume growth increases of 1.8% to 1.7% over the next three years, given Sunderland CCGs distance from target of 12% it has been deemed prudent to assume growth of just 0.5% for the remaining years of the plan. This strategy is further supported through the recent announcement by Simon Stevens of NHS England's intention to move CCGs within 5% of their target allocations over the next 5 years.

SOURCES	2015/16 £,000	2016/17 £,000	2017/18 £,000	2018/19 £,000	Totals £,000
Increased Allocations	8,244	2,166	2,177	2,188	14,775
Tariff Efficiency	11,108	11,546	11,626	11,592	45,872
Prescribing Efficiency	1,498	2,048	2,068	2,089	7,704
R.R.I.'S	*9,599*	*6,412*	*3,000*	*3,001*	*22,011*
Total Sources	**30,450**	**22,172**	**18,870**	**18,869**	**90,361**
APPLICATION					
Tariff Uplift	7,426	13,566	10,754	10,722	42,468
Prescribing Uplift	2,747	2,560	2,585	2,611	10,504
Investments--General	*20,278*	*6,045*	*5,530*	*5,536*	*37,389*
Total Application	**30,451**	**22,171**	**18,870**	**18,870**	**90,361**
Tariff Efficiency	11,108	11,546	11,626	11,592	45,872
Tariff Uplift	7,426	13,566	10,754	10,722	42,468
Net Tariff Contribution	**3,683**	**-2,020**	**872**	**869**	**3,404**

Included within the mapping exercise was a substantial share of the reserves held by the PCT. As a consequence of this within the opening budgets the planning need to identify a 2.5% Non Rec budget and a 1% cumulative surplus have already been identified.

The planning guidance requires a 0.5% contingency and a minimum 1% surplus.

The 2015-16 tariff assumptions are based on 2015-16 planning guidance but it should be noted these have not been agreed due to more than 50% of providers (by income) rejecting the proposed tariff arrangements for 2015/16

Given the degree of uncertainty growth assumptions and tariff efficiency have been reduced over the later years of the plan. Once more information is available the CCGs financial plans will be reviewed, however it can be seen that even by taking a "prudent" approach the aspirations and plans of the CCG are affordable.

RESOURCE RELEASING INITIATIVES (R.R.I.'S)

		2015/16 £,000	2016/17 £,000	2017/18 £,000	2018/19 £,000	Totals £,000
Long Term Conditions						
	M.I.U. Tender	400				400
	O.O.H. Tender	250	250			500
	Others					0
	Totals	**650**	**250**	**0**	**0**	**900**
Urgent Care Conditions						
	CITs, Care Homes, Dementia & EOL	0	3,960	1,980	1,980	7,920
	RAID - Reduction in Non Electives		1,000			1,000
	Misc			*739*	*869*	*1,608*
	Totals	**0**	**4,960**	**2,719**	**2,849**	**10,528**
Mental Health Conditions						
	S.Tyne / GH use of Sund beds	1,000				1,000
	Cost of Care Packages	250				250
	Totals	**1,250**	**0**	**0**	**0**	**1,250**
Planned Care Conditions						
	Comm Servs Review	1,000				1,000
	Community Cardiology	200				200
	Procs of Ltd C.V.	200				200
	High Cost Drugs - Lucentis		1,000			1,000
	NEAS PTS	200				200
	MSK Pathway Changes		202	281	152	634
	Totals	**1,650**	**1,202**	**281**	**152**	**3,234**
Support Functions (business rules adj)		**6,099**				**6,099**
TOTAL ALL R.R.I.'S		**9,599**	**6,412**	**3,000**	**3,001**	**22,011**

The RRI plans for 14/15 and 15/16 were discussed and agreed in principle at CCG development session on the 8th Oct 2013. This assumes a "draw down" from reserves in 14/15 and the reducing the 2.5% NR budget in 15/16 (£6,099k). Plans for 15/16 are as discussed on the 8th Oct and have been refined by the CCG QIPP Group. Work is ongoing to quantify other schemes however for this version of the plan the need to save £6.4m in 16/17 and £3m in 17/18 has been factored into calculations.

PLANNED INVESTMENT AREA'S

		2015/16 £,000	2016/17 £,000	2017/18 £,000	2018/19 £,000	Totals £,000
Out of Hospital						
	Pathway Reforms	750				750
	EMIS Web	250				250
	Readmissions nr to rec	1,000				1,000
	Exercise on Referral	360				360
	Continuing Care etc.	1,946	600	600	600	3,746
	BCF Investments	3,421				3,421
	Telehealth	130				130
	Community Services	1,000				1,000
	Total Out of Hospital	**8,857**	**600**	**600**	**600**	**10,657**
Mental Health						
	MH Growth (LD Patients)	1,000	250	250	250	1,750
	MH 2 Year Investment Prog.	1,013				1,013
	Total Mental Health	**2,013**	**250**	**250**	**250**	**2,763**
Planned Care						
	Access Growth	3,000	3,000	3,000	3,000	12,000
	Total Planned Care	**3,000**	**3,000**	**3,000**	**3,000**	**12,000**
Urgent Care						
	Winter Resilience Top Up	2,310				2,310
	Total Urgent Care	**2,310**	**0**	**0**	**0**	**2,310**
Growth to be spent N/R		**2,998**				**2,998**
7 Day Access / Working			**1,500**	**1,500**	**1,500**	**4,500**
Prescribing (to local Astro PU)		**1,100**				**1,100**
CCG Reform Fund (all aspects)			**695**	**180**	**186**	**1,061**
TOTAL ALL INVESTMENTS		**20,278**	**6,045**	**5,530**	**5,536**	**37,389**
Utilisaiton of Surplus N/R		**3,000**	**3,000**	**3,000**	**3,000**	**12,000**

Our 5 year period investments total £42m. Of this £1.8m is available for Reform activities in the 16/17 to 19/20 period.
Where there are known "pre-commitments" these are detailed (mainly in 15/16). Additionally each year there are changes to tariff structure / issues / growth arising within the acute contracts. Knowing this an allowance has been made within the Planned Care section, however it is to cover all aspects.
As with any "long term" plan there is greater detail in the early years compared to the later ones and there is a need to identify & refine later years QIPP plans
The risk of known commitments / reform in later years will need revisiting once further clarity is known about wider pathway reform activities.
We aware of the need to create the Better Care Fund in 15/16 and have allocated most of the "growth" in 2015/16 to this.
The CCG plans to draw down £9m of the surplus generated at the end of 2015/16 and will invest this to support the transformation of services in Sunderland.
Due to a new Business Rule CCGS more than 5% over target such as Sunderland cannot draw down surplus beyond a 2% level (c£9m)

Item No.10

SUNDERLAND HEALTH AND WELLBEING BOARD 29 MAY 2015

NHS QUALITY PREMIUM 2015/2016

Report of the Chief Operating Officer of Sunderland Clinical Commissioning Group

1. Purpose

The purpose of this report is to provide the Health and Wellbeing Board with an overview of the key requirements outlined in the Quality Premium guidance for 2015/16 and the proposed measures against which the CCG will be assessed in 2015/16.

2. Background

The Quality Premium was introduced in 2013/14 and is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The guidance for 2015/16 sets out both the measures and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards and NHS England local NHS England teams to agree measures to be selected from menus, local measures and levels of improvement in preparation for 2015/16.

The Quality premium will be paid in 2016/17 to reflect the quality of health services commissioned by them in 2015/16 and will be based on the following measures which cover a combination of national and local priorities:

- **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);

- **Urgent and emergency care** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure;

- **Mental health** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure;

- **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

- **Two local measures** which should be based on local priorities such as those identified in joint health and wellbeing strategies (20 per cent of quality premium-10 per cent for each measure).

The total payment for a CCG (based on the performance against the measures outlined above) will however be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to the following:

- Maximum 18 weeks referral to treatment times (RTT);
- Maximum 4 hour wait in A&E;
- Maximum 14 day wait from an urgent GP referral for suspected cancer;
- Maximum 8 minute responses for category A red 1 ambulance calls.

A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money during 2015/16; or

b) ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position; or

c) incurs a qualified audit report in respect of 2015/16.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2015/16.

The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs (285,000 for Sunderland) which equates to a total value of approximately £1,425,000 (This is in addition to a CCG's main financial allocation for 2015/16 and in addition to its running costs allowance.)
Regulations set out that quality premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities.

3. Quality Premium 2015/16

The table below outlines the proposed Quality Premium measures for 2015/16. This proposal was approved by the CCG Executive in May 2015.

Area	% of Total Quality Premium	Proposed Measure	% of Area Premium
Potential years of life lost	10%	6% improvement from 2013/14 baseline	10%
Urgent & Emergency Care	30%	Avoidable emergency admissions composite measure of:	10%

		Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in children; Emergency admissions for acute conditions that should not usually require hospital admission (adults); Emergency admissions for children with lower respiratory tract infection	
		Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays	20%
Mental Health	30%	Reduction in the number of patients attending an A&E department for a mental health related needs who wait more than 4 hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.	30%
Improving antibiotic prescribing in primary and secondary care	10%	Composite measure comprising of three parts: Part a) reduction in the number of antibiotics prescribed in primary care; Part b) reduction in	

		the proportion of broad spectrum antibiotics prescribed in primary care Part C) secondary care providers validating their total antibiotic prescription data.	

There was further discussion in relation to the two local outcome measures, a shortlist was reviewed by the Executive as a result of which the proposed measures are outlined in the table below.

Area	% of Total Quality Premium	Proposed Measure
Two Local Measures	20% (10% each)	Increase in the proportion of patients who have an emergency health care plan coded in EMIS practice systems. The baseline is 0.12%. The proposed increase is 0.25% which is equivalent to approximately 352 additional care plans.
		Increase in direct referrals to the new Sunderland Intermediate MSK service, from 40% to 50%.

4. Recommendations

The Health & Wellbeing Board is now asked to:

- Note the Quality Premium requirements for 2015/16;
- Approve the proposed measures which the CCG will be assessed against in 2015/16.

Author: Lynsey Caizley
Planning and PMO Manager

Sponsoring Director: Debbie Burnicle
Deputy Chief Officer

Date: 6th May 2015

Item No. 11

SUNDERLAND HEALTH AND WELLBEING BOARD 29 MAY 2015

HEALTH AND WELLBEING BOARD FORWARD PLAN AND BOARD TIMETABLE

Report of the Head of Strategy, Policy and Performance Management

1. PURPOSE OF THE REPORT

To inform the Board agenda forward plan.

2. FORWARD PLAN

Health and Wellbeing Board Agenda - Forward Plan 2015 – 16		
	Friday 24th July 2015	Friday 18th September
Standing Items	• Update from Advisory Groups • Closed Board Session Briefing • Health and Social Care Integration Board	• Update from Advisory Groups • Closed Board Session Briefing • Health and Social Care Integration Board
Joint Working	• DPH Annual Report – Healthy City – Healthy Economy • HWBB Peer Review Follow up	• Integrated Impact Assessment – HIA of the Core Strategy (NC/VT)
External Links	• Health Protection Arrangements (GG)	• Update on behaviour change pilots

3. BOARD TIMETABLE

The Board timetable is attached for information.

The dates for future Board meetings are:

- Friday 29 May 2015
- Friday 24 July 2015
- Friday 18 September 2015
- Friday 20 November 2015
- Friday 15 January 2016
- Friday 11 March 2016

4. RECOMMENDATIONS

The Board is recommended to

- Suggest topics for in depth closed/partnership sessions for 2015
- note the forward plan and suggest any additional topics

SUNDERLAND HEALTH AND WELLBEING BOARD SCHEDULE 2015/16

Notification of Agenda items	Adults Partnership Board	Children's Trust	Provider Forum	Integration Board	Deadline For Board Papers (to KG)	Chairs Briefing	Publication Date	Members briefing	HWBB Meeting Date
20 April (Mon)	5 May 2015	Tbc	20th April (broader partner session)	Thursday 9 April 2015 Thursday 14 May 2015	18 May (Mon)	21 May	21 May (Thursday)	22 May (Friday)	Friday 29 May 2015
15 June (Mon)	7 July 2015	Tbc	Wc 29 June	Thursday 25 June 2015 Thursday 23 July 2015	13 July (Mon)	14 July	16 July (Thursday)	17 July (Friday)	Friday 24 July 2015
10 August (Mon)	8 September 2015	Tbc	Wc 24 Aug.	Thursday 10 September 2015	7 September (Mon)	9 Sept	10 September (Thursday)	11 September (Friday)	Friday 18 September 2015
12 October (Mon)	10 November 2015	Tbc	Wc 26 Oct.	Thursday 15 October 2015 Thursday 12 Nov 2015	9 November (Mon)	10 Nov	12 November (Thursday)	13 November (Friday)	Friday 20 November 2015
7 Dec (Mon)	5 January 2016	Tbc	Wc 14 Dec	Thursday 10 December 2015 Thursday 7 January 2016	4 January (Mon)	7 Jan	7 January (Thursday)	8 January (Friday)	Friday 15 January 2016
1 February (Mon)	1 March 2016	Tbc	Wc 15 Feb.	Thursday 4 February 2016 Thursday 3 March 2016	29 Feb (Mon)	1 March	3 March (Thursday)	4 March (Friday)	Friday 11 March 2016