**At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE on WEDNESDAY, 11TH JANUARY, 2012 at 5.30 p.m.**

**Present:-**

Councillor Walker in the Chair

Councillors Fletcher, Francis, Hall, Maddison, F. Miller, Padgett, Shattock, Snowdon and Waller, together with Ms. V. Brown, Dr. J. Dean 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. S. Cummings | - | Northumberland Tyne and Wear NHS Trust |
| Ms. K. Graham | - | Sunderland City Council |
| Ms. R. Grainger | - | Northumberland Tyne and Wear NHS Trust |
| Dr. D. Hambleton | - | NHS South of Tyne and Wear |
| Ms. C. Harries | - | City Hospitals Sunderland NHS Foundation Trust |
| Dr. G. Lawson | - | City Hospitals Sunderland NHS Foundation Trust |
| Mr. G. King | - | Sunderland City Council |
| Mr. D. Noon | - | Sunderland City Council |
| Mr. R. Patton | - | Northumberland Tyne and Wear NHS Trust |
| Mr. N. Revely | - | Sunderland City Council |
| Ms. L. Topping | - | NHS South of Tyne and Wear |
| Mr. J. Usher | - | Sunderland City Council |
| Ms. H. Wardropper | - | Sunderland City Council |
| Ms. S. Winfield | - | Sunderland Teaching Primary Care Trust |

**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 Councillor N. Wright, together with Ms. E. Inglesby.

## Declarations of Interest

Councillor Hall declared a personal interest in item 4 on the agenda (Health, Housing and Adult Services 15 Year Strategy) as an employee of Anchor Trust.

## Minutes of the Last Meeting of the Committee held on 7th December, 2011

1. RESOLVED that the minutes of the last meeting of the Committee held on 7th December, 2011 be confirmed and signed as a correct record.

## Change in the Order of Business

The Chairman advised that he would take the following item of business at this juncture to allow the NHS representatives to leave thereafter.

## NHS South of Tyne and Wear Acute Paediatric Services – Consultation

The Director of Commissioning and Reform submitted a report (copy circulated) which informed the Committee of the public consultation being undertaken to allow health professionals, patients and the general public to give their views on the future of services for acutely sick and injured children across Gateshead, Sunderland and South Tyneside.

(For copy report – see original minutes).

To complement the report, Dr. David Hambleton, provided Members with a comprehensive powerpoint presentation on the process together with Dr. Geoff Lawson who provided the Committee with a clinical perspective.

Members were advised of:-

(i) the following two options for change

Option One:

Implementation of a range of service developments including:

- walk-in services available to children of all ages
- children's community nursing team support for acutely ill and injured children and young people
- children's short-stay assessment units in hospitals in Gateshead, Sunderland and South Tyneside, available for limited hours, eg 8.00am - 10.00pm
- inpatient care available at Sunderland Royal Hospital and the Great North Children's Hospital at the Royal Victoria Infirmary, Newcastle.

Option Two:

Implementation of a range of service developments including:

- walk-in services available to children of all ages
- children's community nursing team support for acutely ill and injured children and young people
- children's short-stay assessment units in hospitals in Gateshead, Sunderland and South Tyneside, available for 24 hours each day
- inpatient care available at Sunderland Royal Hospital and the Great North Children's Hospital at the Royal Victoria Infirmary, Newcastle.

(ii) the drivers for change,

(iii) the engagement work carried out with parents and young people together with the feedback received,

(iv) the data reviews undertaken in Sunderland, South Tyneside and Gateshead,

(v) financial support provided by the PCT to support services for children,

(vi) the clinical evidence base for change including illustrative case studies showing how care would be provided following the reforms,

(vii) the next steps in the review process.

Dr. Hambleton and Dr. Lawson proceeded to address questions and comments from Members in relation to:-

(i) the provision of training to Walk in Centre staff to help them deal with the concerns of anxious parents,

(ii) the availability of appropriate public transport information in the treatment facilities,

(iii) examples of where the preferred model of operation (Option 2) had been successfully introduced elsewhere in the UK,

(iv) the overall percentage of bed losses under the proposal,

(v) concerns from residents that community nursing was not operating as effectively as hoped,

(vi) options available for teenagers to be treated in either paediatrics or mainstream adult services,

(vii) implications of the reforms for GP practices.

Consideration having been given to the matter, Members indicated that they would be minded to support Option 2 with regard to the proposed reform of acute health services for children and young people.

The Chairman having thanked, Dr. Hambleton, Dr. Lawson and Ms. Winfield for their report and presentation, it was:-

2. RESOLVED that the Health and Wellbeing Scrutiny Committee endorsed Option 2 as detailed in 'Getting Better Together' the NHS South of Tyne and Wear public consultation document on acute health services for children and young people.

**Health, Housing and Adult Services 15 Year Strategy – Update**

The Executive Directors of Health, Housing and Adult Services and City Services submitted a joint report (copy circulated) which updated the Committee on the Directorate's 15 Year Strategy and implementation of the 3 year delivery plan.

(For copy report – see original minutes).

Neil Revely, Executive Director of Health, Housing and Adult Services presented the report and submitted apologies from Councillor Allan, the Portfolio Holder for Health and Wellbeing who was unable to attend the meeting.

In addition Mr. Revely provided Members with a comprehensive presentation highlighting:-

(i) the following successes of the first 3 year delivery plan

- Reviewed care management and assessment process – locality working and focus on self-directed support
- Introduction of Reablement at Home Service
- Further development of extra care schemes
- Widened opportunities for accessing universal services e.g. Aquatic Centre Staff
- Jointly funded (NHS/LA) projects within voluntary and community sector via grants assistance process
- Introduced and developed Quality Standards for Care Home for Older People
- Transferred responsibility for commissioning learning disabilities services to the Council
- Put in place outcome based specifications and contracts for services
- Delivered significant levels of efficiency for the Council through reinvesting in key services
- Continue to deliver services across all four Fair Access to Care bands

(ii) the main themes of the current three year plan, i.e. prevention, reablement and personalisation,

(iii) the main policy drivers from central government with regard to the direction of adult social care,

(iv) how the future customer experience would appear e.g.

- Initial contact will be through the customer service network
- Universal Services increasingly being the response to customer need
- Reablement will provide intensive support for short periods
- Further accommodation choices will provide the alternative to institutional care
- Fewer customers will need long term support
- Personal budgets in place for all customers

Councillor Padgett related a case of a constituent having to wait 3 months for an assessment. Mr. Revely replied that the care management and assessment process had been reviewed to improve the end to end process. Clearly 3 months was an unacceptable period of time and Mr. Revely asked Members that any problems of this nature were brought to his attention.

In response to an enquiry from Councillor F. Miller, Mr. Revely outlined the role of advocates and carers with regard to the provision of personal budgets to people who had difficulty with decision making.

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

3. RESOLVED that the update report and presentation on the Health, Housing and Adult Services 15 Year Strategy be received and noted.

**Update on the Development of the HealthWatch Sunderland**

The Deputy Executive Director of Health, Housing and Adult Services submitted a report (copy circulated) which provided Members with information on the Government's HealthWatch Transition Plan, an update on HealthWatch Transition in Sunderland, together with information for future consideration regarding the relationship between the Health and Wellbeing Scrutiny Committee and HealthWatch Sunderland.

(For copy report – see original minutes).

Neil Revely, Executive Director of Health, Housing and Adult Services presented the report, and with regard to local progress advised that a dedicated HealthWatch Transition workstream had been developed with delivery via a working group with representatives from Key Stakeholders. The transition was being led by Sue Winfield, Vice Chair of NHS South of Tyne and Wear supported by Jean Carter, Deputy Executive Director of Health, Housing and Adult Services. The working group would continue to develop the service specification for a local HealthWatch taking into account the views collated to date. As national guidance became available this would be included within the workstream plan.

In response to an enquiry from Councillor Shattock regarding who would hold HealthWatch to account, Mr. Revely advised that this was still to be worked through. It would however be accountable to the Local Authority as commissioner via contractual arrangements, by the Scrutiny Committee with regard to social health care aspects. Health Care England would also hold it accountable at a professional level.

The Chairman welcomed that both he and the Vice Chair would have the opportunity to meet with Mr. Revely and the link officers to discuss the role of the Committee within the new arrangements.

The Chairman having thanked Mr. Revely for his report, it was:-

4. RESOLVED that the report be received and noted.

**Improvements to Out of Hours Provision in Sunderland**

The Executive Director of Health, Housing and Adult Services submitted a report (copy circulated) which briefed Members on continuous improvements made to the Out of Hours provision (OOHs) with regard to Adult Social Care following the last report submitted in December 2010.

(For copy report – see original minutes).

Jim Usher, General Manager, Disability Services presented the report highlighting the following improvements to the Out of Hours Service.

(i) the routing of all OOHs calls through the Customer Contact Centre enabling an improved analysis of demand,

(ii) planned training with Northumbria University to increase the number of Approved Mental Health Practitioners (AMHPs),

(iii) the increased use of agile working to allow Social Care practitioners to work alongside Contact Centre staff to enable issues to be resolved in a more timely way,

(iv) improved communications with housing colleagues to ensure a better use of emergency accommodation.

In response to an enquiry from Dr. Dean, Mr. Usher advised that he felt the service was currently operating at 75% of where he would ideally like it to be.

With regard to an enquiry from Ms. Brown, Mr. Usher advised that the list of emergency accommodation vacancies was held by the Housing Options Team.

The Chairman having requested that the Committee continue to be kept informed of progress, thanked Mr. Usher for his report, and it was:-

5. RESOLVED that the report be received and noted and that further progress reports be submitted in due course.

**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, it was:-

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

**Forward Plan – Key Decisions for the Period 1st January, 2012 to 30th April, 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 January, 2012 to 30th April, 2012.

(For copy report – see original minutes).

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

7. 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 22 February 2012**

**Development of a Sunderland Health & Wellbeing Strategy**

**REPORT OF Head of Strategy, Policy and Performance Management**

## 1. Purpose of Report

1.1 To outline the process and timetable for the development of the Health and Wellbeing Strategy.

## 2. Background

2.1 The Health and Social Care Bill gives 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

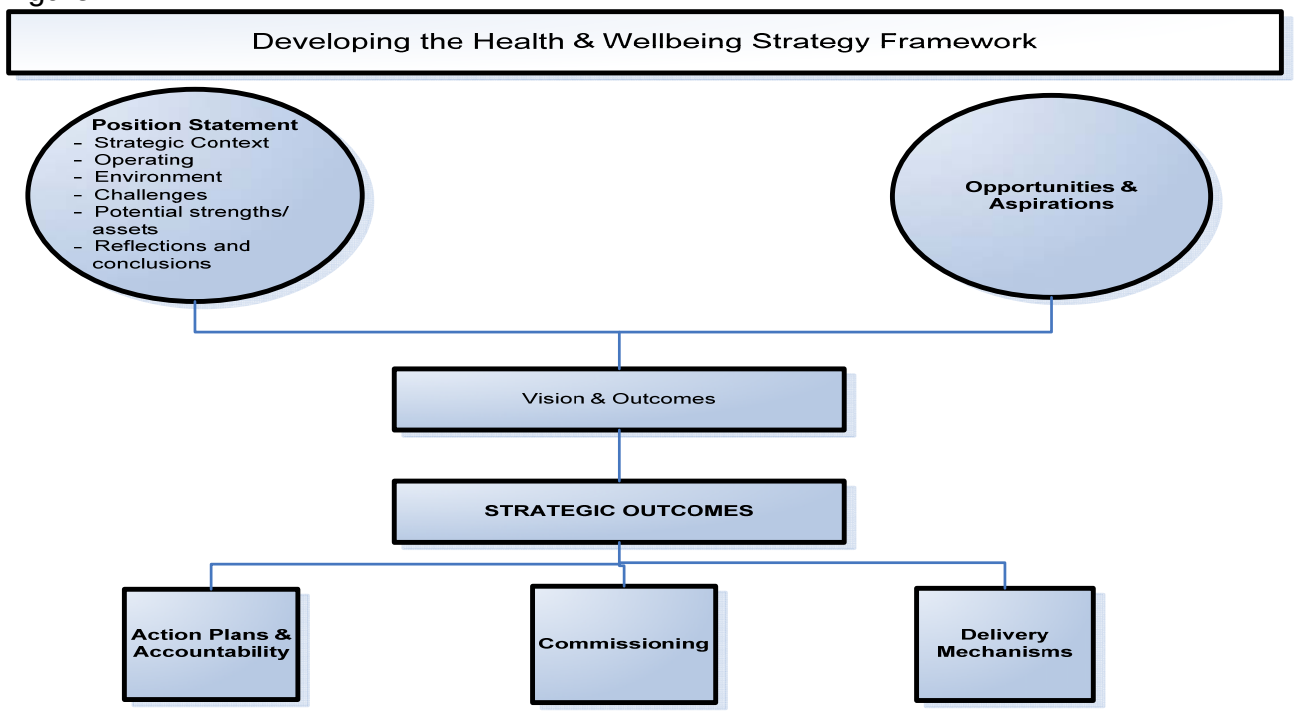
2.2 The Health and Wellbeing Strategy must be completed by October 2012 and must be a joint high-level strategy that spans NHS, social care, public health and the wider health determinants of health such as housing and child and community poverty.

## 3. Current Situation

3.1 The Health and Wellbeing Strategy will be developed as highlighted in figure 1 below. The process started through the establishment of the current position through an examination of the evidence gathered through the development of the Sunderland JSNA alongside priorities set by broader partners at an engagement event held in January.

3.2 The Board is developing its high level visions, values and aspirations which will lead into strategic objectives, commissioning and action planning.

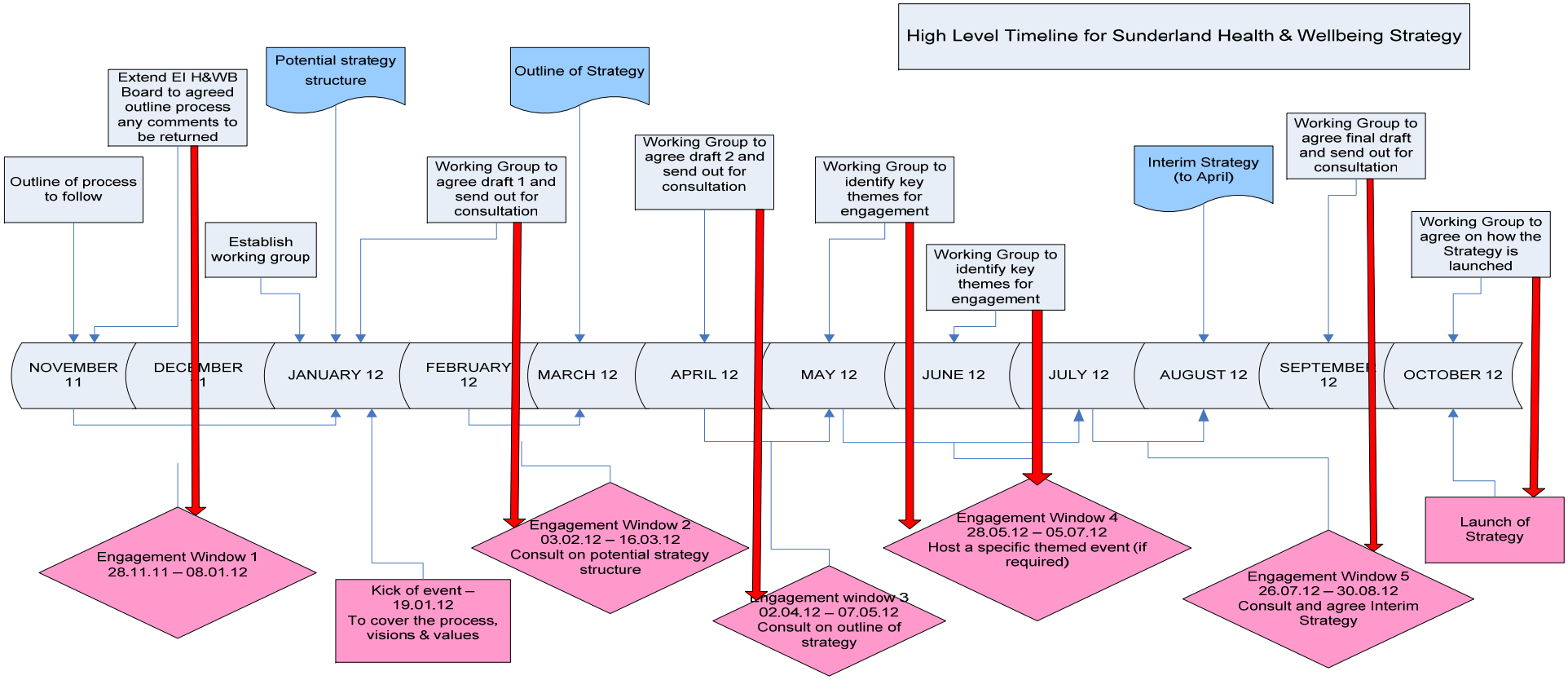
Figure 1




3.3 A working group has been established to oversee the drafting and editing of the strategy. Membership is open to interested parties and currently includes representatives from the local authority, PCT, Clinical Commissioning Group, acute and foundations trusts and Sunderland University. It is chaired by the Executive Director for Health Housing and Adult Services.

3.4 The Board is committed to broadly engaging a wide range of partners in the development of the strategy and as such has developed a full engagement and consultation programme as set out in Figure 2.

3.5 Although engagement windows will be based around central consultation exercises, there is a commitment to engage with partners in a variety of methods and as meets the needs of that group or individual. Iterations of the report will be taken to statutory bodies and partnerships throughout the process for comment and amendment.




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

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

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

## 4. Conclusion & Recommendations

4.1 The Committee is requested to note the content of the report

## 5. Background Papers

Health and Social Care Bill

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**Contact Officer:** Karen Graham
Karen.graham@sunderland.gov.uk

**HEALTH AND WELL-BEING SCRUTINY COMMITTEE 22 February 2012**

# Sunderland Clinical Commissioning Group Commissioning Plan 2012 - 2017

## 1. Purpose of the Report

1.1 To share the draft version of the Sunderland Clinical Commissioning Group (SCCG) Clear and Credible Plan (CCP) with the Committee for consideration and comment.

## 2. Background

2.1 2012/13 is a year of transition for the commissioning of health services in Sunderland. Although the PCT is still formally accountable for the NHS commissioning budget, responsibility is increasingly being delegated to the CCG for the commissioning of those services which will transfer to them, while it is expected that the public health budget and responsibilities will transfer to the Local Authority by April 2012.

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

## 3. Current Situation

3.1 Department of Health guidance on the development of Clinical Commissioning Groups requires them to develop a 5 year strategic plan which sets out:

- their vision;

- the challenges they face;
- their strategy for tackling those challenges; and
- arrangements for delivering the changes.

3.2 The Sunderland CCG Pathfinder Committee has worked since October 2011 to articulate this plan and at the end of December 2011 produced a first draft / work in progress to share with partners at the earliest possible stage to ensure that the plan develops in harmony with the local authority and other local partner plans.

3.3 It is very much a work in progress for early sharing. The Plan is also being shared with patients, carers and the public and offers have been made to visit groups and discuss the plan where requested. The Plan will also be shared with other stakeholders and the Executive Committee are planning an event for key stakeholders in early March along side an event for the 54 member Practices at the end of February.

## 4. Conclusion and Recommendations:

4.1 The Committee is recommended to:

1. Note the draft SCCG Commissioning Plan
2. Discuss and feedback comments on the Plan.
3. Receive a summary of the ISOP and the planned changes for 12/13 at their first meeting in the new financial year.

## 5. Background Papers

NHS Operating Framework 2012/13
Developing Clinical Commissioning Groups – Towards Authorisation (Sept 2011)

Contact Officer: Debbie Burnicle, Head of Commissioning Development, NHS South of Tyne and Wear
debbie.burnicle@sotw.nhs.uk


# Sunderland Clinical Commissioning Group

# Clear and Credible Commissioning Plan

## 2012-2017

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**Draft Version 1: 24.1.12**

# Sunderland Commissioning Plan 2012 - 2017

## Contents



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# Clinical Commissioning Group Chair Foreword

To follow

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# Section 1 – Executive Summary

## Sunderland Clinical Commmissioning Group – Who are we?

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

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

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

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



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

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

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# Section 2 - Vision

## 2.1 Vision

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

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

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

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

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

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

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## 2.2.1 Improve the health and well being of local people

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

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

**Addressing inequalities**

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

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

**Prevention**

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

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

**Identification integration and navigation**

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

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

**Engagement**

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

Improved engagement with communities of greatest need through locality working;

**Choice and control**

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

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

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

.....

## 2.2.2 Integrate services better across health and social care

**Our future services will demonstrate:**

**Integration**

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

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

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

Increased synergies resulting from streamlining and integrating pathways;

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

**Quality**

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

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

**Access and choice**

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

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

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

.....

### 2.2.3 More effective clinical decision making

**By 2017 effective clinical decision making will be evidenced by:**

**Communication**

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

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

**Evidence based**

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

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

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

Using both nationally agreed and local guidance

**Standardisation of provision**

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

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

.....

**In summary by 2017, our patients will:**

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

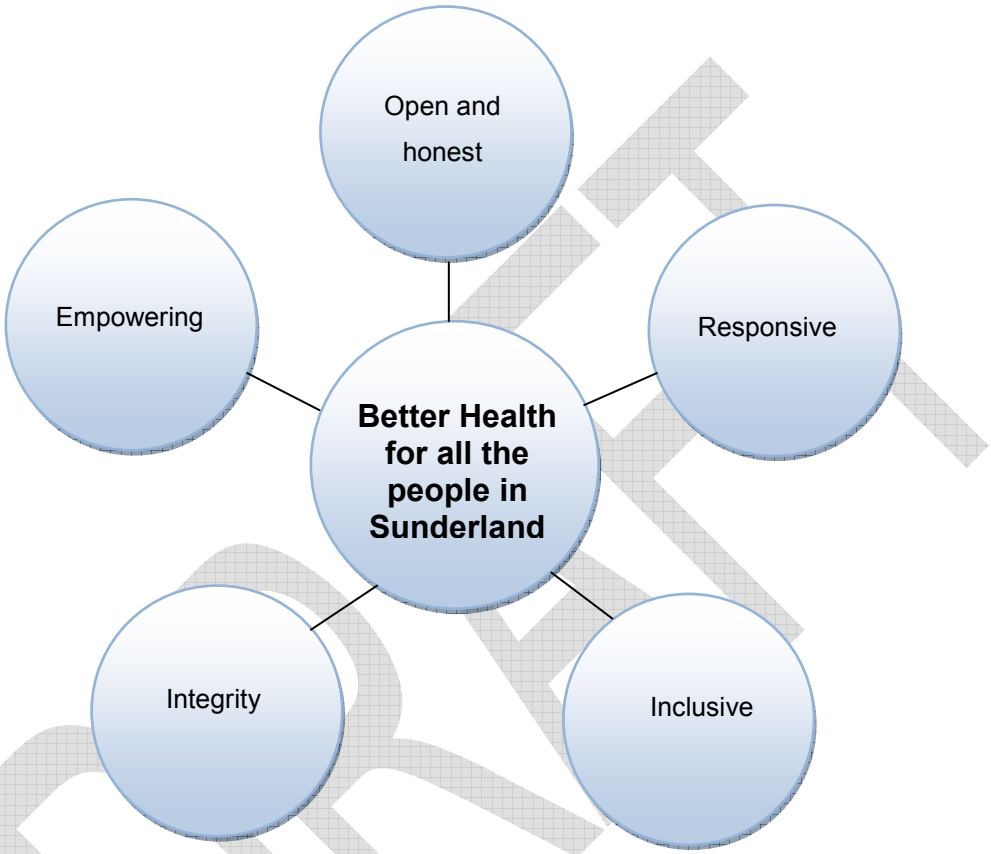
Have input into the processes for making decisions about their healthcare;

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

Have confidence in the services we commission.

## 2.3 Core Values

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




## 2.4 Commissioning for Quality

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

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# Section 3 – The Big Challenges for Sunderland

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

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

**Health which is generally worse than the rest of England;**

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

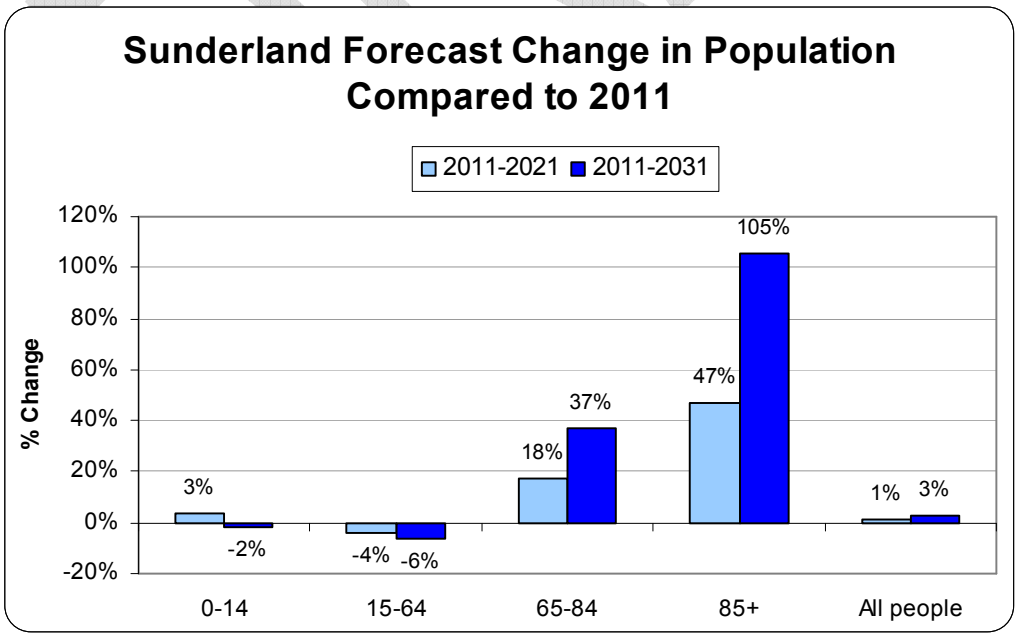
**An over-reliance on hospital care;**

**Services which are fragmented and lack integration.**

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

## 3.1 Overview of the Sunderland population

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




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

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

### 3.1.1 Overview of health in Sunderland

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

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

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## Health summary for Sunderland

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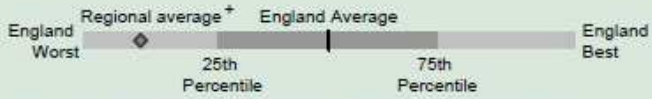
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England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

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



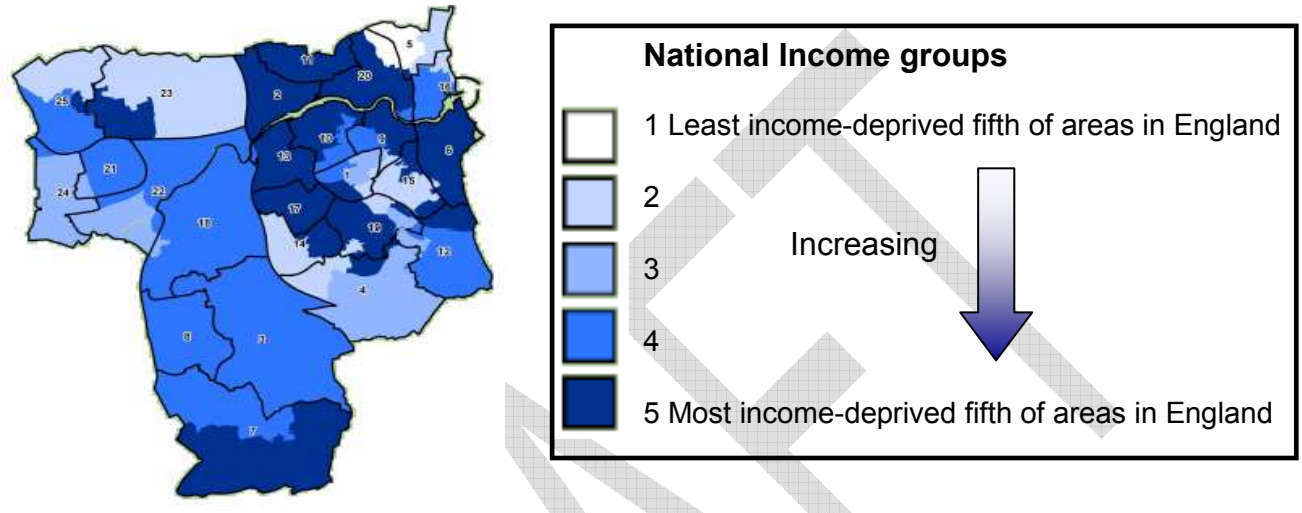

+ In the South East Region this represents the Strategic Health Authority average

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

*Source: Association of Public Health Observatories*

### 3.1.2. Income inequalities

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




## 3.2 Challenges identified in the Joint Strategic Needs Assessment

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

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

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

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

### 3.2.1 Summary of JSNA messages

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

Increasing life expectancy and reducing health inequalities;

A tiered approach to prevention and risk management;

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

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

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

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

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

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

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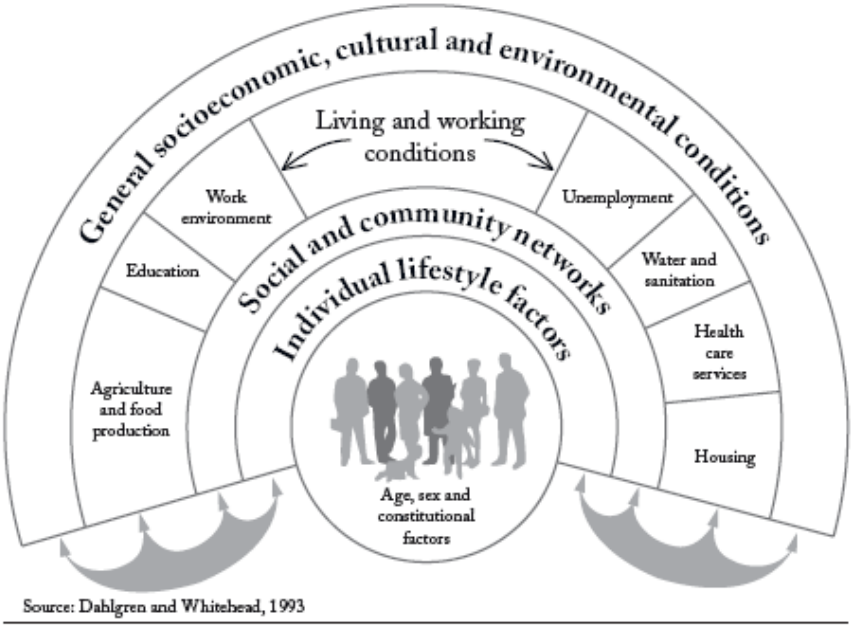
Figure 1. The Main Determinants of Health




Source: Dahlgren and Whitehead, 1993

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

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

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

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

### 3.2.3 Life expectancy challenge

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

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

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

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

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

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

Systematic cardiac rehabilitation;

Systematic COPD treatment with appropriate local targets;

Develop & extend diabetes best practice with appropriate local targets;

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

Cancer early awareness and detection;

Identification and management of Atrial Fibrillation.

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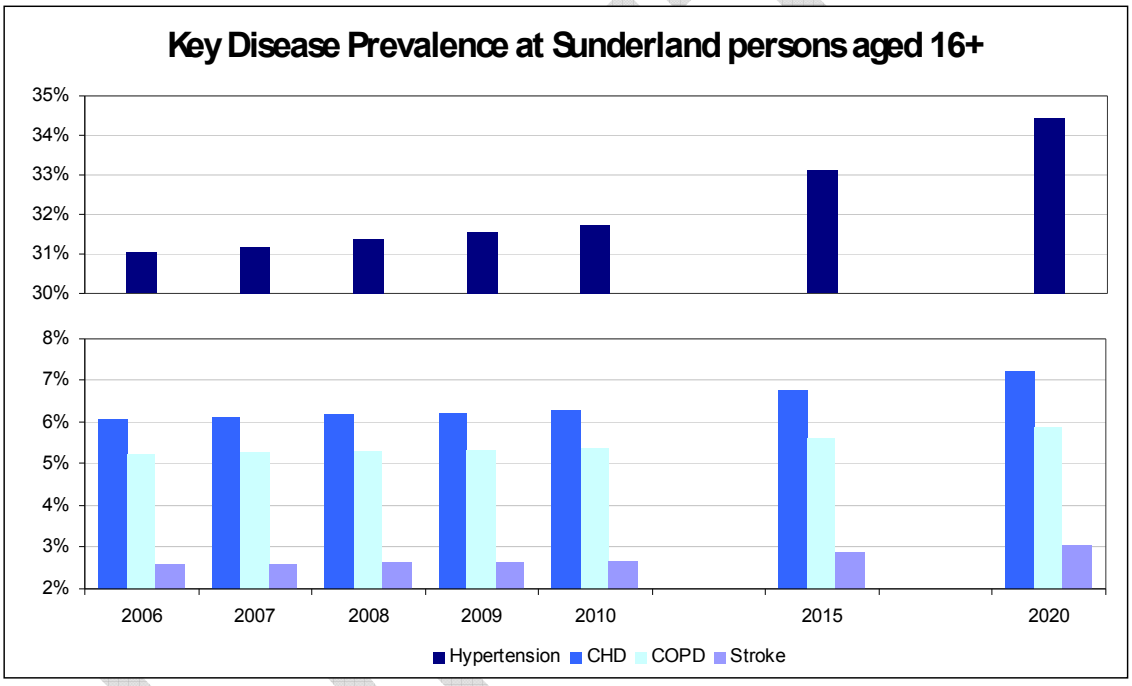
### 3.2.4 Expected disease prevalence

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



## 3.3 Challenges identified by patients, public, clinicians and partners

### 3.3.1 Patients and the public

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

**Further detail to follow…**

### 3.3.2 Clinicians (including practices)

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

**Further detail to follow…**

### 3.3.3 Partners and Stakeholders

**To follow**

## 3.4 Challenges set out in national policy

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

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### 3.4.1. Current performance challenges

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

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

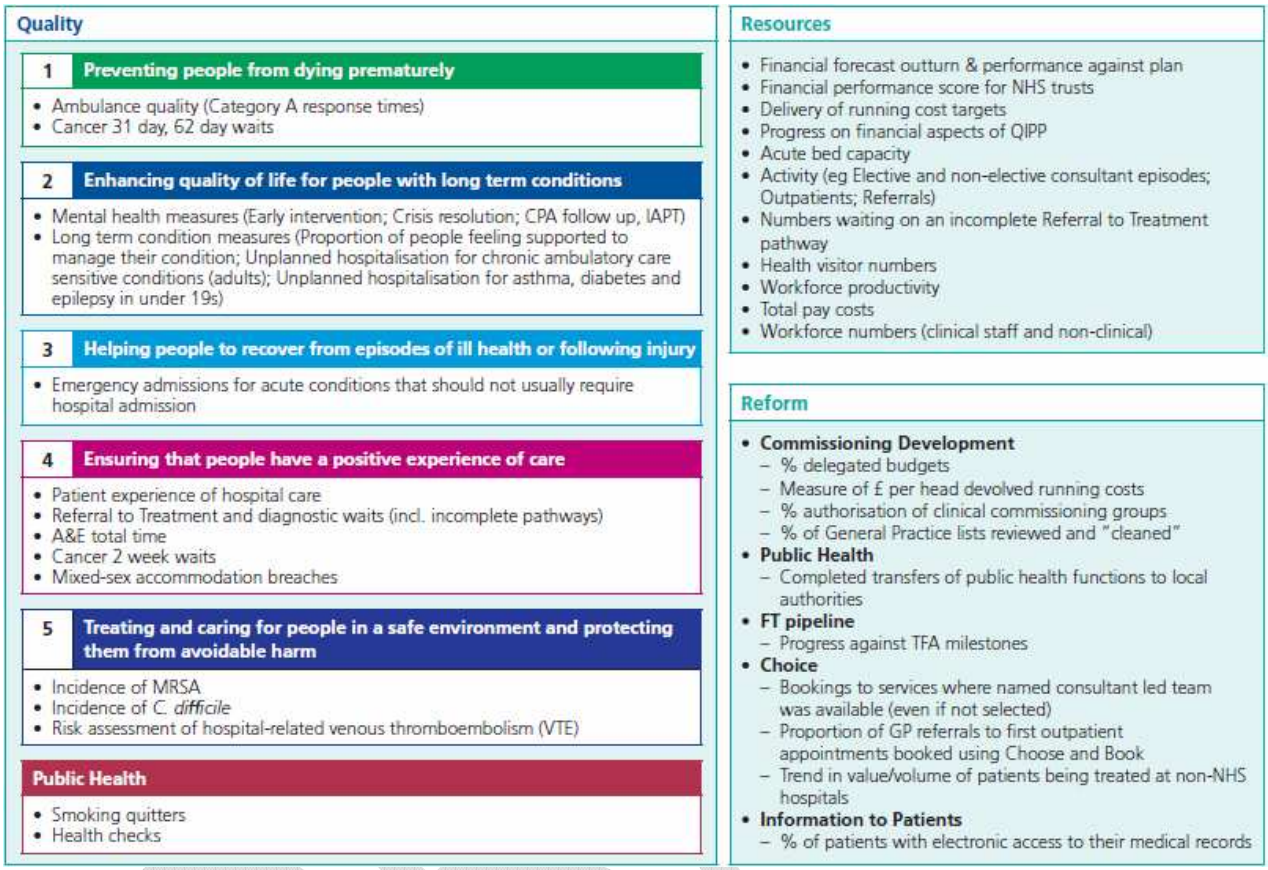
### 3.4.2 Additional challenges in the NHS Operating Framework 2012/13

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

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

- Emergency Preparedness

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




## 3.5 Challenges posed by existing provider landscape

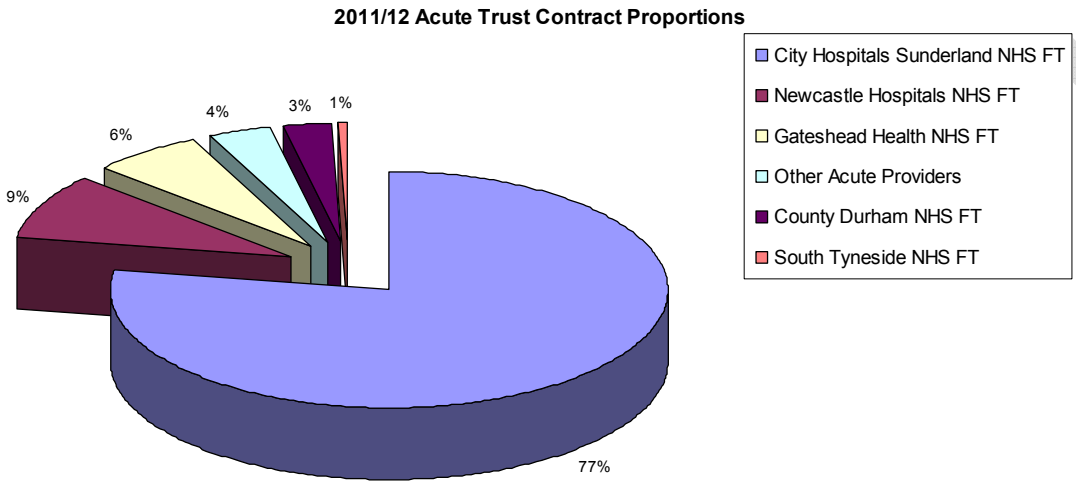
As well as the health and service challenges described in this chapter, the services which we are able to commission are constrained in the short term by the current shape and availability of local services and the major challenges involved in any significant change to this configuration and pattern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

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

### 3.5.1. Current pattern of acute hospital use

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

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



### 3.5.2. Current pattern of Community Service use

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

### 3.5.3 Current pattern of Mental Health Service use

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

## 3.6 Challenges likely in the future

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

The modelling also allows us to ensure that:

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

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

### 3.6.1 Hospital Activity Model

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

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

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

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

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

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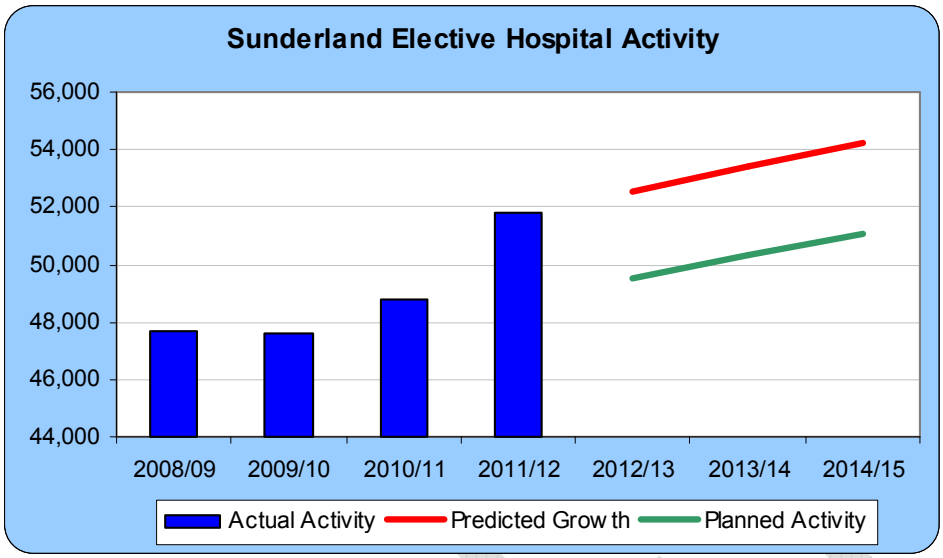
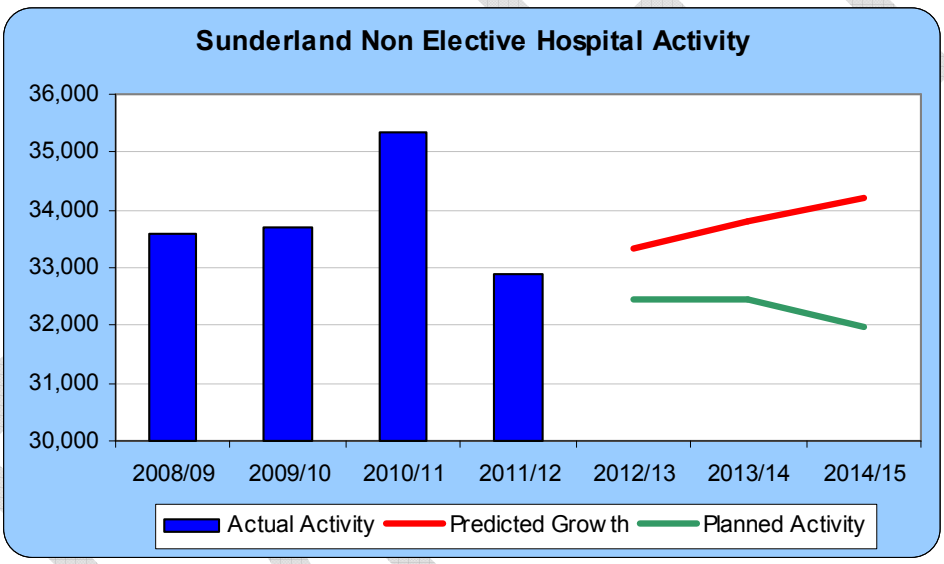
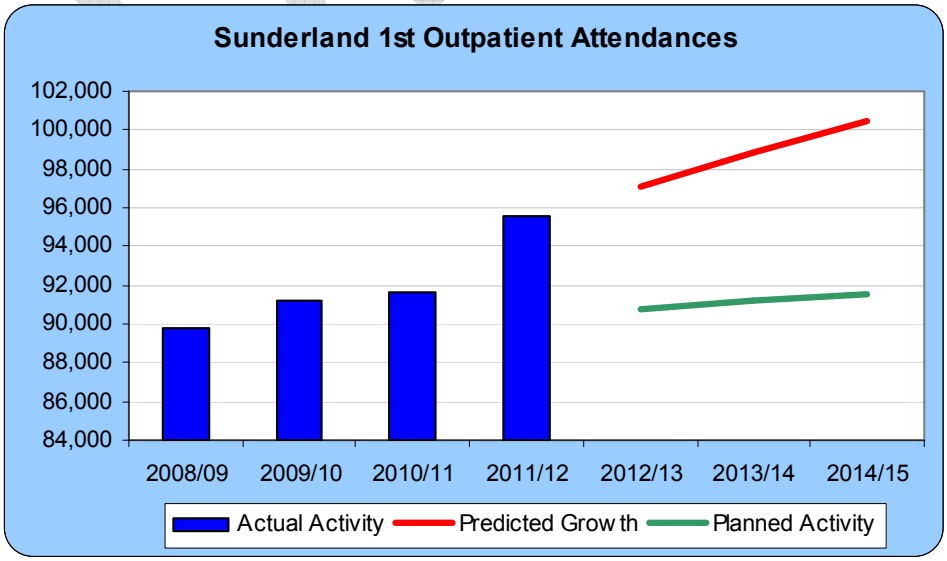
The following charts illustrate the expected impact of our initaitives. The red lines represent the predicted growth in activity over the next three years, while the green lines show how the plans for activity reductions mitigate this growth.



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

## 3.7 Financial Challenges including QIPP

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

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

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# Section 4 – Strategy

## 4.1 Our Success so far

Our pathfinder application set out the following priority areas:

- Urgent Care
- COPD
- Prescribing
- Clinical Effectiveness.

Our achievements to date against these priorities are highlighted below:

**Urgent Care**

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

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

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

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

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

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

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

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

**COPD**

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

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

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

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

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

**Prescribing**

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

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

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

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



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**Clinical Effectiveness**

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

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

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

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

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

**Other work Areas**

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

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

## 4.2 Overview of our Strategic Objectives and initiatives

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

Prevention, empowerment and resilience;

Seamless integrated pathways

Mature Clinical relationships which add value and increased standardisation

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

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

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

Providing More Planned care closer to home

Systematically improving the quality of prescribing in Practices

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

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

From challenges (where are we now?);

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

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

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

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

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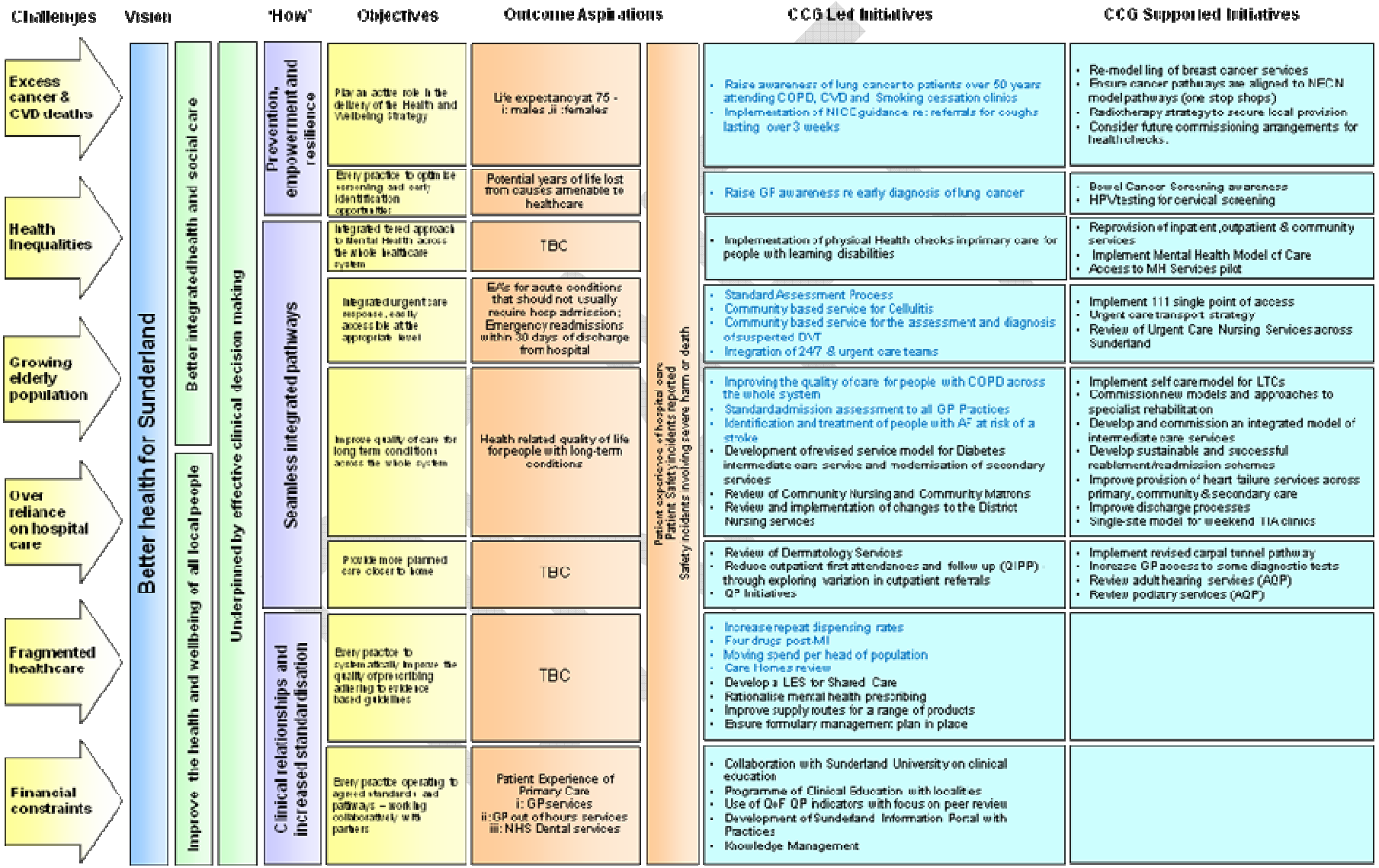
# Future provision of health and social care in Sunderland - 'Plan on a Page'



## 4.2 Initiatives to deliver changes

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

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

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

A process has been used to enable us to:

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

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

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

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

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

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

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

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

## 4.3 Strategic Programmes

### Context, Vision, Strategy, Initiatives, Outcomes, Measures

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

Why is change needed?

How do we want the future to look?

What are we doing about it?

What impact will these actions have?

How much will this cost or save?

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

What is distinctive about the planned approach?

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

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

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# MEDICINES MANAGEMENT

## Why is change needed?

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

## Objective

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

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

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

## What are we doing about it?

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

## How much will this cost or save?

## What KPIs will we use to monitor progress?

**Headline Measures**

**Supporting Measures**

**Local Measures**

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

## Implications, Risks and Mitigating Actions

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

### Communications Implications

- Communication strategy required with all key stakeholders

### Informatics Implications

- Monitoring of action plans

### Estates Implications

- Minimal

### Workforce Implications

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

## 4.4 Prioritisation and financial strategy

To follow

## 4.5 Impact of our strategy on the market

To follow

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# Section 5 – Delivery and Transition

## 5.1 Overview

to follow

## 5.2 Organisational Development

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

An Organisational Development Plan has been developed in order to:

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

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

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### 5.2.1 Internal Leadership

#### 5.2.1.1 Executive Committee

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


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

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

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

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

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

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

## 5.3 Primary Care involvement

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

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

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

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## 5.4 External Leadership

To follow

## 5.5 Working with partners and stakeholders

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

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

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

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

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

## 5.6 Health and Well Being Boards

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

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

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

Development of the Sunderland Health and Wellbeing Strategy;

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

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

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

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

## 5.7 Patients and the Public

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



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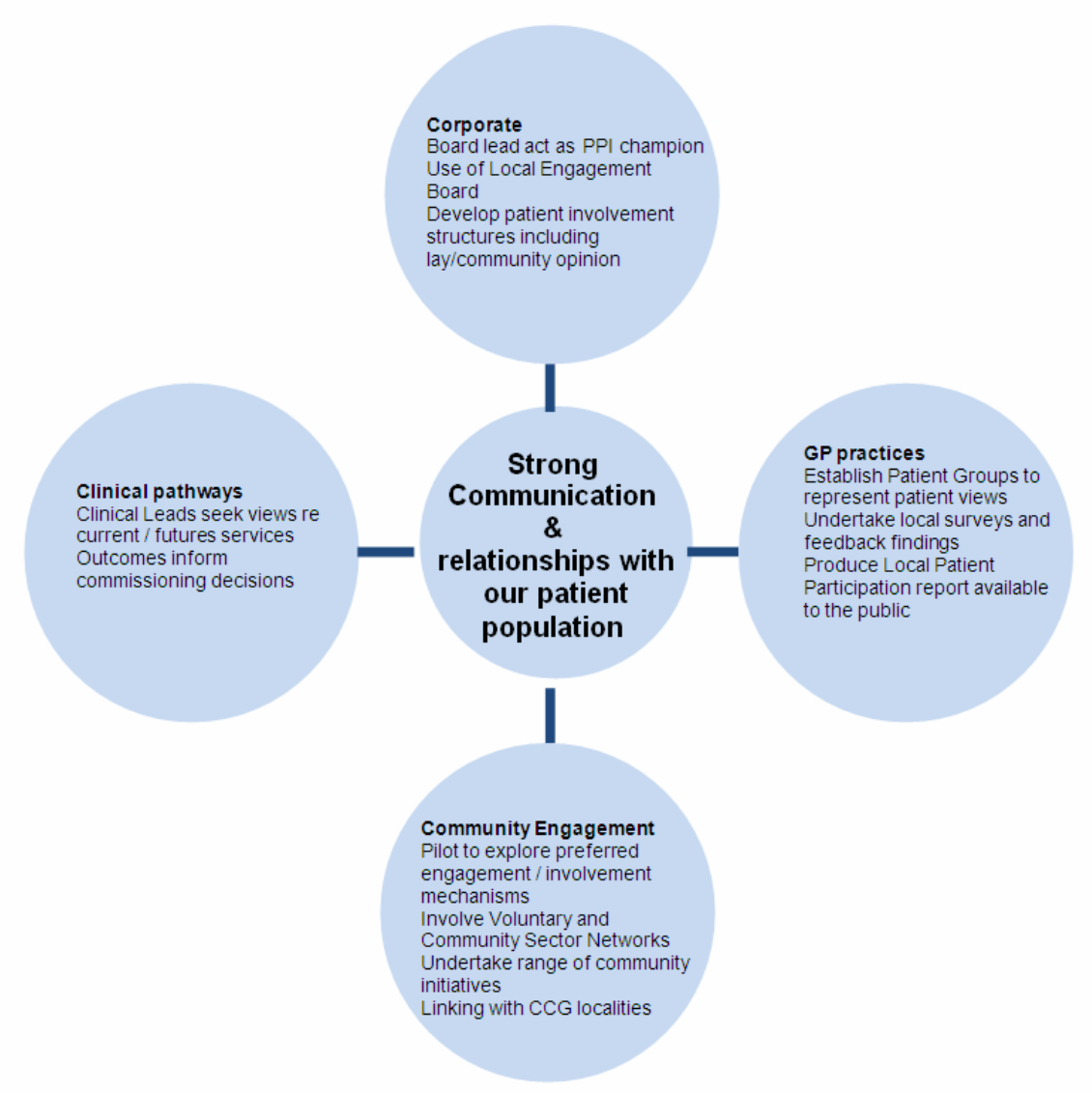
services in order to ensure that their needs and wants are met, and that healthcare is accessible and responsive to their views and experiences. We have a unique position in that we communicate with patients on a daily basis and welcome the opportunity to harness this experience in order to develop strong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

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


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

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



## 5.8 Commissioning Support

### 5.8.1 Current support from the PCT

to follow

### 5.8.2 Commissioning Support Organisation

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

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

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

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

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

| | |
|---|---|
| • Continuing Healthcare<br>• Financial Management | |

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

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

## 5.9 Delivery of safe high quality care

To follow

## 5.10 Workforce

To follow

## 5.11 Estates

To follow

## 5.12 Informatics

To follow

## 5.13 Proactive Management of Risks

### 5.13.1System Risks

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

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

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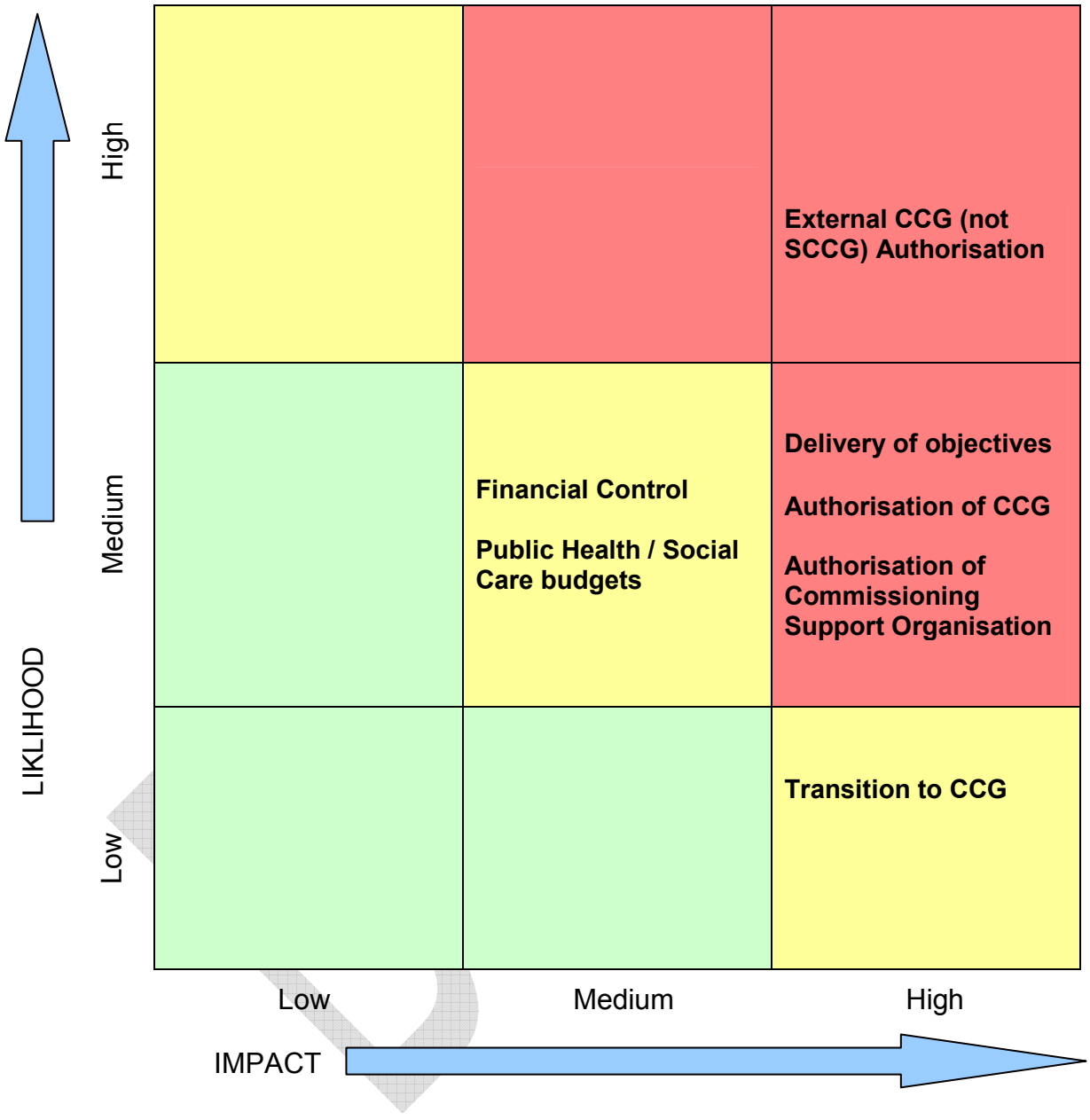
system wide transformational change in the short to medium term. These have been assessed for impact and likelihood and are plotted on the following chart.

***Assessment of cross cutting risks***




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

# RISK LOG

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

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

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

| | |
|---|---|
| | § appointment of AO and DoF, |

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

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

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

## 5.14 Governance

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

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

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

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

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

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# Section 6 – Declaration of Approval from Pathfinder Committee

To Follow

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# HEALTH AND WELL-BEING SCRUTINY COMMITTEE 22 February 2012

## Public Health Transition

### REPORT OF DIRECTOR OF PUBLIC HEALTH AND ASSISTANT CHIEF EXECUTIVE

**1.0 Purpose of the Report**

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

**2.0 Background Information**

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

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

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

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

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

**2.1 Public health in local government**

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

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

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

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

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

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

**2.2 Public Health England's operating model**

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

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

**2.3 A focus on public health outcomes**

In terms of the new Public Health scheme the focus will be on outcomes. A new Public Health Outcomes Framework will set out key indicators of public health from the wider determinants of health

through to effectiveness in reducing premature mortality. The overall goals will be to increase life and healthy expectancy and reduce health inequalities. The Public Health Outcomes Framework was published in January 2012 and will be aligned with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework.

**2.4 The public health workforce**

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

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

**2.5 Timetable for Transitions**

Subject to the passage of the Bill, these statutory changes will take place from 1 April 2013. Much work will need to be done over the next 16 months at a local level to bring in new ways of working. The key milestones are:

- completion of plans for transfer of directors of public health to local authorities – March 2012
- PHE's chief executive designate appointed – April 2012
- PHE organisational design – May 2012
- pre-appointment processes complete – October 2012
- Formal transfers of statutory responsibilities – 1 April 2013.

**3.0 Local Authority Transition Planning Process**

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

| Date in 2012 | Action |
|---|---|
| Fri 27 Jan | SHA clusters make initial submissions for 2012/13 to David Flory cc Performance Delivery Team contact at DH |
| Mon 31 Jan – Wed 8 Feb | First cut analysis of data and submissions by DH & internal DH meetings to discuss plans |
| Thurs 9 Feb – Fri 30 Mar | DH and SHA cluster discussions and feedback on progress of plans |
| 31 Mar | All contracts expected to be signed off |
| Thurs 5 Apr | SHA clusters make final submissions for 2012/13 |

| | |
|---|---|
| Tues 10 Apr – Fri 20 Apr | Analysis of plans by DH & internal DH meetings to discuss plans |
| Wed 25 Apr – Fri 4 May | David Flory meetings with SHA clusters to sign off plans with formal sign off letters being issued shortly afterwards. Meetings will combine a look back at 2011/12 together with forward look |

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

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

Attached in **Appendix 1** is the Public Health Transition Planning Assurance. The Public Health Functions will be integrated within the Sunderland Ways of Working Operating Model; and a draft Memorandum of Understanding for the year 2012/2013 will be drafted between NHS SoTW and Council to assist governance and assurance during transition. A risk register of critical areas moving forwards has been established. As additional guidance is published and on the basis of further discussions internally and with other North East local authorities, it is anticipated that mitigating measures will be in place before formal transition occurs.

A key deadline for Sunderland is the 5th April 2012 where the full and detailed transition plan must be submitted to the DH. The plan will go in advance to both the Council's and PCT's decision making bodies.

It is expected nationally that by the end of October 2012 and definitely no later than 31st December 2012, the majority of PCTs will have transferred the public health duties to local authorities with robust governance in place for the remainder of 2012/13.

By the end of March 2013 all PCTs must have completed the formal handover of public health responsibilities and budgets to local authorities.

## 4.0 Recommendations

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

# Sunderland TPCT/City Council

**RAG rating criteria**

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

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

Criteria Met/Actions completed

## Public Health Transition Planning Assurance 2011-13

| Objective | Ref no. | Requirement | Evidence of Assurance | Is assurance complete? YES | NO | Partially | Rag rating | Comments |
|---|---|---|---|---|---|---|---|---|
| **Ensuring a robust transfer of systems and services** | **1.1** | Is there an understood and agreed (PCT cluster/LA) set of arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013? | PHTP 1A and Appendix 1 Sunderland Operating Model-SR | | | **X** | Amber/Red | Agreement in principle and some detail exists for an operating model during transition. LA have agreed high level and detail required around governance and assurance and financial |
| | **1.2** | Is there a clear local plan which sets out the main elements of transfer including functions, staff and commissioning contracts for 2013/14 and beyond? | PHTP 1B and Appendices 1-3 | **X** | | | | PHTP demonstrates high level work and LA developed workstream spreadsheet demonstrates separate work streams and timelines. Will wish to review progress on |
| | **1.3** | Are there locally agreed transition milestones for the transition year, 2012/13? | PHTP page 5 and throughout | | | **X** | | Significant transition milestones have been agreed e.g. journey through Council and PCT processes |
| | **1.4** | Is there a clear local plan for developing the JSNA in order to support the H&WB strategy? | PHTP 1D Sunderland LSP Website and Minutes of H&WB Meeting December, Agenda for EIH&WB February | **X** | | | | Work on the refreshed JSNA and embedding it within transformed Council processes has been underway |
| | **1.5** | Is there a clearly developed plan for ensuring a smooth transfer of commissioning arrangements for the services described in *Healthy Lives, Healthy People* that Local Authorities will be responsible for commissioning? | Contract Grids available via Mark Overton at NHS SoTW outlining service review work, PHTP 1E, Appendix 1 & 2 | | | **X** | | Service reviews have been delivered in all key health improvement commissioned programmes. Finance, outcomes and current performance have been identified for the most up to date year available. The |

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|---|---|---|---|---|---|---|---|---|
| | **1.6** | Is there a clearly developed plan for ensuring a smooth transfer of those PH functions and commissioning arrangements migrating to NHS CB and PHE? | PHTP 1F | | **X** | | | Commissioning arrangements for health vising are migrating to NHS CB. Other arrangements for 0-5's include local support for breastfeeding, obesity |
| | **1.7** | Is there local agreement on the delivery of a core offer providing LA based public health advice to Clinical Commissioning Groups? | PHTP 1G | | **X** | | | There is current a verbal expression of willingness to share capacity and resource to deliver this by the 3 DsPH but no formal contract. We are |
| **Delivering public health responsibilities during transition and preparing for 2013/14** | **2.1** | Is it clear how future mandated services and steps are to be delivered during transition and in the new local public health services: | Limited evidence but under development in PHTP, Appendices 1-4 | | | | | Delivery during transition is less of a problem - not forgetting that NHS SoTW will also be in transition in relation to shadow CSSs. |
| | | Appropriate access to sexual health services, | PHTP 2A Contract grids, Minutes of Sexual Health Locality Planning Group, Childrens Trust | **X** | | | | Overall there should be no problem during 12/13 and we are continuing our arrangements to secure |
| | | Plans in place to protect the health of the population, | PHTP 2B Appendix 2-3, LRF briefing Note (17th January 2013) | | **X** | | | The statutory duties of NHS bodies and their boards in relation to emergency preparedness, resilience and |
| | | Public health advice to NHS commissioners, | PHTP 2A but discussions underway which will develop approach | | **X** | | | There is no problem during 12/13 and we are continuing our arrangements. There is still a lack of agreement over |
| | | National Child Measurement Programme, | Limited evidence but under development in PHTP 2A, Appendices 1-4 | | | **X** | | We expect 2012/13 to be managed as previous years but there are issues for post 2013 including who will |
| | | NHS Health check assessment? | Contract grids and other Limited evidence but under development in PHTP 2A, Appendices 1-4 | **X** | | | | There is no problem during 12/13 and we are continuing our arrangements to secure |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2.2** | Is there clarity around the delivery of critical PH services/programmes locally, specifically: screening programmes; immunisation programmes; drugs & alcohol services and infection prevention & control? | Evidence around drugs and alcohol- currently up for recommissioning potentially as a LA procurement exercise but otherwise Limited evidence but under development in PHTP 2B, Appendices 1-4 | | **X** | | | There should be no problem during 12/13 for delivery of the critical PH services/programmes as we are continuing our arrangements. There is still a lack of clarity over some of the critical PH |
| **Workforce** | **3.1** | Has the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat? | Work programme to be led by VT/JL in association with the LA HR Leads- expect evidence from JL, PHTP 3Aworkstream evidence in Appendix 2 | **X** | | | | The workforce elements have so far been developed in accordance with the PHHRC. However future working requires integrated working across the LA and the One NE HR service and |
| **Governance** | **4.1** | Does the PCT cluster with LA have in place robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate? | PHTP 4A & Appendix 3 Draft MoU under discussion but currently not agreed | | | **X** | | Each organsiation has robust internal accountability and performance monitoring. We would not anticipate changing these but we do receommend the adoption of an MoU to cover current arrangements even if staff and function are |

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|---|---|---|---|---|---|---|---|
| | **4.2** | Are there robust arrangements in place for key public health functions during transition and have they been tested e.g. new emergency planning response to include: | PHTP 4B and Appendix 2-4 and LRF Briefing (17/01/12) and TC Briefing documents (HPA Consultant for Sunderland) | | **X** | | The statutory duties of NHS bodies and their boards in relation to emergency preparedness, resilience and response remain in place until 31 March 2013.<br>• Unless review is required for immediate operational reasons, all NHS plans and response arrangements at local level will remain in place. Plans will only be revised once final structures are understood.<br>• Unless review is required for immediate operational reasons, all HPA plans at local level will remain in place. Plans will only be revised once final structures are understood.<br>• Exercising of current plans will continue in relation to Olympic assurance.<br>• From 3 October 2011, the three NHS Strategic Health Authorities (NHS North East, NHS North West and NHS Yorkshire and the Humber) have operated under a single management framework, NHS North of England. |
| | | ○ Accountability and governance, | PHTP 4C & Appendix 3- Draft MoU under discussion | | **X** | | . Work is underway and PCT Cluster Transition Plans and possible development of MoU |
| | | ○ Details of how the DPH, on behalf of LA, assures themselves about the arrangements in place, | PHTP 4C & Appendix 3 and LRF briefing re emergency planning - Draft MoU under discussion in relation to support for other key PH functions | | **X** | | . Work is underway and PCT Cluster Transition Plans and possible development of MoU (requested by SCC) will assist in robustness and |
| | | ○ Lead DPH arrangements for EPRR and how it works across the LRF area? | PHTP and LRF briefing (17/1/12) Tricia Cresswell HPA briefing documents | | **X** | | Arrangements have been agreed by NHS players in the NHS emergency planning strategic group and |

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|---|---|---|---|---|---|---|---|---|
| | **4.3** | Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of SUIs/incident reporting and Patient Group Directions? | PHTP 4C, Appendix 2-4 | | | **X** | | During transition we do not anticipate changes to clinical governance arrangements and delivery of the MoU would provide transparency and robustness to verbal |
| | **4.4** | Has the PCT cluster with the LA agreed a risk sharing based approach to transition? | PHTP 4D | | **X** | | | This is an ongoing area for discussion. There are a series of LA Transition Meetings to |
| | **4.5** | Is there an agreed approach to sector led improvement? | PHTP 4E, Appendix 1,2 | **X** | | | | The Sunderland Way of Working and Operating Model implies that this will not be a 'drag and drop' of PH capacity into the Council but an |
| | **4.6** | Is the local authority engaged with the planning and supportive of the PCT cluster approach to PH transition? | PHTP 4F and Appendices 1-3 | **X** | | | | The Assistant Chief Executive and Director of Health Housing and Adult Services have been given the |
| **Enabling infrastructure** | **5.1** | Has the PCT cluster with LA identified sufficient capability and capacity to ensure delivery of their plan? | PHTP and Appendix 2 and MoU | | **X** | | | Staff in both the LA and TPCT are managing planning without additional capacity at this time. The LA may be able to provide additional |
| | **5.2** | Has the PCT cluster with LA identified and resolved significant financial issues? | PHTP 5B Discussion underway at High level LA/NHS SoTW meeting | | **X** | | | Without additional information on the ringfenced budget and the impl,ications going forward, this is difficult to |
| | **5.3** | Has the PCT cluster with LA agreed novation/other arrangements for the handover of all agreed PH contracts? | PHTP 5C | | **X** | | | There is an ongoing discussion over contracts and commissioning which may well require legal opinions to resolve. One view is that |
| | **5.4** | Are all clinical and non-clinical risk and indemnity issues identified for contracts? | PHTP 5D, Appendix 2-3, Financial risk outstanding re evidence | | | **X** | | This work has been underway, clinical risk as currently known is managed by the routine PCT |

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|---|---|---|---|---|---|---|---|---|
| | **5.5** | Are there plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer? | PHTP 5E -During transition will be an issue for MoU post transition | | **X** | | | Arrangements during 2012/13 should maintain as current (to potentiall be agreed in the MoUwith LA and SLA with CSS) but arrangements for 2013 are less clear and require changes in the H&SC |
| | **5.6** | Have all issues in relation to facilities, estates, asset registers been resolved? | Under development and will be found in PHTP and Appendix 2. | | **X** | | | There are limited issues around facilties and estates and asset registers for PH |
| | **5.7** | Is there a plan in place for the development of a legacy handover document during 2012/13? | PHTP 5E and Appendix 2 | **X** | | | | There is a plan in place for the development of a legacy handover document and this |
| **Communication and engagement** | **6.1** | Is there a robust communications plan? Does it consider relationships with the Health and Well being Board; clinical commissioning groups and NHSCB; Health Watch; local professional networks? | Under development but will be found in PHTP 6A and Appendix 2 and links to the Rachel Chapman led work for Transition Planning | | | **X** | | The detailed communication plan has not yet been completed but there is currently communication with NHS SoTW Directors, Sunderland CCG, Sunderland EIH&WBB, Sunderland CC |
| | **6.2** | Is there a robust engagement plan involving stakeholders, patients, public, providers of PH services, contractors and PHE? | Under development but will be found in PHTP6B and Appendix 2 and links to the Rachel Chapman led work for Transition Planning | | | **X** | | The detailed engagement plan has not yet been completed but there is currently engagement with a range of |

# HEALTH & WELL-BEING SCRUTINY COMMITTEE

**22 February 2012**

## ANNUAL WORK PROGRAMME 2011-12

### REPORT OF THE CHIEF EXECUTIVE

**1. Purpose of Report**

1.1 For the Scrutiny 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.

Health Development Event

Some members of the Committee attended a regional health event held in Hartlepool on 31 January facilitated by Professor Stephen Singleton, Medical Director at NHS North of England. The session debated scrutiny's emerging roll in relation to Public Health and health and well-being boards.

Policy Review – Evidence Gathering Meeting

An evidence gathering meeting was held on 12 January taking evidence from the Sunderland Clinical Commissioning Group on how GPs work with and are supported by other services; Hospital Social Workers in relation to Hospital Transfer & Discharge Policy at City Hospital Sunderland and Northumberland, Tyne & Wear NHS Foundation Trust in relation to discharge from mental health and disability services.

Policy Review – Patient Consultation

During February Sunderland Links are working within Sunderland Royal Hospital to gather views of patients by working on a number of wards and in the discharge lounge to complete a detailed survey to gather the views of patients and their families.

Policy Review – Stakeholder Event

A stakeholder event will be held on 29 February at the Stadium of Light. The event will bring together all stakeholders patients, carers, providers, and commissioners to share views and experiences and to debate key improvement areas. It is anticipated there will approximately 100 delegates in attendance. The Committee's budget will be available to fund this event which will be free of charge to stakeholders.

## 4. Conclusion & Recommendation

4.1 That Members note the 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<br><br>Setting the Scene – Delayed Discharge (JC/AN)<br><br>Monitoring Action Plans: Dementia, Home Care, Health Inequalities | Community Health Services (BA)<br><br>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)<br><br>Integrated Strategic & Operational Plan (STPCT)<br><br>Health & Well-Being Board (NR) | Campus Completion Programme (PCT/NTW)<br><br>Training Standards Care Homes (GK) | Procurement of social care for adults with a learning disability – progress report (PF) | Meals at Home Service (PC)<br><br>Barmston Medical Centre Procurement (PCT)<br><br>End of Life Facilities (PCT) | | In-patient beds for LD (NTW)<br><br>Community Covenant (KB)<br><br>Social Care Contributions consultation (GK) | HHAS 15 year strategy (NR/DA)<br><br>Health Watch (JC)<br><br>Acutely sick children consultation (SOTW) | | Public Health Transition update (SR)<br><br>Health Strategy consultation (VT)<br><br>'Clear & Credible' Plan (CCG) | | Annual Commissioning Plan (STPCT)<br><br>Urgent & Emergency Care Services (NHS SOTW) |
| **CCfA/Members items/Petitions** | | Request to attend conferences<br><br>Feedback visit to Wearmouth View | | | | | | | | | Draft Annual Report (KB) |

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

# HEALTH & WELL-BEING SCRUTINY COMMITTEE

**22 February 2012**

## FORWARD PLAN – KEY DECISIONS FOR THE PERIOD 1 February – 31 May 2012

### REPORT OF THE CHIEF EXECUTIVE

**1. Purpose of the Report**

1.1 To provide Members with an opportunity to consider the Executive's Forward Plan for the period 1 February – 31 May 2012.

**2. Background Information**

2.1 The Council's Forward Plan contains matters which are likely to be the subject of a key decision to be taken by the Executive. The Plan covers a four month period and is prepared and updated on a monthly basis.

2.2 Holding the Executive to account is one of the main functions of scrutiny. One of the ways that this can be achieved is by considering the forthcoming decisions of the Executive (as outlined in the Forward Plan) and deciding whether scrutiny can add value in advance of the decision being made. This does not negate Non-Executive Members ability to call-in a decision after it has been made.

2.3 In considering the Forward Plan, members are asked to consider only those issues which are under the remit of the Scrutiny Committee. These are as follows:-

*General Scope: To consider issues relating to health and adult social care services*

*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)*

**3. Current Position**

3.1 The relevant extract from the Forward Plan is attached.

3.2 In the event of members having any queries that cannot be dealt with directly in the meeting, a response will be sought from the relevant Directorate.

**4. Recommendations**

4.1 To consider the Executive's Forward Plan for the current period.

**5. Background Papers**

Forward Plan 1 February – 31 May 2012

Contact Officer : Karen Brown, Scrutiny Officer
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# Forward Plan - Key Decisions for the period 01/Mar/2012 to 30/Jun/2012

**E Waugh,**
**Head of Law and Governance,**
**Sunderland City Council.**

**14 February 2012**

# Forward Plan: Key Decisions from - 01/Mar/2012 to 30/Jun/2012

| No. | Description of Decision | Decision Taker | Anticipated Date of Decision | Principal Consultees | Means of Consultation | When and how to make representations and appropriate Scrutiny Committee | Documents to be considered | Contact Officer | Tel No |
|---|---|---|---|---|---|---|---|---|---|
| 01562 | To approve the Public Health Transition plan | Cabinet | 14/Mar/2012 | Cabinet, Council Directorates, Council Partners connected to health agenda | Discussion and circulation of drafts of the plan through the Early Implementer Health and Wellbeing Board in early draft (public meeting) and advisory boards. Circulation of draft plan through the LSP and on the LSP website | Via the Contact Officer by 22 February 2012 - Health and Well-Being Scrutiny Committee | Public Health Transition Plan for Sunderland and Cabinet paper | Sarah Reed | 5611134 |
| 01565 | To approve the Local Authority Mortgage Scheme | Cabinet | 14/Mar/2012 | Cabinet, Service Users and Ward Members, Portfolio Holders | Briefings and/or meetings with interested parties | Via the Contact Officer by 22 February 2012 - Health and Wellbeing Scrutiny Committee | Full Report | Phillip Foster | 5662042 |