SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

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

MINUTES

Present:

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

In Attendance:

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

HW9. Apologies

Apologies for absence were received from Councillors Allan and Oliver.

HW10. Minutes

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

HW11. Strategic Planning Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It was: -

RESOLVED that: -

(i) the report be received for information; and

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

HW12. NHS Reform

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Following detailed discussion, it was: -

RESOLVED that the report be received for information.

HW13. Health and Wellbeing Board Development

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

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

- To promote joint commissioning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED that the information be noted.

HW15. Update on the JSNA Priority Setting Process

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

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

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

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

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

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

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

RESOLVED that the information be noted.

(Signed) P WATSON
Chair

Item No. 3

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **25 NOVEMBER 2011**

UPDATE FROM SUNDERLAND CLINICAL COMMISSIONING GROUP

1. PURPOSE OF THE REPORT

Sunderland Clinical Commissioning Group (SCCG) are at the beginning of their journey to becoming an authorised statutory body responsible for the commissioning of the majority of local health services no later than April 2013. The SCCG are aiming to be ready to be authorised by October 2012.

A national framework for authorisation is now available although more detail on the actual authorisation requirements is due to follow early in the New Year.

The purpose of this report is to update the Board on the journey and initial requirements

2. CONTEXT

The first stage is to review the configuration of the emerging CCG and Appendix 1 sets out the SCCG response to the first stage.

The SHA also requested a trajectory from each CCG to authorisation attached as Appendix B and this sets out key milestones and timeframes including the configuration milestone.

The next milestone is to develop a Clear and Credible Plan (CCP) by the end of December. The CCP will be the CCG's 3 year Strategic Plan which will continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources in line with national requirements and the local joint health and wellbeing strategy. Appendix C sets out an overview of the requirements and how these link with the PCT requirement to produce a Sunderland Integrated Strategic and Operational Plan (ISOP).

The 2012/13 year is a transition year recognising that the CCG will not take responsibility for all commissioning of health services in the future so in the interim the PCT needs an ISOP which covers all the current services commissioned.

The SHA have recently agreed that the timeline for the CCP should align with the timeline for the ISOP. A draft of the CCP will need to be provided by the end of December, however, it is possible to refine the Plan and engage with key stakeholders with a final Plan by the end of March 2013.

The third milestone is the requirement to engage with the development of Commissioning Intentions for 12/13. These intentions provide a signal to providers about the potential changes to their contracts. A draft or interim set is produced and was circulated to providers in early October by the PCT. (Appendix D)

The CCG engaged in this process for the first time in September when the focus was on an initial review with the understanding that there would be to the end of December to conclude the Intentions. Again the intentions cover all the PCT current statutory requirements, some of which will move to the Local Authority, Public Health England and the National Commissioning Board. The remainder will be in the CCG remit although over the transition year they need to consider which intentions they will actively lead and which the PCT will lead and the CCG will influence. This exercise is to take place over November and the Deputy Director of HHAS will be part of the Board Development sessions to conclude the work. As a result the current interim intentions attached will be managed jointly via the PCT and SCCG.

The Commissioning Intentions will also influence the CCP for 12/13 and will inform the CCG track record required as part of the authorisation process. The track record is referred to as the Operational Period and is the 5th milestone on the trajectory to authorisation.

Finally the fourth milestone requires the CCG to lead the contracting round for 2012/13. SCCG has agreed a position with the other 2 CCGs in the SOTW area and will be leading on the mental health and acute contracts.

RECOMMENDATIONS

The Board is recommended to receive the update for information and note the draft Clear and Credible Plan will be presented to the January HWBB. Further CCG updates will follow at each meeting.

Author: D Burnicle, Head of Commissioning Development (Sunderland)

Appendix A

CCG configuration

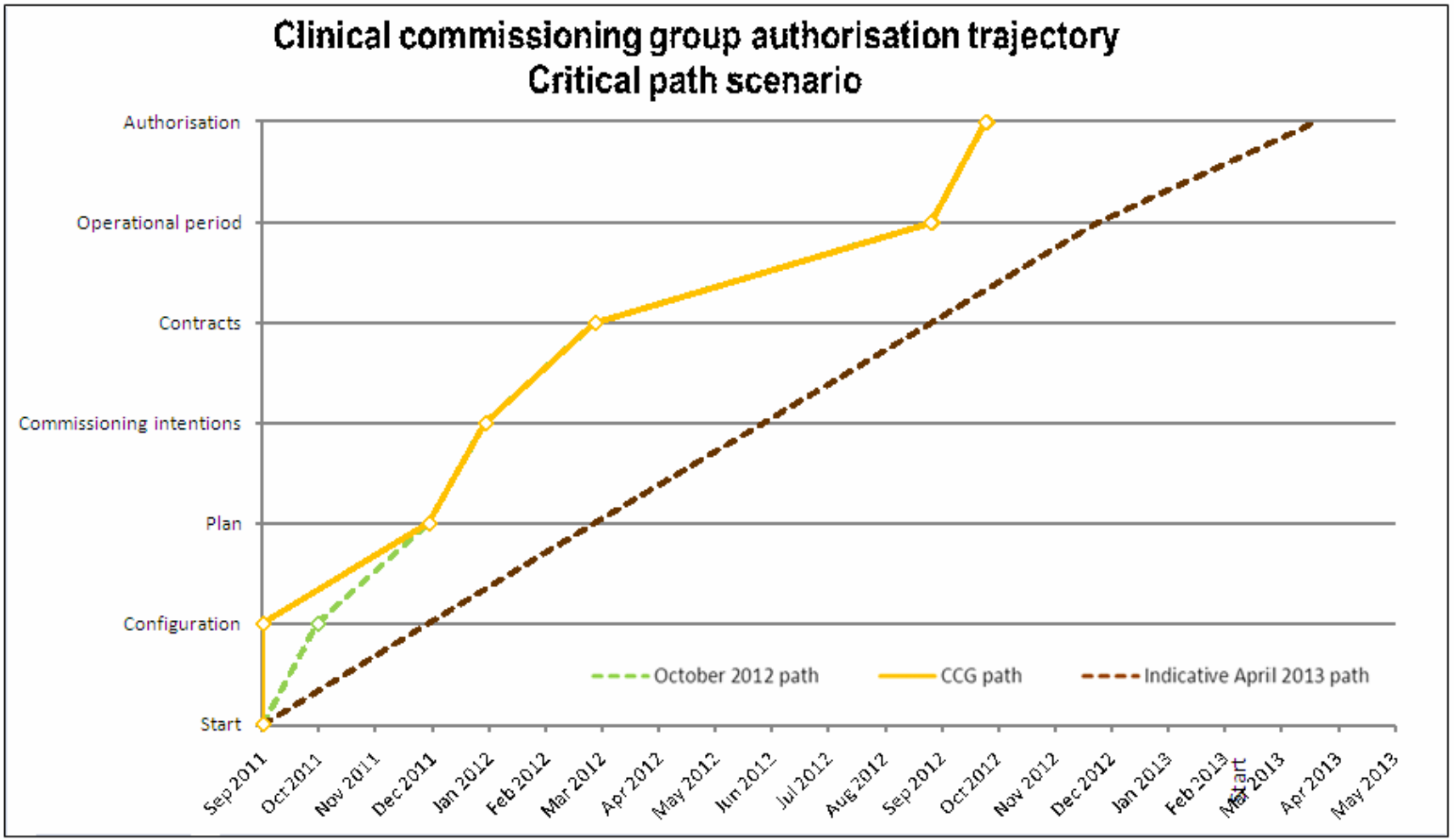
Sunderland Clinical Commissioning Group

Please select the RAG rating appropriate for your CCG and hit any key in the blue RAG box for each question. The appropriate colour will show.
Please provide any additional notes on the 'notes column

		R	A	G	Notes
1. Member practices:					All Practices were consulted about forming 1 city wide CCG, facilitated by the LMC early in the year and Practices elected the Board. All Practices are in the process of signing individual Practice Agreements by 7th October 2011.
R	Practices do not support proposed CCG configuration				
A	Moving towards all practices supporting CCG configuration especially re shape, LA boundaries and organisational variability				
G	Practices support proposed CCG configuration especially re shape, LA boundaries and organisational variability				
		R	A	G	Notes
2. Proposed CCG geography - boundary / population					Practices were consulted about options for localities to support the Board and 5 Localities were agreed and all Practices responded and have now agreed which Locality they sit within. The 5 Localities reflect the 5 Local Authority area regeneration frameworks which make up the city of Sunderland.
R	Does not reflect entire geographic population				
A	Is convoluted and/or contains a practice not contiguous with others				
G	Reflects entirety of geography				
		R	A	G	Notes
3. Geography - LA Boundaries					See above (notes question 2). The Local Authority supported the Pathfinder application and 5 localities infrastructure. The application includes suport for Joint Commissioning - this will be informed by the corporate Board as well as the Localities. One of the purposes of Localities is to faciltate joint working between LA, Health and community staff within communitites.
R	CCG cannot demonstrate reason for straddling upper tier LA boundaries				
A	CCG can demonstrate reason for straddling upper tier LA boundaries but cannot demonstrate LA support				
G	CCG boundary is coterminous with upper tier LA boundary or falls within boundary or can demonstrate population centres reason for straddling boundary and has LA support for joint				
		R	A	G	Notes
4. Impact of CCG size					300 000 weighted population connected by 1 CCG supported by 5 localities and a cadre of clinical leads (latter in development) and individual Practices signed up to the CCG. Constitution to support the relationship nearing completion.
R	Very small and cannot identify future capacity and capability for commissioning responsibility within RCA OR very large and no plans for practice engagement				
A	Very small and developing options for capacity and capability for commissioning responsibility within RCA OR very large and developing options for practice engagement				
G	Very small and confident of securing capacity and capability for commissioning responsibility within RCA OR very large and on track for practice engagement				

Appendix B

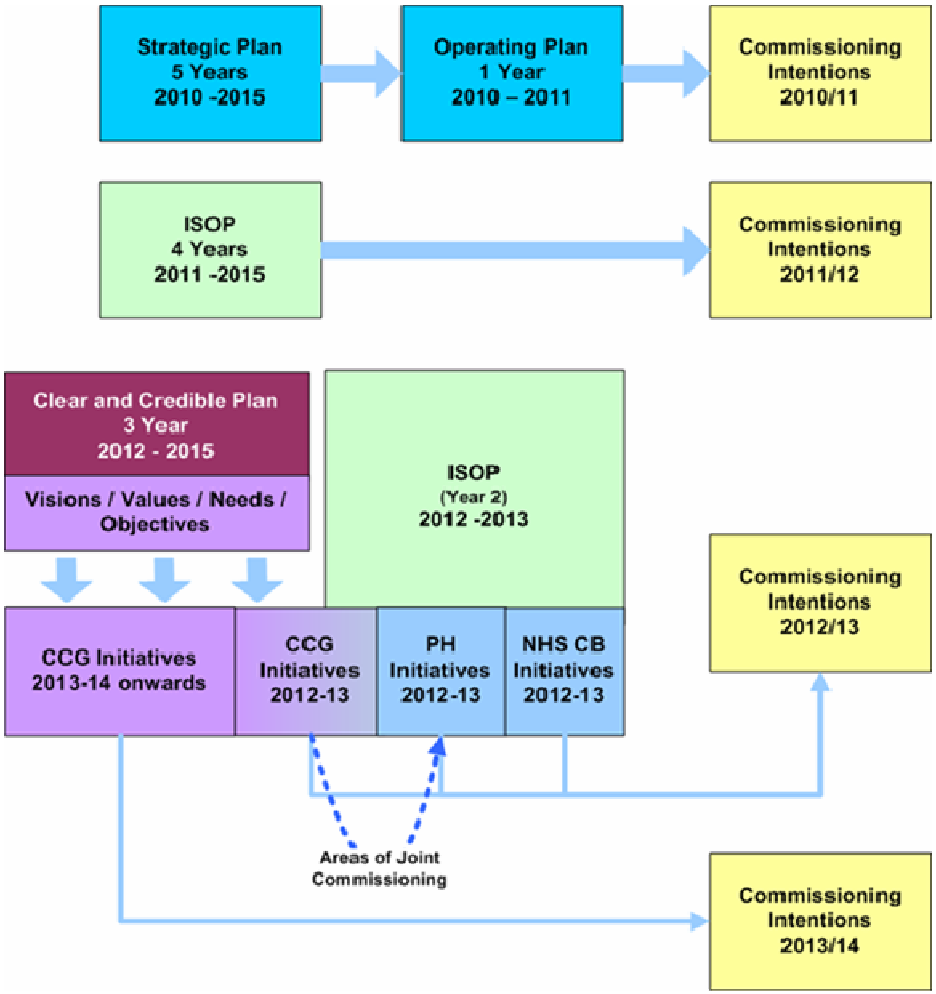
Clinical commissioning group: Sunderland Clinical Commissioning Group



Appendix C


What's in a plan?
Where are we now?
Demographics, health, services, patient views, clinician insights, money, providers
What do we need to do to close the gap?
Strategic objectives, initiatives, prioritisation
Delivery
Capacity, risks, estates, workforce, informatics, money, leadership, partnership, performance, governance
Where do we want to be?
Vision, values, future state, outcomes
Where will we be if we do nothing?
Population change, clinical developments, political changes

ISOP & Clear and Credible Plan



Appendix D

NHS South of Tyne and Wear

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

SUNDERLAND CLINICAL COMMISSIONING GROUP and PCT

2012/13 Interim Commissioning Intentions

September 2011

Sunderland Clinical Commissioning Group

2012/13 Commissioning Intentions

1. Introduction

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

This paper will be superseded by a more detailed document at the end of December following the release of the 2012/13 Operating Framework and tariff. That document will set out a detailed analysis of intended contract activity and costs for 2012/13, including the activity and cost implications of the 2012/13 resource releasing initiatives (RRIs).

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

The document makes reference to the following key issues:

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

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

This high level document is intended to reinforce and update, where necessary, on the Commissioning Intentions document which was published in January 2011 and does not therefore signal a material departure from the plans that have previously been shared with providers. This document will support the agreement of 2012/13 contracts by 28th February 2012.

2. Sunderland Clinical Commissioning Group (SSCG)

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

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

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

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

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

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

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

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

However, the CCG is increasingly taking a lead role with the commissioning of local health priorities out with the pathfinder but part of the Sunderland Integrated Strategic and Operational Plan (ISOP). This leadership is subject to capacity issues (both clinical and managerial) and the level or impact of the proposal currently and in the future e.g. where a decision taken now by the PCT may impact on the CCG when it becomes a statutory body. This leadership will increase over 2011/12 as the CCG develops as an organisation and agrees the level of commissioning support from the PCT.

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

3. Sunderland Integrated Strategic and Operational Plan (ISOP)

The Sunderland ISOP, refreshed in April 2011, just as SCCG were forming, sets out how (with the current PCT until April 2013) the CCG will change the shape of health services across Sunderland over the next three years, and shift the balance from treating illness to helping and supporting individuals to live longer and healthier lives.

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

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

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

In order to achieve this “future state”, the focus of the strategy is on prevention, secondary prevention and long term conditions. Care will be delivered closer to patient’s home through the commissioning of new services supported by integrated pathways together with the radical reform of current provision aimed at eliminating waste and moving care out of hospitals.

In particular SCCG are committed to providing excellent health outcomes for patients. The CCG is passionate that these outcomes will be best achieved by developing closer and more effective working relations between primary and secondary care whilst integrating the health needs with the social and community needs of patients.

The CCG will work in collaboration with the PCT, local providers, the Local Authority and patients to ensure that the vision is targeted via a whole system approach. They will work within the ISOP and also the Joint Strategic Needs Assessment and are

committed to delivering collaboratively on the local QIPP agenda to which CCG plans are aligned.

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

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

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

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

4. Resource releasing initiatives (RRIs)

In order to fund the extensive investment programme and absorb additional financial pressures (inflation, increasing elderly population, clinical developments etc) given the expectation of nil or minimal growth in PCT budgets, a range of disinvestment initiatives were identified in the ISOP and have continued to be updated and refreshed.

2012/13 is the 3rd year of the QIPP / RRI programme and detailed plans are in place to deliver these challenging savings. These plans will be subject to detailed review by the CCG and PCT over the next 3 months, with a detailed activity and financial breakdown of individual RRIs included in the final version of the Commissioning Intentions to be issued early next year.

5. Delivery of National Priorities

The 2012/13 Operating Framework will be published in December 2012 and is expected to be accompanied by revised PbR tariffs and updated versions of standard legally binding contracts.

The framework is also likely to provide further clarity on the key priorities the NHS is required to address in the new financial year and which will need to be reflected in contract negotiations and final agreements. Until such time that national priorities are revised to reflect any changes proposed by the coalition government, commissioners will continue to pursue the 2011/12 Operating Framework objectives within contract agreements, as follows:

Improving cleanliness and reducing Healthcare Associated Infections (HCAIs): Specifically reducing MRSA and Clostridium difficile infections in line with agreed trajectories.
Improving access: Ensuring that the requirements of the NHS Constitution are fulfilled and that patients are offered a choice of provider and a guarantee of receiving treatment within 18 weeks from GP referral.
Keeping adults and children well, improving their health and reducing inequalities: The CCG and PCT will continue to work with partners to implement initiatives linked to the key service priorities.
Military veterans: The CCG and PCT will work with providers to ensure our contracts provide military veterans with appropriate treatment, ensuring a smooth transition for injured personnel into NHS care as well as providing priority treatment for conditions relating to their service.
National Dementia Strategy: The CCG and PCT will work with partner organisations to implement the requirements of the National Dementia Strategy and in line with the revised Operating Framework published in June 2010, will publish how we are implementing the strategy to increase local accountability for prioritisation.
Increasing access to psychological therapies (IAPT): the CCG and PCT is expected to continue expanding access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions.
Mixed sex accommodation: We will actively monitor compliance in respect of this important patient experience issue.
30 day re-admissions: Subject to any revised PBR guidance, the CCG and PCT expects acute providers to remain responsible for a patient for thirty days following their discharge from hospital. As such the commissioner will not fund the cost of treating patients who are re-admitted within this timeframe and expects Foundation Trusts to work with community based and local authority providers to address this issue and make significant improvements to patient experience.

The CCG and PCT will continue to work with partners to address the following key issues.

Improving patient experience, satisfaction and engagement.
Emergency preparedness.
Improving the health and well being of the population.

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

The final Commissioning Intentions to be published in January 2012 will reflect the requirements of the updated Operating Framework which we expect to reflect within contract agreements.

6. National tariff and planned activity profiles

Detailed financial and activity schedules outlining the impact of commissioning intentions and reflecting modelled activity requirements will be published in January, in conjunction with an update to this document.

The final commissioning intentions will reflect any updates to the PbR rules which may be published in the Operating Framework in December.

7. Any Qualified Provider

Plans to implement the AQP initiative are currently being developed in accordance with the national timeframe which requires PCOs to have commissioned a minimum of three services on this basis with effect from October 2012.

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

8. Investing in quality

National context

'Equity and Excellence: Liberating the NHS' (July 2010) placed a significant emphasis on developing and implementing quality standards to improve healthcare outcomes for patients. As the architecture of the new NHS develops the mechanisms to do this are evolving. The NHS Commissioning Board (NHSCB) will have a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of health services. Securing improvement in outcomes, as defined by the *NHS Outcomes Framework* will be particularly important as the Board will be held to account using this framework. It is anticipated that the NHSCB will use Quality Standards developed by NICE to drive its commissioning processes. NICE Quality Standards – and accredited evidence produced by other groups such as the Royal Colleges – will underpin the *Commissioning Outcomes Framework*, through which clinical commissioning groups will be held to account. Quality Standards are intended to be the backbone of the commissioning system, supporting consistent improvement in all parts of the country.

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

for Quality and Innovation (CQUIN) schemes align well with the NHS Outcomes Framework and this alignment will be made more explicit in 2012/13.

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

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

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

Patient safety

- Strengthening of Serious Untoward Incidents (SUIs) processes and development of consistent reporting
- Infection control
- Safeguarding
- Reducing hospital mortality (Including reducing deaths from veno-thrombo embolism)
- Reducing harm from pressure damage and falls
- Discharge communication

Clinical effectiveness

- NICE guidance compliance
- NICE quality standards, particularly stroke, heart failure and dementia
- Specific clinical areas linked to strategic priorities

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

Patient experience

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

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

Commissioning for Quality and Innovation (CQUIN) 2012/13
Where an NHS Standard Contract is in place 1.5% of the contracts outturn value is awarded to the provider for the achievement of CQUIN goals. It is expected that the Operating Framework for NHS England 2012/13 will indicate the CQUIN arrangements for 2012/13 e.g. any nationally mandated goals and the value of schemes.

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

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

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

9. Timetable

Attached as an appendix to this document is a timetable which outlines the key tasks and milestones to be achieved to ensure that 2012/13 contract negotiations are successfully completed and contracts are formally signed off by the 15th March 2012.

10. Local contracting issues

Final Commissioning Intentions to be issued in January 2012 will outline in detail the commissioner approach to a range of contracting issues. The following list reflects a flavour of what this is likely to include and should not be viewed as exhaustive at this point:

Contract documentation: Where appropriate, the revised standard contract will be adopted and where existing contracts extend beyond the one year term, discussions will take place regarding the potential, by mutual agreement, to adopt the revised standard contract.

Local Tariffs: Where appropriate, local tariffs will continue to be reviewed with a view to identifying areas of potential efficiency. The emphasis will be on identifying opportunities for reduced expenditure which allow providers to release costs.

Block Contracts: Review of remaining block contracts will be undertaken in accordance with the ongoing contract management arrangements.

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

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

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

Contract Management: Subject to changes in GP generated demand, the commissioner expects providers to undertake out patient and elective activity in accordance with agreed activity profiles and within annual planned activity targets and expects that contract queries raised through the contract review mechanism are resolved in a timely manner.

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

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

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

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

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

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

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

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

Contract penalties: Commissioners expect to re-negotiate the penalty schedule which was agreed in 2011/12 contracts. Discussions regarding the proposed content of the revised schedule are currently ongoing however, the principles governing their implementation which are reflected in current contract agreements are expected to continue to apply.

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

Public Health: During Autumn/Winter 2011/12 there will be further guidance and specific detail of both the ring fenced public health budget allocations and further guidance on the Public Health Services which Local Authorities become responsible for commissioning in April 2013. It is unclear how similar the ring fenced allocation will be to the current PH spends across the three PCTS in SOTW.
Services are currently commissioned across a range of providers in the NHS, Local Authorities, the Independent, Private and Voluntary Sectors with a wide range of notice periods, from three to 12 months. In these circumstances it is possible that there may be a reduction in available funding and based on Joint Strategic Needs Assessments and Health and Wellbeing Board discussions and decision making during 2011/12 and 2012/13, it is highly likely each PCT and Local Authority may need to make alterations to current commissioning arrangements. These will be dependent on individual circumstance but further detail is not available until the DH issue the budget.

Primary Care: Contract management arrangements for Local Enhanced Services will be confirmed whilst the North East Primary Care Services Agency will coordinate the re-procurement of APMS contract where these are due to come to an end.

In 2012/13, the North East Primary Care Services Agency on behalf of NHS SoTW will carry out service reviews on the four GP practices transferred to STFT. This process will enable commissioners to determine the best way of meeting the needs of the patients when the current agreements come to an end. There will be a similar process for the Blaydon MIU and GP practice timed for the end of that contract in 2014. The Blaydon service review will have two components as the MIU service will be reviewed by GP Commissioners and the GP service by the NEPCSA in line with Barbara Hakin's guidance.

Network commissioning issues: The focus of this document is on commissioning intentions related to services directly commissioned by the CCG and PCT. Services which are jointly commissioned or which are commissioned on a network basis, for example, specialised commissioning and the North East Cancer and CVD Networks will be addressed through the established routes.

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

11. Equality, Diversity and Human Rights

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

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

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

12. Equality Impact Assessment

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

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

As part of the practical work that is undertaken to develop service specifications for new or changing services as part of our commissioning development work, we will undertake equality impact assessments to ensure that our services provide equity of opportunity, equity of access and equity of outcomes.

13. Initial 2012/13 initiatives

Appendix 1 is intended to give providers a high level view of the initiatives the CCG and PCT will be implementing in 2012/13. Work has already commenced on a number of these initiatives which were identified in last year's Commissioning Intentions document.

Work is ongoing to further refine and develop this list through the next three months to produce final commissioning intentions and a draft refreshed ISOP for Sunderland by January 2012.

14. Summary

This initial Interim Commissioning Intentions document is aimed at raising awareness of the initiatives which the CCG supported by the PCT intends to implement during the next contract year, some of which are already in development. This document will be updated and re-issued in January 2012 to provide a more detailed description of our Commissioning Intentions for 2012/13 and which will be accompanied by detailed activity and cost schedules clearly outlining the expected impact of all initiatives, including those which will release resources (RRIs).

Sunderland Commissioning Intentions 2012/13

Attached below are the Sunderland Commissioning Intentions 2012/13 split by Commissioning Responsibilities. Please note that this is a provisional split based on information known to date:

Clinical Commissioning Groups

Strategic Priority	**Action**
Cancer Services	**Remodel Breast Cancer Services across NHS SoTW (excluding screening services) in order to implement a sustainable service model. Developments include; 5 year follow up clinics to be nurse led. Remove Gynaecomastia from normal breast service and send difficult cases to plastic surgery. The remodelled service is expected to be operational during 2012/13.
	Ensure cancer pathways for Foundation Trusts are in line with North East Cancer Network model pathways. Issues to consider include pathology centralisation, impact on one stop services and the ability of Foundation Trusts to report.
	Work with Foundation Trusts to ensure processes are in place to recoup funding through Patient Access Schemes for High Cost Cancer Drugs.
	Increase the uptake of Radiotherapy Services by implementing a strategy to secure local provision.

Child and Adolescent Mental Health Services and Learning Disabilities	Development of Tier 2 CAMH service provision including improved access to talking therapies. Re-alignment of resources/ changes in service provision for children and young people with ASD based on outcomes of 2011/12 review that will take into account: • Changes in specialist community service provision (newly awarded CAMHS/ LDD contract) • Newly published NICE Guidance in line with the outcome of the review of 2011/12 • Development of services to support implementation of continuing care guidance • Services for Looked After Children • Child protection services. • Services for children and young people involved in the criminal justice system.
Learning disabilities	Ensure that physical health care checks in primary care for people with learning disabilities are implemented.
	Develop an Autism Spectrum Disorder assessment and diagnostic service across Sunderland from April 2012.
Mental Health	Implement the emotional health & wellbeing plan. Implement mental health specific actions within the Suicide strategy.
	Continue to work with NTW to realise efficiencies in relation to QIPP & ensure continued engagement in the delivery of resource releasing initiatives. Use quality initiatives to support service development.
	Work with NTW to support the implementation of the business case for reprovision of in patient, out patient & community services regarding new facilities at Ryhope & Monkwearmouth during 2012/13.
	**Continue implementation of the Mental Health Model of Care for SoTW. • Secondary care remodelling including liaison & services for veterans. • Further development of mental health in primary care including a review of access to practice based counselling. • Further development of the dementia strategy including anti psychotic prescribing plan.

	Continue the process of repatriating high cost out of area placements to locally provided services.
	Develop and agree an adult attention deficit and hyperactivity disorder assessment, diagnosis and treatment service.
	Lead the implementation of CPPP (PbR for mental health) in shadow form across contracts.
	Re-provide BME and LGBT wellbeing programmes
	Review workplace health programme with improved service offer for organisations not pursuing NE Better Health at Work Award.
	Implement recommendations arising from report on outcomes of physical health improvement programme for people with severe mental illness (SMI).
Children's Services	Implement the recommendations from the review of Speech, Language and Communications needs across SOTW. Working in partnership to ensure the new model of provision is embedded and sustainable.
	Review Children's Community Nurses (CCNs) and palliative care for children in line with requirements set out in Aiming High for Disabled Children. Working in partnership with Local Authorities support the review of SEN assessment and statement framework. This will explore the potential for replacing the existing system with an assessment process, a single, joined up 'Education, Health and Care Plan'. Explore opportunities to implement personal health budgets for children as part of this overall review.
	Review occupational therapy and physiotherapy services for children and young people. This review is expected to commence during 2011/12.
Urgent Care	Implement the 111 single point of access for urgent care to signpost patients with an urgent care requirement to the most appropriate service to meet their needs. The contract to provide the 111 service will be awarded in November 2011; between November 2011 and September 2012 urgent care services will need to be aligned to the 111 operational model (including GP out of hours) which will include a range of re-procurements where necessary or variation of current contracts.

	Develop an urgent care transport strategy to support the implementation of 111.
	Arrange an annual 'Choose Well' public information campaign to publicise the range of services, points of access, hours of operation and areas of exclusion by targeting focus groups in SoTW in order to help reduce demand for secondary care services.
	**Following the evaluation of the current models of minor injury and illness units across SoTW, a standard model of GP integrated working will be implemented across all MIUs. Modelling work will also look at the number of services required, the most appropriate locations and associated commissioning actions. • Houghton MIU will be open in 2012. The model and procurement options work stream is being developed. • The exploration of a primary care presence in the A&E footprint at SRH is underway
	Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted.
	Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality.
	Review Urgent Care Services across SoTW to understand the current state of urgent care provision and develop a future state. Work on this will continue over the next four years.
	Expected impact of the introduction of Trauma Centres and locally the potential re-classification of our local FTs as Trauma Units.
	**Develop a community based cellulitis model and service.
	**Develop a community based DVT model and service.
Long Term Conditions	**Develop a commissioning model for Long Term Conditions incorporating self care and rehabilitation. Also linking LTC to EoL care at the top end of the pyramid, avoiding duplication in the hospital setting to reduce unnecessary readmissions. Consider whether a new service as required rather than individual specialities to look after the

	patient.
	Develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with LTCs and frail elderly, including care within individuals own homes and community based ‘step up’ facilities.
	**Develop Integrated Teams e.g. Joint Urgent care team and 24/7 team to avoid current confusion about roles/access points.
	**Review role and effectiveness of Community Nursing and Community Matron.
	**Complete the review and implementation of changes to the District Nursing services whilst retaining the option to procure alternatives depending on the outcomes.
	Having completed the review of the impact of the additional reablement investment in 2011/11 we will work with stakeholders to develop investment plans for 2012/13.
	Further review of heart failure services in Sunderland.
	Commission systematic cardiac rehabilitation services across Sunderland including heart manual. Introduce a minimum data set and outcome measures and ensure that all eligible patients are included for rehabilitation. This will have an impact on hospital re-admissions.
	Implement actions from the QIPP/LTC Ignition Phase. Review the COPD pathway and identify improvements that could be made to improve patient care. It is expected that this will have an impact on hospital admissions.
	Review other Ambulatory Care Sensitive conditions including asthma and non acquired cardiac conditions.
	**Improve discharge processes (including documentation) and opportunities for early supported discharge by rolling out multi-disciplinary huddles/pow wows/clusters across all inpatient wards and developing in-reach/out-reach models of rehabilitation and reablement in Sunderland.

	Develop single-site model for weekend TIA clinics in Sunderland. This should lead to a reduction in inpatient admissions for high risk TIA due to weekend service and increased outpatient activity.
	Review specialist inpatient and community neurological rehabilitation services and commission revised pathways as a result of the review.
	**Develop a revised service model for an intermediate community diabetes service and modernise current secondary services to reduce unnecessary admission and length of stay.
	Evaluate outreach community pilot arrhythmia service and make recommendations for future service commissioning. Over time this should have an impact on hospital activity.
	**Develop a community based anti-coagulation and INR model and service
	**Develop a clinician led integrated intermediate care inpatient service at Houghton Primary Care Centre.
	Review end of life service to ensure advanced care plans in place across conditions
	Improve the management of AF and develop a community model and anti-coagulation in the community.
Planned Care	Reduce the number of procedures of limited clinical value.
	Implement the revised pathway for patients with carpal tunnel syndrome and explore further alternative surgical pathways.
	Reduce outpatient first and follow up attendances.
	**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.
	Review dermatology services with a view to aligning the service model with services commissioned for Gateshead and South Tyneside.
	In relation to nurse led clinics, secure a nurse led tariff adjustment, scope out nurse led clinics and where appropriate de-commission and/or re-locate clinics. Scope out nurse led telephone clinics and replace nurse led outpatient attendances with telephone consultations where appropriate.
	Review Adult Hearing Services with an aim to improving access, choice and quality of care.

	Review podiatry services with an aim to improving access, choice and quality of care.
	Commissioning of home oxygen assessment service.
	**Review of provision of long term oxygen therapy.
	Potential procurement of Primary care and Secondary Care based orthodontic services.
End of Life Care	**Reduce the amount of time spent organising care packages by community nurses to enable more clinical time to be spent with patients as long as an alternative for delivering the organisation of care packages is in place agreed with SCCG. Would need to also review District Nursing team to enhance the quality of primary care.
	Evaluate the long-term sustainability of end of life facilities in Sunderland.
	Understand impact of funding review and move to tariff based commissioning of services.
	Re-provide St Benedict's Hospice.
Medicines Management	**Refresh action plans with SCCG to deliver efficiencies and improve the quality of prescribing.
	Optimise medicines usage in patients with long term conditions to ensure quality of care and cost effectiveness.
	**With regard to primary care prescribing - identify opportunities for disinvestment in collaboration with SCCG.
	Work with both secondary and primary care to develop a health economy approach to prescribing of medicines across pathways of care including improving the effectiveness of communication, the provision of shared care medicines and outpatient prescribing.
	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, stoma and incontinence and wound management.

	Improve the introduction and management of the high cost drug exclusions.
	**Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including improving rates of repeat dispensing, New medicines service and targeted use of medicines usage reviews. Addressing quality and safety aspect of NOMAD and Repeat Dispensing
	Work with SCCG to ensure there are robust local mechanisms for funding approval for medicines.
	**Review the contract for provision of medicines management support to individual practices within the SCCG to ensure a Sunderland wide approach, where the contract will prioritise QOF,QP; QIPP and PIS.
	**All secondary care and primary care providers to ensure patients post MI benefit from 4 drugs – aspirin, beta-blocker, stain and ACEI

Public Health England/Local Authority Responsibilities

Strategic Priority	Action
Cancer Services	Expand upper age range to 73 for Breast Cancer Screening.
	Expand age range for Bowel Cancer Screening and raise awareness to increase uptake, whilst ensuring contract volumes reflect anticipate increases in demand.
	Introduction of HPV testing for Cervical Screening.
	**Increase the early detection and identification of cancer and increase uptake rates of screening programmes. Implement urgent lower GI investigation by adopting the Hamilton Risk Assessment Tool into TWW time frame.
	Enhance engagement and uptake of services following HEA of Breast Screening Service.
Joint commissioning	Implementation of robust joint commissioning arrangements with Sunderland LA through the use of Health Act flexibilities. Simplify & integrate commissioning of CHC, FNC & s117. Continue to implement the Carers strategy.
	Enhancement of governance & quality arrangements with independent sector providers.
	Work collaboratively to bring together plans for development of physical health, mental health, medicines management and end of life care for Sunderland care homes.
Children's Services	Review school nursing services across SOTW to ensure all key elements of the Healthy Child Programme 5-19 years are delivered and key outcomes are achieved.
	Develop an early intervention and prevention strategy with local partners to ensure effective evidence based interventions are delivered and monitored in accordance with need to reduce health inequalities and narrow the gap in outcomes.

	Review children's overweight and obesity services (across all the tiers) to ensure children and young people have access to timely, appropriate and accessible support to meet their needs. Identify opportunities to develop family based interventions (lifespan approach).
	Implement the risk and resilience model across SOTW reviewing service provision to ensure services are targeted appropriately across the four levels of need. A risk and resilience training package will be developed across SOTW in partnership with Local Authorities. Review workforce skills and competencies against the core standards of the model.
	Develop a phased approach to the implementation of 'You're Welcome' quality standards across SOTW. Ensure service providers deliver in accordance with 'You're Welcome' standards.
	**Agree with SCCG the recommendations- from the sexual review and sexual health HEA (health equity audit) and implement agreed recommendations. Ensure all providers are signed up to the new electronic C Card and are using it appropriately.
	Ensure compliance with NHS SOTW strategy, policies and procedures for Safeguarding Adults and Children.
	Implement recommendations from the CQC and Ofsted joint inspections of Safeguarding and Looked After Children. Develop the service specification for services for Looked after children in line with the tier 3 CAMHS review and following the outcome of the Looked after Children Health assessment RPIW.
	Review drug and alcohol services for children and young people in Sunderland and implement recommendations in line with the risk and resilience model.
Prevention/Staying Healthy	Following completion of evaluation, amend/re-provide NHS Health Checks services/interventions as necessary to ensure scale required is met and inequalities are reduced.
	Following completion of evaluation, amend/re-provide Obesity services as necessary (including exercise on referral) to follow a life span approach.
	Following completion of review & HEA, amend/ re-provide Stop Smoking services.

	Re-commission alcohol & drugs services in line with the National Drugs Strategy with a focus on recovery and outcomes from treatment.
	Re-provide Chlamydia screening services (this is in 11/12 and for 11/12 we have a short term arrangement with NECA but require longer term arrangement).
	Following review & evaluation, amend/re-provide Sexual Health Services as necessary.
	Develop integrated approach to domestic violence.
	Re-align pathway of care for offenders on release of prison as necessary.
	Review the commissioning arrangements of FRESH and Balance.
	Assess and enhance capacity of service for engaging with ex-service personnel where necessary.
	Re-provision of Health Trainer Service.
	Review provision and coordination of training & capacity building across lifestyle services and re-align services accordingly. Re-procure Health Champion suite of training.
	Utilise findings of the Lifestyle Survey (due March 2012) to inform in year variations in lifestyle services and inform commissioning intentions 2012/13 utilising a social marketing approach.

NHS Commissioning Board Commissioning responsibilities

Strategic Priority	Action
Children's Services	**Continue to implement the expansion programme for Family Nurse Partnership (FNP) and Health Visiting Services across SOTW. Ensure the Health Visitor service meets the requirements of the new national model and service specification in agreement with SCCG. The changes will come into affect from 1 April 2012 (as per requirements of Early Implementer Site status). Continue to review the impact of the new model working in partnership with early years providers and SCCG to ensure the best start in life is achieved. Review skill mix within the Health visiting service and explore opportunities nationally to expand the FNP offer.
	Develop a review programme of services against existing evidence base and identify opportunities to develop innovative practice to support the development of evidence base.
	Review commissioning arrangements for newborn screening programmes and develop service specifications accordingly.
Maternity Services	Carry out social marketing exercise across Sunderland using a regional model to increase the number of women breastfeeding.
	Increase breastfeeding rates by implementing peer support programmes.
	Support acute hospitals to achieve Baby Friendly Status.
	Review pathways in relation to obesity, substance misuse, mental health for pregnant women.
	Reduce the numbers of unplanned admissions during pregnancy. Review the current position and develop a future model to manage pregnancy related concerns in the community.

DRAFT 07-Jul-11

Planning Timetable 2012/13

Week commencing: Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12

		Responsibilty
Tariff Arrangements	Tariff Sense Check — Sense Check	
	2012/13 PBR Road test — .mid Dec11 PBR Road Test	
	Agree interpretation of tariff for 2012/13 — .20 Jan 2012	Finance
	PBR guidance / tariff issued (including reablement and post discharge support) including tariff deflation — Tariff confirmed	
	Clusters, GPCC and providers review non tariff prices	
	Agree with providers what is included in tariff — .26 Jan 2012	
	Agree /understand differences in tariff interpetation in the NE — .26 Jan 2012	
CQUIN	Agree timetable and work programme for delivering 2012/13 CQUIN schemes across clusters — .mid July 2011 programme agreed	CQUIN Group
	Agree timetable with NHS Management Board North East — .15 July 2011 timetable agreed	NHSMBNE
	Agree timetable with all chief executives at Chief Executives' Forum — .22 July 2011 timetable agreed	SHA Director of Ops
	Measures for CQUIN identified by Specialist Clinical Networks, BHFH and SCNE proposed to regional CQUIN group — .30 Sept 2011	All + SHA to champion
	Identify local clinical priorities from GP commissioning consortia taking account of clinical consensus for change from Specialist Clinical Networks and provider input requested at early stage — .30 Sept 2011	CQUIN Group
	Review content from 2010/11 CQUIN for continued applicability including discussion with provider organisations — .30 Sept 2011	CQUIN group
	Alignment of CQUIN with business critical areas — .30 Sept 2011	CQUIN group
	Prioritisation process re CQUIN goals and measures to be included (early Oct and early Nov mtgs as a min) — .15 Nov 2011	CQUIN group
	NHSMBNE consider draft regional CQUIN indicators for alignment with north east priorities — .22 Nov 2011	NHSMBNE
	Standardisation of metrics and methodologies and provision of baseline data for CQUIN — Metrics and baselining etc	CQUIN group
	NORSCORE to conduct own process in parallel and formally feed in to CQUIN Leads group for consistency etc — NORSCORE process	NORSCORE
	NEQOS to provide support within SLA	NEQOS
	Discussion with providers on CQUIN — CQUIN discussions	Clusters / GPCC
	Negotiation of CQUINs with providers (early milestone end of Jan 12) — CQUIN negotiations	Clusters / GPCC
	CQUINs agreed — .28 Feb 2011	Clusters / GPCC / provide
	CQUINs signed off — .15 Mar 2	Clusters / GPCC
North east 2012/13 plan	Agree planning timetable at NHSMBNE on 15 July 2011, share at CE Forum 22 July 11. — .30 Sept 2011	SHA Director
	Seek to agree contracting deadlines with Monitor consistent with DH deadlines — .30 Sept 2011	SHA / Clusters
	Propose draft format for cluster / GPCC ISOP submissions for 2012/13 — .23 Sept 2011	CSM Executive
	DH publishes Operating Framework — .mid Dec11	Department of Health
	Review proposed format for cluster /GPCC submissions for 2012/13 ISOP for alignment with Operating framework — .mid Dec11	SHA Director of Ops
	Finance assumptions / DH Planning checklist issued — .mid Dec11	Department of Health
	Revised standard contract published — .mid Dec11	Department of Health
	Updated 2012/13 ISOPs submitted — .12 Jan11 — .13 Feb11 — .12 Mar1	Clusters / GPCC
	SHA feedback on activity and finance on updated ISOPs via NHSMBNE — .20 Jan11 — .20 Feb11 — .20 M	SHA Director of Ops
Contract negotiations	Clarify contract arrangements regarding GP / clinical involvement and lead — .7 July 2011	
	Specialised commissioning group to work with PCT clusters to identify the consequences of disaggregating specialised activity — July to October 2011	
	Identify services to be commissioned nationally and identify activity and financial implications of disaggregating specialised activity from PCT contracts — .31 Oct 2011	
	Standardise contract schedules across all contract types where this is applicable — .30 Sept 2011	
	Cluster / GPCC Demand and Capacity Assessments-potential impact for 2012/13 and future - Reconciliation with Providers	
	Cluster / GPCC Demand and Capacity impact for 2012/13 — .30 Dec11	
	Agree control totals for acute contracts — .6 Sept 2011 indicative — .3 Jan 2012 indicative	
	Clusters/GPCC commissioners and providers to confirm names of those who will negotiate contracts — .30 Sept 2011	
	Negotiating strategy for North East agreed — .30 Sept 2011 — .24 Jan 2012	
	Format of commissioning intentions to be consistent — .12 Aug 2011	
	Recommendations from Specialist Clinical Networks, BHFH and SCNE considered in commissioning intentions — .30 Sept 2011	
	Commissioning intentions finalised to align with ISOPs — .mid Dec11 Commissioning intentions finalised	
	Commissioning intentions published (including CQUIN) — w/c 16 Jan 12 Commissioning intentions published	
	Finalise Performace, Information, CQUIN Schedules and Incentives and consequences of contract breach — .mid Dec11 — .12 Jan12	
	Negotations with providers-Pricing and Adjustments to Activity Levels — .12 Jan12 — Pricing/activity	
	Contracts agreed by cluster and GPCC — .29 Feb12	
	Contracts signed by cluster and GPCC — .15 Mar12	
	Signed contacts to SHA — .30 Mar12	
Governance	**Meeting of NHS Management Board North East** — .10 VC — .1 VC — .15 Ju VC — .5 VC — .19 VC — .2 VC — .16 VC — .7 VC — .28 VC — .11 VC — .2 VC — .23 VC	
	Meeting of Chief Executives' Forum — .24 June11 — .22 July 11 — .30 Sept — .21 Oct 11 — .25 Nov — .16 Dec 11	
	Meeting of NE PCO contracting Group (Louise Robson) Dates tbc — .7June 11	
	• **Acute and community sub group (Colin Smith)** — .7July 11 — .9 Sept 11 — .10 Nov 11 — .12 Jan 12 — .8 Mar 12	
	• **Mental Health sub group (??Ian Holliday)**	
	• **CQUIN sub group (Lucy Topping)** - monthly meetings from August 2011	
	· **Ambulance sub group (Jeff Goldthorpe) - weekly contract review meeting**	
	ISOP assurance meetings SHA-Cluster/GPCC review meetings — .17 Jan 12 — .17 Feb 12 — .16 Mar12	
	Cluster ISOP review meetings with GPCC, clusters, FTs,and LAs (end April 2011)	
Supporting activities	DH workshop to explain 2012/13 contract issues — .early Jan12	

Item No. 5

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **25 NOVEMBER 2011**

BRIEFING NOTE ON THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT – HEALTH AND SOCIAL CARE SYSTEM SUPPORT DIAGNOSTIC

Background

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

Current Situation

The Institute have met with the Sunderland Health and Wellbeing Executive group to provide information on the nature of support that is available, the timescales for delivery and the commitment that will be required of the Board and partners.

A summary of the support tool is included an Appendix1.

The support involves a number of key stages including

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

The Institute have indicated that there is capacity to start the support in Sunderland in early January, with reports being produced in February/March. The host for the project will be Sunderland City Council, with the secretariat role completed by the Chief Executives strategy, policy and performance management service.

The Institute have requested that a week be highlighted when they will be in Sunderland and undertake interviews with key players. In principle it is proposed that this be the week commencing 16th or 23rd January depending on availability.

Although the involvement of individuals is key to the success of the programme, the Institute have provided assurances that no single person will be required to provide any more than 1 hour of individual time for the process.

The focus of the review in Sunderland will be on the development and maintenance of relationships to ensure the effective functioning of the Health and Wellbeing Board. This will cover both existing Board members and those currently involved as part of the advisory groups of the Adults Partnership Board and the Children's Trust.

This will help to satisfy the requirement of the Board's Early Implementer status to review the membership and functioning of the Board to ensure appropriate structures are taken forward into the shadow and full Board status.

Recommendations

The Board is recommended to

- Note the summary of the Institute's support service
- Agree for the Institute to start work in Sunderland in January 2012
- Agree to be available for interviews either w/c 16th or 23rd January
- Receive reports on the recommendations of the Institute on completion

NHS
Institute for Innovation and Improvement

The Health and Social Care System Support (HSCSS)

A reflective process to help local government and NHS leaders work together to deliver locally the new and emerging national policy changes at scale and pace, for the benefit of the population they serve

'Working Together for Great Change'

Introduction

to the Health and Social Care System Support (HSCSS)

The Government's plans to reform the NHS require leaders from across health and local government to work together in a new whole system model. Leaders of the system need to understand each other's priorities and collectively plan and deliver health and social care by taking a transformational approach. More of the same will not deliver the new agenda. The current financial and economic climate also requires more cross organisational working and local leaders need to review and reflect on how their roles and organisations can contribute to this challenging agenda.

The new system will require more consideration of planning at local level, co-production of local implementation plans will need to be undertaken across key stakeholders, and local leaders need to be supported to develop new skills. The newly emerging systems need to develop shared values, visions and ways of working to create the right environment for the delivery of these changes.

The NHS Institute has developed a programme to help the leaders of local government and the NHS working across a specific geographical area to respond to national policy and understand how working collectively can support faster implementation of major change initiatives for the benefit of the people they serve.

Using our experience and knowledge of applying the theory of large scale change, the NHS Institute is now able to offer practical support and assistance to health and social care systems through a flexible and adaptable system support programme.

The programme comprises two elements - the **diagnostic phase** which leads to the production of a reflective report, and a **proposed development programme** which is an output of the report.

The HSCSS diagnostic work will deliver a reflective report based on the information gathered through

- a chief executive listening exercise
- a stratified staff survey
- a review of key organisational and system strategic documents (including a review of public and patient engagement plans) and the Joint Strategic Needs Assessment.

The process also involves an in-depth on site interview process of organisations' senior leadership teams. We also review the system data to highlight any productivity opportunities or areas that could be considered for further joint work.

The reflection report will identify key areas for consideration, highlighting the areas for collective action. This will be discussed with the leadership community when the report is presented and can lead to the second phase of the work the development programme.

How the NHS Institute works with you to deliver the HSCSS

As the emerging landscape develops, the relationship between public health, primary care, secondary care and local government is more important than ever before, both at a strategic and operational level.

We recognise that leaders of organisations across health and social care systems have different priorities, requirements, drivers and perspectives; so the first work we do with you is a system wide diagnosis. This work is led by a team of highly experienced senior consultants from the NHS Institute. Each of our team members has worked at executive level in either health organisations or local government and is trained to lead our diagnostic approach.

The diagnostic phase comprises the following elements:

- A pre-meeting with system sponsor(s)
- Analysis of system data, demographics, priorities, key strategic and operational plans (including patient and public engagement plans and JSNA)
- Executive partnership / leadership briefing meeting
- A chief executive listening exercise
- Stratified survey of organisational staff via a locally framed questionnaire
- Interviews with key system leaders (including elected members, non-executives and executive teams)
- The option to use patient and service user focus groups
- Production of a comprehensive reflection report
- Presentation of the report to a locally agreed chief executive officer forum
- CEO forum sign off and agreement of recommendations.

The team can also support you with the alignment of the report to the system's transition plan if required.

> "The HSCSS diagnostic came at a great time for our health system as we were in the midst of developing our response to the NHS reform agenda. The HSCSS intervention provided an incisive and challenging analysis of partnership working across the patch and has really helped us to strengthen our relationships and sharpen our focus."
>
> **Stephen Eames, CEO, County Durham & Darlington NHS Foundation Trust**

The second phase, that of development programme is offered separately, because until the diagnostic report is produced it is impossible to identify the areas of development required or the appropriate skills and support the NHS Institute could offer.

Developmental areas that have been identified in our test sites have included:

- Support for the Transformation Board and cross system leadership development
- Organisational development support for the emerging Clinical Commissioning Groups
- Facilitation of the development of the new Health and Well Being Boards
- Support to develop medical engagement across primary and secondary care
- Provider development and service redesign
- Support to engage the public and patients in redesign of services
- Help to develop understanding of organisational roles and functions
- The development of leadership compacts and system vision
- Governance and system support.

The two phases are represented in the diagram below:

Health and Social Care System Support Programme

Ongoing engagement, better partnership working, wider system mobilisation for large scale change, system and service improvement

Diagnostic phase/reflection report

We will develop relationships with partners in the health and social care system to utilise their skills, knowledge and expertise to ensure we optimise the opportunities available to support system change. We will also utilise our model for improvement to support systems change including continuous measurement, evaluation and evolution.

- Analysis of system data and documents
- Stratified questioning of organisational staff
- Chief Executive listening exercise
- Executive leaders briefing and engagement meeting
- Interviews with execs and managers

This will lead to...

1. A reflective report summarising our findings and suggesting priority areas for potential work programmes (to align with and build upon existing work taking place within the system).
2. A chief execs forum to discuss the report and identify and agree the work to be carried out in each strand of the Delivery Phase:

Developmental phase

System leadership support programme

Work directly with system leaders to build foundations for partnership working.

Support tailored to the needs of system leaders may include

- System leaders' events
- Developing a common vision
- System leaders' compact
- Change narrative/story
- Culture change
- 1:1 coaching.

Large scale change events

Using the model and theory of large scale change to engage a wider stakeholder group in taking the system priorities forward, developing commitment, support and interest.

Accelerated learning events that use our scan, focus, act methodology.

Detailed work programmes

To be agreed at the end of the reflection phase.

Our pilot sites to date have requested the following support:

- Support the development of the Health and Wellbeing Boards
- Support for emerging Clinical Commissioning Groups
- Provide support for service redesign
- CEO officer leadership support and development
- Governance and system support
- Clinical engagement and development.

What needs to be in place to proceed?

- Agreement of the leaders of the organisations within the system that this programme is useful and the desire to participate.
- An identified CEO sponsor who will also provide an administrative coordination function and act as a contact point.
- As leaders of the system we ask that you make yourselves available for a scheduled interview and that you identify senior staff who will also be available for interview.
- A way of distributing the questionnaire to people in your organisation working at the interface between health and social care.

The diagnostic work commences once we have agreement from all organisations in the system. It takes between four to six weeks to establish the team to work with your system and undertake all the preparatory work. We then work in the organisations in your system to carry out the activities required which result in the report.

How much will this offer cost?

The diagnostic phase will cost the system £45k. This incorporates all of the preparatory on site work, on site diagnostic and the analysis of the system data and stratified questionnaire.

The development programme is priced separately and is an offer made specifically to each system based on the findings detailed in the diagnostic report.

Our programme team

The programme is run by a team of highly skilled experts from a variety of professional backgrounds (including executive and clinical). Each health and social care system we work with is allocated a team of individuals with a wide range of knowledge and skills and an understanding of the national policy and priorities for health and social care.

Want to know more?

If you would like to find out more about the Health and Social Care System Support programme we would be delighted to talk to you and will send you more detailed information about logistics, timing and cost.

In the first instance please email us at healthsystemsupport@institute.nhs.uk

www.institute.nhs.uk/HSCSSP
Telephone: 02476 475800
e-mail: enquiries@institute.nhs.uk

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **25 NOVEMBER 2011**

DEVELOPMENT AND EVALUATION OF THE EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

1.0 PURPOSE OF THE REPORT

The Sunderland Early Implementer Health and Wellbeing Board (HWBB) met for the first time in July 2010 as a new partnership to steer the Health and Wellbeing agenda for the City. The HWBB will be responsible for promoting joint commissioning and integrated provision between health, public health and social care. It will lead the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. It will also be involved as Clinical Commissioning Groups develop their commissioning plans and there will be an expectation, set out in statutory guidance, for the plans to be in line with the Health and Wellbeing Strategy.

As part of being granted Early Implementer status, there is an obligation to review and evaluate the structure, membership and operation of the Health and Wellbeing Board.

This paper sets out the outcome of a Board member training audit, current opportunities for development alongside proposals for the evaluation of the Early Implementer Stage.

2.0 DEVELOPMENT OF THE EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

2.1 Board Development

It is recognised that there is a desire from the Board to undertake training and development activities both as a whole Board and on an individual or small group basis in order to develop a shared vision, joint practices and fuller understanding of constituent organisations.

The Board needs to establish

- Values: what are the shared values that all members of the HWB bring to the table?
- Goals: What is our vision and what are our key objectives and goals? How do we tackle long-standing issues that have proved hard to address? and
- Tasks: What do we need to do to achieve our objectives and who will do this?

The results from the training needs survey carried out in October highlighted that a consistent priority for development was clarity on relationships between

the Board and other groups but also on roles and responsibilities, media relations and understanding of timelines and deadlines.

2.2 Wider Member Awareness

The importance of ensuring the elected members as a whole are aware of the developing health and wellbeing agenda is also recognised. It is proposed that the council's Community Leadership Programme is used to develop an ongoing programme of awareness raising with frontline councillors under the banner of the Health and Wellbeing Board.

A brief awareness assessment of all frontline Councillors was completed in October through the member account manager network and all of the respondents stated that they would be interested in receiving further training and development (mainly in written format) on the developments in local authority responsibilities for public health.

2.3 External Development Opportunities

Regionally, the ANEC Improving Health Task and Finish Group have proposed that consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBBs, to take forward the health agenda.

ANEC have also recognised that there is much that local authorities will wish to pursue at a local level with partners, and bespoke to their own context and requirements. As such, there is potential to offer each local authority/Health and Wellbeing Board a sum of £10K to support the development of capacity building in relation to Public Health and/or Health and Wellbeing Boards.

Nationally Sunderland has expressed an interest to host a national learning set on the topic of "maximising opportunities for joint commissioning and integration across the NHS and local government". Sunderland has been included in its chosen learning set, but we have yet to have confirmation of whether this will be as a host or contributing member.

We have been approached a number of potential facilitators including Sunderland University school of public health with regards the provision of training around public health and Dr Mike Grady (senior research fellow with Marmot team) who have now been funded for the next three years by government to become the Institute of Heath Equality with a remit of helping to enable all Local Authorities to establish Heath and Wellbeing Boards across the country.

2.4 Proposals for Sunderland

It is proposed that a series of sessions be developed between now and March 2013 to cover issues raised in the training audit and to reflect good practice in

terms of recommendations for Board development, brining in external trainers and facilitators as required.

It is proposed that an initial facilitated whole board session be held to establish shared values, goals and tasks, based on initial exploratory interviews with Board members looking at identifying aspirations, concerns and priorities in relation to the HWBB with the potential of developing a self-regulation model with a development plan to demonstrate continuous learning.

This will then be followed by a series of thematic briefings and workshops including:

- Relationships between the Board & other groups
- Developing a joint view on commissioning
- Priority setting
- Health and wellbeing strategy
- Engagement

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It is also proposed that sessions be devoted to problem solving and scenario running in a 'safe' environment to look at how the Board will tackle difficult issues such as

- personal health budgets
- urgent care
- service reconfiguration
- links to wider determinants of health

Individual or small group training around media relations, accessing data, representation and understanding organisational outcomes will also be convened.

3. EVALUATION OF THE EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

As part of being granted Early Implementer status, there is an obligation to review and evaluate the structure, membership and operation of the Health and Wellbeing Board.

To give an independent view on the membership and structure of the Early Implementer Health and Wellbeing Board, Sunderland have been offered support by the NHS Institute for Innovation and Improvement to undertake the diagnostic stage of their Health and Social Care System Support (HSCSS) leading to a reflective report and a proposed development programme. This will cover issues such as

- Analysis of system data and documents
- Stratified questioning of organisational staff
- Chief executives listening exercise
- Executive leaders briefing and engagement
- Interviews with execs and managers

As highlighted in a previous paper to the Board, the Institute are starting their review in January and this will satisfy the need for an independent review of membership and relationships with recommendations for Shadow and Full Board status being fed back into the Board in March.

At its inaugural meeting in July 2011, the Early Implementer Health and Wellbeing Board defined what, for members, would constitute success by April 2012, namely:

- To have aligned commissioning intentions from all partner organisations to improve Health and Wellbeing outcomes
- To have an established plan for the engagement of VCS, providers and wider partners
- To have an established plan for the engagement of the broader community and users.
- To have engaged with the GP Commissioning Board and seen progress towards authorisation
- To have a plan for the movement of public health including ring fenced finance implications
- To have a final draft of the Health and Wellbeing Strategy to include outcome measures

However, as the success of the Early Implementer stage of the Sunderland Health and Wellbeing Board is based not only on the views of the Board, but also of the Health and Wellbeing sector as a whole, it is proposed that a broader evaluation of success is undertaken firstly by establishing a wider set of success criteria and secondly be undertaking a survey of a broad range of parties in scoring this success.

In order to provide a joint view on what success will look like, it is proposed to seek the views of advisory groups and other interested parties, with open invitation meetings be held for both VCS and providers to input their views into the process. It is envisaged that by engaging with these groups the evaluation of the Early Implementer Health and Wellbeing Board's success will be more robust.

The success factors as agreed by the Early Implementer Health and Wellbeing Board will be collated with the responses from the advisory groups and the VCS and a composite list brought back to the Board in January following which a questionnaire will be published asking for people to rate their views of the success of the Board.

It is, however, recognised that the Board and advisory group structure will only have been in place for a limited period and as such the learning from the initial evaluation will be limited. It is therefore proposed that the evaluation be delayed for 6 months to accurately measure improvement and distance travelled and to build on the recommendations from the Institute diagnostic which will have been received in March.

4.0 RECOMMENDATIONS

The Board is recommended to:

- Agree to hold a whole board values, goals and tasks session
- Agree to establish an ongoing training plan to March 2013
- Agree to involve advisory groups and broader partners in setting success criteria
- Agree to engage the NHS Institute for Innovation and Improvement to undertake the HSCSS diagnostic

Item No. 8

25 NOVEMBER 2011

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

PUBLIC HEALTH TRANSITION PLANS FOR SUNDERLAND

Report of the Assistant Chief Executive and Director of Public Health

1.0 PURPOSE OF THE REPORT

1.1 To provide an initial update on the proposed process for transitioning the management and delivery of the Public Health Service from Sunderland Teaching Primary Care Trust, (STPCT), to Sunderland City Council.

1.2 To provide an overview of the key risks and dependencies involved in the transition process and to gain direction and approval on some of the issues outlined in this paper.

2.0 BACKGROUND

2.1 The NHS White Paper "Equity and Excellence: Liberating the NHS" was published in July 2010 and was followed by a number of consultation documents, which outlined that, as one of number of health service change proposals, Local Authorities would take on the Public Health function.

2.2 The White Paper and consultation documents were followed by the Health and Social Care Bill which was introduced in the House of Commons in January 2011. The Bill amends a number of Acts, mainly the National Health Service Act of 2006, and underpins the creation of a new public heath managed and delivered with the Local Authority.

2.3 The key benefits of having the Public Health function within the Local Authority are identified as:

- Enabling "an enhanced role for elected Local Councillors and Local Authorities, as a more effective way to boost local democratic engagement".
- Ensuring service integration between all public health functions.
- Facilitating a joined up commissioning approach between GP consortia and Local Authorities.
- Having the management responsibility of Early Implementer Health and Wellbeing Board ensures engagement, joint working and decision making with all relevant health partners.

2.4 The paper also identifies that to enable the effective transition of Public Health Directors of Public Health (DPH) will transfer to Local Government and be jointly appointed by the Local Authority and a new national Public Health Service. In Sunderland there has already been a jointly funded and jointly appointed Director of Public Health for over 4 years. As part of the transition, there will be a

"transferred resource" which is still to be determined. Currently in Sunderland there are some public health staff co-located within the council (for example within Children's Services and those connected with community safety commissioning and support)

2..5 The Government's timescale for the transition of Public Health is April 2013, however, Sunderland are proposing that transition planning and an operating model should be completed by April 2012 with the transition being implemented by October 2012. This builds upon the current arrangements and it is proposed to set out clearer ways of working. There is more national guidance due at the end of November/December which will set out greater clarity around the public health function and resource that will be transferring under transition arrangements.

3.0 TRANSITION PROCESS

The following section sets out the key consideration for the transition of public health. These are current issues that will be reflected upon, after further guidance is received.

3.1 Public Health staffing, structure and governance

3.1.1 It is known that from April 2013, the Director of Public Health, (DPH), will transfer to Local Government, and as directed by Government, will be directly managed by the Chief Executive within the appropriate management arrangements. Currently the DPH reports directly into the PCT as well as reporting lines into the council. They will bring with them a "transferred resource", which is still to be determined, and this budget will be ring fenced within the Local Authority. The DPH will have strategic influence over the wider determinants of health, independently advising elected members and being part of the senior management arrangements in the local authority

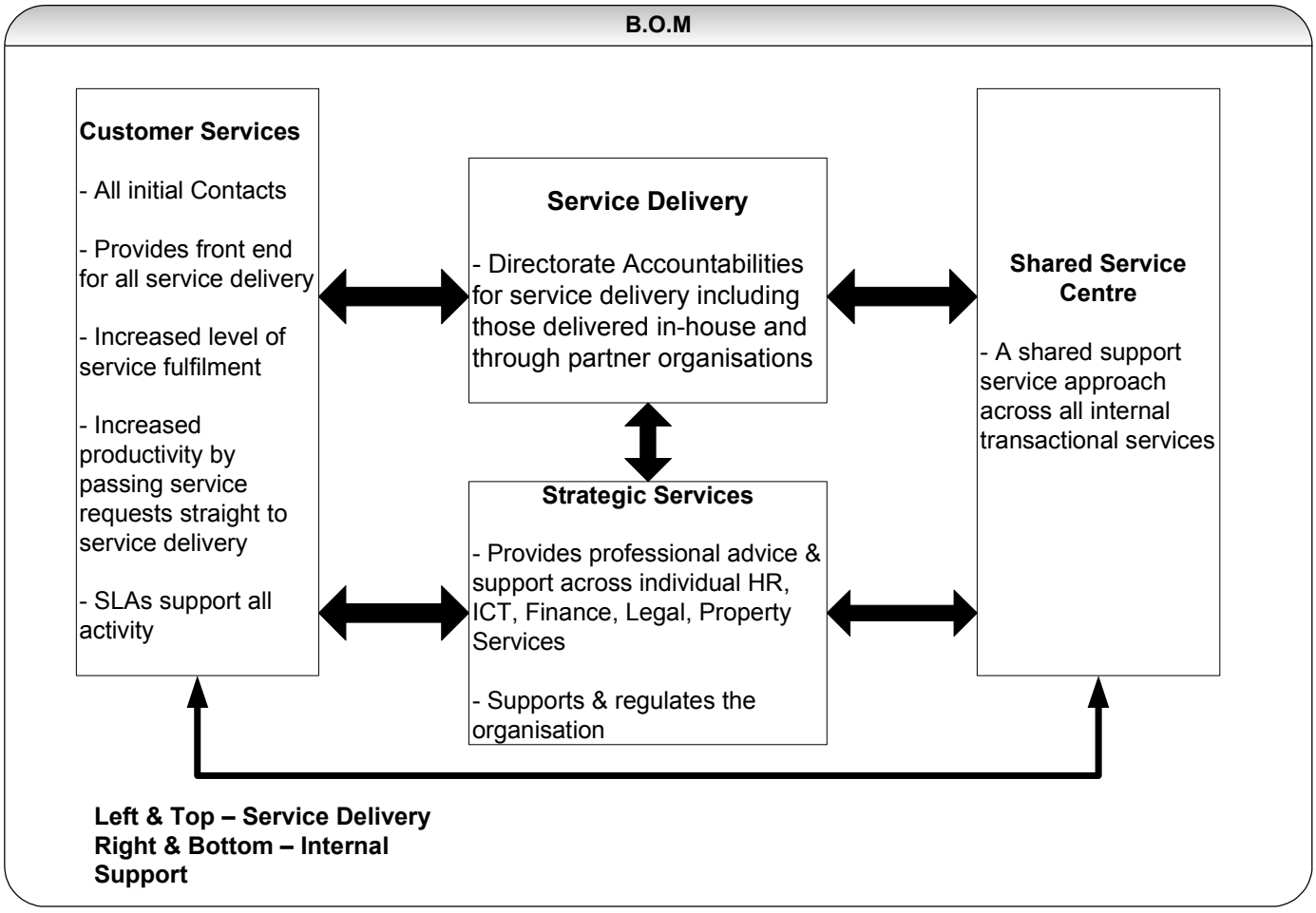
3.1.2 Currently there are ongoing discussions between the current DPH, Sunderland Council and NHS South of Tyne and Wear to consider the role of the Director of Public Health within the new transitioned service. This is partly driven by the fact that across Sunderland, South Tyneside and Gateshead all three Directors of Public Health will need to be recruited to as posts become vacant and to facilitate the new arrangements which are significantly different from those that currently exist. Currently Gateshead has commenced its recruitment process for a Director of Public Health and in South Tyneside there is a six month interim arrangement to fill the vacant DPH post. In Sunderland the post is not vacant and the incumbent currently acts as DPH for 8 sessions per week. She is also currently heavily engaged in the establishing and implementing of Clinical Commissioning Group plans.

3.1.3 A recent financial analysis of public health spend was undertaken by the PCTs as part of a submission to the Department of Health (DH)including the analysis of spend across South of Tyne and Wear and by geographical areas. The current funding spent in Sunderland on public health leadership, services and programmes identified in the White Paper is almost £28m.This will help the formulation of the public health budget for 2012-2013 against which

commissioning intentions will be outlined. For 2013-2014 when public health is transferred it is still uncertain as to the level of the budget although it is expected to significantly reduce, further information is expected in late November/early December. The impact of reduction in ring fenced budget is likely to affect both staffing and commissioned services. Additional detail is likely to be outlined in forthcoming national policy guidance and therefore it would be more appropriate to consider future staffing transition when this is available.

3.1.4 Within the council early discussions are commencing to ascertain how best the transition arrangements could operate and align with the current operating model in the council. The recent changes within the council in terms of ways of working and staffing structures will have an impact on future arrangements.

Sunderland Council Business Operating Model (BOM)



3.1.5 Government guidance on staffing transfers and workforce information will not be available until November/December, and it is anticipated that this will give further information on the way forward. Once more clarity is established, HR resources from both organisations acting in accordance with the NHS HR Transition Framework will work together to enable the transition to go ahead.

3.2 Funding Allocation.

3.2.1 For 2013 and beyond, some of the current funding will be transferred to the Public Health England, to Commissioning Support Organisations and to the NHS Commissioning Boards as function residing within PH Departments is transferred to new structures. It will be essential that all local commissioners, ie the Clinical Commissioning Group and the Local Authority work together to target funding and commissioning of services to health improvement priority areas so impact on access to and delivery of provision due to any reduction in allocated PH funding is minimised. This will be predicated on the outcomes of the refreshed JSNA and be facilitated through the Early Implementer Health and Wellbeing Board.

3.2.2 Current activity is establishing what current funding is commissioning and delivering as outcomes in relation to the areas highlighted for transfer to the Local Authority. The priority areas for future spend and delivery will be decided as an outcome of the prioritisation exercise looking at the Sunderland Outcomes Framework and the JSNA. . The Local Authority will also establish its existing current spend on health improvement related activity, identifying those services commissioning by Public Health and other activity funded through central monies to build up a current health spend picture in Sunderland.

3.3 Commissioning and Delivery

3.3.1 Public Health staff are currently carrying out an exercise to look at all their current commissioning commitments. Commissioning intentions are already being prepared for the services to be commissioned in 2012/13. As there is uncertainty over whether the budget in 2013/14 will match that of the current year, and as some services have notice periods of twelve months, the final NHS SoTW Commissioning Intentions document will identify that there is a risk some notices may need to be issued during the first quarter of 12/13 but there is currently insufficient information in the system.

3.3.2 Sunderland Clinical Commissioning Group are also engaged in discussions around the SoTW Commissioning Intentions for 2012/13 and recognising that health improvement services will not be within their commissioning remit in the future have asked public health teams and the PCTs to facilitate the detailed work in these areas, whilst they do retain an overview. Discussions are currently underway over a limited number of clinical service areas where the CCG will lead the 2012/13 Commissioning round although a number of these do link with the inequalities and health improvement agenda, e.g. ensuring people with learning disabilities receive primary care health checks.

3.3.3 Sunderland Council has four directorates that commission services; namely Health & Housing, City Services, Children's Services and Chief Executives. An exercise will be carried out to establish what each directorate delivers on behalf of Public Health and what additional health related services the council commissions and either procures or delivers in house.

3.3.4 Once the above exercises are carried out, as part of transition a full overview of commissioning will be summarised to then align with the work on the JSNA and emerging Health and Wellbeing Strategy. As part of this there will need to be common understanding of what is meant by commissioning and an alignment of commissioning cycles across all parties. This will help to also shape the retained delivery mechanisms that will be within the local authority.

3.3.5 In addition to delivering services locally, joint delivery and commissioning of services, sub regionally will be included in transition proposals, especially in respect of emergency preparedness planning.

3.4. Performance monitoring.

3.4.1 The Public Health Transition plan will outline how performance is currently monitoring measured and reported and future monitoring will be developed as part of the future operating model. This will need to be a joint plan between the PCT and council as well as having overview from the Early Implementer Health and Wellbeing Board.

3.5 Intelligence and Information management

3.5.1 As part of the baseline information the IT element will be investigated to establish, which data systems and data needs to be transferred to the Councils IT systems and ensure that capacity and capability of Public Health systems can be managed within the Council IT infrastructure.

3.5.2 Further guidance will be published by Public Health North East which will outline how information and intelligence should be transferred and shared.

3.6 Communication, Consultation and Engagement

3.6.1 As part of the ongoing development and engagement in the Health and Wellbeing Project a number of workshops have been delivered and are planned to support the Transition of Public Health and future delivery of services.

3.6.2 A further engagement and communication plan will be developed once the government guidance has been issued in November/December 2011, and internal decisions are made about what the Public Health Function will look like in the Sunderland.

3.6.3 A Public Health and Wellbeing working group will be established that include key specialists from both Public Health & the council to prepare for the transition. This group will include representation from: HR, Commissioning, ICT, Health delivery and Finance. Key guidance will not be received until December and this leaves a tight timescale to develop a transition plan for April. It is recommended that this group meet to understand all the guidance to date about the transition, carry out some preparatory work in readiness for December's guidance so transition work can start immediately after guidance is received. This will also align with arrangements that cover all of South of Tyne and Wear as currently activities are undertaken jointly across the three geographical areas.

3.7 Resources

3.7.1 This paper has outlined some of the key areas that need to be considered and developed, however a detailed plan of all project tasks is being developed in partnership with Public Health to ensure that all areas affecting the transition are included in the project delivery. A number of specialist resources are required to deliver the project outcomes the existing Project Team are developing specific work packages to secure the resources to develop and deliver the transition.

4.0 Recommendations

4.1 The board is asked to support and agree the outlined processes and direct and facilitate solutions to the key issues that will enable Public Health in its transition into Local Authority responsibility and management.

5.0 Background Papers and Supporting documents

Equity and excellence: Liberating the NHS dated July 2010
Liberating the NHS: Legislative framework and next steps dated December 2010
Health and Social Care Bill 2011
Public Health – Detailed Project Transition Plan

Item No. 9

25 NOVEMBER 2011

REPORT TO THE SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

HEALTHWATCH TRANSITION PLAN UPDATE

Report of Sue Winfield, Healthwatch Transition Lead

1.0 PURPOSE OF THE REPORT

1.1 To provide board members with an update on national and local progress with HealthWatch transition

1.2 To assist board discussions on patient and public representation on the Shadow Health and Wellbeing Board from April 2012 to the commencement of Healthwatch in October 2012.

2.0 BACKGROUND

2.1 The HealthWatch Transition Plan was published on 29 March 2011 describing the journey of strengthening the patient and public voice via HealthWatch at both local and national level

2.2 The April to July 2011 Listening Exercise considered patient involvement and public accountability as one of the key themes.

2.3 The outcomes of the Listening Exercise in relation to HealthWatch strengthened the principles of patient and public involvement at all levels including shared decision making at every opportunity

2.4 The commencement date for HealthWatch is October 2012 with NHS Complaints Advocacy delivery commencing in 2013

2.5 The paper assumes that the sections of the Health and Social Care Bill 2011 relating to HealthWatch pass into law without significant amendments.

3.0 NATIONAL PROGRESS

3.1 HealthWatch England

The development of HealthWatch as a subcommittee of the Care Quality Committee (CQC) is progressing. The *Preparing for HealthWatch* document outlining the plan for CQC setting up HealthWatch England was published in October 2011. HealthWatch England will be a statutory committee of CQC with a Chair who will be a non-executive director of CQC. Recruitment for the post of Chair will

commence in November 2011 and the successful appointee will take up post in April 2012.
Other planned developments include putting senior staff in place and creating information and briefings for local HealthWatch by June 2012.

3.2 Action Learning Sets

Action Learning sets have commenced and are offered to LINKs wishing to develop and build capacity for the future via peer learning and sharing.

3.3 Pathfinders

All 75 applications for Pathfinder status were agreed. The North East Local HealthWatch Pathfinders are Gateshead, Hartlepool and Northumberland. Appendix 1 details the areas of exploration for the three local Pathfinders. Learning events will take place based on the Pathfinder experiences in the near future.

3.4 National Programme Board and Advisory Group

The National Programme Board for HealthWatch transition is supported by the HealthWatch Advisory Group, of which the Chair of the Sunderland LINKs is a member. Published Minutes from the National Programme Board are not available after May 2011 therefore updated activities of the Board are not available. Previous minutes detail the internal work to look at capacity for transition support and funding arrangements

The Advisory Group has produced an October 2011 Bulletin describing progress of the five task and finish groups:

- HealthWatch England Principles and Practicalities
  Acting as a sounding board for HealthWatch England development in areas such as the job description for the Chair and Director and the operating model.

- Local HealthWatch: Building a convincing case
  Three critical relationships have been identified for development.
  - Local HealthWatch and HealthWatch England
  - Local HealthWatch and CQC
  - Local HealthWatch and its commissioners i.e. local authorities

  Learning from HealthWatch Pathfinders will inform this work.

- Local HealthWatch: creating a good local HealthWatch
  Concentrating on key finance dates, suggesting local TUPE resolution not national adjudication, learning from Pathfinders and development of Regional transition leads. The North Regional Transition Lead is Julie Turner, South Tyneside City Council.

- Communication and engagement: a strategy
  Work continues with a communications agency with a key output of a communications toolkit for local HealthWatch by June 2012. It is hoped that all local HealthWatch organisations will use the collectively developed identity for HealthWatch. It will provide some highly effective tools such as a logo and templates for leaflets. A final HealthWatch 'brand' will be shared in 2012, local transition groups are requested not to develop a brand in the interim.

3.5 Funding consultation

The Department of Health (DOH) circulated a consultation document on allocation options for distribution of additional funding to local authorities for Local HealthWatch, NHS Complaints Advocacy and PCT Deprivation of Liberty Safeguards on 27 July 2011. The consultation asked for views on the allocation options for the transfer of funds for the three areas mentioned above by 24 October 2011. Two main options were presented for and a minimum allocation for each local authority, to reflect the fixed costs of setting up and running a signposting service.

The two allocation options stated for Local HealthWatch and NHS Complaints Advocacy were:

1. LHW1 / NHSCA1: Adult working age population, adjusted for area costs
2. LHW2 / HNSCA2: The social care relative needs formula

<u>Sunderland's Local Health Watch 2012/13 funding options (full year effect):</u>

LHW1 Without Min Allocation (£)	LHW1 With Min Allocation (£)	LHW2 Without Min Allocation (£)	LHW2 With Min Allocation (£)
120,178	120,000	161,937	161,633

The option bringing the greatest financial benefit for Sunderland's population was option LHW2 for HealthWatch funding. This is also the preferred option stated within the consultation document.

The figures above illustrate the transfer of funding from PCT PALS to local authorities for signposting services, and include start up costs and increased demand. They allocate a total of £23 million per year. This amount is illustrative. The actual funding in 2012/13 will be for part of the year. The transfer amount will be confirmed when the current data collection exercise is complete, and DOH has completed its 2012/13 financial planning round.

Sunderland's NHS Complaints Advocacy 2013/14 funding options:

NHSCA1 (£)	NHSCA2 (£)
74,306	94,827

The option bringing the greatest financial benefit for Sunderland's population was option NHSCA2 for NHS Complaints Advocacy funding. This is also the preferred option stated within the consultation document.

The figures above also illustrate the transfer of funding to local authorities to commission NHS complaints advocacy services, and include funding for lost economies of scale. They allocate a total of £14.2 million per year. This amount is illustrative. The actual funding in 2012/13 will be for part of the year. The transfer amount will be confirmed when the DOH has completed its 2012/13 financial planning round.

4.0 LOCAL PROGRESS

4.1 A dedicated HealthWatch Transition workstream has been developed with delivery via a working group with representation from key stakeholders. Representation is currently being sought for Children and Young People as the latest funding consultation document clarifies the expectation that HealthWatch will engage with younger age groups.

4.2 A project plan has been developed which includes development of an engagement plan to develop the service specification for Local HealthWatch in Sunderland. This will include an engagement event on 22 November 2011 and other methods of engagement via established groups within communities. Elected Member engagement is ongoing and specific consideration is being given to the parallel HealthWatch scrutiny function and that of Council led overview and scrutiny.

4.3 Specific dialogue has taken place to ensure alignment to other Council developments such as the Information, Advice and Guidance Review, Community Resilience and Local Responsive Services.

4.4 Procurement advice has been included in the workstream as once the service specification for Local HealthWatch has been developed and agreed a procurement exercise will take place. It is now clear that the HealthWatch procurement will be a process taking anything from 159-189 days once the final specification has been developed and agreed. This has implications for the Shadow Health and Wellbeing Board.

4.5 The Board will need to consider the Patient and Public representation on the Shadow Health and Wellbeing Board from April 2012 until HealthWatch is in place in October 2012.

5.0 NEXT STEPS

5.1 Engage in national and regional Pathfinder learning events

5.2 Complete the engagement activities to inform the service specification for Sunderland HealthWatch

5.3 Initiate a formal procurement process once the service specification is agreed

5.4 Develop financial planning for national and local PCT PALS funding transfer to include consideration of any TUPE requirements

5.4 Engage in regional discussions regarding provision of NHS Complaints Advocacy

5.5 Seek advice on the interim arrangements for Patient & Public representation on the Shadow Health and Wellbeing Board

6.0 RECOMMENDATIONS

6.1 Early Implementer Health and Wellbeing Board are requested to receive the report for information

6.2 Early Implementer Health and Wellbeing Board are requested to agree the next steps.

6.3 Early Implementer Health and Wellbeing Board are asked to consider Patient and Public representation on the Shadow Health and Wellbeing Board from April 2012 to October 2012.

Appendix 1

SUMMARY OF NORTH EAST PATHFINDERS

Pathfinder	***Synopsis of the pathfinder***	***Main contacts***
Gateshead	Building on a community development approach to engagement and relationships with the voluntary and community sector, this will empower people and their communities to have effective relationships with public bodies. This pathfinder will focus on establishing a two-way relationship of sharing information between the Local HealthWatch and GatNet i.e. clinical commissioning groups.	AndiParker@Gateshead.Gov.UK
Hartlepool	Creating a model to instil a culture of active responsibility where everyone, including local HealthWatch, is empowered to ask, challenge and intervene to help ensure that resources are used effectively to deliver better health and social care. This pathfinder will focus on building relationships with new bodies such as the GP commissioning consortia and the Local Authority Health and Wellbeing Board, where Local HealthWatch has a key role in providing the evidence about what local people need and want.	Leigh.Keeble@hartlepool.gov.uk
Northumberland	Exploring the Northumberland need for independent NHS complaints advocacy service is required for Northumberland, with particular consideration given to its unique and challenging geography and demographics. This pathfinder will focus on the innovation required by a Local HealthWatch to meet the ask of local people for the accessibility to complaints advocacy service in a rural county.	RachelT@adapt-tynedale.org.uk

Item No. 10

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **25 NOVEMBER 2011**

BRIEFING ON ASSOCIATION OF NORTH EAST COUNCILS IMPROVING HEALTH TASK AND FINISH GROUP REPORT

1.0 Purpose of the ANEC Task and Finish Group

1.1 The ANEC task and finish group was set up as a means to engage with elected members across the region and to harness the expertise in helping shape the role of local government going forward. The particular focus of the group was to look at the NHS reforms, other relevant evidence and make recommendations. Sunderland was represented on the group by Councillor Mel Spedding and Councillor Florence Anderson.

1.2 The task and finish group was asked to focus on outcomes in terms of clear recommendations for action. The outcomes can include the following;

- Partnership working across local government
- Identifying, disseminating and building on best practice
- Engaging with key stakeholders, bringing an external perspective when debating issues
- Developing advocacy positions
- Providing recommendations that are targeted at Government, local government and partner organisations
- Making a difference and adding value whether in terms of efficiencies, cultural change or by reducing costs

2.0 Key Recommendations of the Task and Finish Group

2.1 The task and finish group set out an number of key recommendations in their report, these are as follows;

- Local authorities should recognise the ambitions set out in *Better Health, Fairer Health* as a valid current statement of themes and consider this when discharging their public health function
- ANEC should ensure that there is early discussion at both the Chief Executive Group and the Leaders and Mayors group about how to work differently to address critical issues, achieve better values and work better collectively
- Consider holding a Health and Wellbeing summit for members and ask ANEC to host a working group with the 12 chairs of the Health and Wellbeing Board
- A declaration of intent be developed and agreed by the 12 authorities to ensure that the population if the North East will have the best fairest health and wellbeing
- Further discussion is needed on the role of clinical senates and networks, Public Health England and the National Commissioning Board

- Seek the retention of funding by the PCT's in respect of FRESH and BALANCE so that a way forward can be determined
- Where issues such as alcohol represent cultural problems this should not be used as an excuse to do nothing
- ANEC should be asked to consider further how the 12 Health and Wellbeing Boards can work together and be effective

ASSOCIATION OF NORTH EAST COUNCILS

Association of North East Councils
Improving Health Task & Finish Group Report

Asscociation of North East Councils
Improving Health Task & Finish Group Report

Introduction

1. Task & Finish Groups (T&FGs) have proved to be an important way of working for the Association. They are a means of engaging the experience and expertise of elected members across the area, helping to shape thinking and unite behind actions and activity in support of local government's role. They allow members to undertake a rapid, time-limited, in-depth and non-bureaucratic examination of some of the key issues facing councils.

2. Task & Finish Groups focus on outcomes in terms of clear recommendations for action. Typically, outcomes can include:

    - identifying scope for working across local government and with partners;
    - identifying, disseminating and building on best practice;
    - getting key stakeholders to contribute to the debate and bring an external perspective to bear on the issue;
    - developing advocacy positions;
    - recommendations targeted at local authorities, partner organisations and government; and
    - adding value and making a difference – whether in terms of reducing costs, creating efficiencies, achieving cultural change etc.

3. Each Task & Finish Group report is presented to Leaders and Elected Mayors for approval and then widely disseminated.

4. Early in 2011, Association members considered proposals to set up Task & Finish Groups in a number of areas, one of which was around the wider impacts of health in the North East – having regard to the fact that the Government was embarking on a programme of reform to the National Health Service, as summarised below. This Group – the Improving Health Task & Finish Group – was consequently established. Its remit has been to consider the NHS reforms and other relevant evidence, and to make recommendations – to the 12 member authorities, Government, NHS bodies and other partners – as to how they can take advantage of the opportunities presented by the NHS reforms to improve health outcomes for the people and communities of the North East.

5. This report explains how the Task & Finish Group approached its role, and goes on to set out the Group's findings and recommendations.

Background - the NHS reforms

6. Reforming the NHS has been a significant – and sometimes controversial – element of the coalition Government's legislative programme. The Government's proposals are set out in a number of documents including:

    - two White Papers: *'Equity and Excellence: Liberating the NHS'* (July 2010) and *'Healthy Lives, Healthy People: our strategy for public health in England'* (November 2010);
    - a number of consultation papers on specific aspects of the above;
    - the Health and Social Care Bill, introduced into Parliament in January 2011; and
    - the Government's response to the report of the NHS Future Forum (June 2011) – the Forum had been established during a 'pause' in the passage of the Bill to carry out consultations on a number of expressed concerns.

7. The Government's proposals, as they now stand following the response to the NHS Future Forum, can be summarised as follows:

    - the Secretary of State will as now be accountable for the NHS, though rather than secure services directly, he will exercise his responsibility through his relationship with the bodies, such as the NHS Commissioning Board, to be established through the Bill;
    - Primary Care Trusts and Strategic Health Authorities will be abolished;
    - clinical commissioning groups (CCGs) will take responsibility for the bulk of NHS commissioning. They will be led by GPs but their membership will ensure involvement of patients, carers, the public and a wide range of health professionals. They will be under a duty to promote integrated services and will be required to operate in an open and accountable manner;

- local authority led Health and Wellbeing Boards (HWBs) will be responsible for promoting joint commissioning and integrated provision between health, public health and social care. They will lead the development of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. They will also be involved as CCGs develop their commissioning plans and there will be an expectation, set out in statutory guidance, for the plans to be in line with the Health and Wellbeing Strategy;
- membership of HWBs will bring together locally elected councillors with the key commissioners in the area, including representatives of CCGs, directors of public health, children's services and adult social services and a representative of local HealthWatch. It will be for local authorities to determine the number of councillors on the HWB, and they will be free to insist on having a majority of elected councillors;
- the existing statutory powers of local authority scrutiny will continue to apply, and local authorities will still be able to challenge any proposals for the substantial reconfiguration of services;
- on the provider side, all acute trusts will become Foundation Trusts with greater freedoms, but will face competition from 'any qualified provider'. However, competition will be on the basis of quality not price, with safeguards against price competition and 'cherry-picking'. The core duty of the regulator, Monitor, will be to protect and promote patients' interests; and
- local authorities will take responsibility, alongside Public Health England, for improving the nation's health. They will be allocated a ring-fenced public health budget, with a 'health premium' for those authorities that achieve specified health outcomes.

8. The Task & Finish Group noted that there are still many 'unknowns', some of them significant. Government has still to publish its proposals on such key issues as the public health outcomes framework and funding regime; these are expected during the autumn, and will be a critical factor in determining whether local authorities are actually in a position to fulfil their ambitions. Government will also be issuing guidance, such as the statutory guidance on Joint Strategic Needs Assessments, which we have yet to see. There are also uncertainties about the roles of national bodies including the NHS Commissioning Board, Public Health England and Monitor and how they will impact on local authorities. In short, we are still in a period of transition. However, with local authorities already advanced in their preparations – in setting up their HWBs for example – we feel that it is essential to disseminate our recommendations as soon as possible, while there is an opportunity to influence new structures and working arrangements.

The Context for the North East

9. Health is a critically important agenda for the North East. Whilst great progress has been made on a number of issues, health inequalities still exist both between the North East and other regions, and between different parts of the North East. These inequalities manifest themselves in terms of:

    - the determinants of health, including housing, employment, education, the environment, alcohol, smoking, diet;
    - inequalities in access to some services; and
    - inequalities in outcomes such as life expectancy.

10. To give just a few examples:

    - the North East has the worst levels of deprivation and the lowest life expectancy in England;
    - it has the highest rate of early deaths from cancer; and
    - the North East's rates of smoking in pregnancy and breast feeding initiation are the worst in England.

11. However, much good work has been done:

    - in recent years, life expectancy has been rising faster in the North East than in any region except London;
    - cardiovascular disease has been falling more quickly than the national average; and
    - smoking prevalence has fallen dramatically since 2005.

12. There are also significant inequalities within the region – for example there are considerable differences between Northumberland and Middlesbrough in terms of male life expectancy, cardio-vascular heart disease and stroke, and cancer. But there is still much more to do, and a number of people who gave evidence to us pointed out that preventative spend has not been as significant as claimed.

13. The issue of health inequalities is not of course a new one. Professor Michael Marmot's significant report '*Fair Society, Healthy Lives*', published in February 2010, pointed out that the people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life. Marmot argued that health inequalities result from social inequalities, and that action on health inequalities requires action across all the social determinants of health. Delivering this would require action by central and local government, the NHS, the third and private sectors and community groups.

14. The case for change is clear but in an environment of resource reduction and tightening budgets, how might this happen? Will there be pressure on social care or other budgets, for example, to fill gaps? In an age of austerity, will this be possible, even if it is desirable? We return to this point later in our report.

15. The North East has long recognised the necessity of tackling these inequalities often through a collective effort between partners – in the health service, local government, the third sector and elsewhere. In 2008 regional partners agreed an ambitious strategy for health and wellbeing that aimed to make the health of the North East the best of any region in the country over the next 25 years. The Strategy – entitled *Better Health, Fairer Health* – was based on a number of principles including:

    - improve health for all, achieve equal health where possible and ensure fairness always;
    - add value to local and national action;
    - move the North East further and faster in improving health; and
    - address fundamental causes of health and wellbeing and their absence.

16. The strategy identified ten key themes for action:

    - economy, culture and environment;
    - mental health, happiness and wellbeing;
    - tobacco;
    - obesity, diet and physical activity;
    - alcohol;
    - prevention, fair and early treatment;
    - early life;
    - mature and working life;
    - later life; and
    - a good death.

    Each of themes was taken forward by a inter-agency regional advisory group (RAG).

17. Particular mention should be made here of the approach that has been taken to tobacco and alcohol. The Fresh programme was established in 2005 as the UK's first dedicated office and programme for tobacco control. Its approach is one of *de-normalisation* – shifting the social norms around tobacco so that it becomes less desirable, less acceptable and less accessible. Outcomes to date in the North East include the furthest and fastest decline of smoking rates of any region in the country, from 29% in 2005 to 22% in 2009. Fresh is currently funded by the 12 Primary Care Trusts in the North East until March 2012, with a budget of £713,000 for 2011/12.

18. Balance, the North East Alcohol office, was set up in January 2009 to deliver a similar de-normalisation approach, calling for changes in the way alcohol is priced, promoted and sold and thus helping individuals to reduce their consumption. Like Fresh, it is funded by the 12 PCTs until March 2012, with a budget of £680,000 for 2011/12.

19. The future of the Regional Advisory Groups (which for tobacco and alcohol are linked to but separate from FRESH and BALANCE) is now under consideration, given the imminent removal of the regional tier in health service management (SHA, PHNE), which co-ordinated and provided support for this activity. There needs to be open and constructive dialogue with those who will be key players in the future; local authorities, Directors of Public Health, Clinical Senates/clinical networks, Public Health England and others, on agreeing a way forward – which we pick up later in the document.

Our approach

20. The membership of the Task & Finish Group included representation from all 12 local authorities in the North East, on a cross-party basis (a list of members is at Appendix A). We met three times. We worked closely with our health partners and throughout our deliberations we had the advice and support of Ian Parker, Chief Executive of Middlesbrough Council and Chris Willis, Transition Programme Director, NHS North East. At the second of our three meetings we had a panel discussion with senior NHS representatives from a variety of NHS organisations including commissioners and providers (also listed in Appendix A) which enabled us to explore the key issues in depth. At our third meeting we had a presentation from Kevin Rowan and Tom Ross of the Northern TUC on the Healthy Workplaces Project; more is said about this in paragraph 34. We are grateful to all those who contributed for making their time available. We were supported by ANEC staff Melanie Laws, Andy Robinson and Jonathan Rew.

21. Throughout our deliberations, members expressed a strong view that they wished to focus on how local authorities could use the opportunities presented by the NHS reforms to bring about improvements in health outcomes for the people and communities of the North East. These opportunities include:

- the lead role that local authorities will play in setting up and running Health and Wellbeing Boards;
- the strong role that HWBs will have in joining up health, public health and social care, as well as wider local authority services that impact on health, through the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy;
- the involvement of HWBs as clinical commissioning groups develop their commissioning strategies; and
- the return of public health functions to local government (alongside Public Health England) with a ring-fenced budget, and the location of Directors of Public Health with local authorities. (A list of the specific public health responsibilities assigned to local authorities is set out at Appendix B).

22. In considering how best to take advantage of these opportunities, the Group identified four key questions which it felt needed to be addressed. These questions are:

i) what are the key public health challenges for the North East, and how do we address them?
ii) how do we ensure the new structures – particularly the Health and Wellbeing Boards – can be made to work effectively?
iii) are there any 'must dos' (or must don'ts) that apply to every authority? and
iv) what are the opportunities for political leadership in improving health – for example, allocating resources, shaping the agenda, scrutiny?

23. Our conclusions on each of these questions are set out below.

Question 1: What are the key public health challenges for the North East and how do we address them?

24. We support the view that *Better Health, Fairer Health* remains valid in terms of its evidence base and its analysis of the public health challenges facing the North East. While the political landscape and the financial situation have changed since it was produced, our ambition to tackle the issues it identifies should not, and it would be useful for the 12 authorities to make a collective declaration of intent to work in our localities and where appropriate, collaboratively, to ensure that the population of the North East will have the best and fairest health and well being. We would see this declaration not as 'top down' but as something developed by the 12 authorities as a high-level statement of our collective vision to achieve the best and fairest health and wellbeing, while recognising that each authority has a different health profile and priorities.

25. However, it is one thing to identify the issues, another thing to prioritise them, especially in a period of financial constraint and when the future public health budget is far from clear. Some things are more complicated to deal with (eg: mental health). Equally, each local authority will have its own local priorities and will need to work out for itself both how it allocates its ring-fenced public health budget and to what extent it is able to bring

its mainstream budget to bear – although the strategic role of Health and Wellbeing Boards should ensure that their work is based on evidence and oversight of budgets to avoid budgets being used inappropriately to plug holes when funding should come from other sources.

26. Local authorities and health partners will also need to consider, in the light of all factors including finance, how the ambitions set out in *Better Health, Fairer Health* should be taken forward, by whom and at what spatial level. Though the final decision must rest with each local authority or principal partner, some collective discussion from a local authority perspective through ANEC would be very helpful. The role of Public Health England, clinical senates and networks in this respect is as yet unclear and needs also to be better understood before final decisions are made. Scarcity of resources (human and financial) will be a factor, and economies of scale will need to be taken into account.

27. We suggest that ANEC should consider holding a Health and Wellbeing summit to take forward key health issues and get councils, and elected members, thinking about them. It should also be considered whether there would be merit in having a permanent member group to take forward the health agenda. The Task & Finish Group approach has been valuable and effective in ensuring that attention is given at an early stage to health transition issues; to ensure that the health agenda retains a high priority into the future, there is a case for setting up a working group consisting of health lead members (possibly the Chairs of HWBs) from each of the 12 authorities. If such a group is set up it could prepare the declaration of intent referred to in paragraph 24.

28. We noted the achievements of Fresh and Balance in relation to tobacco and alcohol use and the cost-effectiveness of their approach which focuses on those areas which are best done once rather than 12 times. We also note that the current funding regime through the 12 Primary Care Trusts expires in March 2012. We would wish to see the current approach maintained, at least for the time being, so that when the responsibilities pass to local authorities, we have a 'steady state' position from which we can move forward and determine a way forward for the future.

29. On a separate but related point, it is sometimes suggested that some of the public health challenges facing the North East, for example those relating to alcohol, are a product of North East 'culture'. Without wishing to get into a philosophical debate about this, we would urge that to the extent that such a culture exists, it needs to be challenged; it must not be used as an excuse for doing nothing.

30. We therefore recommend:

- **that local authorities recognise the ambitions set out in *Better Health, Fairer Health* as a valid, current statement of themes that they will need to consider in discharging their public health functions;**
- **that ANEC should ensure that there is early discussion, through the Regional Chief Executives Group and the Leaders and Elected Mayors Group, of the scope for working at different spatial levels and in different ways to address critical issues, with the aim of achieving better value and making a greater impact through working collectively;**
- **that consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBs, to take forward the health agenda;**
- **that a declaration of intent is developed and agreed by the 12 authorities, to seek to ensure that the population of the North East will have the best and fairest health and well being;**
- **that there is further discussion with local authorities on the roles of clinical senates and networks, Public Health England and the National Commissioning Board (and its 'outposts');**
- **that as part of this discussion, we would seek the retention by PCTs of funding in respect of FRESH and BALANCE so that a way forward can be determined for the future (so for this purpose PCTs should be asked to continue to fund them in 2012/13, and local authorities be recommended to support the initiatives, going forward); and**
- **where cultural issues might be responsible for some public health challenges (such as alcohol), this should not be used as an excuse to do nothing.**

31. One issue that was put to us strongly is the balance between acute services and public health – the importance of tackling the sources of ill health rather than spending money on treating illness. This is an issue that particularly affects the North East where the figures show that hospital use is the highest in the country. However, if we are going to reduce demand for services in hospitals, effective services in the community will be needed and this might also impact on hospital configuration in due course. The implications of this would need to be worked through in a collaborative way. It was reported to us that GPs are keen to do more in this respect but conflicts of interest arise in their role as provider as well as commissioner which have yet to be resolved. GPs need to ensure that they are working very closely with their council(s) when considering their role in the commissioning and provision of community services. Equally, all partners need to think carefully about their commissioning roles and ensure a joined up approach is taken – otherwise this could lead to destabilisation in the supplier/provider market which, apart from anything else, could lead to significant difficulties.

32. We note that management of long-term conditions has an important role to play in reducing pressures on the public health budget; this includes helping patients to manage their own conditions.

33. Local authorities will also need to think carefully about how they will use their wider responsibilities – such as employment, education, children's services, environment, housing and transport – to improve the health and wellbeing of their communities and achieve change at the local level. There is a great opportunity here for addressing the wider, social determinants of health but it will not happen automatically; local authorities will need to embed public health across all their services (see also the discussion on the role of Health and Wellbeing Boards).

34. Another role of local authorities that should not be overlooked is as the employer of a substantial workforce. In this context, we were greatly impressed by a presentation from Kevin Rowan and Tom Moss of the Northern TUC on the TUC's Healthy Workplaces project. The aim of the project is to improve public health by promoting wellbeing and health activities through workplaces; over 200 North East employers, and 250,000 employees, have been involved so far, mostly in the private sector. There have been some remarkable results, not least in reaching members of the workforce who do not normally engage with health services, enabling potentially threatening conditions to be picked up before they become serious. We would encourage member authorities, and their partner organisations, to consider adopting similar workplace health initiatives. They should also consider how their workforce, through their regular contacts with a wide range of individuals, can act as a resource to promote and improve the health of the community.

35. We considered the relationship of the HWB, as a committee of the council, to other partnerships and structures. We noted that the changes, particularly the creation of HWBs, present the opportunity for councils to review and refresh their approach to partnerships, including the LSP, should they wish to take it. The role of the HWB in relation to the Local Strategic Partnership will be important, as will the relationship to Children's Trusts. On the latter point, we consider that children's health is a vital issue. We noted that currently, most local authorities are retaining their Children's Trusts at least until their HWB is properly established. There is an opportunity here to eliminate duplication of roles within the local authority.

36. We recommend that local authorities:

- **work with health partners to examine the balance of resources between acute services, community services and public health;**
- **ensure that public health is embedded across all their services, using their wider responsibilities to improve the health and wellbeing of their communities, and reviewing where appropriate their approach to partnerships; and**
- **use their role as major employers to improve to improve the health of the community, by introducing workplace health initiatives and by considering how their workforce can promote health through their contacts with individuals.**

37. In addition, there are some critical areas where decisions and action by Government will impact on local authorities' ambitions for improving health outcomes. The first of these is finance: we do not yet know how the ring-fenced public health budget will be allocated between Public Health England and local government, and between individual local authorities (although we note that local authorities are being involved in the preparation of 'shadow' public health allocations for 2012/13, a helpful development). Further, while the principle of bringing other local authority services to bear on health is one that we support, this should not mean using mainstream budgets to remedy under-funding of the public health budget. Secondly, it is clear that national bodies including the NHS Commissioning Board, Public Health England and Monitor (and their outposts) will be major players; it is essential that they do not impose 'top down' approaches that hamper local authorities' ability to achieve their goals. Health and Wellbeing Boards will also need to develop working relationships with the new national bodies.

38. We recommend that these concerns are raised with the Government.

Question 2: How can we ensure the new structures – particularly the Health and Wellbeing Boards – can be made to work effectively?

39. We consider it is essential that each HWB thinks carefully about its purpose. The HWB should avoid becoming part of some bureaucratic process, a 'hoop' that has to be gone through; it needs to play a positive and proactive role, to make things happen, working with partners to shape and redesign services to meet the needs of its locality. It should ensure that it tackles the big issues that have real impact – it should not try to do everything itself.

40. It would be helpful if each HWB was at an early stage to set out its:

- values: what are the shared values that all members of the HWB bring to the table? (In this context it should be noted that the diagnostic tool for the establishment of clinical commissioning groups published by the Department of Health on 4 August makes reference to establishing values and behaviours as a key component of a CCG; read-across and consistency between the CCG's values and those of a HWB will be important);
- goals: What is our vision and what are our key objectives and goals? How do we tackle long-standing issues that have proved hard to address? and
- tasks: What do we need to do to achieve our objectives and who will do this?

41. These issues will be at the heart of a Health and Wellbeing strategy. They will also require strong political leadership (see below).

42. Crucially, the HWB should be a focus for **joining up commissioning and service provision** both within the local authority and with other partners and players who have an impact on health. The scope for exploring and developing integrated commissioning is something which could have potential too.

43. Following the report of the NHS Future Forum, it is clear that HWBs will be expected to be involved throughout the process as clinical commissioning groups (CCGs) develop their commissioning plans, and statutory guidance will set out the expectation that commissioning plans will be in line with the Health and Wellbeing Strategy. **We urge HWBs and CCGs to make the most of this opportunity – the process should ideally be one of co-production and not of checking, after the event, that the clinical commissioning plan is aligned with the HWB strategy.**

44. The Health and Wellbeing Board should have a key role in public and patient involvement: it should be the focus for engagement with the patient and community voice, involving them in the process of identifying local needs and developing the Health and Wellbeing Strategy. CCGs will clearly have an important role in understanding and addressing the health needs of their local population, but HWBs have the advantage of being able to take into account all factors influencing the health and wellbeing of people, and should look to address these through a cohesive approach. As part of this, the contribution that local councillors can make to this process as representatives of their local community will be critical, given the breadth of the role of a local councillor – we noted that councillors are often the only people who can see the whole system from top to bottom.

45. Further, the HWB will need to think through how it will engage with the voluntary and community sector (VCS). The VCS has a number of vital roles to play: in informing need through the Joint Strategic Needs Assessment, in developing the Health and Wellbeing Strategy and in delivery of a range of services. The VCS does of course comprise a very wide range of organisations and the HWB will need to give careful thought to how its voice can be heard and its contribution taken fully into account.

46. The role of scrutiny will also be important and, amongst other things, it will enable HWBs and their health partners to receive third party observations and advice on their important work.

47. One specific issue that each authority will want to address is how to ensure that the perspectives of provider organisations (both inside and outside the NHS) are available to its HWB as it shapes the health and wellbeing strategy. Authorities are approaching this in different ways, with some including provider representation in the membership of their HWB, others not. It is clearly a matter for each authority to decide its own approach – **the essential thing is that there is some mechanism for taking the provider perspective into account – including those providers who cross boundaries (this latter point could benefit from further consideration in the context of how HWBs work together in future).** Where there are any conflict of interest issues, these will need to be addressed through transparent governance mechanisms. Local authorities have scope to both commission and provide in almost every area of their activity and therefore this is nothing new. The key is that HWBs need to be a focus for joining up.

48. Given the commonality of health issues facing the North East, we feel that it is important that the 12 Health and Wellbeing Boards do not operate in isolation from each other; it is vital to share information, learning and good practice. It will also be important to consider how we use scarce resource (both money and people), looking at opportunities to share where it makes sense to do so. At the same time, we must avoid a bureaucratic structure of joint meetings simply for the sake of it. We suggest that ANEC should give further consideration as to how the 12 HWBs can work together most effectively and how it might help in this process.

49. Another issue that HWBs will need to consider is how they are going to work with those providers who operate on a wider base than a single local authority? Should they each have an individual relationship with the provider body in question, or should this be through some collective mechanism?

50. Those who submitted evidence to us noted that political leadership provided through ANEC is probably the only opportunity left to ensure that the area as a whole is able to take a strategic approach where required (and where economies of scale are helpful at that spatial level); for example, on issues such as aspects of health promotion and marketing, and other work. We pointed out that ANEC is a body of, and owned by, the local authorities. ANEC's political advocacy work is considered to be very valuable.

51. We recommend that:

- **each HWB should take some time to consider its approach - how it can play a positive, non-bureaucratic role, tackling the big issues that have real impact;**
- **HWBs should ensure that they are involved as co-producers with clinical commissioning groups of their commissioning plans;**
- **HWBs should ensure that they develop working relationships with national bodies including NHS Commissioning Board, Public Health England and their outposts, and with provider bodies that operate on a wider base than a single local authority;**
- **HWBs should play a key role in their area on involving the public in identifying local needs and developing the Health and Wellbeing strategy;**
- **each HWB should consider how it will engage with voluntary and community sector across the various roles that the VCS plays;**
- **as part of this, HWBs should ensure that the contribution of local councillors is actively sought, that arrangements for HealthWatch are made and engagement established;**
- **each local authority should ensure that the provider perspective is available to its HWB; and**
- **ANEC should be asked to further consider how the 12 HWBs can work together most effectively and its role in this agenda, going forward.**

Question 3: Are there any 'must dos' (or must don'ts) that apply to every authority?

52. In the previous sections we have set out a number of issues which we believe authorities should be addressing. It is worth re-emphasising here some key principles:

- local authorities should take a 'whole systems' approach to health, ensuring that the widest possible range of local authority functions contribute to improving health functions (this is the rationale for returning public health to local authority control);
- it is vital for local authorities and clinical commissioning groups in particular to develop strong, constructive relationships;
- local authorities should play a key role in facilitating relationships between NHS Trusts and CCGs;
- HWBs, CCGs and other partners should consider data and intelligence requirements and aim if possible to create a 'hub' or single point for partners to utilise so all are working to the same evidence base (where appropriate making use of existing resources, such as the North East Public Health Observatory);
- while recognising that health services and issues inevitably have a strong political dimension, authorities should as far as possible avoid allowing issues about structure to dominate their focus;
- acknowledging the important role of HealthWatch as a forum for local people to express their views on health issues, it is essential to engage local councillors, as the democratically elected representatives of local people, in identifying local health needs and drawing up strategies to meet them. Local councillors are ideally placed in this respect as they represent their communities on the breadth of issues which make up the determinants of health (see question 4);
- member development and capacity building will need to be an important priority – it will be essential to invest in developing members' capacity to deal with health issues; and
- local authorities should review where the HWB sits in relation to the Executive/Cabinet, with the aim of ensuring that it does not operate in isolation but is seen as fully part of the corporate decision-making processes of the authority.

Question 4: What are the opportunities for political leadership in improving health?

53. Local government is an equal partner in addressing health inequalities. Democratic accountability and political leadership are critical elements of the health reforms. We would see the role of political leadership as encompassing:

- providing leadership and vision;
- advocacy and challenge;
- working together, facilitating, developing relationships – including with CCGs – and between CCGs, Foundation Trusts and other partners;
- ensuring that structural inequalities are addressed;
- bringing the authority's mainstream services to bear on health;
- ensuring community engagement;
- ensuring that key issues are embedded into strategies, not just the health and wellbeing strategy but other relevant local authority strategies – and are followed up; and
- ensuring cross-boundary working where appropriate.

54. Under the Health and Social Care Bill as it currently stands, it is formally the responsibility of the Leader or Elected Mayor to nominate the local authority member(s) of the Health and Wellbeing Board. In addition, or instead, he/she may choose to be a member of the HWB. It goes without saying that this is an opportunity to secure appropriate high-level political representation on the HWB – if not by the Leader/Elected Mayor then through the Health and other portfolio holders (adults, children's services).

55. In any event the Leader/Elected Mayor will want to ensure that health issues are brought to Cabinet where appropriate and that links are made at Cabinet level between the Health and Wellbeing Strategy and other relevant strategies and partnerships – including the Local Strategic Partnership, if the local authority chooses to continue with it.

56. Local authorities will also want to consider the whole Council role in the health agenda. All areas of the council have a contribution to make. Again, the Leader/Elected Mayor will want to ensure that this consideration takes place.

Conclusions

57. We repeat our belief that health is a critically important agenda for the North East, and that the NHS reforms present local authorities with real opportunities to bring about improvements in health outcomes for the people and communities of the North East, provided the right conditions are in place: finance, resources and freedom from central control. Our role has been to consider how to make this happen. We feel that the important thing is to start by trying to understand where we want to be and to work back from there, looking at how we might achieve our goals and objectives. We have tried not to focus on structures for their own sake but to think about how the new structures – Health and Wellbeing Boards in particular – can work effectively, building strong partnerships, working at the appropriate spatial level and focusing on the key public health issues.

Appendix A

Membership of the Task & Finish Group

Members:

Councillor Nick Forbes (Chair)	Newcastle City Council
Councillor Florence Anderson	Sunderland City Council
Mayor Linda Arkley	North Tyneside Council
Councillor Jim Beall	Stockton on Tees Borough Council
Councillor Barry Coppinger	Middlesbrough Council
Councillor Kevin Dodds	Gateshead Council
Councillor Mary Foy	Gateshead Council
Councillor Pamela Hargreaves	Hartlepool Council
Councillor Eunice Huntington	Durham County Council
Councillor Liz Langfield	Newcastle City Council
Councillor Tristan Learoyd	Redcar & Cleveland Borough Council
Councillor Ian Lindley	Northumberland County Council
Councillor John McCabe	South Tyneside Council
Councillor Charles Rooney	Middlesbrough Council
Councillor Andrew Scott	Darlington Borough Council
Councillor Mel Speding	Sunderland City Council

Advisors:

Ian Parker	Chief Executive, Middlesbrough Council
Chris Willis	Regional Director – White Paper Transition, NHS North East
Melanie Laws	Chief Executive, Association of North East Councils
Andy Robinson	Head of Local Government Policy, Association of North East Councils
Jonathan Rew	Specialist Support Officer, Association of North East Councils

Participants in panel discussion:

Wendy Balmain	Deputy Regional Director Social Care and Partnerships, Public Health North East
Richard Barker	Director of Commissioning Development, NHS North East
Ken Bremner	Chief Executive, City Hospitals Sunderland NHS Foundation
Paul Hanson	Strategic Director of Community Services, North Tyneside Council
Professor Peter Kelly	Acting Regional Director of Public Health
Guy Pilkington	Chair, Newcastle Bridges Consortium (Pathfinder)
Colin Shevills	Director, Balance North East

Appendix B

Proposed public health responsibilities of local authorities

Subject to further engagement, the new responsibilities of local authorities will include local activity on:

- tobacco control;
- alcohol and drug misuse services;
- obesity and community nutrition initiatives;
- increasing levels of physical activity in the local population;
- assessment and lifestyle interventions as part of the NHS Health Check Programme;
- public mental health services;
- dental public health services;
- accidental injury prevention;
- population level interventions to reduce and prevent birth defects;
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions;
- local initiatives on workplace health;
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation programmes;
- comprehensive sexual health services;
- local initiatives to reduce excess deaths as a result of seasonal mortality;
- having a role in dealing with health protection incidents and emergencies, alongside Government departments and NHS bodies;
- promotion of community safety, violence prevention and response; and
- local initiatives to tackle social exclusion.

Appendix C

Summary of recommendations

1. Local authorities should recognise the ambitions set out in *Better Health, Fairer Health* as a valid, current statement of themes that they will need to consider in discharging their public health functions.

2. ANEC should ensure that there is early discussion, through the Regional Chief Executives Group and the Leaders and Elected Mayors Group, of the scope for working at different spatial levels and in different ways to address critical issues, with the aim of achieving better value and making a greater impact through working collectively.

3. Consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBs, to take forward the health agenda.

4. A declaration should be developed and agreed by the 12 authorities of intent to work in our localities and where appropriate, collaboratively, to ensure that the population of the North East will have the best and fairest health and well being.

5. There should be further discussion with local authorities on the roles of clinical senates and networks, Public Health England and the National Commissioning Board (and its 'outposts').

6. As part of this discussion, we would seek the retention by Primary Care Trusts of funding in respect of FRESH and BALANCE so that a way forward can be determined for the future (and for this purpose PCTs should be asked to continue to fund them in 2012/13, and local authorities be recommended to support the initiatives, going forward).

7. Where cultural issues might be responsible for some public health challenges (such as alcohol), this should not be used as an excuse to do nothing.

8. Local authorities should work with health partners to bring about a shift in the balance of resources between acute services, community services and public health.

9. Local authorities should ensure that public health is embedded across all their services, using their wider responsibilities to improve the health and wellbeing of their communities, and reviewing where appropriate their approach to partnerships.

10. Local authorities should use their role as major employers to improve the health of the community, by introducing workplace health initiatives and by considering how their workforce can promote health through their contacts with individuals.

11. Government's attention should be drawn to concerns about (a) the allocation of the ring-fenced public health budget between Public Health England and local government, and between individual local authorities, and (b) the need to avoid 'top down' approaches by national bodies including the NHS Commissioning Board, Public Health England and Monitor.

Making the new structures work effectively

12. Each Health and Wellbeing Board should take some time to consider its approach – to think about how it can play a positive, non-bureaucratic role, tackling the big issues that have real impact, and to set out, at an early stage, its values, goals and tasks.

13. Health and Wellbeing Boards should ensure that they are involved as co-producers with clinical commissioning groups of their commissioning plans.

14. Health and Wellbeing Boards should ensure that they develop working relationships with national bodies including the NHS Commissioning Board, Public Health England and their outposts, and wider base than a single local authority.

15. Health and Wellbeing Boards should play a key role in their area on involving the public in identifying local needs and developing the Health and Wellbeing strategy.

16. As part of this, Health and Wellbeing Boards should ensure that the contribution of local councillors is actively sought, that arrangements for HealthWatch are made and engagement established.

17. Each Health and Wellbeing Board should consider how it will engage with the voluntary and community sector across the various roles that the VCS plays.

18. Member development and capacity building will be an important priority.

19. Each local authority should ensure that the provider perspective is available to its HWB.

20. ANEC should be asked to further consider how the 12 Health and Wellbeing Boards can work together most effectively and its role in this agenda, going forward.

'Must dos' (and must don'ts)

21. In addition to the other recommendations in this report, local authorities should keep in mind:

- the need to take a 'whole systems' approach to health, ensuring that the widest possible range of local authority functions contribute to improving health outcomes;
- the need to develop strong, constructive relationships with clinical commissioning groups in particular;
- their key role in facilitating relationships between NHS Trusts and CCGs;
- the need to consider, with partners, their data and intelligence requirements, with the aim of creating, if possible, a 'hub' or common evidence base for all partners to use, making use of existing resources where appropriate;
- the need to avoid allowing issues about structure to dominate their focus; and
- the importance of engaging local councillors in identifying local health needs and drawing up strategies to meet them.

Opportunities for political leadership

22. Local authority political leaders should recognise their key role in ensuring that their authority maximises the opportunities to improve health outcomes, through exercising the political leadership roles identified in paragraph 53.

23. In particular the Leader/Elected Mayor should ensure that health issues are brought to Cabinet where appropriate and that links are made at Cabinet level between the Health and Wellbeing Strategy and other relevant strategies and partnerships.

24. The Leader/Elected Mayor should also ensure that the authority considers the arrangements by which all areas of the Council can contribute to the health agenda.

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