Item No. 2

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

Held in Committee Room 1, Sunderland Civic Centre on Friday 16 September 2011

MINUTES

Present:

Councillor P Watson (Chair)	-	Sunderland City Council
Councillor P Smith	-	Sunderland City Council
Councillor M Speding	-	Sunderland City Council
Neil Revely	-	Executive Director, Health, Housing and Adult Services, Sunderland City Council
Ron Odunaiya	-	Executive Director, City Services, Sunderland City Council
Keith Moore	-	Executive Director, Children's Services, Sunderland City Council
David Hambleton	-	Director of Commissioning and Development, Sunderland TPCT
Nonnie Crawford	-	Director of Public Health, Sunderland TPCT
Sue Winfield	-	Chair of Sunderland TPCT
Dr Ian Pattison	-	Chair of Sunderland Clinical Commissioning Group

In Attendance:

Councillor J Wiper	-	Sunderland City Council (Observing)
Alan Patchett	-	Age UK (Observing)
Wendy Balmain	-	Deputy Regional Director of Social Care and Partnerships, Department of Health
Gillian Gibson	-	Sunderland TPCT
Mike Lowthian	-	Sunderland LINk
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Warnes	-	Governance Services, Sunderland City Council

HW9. Apologies

Apologies for absence were received from Councillors Allan and Oliver.

HW10. Minutes

The minutes of the meeting held on 27 July 2011 were agreed as a correct record subject to an amendment to the second sentence of the second paragraph on page 7 to read: - *Nonnie Crawford highlighted that a good example of this was the impact a Practice Based Commissioning Group had made on the treatment of COPD which had been so effective it was going to be rolled out across all practices in the city*.

HW11. Strategic Planning Overview

The Executive Director of Health, Housing and Adult Services presented a report providing board members with an overview of the Strategic Planning Process of the Council.

The Council was developing its priorities into an outcomes framework across the city for the forthcoming financial year and the subsequent two years which would lead to a continued improvement in service delivery and the use of resources. Three year plans would be developed, led by Executive Directors and aligned with the medium term financial planning for the city and priorities, commissioning intentions and planning. The Strategic Planning Process would both be influenced by and influence the Joint Strategic Needs Assessment and would sit alongside other strategies such as the Economic Masterplan.

With regard to Health, Housing and Adult Services, Neil Revely advised that they would further develop the 15 year vision which was to prevent, to re-able and to personalise. It would be key to align the respective processes and the Board in future may like to invite other organisations such as the local NHS Foundation Trust to consider how planning could be aligned between partner organisations.

Ron Odunaiya reported that through key service requests, City Services was developing its priorities whilst considering resource availability issues. The five themes identified were community centred services, mixed use community facilities, strengthening communities, attractive and inclusive communities and improving individual and community wellbeing.

From the Children's Services point of view, Keith Moore highlighted that the service saw its role as working from birth to 18 and beyond. A comprehensive review was being undertaken of early years and children's centres and there was a build up on early intervention and prevention work and additional specialist work carried out on youth services. He reported that education performance in the city had been the best ever over the whole range of exams. The key strategic driver for all the priorities was the Children's Trust arrangements.

As directorate strategic plans clearly meshed together to support the Health and Wellbeing Strategy, Sue Winfield asked how this could be made clear to members of the public.

Councillor Watson emphasised that all Board members should be ambassadors for strategic planning and get the people and press interested. Most of the relevant

organisations were engaged through the Children's Trust and Adult Social Care Partnership Board but there was no perfect way of reaching everyone.

Neil Revely noted that the Council's outcomes framework was built on the citizen interface and was added to by other engagement work which had been done. Beyond that, the Council was ensuring that it engaged with the new Clinical Commissioning Group (CCG) and would look to enrich its engagement with other partners and local people.

David Hambleton explained to the Board that in 2009, the PCT had been asked to develop a five year strategic plan, and from this Integrated Strategic and Operational Plan (ISOP), the PCT strategic priorities were drawn up. Each year the plan was refreshed and the current revision would be complete in January 2012. The plan covers all areas of the PCT commissioning function but the new Clinical Commissioning Groups would also be asked to produce a 'clear and credible' plan.

The ISOP would have to include public health and primary care commissioning and the clear and credible plan required wide engagement. The PCT would want to make sure that NHS health planning was aligned to the rest of the city.

The Council was working to integrate their own strategic planning by bringing all the policy officers together and consideration now had to be given to how this could be integrated across Sunderland and an intelligence hub developed for the whole city.

Dr Pattison commented that the Clinical Commissioning Group were aware that they must add value and it was essential that they were seen to do this now, without impacting on stability or current projects.

The Board was asked to consider inviting partners to present their organisations' strategic plans to the next meeting of the Early Implementer Health and Wellbeing Board. It was felt that this would be beneficial within the early implementer stage of the Health and Wellbeing Board. Wendy Balmain reported that there was a significant variations in the region with regard to having providers on the Board and she advised the Board to have a discussion with partners sooner rather than later.

It was felt that there would need to be some very detailed conversations and that a workshop style event might be the most useful approach. It was proposed that a one off event take place and a report be brought back to the Early Implementer Health and Wellbeing Board. Karen Graham undertook to arrange this.

It was: -

RESOLVED that: -

(i) the report be received for information; and

(ii) that a meeting be arranged for providers and partners to share their strategic plans and the resulting information brought back to the next meeting of the Early Implementer Health and Wellbeing Board.

HW12. NHS Reform

The Executive Director of Health, Housing and Adult Services presented a report updating members on the current position with regard to the reform of the NHS following the 'listening exercise' which had taken place.

The Health and Social Care Bill was due to have its third reading in the House of Commons in early September and the main changes for the NHS within the Bill were a changing role for the Secretary of State, the development of a National NHS Commissioning Board, the creation of Clinical Commissioning Groups and changing roles for Monitor and the Care Quality Commission.

The Strategic Health Authorities (SHAs) in England had been clustered into four separate areas. Ian Dalton CBE had been appointed to the post of Chief Executive for the North of England and would take up his post on 3 October 2011 and continue until the abolition of SHAs in 2013.

The NHS Commissioning Board would be a national organisation but many functions would be delivered sub-nationally. A Chief Executive had been appointed and the Board would start to operate in a shadow form as a special health authority in October 2011 and would become an independent statutory body with powers for the authorisation of Clinical Commissioning Groups by October 2012.

It was expected that a series of Public Health Reform Updates would be published between now and November and subject to Parliamentary approval, local authorities would take on new public health responsibilities in April 2013.

The key implications for Sunderland were outlined within the report and these included the establishment of new or revised relationships within the new NHS landscape at national and local level and revising governance arrangements to support an integrated approach to health and social care for Sunderland. The Public Health transition plan was being developed to include finance, workforce and the relationship to Public Health England and there would need to be the provision of local authority support during the Clinical Commissioning Group authorisation process.

Dr Pattison advised that the configuration of the Sunderland Clinical Commissioning Group was in line with the current guidance but the exact configuration had not been finally confirmed by the Government. Nationally there were some issues and concerns about financial stability.

The Clinical Commissioning Group was in the process of formalising relationships and would meet with the Strategic Health Authority in October.

With regard to the public health transition, Neil Revely reported that Dave Smith was on the national planning board for the transition. Sarah Reed, the Assistant Chief Executive had responsibility for the local transition plan and this would be brought to the Board for information. The five policy papers expected in the autumn would be very important in planning for the transition and shadow plans to be in place for October 2012.

The PCT would have the responsibility for delivering the transition and Human Resources consultation work would begin in April 2012.

Sunderland PCT had apportioned its spend on public health in 2010/2011 and submitted the information to Government. It was clear that the amount allocated to local authorities to deal with public health issues would be reduced. The Chair pointed out that just looking at the spend did not take into account the impact that the public health work had on the wellbeing of the city's residents.

Sue Winfield highlighted that the PCT had prioritised the issue of spend on health improvement in recent years and they were anxious about how this would unfold within the new arrangements. The PCT would work through this with the local authority.

Councillor Speding expressed concern that the savings being made in the NHS across the country were disproportionate and that reductions in one area may be passported to more affluent regions. David Hambleton advised that the funding formula was weighted to take into account disadvantage and deprivation and this applied in Sunderland. If funding was calculated using just the practice population in the city, it would be reduced by 12%.

In respect of the NHS Commissioning Board and its role in overseeing Clinical Commissioning Groups, it was stated that there would be a system of authorisation so that CCGs could take on commissioning and budget responsibilities when they were ready. The Chair queried if this would be sooner rather than later.

Dr Pattison advised that a variety of options were being put forward and most CCGs were aiming to be ready for this by October 2011 as they had to be in operation for six months before they could be authorised by the NHS Commissioning Board.

There had been no changes to the development of HealthWatch apart from some alterations to the timescales but the transition plan was on target and it is expected to be ready when the Early Implementer went to Shadow Board format.

Following detailed discussion, it was: -

RESOLVED that the report be received for information.

HW13. Health and Wellbeing Board Development

Wendy Balmain, Deputy Regional Director of Social Care and Partnerships, Department of Health, delivered a presentation giving a high level view on the development of Health and Wellbeing Boards.

Social care had a much greater presence in the new system and following the listening exercise, changes had been made so that Health and Wellbeing Boards would have a stronger role: -

- To promote joint commissioning

- To develop commissioning plans and refer these to NHS Commissioning Board if not satisfied; and
- To have a formal role in the authorisation of clinical commissioning groups.

Integration was also being placed at the heart of the reforms and Health and Wellbeing Boards would have stronger duties to promote integration and other organisations would be required to promote the integration of health and social care.

Early Implementer Health and Wellbeing Boards were established in all 12 of the North East local authorities. A Health and Wellbeing workstream group, linked with the Association of North East Councils (ANEC) and the Department of Health, was meeting to discuss developments and to feed into the NHS Transition Board and Local Authority Chief Executives Forum.

Work had also started to consider the role of Clinical Senates, they were unlikely to be decision making bodies but partners would need to look at how the Health and Wellbeing Board could access expert clinical advice. There would be a challenge in developing a consensus on what wellbeing really means and how organisations contribute to the health of a community. A joint narrative and clear priorities were required and a plan for how investment would be balanced across Sunderland for the future.

Moving forward, it was felt that there was genuine enthusiasm and that Health and Wellbeing Boards would be a vehicle for integrating change at a local level which should be actively encouraged.

The Chair commented on the new provision to refer commissioning plans back to the NHS Commissioning Board and suggested that it would be a failure for the Board if it found itself in that position. He asked if the Clinical Senate was to offer feedback to CCGs. Wendy advised that her view was that it was not there to scrutinise but could advise CCGs. She also noted that this was the opportunity for Early Implementer Health and Wellbeing Boards to think about what they would want from a Clinical Senate.

The Board were of the opinion that the Senate should bring a broader clinical perspective against the local view of the CCG but they must be wary of the Clinical Senate having a differing ethos based on the principles of cost effectiveness against the desire for better outcomes from the CCG.

At this point, Neil Revely highlighted that the presentation had set the scene for the Board to consider its future development. The Department of Health had established an Early Implementer Learning Network with seven learning sets of which only 15 local authorities could be members. He described the individual learning sets and that each Early Implementer was able to select their top three to be involved with. He asked the Board their preferences on the available learning sets. The seven themes for the learning sets were: -

1. Improving services for the community
2. Improving the health of the population
3. Bringing collaborative leadership to major service change

4. Creating effective and accountable structures
5. Raising the bar in joint needs assessment and strategies
6. Maximising opportunities for joint commissioning and integration across the NHS and local government
7. Making engagement rather than consultation with communities the norm

The Board agreed to express their interest in the learning set on 'Maximising opportunities for joint commissioning' and also to confirm that Sunderland would be happy to lead on one of the themes. The learning set preference had to be submitted by 23 September and Wendy Balmain agreed to pick that up outside of the meeting. The two fall-back themes would be 'bringing collaborative leadership to major service change' and 'improving the health of the population'.

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

(ii) Sunderland Early Implementer Health and Wellbeing Board express a preference to be involved in the Early Implementer Learning Set on 'Maximising opportunities for joint commissioning and integration across the NHS and local government'.

HW14. Update from the Adult Social Care Partnership Board and the Children's Trust

Councillor Speding, as Chair of the Adult Social Care Partnership Board, reported that the Partnership Board was moving to a new function position and acting as an agent of, and advisory body to, the Early Implementer Health and Wellbeing Board.

Neil Revely added that a good discussion had taken place regarding the relationships between the Partnership Board, the Children's Trust and the Health and Wellbeing Board and they would move forward on this by reviewing the membership of the Board, its terms of reference and the scheduling of meetings.

The main agenda items considered at the meeting held on 13 September had been: -

- Presentation on benefit reform – the Partnership Board had commissioned some work to look at the impact of this on the health and wellbeing of people in the city and would bring the findings back for consideration.
- Carers Strategy – it was felt that it was an appropriate time to review the strategy given the forthcoming changes as result of the Health and Social Care Bill.
- Joint Strategic Needs Assessment – the process was discussed and commented upon by the Partnership Board as a vehicle for the Early Implementer Health and Wellbeing Board.

The Chair was mindful that the benefits reform issue also affected young people and this needed to be taken on board in any work which was being carried out. Neil advised that the city as a whole was being looked at and early discussions had already taken place with Keith Moore and Nonnie Crawford on the issue.

In respect of the Children's Trust, Keith Moore highlighted that it was a secure, mature partnership with strong reporting and scrutiny arrangements with the Sunderland Safeguarding Children Board. Through 12 sub groups the core plans were developed and the Children and Young People's Plan Annual Report 2010/2011 was currently going through the formal Council processes for approval.

There continued to be a number of chronic children's health challenges including teenage pregnancy, obesity and levels of breast feeding. Services for early intervention were currently under review to identify where work should be targeted. Between the Children's Trust and Adult Social Care Partnership Board there was a responsibility for the whole family and a report on the formal relationship between the two groups and the Early Implementer Health and Wellbeing Board would be considered at the next meeting of the Trust in October.

Sue Winfield commented that the learning process from a recent Serious Case Review had served to reinforce the need to have a whole family approach and these linkages could be made through the Health and Wellbeing Board.

Having thanked the officers for their updates, the Early Implementer Health and Wellbeing Board: -

RESOLVED that the information be noted.

HW15. Update on the JSNA Priority Setting Process

Nonnie Crawford reminded the Board that a list of priority areas had been considered at the last meeting and reported that since then, a workshop session had been held with officers to start the process.

This would be a major renewal, with 28 priority areas to be considered and officers had already identified the current situation and any gaps which existed. The main gap was the lack of Equality Impact Assessments for a number of the areas.

The first draft of the document would be completed by 30 September and would be loaded on to the Sunderland Partnership website for comments to be made to the profile lead officers. It was also intended to have engagement managers to link with officers to assess the work that needed to be carried out.

The documentation would be completed by mid November and Sarah Reed would lead a group which would then develop a report for the Early Implementer Health and Wellbeing Board to consider in the New Year alongside priorities for commissioning plans. This work would lead to a much more coherent strategic needs assessment than had previously existed.

The report would be presented first to the Adult Social Care Partnership Board and the Children's Trust so that their comments could be fed into the Early Implementer Board.

The Chair highlighted that the Council was trying to achieve Level 3 of the Equalities Standard and that the Equalities Impact Assessment needed to be embedded in the decision making process to help achieve this aim.

He also raised the issue of community leadership and engagement with this process. Neil Revely advised that representatives from the community and voluntary sector had been part of the initial group as it had been the intention to engage them in forming what was being done, not to be consulted after it was done. It was felt that this had gone some way to informing the wider sector and Nonnie stated that it was hoped to have someone nominated from the Community Network to act as a link on specific priorities.

RESOLVED that the information be noted.

(Signed) P WATSON
Chair