At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE on WEDNESDAY, 22ND FEBRUARY, 2012 at 5.30 p.m.

Present:-

Councillor Walker in the Chair

Councillors Fletcher, Francis, Hall, Maddison, Padgett, Shattock, Snowdon and Waller, together with Ms. V. Brown, Ms. Inglesby and Mr. R. Price.

Also in Attendance:-

Ms. K. Brown	-	Sunderland City Council
Mr. B. Craddock	-	Member of the Public
Ms. N. Crawford	-	Sunderland Teaching Primary Care Trust
Ms. K. Graham	-	Sunderland City Council
Ms. C. Harries	-	City Hospitals Sunderland NHS Foundation Trust
Dr. G. McBride	-	Sunderland Clinical Commissioning Group
Mr. D. Noon	-	Sunderland City Council
Ms. S. Reed	-	Sunderland City Council
Councillor R.D. Tate	-	Chairman of Management Scrutiny Committee - Sunderland City Council
Ms. H. Wardropper	-	Sunderland City Council
Ms. J. Whitehouse	-	NHS South of Tyne and Wear

Welcome and Introductions

The Chairman welcomed everyone to the meeting and invited them to introduce themselves.

Apologies for Absence

Apologies for absence were submitted to the meeting on behalf of Councillors F. Miller and N. Wright, together with Dr. J. Dean, Ms. S. Cummings and Mr. R. Patton.

Minutes of the Last Meeting of the Committee held on 11th January, 2012

1. RESOLVED that the minutes of the last meeting of the Committee held on 11th January, 2012 be confirmed and signed as a correct record.

Declarations of Interest

There were no declarations of interest made.

Development of a Sunderland Health and Wellbeing Strategy

The Head of Strategy, Policy and Performance Management submitted a report (copy circulated) which informed the Committee of the process and timetable for the development of the Health and Wellbeing Strategy.

(For copy report – see original minutes).

Karen Graham, Assistant Policy Lead for Health presented the report. Members were informed that the Health and Social Care Bill gave the Local Authority the responsibility for 5 key areas of development –

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

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

Ms. Graham advised Members that a working group had been established to oversee the drafting and editing of the Strategy and that upon completion of the full draft, a copy would be submitted to the Committee for comment.

Councillor Shattock expressed concern as to whether the Health and Well Being Board had any real powers to ensure the Commissioning Consortia implemented the Strategy. Ms. Graham replied that the Board did have powers but it still only existed in a shadow form. Nonnie Crawford advised that the Bill still needed to be enacted but it had the potential to provide additional regulatory powers for the Health and Well Being Board. The Health and Well Being Board would look to the Clinical Commissioning Group to align as it was in the best interests of both to work together to improve the health of the people of Sunderland.

Dr. McBride confirmed that close links already existed with the Local Authority. Joint Development meetings had been held with the Executive Director of Health, Housing and Adult Services to ensure the formal and informal links were in place.

In response to an enquiry from the Chairman regarding the main challenges to be faced in delivering priorities, Ms. Crawford advised that there were a number. There were currently finite resources in the system and there would be finite resources going forward. Acute services needed to be commissioned via hospitals with GPs providing primary services. There was a real need to address obesity and alcohol abuse and to identify planned need as well as addressing urgent issues. In addition Dr. McBride advised that the Clinical Commissioning Group would commission only a very small amount of GP services, the majority of which would be commissioned by the National Board.

In response to an enquiry from Councillor Francis regarding checks to ensure funding was being spent rather than hoarded away, Dr. McBride advised that under statute, the Responsible Financial Officer would only be permitted a £1m carry over at the end of each year.

Carol Harries added that City Hospitals Sunderland had independent regulators who monitored the Trust on a monthly basis. Robust monthly contract discussions were held regarding the quantity and quality of service delivery.

The Chairman having thanked Ms. Graham for her report, it was:-

2. RESOLVED that the report be received and noted.

Sunderland Clinical Commissioning Group Commissioning Plan 2012-2017

The Head of Commissioning Development NHS South of Tyne and Wear submitted a report (copy circulated) which appended the draft version of the Sunderland Clinical Commissioning Group's (SCCG) Clear and Credible Plan 2012-2017 for the Committee's consideration and comment.

(For copy report – see original minutes).

To complement the report, Dr. Gerry McBride provided Members with a comprehensive powerpoint presentation which highlighted the following:-

- the SCCG was formed in March 2011, was made up of 54 GP practices in Sunderland who had elected 6 GPs to form an Executive Committee and appointed a practice manager;

- the CCG was established in response to the Governance changes to the commissioning of health care. CCG's would be responsible for commissioning the majority of services alongside the Local Authority and the National Commissioning Board;

- the CCG's vision and core values;

- the main challenges to be faced i.e.

    - Excess Cancer and CVD deaths
    - Fragmented healthcare
    - Health Inequalities
    - Over Reliance on Hospital Care
    - Growing elderly population
    - Financial constraints

- success so far, e.g. the single point of access to urgent care teams;

- the 'Plan on a Page' guide to the future provision of Health and Social Care in Sunderland; and

- how the CCG will engage with the public.

Mr. McBride then addressed questions and comments from Members in relation to:-

- whether the CCG had the capacity and skills sets necessary to undertake the duties it was being asked to perform;

- the status of the Joint Strategic Needs Assessment;

- the need for a truly federated approach to avoid a postcode lottery;

- concern that there was an over emphasis on choice. Patients just wanted their GP to advise on the best treatment available.

The Chairman having thanked Mr. McBride for his presentation it was:-

3. RESOLVED that:-

    (i) the report be received and noted; and

    (ii) a summary of the ISOP and the planned changes for 2012/13 be submitted to the Committee at its first meeting of the new financial year.

Public Health Transition

The Director of Public Health and Assistant Chief Executive submitted a report (copy circulated) which provided an update on recent publications by the Department of Health in relation to health reform and the implications for the transition of public health in Sunderland together with details of the draft transition planning.

(For copy report – see original minutes).

In addition the report also introduced a complementary powerpoint presentation from Nonnie Crawford, the Director of Public Health which highlighted:-

- the 5 themes emanating from the White Paper 'Equality and Excellence Liberating the NHS namely:-

    - Strengthening Commissioning of NHS Services
    - Increase Democratic Accountability and Public Voice
    - Liberate provision of NHS Services
    - Strengthening Public Health Services
    - Reforming Health and Care Arms-length bodies

- Local Government's New Functions under its duty to Improve the Health of the Population:-

    - Commissioning responsibility
    - Working with Clinical Commissioning Groups to integrate care pathways
    - Using Health and Wellbeing Board to integrate commissioning approaches
    - Providing population healthcare advice to the NHS
    - Duty to ensure plans are in place to protect health

- the implications of the reforms i.e:-

    - 'System leadership' for health and care would be shared across Local Authorities, and Health.

    - Local Authorities would commission Local HealthWatch as the independent consumer champion for health and social care.

    - New relationships would need to be forged with the NHS Commissioners – Clinical Commissioning Groups and the National Commissioning Board.

    - Balancing act between various spatial levels of provision and commissioning.

- the mandatory and non mandatory commissioning requirements and services.

- the Local Authority Transition Planning Process and the Budget allocations available.

Ms. Crawford and Sarah Reed, Assistant Chief Executive then addressed questions and comments from Members in respect of:-

- timescales regarding staffing and TUPE transfers.

- publicity and consultation on the changes.

- the review of existing public health contracts.

- the view that alcohol and drugs should be included in the list of mandatory rather than non mandatory requirements.

- the position of the North East Council for Addiction within the proposals.

The Chairman having thanked, Ms. Crawford and Ms. Reed for their report and presentation, it was:-

4. RESOLVED that the progress on the transition of Public Health in Sunderland be noted and that it be recommended that Alcohol and Drugs should be included in the list of mandatory commissioning requirements and services.

Annual Work Programme 2011-12

The Chief Executive submitted a report (copy circulated) appending an updated copy of the Committee's work programme for Members' information.

(For copy report – see original minutes).

Helen Wardropper, Scrutiny and Area Support Officer, having briefed the Committee on the current position regarding activities which had taken place since the last meeting and provided a reminder as to the extraordinary meeting to be held on Wednesday, 14th March, it was:-

5. RESOLVED that the contents of the report be received and noted.

Forward Plan – Key Decisions for the Period 1st February, 2012 to 31st May, 2012

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider the Executive's Forward Plan for the period 1st February, 2012 to 31st May, 2012.

(For copy report – see original minutes).

Helen Wardropper, Scrutiny and Area Support Officer, having presented the report, it was:-

6. RESOLVED that the contents of the report be received and noted.

The Chairman then closed the meeting, having thanked Members and Officers for their attendance and contribution to the meeting.

(Signed) P. WALKER,
Chairman.

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 4th April 2012

Sunderland PCT and Clinical Commissioning Group Commissioning Intentions for 2012/13

REPORT OF SUNDERLAND PCT AND SCCG

1. Purpose of Report

1.1 The purpose of the report is to highlight the potential changes to services in 2012/13 so that the Committee can seek further information on any plans that they may represent a substantial changes/variation and request more information. This may involve a report; a PCT or CCG member in attendance at a future meeting or written information circulated to members.

2. Background

1.1 Each year the PCT signals to its Providers any changes it may want to make to current commissioned services. This may result in commissioning new services or decommissioning a current service. Providers receive the intentions in advance of the year in which the changes may take place so that they can make any necessary preparations. The Document outlining the intentions is attached.

3. Current Situation

3.1 With the establishment of shadow Clinical Commissioning Groups (CCGs), Sunderland CCG has been actively involved in the development of the intentions for 2012/13. They are clear about the service areas that will be their responsibility from April 2013 as set out in appendix 2 of the document attached. The CCG is now much more aware of the purpose of the intentions and the areas covered following a number of development sessions. They have also identified a number of particular intentions where they want to actively lead the developments over their shadow year.

3.2 There are a number of intentions which from April 2013 will move to other bodies e.g. the Local Authority (Public Health related intentions) and the National Commissioning Board. These are indicated in Appendix 2 to the attached document.

4. Conclusion & Recommendations

4.1 The Committee is recommended to note the PCT/CCG Commissioning Intentions for 2012/13 and consider where they might want further information on any particular intention.

5. Background Papers

5.1 Sunderland PCT and CCG Commissioning Intentions 2012/13 attached

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NHS South of Tyne and Wear

serving Gateshead Primary Care Trust, South Tyneside Primary Care Trust and Sunderland Teaching Primary Care Trust

SUNDERLAND CLINICAL COMMISSIONING GROUP and PCT

2012/13 Commissioning Intentions

January 2012

Sunderland Clinical Commissioning Group

2012/13 Commissioning Intentions

1. Introduction

This document sets out Commissioning Intentions for Sunderland for 2012/13. The Sunderland Clinical Commissioning Group (CCG) has played a leading role in developing these intentions, but the continuing statutory responsibilities of the PCT and the need to provide a comprehensive assessment of commissioning plans across the broad range of services means that the document also outlines plans for those services expected to transfer to other commissioning organisations from April 2013, including a range of Public Health initiatives.

The Commissioning Intentions for Sunderland have been developed to deliver the longer term strategic objectives described in the Sunderland Integrated Strategic and Operational Plan (ISOP) and those emerging from the developing Clear and Credible Plans (CCP) of the CCG, but focus in particular on investment and disinvestment priorities we intend to progress in 2012/13.

The document makes reference to the following key issues:

Sunderland Integrated Strategic and Operational Plan
Sunderland Clinical Commissioning (SCCG) Group Pathfinder priorities
SCCG Clear and Credible Plan
Resource releasing/QIPP programme initiatives
National priorities/local contracting issues
National tariff and planned activity
Investing in quality

The 2012/13 Commissioning Intentions outline our plans in relation to acute, primary care, mental health/learning disabilities and community based contracts and set the scene for the 2012/13 contract discussions. The document describes the SCCG and PCTs' approach to a variety of issues which will impact on 2012/13 contracts with local providers.

This document is intended to reinforce and update, where necessary, on the Commissioning Intentions document which was published in October 2011 and does not therefore signal a material departure from the plans that have previously been shared with providers. This document will support the agreement of 2012/13 contracts by 15th March 2012.

Appendix 1 provides an analysis of the 2012/13 Resource Releasing Initiatives (RRIs) for Sunderland TPCT and appendix 2 provides the detail of the initiatives the CCG and PCT will be implementing in 2012/13. Work has already commenced on a number of these initiatives which were identified in last year's Commissioning Intentions document.

2. Sunderland Clinical Commissioning Group (SSCG)

SCCG is made up of 54 constituent practices led by an Executive Committee of 6 GPs elected by their peers. The CCG is a pathfinder testing the arrangements for clinically led commissioning over the next 12 months. The Pathfinder Sub Committee of the PCT (with both executive, non executive and SCCG membership) is the committee that assures the PCT statutory board during transition and has given delegated responsibility for commissioning to the CCG.

In terms of interim delegation of responsibility for the overall commissioning budget until the CCG becomes a statutory body, a timetable has been agreed with the PCT. The total budget amount excludes the current PCT budget on areas such as primary care, specialised services and public health which will transfer to other bodies. A high level overview has been agreed of the programme and service areas which will become the delegated responsibility of the CCG to commission and the suggested timetable for that transfer of delegated responsibility. Day to day responsibility for service areas will be agreed with indicative amounts over time and this will increase in percentage terms until 100% is transferred by April 2012. This has been aligned with the PCT's scheme of delegation and standing orders.

The CCG has taken a lead role in developing the intentions for 2012/13, supported by the PCT management team particularly over the transition period to authorisation as a statutory body in 2013

The commissioning intentions reflect the SCCG Pathfinder priorities. These areas are where the CCG is currently taking a leadership role and responsibility and these align to the local Quality, Innovation, Productivity and Prevention (QIPP) agenda for improving use of resources and are supported by Practice engagement:

- **Improving the whole system Urgent Care response**
- **Improving the quality of care for people with chronic obstructive pulmonary disease (COPD) across the whole system as a key step to taking on more responsibility for patients with a range of long term conditions**
- **Improving the quality and reducing the cost of prescribing**
- **Addressing clinical effectiveness in primary care**

This focus follows work with the Health Inequalities National Support team and the Director of Public Health to identify the factors contributing to the significant life expectancy gap in Sunderland and the worsening position for men in particular. Over 60% of the gap is as a result of cardio-vascular disease, cancer and respiratory diseases. Eight high impact interventions have been agreed and the CCG is leading on four of these.

- Consistent use of beta blockers, aspirin, ACE inhibitor and statins following a circulatory event
- Systematic treatment for COPD
- Cancer awareness and early detection
- Identification and management of atrial fibrillation

The initial focus is on delivery of the 4 areas above as these are priority health requirements for the people of Sunderland and achievable within the pathfinder timeframe.

However, the CCG is increasingly taking a lead role with the commissioning of local health priorities out with the pathfinder but part of the Sunderland Integrated Strategic and Operational Plan (ISOP) and the CCG Clear and Credible Plan. This leadership is subject to capacity issues (both clinical and managerial) and the level or impact of the proposal currently and in the future e.g. where a decision taken now by the PCT may impact on the CCG when it becomes a statutory body. This leadership will increase over 2011/12 as the CCG develops as an organisation and agrees the level of commissioning support from the PCT. The CCG is now clear about those intentions where it will take the lead for ensuring progress in 2012/13 as these will contribute to its track record required for authorisation. However, the CCG equally recognises the need to influence and support the remaining intentions.

As part of the transition, the CCG expects to be authorisation ready by October 2012 and authorised to take on statutory responsibility for commissioning no later than March 2013.

3. Sunderland Integrated Strategic and Operational Plan (ISOP) and the SCCG Clear and Credible Plan

The Sunderland ISOP, refreshed in April 2011, just as SCCG were forming, sets out how the PCT will change the shape of health services across Sunderland over the next three years with the support of the CCG, and shift the balance from treating illness to helping and supporting individuals to live longer and healthier lives.

The CCG embraces the intention behind the current NHS South of Tyne and Wear vision for the future as it applies to Sunderland - to work together to **make South of Tyne and Wear healthy for all** which is under pinned by the following key aspirations:

- **Better health** to live longer, with better quality of life and fair access to services;
- **Excellent patient experience** ensuring safe care, effective treatment and quality services;
- **Wise use of your money** with the right services at the right place and time, reducing waste and ensuring value for money.

Underpinning this vision, is the need to change the shape of services away from an emphasis on treating ill health to one of enabling and supporting individuals to live healthier lifestyles and adopt positive behaviors, supported by an integrated tiered healthcare system.

In order to achieve this “future state”, the focus of the strategy is on prevention, secondary prevention and long term conditions. Care will be delivered closer to the patient’s home through the commissioning of new services supported by integrated

pathways together with the radical reform of current provision aimed at eliminating waste and moving care out of hospitals.

SCCG has developed its own draft Clear and Credible Plan for the next 5 years which will be aligned with the ISOP and has set out the following draft Vision:

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

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

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

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

The CCG is working with the PCT, local providers, the Local Authority and patients to ensure that the vision is delivered via a whole system approach. They will work within the ISOP framework and also the Joint Strategic Needs Assessment and are committed to delivering collaboratively on the local QIPP agenda to which CCG plans are aligned.

The PCT has identified seven areas (strategic objectives) in which major change is needed in order to move towards the vision of the future and the thirteen programmes of initiatives to be undertaken:

Prevention	Reducing CVD and cancer deaths	• Obesity • Smoking • Alcohol
	Ensuring all children have the best start in life	• Child Health • Maternity
Long term conditions	Identifying people with long term illnesses & risk factors then providing appropriate, high quality care and preventative treatment	• CVD risk • Cancer • Long term conditions & Rehabilitation
Safer, better quality services, delivered closer to home with no duplication or	Streamlining high quality urgent care for adults and children	• Sick & Injured children • Urgent care
	Providing more, high quality planned care closer to home	• Planned care
	Changing the way mental health services are provided	• Mental Health

	Providing those at the end of life with a good death	• End of Life Care

The CCG has initially identified a number of areas (strategic objectives) in which major change is needed in order to move towards its vision of the future. The commissioning intentions led by the CCG are examples of initiatives that will be progressed however further work is taking place on the key programmes (with linked initiatives) required to deliver the objectives:

- Play an active role in the delivery of the **Health** and **Wellbeing Strategy**
- Every practice to optimise **screening** and **early identification** opportunities
- Integrated tiered approach to **Mental Health** across the whole healthcare system
- Integrated **urgent care** response, easily accessible at the appropriate level
- Improve quality of care for **long term conditions** across the whole system
- Provide more **planned care** closer to home
- Every practice to systematically improve the quality of **prescribing** adhering to evidence based guidelines
- Every practice operating to agreed **standards** and pathways – working collaboratively with partners

The PCT will publish a refreshed ISOP in early 2012 and the CCG will publish a draft CCP which will outline the key initiatives to be undertaken in 2012/13 building upon progress achieved in 2011/12. The initiatives outline the activities to be undertaken in delivering strategic objectives including the full QIPP programme, in all sectors of healthcare provision including primary care, community, mental health and acute.

The plans will also address the specific actions required to address the national requirements as outlined in the forthcoming 2012/13 Operating Framework.

4. Resource releasing initiatives (RRIs)

2012/13 will be the third year of our programme of Resource Releasing Initiatives (RRIs). Last year the Operating Framework increased the time period over which the total programme of financial savings must be realised so schemes were re-phased to recognise this additional year; RRI schemes run until 2014/15.

Tariff efficiencies continue into 2012/13 from 2011/12 which has allowed us to focus on those schemes which are of the most strategic importance, which are most easily delivered and which provide the greatest savings which significantly reduces the risks to delivery of savings.

Appendix 1 details a breakdown of the level of savings for each RRI for each of the following three years, split by PCT.

Detailed activity and financial breakdowns for each RRI are included in the planned activity and financial profiles which are being issued in tandem with this document.

5. Delivery of National Priorities

The 2012/13 Operating Framework was published in December 2011. The framework details a number of key areas that require particular attention during 2012/13 to provide the bedrock for a health service driven by patients and clinicians:

- Dementia and care of older people
- Carers
- Military & veterans' health
- Health Visitors and Family Nurse Partnerships
- An outcomes approach

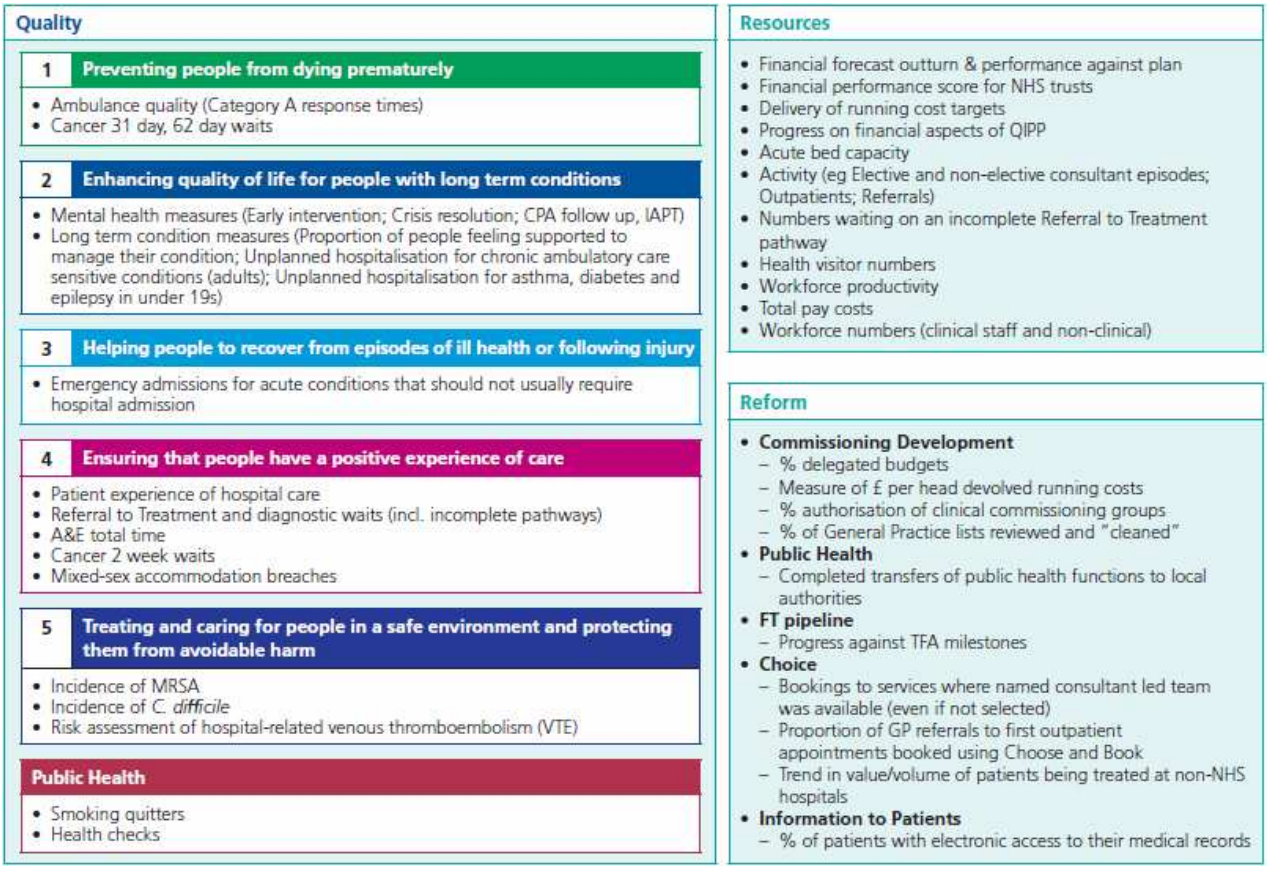
The National Operating Framework emphasises that the experience of patients, service users and their carers should drive everything the NHS has to do. National measures have been set out and can be grouped into 3 categories:

- Quality – those indicators of safety, effectiveness and patient experience that provide an indication that standards are being maintained or improved;
- Resources – those indicators of finance, capacity, and activity that demonstrate the robustness of organisations; and
- Reform – indicators that demonstrate commissioner and provider reform, with more information and choice provided to patients.

Within these categories there are 5 domains:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Detailed below are the key performance measures which will be subject to national assessment in 2012/13:



The key priority of ensuring the services we commission are of the highest quality will be addressed through further development of the CQUIN scheme and via the continued development of the infrastructure to support quality improvement with our providers as outlined later in this paper.

6. Workforce Assurance:

A key requirement of the NHS Operating Framework 2012/13 is that each PCT seeks assurance from the providers it commissions services from, that they have a safe and affordable workforce in place. As part of this, the PCT will seek assurance around the 9 workforce key lines of enquiry, to assure ourselves in relation to the following areas:

- Has the plan been developed using good data/intelligence and with clinical engagement?
- Is it safe, affordable and integrated?
- Is there a robust process in place to monitor progress against plan?

In addition to the assurance of plans, the PCT is required to submit workforce forecasts for 2012/13 and narrative describing the process. In constructing the

workforce forecasts for 2012/13 the PCT seek provider cooperation in determining and signing off an appropriate forecast.

7. National tariff and planned activity profiles

Where relevant, detailed financial and activity schedules outlining the impact of commissioning intentions and reflecting modelled activity requirements will be issued in association with this document. Proposed activity volumes will be costed using the draft PbR tariff. The basis on which activity assumbtion have been modelled will be shared with the providers for discussion and agreement as aprt of the contract negotiations.

NHS SoTW will work with providers to effectivley manage the impact of revised tariff arrangements and explore potential to adopt tariff flexibilities.

8. Any Qualified Provider

Plans to implement the AQP initiative are in progress in accordance with the national timeframe which requires PCOs to have commissioned a minimum of three services on this basis with effect from October 2012. Adult hearing aid in the community, podiatry and anticoagulation services are to be commissioned on an AQP basis by NHS SoTW.

Providers will be kept informed of the implications this may have on existing contract agreements as the implementation process develops.

9. Investing in quality

National context

'Equity and Excellence: Liberating the NHS' (July 2010) placed a significant emphasis on developing and implementing quality standards to improve healthcare outcomes for patients. As the architecture of the new NHS develops the mechanisms to do this are evolving. The NHS Commissioning Board (NHSCB) will have a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of health services. Securing improvement in outcomes, as defined by the *NHS Outcomes Framework* will be particularly important as the Board will be held to account using this framework.

It is anticipated that the NHSCB will use Quality Standards developed by NICE to drive its commissioning processes. NICE Quality Standards – and accredited evidence produced by other groups such as the Royal Colleges – will underpin the *Commissioning Outcomes Framework*, through which clinical commissioning groups will be held to account. Quality Standards are intended to be the backbone of the commissioning system, supporting consistent improvement in all parts of the country.

It seems clear from the emerging national picture that the NHS Outcomes Framework underpinned by NICE Quality Standards will increasingly influence the focus of attention within quality improvement work going forward. It is important therefore whilst the statutory duty of quality lies with PCTs that in 2012/13 our quality

review mechanisms take these into account. Existing quality schedules and Commissioning for Quality and Innovation (CQUIN) schemes align well with the NHS Outcomes Framework and this alignment will be more explicit in 2012/13.

The Operating Framework for NHS England 2012/13, as in previous years, outlines requirements linked to quality and these will also need to be taken into account.

During this transition period SoTW will maintain a focus on quality assurance and improvement during 2012/13 using existing quality mechanisms linked to contractual process for instance quality review meetings, monitoring against quality schedules and CQUIN schemes in addition to safety systems such as serious incident reporting.

Local priorities for quality assurance or improvement
The process of identifying priorities for quality assurance and improvement has begun and it is anticipated that these will be agreed in January by relevant groups.

Patient safety

- Strengthening of Serious Untoward Incidents (SUIs) processes and development of consistent reporting
- Infection control
- Safeguarding
- Reducing hospital mortality (Including reducing deaths from Venous Thromboembolism (VTE))
- Reducing harm from pressure ulcers
- Discharge communication

Clinical effectiveness

- NICE guidance compliance
- NICE quality standards, particularly stroke, heart failure, dementia, chronic obstructive pulmonary disease and VTE prevention
- Specific clinical areas linked to PCT strategic priorities

Providers will be asked to share and discuss their clinical audit programme for 2012/13 through the relevant quality review group by end of April 2012.

Patient experience

- Collection and review of patient experience information and completion of related actions
- Patient reported outcome measures (PROMS)
- Delivering single sex accommodation
- Continued development of a programme of PCT non-executive director visits to provider organisations focused on patient experience.

Providers will be asked to share and discuss their patient experience programme for 2012/13 through the relevant quality review group by end of April 2012.

Commissioning for Quality and Innovation (CQUIN) 2012/13
Where an NHS Standard Contract is in place, 2.5% of the contract's outturn value will be awarded to the provider for the achievement of CQUIN goals. This is a significant increase from 1.5% in 2011/12. The Operating Framework for NHS England 2012/13 includes the CQUIN arrangements:

- Nationally mandated goals on VTE risk assessment and on responsiveness to personal needs of patients will continue to be in place.
- New national goals in relation to improving diagnosis of dementia in hospitals and use of the NHS Safety Thermometer have been added.
- National goals must continue to be linked to around one fifth of the value of the CQUIN scheme unless commissioners decide there is negligible room for improvement.
- Commissioners and providers should have due regard to the NHS Chief Executive's Innovation Review when developing local CQUIN schemes for 2012/13, as this will be used as a pre-qualification criteria for CQUIN in 2013/14.

North East PCOs have worked together, and in conjunction with the SHA, on a timetable for the 2012/13 commissioning round; the CQUIN timetable has been agreed as part of this wider commissioning timetable referred to below.

A range of stakeholders including Clinical Innovation Teams, the North East Quality Observatory, providers and commissioners are currently involved in the development of suggested measures for CQUIN schemes. Proposals for CQUIN indicators should have a clear rationale, existing data flow where possible and sufficient baseline data to adequately inform goal setting prior to contract agreement.

It is expected that draft CQUIN schemes will be reviewed/agreed by the Quality, Patient Safety and Clinical Governance Committee and Clinical Commissioning Groups in January.

10. Timetable

The Interim Commissioning Intentions included a contract timetable outlining key milestones to be achieved as part of the contract agreement process. Nationally there is an expectation that the contracts will be agreed by Thursday 15th March. Locally NHS SoTW intends to work with providers to reach agreement and formally sign off contracts by Friday 9th March. It should be noted that this will be dependent on the publication of the final tariff which is expected mid February.

Appendix 3 identifies the process and timeframes adopted by the CCG for the 2012/13 planning round.

11. Local contracting issues

The following contract issues will be addressed with the providers by NHS SoTW as part of the contract negotiation process:

Contract documentation: Where appropriate, the revised standard contract will be adopted and where existing contracts extend beyond the one year term, discussions will take place regarding the potential, by mutual agreement, to adopt the revised standard contract. Altrernatuively it is the xpectation of NHS SoTW that the DoH standard deed of variation will be adopted. In particular, a joint programme of work will be agreed as part of the Service Development and improvement plan to develop service specifications for services delivered under the contract.

Local Tariffs: Where appropriate, local tariffs will continue to be reviewed with a view to identifying areas of potential efficiency. The emphasis will be on identifying opportunities for reduced expenditure which allow providers to release costs. Tariff efficiencies outlined in PbR Guidance may be applied to non tariff services.

Block Contracts: Where relevant, review of remaining block contracts will be undertaken in accordance with the ongoing contract management arrangements.

Coding and Counting Changes: Where counting and coding changes are agreed during the negotiation process a commissioner based risk assessment will be required from providers prior to entering into any discussions regarding implementation. In addition, commissioners expect that any such coding changes will be under pinned by an appropriate in year risk share arrangement to protect both providers and commissioners from unanticipated financial risk.

High Cost and Excluded Drugs: Commissioners will continue to work with providers to more accurately predict the level of expected spend in order to agree realistic baselines within contracts. Commissioners expect that providers will supply patient level details related to all high cost and excluded drugs, linked to condition.

Never events: In line with the 2011/12 Operating Framework, and as outlined in the revised standard contract, the commissioner will not fund those spells identified as “never events”.

Contract Management: In line with the revised standard contract, NHS SoTW expects to agree indicative contract acrivity plans which will be affordable, deliverable and which will ensure key performance targets are achieved. It is expected that the activity plans will be based on clear activity planning assumptions which will form part of the contract agreement and which will be reviewed in year in the context of any material variance from planned levels. In accordance with the requirements of the standard contract, NHS SoTW expects that contract queries raised through the contract review mechanism will be resolved in a timely manner.

Trauma networks: Commissioners will work in conjunction with local providers to implement the trauma network arrangements in accordance with the implementation timetable.

Specialised commissioning: Work will be undertaken with the North East Specialised Commissioning Group, in conjunction with providers, to effectively map out the activity and financial implications on individual contracts arising from the introduction of revised specialised commissioning definitions, the intention being to reduce the level of financial risk to both commissioners and providers.

NEAS: Commissioners will continue to actively contribute and support the lead commissioner of ambulance services, particularly in the development of PbR related tariffs in line with national currencies which will be implemented in April 2012. The commissioner expects that, following specific discussions with the provider, where it is clinically safe to do so, there will be a significant increase in the number of patients transported to MIUs as an alternative to A&E.

Community services and joint commissioning: Where appropriate, community based contracts will be reviewed to continue the process of ensuring high quality cost effective services which meet the needs of the local population.

Commissioners, in conjunction with CCG leads, intend to progress a number of procurements as outlined in the appendix to this document.

We will continue to work with local authorities and other local government services to deliver statutory requirements and identify opportunities to work better together to improve peoples health and well being and achieve more efficient and integrated delivery of services: developing and delivering joint commissioning arrangements for locally agreed health and care services as appropriate; pooled budgets, lead commissioner arrangements and / or commissioning of integrated health and care services.

We will review and develop the statutory NHS Continuing Health Care function; mental health and learning disability out-area-placements; and statutory s.117 (MHAct 1983) aftercare arrangements.

Mental health contracting: 2012-13 is the introductory year for what is a major change in the way that mental health care is currently funded, a shift from block grants to PbR currencies which are associated with individual service users and their interactions with mental health services. Commissioners will work constructively with providers to ensure a smooth transition to this new Care Packages and Pathways Programme (CPPP) system throughout 2012/13.

Contract penalties: In addition to the standard penalties outlined in the legally binding contract, NHS SoTW expects to re-negoiate the existing locally agreed penalties with a focus on agreeing a small number of penalties focussed on encouraging service improvements. The principles governing the application of the contract penalties which are reflected in current contract agreements are expected to continue to apply.

The rationale supporting the introduction of the penalty schedule remains the need to support the delivery of continued national and local targets and which enhance patient experience and good system management.

Consultant to Consultant Referral Policy: The CCG, in conjunction with the PCT and provider colleagues, plans to revise the existing Consultant to Consultant referral policy.

Public Health: Further guidance and specific detail of both the ring fenced public health budget allocations and further guidance on the Public Health Services which Local Authorities become responsible for commissioning in April 2013 is still emerging. It is unclear how similar the ring fenced allocation will be to the current PH spends across the three PCTs in SoTW.

Services are currently commissioned across a range of providers in the NHS, Local Authorities, the Independent, Private and Voluntary Sectors with a wide range of notice periods, from three to twelve months. In these circumstances it is possible that there may be a reduction in available funding and based on Joint Strategic Needs Assessments and Health and Wellbeing Board discussions and decision making during 2011/12 and 2012/13, it is highly likely each PCT and Local Authority may need to make alterations to current commissioning arrangements. These will be dependent on individual local authority's financial circumstances and associated decision making and might require the formal giving of notice on all Public Health contracts but further detail is not available and discussions cannot commence until the DoH issue the shadow budget allocations for 2013/14 and associated guidance.

Primary Care: Contract management arrangements for Directed and Local Enhanced Services are being agreed between the PCTs and the North East Primary Care Services Agency. From April 2012, there will be a transfer of commissioning responsibilities for the local enhanced services to PCTs as an interim arrangement pending DoH confirmation of commissioning responsibilities for these services in the future.

The North East Primary Care Services Agency will coordinate the re-procurement of APMS GP practice contracts where these are due to come to an end. In 2012/13, the NEPCSA, on behalf of NHS SoTW, will complete service reviews on the Barmston and Encompass 1 GP practices and make recommendations to Sunderland Teaching PCT on future service provision. Service reviews will start on the four GP practices transferred to STFT. This process will enable commissioners to determine the best way of meeting the needs of the patients when the current agreements come to an end. There will be a similar process for the Blaydon MIU and GP practice timed for the end of that contract in 2014. The Blaydon service review will have two components as the MIU service will be reviewed by GP Commissioners and the GP service by the NEPCSA in line with Barbara Hakin's guidance.

Network commissioning issues: The focus of this document is on commissioning intentions related to services directly commissioned by the CCG and PCT. Services which are jointly commissioned or which are commissioned on a network basis, for

example, specialised commissioning and the North East Cancer and CVD Networks will be addressed through the established routes.

Health equity: The CCG and PCT expect all providers to actively engage in initiatives at both PCT and locality level which are aimed at establishing fair access to services and in particular demonstrate, in conjunction with the commissioner, practical changes to service delivery to improve equity of delivery.

12. Equality, Diversity and Human Rights

SCCG and NHS South of Tyne and Wear are committed to promoting human rights and providing equality of opportunity; not only in our employment practices but also in the way we commission our services. The organisation also values and respects the diversity of our employees and the communities we serve. In applying this policy, the organisation will have due regard for the need to:

Promote human rights
Eliminate unlawful discrimination
Promote equality of opportunity
Provide for good relations between people of diverse groups
Consider providing more favourable treatment for people with disabilities

This policy aims to be accessible to everyone regardless of age, disability (physical, mental health or learning disability), gender (including transgender) race, sexual orientation, religion or belief or any other factor which may result in unfair treatment or inequalities in health or employment.

13. Equality Impact Assessment

Positive Impact – the Commissioning Intentions sets out that there is a duty on the Provider of services to ensure equity of access to their services for people from all groups regardless of race or ethnicity, disability (physical, mental and learning disabilities), gender (including transgender), age, sexual orientation, religion and belief or any other factor which may result in unfair treatment or inequalities in health. It also recognises that there are some services for specific groups – for example, gender specific breastfeeding services. It is anticipated that the Commissioning Intentions will ensure providers deliver a service that promotes equality and has a positive impact on all groups.

The development of the Sunderland ISOP has sought to promote equality, human rights and tackle health inequalities. This has been through carrying out health needs assessments, life-style surveys, publication of the Single Equality Scheme, Health Impact Assessments, Equality Impact Assessments and involving partners, stakeholders and local communities in the design, planning and development of services.

As part of the practical work that is undertaken to develop service specifications for new or changing services as part of our commissioning development work, we will

undertake equality impact assessments to ensure that our services provide equity of opportunity, equity of access and equity of outcomes.

14. Summary

This Commissioning Intentions document is aimed at raising awareness of the initiatives which the CCG supported by the PCT intends to implement during the next contract year, some of which are already in development. As plans are developed and implemented, the impact on individual contracts will be discussed with the providers. Where applicable, the detailed activity and cost schedules which accompany this document identify the activity and financial impact of the 2012/13 resource releasing initiatives.

Appendix 1

SUNDERLAND TPCT

Programme Board	RRI	Year on year target savings £k			
		2012/13	2013/14	2014/15	Total
Children's					
	Reform care of sick & injured child	£0	£0	£0	£0
	Total	£0	£0	£0	£0
Long Term Conditions					
	Reduce emergency admissions (EL Re-admissions)	£480	£0	£0	£480
	Reduce emergency admissions (NEL Re-admissions)	£294	£0	£0	£294
	Reduce emergency admissions	£0	£338	£806	£1,145
	Reduce excess hospital bed days	£442	£442	£442	£1,326
	Total	£1,216	£780	£1,248	£3,244
Urgent Care					
	Reduce emergency admissions (EL Re-admissions)	£1,100	£0	£0	£1,100
	Reduce emergency admissions (NEL Re-admissions)	£320	£0	£0	£320
	Reduce emergency admissions	£0	£367	£874	£1,240
	Total	£1,420	£367	£874	£2,660
Mental Health					
	Reduce price paid for Gateshead FT older peoples mental health service	£0	£0	£0	£0
	Total	£0	£0	£0	£0
Planned Care					
	Reduce outpatient first attendances	£177	£177	£177	£531
	Reduce outpatient review attendances	£239	£239	£0	£478
	Move Carpal tunnel out of hospital	£200	£200	£0	£400
	Reduce nurse led outpatient clinics	£265	£265	£265	£795
	Review ISTC (Spire) contract	£320	£160	£0	£480
	End short term funding to community services for HCAIs	£0	£0	£0	£0
	Research grant funding for cancer drugs, not currently reimbursed	£0	£0	£0	£0
	Total	£1,201	£1,041	£442	£2,684
Primary & Community based services					
	Reduce Primary Care budgets	£500	£0	£0	£500
	Total	£500	£0	£0	£500
Medicine Management					
	Reduce prescribing costs to North East average (Astro PU)	£650	£650	£650	£1,950
	Total	£650	£650	£650	£1,950
Support Functions					
	Reduce PCT management Costs (Including Community Health Services)	£310	£0	£0	£310
	Total	£310	£0	£0	£310
Public Health					
	Public Health	£0	£0	£0	£0
	Total	£0	£0	£0	£0
	Total	**£5,297**	**£2,838**	**£3,214**	**£11,349**

Appendix 2

Sunderland Commissioning Intentions 2012/13

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

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

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

NB: Table updated January 2012

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

	Continue the process of repatriating high cost out of area placements to locally provided services.
	Develop and agree an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service.
	Implement mental health specific actions within the Suicide strategy.
	Specialist / Secondary Care
	Continue to work with NTW to realise efficiencies in relation to QIPP & ensure continued engagement in the delivery of resource releasing initiatives. Use quality initiatives to support service development.
	Work with NTW to support the implementation of the business case for re-provision of in-patient, outpatient & community services regarding new facilities at Ryhope & Monkwearmouth during 2012/13
	Continue implementation of the Mental Health Model of Care § Secondary care re-modelling including liaison and services for veterans § Further development of mental health in primary care (Primary Care Mental Health Service) including a review of access to practice based counselling § Further development of the dementia strategy including anti psychotic prescribing plan (Links with medicines management) § Moving to tariff § Potential move towards AQP for psychological therapies in primary care.
	Contracts / QIPP
	Lead the implementation of CPPP (PbR for mental health) in shadow form across contracts
	Consider existing commissioning arrangements moving to Any Qualified Provider for psychological therapies in Primary Care
Children's Services	Implement the recommendations from the review of Speech, Language and Communications needs. Working in partnership Local Authority and Community provider/ other key partners to ensure the new model of provision is embedded and sustainable.
	Review Children's Community Nurses (CCNs) and palliative care for children in line with requirements set out in Aiming High for Disabled Children.
	Review occupational therapy and physiotherapy services for children and young people and consider future commissioning intentions.

	Review the implications for new national tariff for children's diabetes
Urgent Care	Implement the 111 single point of access for urgent care to signpost patients with an urgent care requirement to the most appropriate service to meet their needs. The contract to provide the 111 service was awarded in November 2011; between November 2011 and September 2012 urgent care services will need to be aligned to the 111 operational model (including GP out of hours) which will include a range of re-procurements where necessary or variation of current contracts.
	Develop an urgent care transport strategy to support the implementation of 111.
	Arrange an annual 'Choose Well' public information campaign to publicise the range of services, points of access, hours of operation and areas of exclusion by targeting focus groups in SoTW in order to help reduce demand for secondary care services.
	Following the evaluation of the current models of minor injury and illness units across SoTW, a standard model of GP integrated working will be implemented across all MIUs. Modelling work will also look at the number of services required, the most appropriate locations and associated commissioning actions. • Houghton MIU options to be agreed • The exploration of an urgent care hub in CHS is underway.
	Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted.
	Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality.
	Review Urgent Care Nursing services across Sunderland to understand the impact to develop a future state.
	Expected impact of the introduction of Trauma Centres and locally the potential re-classification of our local FTs as Trauma Units.
	Develop a community based cellulitis model and service.

	Develop a community based DVT model and service.
Long Term Conditions	**Develop a commissioning model for Long Term Conditions** **Self Care** Implement self care model for LTCs, including reviewing current provision of self management education and support, improving access to a menu of options, systematic delivery within pathways, and workforce development to increase capacity and capability. To review the future commissioning arrangements of self care services To embed self care opportunities into health care core services
	Develop a commissioning model for Long Term Conditions Specialist Rehabilitation Consider the findings of the review and commission new models and approaches to specialist rehabilitation which provides increased access from primary care, a menu based approach to service delivery and ensure synergies and joint working between specialist professionals
	Develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with LTCs and frail elderly within each PCT locality, including care within individuals own homes.
	Develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with LTCs and frail elderly within each PCT locality, including community based 'step up' facilities.
	To review the existing rapid access community nursing teams and consider opportunities for improved access and clarity of role. In particular to develop integrated teams including a joint urgent care and 24/7 team (linked to intermediate care, see above)
	Review provision, role and effectiveness of Specialist Community Nursing and Community Matrons to develop appropriate models of case management that support proactive and anticipatory primary care. This may require decommissioning elements subject to the review.
	Complete the review and implementation of changes to the district nursing service whilst retaining the option to procure alternatives depending on the outcomes

	Having completed the review of the impact of the additional reablement/readmission investment in 2011/12 we will work with stakeholders to develop sustainable and successful schemes for 2012/13.
	Improve provision of heart failure services across primary community and secondary care
	Review the COPD pathway and identify improvements that could be made to improve patient care.
	Improve discharge processes (including documentation) and opportunities for early supported discharge.
	Implement single-site model for weekend TIA clinics.
	Develop a revised service model for the provision of diabetes services across primary community and acute.
	Develop recommendations for future commissioning following the pilot of the community arrhythmia service. .
	Implement an AQP procurement for community based INR services
	Improve the management and provision of AF services across Primary, Community and Secondary care including developing a community model and service.
	Commission a home oxygen assessment service.
	Increase the use of risk stratification tools across primary community and secondary care
	Diabetic Retinal Screening - Vary service specifications to reflect the new national commissioning pathway
Planned Care	Reduce the number of procedures of limited clinical value for varicose veins.
	Implement the revised pathway for patients with carpal tunnel syndrome
	Explore further alternative surgical pathways including Trigger Finger and Dyputrens contracture
	Explore variation in outpatient referrals in order to reduce outpatient first and follow up attendances where

	appropriate
	Explore feasibility of increased GP access to diagnostic tests for non obstentric ultrasound and MRI for dementia
	Review dermatology services and consider aligning the new service model if appropriate with the model commissioned for Gateshead and South Tyneside.
	Following scoping of nurse led clinics in terms of continued viability and cost, agree clinics to "decommission" or change to ensure added value to patient pathways
	Review Adult Hearing Services with an aim to improving access, choice and quality of care (AQP).
	Review podiatry services with an aim to improving access, choice and quality of care (AQP).
End of Life Care	To ensure end of life care packages are co-ordinated and available 24/7
	To have advanced care plans and DNAR in place for all appropriate patients
	Re-provide St Benedict's Hospice.
	Deliver outcomes of specialist palliative care standards in collaboration with NECN
Medicines Management	To have an action plan in place to improve the quality of prescribing, optimise medicines usage in patients with long term conditions and deliver disinvestment opportunities in Primary care prescribing.
	To manage prescribing expenditure within prescribing envelope, to move closer to the North East average to release resources to invest in better quality service. (Astro PU)
	Work with both secondary and primary care to develop a health economy approach to prescribing of medicines across pathways of care.
	Through the contracting process to develop plans for a consistent and collaborative approach for the transfer of prescribing responsibility, including improving the effectiveness of communication, provision of shared care medicines and outpatient prescribing,
	Work with Primary Care to develop a LES for Shared Care
	Explore options to develop services to improve medicines management in care homes in order to reduce the number of emergency admissions and reduce medicines wastage.

	Explore options for collaborative working across primary and secondary care in relation to the provision of stoma and incontinence
	Explore options for collaborative working across primary care and communality in relation to the provision of wound management products, including encouraging appropriate use of the wound management formulary
	Improve the systems for high impact / cost drug exclusions to include a consistent approach across the locality / region and effective implementation of the decisions.
	Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including . Improving rates of repeat dispensing, (implementation of the actions of the repeat dispensing RPIW) . New medicines service . Targeted use of medicines usage reviews . review of the use of MDS
	Ensure there are robust local mechanisms for decision making around medicines.
	Review the contract for provision of medicines management support to individual practices within the SCCG to ensure a Sunderland wide approach to priorities.
	All secondary care and primary care providers to ensure patients post MI benefit from 4 drugs – aspirin, beta-blocker, stain and ACEI
Childrens Acute	Enhance services provided by CCNTs to include care of acutely sick and injured children and with extended hours (evenings and weekend working). Evaluate the ongoing testing of the revised CCNT model in Sunderland and use the evaluation to inform future development of services.
	Subject to public consultation, implement the agreed paediatric emergency pathway; including children's assessment and short stay services.
	Implement a contract variation to extend the role of Walk-in-centres and Minor Injury Units to include assessment and treatment of children under two years of age.

Public Health England/Local Authority Responsibilities

Strategic Priority	Action
Cancer Services	Increase uptake of Bowel Cancer Screening by raising awareness. Whilst ensuring contract volumes reflect anticipated increases in demand.
	Introduction of HPV testing for Cervical Screening.
	Implement urgent lower GI investigation by adopting the Hamilton Risk Assessment Tool into 2WW time frame.
	Enhance engagement and uptake of services following HEA of Breast Screening Service.
Joint commissioning	Implementation of robust joint strategic function arrangements with Sunderland LA through the use of Health Act flexibilities.
	Implement current preferred option from the outcome of the review of the assessment and commissioning processes around CHC, FNC(Free Nursing Care) & s117 (Section 117) and consider future commissioning intentions
	Continue to implement the Carers strategy and local action plans in each locality.
	Enhancement of governance & quality arrangements with independent sector providers. Building on stock take around contracting to ensure all provider relationships are underpinned with provider contracts.
	Work collaboratively to bring together plans for development of physical health, mental health, medicines management and end of life care for Sunderland care homes. (Links with Urgent care and frailty Team in Sunderland.)
Mental Health	Implement the emotional health & wellbeing plan.
	Implement mental health specific actions within the Suicide strategy.
	Re-provide BME and LGBT wellbeing programmes.
	Re-provide workplace health programme with improved service offer for organisations not pursuing NE Better Health at Work Award.

Children's Services	Review school nursing services for provision and capacity to ensure all key elements of the Healthy Child Programme 5-19 years are delivered and key outcomes are achieved.
	Develop an early intervention and prevention strategy with local partners and consider future commissioning intentions to ensure effective evidence based interventions are delivered and monitored in accordance with need to reduce health inequalities and narrow the gap in outcomes.
	Review children's overweight and obesity services (across all the tiers) to meet the requirements of a life course approach and ensure children and young people have access to timely, appropriate and accessible support to meet their needs, and consider future commissioning intensions. (Links with Prevention and Staying Healthy)
	Implement a model to minimise risk taking behaviours and build resilience. To build associated workforce capacity, a risk and resilience training package will be developed in partnership with the Local Authority. Review workforce skills and competencies against the core standards of the model.
	Develop a phased approach to the implementation of 'You're Welcome' quality standards. Ensure service providers deliver in accordance with 'You're Welcome' quality standards.
	Ensure all appropriate providers are signed up to the new electronic C Card and are using it appropriately and develop on basis of need.
	Ensure compliance with NHS SOTW strategy, policies and procedures for Safeguarding Adults and Children.
	Implement recommendations from the CQC and Ofsted joint inspections.
	Review drug and alcohol services for children and young people in Sunderland and implement recommendations in line with the risk and resilience model.
	Ensure increased focus on short breaks for young carers and parents of children with disabilities
	Review stop smoking services for young people in line with NICE guidelines. (As part of the Stop Smoking Services review).
Prevention/ Staying Healthy	Following completion of evaluation of Healthcheck Programme, consider future commissioning arrangements
	Following completion of evaluation, consider future commissioning intentions for prevention and treatment of obesity and exercise on referral services
	Following completion of review & HEA, amend/re-provide Stop Smoking services.
	Re-commission alcohol & drugs services in line with the National Drugs Strategy with a focus on recovery and outcomes from treatment.

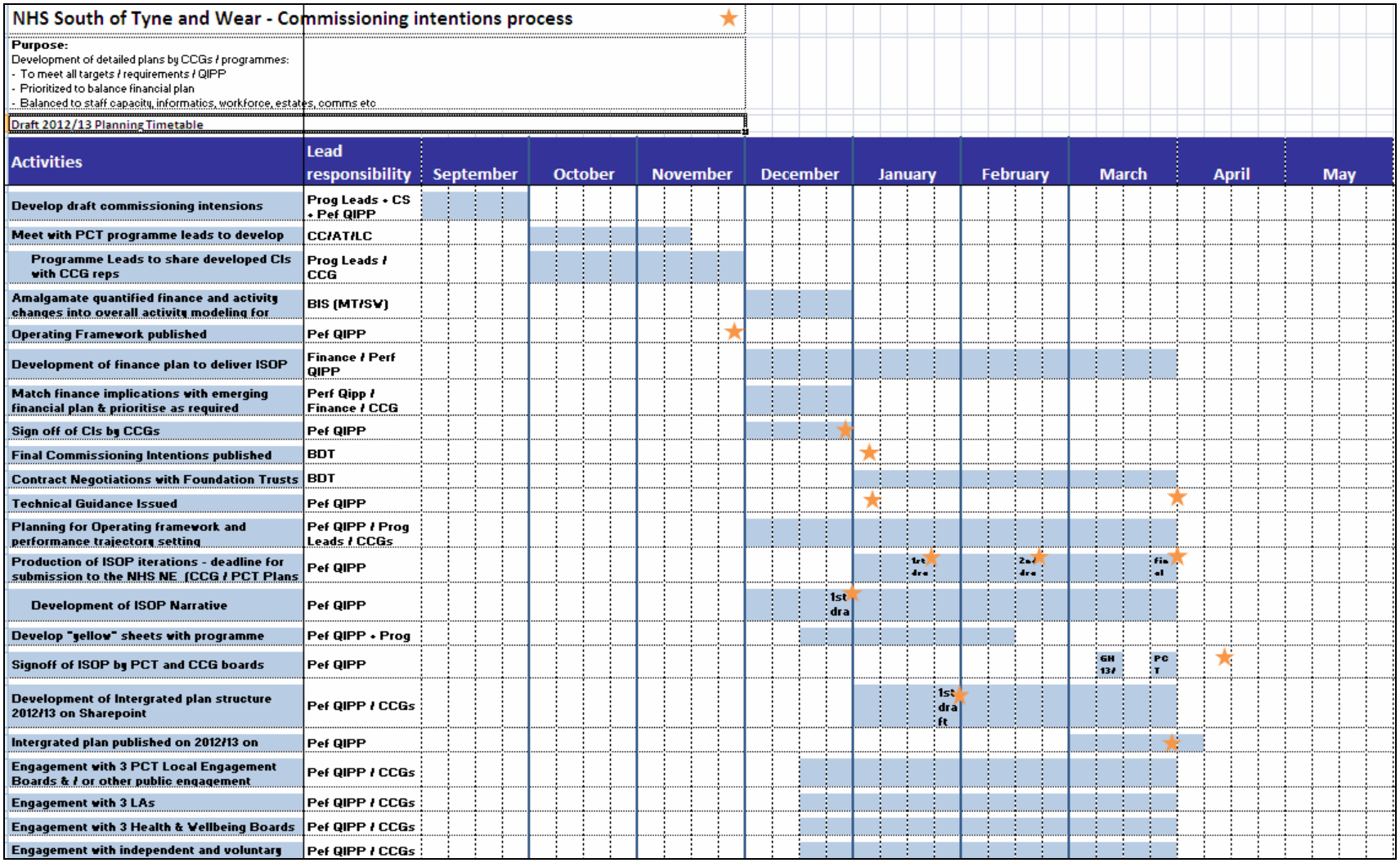
	To re-commission the Chlamydia programme across SOTW when clarification on 2012/13 targets received.
	Implement the sexual health locality action plan which is informed by the findings of the sexual health review with a focus on: - • Governance arrangements • Access to Contraception • Reducing the prevalence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

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

NHS Commissioning Board Commissioning responsibilities

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

Appendix 3


NHS South of Tyne and Wear - Commissioning intentions process
Purpose:
Development of detailed plans by CCGs / programmes:
- To meet all targets / requirements / QIPP
- Prioritized to balance financial plan
- Balanced to staff capacity, informatics, workforce, estates, comms etc
Draft 2012/13 Planning Timetable
Activities
Lead responsibility
September
October
November
December
January
February
March
April
May
Develop draft commissioning intensions
Prog Leads + CS + Pef QIPP
Meet with PCT programme leads to develop
CC/AT/LC
Programme Leads to share developed CIs with CCG reps
Prog Leads / CCG
Amalgamate quantified finance and activity changes into overall activity modeling for
BIS (MT/SW)
Operating Framework published
Pef QIPP
Development of finance plan to deliver ISOP
Finance / Perf QIPP
Match finance implications with emerging financial plan & prioritise as required
Perf Qipp / Finance / CCG
Sign off of CIs by CCGs
Pef QIPP
Final Commissioning Intentions published
BDT
Contract Negotiations with Foundation Trusts
BDT
Technical Guidance Issued
Pef QIPP
Planning for Operating framework and performance trajectory setting
Pef QIPP / Prog Leads / CCGs
Production of ISOP iterations - deadline for submission to the NHS NE (CCG / PCT Plans
Pef QIPP
Development of ISOP Narrative
Pef QIPP
1st dra
Develop "yellow" sheets with programme
Pef QIPP + Prog
Signoff of ISOP by PCT and CCG boards
Pef QIPP
Development of Intergrated plan structure 2012/13 on Sharepoint
Pef QIPP / CCGs
1st dra ft
Intergrated plan published on 2012/13 on
Pef QIPP
Engagement with 3 PCT Local Engagement Boards & / or other public engagement
Pef QIPP / CCGs
Engagement with 3 LAs
Pef QIPP / CCGs
Engagement with 3 Health & Wellbeing Boards
Pef QIPP / CCGs
Engagement with independent and voluntary
Pef QIPP / CCGs

HEALTH AND WELLBEING SCRUTINY COMMITTEE 4th APRIL 2012

PERFORMANCE REPORT QUARTER 3 (OCTOBER – DECEMBER 2011)

REPORT OF THE CHIEF EXECUTIVE

1.0 PURPOSE OF THE REPORT

The purpose of this report is to provide Health and Wellbeing Scrutiny Committee with a performance update for the period October to December 2011.

2.0 BACKGROUND

Performance reports provided to Scrutiny Committee prior to March 2011 were based on performance indicators from the previous government's national indicator list, with a particular focus on those prioritised within the Local Area Agreement. In October 2010 the Coalition Government announced the deletion of the National Indicator set and also announced that from April 2011 there would no longer be a requirement for council's to produce an LAA. Both announcements signalled a move towards self regulation and improvement with more flexibility to report against local priorities using a set of locally determined measures.

For 2011/12 and beyond the Council's aim is that performance reporting should be focused on the key priorities for the people, place and economy of Sunderland. This new approach will be reflected in the performance reports and evolve and develop over 2011/12. Performance reports will include former national performance indicators reported to scrutiny committee adopted into the local performance framework for 2011 – 2012 (and those that continue to provide performance reporting relevant to the key issues and priorities for Sunderland will continue be part of the reporting framework for 2012 – 2013). In addition as part of the Council's annual planning arrangements, consideration is also being given to identifying new localised performance measures which will also be needed to support a robust performance framework tailored to local needs. These will be reported to the relevant scrutiny committee as appropriate and some of these new measures will be reported in 2011/12, where information is available and adds value to the review of performance. Members should also be aware there are also some former national indicators that are no longer available and have therefore been removed from the performance framework.

For this Health and Wellbeing Scrutiny report former national indicators for Adult Social Care have been replaced with the new national indicators identified within the national *Adult Social Care Framework 2011/2012.*

As part of the move to providing a more holistic view of health and well being across the city the report also includes details of performance in relation to the health and well being of Children In Sunderland. This information is also reported to the Children and Young People Scrutiny Committee

Attached at Appendix 1 is an extract of the basket of indicators that the Council has identified within the self-regulation performance framework for 2011-2012 that demonstrate progress against priorities that fall within the remit of this committee.

3.0 PERFORMANCE UPDATE

The following section contains a summary of performance across the key performance areas of Adult Social Care, Health Inequalities, Sport and Leisure and Environmental Health.

Adult Social Care

3.1 There has been a significant increase in the percentage of new and existing customers receiving self-directed support, both managed accounts and/or direct payments, from 31.81% in 2010/11 to 61.65% for the period 1 January 2011 to 31 December 2011. All new and existing customers are offered self-directed support, where appropriate, and the significant improvement in the first half of the year indicates that the 68% target set for 2011-12 should be achievable. There has also been an increase in customers choosing to take their personal budget as a direct payment has also increased from 14.96% in 2010/11 to 16.75% for the period 1 January 2011 to 31 December 2011.

3.2 The Vision for 2025 for Health, Housing & Adult Services is also to promote independent living and increase choice and control for its customers. Research suggests that many customers would prefer to stay in their own homes and communities rather than be admitted to permanent care. Through the use of alternative solutions customers are able to live more independently in their own homes for longer e.g. reablement service, overnight service, extra care service and the recently implemented 'time to think' beds, these all may help to assist in preventing avoidable admissions to permanent residential and nursing care.

The number of people aged 18 to 64 admitted to permanent residential and nursing care has increased to 50 (equating to 28.02 per 100,000 population aged 18 to 64) for the period 1 January 2011 to 31 December 2011, a substantial increase from the 18 admissions (equating to 10.09 per 100,000). This increase is due to a number of previously health funded cases transferring to the Council, due to changes in funding streams. The issue was further compounded by the demise of Choices Care which provided care within Learning Disabilities small group living schemes. The service was taken over by a Care and Support Sunderland Ltd, a local authority trading company. As a consequence a number of clients were re-classified as admissions to care.

The number of people aged 65 and over admitted to permanent residential and nursing care has increased to 404 (equating to 872.10 per 100,000 population aged 65 & over) for the period 1 January 2011 to 31 December 2011, a substantial increase from the 353 admissions (equating to 762.01 per 100,000 population aged 65 &over). The Council is currently working with health partners

to develop better accommodation pathways to prevent admissions to permanent care for individuals. Although there has been an increase in admissions to permanent residential and nursing care during 2011-12, there has also been an increase in the number of older people helped to live at home meaning more older people are being helped through adult social care to live independently in their own homes.

3.3 Another aspect to ensure that people are able to live independently at home is to minimise delayed transfers of care. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, based on a clinical decision, but is still occupying such a bed. The delay can be the result of poor communication and co-ordination between organisations.

The number of delayed transfers of care has increased from 11.3 per 100,000 adult population in 2010/11 to 13.2 per 100,000 adult population for the period 1 April 2011 to 31 December 2011. The Council, PCT and CHS are making progress with a joint project in 2011-12 to improve the joined-up pathways of support as both an alternative to hospitalisation and those on hospital discharge.

Health and Wellbeing (Adults)

3.4 The aim of the council in relation to its priority around Health City is to work with partners to provide improved access to, and quality of, healthcare and to support people living in the city to make healthy lifestyle choices to enable everyone to live long, healthy, happy and independent lives.

3.6 An overall measure of health and wellbeing can be considered in terms of overall mortality rates linked with mortality for the major killers such as cancers and circulatory diseases. The latest mortality figures for all ages all causes are for the three-year pooled period 2008-2010 and thus there is no update on the previous performance report provided to scrutiny for quarter 2. Figures previously provided to scrutiny show that there is a continued higher rate of mortality amongst males than females in Sunderland; 567,000 per 100,000 of the population for females compared to 795,000 per 100,000 of the population. The South of Tyne and Wear (SoTW) Primary Care Trust (PCT), helped by the national health inequalities support team, have developed a comprehensive programme of targeted lifestyle change, prevention, and identification / management of high risk people; including NHS Health Checks, smoking, obesity & alcohol services. Evaluation and development of these services

3.7 Key to improving the health and wellbeing of residents within the city is reducing the incidence of life style choices that have a clear link with poor health such as smoking and excessive consumption of alcohol.

3.8 Comparable, comprehensive, good quality data on smoking prevalence has not been available at local level. Such data will be available for forthcoming years through the integrated Household Survey and it is anticipated it will be used from 2012/13. Until this data becomes available, figures for the rate of self-reported 4-week smoking quitters per 100,000 population over 16 or over provide a proxy

measure. There is evidence that this is improving on last year with performance data for quarter 2 (April to Sept 2011) showing 1,675 smoking quitters (within 4 weeks) reported at the end of Sept 2011. Latest performance data for the stop smoking services shows a marked improvement over the last three months, with numbers increasing from 825 quits in Quarter 1 to 1675 quits at the end of Quarter 2. This is up on performance at the same point last year (1445 quits) and is above target for Quarter 2. Current predictions suggest that the end of year target will be achieved.

3.9 Alcohol consumption is increasing nationally and locally and the patterns of how and when people drink are changing. The former Local Area Agreement 2008 – 2011 reported admissions to hospital due to alcohol in Sunderland as much higher, almost double the national average. The latest available figures relate to June 2011 and show a slight increase on the same time previous year; from 729 per 100,000 June 2010 to 739 per 100,000 June 2011, an increase of 2.2%. This compares favourably with the North East trend (a 4% increase) and is close to the 2% increase experienced nationally.

Health and Wellbeing (Children and Young People)

3.10 Quarterly prevalence of breastfeeding has improved quarter 2 (July to September 2011) to quarter 3 (October – December 2011), from 20.7% to 27% and is above the performance for the same period last year (October to December 2011) when performance was at 21.5%. When aggregated, however, performance is likely to be below the year end target of 27.4%.

3.11 The latest information for the percentage of children in Year 6 with height and weight recorded, published autumn 2011, shows that around 1 in 5 children (21.9%) were obese during the academic year 2010-2011. This is a slight increase on the previous figure of 21.2% and keeps Sunderland above the national average of 19%. There has however been a slight decrease, down to 1 in 10 (10.2%) for the percentage of children in Reception with height and weight recorded as obese; the national average is 9.4%.

The engagement of children and young people in sport and leisure activity may assist in preventing obesity. Schools can support this through the time dedicated to physical activity. The percentage of children and young people participating in high-quality PE and sport (NI 57) was 86% for the academic year 2009-2010. Performance has continued to improve year on year, from 72% to 78% to 86% over the three academic years 07/08 to 09/10.

Sunderland Healthy Schools was launched in January 2012 to transition schools from the now defunct National Healthy Schools programme. The new programme is outcomes driven and focuses on meaningful school improvement through a plan, do and review model. It is expected it could take schools up to 2 years to achieve the award due to the focus on improving health inequalities. 99% of schools in Sunderland are eligible to start work on the new model having already

demonstrated a foundation in promoting health and wellbeing through National Healthy Schools.

There has also been an improvement as at 31st December 2011 in the take up of healthy school meals in both primary and secondary schools; 54% and 60% respectively. This has been achieved through a range of targeted actions including better marketing, menu development, and feedback from pupils. It should be noted that improved performance comes against a backdrop of a 10p increase in school meal prices from September 2011 (the first for 3 years).

It must also be noted that preparation is also underway within the city of Sunderland as to the impact of the Government's Welfare Reform Programme; The Welfare Reform Programme is expected to have a number of projected impacts on both families and individuals; from housing to financial to social care issues. One of the key activities already being progressed in the city is the increased free school meal take up which is being delivered in conjunction with the Child and Family Poverty Board. The activity will maximise funding through the Pupil Premium into Sunderland Schools and ensure that all eligible children and young people have the opportunity to access free school meals through an assumed consent arrangement.

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

3.12 In respect of teenage pregnancy the latest published annual data which relates to the year ending December 2010 shows that the under 18 conception rate has reduced from 52.8per 1,000 pop in 2009 to 50.1 in 2010, representing a real reduction from 288 to 264 conceptions. This represents a continuing trend in reducing teenage pregnancy in Sunderland. The Sunderland rate, however, is above both national (35.4) and North East averages (44.3). The rate of reduction since 1998 baseline is 21% in Sunderland compared to 24% nationally and 22% in the North East.

The Electronic C-Card System provides young people in the city with access and services relating to contraception, sexual health, substance misuse and Chlamydia screening. Data available as at January 2012 shows that there have been 1870 c-card registrations since April 2011. There are currently 77 trained outlets in Sunderland; approximately 15 per locality. The National Sexual Health Strategy is expected to be published in spring 2012.

3.13 At the end of quarter 3, 7,986 Chlamydia screens have taken place, representing 20% of target population screened which is in line with the national average at 20.3%. The percentage testing positive is 9.3%, which is higher than national average at 7.3%.

Sport and Leisure

3.14 Adult participation in sport and leisure is measured through the *Active People Survey* (coordinated by Sport England) The Active People Survey shows how many adults in Sunderland are active in sport and physical activity, whether this takes place in a private gym, a school, on the beach, in a park, on a sports field, or in a public leisure centre. The survey undertaken by MORI provides the largest sample size ever established for an adult (16+) sport and recreation survey. The survey is undertaken annually and the latest results for 2011 have recently been released.

The percentage of the adult population in Sunderland participating in at least 30 minutes of sport and active recreation of at least moderate intensity on at least 3 days a week, has decreased from 22.50% in 2010 to 21.30% in 2011. Sunderland's participation levels still remain higher than average scores for Tyne & Wear, the North East.

However, since the Active People Survey (APS) commenced in 2005, Sunderland has improved the percentage of adults participating in sport and physical activity, rising from 20.3% to 21.3% in 2011.

Sport volunteering in the city is also measured through the national Active People Survey. The latest results for 2011 show that participation in Sunderland fell below the national average (7.3%).

Sport England, have confirmed that there are a number of reasons why participation levels in sport have reduced nationally and these include, cost of activities, lack of time to participate and significantly less money being spent on sport and cultural activities. The Olympic and Paralympic Games in 2012 will be an opportunity and potential catalyst, against the challenges of the current economic climate, to improve participation and volunteering levels and create a lasting legacy in sport.

3.15 Attendance at the city's leisure complexes shows a decline in performance for both wet and dry visits compared to the same period in 2010/11. The number of visits (swims and other visits) to Sunderland leisure centres from October to December 2012 was 1,634,688 compared to October to December 2011 when the number of visits was 1,659,366 (24,678 less visits). The free swimming initiative inflated performance in 2010/11. This programme has now ended and together with the economic downturn, this is having an impact on the figures seen so far in 2011/12. Performance however continues to be ahead of target (total number of visits ahead by 39,690, swims ahead by 8,627 and other visits ahead by 31,063). It should be noted however, that targets have been set lower than compared to last year due to the cancellation of the Free Swimming Programme, the economic downturn and the implementation of new facility operating models at Crowtree, Community North and Silksworth Sports Complex.

3.16 Please see ***Appendix 1*** for the full overview of performance measures relevant to Health and Wellbeing Scrutiny.

4. Recommendation

That the committee considers the continued good progress made by the council and the Sunderland Partnership and those areas requiring further development to ensure that performance is actively managed.

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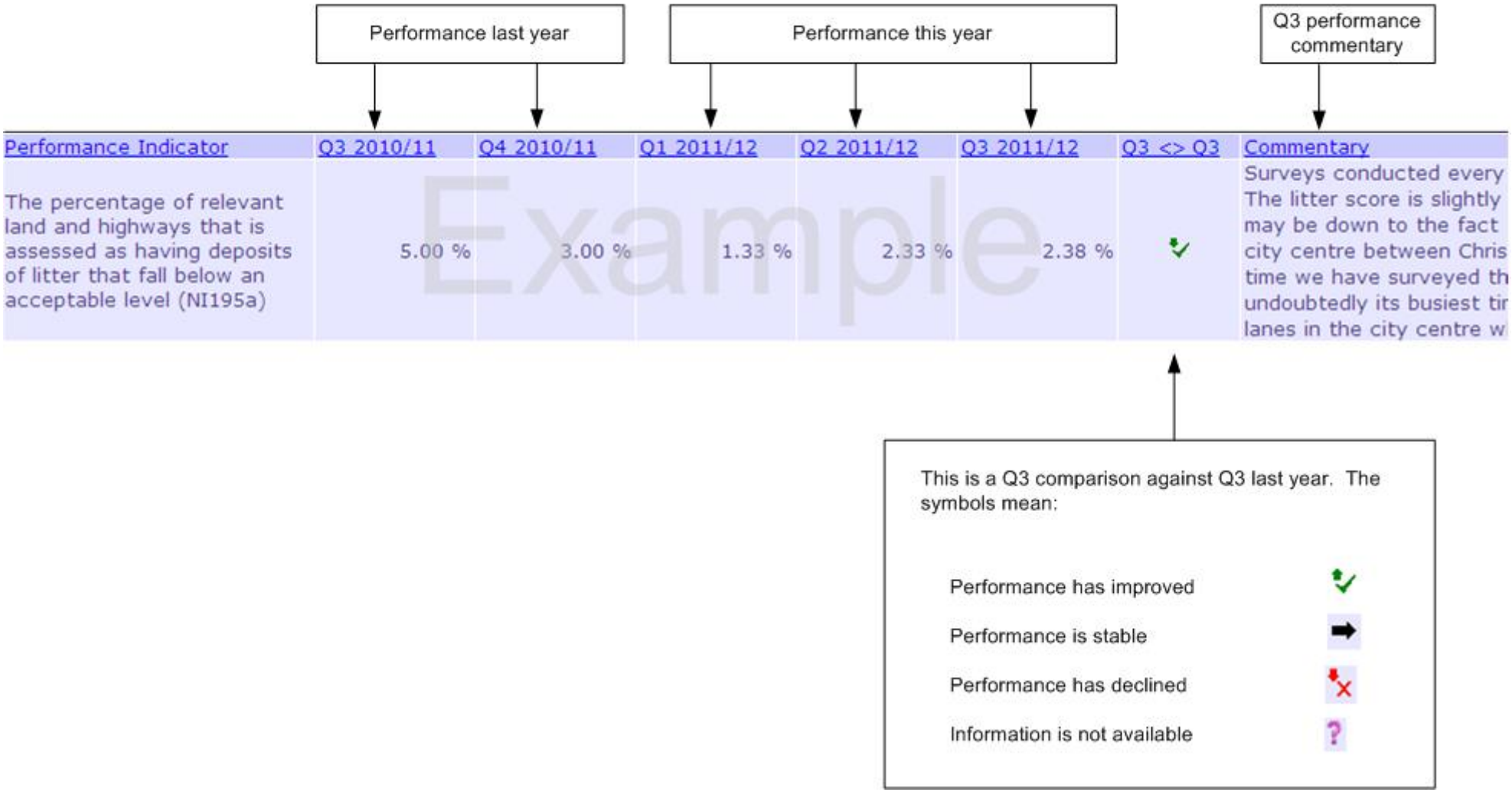
Report Key


Performance last year
Performance this year
Q3 performance commentary
Performance Indicator
Q3 2010/11
Q4 2010/11
Q1 2011/12
Q2 2011/12
Q3 2011/12
Q3 <> Q3
Commentary
The percentage of relevant land and highways that is assessed as having deposits of litter that fall below an acceptable level (NI195a)
5.00 %
3.00 %
1.33 %
2.33 %
2.38 %
Surveys conducted every
The litter score is slightly
may be down to the fact
city centre between Chris
time we have surveyed th
undoubtedly its busiest tir
lanes in the city centre w
Example
This is a Q3 comparison against Q3 last year. The symbols mean:
Performance has improved
Performance is stable
Performance has declined
Information is not available

Adult Social Care

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Commentary
The % of clients receiving community-based services and carers receiving carers' specific services aged 18+ who also receive self-directed support in the year to 31st March. \n \nusers/carers receiving self-directed support in the year to 31st (NPI003i)	?	31.81 %	46.96 %	56.17 %	61.65 %	?	The percentage of new and existing customers receiving self directed support, via managed services and/or through direct payments, has increased from 31.81% in 2010/11 to 61.6% for the period 1 January 2011 to 31 December 2011, further improving towards the 68% target set for 2011-12.
The % of clients receiving community-based services and carers receiving carers' specific services aged 18+ who also receive direct payments in the year to 31st March (NPI003ii)	?	14.96 %	?	15.74 %	16.75 %	?	In line with the increase in the percentage of new and existing customers receiving self directed support, there has been an increase in the number of customers choosing to take a direct payment from 15% in 2010/11 to 16.75% for the period 1 January 2011 to 31 December 2011.
Proportion of adults with learning disabilities in paid employment (NPI005)	?	4.37 %	5.21 %	5.22 %	5.64 %	?	The number of people with learning disabilities, known to adult social care, in paid employment at their latest assessment or review has improved from 4.37% (35 people) in 2010/11 to 5.6% (48 people) for the period 1 January 2011 to 31 December 2011.

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Commentary
Proportion of adults with learning disabilities who live in their own home or with their family (NPI007)	?	77.78 %	80.09 %	79.00 %	76.85 %	?	Performance against the percentage of people with learning disabilities known to adult social care living in their own home has declined slightly from the 2010/11 outturn of 77.8% to 76.9% for the 12 month period 1 January 2011 to 31 December 2011, slightly below the target set for 2011/12 of 79%.
Number of council-supported permanent admissions of younger adults (18 - 64) to residential and nursing care during the year (excluding transfers between residential and nursing care) per 100,000 pop aged 18 - 64(NPI009i)	?	762.01 %	27.46 %	25.21 %	28.02 %	?	The number of admissions for people aged 18 to 64 to permanent residential and nursing care has increased to 50 (equating to 28.02 per 100,000 population aged 18 to 64) for the period 1 January 2011 to 31 December 2011, a substantial increase from the 18 admissions (equating to 10.09 per 100,000 population aged 18 to 64) in 2010/11.
Number of council-supported permanent admissions of older people (aged 65 and over) to residential and nursing care during the year (excluding transfers between residential and nursing care) per 100,000 pop aged 65+ (NPI009ii)	?	10.09 %	803.02 %	887.21 %	872.10 %	?	The number of admissions for people aged 65 and over to permanent residential and nursing care has increased to 454 (equating to 872.1 per 100,000 population aged 65 and over) for the period 1 January 2011 to 31 December 2011, an increase from the 353 admissions (equating to 762.0 per 100,000 population aged 65 and over) in 2010/11.
Average number of delayed transfers of care from hospital attributal to adult social care per 100,000 populated aged 18+ (NPI011ii)	?	?	9.79	7.78	7.78	?	The number of delayed transfers of care attributable to social care is 7.78 per 100,000 population for the period 1 April 2011 to 31 December 2011, exceeding the target set for 2011/12 of no more than 1 per 100,000 population.

Adult Health Inequalities

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
The rate of alcohol related hospital admissions per 100,000 population (NI039).	2,177.00	2,580.83	739.00	?	?	?	Data extracted from Local Alcohol Profiles for England (LAPE) website. 6-7 month timelag. Q1 will not be available until December 10/January 11. Currently achieving target
The mortality rate per 100,000 population, from all causes at all ages - females (NI120f).	578.70	555.00	555.00	555.00	555.00	✓	Helped by the national health inequalities support team, a comprehensive programme of targeted lifestyle change, prevention, and identification / management of high risk people is in place including NHS Health Checks, smoking, obesity & alcohol services. Evaluation and development of these services features in the 2011-2015 ISOP (Integrated Strategic Operational Plan). Latest data relates to March 2011.
The mortality rate per 100,000 population, from all causes at all ages - males (NI120m).	851.00	758.00	758.00	758.00	758.00	✓	As Above.
Mortality rates from all circulatory diseases per 100,000 population aged under 75 (NI121).	88.90	78.30	78.30	78.30	78.30	✓	As Above.
Mortality rates from all cancers per 100,000 population aged under 75 (NI122)	141.14	147.00	147.00	147.00	147.00	✗	As Above.

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
The rate of self-reported 4-week smoking quitters per 100,000 population aged 16 or over (NI123).	782.94	1,230.74	356.26	719.02	?	?	Latest available data relates to Qtr 2
The % of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy (NI126)	73.90 %	82.10 %	107.30 %	107.60 %	?	?	Latest available data relates to Qtr 2
Proportion of adults in contact with secondary mental health services in paid employment (NPI006)	?	12.50 %	5.61 %	5.51 %	5.62 %	?	A year on year analysis is unavailable at quarter 3
Proportion of adults in contact with secondary mental health services living independently, with or without support (NPI008)	?	79.40 %	69.63 %	72.80 %	74.62 %	?	A year on year analysis is unavailable at quarter 3
Average delayed transfers of care from hospital per 100,000 population (NPI011i)	?	11.30	12.90	13.35	13.20	?	The number of delayed transfers of care has increased from 11.3 per 100,000 population in 2010/11 to 13.2 per 100,000 population for the period 1 April 2011 to 31 December 2011, also above the target set for 2011/12 of no more than 9 per 100,000 population.

Childrens Health Inequalities

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
% of schools submitting healthy schools action plans (LPI085i)	?	?	?	?	?	?	Sunderland Healthy Schools was launched in January 2012 to transition schools from the now defunct National Healthy Schools programme. The new programme is outcomes driven and focuses on meaningful school improvement through a plan, do and review model. It is expected it could take schools up to 2 years to achieve the award due to the focus on improving health inequalities. 99% of schools in Sunderland are eligible to start work on the new model having already demonstrated a foundation in promoting health and wellbeing through National Healthy Schools.
% of schools that have achieved Sunderland Healthy Schools Status (LPI085ii)	?	?	?	?	?	?	As above
The self assessed score (level 1 to 4) for the effectiveness of child and adolescent health (NI051)	16.00	16.00	16.00	16.00	16.00	➡	Latest available data relates to Qtr 1

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
The % take up of school lunches (primary schools) (NI052i)	53.00 %	55.90 %	53.40 %	53.00 %	54.00 %		Cumulative P1-8 54.3% - Higher performance is due to services being responsive to customer needs. For example, responding to the findings of the School Meals Investigators' pupil-led consultation exercise and introducing plates and bowls instead of airline trays, or increasing the number of theme days. It should be noted that improved performance comes against a backdrop of a 10p increase in school meal prices from September 2011 (the first for 3 years). The service has also initiated an additional sales programme for catering employees (e.g. selling breads and cakes to school staff), which has helped enhance service reputation but also encouraged catering employees to take a more proactive approach to assessing and delivering on customer needs and expectations.
The % take up of school lunches (secondary) (NI052ii)	49.06 %	60.20 %	56.80 %	55.60 %	60.00 %		Cumulative P1-8 59.5% - In addition to the ongoing support of schools in implementing closed gate policies, the higher level of performance is due to services being responsive to customer needs. For example, the ongoing development of the menu and product offer based on feedback from pupils. It should be noted that improved performance comes against a backdrop of a 10p increase in school meal prices from September 2011 (the first for 3 years).
The % of infants being breastfed at 6-8 weeks (breastfeeding prevalence) (NI053i)	21.50 %	23.30 %	23.60 %	20.70 %	27.00 %		Quarterly prevalence of breastfeeding has improved Q2 to Q3, from 20.7% to 27% but is likely to remain below year end of 27.4% when aggregated.

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
Percentage of infants for whom breastfeeding status is recorded (breastfeeding coverage) (NI053ii)	95.20 %	95.90 %	95.90 %	97.70 %	?	?	Latest available data relates to Qtr 2
Total number of primary school age children in Reception recorded as obese for their age in the past school year (NI055i)	302.00	309.00	309.00	309.00	309.00		This data relates to the 2009/10 academic year.
Total number of primary school age children in Reception with height and weight recorded in the past school year (NI055ii)	2,748.00	2,768.00	2,768.00	2,768.00	2,768.00	✓	This data relates to the 2009/10 academic year.
Total number of primary school age children in Reception (NI055iii)	2,881.00	3,171.00	3,171.00	3,171.00	3,171.00	n/a	This data relates to the 2009/10 academic year.
% children in reception with height and weight recorded who are obese (NI055iiii)	11.00 %	11.16 %	11.16 %	11.16 %	11.16 %		Data relates to the 2009/10 academic year A comprehensive redesign of the data collection process is underway. Planned nutrition, exercise and family support services are all now in place and we expect to see their impact in Autumn 2011. Actions to note at Quarter 4 include the LAF Programme (Lifestyle, Activities and Food), which commenced April 2010 and has had 92 children complete the programme between May 10 to July 11. A Kaizen event was held in May for the National Childhood Measurement Programme, which identified a number of actions to ensure timely and complete submission of data and better engagement with parents.

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
Percentage of children in Reception with height and weight recorded (NI055iiiii)	95.40 %	87.30 %	87.30 %	87.30 %	87.30 %		Data relates to the 2009/10 academic year As above.
Total number of primary school age children in Year 6 recorded as obese for their age in the past school year (NI056i)	577.00	556.00	556.00	556.00	556.00		This data relates to the 2009/10 academic year.
Total number of primary school age children in Year 6 with height and weight recorded in the past school year (NI056ii)	2,858.00	2,630.00	2,630.00	2,630.00	2,630.00		This data relates to the 2009/10 academic year.
Total number of primary school age children in Year 6 (NI056iii)	3,063.00	3,211.00	3,211.00	3,211.00	3,211.00	n/a	This data relates to the 2009/10 academic year.
Percentage of children in Year 6 with height and weight recorded who are obese (NI056iiii)	20.20 %	21.10 %	21.10 %	21.10 %	21.10 %		Data relates to 2009/10 academic year 23 primary schools have signed up to school enhancement work with a focus on Healthy Weight and are planning school based interventions, with links being made to the Lifestyle and Activity Food (LAF) programme. LAF supports physical activity levels, improving understanding of healthy eating and weight maintenance. The Child Weight Management Programme and training providers framework has been commissioned to 2013 which supports local commissioning of weight management services for children and young people, offering training and support in the delivery of specific approaches to weight management for at risk, overweight and obese children and young people.

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
Percentage of children in Year 6 with height and weight recorded (NI056iiiii)	93.30 %	93.00 %	93.00 %	93.00 %	93.00 %		This data relates to the 2009/10 academic year. National Child Measurement Programme (NCMP) published data was refreshed locally due to data quality issues. The refresh figures show a participation rate of 93% in year 6 in 2010/11. Work is ongoing across South of Tyne and wear to ensure a consistent and accurate information capture. Participation rates are being closely monitored and interventions will take place where there is evidence of participation rates dropping in future.
The % of 5-16 year olds who do 5 hours of high quality Physical Education (PE) and Sport per week (NI057)	78.00 %	86.00 %	86.00 %	86.00 %	86.00 %		Data relates to 2009/10 academic year Performance continues to improve year on year, from 72% to 78% to 86% over the last three years.
The rate of finished in-year emergency admissions of children and young people to hospital as a result of unintentional and deliberate injury, per 10,000 population of children and young people (NI070)	155.50	193.10	?	?	?		Latest available data relates to 2010/11 outturn

Performance Indicator	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
The change in rate of under-18 conceptions per 1,000 girls aged 15-17 years resident in the area for the current calendar year, as compared with the 1998 baseline, shown as a percentage of the 1998 rate (NI112)	-16.30 %	-16.32 %	-16.80 %	-12.68 %	-20.60 %		Published annual data through to December 2010 shows that the <18 conception rate has reduced from 52.8 per 1,000 pop in 2009 to 50.1 in 2010, representing a real reduction from 288 to 264 conceptions. Sunderland rate at 50.1 is above both national (35.4) and North East averages (44.3). The rate of reduction since 1998 baseline is 21% in Sunderland compared to 24% nationally and 22% in the North East. As of yet no target has been set for reducing teenage pregnancy since the 50% reduction set out in the 10 year National Teenage Pregnancy Strategy (this was stretched to 55% in Sunderland). A final assessment of the target will be made in February 2012 [reflecting data for 2010]. The National Sexual Health Strategy is expected in Spring 2012, which may identify future Teenage Pregnancy Targets.
Percentage of the resident population aged 15-24 accepting a test/screen for chlamydia (NI113i)	21.60 %	32.00 %	4.81 %	13.00 %	20.00 %		At Q3, 7,986 chlamydia screens have taken place, representing 20% of target population screened which is in line with the national average at 20.3%. The percentage testing positive is 9.3%, which is higher than national average at 7.3%.
Prevalence of Chlamydia in under 25 year olds (NI113ii)	?	5.10 %	4.80 %	9.20 %	9.30 %		As above

Sport and Leisure

Performance Measure	Q3 2010/11	Q4 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q3 <> Q3	Comments
% of population volunteering in sport and active recreation for at least one hour per week (LPI018).	7.20 %	7.20 %	7.20 %	7.20 %	3.70 %		A fall from 7.2% to 3.7%. It should be noted that this indicator reflects all voluntary and private sector voluntering in the city and is not necessarily a reflection of the Council's performance.
Total number of visits overall to leisure centres (swims+other visits) (LPI021)	1,659,366.00	2,265,159.00	573,495.00	1,111,810.00	1,634,688.00		2010/11 attendances included free swimming statistics which inflated last year's attendances. The economic downturn has also had an effect on leisure complex visits.
Total number of swims within leisure centres (LPI022)	491,115.00	667,214.00	157,513.00	323,447.00	471,416.00		Last year's attendances included free swimming statistics which inflated attendances.
Total number of other visits to leisure centres (LPI023)	1,168,251.00	1,597,945.00	415,982.00	788,363.00	1,163,272.00		Attendances are slightly down on last year, with the economic downturn having an effect.
The % of the population (aged 16 plus) who participate in sport for at least 30 minutes on 3 or more times a week (NI008)	22.50 %	22.50 %	22.50 %	22.50 %	21.30 %		Above Tyne & Wear and North East averages. Slightly below national average of 21.8%

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 4 April 2012

ANNUAL REPORT 2011 / 2012

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 For the Committee to approve the draft Health and Wellbeing Scrutiny Committee annual report which will form part of the overall scrutiny annual report 2011/12 that will be presented to Council.

2. Background

2.1 The annual report reflects the Scrutiny Committees work programme and includes achievements, highlights and policy review work.

2.2 The annual report is a single combined report for the seven Scrutiny Committees. The combined annual report will include developments in the scrutiny function and provide snapshots of the outcomes achieved during this Council year.

3. Health and Wellbeing Scrutiny Committee 2011/12

3.1 The draft Health and Wellbeing Scrutiny Committee annual report is attached at Appendix 1 for member's consideration. The report provides a very brief overview of the some of the key activities undertaken by the Committee during 2011/12. It should be noted that the report is written from the perspective of the Chair of the Committee reflecting over the last year.

3.2 Some of the main themes covered in the annual report are:

- New Health and Social Care arrangements
- Personalisation Agenda
- Policy Review: Rehabilitation and Hospital Discharge

4. Recommendation

4.1 That Members approve the Health and Wellbeing annual report for inclusion in the Overview and Scrutiny Annual Report 2011/12.

5. Background Papers

2011/12 Health & Well-Being Scrutiny Committee Agendas

Contact Officer: Karen Brown, Scrutiny Officer
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Health & Well-being Scrutiny Committee 2011/12

Our work programme this year has understandably been influenced by the restructuring of health services including the impact of economic constraints on health and social care services. Our work has included an overview of how the council is taking forward its efficiency and transformation agenda whilst maintaining a high standard of adult social care.

We have reviewed the impact on residents of the fluctuation in the residential care market, including the well publicised financial difficulties of Southern Cross. We considered what this would mean for the residents of the 14 homes in Sunderland to ensure continuity of care to residents and ensure that the amount of disruption was minimal.

Our main review this year was about rehabilitation and hospital discharge. Many people may need a stay in hospital at some stage of their lives, and we know that health and social care staff do their utmost to support each individual to rehabilitate. We have heard examples of a lot of good practice around smooth transitions of care but all too often the patients with complex post-hospital needs find themselves having to be re-admitted, often unnecessarily. Our aim has been to review the policies and strategies and to determine if they are fit for purpose with evidence focusing heavily on service user experience. From the evidence patients, families and carers have provided we hope to make improvement around some key areas. For example, we have emphasised the need for an integrated approach including a specific recommendation for jointly agreed protocols including with the voluntary sector. We have suggested that research is carried out into which A&E admissions are avoidable. We have suggested improvements are needed at points of transfer of care to make sure, for instance, that patient records are available when needed. We were ably supported in this work by four coopted members who between them had a range of knowledge and expertise that we have found extremely valuable in pursuing this review.

The NHS reported a variety of consultations to health scrutiny including reconfiguration of children's heart surgery, the campus closure programme for people with learning disability, reviews of end of life facilities and in-patient beds for those with learning disabilities, and new services for acutely sick children.

Local authority services were scrutinised including the implementation of personalisation whereby individuals choose how they meet their own care needs through use of a personal budget. We considered the review of the current charging regime for adult social care to support personalisation. While being aware that the Council needs to bring social care contributions into line with national trends and policy developments it was important that we scrutinised the process to ensure the system is open, fair, transparent and easy to understand.

The Committee has taken an overview of the strategic plans of all organisations and we look forward to being involved in the development of the new health strategy. At a regional level I represented the council on the regional health committee where we considered issues across local authority boundaries including children's heart surgery and reconfiguration of ambulance services.

The transfer of public health responsibilities to the council is imminent and scrutiny will have an 'overview' of health improvement. The council's public health responsibilities will extend to wider determinants of health including leisure, housing, transport and employment. Scrutiny will need to play a role in starting to develop new relationships and new ways of working to assist the Council to self-regulate its own performance in addressing health inequalities. All providers of NHS services will be subject to scrutiny, irrespective of the sector to which they belong. This would represent a significant enlargement of the health scrutiny role as it now stands.

This has been a challenging but exciting year and with the council's increased role in public health and new scrutiny powers and different relationships the year ahead promises to set new challenges.

Councillor Peter Walker
Chair of the Health and Well-Being Scrutiny Committee

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 4th April 2012

POLICY REVIEW – DRAFT FINAL REPORT REHABILITATION AND HOSPITAL DISCHARGE

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 For the Scrutiny Committee to endorse the draft final report following an enquiry into rehabilitation and hospital discharge.

2. Background

2.1 A key function of the Scrutiny Committee is to evaluate and review policy and make proposals to Cabinet and to partner organisations for policy development.

3. Policy Review Recommendations

3.1 The summary of findings will draw out recommendations relating to:
(a) an integrated, whole system way of working;
(b) avoidable admissions;
(c) planning for discharge;
(d) supporting patients at points of transfer of care;
(e) medication support;
(f) support for carers

4. Conclusion & Recommendations

4.1 The draft final report, which will be available prior to the Committee, will be for discussion and endorsement by the Scrutiny Committee. It is recommended to Members that the report is also submitted to Cabinet for endorsement.

5. Background Papers

Health & Well-Being Scrutiny Committee reports (as referenced in policy review report)

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HEALTH & WELL-BEING SCRUTINY COMMITTEE

4th April 2012

ANNUAL WORK PROGRAMME 2011-12

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 For the Committee to receive an updated work programme for 2011-12.

2. Background

2.1 The Scrutiny Committee is responsible for setting its own work programme within the following remit:

> *Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Citizenship (Adults); and External inspections (Adult Services)*

2.2 The work programme can be amended during the year and any Member of the Committee can add an item of business.

3. Current Position

3.1 In addition to the items taken at the scheduled meetings the following activities have taken place since the last meeting.

3.2 A Joint Health Regional Committee meeting was held on 15 February 2012 dealing with the following issues:

- North East Ambulance Service – Review of A&E Services
- Progress of 111 – Report from NHS North East
- The Transition to the new Healthcare system
- Patient Transport Criteria

4. Conclusion & Recommendation

4.1 As this is the final work programme report for the current municipal year, any additional suggestions will be fed into the work planning for the new municipal year. Members are asked to note updated work programme.

5. Background Papers

None

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE WORK PROGRAMME 2011-12

	JUNE 08.06.11	JULY 19.07.11	SEPTEMBER 6.09.11	OCTOBER 19.10.11	23.11.11	DECEMBER 07.12.11	JANUARY 11.01.12	12.1.12	FEBRUARY 22.02.12	29.2.12	APRIL 4.04.12
Cabinet Referrals & Responses			Cabinet Response to 2010/11 Hospital Food & Veterans Policy Reviews		Policy Review: Evidence Gathering Day			Policy Review: Evidence Gathering Day		Policy Review: Community Event	
Policy Review	Work Programme & Policy Review – Delayed Discharge & Reablement (KB)	Scope of Policy Review (KJB)	Endorse co-opted representation Setting the Scene – Delayed Discharge (JC/AN) Monitoring Action Plans: Dementia, Home Care, Health Inequalities	Community Health Services (BA) CQC In-patient survey leaving health services			Out of Hours (JU)				Final Report
Performance			Q4 Performance Report (KDP)			Q1 & Q2 Performance (ML)					Q3 Performance (SL)
Scrutiny	Safe and Sustainable: Consultation (KB) Integrated Strategic & Operational Plan (STPCT) Health & Well-Being Board (NR)	Campus Completion Programme (PCT/NTW) Training Standards Care Homes (GK)	Procurement of social care for adults with a learning disability – progress report (PF)	Meals at Home Service (PC) Barmston Medical Centre Procurement (PCT) End of Life Facilities (PCT)		In-patient beds for LD (NTW) Community Covenant (KB) Social Care Contributions consultation (GK)	HHAS 15 year strategy (NR/DA) Health Watch (JC) Acutely sick children consultation (SOTW)		Public Health Transition update (SR) Health Strategy consultation (VT) 'Clear & Credible' Plan (CCG)		Annual Commissioning Plan (STPCT)
CCfA/Members items/Petitions		Request to attend conferences Feedback visit to Wearmouth View									Draft Annual Report (KB)

At every meeting: Forward Plan items within the remit of this committee / Work Programme update