SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 1) on Friday 18 September 2015 at 12.00noon

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

For further information and assistance, please contact:

Gillian Kelly, Principal Governance Services Officer Tel: 0191 561 1041
gillian.kelly@sunderland.gov.uk

9.	**Smoke Free Play Areas**	127
	Report of the Sunderland Tobacco Alliance (attached).	
10.	**Health and Wellbeing Board Forward Plan and Board Timetable**	133
	Report of the Head of Strategy and Policy (attached).	
11.	**Date and Time of the Next Meeting**	-
	The next meeting of the Board will be held on Friday 20 November 2015 at 12noon.	

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

10 September 2015

Item No. 3

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 24 July 2015

MINUTES

Present: -

Councillor Paul Watson (in the Chair)	-	Sunderland City Council
Councillor Pat Smith	-	Sunderland City Council
Councillor Mel Speding	-	Sunderland City Council
Neil Revely	-	Executive Director of People Services, Sunderland City Council
Dave Gallagher	-	Chief Officer, Sunderland CCG
Gillian Gibson	-	Acting Director of Public Health
Dr Ian Pattison	-	Chair, Sunderland CCG
Ken Bremner	-	Sunderland Partnership

In Attendance:

Liz Highmore	-	DIAG
John Mooney	-	University of Sunderland
Victoria French	-	Assistant Head of Community Services, Sport and Leisure
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

HW14. Apologies

Apologies for absence were received from Councillors Kelly, Leadbitter and Miller and Kevin Morris and Dr McBride.

HW15. Declarations of Interest

There were no declarations of interest.

HW16. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 29 May 2015 were agreed as a correct record.

HW17. Feedback from Advisory Boards

Adults Partnership Board

Karen Graham informed the Board that the Adults Partnership Board had met on 7 July 2015 and the main issues concerned had been: -

- Health and Wellbeing Board Peer Challenge Feedback
- Winter Monies Evaluation
- Age Friendly Update

Dave Gallagher highlighted that the winter monies project was part of a wider CCG sponsored scheme which was being looked at for next year.

RESOLVED that: -

(i) the Health and Wellbeing Board receive an annual report from the Adults Partnership Board; and

(ii) opportunities for continuation funding for the winter health programme, particularly through social prescribing, be explored.

NHS Provider Forum

Ken Bremner informed the Board that the NHS Provider Forum had met on 1 July 2015 and the main issues concerned had been the engagement event and Vanguard status.

Ken highlighted that there had been some confusion about the different initiatives which were going on and where partners should be in relation to these. It was planned to hold an additional engagement event later in the year to provide information about funding and gathering views on policy changes.

With regard to the Vanguard status, Dave Gallagher advised that this was a delivery mechanism and the Sunderland Integrated Community Services Provider Board was a subset of that work. He commented that there would be some merit in looking at the plethora of different structures in place and the Chair added that there was a need to have an understanding of what was happening.

The Chair also highlighted the devolution agreement in Manchester and queried whether partners would be interested in that sort of arrangement in the North East. Ken noted that the role that health services were to play in the devolution set up was not really clear and the powers may not be as local as was originally envisaged.

Neil Revely commented that the engagement and link to communication needed to be broader across the city and that messages had to be transmitted as a system. Groups such as the Provider Board, the Transformation Board, CCG and the Integration Board needed to be aligned.

Ken advised that the Provider Forum had discussed the metrics that the Health and Wellbeing Board should be looking for and Karen Graham added that she was

carrying out a mapping exercise for the Integration Board with the aim of clarifying where everything was positioned within the system. This work would be brought back to the Health and Wellbeing Board and its advisory groups.

Gillian Gibson highlighted that the 'All Together Sunderland' approach had been adopted but there was not a lot of structure and process around this at the moment. Neil noted that this approach would avoid duplicating work and help the overarching communications across the city to be better coordinated and to have a single strategic approach as far as possible.

It was suggested that Phil Spooner could be invited to one of the Board development sessions and for communication leads to be involved to explain what they wanted from the All Together Sunderland approach. Ken advised that this had been the impetus behind the Provider Forum's proposal for a Chief Executive level meeting, to enable them to have an oversight of the system which had been created.

Accordingly the Board RESOLVED that: -

(i) the dissemination and development role identified in the development session in relation to the policy changes arising from the Better Care Fund and the Care Act be addressed by the Health and Wellbeing Board;

(ii) reports be received from the Integrated Community Services Provider Board on the benefits from the Vanguard status; and

(iii) it be noted that a Chief Executive level meeting was to be arranged to consider risk and structures in relation to the Vanguard and to receive an update on the discussions.

HW18. Update from the Health and Social Care Integration Board

Dr Pattison advised that the Health and Social Care Integration Board had met on 25 June 2015 and highlighted that the minutes of the previous meeting which had taken place on 14 May were attached for the information of Board members.

Dr Pattison outlined the seven pools which made up the Better Care Fund: -

Pool 1 - Community Integrated Teams, including Recovery at Home
Pool 2 - Mental Health Community Services
Pool 3 - Carers Services
Pool 4 - Learning Disability Services
Pool 5 - Community Packages (including CHC)
Pool 6 - Equipment Services
Pool 7 - Disabled Facility Grant

It was noted that the benefits of working more closely together had already been seen with regard to community packages and partners were confident that they would get what they wanted to be delivered. There was a total of over £150m spread over the seven pools and there was a need to capture the reporting on each pool. Neil added that there had been discussions about how services were or could be

integrated in general terms, not in relation to the Better Care Fund, and how this could achieve better outcomes for the city.

The Chair asked if there was some disjointedness with the work and Dr Pattison stated that this was more about getting to know each other. There was a willingness to come together but there had been some practical issues between the local authority and the CCG such as different contracting periods and procedures. It was noted that there had been a focus on finance in the early days of the Better Care Fund but it was the intention to bring performance and monitoring into this. Dr Pattison also said that he hoped to see more real financial information coming through, not just projections.

RESOLVED that the feedback from the Health and Social Care Integration Board be noted.

HW19. Health and Wellbeing Peer Review

The Assistant Chief Executive submitted a report advising of the outcome of the Local Government Association Health and Wellbeing Peer Review follow up which took place in April 2015.

The original peer review had taken place in March 2014 and presented a number of recommendations from which an implementation plan had been prepared and was brought to the Health and Wellbeing Board on a six monthly basis. The peer review team had returned in April 2015 to take stock of progress against the plan and had considered a number of topics including health and social care integration, the role of the Board's advisory groups and the role of the Council's Public Health team.

The letter from the team providing feedback was attached as an Appendix to the report and the main issues arising were as follows: -

- In terms of integration, the Accelerated Solutions Event was impressive but more needed to be done to communicate to the health sector the progress being made in respect of integrated commissioning and integrated locality working. The Board should be clear about the outcomes of integration and articulate these to local people and further relationships with providers need to be reviewed based on the impact of the Better Care Fund and the Vanguard to ensure that the best was made of future opportunities.
- The future role of the Adults Partnership Board and Children's Trust needed to be considered.
- The Board should ensure that a coherent set of action plans be developed for their recently agreed priorities and that these were implemented quickly.
- The Public Health team was in a transition period due to the departure of the Director of Public Health and this afforded the opportunity to strengthen the team and the role of public health more generally.
- In terms of community engagement, there was evidence of strong relationships and lots of activity at local level, however there was an opportunity to join up activity across partners and make best use of diminishing resources.

Karen Graham advised that she was working with Gillian Gibson to develop action plans quickly to make sure that the momentum was there. With regard to the role of advisory groups, there was an opportunity to look more closely at the role of the Adults Partnership Board and Children's Trust and how they could be working more actively. There was an event to be held for the Children's Trust in August and a report would be presented to the Adults Partnership Board in September. It was highlighted that there was a need to make sure that the Health and Wellbeing Board did not forget about health inequalities and prevention.

The Board RESOLVED that: -

(i) a revised action plan be developed based on the overall findings of the LGA Peer Review; and

(ii) six monthly updates on progress against the action plan be received.

HW20. Active Sunderland Board

The Executive Director of People Services submitted a report advising the Health and Wellbeing Board of the establishment of the Active Sunderland Board, whose aim it would be to drive forward participation levels in physical activity and sport.

In November 2014, a direction of travel was agreed for the city with regard to a joined up approach to improve levels of physical activity and a move towards an increasingly active Sunderland. The new approach aims: -

- to impact on the greatest number of people (children and adults)
- to enable children and young people to have the best start in life
- to support people in families and communities that are benefitting least from the opportunities that being active brings
- to provide access to all our infrastructure, green and blue space as well as sport and leisure facilities, including pathways to sporting excellence.

The approach would provide a clear direction and identify a new joined up approach to an Active Sunderland; develop shared priority outcomes for partners and city residents; create 'All together an Active Sunderland' – a city where everyone is as active as they can be; and target a reduction in levels of inactivity.

Victoria French, Assistant Head of Community Services, was in attendance to present the report. She advised that a new strategic group was to be established called the Active Sunderland Board and that this group would provide the necessary leadership to empower a thriving city partnership, where enabling people to be physically active would become everyone's business. The priorities of the Board would be aligned to the Health and Wellbeing Board's priority of reducing inactivity.

Membership of the Active Sunderland Board would include local authority representatives from the Council's Cabinet, Sport and Leisure and Education services, Tyne and Wear Sport, Sunderland AFC Foundation, Sunderland Cultural Partnership, Everyone Active, Sunderland AFC, Sunderland College, Sunderland University, Public Health and the NHS - NTW. It was recommended that the

reporting arrangements for the Active Sunderland Board should be through the Health and Wellbeing Board.

An initial workshop had been convened to commence development of the Board and to seek partner's views and Neil Revely commented that all sessions with partners had been vibrant and that there was strong buy-in across the city and from national bodies such as Sport England. As a Community Leadership Council, it was the authority's role to stimulate and facilitate active citizens, and a fairly broad consensus had been reached which would give vibrancy to plans to create active citizens.

Liz Highmore commented that DIAG had received a presentation from an officer from sport and leisure but it had not been clear what provision was available for disabled people in the city. Victoria stated that there was a lot on offer but it was not always easy for customers to access this information. This issue would be picked up at the Active Sunderland Board as partners could help ensure that facilities were publicised to all groups.

Dave Gallagher stated that it was good to see mental wellness involved in this approach through NTW but highlighted the need to be joined up in the commissioning of services. Victoria referred to scientific evidence about the impact of activity on health and Neil added that it had been found that young people had an additional 8% attainment in Maths and English if they were active, linking Active Sunderland to the Education and Skills Strategy. He stated that there would be a strategic commissioning and community leadership approach to how this was driven forward.

Victoria highlighted that discussions with schools were now based on attainment and conversations were ongoing about how the excellent facilities in schools could be made available to the wider community. This was moving in the right direction and support would be provided on issues such as pricing strategy.

Neil noted that there would be discussions about the frequency of the reporting from the Active Sunderland Board to the Health and Wellbeing Board as the proposed quarterly arrangement would not fit with the existing Board timetable.

Having considered the report, the Board RESOLVED that: -

(i) the content of the report be noted for information;

(ii) the Active Sunderland Board and its membership be formally established; and

(iii) regular updates be received from the Active Sunderland Board.

HW21. Update on Health Harms of Alcohol and Licensing Policy Consultation

The Acting Director of Public Health submitted a report providing the Board Members with an update on the hidden harms of alcohol in Sunderland and to make Members

aware of the Statement of Licensing Policy consultation which was open until 16 August 2015.

Gillian Gibson reminded Board Members that Sunderland had signed up the Alcohol Declaration and had previously discussed issues in the city which were related to excessive alcohol consumption and the costs which resulted from alcohol related problems. There was now an opportunity to look at the Council's licensing policy as this was currently under review and open to comments from partners until 16 August 2015.

Gillian introduced John Mooney, Senior Lecturer in Public Health from the University of Sunderland who was working with the Public Health team in the local authority. John delivered a presentation to the Board on the options around Local Alcohol Policy and examples of good practice in Statements of Licensing Policy.

John advised that the rationale for a pro-active approach to alcohol licensing in Sunderland was due to the very high rates of hospital admissions for alcohol related disease, the substantial cost burden across the NHS, crime and licensing, social services and the workplace, the five Public Health outcomes related to alcohol harms and an opportunity to reduce consumption by acting through the licensing process to influence price and availability. The four licensing objectives were: -

- The prevention of crime and disorder
- The maintenance of public safety
- The prevention of public nuisance
- The protection of children from harm

Three licensing policy options were outlined to the Board; Cumulative Impact Policy, Reducing the Strength Programme and specified/ agreed licensing conditions. John highlighted that other local authorities had dealt with challenges in a number of ways including more creative use of licensing objectives to accommodate a health perspective, collaboration with police partners in embracing the wider concept of alcohol harms and using in-house legal expertise to deal with resistance from the industry lobby.

Suggested ways forward for the Statement of Licensing Policy were: -

- Use of the Statement of Licensing Policy to commit to exploring ways of tackling adverse drinking environments and licensing practices;
- Arrange for ease of information exchange between police, NHS and local council Public Health Teams; and
- Emphasise the potential health and economic benefits of a more pro-active approach to excess availability, in both on trade and off trade sectors.

The Chair noted that currently local authorities tended to remove personal licenses rather than premise licenses and that this was not effective. John Mooney advised that in other areas, Police did undertake compulsory reviews of premises so that a challenge to a license would apply whoever held the license.

It was noted that minimum unit pricing was one way of addressing alcohol related problems and John commented that this policy would usually impact on the off trade

and lead to a decrease in consumption, followed 18 months to two years later with a reduction in liver cirrhosis disease.

The Chair advised that he was the Alcohol Champion for the North East as part of his role as the chair of the Association of North East Councils and he felt that it was important for local authorities to work together on this as it was very difficult to run big campaigns individually. Alcohol needed to be pushed as part of the main Health and Wellbeing Strategy in the context of people making better decisions about their health.

Dr Pattison commented that as GP, he felt that the situation was getting worse and not better. Drinking culture had changed and the patients with the biggest problems were those who stayed at home drinking. He added that he would like to see alcohol treated in the same way as cigarettes and that there was a normalisation of alcohol in society.

It was suggested that licensed premises should be encouraged to improve the range and quality of the non-alcoholic drinks on offer and that prices should be lowered. It was also felt that the hard sell for alcohol in supermarkets should not be accepted and that minimum unit pricing would demonstrate to the alcohol trade that the Government was serious about tackling the problem.

Karen Graham asked if John felt that the reviewed Statement of Licensing Policy was proactive and John said that there were a few areas which could be developed including the exclusion of consideration of a late night levy or Cumulative Impact Zone. He suggested that the statement could say that the local authority was prepared to explore any initiatives to determine what was right for Sunderland.

Councillor Speding commented that it had to be the Licensing Authority which was strong and had to address the whole system. Gillian Gibson acknowledged that this would not be straightforward, and may be high risk, but if a stand was not made, and then the culture would not change.

Alcohol was a whole community issue and it was suggested that the Council's Licensing Officer could be invited to the Board to provide some ideas about what it would be possible to do under the existing licensing regulations. Neil Revely commented that he supported any recommendation which would give the licensing authority additional tools and allow the Licensing Committee to use these for the benefit of the health and wellbeing of the people of Sunderland.

Turning to the consultation on the Statement of Licensing Policy, Gillian suggested that she would pull something together on behalf of the Board which would reflect the discussions which had taken place at the meeting and the will of the Board to change things in a sensible way.

Following a full discussion, the Board RESOLVED that: -

(i) the review of the Statement of Licensing Policy be noted; and

(ii) any comments on the revised Statement of Licensing Policy be forwarded to Public Protection and Regulatory Services by 16 August 2015.

HW22. Integrated Wellness – the Live Life Well Service

The Acting Director of Public Health submitted a report providing an update regarding the development of the Integrated Wellness Service, now known as the Live Life Well Service, in the context of Sunderland being a healthy place being identified as one of the Board's priorities.

Gillian Gibson reported that the integrated wellness model had been developed over the last two years and following a large amount of engagement work with communities, groups and stakeholders, Public Health had developed a model which was re-named the 'Live Life Well Service' and began service delivery in April 2015.

The new model would deliver an approach taking into account the health needs of the whole population whilst also being personalised to individual needs. This was a tiered approach as many people did not need services but wanted to maintain healthy choices in their lives. The Live Life Well service worked city wide and on area based priorities with a lead for each locality area and priority Public Health areas.

Gillian highlighted that the service needed to join up with work on integration and to highlight any key assets which could be promoted within the service, for example activities for disabled people. If any particular organisations wanted to make links, then Public Health could ensure that they were supported. As a new service it would learn and move on through feedback.

It was confirmed that GPs should pass on the new 0800 number for the service to patients and that it was hoped to develop an extensive marketing campaign moving forward.

The Board RESOLVED that: -

(i) partners identify key assets within their services which the Live Life Well service could promote or work with;

(ii) the members of the Health and Wellbeing Board identify any issues within their local organisations which the Live Life Well service could help to address; and

(iii) feedback regarding the Live Life Well service be forwarded to Public Health in order to continue to influence the delivery of the service.

HW23. Health and Wellbeing Forward Plan and Board Timetable

The Head of Strategy and Performance submitted a report presenting the Board forward plan for 2015/2016.

Karen Graham requested that Board Members let her know if they had any items for future meetings and advised that she had circulated a blank forward plan to the Board and asked that it be populated.

The Board RESOLVED that: -

(i) consideration be given to topics for in depth closed partnership sessions for 2015/2016; and

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

HW24. Date and Time of Next Meeting

The next meeting of the Board will be held on Friday 18 September 2015 at 12noon

(Signed) P WATSON
Chair

Item No. 4a

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

FEEDBACK FROM THE ADULTS PARTNERSHIP BOARD

Report of the Chair of the Adults Partnership Board

The Adults Partnership Board met on Tuesday 8th September, 2015.

3. Matters Arising

KG confirmed Michelle Meldrum, Gentoo will be attending the next Board to give a further update on the Over2You project.

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4. Health & Wellbeing Board – Agenda

KG provided details of the agenda items for next HWBB.

5. Launch of Age Friendly City

SC reported feedback from the World Health Organisation (WHO) on Age Friendly City status had been expected in August. Age UK have organised a launch event on the 19th October. The event will be held at Bede Tower and the invitations will be going out shortly. SC noted the Chair would give a speech which will include celebrating 65 years of work by AgeUK. There will be workshops and discussion groups later in the day trying to establish where people can commit to action to take forward the age friendly agenda.

6. VCS Provider Event – 'The Shape of Things to Come'

GK provided details on a VCS Provider Event. The event will be held in Newcastle on the 29th September and is aimed at VCS Care & Support providers looking at their future role in delivering health and social care. The event is free and aimed at current and prospective VCS providers of Care & Support services for adults. There are 3 places open to each organisation.

Any Other Business

CH asked if the Board could revisit the Terms of Reference and its core purpose. KG suggested reviewing both the Childrens Trust and Adults Board together at the report to the November meeting.

Date and Time of Next Meeting
Tuesday 10th November, 2015 at 2.30pm.

Item No. 4b

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

FEEDBACK FROM THE PROVIDER FORUM

Report of the Chair of the Provider Forum

The Provider Forum met on the 25th August 2015.

Items on the agenda were:
The Role for Health Prevention

The Role for Health Prevention

The Acting Director of Public Health gave a presentation to the Board about the 'Role of Health Prevention'. This highlighted the deteriorating rate of healthy life expectancy and the increasing rate of dependency of older people in Sunderland through to 2031.

Disease and co-morbidities are causing the most disability and pressure on services with global and national issues such as smoking and alcohol being the main risk factors in Sunderland also. These have implications for the health of the local workforce too with resulting negative impacts on productivity and recruitment.

The Provider Forum is considering the how to best approach the prevention agenda by identifying appropriate interventions and the necessary structures to support these. **The Forum will bring the resulting recommendations to the next meeting of the Health and Wellbeing Board**.

Item No. 4c

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

FEEDBACK FROM THE CHILDREN'S TRUST

Report of the Chair of the Children's Trust

A workshop was held on the 6th August 2015 to which partners were invited to discuss the future arrangements for a Childrens and families advisory group to the Health and wellbeing Board.

It was recognised that as the Childrens Trust had not met in over a year, there was a need to revisit the priorities that would drive the Children's and Young People's agenda through the Childrens and young people plan and also to look at the role and purpose of the group.

Key to the revised focus would be the advisory role to the health and wellbeing board.

A further meeting is to be convened in September/October to progress the priority setting.

Item No. 5

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

FEEDBACK FROM THE HEALTH AND SOCIAL CARE INTEGRATION BOARD

Report of the Chair of the Health and Social Care Integration Board

The Health and Social Care Integration Board has continued to meet under the new arrangements established by Health and Wellbeing Board to oversee the delivery of health and social care integration.

The minutes of the meeting held on 25 June 2015 and 23 July 2015 are attached for information. At the meeting on 23 July, the Board had looked at the broader system and future planning and had considered the vision for the Better Care Fund and how the Board might develop as this work moved forward.

The next meeting of the group was scheduled to take place on 10 September and would consider regular financial reports and funding opportunities for health and wellbeing.

Recommendation

The Health and Wellbeing Board is asked to note the update from the Health and Social Care Integration Board.

HEALTH AND SOCIAL CARE INTEGRATION BOARD

Thursday 25 June 2015

Present: -

Dr Ian Pattison (Chair)	-	Chairman, Sunderland Clinical Commissioning Group
Councillor Mel Speding	-	Cabinet Secretary, Sunderland City Council
Fiona Brown	-	Chief Operating Officer, People Services, Sunderland City Council
Dave Chandler	-	Acting Chief Finance, Officer Sunderland CCG
Dave Gallagher	-	Chief Officer, Sunderland CCG
Gillian Gibson	-	Acting Director of Public Health
Ian Holliday	-	Head of Reform and Joint Commissioning, Sunderland CCG
Pat Taylor	-	Audit Chair, Sunderland CCG
Sonia Tognarelli	-	Chief Finance Officer, Sunderland City Council

In attendance:

Graham King	-	Head of Integrated Commissioning, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

IB16. Apologies for Absence

Apologies for absence were received from Neil Revely, Sarah Reed, Debbie Burnicle and Karen Graham.

IB17. Declarations of Interest

IB21. Financial Report for the Period to 31 May 2015 (Month 2)

Dave Chandler declared an interest in this item with regard to Virement 4 as his wife was Head of Costing, Income and Contracts at South Tyneside Foundation Trust.

IB27. Carers Improvement Scheme 2015-2016

Dr Pattison declared an interest as he was referred to in the policy document.

IB18. Notes of the last Meeting

The Notes of the meeting of the Board held on 17 May 2015 were accepted as a correct record subject to the amendment of Dave Chandler's job title to 'Acting Chief

Finance Officer', the removal of the word 'we' from the final sentence on page 4 and the deletion of the second sentence under the second action on page 6.

Matters Arising

IB11. Sunderland City Council and Sunderland CCG Better Care Fund Pooled Budget

Gillian Gibson referred to her query as to whether Ben Seale was the appropriate person to have been identified as Local Authority Commissioning Support for Pool 2: Mental Health Community Services.

Graham King advised that efforts were being made to find a way to describe people as equal partners and to clarify if it was possible to have a joint lead for the pools.

IB19. Action Points from the Last Meeting

The Board considered the Action List arising from the meeting held on 14 May 2015 and identified the following actions as being complete: -

- Revised terms of reference for the Integration Board circulated to members;
- Reporting template from the Better Care Fund Implementation Group established;
- Minutes of the Integration Board placed on the Health and Wellbeing Board agenda;
- The Chair and Karen Graham to be notified of additional agenda items for Integration Board meetings;
- Sarah Reed to follow up on the LGA health and social care integration project; and
- Provider Board report to be circulated to all members.

The Chair requested that timelines be added to the action list so Board members were able to monitor the progress against identified actions.

ACTION: Timescales to be added to the Action List

With regard to the request for the Provider Board to submit a 'high level' action report to the Integration Board, the Provider Board had discussed this and proposed that their report to the Out of Hospital Board be presented to the Integration Board. It was noted that this would be a standing item on the agenda for assurance purposes and would provide the context alongside the financial reporting from the Better Care Fund Implementation Group.

Ian Holliday queried if he should act as the link between the Provider Board and the Integration Board or if the report author should attend the meetings. It was felt that it would be fine for Ian to be the link if he was comfortable in fulfilling this role and there was always the option of another member of the group attending to provide further information if necessary. Dave Chandler highlighted that the process for

quarterly reporting had been agreed for the Provider Board and due to timings, the Chair would agree reports and advise the Board retrospectively.

The Chair highlighted that conflicts of interest needed to be a standing agenda item in the future and that this needed to be recorded as part of the decision making process.

ACTION: Record of Declaration of Interests for Board Members to be established.

IB20. Design of Discussion on Broader System and Future Planning

It was proposed that one of the Integration Board meetings be set aside for a development session and a strategic discussion on the broader system and future planning. The Board felt that it would be useful to talk about the current challenges and how these should be addressed and to consider the overall Better Care Fund elements and whether the work needed to be wider.

ACTION: The next Board meeting to be set aside for a discussion on the broader system and future planning.

Fiona Brown queried if there were some parameters which would need to be considered and priorities which needed to be addressed sooner rather than later. Gillian Gibson added that this would be about understanding principles, what the criteria would be and how far that partners wanted to take this. Pat Taylor noted that the broader system view had already been taken into account in bringing more money in to the fund and it would be helpful to test which additional areas might fall under the Better Care Fund remit.

The Board needed to be able to stand back and assess whether the £152m in the Better Care Fund was doing partners wanted and it was also important to ensure that there were no unintended consequences of the fund. The Chair suggested that the Board should look at what the Better Care Fund was meant to be, what did the Council and the CCG wanted it to be and how this could be achieved.

Dave Gallagher proposed that he and Neil Revely look at the agenda and structure for the session and draw up a paper for the Board setting out the current position and options for the future.

ACTION: Dave Gallagher and Neil Revely develop a paper for the broader system discussion.

IB21. Financial Report for the Period to 31 May 2015

The Board received the report of the Better Care Fund Implementation Group which presented the summary financial position for the Better Care Fund at month 2 and requested approval of budget virements.

Dave Chandler advised that budget was effectively reporting as plan at the current time as any information on variances would not have come through the system as yet and the financial position assumed that the non-elective reduction of 0.8% was achieved. The forecast assumed that the fund would break even with the exception of unidentified local authority efficiencies of £2.1m.

The Board were advised that there were budget virements to approve which were beyond the scope of the Implementation Group. Budgets had been set in line with the commitments which were being made but some budgets had only been funded once the contract value was known. Changes had been made to ensure that funding was recorded in the current budget line and it was highlighted that the local authority overheads had been removed from the Better Care Fund in its entirety. All virements had effectively been approved by the Implementation Group and recommended to the Integration Board.

The virements were as follows: -

- Virement 1 – Removal of Sunderland City Council Overheads as per agreement at CCG Governing Body
- Virement 2 – Correction of application of Health and Social Care funding to individual schemes. Carried out in line with plan agreed at Health and Wellbeing Board
- Virement 3 – Update of contract figures with Northumberland, Tyne and Wear NHS Foundation Trust in line with signed off contract
- Virement 4 – Update of contract figures with South Tyneside NHS Foundation Trust in line with signed off contract
- Virement 5 – Amendment of budget for £5 per head allocation in line with agreed business case for Out of Hospital Services for 2015/2016
- Virement 6 – Add in LD packages budget held with NTW
- Virement 7 – Update of contract figures with Sunderland Counselling Contract in line with signed off contract
- Virement 8 – Correction of DFG budget to remove double count of health and social care funding

Pat Taylor referred to the Mental Health Services pool and that there appeared to be an overspend in this area, leading to an outturn of £194m. Dave Chandler stated that there had been an error in the calculation on the sheet and assured the Board that the fund was not overspent by £35m.

Ian Holiday advised that the Packages pool had been the area most at risk of over and under performance and Graham King noted that it had been agreed to forecast based on commitments in order to give a truer picture. There had been long discussions about the packages pool as this was most heavily influenced by what other pools were doing and how they were performing.

The Integration Board then received a presentation on the Better Care Fund Governance Arrangements and Financial Monitoring. The presentation highlighted that the Scheme of Delegation for the fund was in line with that of the schemes of respective organisations but the limits were set as: -

- Scheme Managers up to a maximum of £104,000
- Better Care Fund Implementation Group up to a maximum of £200,000
- Integration Board up to a maximum of £1million
- Anything greater than £1million to be approved by both the CCG Governing Body and Local Authority Cabinet

The presentation also outlined the responsibilities of Scheme Managers and Graham King advised that, within the local authority, packages of care would be approved by the Head of Adult Social Care, rather than the scheme manager and there any need to be further discussions on this. Pat Taylor commented that it was important that nothing was delayed due to issues around who could approve packages and that, if there were no wider implications, existing processes should be used.

Graham noted that it had originally been planned to identify members of the commissioning team as scheme managers and the suggestion had been made to have joint scheme managers. The Chair stated that the Board needed to be assured that the correct people had been named as scheme managers.

ACTION: The Board to be assured that the right people have been identified as scheme managers.

Dave Chandler highlighted that there were a number of cost reduction schemes within the fund, aiming to reduce spend in certain areas. The efficiency target would remain with the host partner until a cost reduction scheme was identified. Dave Gallagher stated that these targets needed to be fundamental within the financial report, forcing partners to have that discussion.

The Chair commented that sometimes it was part of the organisational culture to spend everything in the budget as it was believed that an underspend would lead to a cut the next financial year. Ian Holliday advised that this was part of a discussion with fund managers so that they understood that nothing was ring-fenced.

Where underspends were identified, Pat Taylor stated that she expected to see virements to reduce cost savings and to the uncommitted pool. Dave Chandler advised that the first call on any underspend would be any potential Better Care Fund overspends and fund managers were aware of that.

There was a £12million target for local authority efficiencies in 2015/2016 and plans for £9million of these were set out in the presentation. Graham King said that he could provide more detail on these if required but was reasonably confident that they were on track, although the gap was still £2.1m. He added that in-year monitoring had suggested that the additional costs of the Care Act would be £1.1million, so pressure may be felt later in the year. Longitudinally, in the next five to ten years, the costs could be in the region of £5 to £8million due to a combination in the change of eligibility and demography.

ACTION: Consider the long term costs of the Care Act as part of the broader system discussion at the next meeting.

Turning to the virements which were listed in the report, Board Members were not clear which of these they were required to approve and that the difference between the total sums and the amounts of money being moved around seemed to suggest that the approval would fall outside of the Board's remit.

It was felt that the report needed to fully set out exactly what the Board was being asked to do and that without a clear explanation, the Board was not in a position to make any decisions and requested that the month 2 virements be brought back to the next meeting.

The Board RESOLVED that: -

(i) the Summary Financial Performance to 31 May 2015 be noted; and

(ii) consideration of the Budget Virements for month 2 be deferred to the next Board meeting.

IB22. Q4 Better Care Fund Assurance Submission

The Board received a report presenting the Q4 Better Care Fund Assurance Report which was submitted to NHS England in May 2015.

Ian Holliday advised that the report was presented for information as timescales had meant that it had not been possible to bring this to the Integration Board prior to submission. Future reports would be considered and signed off by the Board before being presented to NHS England.

Ian stated that the template for the submission for June had not yet been received so the dates for submission were not known. Pat Taylor commented that the arrangements for signing off the submission by the Board could be agreed but were unlikely to work in practice. She suggested that it would be useful to obtain some detail about the quarterly reporting process and Dave Gallagher undertook to raise this at the NHS Area Team meeting on 8 July.

The Board RESOLVED that: -

(i) the Q4 submission be received for information; and

(ii) sign-off arrangements for future submissions be agreed.

IB23. Provider Board – High Level Update

Ian Holliday reported that the Provider Board had met the previous week for the second time and had chiefly discussed their terms of reference and compact arrangements. The key focus of the Provider Board was the delivery of the Vanguard programme in relation to integrated teams, recovery at home and primary care development and enhancement.

A lot of time was being taken up with the relationship with the central Vanguard programme as funds had been promised to support the programme. The Vanguard team had carried out a site visit, which had gone well, and there was now a process to follow with regard to accessing support funds. The Board had initially drawn up a wish list for £12m of support but the available pot of money was dwindling.

There was a defined process of how the funds would be allocated, some was to enable national work, some for a cohort of specialist programmes and then a tranche for support. A value proposition had to be submitted by 30 June 2015 and this had to set out how the money would help the delivery of the Vanguard and how current investment plans would progress.

Dave Chandler stated that the Vanguard Programme Board had said that £120m was available in 2015/2016 for Vanguards and would consider the value proposition at their meeting on 7 July 2015. Ian advised that the case would still be made for £12million of funding and suggested that the value proposition could be provided to the Integration Board for their information.

ACTION: Detail of the value proposition for funding to support the delivery of the Vanguard programme be circulated for information.

IB24. Section 117 Aftercare

Ian Holliday advised that the potential change in the guidance and policy for Section 117 aftercare had been highlighted at the last Board meeting. The financial responsibility had changed so that the health aspect of funding for individuals who were placed in the city from outside the area would be met by Sunderland health services. The Chair queried if this covered mental health patients and Ian stated that this would be the case.

Pat Taylor asked if, for example, an individual was receiving a care package in Middlesbrough and then was moved to a Sunderland provider, when would the decision making process involve Sunderland. Ian stated that the receiving authority should be involved right at the beginning of the process and that they should also have the right to challenge whether the move was appropriate.

The Chair commented that this was a system risk and could mean that areas were less likely to invest in ‘gold standard’ services. It was confirmed that the risk had been highlighted to the central team and that the transportability element under the Care Act did not apply for Section 117.

Dave Chandler highlighted that this was guidance at the moment and the law would have to change for the arrangements to be altered. The clinical risk was an important consideration, as was who was responsible for the care package. The issue was being picked up through the CCG Forum and once a paper was produced, it would be brought to the Integration Board. Arrangements needed to be looked at regionally to achieve a pragmatic way forward whilst considering patient safety and financial implications.

IB25. LGA Care and Health Improvement Programme

The Board received details of the LGA's Care and Health Improvement Programme 2015/2016 for information.

IB26. Briefing on the EU Health Programme Call for Projects

The Board received a report providing a briefing on the notification for the open call for applications for funding through the EU Health Programme. The key topics for the programme were: -

- Objective 1 – Promoting health, preventing diseases and fostering supportive environments for healthy lifestyles taking into account the 'health in all policies' principle
- Objective 2 – Protecting Union citizens from serious cross-border health threats
- Objective 3 – Contributing to innovative, efficient and sustainable health systems
- Objective 4 – Facilitating access to better and safer healthcare for Union citizens.

Pat Taylor queried if any of the existing projects would fit into this programme and Dave Chandler advised that bids to this programme had to be across three countries in the EU and be replicable. He believed that Sunderland could do this and it was a great opportunity currently being considered by the local authority, CCG and the universities.

It was noted that there were officers who were expert in making applications for European funding and it was suggested that someone be invited to the next Board meeting to assist the discussion.

ACTION: James Garland be invited to the next meeting of the Board to discuss opportunities for European funding.

IB27. Carers Improvement Scheme 2015-2016

The Board received the Carers Improvement Scheme 2015-2016 document for information. Ian Holliday advised that this had been to the Executive for approval in terms of spend against the Carers pool.

Pat Taylor made an observation that it was very surprising to note that out of 32,500 registered carers, only 650 had made it onto any GP registers. The Chair highlighted that as a GP he referred people to the Carers Centre but they did not always attend. Anyone who was classed as a carer was recorded on the system and when they did contact the centre they found it extremely helpful.

Gillian Gibson commented that the community connectors should be linking carers in to this and the Chair said that there was a care co-ordinator type role as part of the scheme and felt that the developments were positive moving forward.

IB28. Items for the Next Agenda and Forward Plan

This item had been discussed in full earlier in the meeting.

IB29. Any Other Business

There was no other business.

IB30. Dates and Times of Future Meetings

The following schedule of meetings was noted: -

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

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

(Signed) Dr Ian Pattison
Chair

HEALTH AND SOCIAL CARE INTEGRATION BOARD

Thursday 23 July 2015

Present: -

Dr Ian Pattison (Chair)	-	Chairman, Sunderland Clinical Commissioning Group
Councillor Mel Speding	-	Cabinet Secretary, Sunderland City Council
Fiona Brown	-	Chief Operating Officer, People Services, Sunderland City Council
Debbie Burnicle	-	Director of Planning, Commissioning and Reform, Sunderland CCG
Dave Gallagher	-	Chief Officer, Sunderland CCG
Gillian Gibson	-	Acting Director of Public Health
Karen Graham	-	Associate Policy Lead for Health, Sunderland City Council
Ian Holliday	-	Head of Reform and Joint Commissioning, Sunderland CCG
Sarah Reed	-	Assistant Chief Executive, Sunderland City Council
Neil Revely	-	Executive Director, People Services, Sunderland City Council
Pat Taylor	-	Audit Chair, Sunderland CCG
Sonia Tognarelli	-	Director of Finance, Sunderland City Council

In attendance:

Tarryn Lake	-	Sunderland CCG on behalf of David Chandler
Zena Wilkinson	-	Governance Services, Sunderland City Council

IB31. Apologies for Absence

Apologies for absence were received from David Chandler.

IB32. Declarations of Interest

There were no declarations of interest.

Dr Pattison advised that, as agreed at the previous meeting, a Register of Interest was in the process of being completed.

IB33. Notes of the last Meeting

The Notes of the meeting of the Board held on 25 June 2015 were accepted as a correct record subject to the following amendments:

Pat Taylor noted that at commencement of the previous meeting there was not a quorum and recommended the minutes reflected when individuals joined the meeting. Dr Pattison agreed with the recommendation.

ACTION: Minutes to reflect the attendance/quorum for future meetings.

Page 3, 5th paragraph: *… Better Care Fund was doing what partners wanted….*
… Council and the CCG want it to be ….
Page 5, 1st paragraph: … scheme manager and there may need ….

IB34. Matters Arising

IB19. Action Points from the Last Meeting

Dr Pattison noted that Karen Graham was not receiving notification of additional agenda items within the agreed timescales. Karen requested that Members note the agenda item deadlines for future meetings and the Chair asked Karen to continue to raise this as an issue if there was no improvement.

IB22. Q4 Better Care Fund Assurance Submission

Pat Taylor advised that she was uncertain if this section correctly reflected that the Chair needed to sign off the submission and the need to review submissions. Pat noted that the meeting schedule had not been changed therefore the reports would not be available to be signed off during the Board meetings.

Ian Holliday advised that he had just received the date of the next submission and that guidelines would be circulated and schedule of meetings amended where necessary. However, it was highlighted that at the present time the final submission date was being provided at very short notice and it may not be possible to present it to the Board in advance.

Pat Taylor stated that she was concerned that a schedule had not been implemented for reporting on funding. Dave Gallagher shared that he would report the concerns back but proposed that for the next submission, information was circulated electronically to members.

ACTION: Dave Gallagher to circulate the next Better Care Fund Assurance Submission electronically to Board Members.

The Chair agreed that it was important to have the schedule information so that meeting dates would tally where possible.

ACTION: Meeting dates to be rescheduled to marry up with the required submission dates for reports.

IB26. Briefing on the EU Health Programme Call for Projects

Board members agreed James Garland would be invited to attend the next meeting, to be held on 10 September 2015. Sonia Tognarelli advised that she had received a briefing from James for the next meeting.

ACTION: Action Point to be amended to reflect the revised date for James Garland to attend the Board meeting.

IB35. Action Points from the last Meeting

IB10: People Services Structure Chart to be revised to show the names of individuals in post.

Dr Pattison questioned if there was any further update. Pat Taylor stated that she believed the information previously circulated was not complete. Neil Revely advised that the Structure Chart had been revised again, with additions to Children Services.

Members agreed the action was outstanding and the timescale for completion would be changed to the next meeting date.

IB11: Provider Board to be requested to submit a "high level" action report of what is and what is not on track.

Debbie Burnicle advised that she was concerned about this action and queried whether this action had been misinterpreted from the previous meeting. She explained that the Provider Board was about Vanguard and she believed the high level update on progress was part of Finance/Progress Report. Debbie stated that this was a large area and the Out of Hospital Board was there to assure and this was only part of what this Board was responsible for.

Ian Holliday stated that he felt the action came from the combined business cases and how updates would be reported but agreed this was wider in terms of the BCF.

Debbie Burnicle advised that this was a useful document/overview about what had been undertaken for that part. Sonia Tognarelli agreed with Debbie's comments and felt that the Finance Report did not cover all the information, but felt these were development issues.

Debbie Burnicle highlighted that there would be quarterly BCF report indicators, together with the monthly Finance Reports with progress which would provide high level reporting from each Lead. The quarterly report would also provide an opportunity to respond.

The Chair questioned if Members were satisfied that these were areas which should be discussed within the meeting, to provide assurance that there were no gaps.

Debbie Burnicle explained that she had not been in attendance at the last meeting and she felt it would be useful to have the slides circulated in relation to governance.

Sonia Tognarelli shared that she believed it was important to understand how the pots were being managed and key changes.

Dr Pattison questioned how this would be taken forward and who would be tasked to undertake this piece of work. Pat Taylor recommended reflecting on this during the review of the Finance Report, as this would provide clear information on what the Board wanted to see being reported, such as were plans on track and were actions being followed up..

The Chair agreed that this was an important area and stated that he believed this should remain on the action plan to ensure alignment of the report and agreement. He advised that he believed this needed to be a joint responsibility, across the organisations.

It was agreed this Action Point would remain but updated to include Graham King within responsibilities and a changed timescale for the next meeting.

IB19: - Timescales to be included within the Action List

Board members noted this action was completed.

- *Record declarations of Interest for Board members to be established and agenda to be structured so that it was clear which reports are for decision and which for information.*

Board Members noted the request for declarations of interest was nearing completion.

Future agendas to clearly indicate which reports were for decisions and which for information, together with presenting representative details.

IB20:
- *The next Board meeting to be a development session looking at the broader system and future planning.*
- *A paper to be developed for the broad system discussion to take place at the next Board meeting*
-

Board members confirmed this action would be completed at today's meeting.

IB21: - The Integration Board to be assured that the right people have been identified as scheme managers

Board members resolved that the scheme managers had been identified and agreed this action was complete.

- *Long term costs of the Care Act to be considered as part of the broader system discussion scheduled for the next meeting.*

Fiona Brown advised that she believed this action was based on whether this was a recurring issue or a one off.
Debbie Burnicle stated that she believed it had been agreed Care Act responsibilities would be shared across the pools but as a "one off" for this year the CCG had contributed £800,000.

Pat Taylor stated that she believed the action was about specific discussions in relation to the Care Act and the financial implications. Tarryn Lake advised that no further scoping exercise had been undertaken following the last meeting.

Dr Pattison advised that he believed this issue could be discussed during the development sessions.

IB23. Detail of the value proposition being submitted for funding to support the delivery of the Vanguard programme to be circulated to Board members for information.

Neil Revely advised that he had no knowledge of this action and had not been in attendance at the last meeting.

Ian Holliday agreed to take forward this action with a completion date for the next meeting.

IB26. Invite James Garland to the next meeting of the Board to highlight opportunities for EU funding.

Karen Graham highlighted that the deadline for submission was September 2015 and the next Board meeting was scheduled for September 2015. She questioned whether, if the submission was developed outside of the meeting, the invitation needed to be progressed.

Sonia Tognarelli requested clarification of who would be dealing with funding, as the bid was over €2million. Ian Holliday advised that this had not been raised within the Integration Board but it was noted that there could be opportunities within this. The Chair asked if relevant individuals could check if the funding bid was available and Tarryn Lake agreed to take this forward. It was acknowledged that there may be a need to be reactive on this occasion but in future the Board could be proactive.

Pat Taylor felt a general discussion about the European Funding was not something CCG was used to and there was a need to be clear that any bid proposals were cost effective. She stated that it would be helpful if someone was invited to attend a Board meeting to talk about these.

David Gallagher advised that there may be some actions which needed to be taken forward without being presented to the Board for discussion.

ACTION: Confirmation to be sought about whether there was funding available through the EU Health Programme.

IB36. Better Care Fund Financial Report for the Period to 30 June 2015

Tarryn Lake presented Better Care Fund Financial Report for the period to 30 June 2015 (Month 3) to the Board.

Sonia Tognarelli advised that she felt an issue which had been omitted from the Financial Efficiency Requirements and Current Efficiency Plans table was an unidentified section for Adult and Social Care. Within 2017/2018 additional savings would be required and this would be ongoing. Sonia acknowledged that this was dependent on the outcome of the spending review but stated that she felt it was important to consider the level of challenge that would be faced.

Tarryn Lake outlined that the report detailed the total efficiency requirements of BCF budgets and the non-elective activity efficiency requirements and advised that penalties would be implemented if these were not achieved.

In terms of savings the detail did not include the living wage proposals by Government and this could have a significant impact, which was being scoped by the Local Authority Finance Team.

Sunderland Care and Support Limited also had efficiencies to find and these had been aligned to the high level target for the Local Authority.

Tarryn Lake advised that finance workshops had been undertaken by the BCF Implementation Group. It was acknowledged that Health and Social Care contractual arrangements differed and needed to be reformed, which would be time consuming. She recommended that these facts were noted in terms of achieving services.

Tarryn Lake explained that a further area which was being considered was the duplication of services, understanding what Sunderland Care and Support was providing and where historical efficiencies had been made, as well as what was happening within Health. Currently a baseline review of contracts was being undertaken to ensure value for money. She advised that some discussion had been held about external support and whether there was a need for assistance in relation to the high level areas.

Fiona Brown noted that the total value of BCF efficiencies was £9.4 million and questioned whether this was all from the Local Authority side. Tarryn advised that it was but highlighted that within Health next year there would be pay inflators, therefore they had not applied a target on this.

Fiona Brown stated that it would be helpful to understand the level of efficiencies from Health and Social Care. Tarryn Lake advised that the detail provided was the combined savings for BCF. Fiona Brown explained that she would find it beneficial to know the efficiencies across providers. Tarryn Lake shared that in terms of efficiencies, Health requirement was £4.3 million, within health providers. Debbie Burnicle questioned if this was over and above emergencies etc. Tarryn Lake stated yes.

Sonia Tognarelli questioned the outstanding Local Authority efficiencies of £2.1 million for 2015/16 and £3.0 million recurrently. Tarryn Lake advised that these were included within the report but some discussion was still outstanding about this, which was why they were listed as recurrent efficiencies.

Sonia Tognarelli advised that feedback from the meeting had not provided much assurance about where the efficiencies would come from, as there were no obvious areas being considered. Tarryn Lake agreed but advised that there was justification as schemes had been identified, for example Mental Health Services, that were no longer in place. There was a need to understand about what these budgets were now funding and Scheme Managers were finding it frustrating, trying to ascertain what funding was being used for. He cited mental health as an example, as it was believed significant savings could be made but they were trying to ascertain where the money was currently sitting and being used for as it was believed that they received funding day care services. Ian Holliday stated that there was a need to ensure full transparency of budgets.

Tarryn Lake acknowledged that there was a need to gather momentum on this and Ian Holliday advised that savings had been highlighted but it had then been found that efficiencies had already been made within the areas. He acknowledged that there was a risk of whether this money would come out of the report for this year.

Dave Gallagher stated that he was concerned the Board was being provided data with risks highlighted and questioned if the Board would, at some time, agree that they would not be able to take this forward and have alternative plans.

Debbie Burnicle questioned the alternative plans, for example the risk of overspend or Local Authority efficiencies. Tarryn Lake advised that this would be considered under BCF Section 75. Sonia Tognarelli advised that the Local Authority would look at the savings required and where these could come from.

Ian Holliday stated that he felt the conversation being held reflected what had been discussed within the BCF Implementation Group; where providers made efficiencies, exactly whose efficiencies were these. He stated that he believed there was a need to flesh this out. David Gallagher questioned if this would entail more time to work through the issues. Ian Holliday stated yes.

Ian Holliday advised that there were pools where there was an expectation that real efficiencies could be made but there were also some pools where this would not be possible due to the current contractual arrangements in place for this year.

Sonia Tognarelli stated that she felt there was a need to understand this detail in full, to ensure, where needed, that notices were implemented. Ian Holliday advised that this was not a straight forward exercise.

Dr Pattison acknowledged the need for transparency and stated that if the process was not transparent the required efficiencies would not be implemented. He questioned if Board members were assured that this work was being done. Ian Holliday stated that the work was taking place.

Dr Pattison confirmed the Board were happy that the work was being taken forward and there were no blockages.

Sonia Tognarelli stated that at the last Board meeting it had been reported that there would be a proposal in place to deal with the required £2.1 million efficiencies but at this stage the local authority had been unable to address this. She stated that for the next Board meeting she believed there was a need to identify any blockages and how these could be dealt with.

Neil Revely stated that he felt the process was transparent and it was more about understanding the issues and the Chair agreed.

Tarryn Lake summarised that at this time BCF were still reporting that they would break even for a vast majority of pools but it was still quite early in the financial year. Further information had been provided about areas of risk. The issues in relation to the £2.1 million and non-elective penalties were not achieved but were expected to be achieved.

Tarryn Lake requested Board members approval for the following budgetary virements:

Virement 2 – Health and Social Care Funding Correction

The proposed budget transfer was due to the requirement to correct the split of the Health and Social Care Funding received by NHS England of £7.186m in 2015/16 across schemes.

Virement 5 - Out of Hospital Reforms 2015/16 Funding Correction

- £0.72m of non-recurrent support for mobilisation of the reforms had been made available by the CCG from delaying pre committed investments.
- £0.256m for services which, following the business case approval, had been identified as being within the scope of the Out of Hospital Services.

Virement 8 – Disabled Facilities Grant Funding Correction

The proposed budget transfer was to correct an accounting error which had led to the double count of £0.3milion of funding in the Disabled Facilities Grant scheme.

Tarryn Lake advised that the BCF Implementation Group had assessed the financial risk and the report detailed the top three issues. She advised that these issues were being closely monitored and action plans had been reviewed.
Fiona Brown questioned the financial risk if the emergency admission rate was not reduced. Tarryn Lake acknowledged that this was a risk, as penalties would be implemented, but advised that this was not considered to be within the top three risks.

Tarryn Lake advised that in relation to the ‘Time to Think’ bed proposals, funding had been considered in terms of value for money and effectiveness, with a proposal for these to be left open.

Tarryn Lake explained that the preferred options had been identified but the Implementation Group had indicated a 2 year closure plan, with an option to transfer some resources to CHC beds, but there were some patient issues within this.

Board members were advised that the Vanguard funding had been confirmed for the 2015/16 pressure (£735,996) but 2016/17 was yet to be confirmed. Tarryn advised that it was proposed to bring this to the next meeting.

Tarryn Lake put forward the following recommendations:

- Note the financial efficiency requirements for the BCF and the current efficiency plans which were being proposed;
- Note the summary financial performance to 30 June 2015;
- Approve the proposed budget virements;
- Note the budget virements that have been approved by the CCG Executive Committee and were due to be approved by the Local Authorities Cabinet; and
- Approve the financial proposals associated with the TTT bed closure plan.

Pat Taylor advised that in relation to the recommendation to approve the proposed budget virements the Board still only had the numbers coming into the budget. She stated that the paper explained the background but there was no financial assurance that these were on track. Pat Taylor acknowledged that the recommended virements had been explained in detail by Tarryn Lake and commended her for the information provided.

Pat Taylor expressed concern that the Cabinet would not be signing off the report until October 2015 and that the figures presented in the BCF Assurance Submission would therefore be incorrect. Sonia Tognarelli explained that as these were only technical adjustments this would not have an adverse impact. .

The Chair recommended the Assurance Submission be submitted with a caveat to say that this was subject to Cabinet approval. He stated that he believed this would provide clear governance whilst recognising the technicality of the process, allowing transparency.

Sarah Reed withdrew from the meeting.

Dave Gallagher advised that this issue was more about ensuring the sequence was correct. Dr Pattison advised that he believed auditors would check any actions, especially in relation to virements, and there was a need to ensure these followed the scheme of delegation.

Pat Taylor questioned whether the Integration Board had a role to recommend the virements to CCG and Tarryn Lake confirmed that this was being broached. Pat Taylor explained that there was a need to be aware of making recommendations above the Board's level of delegation.

ACTION: The BCF Assurance Submission be submitted with the caveat that the final figures would be subject to Cabinet approval

The Board RESOLVED that: -

(i) the financial efficiency requirements for the BCF and the current efficiency plans which were being proposed be noted;

(ii) the summary financial performance to 30 June 2015 be noted;

(iii) the proposed budget virements were approved;

(iv) it be noted that the budget virements that had been approved by the CCG Executive Committee and were due to be approved by the Local Authority Cabinet; and

(v) the financial proposals associated with the TTT bed closure plan be approved.

IB37. The Broader System and Future Planning

David Gallagher presented the Board System and Future Planning presentation to Board members

Following the presentation Board members were invited to respond to the following questions:

Question 1: In light of the priorities does the vision still stand? Are these still the "right things"?

The following issues were raised: -

- Following the election, it did not feel that things had changed as yet. However reduction in welfare benefits, may impinge on this and may increase the demand on services.
- A lot of time was spent integrating within health and then within social care and this was one of the challenges to be worked with.
- Strengthening within the community would address some of the issues and there was uncertainty whether this was being done.
- Evident that the concentration was on budgets rather than changes – was the Board was making the most of opportunities available to them at present and were they moving forward.
- Maybe moved very quickly to meet pressures rather than considering what was best for the community – should there be two workstreams – transformation and then savings.
- Transformation and required savings made the process very difficult. Agree that transformational changes were being considered to make savings and there may be a need to look at transformation first.
- Board should be unapologetic about the decision to make efficiencies but see it as an opportunity to fix systems. Following these economically challenging times growth would take place and should think about what would be possible from working together. Finance drives care and outcomes for patients but further opportunities would come from the joint working.

- Vision was still correct but has BCF had lost direction? If the Board wants to incorporate children and public health services, it could decide to follow a different model.
- Initial concerns around person centred care had come from practice care. It was evident how people were receiving services, but these seemed fragmented.
- The scale of transformation was enormous and Sunderland were held in high regard for what we were doing ie enablers.
- Within mental health and learning disabilities there were already principles about pooled budgets.
- Need to remember that this was still at an early stage but this was a timely reminder that this was not done to look at better care funds but to think as a single organisation – to integrate funding and some of providers to enable integrated services. This was a journey and there was a need to drive this as far as possible.
- This was difficult to do because of financial constraints. Historically "plasters" had been used rather than reviewing services. At some point, Health and Social Care should receive additional funding and by this time it was hoped that there would be single services rather than overlapping.
- Acid test would be people's perception of the services provided. If providers or users considered this a single Sunderland approach then the process would have been successful. Their perception would be that Sunderland was organisationally boundary less.
- Integration clearly had an impact on economic improvement. This type of forum provided the opportunity to discuss this.
- There was a need to go back to what people think integration means – person centre co-ordinated care.
- People think that services are completely integrated and seamless but it was not until they actually got into the systems that they realised services were not. People want continuity and it was hoped the impact from this exercise would enable this. A lack of integration because individuals did not know which services where to sign post people to.
- As the process developed there was a need to decide how far we it was going to go. The initial decisions in the vision set up for Care and Support was that eventually there would be no direct contact with customers – following the implementation of personal health budgets Health may be the same.
- Discussions were currently being held about whether SCC should have home care contact. If partners did not get ahead of the game then people may be requesting budgets but be stuck in contracts with providers.
- Interested to ascertain how these single/one payments would fit within the personalised approach.
- Need to concentrate on what we needed here and now and then consider the very specific elements.
- Vision is patient led. Clients were customers and providers were coming to realise this.
- If providers were doing what people wanted, then they would go to them.
- Discussed at Vanguard meeting - how you would hold central funds and how these would fit into the NHS contract.
- It felt good to meet particular issues but she did not feel that it met priorities or dealt with current issues for example the aging population. There was need to be

moving down the triangle quite rapidly, focusing on who were putting most pressure on the systems now. The aging population was also becoming unhealthier and needed to be addressed.

- This process had commenced, considering the top 2-5% needs.
- The work had begun at a time when the PCT and LA had visions of integrated working; the vision was that if initially they tackled the top 3% then work could move down. Now need 3% just to survive and there was a need to move down the pyramid.
- Integration at the bottom of the pyramid may have nothing to do with the integration of Health and Social Care and may be about implementing intelligence into the communities.
- Some locality practices could see opportunities and wanted to do something about these ie working closely in schools with the school nurse to explain when individuals should or should not go to A&E. There was a desire to change but it was about how this was implemented.

OUTCOME: Board Members agreed the vision still stood.

Pat Taylor withdrew from the meeting.

Question 2: What else (internal and external factors) will impact on future work?

The following issues were raised: -

- There was potential for devolution, for example the Manchester model. However it was highlighted that the Manchester model was not necessarily what people thought it was.
- Consideration of about possible impacts and to be aware of how this could change things.
- Manchester model was an example because if this was not implemented their organisations did not believe they would meet their economic requirements. Economy from one area could be moved to different parts of the system to improve the health of the population.

Tarryn Lake withdrew from the meeting.

- An impact was workforce, either internal or external, there were massive skills shortfalls which should not be ignored. If there was insufficient workforce you could not take things forward.
- With one workforce there is the opportunity to have a more generic workforce – this was a big leap from the current position but the benefits were evident.
- The 5 year plan talked about technology and how this can be used. Health and Social Care had been a little slow taking forward the technological possibilities.

Question 3: So what should be next?

- **boundaries?**
- **principles?**
- **timescales?**

David Gallagher explained that this was in relation to now or 2/3 years; where does other services fit in with this vision, for example children services, housing.

Question 4: As a board, how do we get to "we"?

- May be appropriate to do some "team building" as a group.
- If aligned at a strategic level, this would trickle down but if organising "team building" session, consideration of attendance should include others that were involved in the work.
- This was something to be worked on, inevitably this change would take time but needed to be driven forward.

Next Steps: Board development?
Workshops?

- Board development would be team development; workshops – developmental work to explore some of the issues raised.
- Back to original intention of bigger transformation with a need to recognise the significant financial challenges in 2015/2016, which need to be dealt with to enable arrangements to be implemented for 2016/2017.
- There was a need to be more organised and possibly identify some Board meetings as being purely development sessions.

IB38. Items for the Next Agenda and Forward Plan

Dr Pattison requested individuals to provide agenda items for the next meeting directly to Karen Graham, in line with the agreed schedule.

IB39. Any Other Business

No further items of business were raised.

IB40. Date and Time of Next Meeting

The next meeting of the Board would take place on Thursday 10 September 2015 at 3.00pm.

(Signed) Dr Ian Pattison
Chair

Item No. 6b

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

OFSTED INSPECTION – UPDATE

Report of the Chair of the Sunderland Safeguarding Children Board

1. Purpose of the report

1.1 Health and Wellbeing Board Members will recall that Ofsted has recently undertaken an inspection of Local Authority services for children in need of help and protection, children looked after and care leavers. At the same time Ofsted reviewed the effectiveness of the Local Safeguarding Children Board (LSCB). The inspection was undertaken between 11th May and 4th June 2015, with the final report published on the 20th July 2015.

1.2 The purpose of this report is to provide members of the Health and Wellbeing Board with an update on progress against the seven Ofsted recommendations made to the LSCB.

2. Background

2.1 Ofsted is currently undertaking a national programme of inspections of Local Authority Children's Services and related LSCBs. There have been 58 inspections of LSCBs (between November 2013 – June 2015) and all inspection reports have been published.

2.2 In Sunderland, Ofsted last inspected Children's Services for children looked after, safeguarding arrangements and the five Children's Homes in April 2012. The judgement delivered at that time was that across the above three domains services were either good and in one case outstanding. The judgement delivered by Ofsted in July 2015 was that across the range of inspected services, including the LSCB, services were deemed inadequate.

2.3 Immediately prior to publication, Ofsted provided both the Local Authority and the LSCB with a series of recommendations with actions required to address the identified shortcomings.

3. Recommendations for the LSCB

As indicated above, there are seven specific recommendations identified for the LSCB.

These are set out below:-

a) Ensure full Board approval of agreed priorities and action planning
b) Ensure that the Board is able to effectively monitor the quality and impact of services for children across the Partnership

c) Accelerate implementation of an early help strategy, ensuring that it is consistent with the 'multi-agency threshold guidance' document and then monitor its effectiveness
d) Review multi-agency training to ensure it supports and promotes front line practice and is able to respond to demand following imminent publication of a high number of Serious Case Reviews (SCRs); then ensure lessons are learnt and improvements embedded
e) Agree with partner local authorities on Child Death Overview Panel (CDOP), a coordinated response to the high number of SCR's awaiting publication
f) Ensure that multi- agency arrangements for the oversight of children missing and at risk of sexual exploitation or trafficking are driven by effective information sharing, performance monitoring, action planning, and are strategically coordinated and monitored by the Board.
g) Review the resources available to undertake the governance of Multi-Agency Looked After Partnerships (MALAP) to ensure a sufficient focus.

Members of the Health and Wellbeing Board will have been aware that some time before the inspection there were already concerns about the effectiveness of the LSCB, and that these were the subject of a Board development event held in September 2014. Specific concerns focussed upon the extraordinary high number of SCRs that had been commissioned by the LSCB, and the impact that had in terms of diverting the Board's attention away from what is considered to be its 'core business'. A series of recommendations came from that event, including making some significant changes to the governance arrangements (for the Board, its Executive and the supporting sub-committees); developing urgent proposals to address some core business failings; and adopting a more focussed action planning around the outstanding SCRs. In addition, attention was also given to repairing, what was considered to be in part, failing partnership working especially relationships between members of the Partnership and Local Authority colleagues.

Significant work took place between December 2014 and April 2015 that focussed upon bringing improvements to the above, and it's fair to say that by the time Ofsted inspected the LSCB in May 2015, much progress had been made across all areas. Ofsted reported at the inspection feedback session that they recognised that whilst a great deal of progress had been made in addressing and rectifying the shortcomings of the LSCB, at the time of the inspection it was just too early to measure the impact of those changes, and consequently judged the LSCB to be inadequate.

4. Current Position

4.1 Upon receipt of the Ofsted recommendations the SSCB Executive group immediately set about ensuring that a speedy and comprehensive 'Recovery Plan' was produced. This is attached as Appendix 1. A number of the Ofsted recommendations have already been progressed within the SSCB Ofsted Action Plan. For example:-

Ofsted recommendation no.2 is in part a criticism that (at the time of the Inspection) the LSCB's Section 11 audit was incomplete, (even though the LSCB was still within timescale to complete it) and since then this has been significantly progressed.

4.2 Similarly, the Early Help Strategy (Ofsted recommendation no. 3) is making good progress (but of course is very much an underpinning strategy that needs to be scoped and owned across the full partnership, especially by colleagues in Children's Social Care).

4.3 Ofsted recommendation no. 4 relates to the learning from SCRs although, at the time of the inspection, only 2 SCRs had actually entered the public domain.

4.4 Ofsted recommendation no. 7 relates to the Multi-Agency Looked After Partnership (MALAP) – a responsibility that was only taken over by the LSCB just prior to Ofsted's inspection in order to ensure that this statutory responsibility was met fully – and this responsibility has now been returned to the Local Authority (which is the appropriate place).

4.5 The LSCB must, of course, take care not to minimise the validity and voracity of the Ofsted recommendations – and here I must provide the HWB with assurance about the absolute determination of the LSCB to ensure that the performance of the LSCB (and within this, the Ofsted recommendations) improves to required levels. Should Ofsted quickly return and review progress, significant improvement taking the LSCB out of its 'inadequate' classification would be witnessed and of course, crucially, evidenced. It is important that the HWB understand that there is full commitment to achieving this position right across the Partnership including Children's Social Care.

5. Recommendation

5.1 **Members of the Health and Wellbeing Board are asked to:-**

a) Note the contents of this report

b) Acknowledge the good progress already made in terms of addressing the recommendations from the Ofsted inspection

c) Receive a further report later in the year confirming that full implementation has been achieved

Appendix 1

SSCB Ofsted Action Plan
Updated 4th September 2015

This is the SSCB Ofsted Action Plan based on the findings of the Inspection of the SSCB in May 2015

Ofsted Recommendation	Action	Lead	Progress	Deadline
142. Ensure full Board approval of agreed priorities and action planning	Agree mechanism and governance for safeguarding structure via: •Discussion with Children's Services Commissioner (NW) •Partnership meeting to be held regarding future of the Children's Trust Board and it's replacement if appropriate	Chief Operating Officer, Sunderland People Services	Planning session held August 2015	September 2015
	Implement robust attendance monitoring and reporting arrangements from SSCB Sub Committees through to Board to include challenge process for non-engagement	SSCB Business Manager/SSCB Chair	All SSCB Board and Sub Committees have attendance monitoring on agenda to be discussed as part of every meeting. Attendance reporting system from sub committees through to Board meetings in place. Issues of non-attendance/lack of engagement to addressed immediately by subcommittee and SSCB chairs Meeting with sub committee chairs on 09.09.15 to confirm requirements above.	
	Business Case report to go to Children's Services improvement Board to demonstrate the need for additional funding/resources from partners for a limited period of time and to cover costs for additional SCRs	SSCB Business Manager/Head of Integrated Commissioning	Report written August 2015 and Discussed at SSCB Executive Group on 17.08.15	October 2015

Ofsted Recommendation	Action	Lead	Progress	Deadline
	Review SSCB Partner's Annual Safeguarding Report and Section 11 Audits to determine the level of commitment of partners	SSCB Business Manager/SSCB Vice Chair	Section 11 Audits reviewed July 2015 Initial evaluation of evidence for 5 agencies received at meeting 11.08.15 Section 11 Audits of agencies are in progress	
143 Ensure that the board is able to effectively monitor the quality and impact of services for children across the partnership.	Embed the SSCB Quality Assurance and Performance Framework and agree dashboard/RAG Rating on key performance indicators	SSCB Quality Assurance Sub Committee Chair		October 2015
	Agree 12 Key Performance Indicators to report to SSCB		SSCB Quality Assurance Workshop to be held	
	Benchmark SSCB against arrangements in Leeds/Essex/Nottingham County	Performance and Improvement Lead, People Services, Sunderland Council		September 2015
	Benchmark SSCB against arrangements in Richmond on Thames through Sunderland Children's Services Commissioner/Performance Lead	SSCB Quality Assurance Sub Committee Chair		January 2016
	Report to SSCB to propose method/tools to support SSCB to effectively monitor quality and impact of services		SSCB Quality Assurance Workshop to be held	October 2015
144 Accelerate implementation of an early help strategy, ensuring	Launch and implement Early Help	SSCB Vice Chair/Interim Head of	The Early Help Strategy has been signed off. CM to draft a foreword for the Early Help Strategy. Implementation	September 2015

Ofsted Recommendation	Action	Lead	Progress	Deadline
that it is consistent with the 'multi-agency threshold guidance' document and then monitor its effectiveness.		Safeguarding, Children's Safeguarding, Sunderland Council	plan to be developed	
	SSCB to raise awareness of thresholds for intervention as outlined in SSCB Early Help Strategy and Threshold Guidance	SCB/SSAB Training and Workforce Development /Communication and Engagement Sub Committee		
	Develop and deliver a programme of mandatory multi-agency workshops/training to ensure there is a comprehensive understanding of Early Help across partners	SSCB/SSAB Training and Workforce Development Sub Committee		
	Map out current provision and areas for development.	SSCB Quality Assurance Sub Committee Chair		
	Develop and implement reporting arrangements for the scope and effectiveness of Early Help provision across the local partnership			
145 Review multi-agency training to ensure it supports and promotes front line practice and is able to respond to demand following the imminent publication of a high number of Serious Case Reviews (SCRs); then	Review and update multi-agency training including, content, methods of delivery and evaluation process to support frontline practice.	SSCB/SSAB Training and Workforce Development Sub Committee Chair		September 2015
	Identify the multi-agency training needs from serious case reviews in Sunderland and externally where appropriate			

Ofsted Recommendation	Action	Lead	Progress	Deadline
ensure lessons are learnt and improvements embedded	Update SSCB Training Strategy and Training Programme based on the needs identified			
	Review and implement the SSCB Quality Assurance of training process		JU will review 'Thresholds' from the performance data at the T&WD Sub Committee. 'Deep dive' by partner organisations, early warning indicators, audits required.	
	Undertake audit to measure the impact the training has made	SSCB Development and Training Officer		
146 Agree with partner local authorities on Child Death Overview Panel (CDOP), a coordinated response to the high number of SCRs awaiting publication	Review LCDRP and SOTW CDOP terms of reference and update as appropriate	SSCB Local Child Death Review Panel Chair		September 2015
	Review and update the SOTW CDOP Business Plan			
Ensure that multi-agency arrangements for the oversight of children missing and at risk of sexual exploitation or trafficking are driven by effective information sharing, performance monitoring, action planning and are	Complete a multi-agency Child Sexual Exploitation (CSE) data mapping exercise	SSCB Chair	Section 11 Audit included Section 11 Agency dates on CSE. Information collated to inform profile. Palantir being used to collate data and information held by agencies. Initial Data Set identified in SSCB, QA and Performance. Agreed in July 2015	September 2015
	Complete a CSE Needs Assessment to inform a developing Action Plan			

Ofsted Recommendation	Action	Lead	Progress	Deadline
strategically coordinated and monitored by the board.	Agree and implement MSET Subcommittee arrangements to ensure robust attendance and engagement and CSE reporting arrangements to ensure SSCB has an up to date and informed view of current levels of risk, alongside intervention and disruption activity	SSCB MSET Sub committee Chair	Review of membership planned for 08.09.15. Attendance Monitoring to begin 08.09.15 to include immediate escalation and challenge where attendance/engagement not adequate.	
	SSCB to commit to working in partnership to raise awareness of CSE	SSCB Chair	SSCB is part of high profile sub regional MSET focusing awareness week in October 2015 to include CSE conference on 20.10.15. Week will include activity around CSE, Trafficking etc.	September 2015
	Police to share information re: campaigns/ awareness raising/ publicity.	ACC Northumbria Police		
148 Review the resources available to undertake the governance of Multi-Agency Looked After Partnership (MALAP) to ensure a sufficient focus	MALAP to sit with LA and SSCB to hold it to account.	Interim Associate Director Children's Services	•Agreed at Development Session (20.09.15) and Executive Group Meeting (17.08.15) that MALAP to revert to Local Authority arrangements.	August 2015
	Brief report to go to SSCB recommending	Interim Head of Looked After Children, Children's Services	MALAP Report to be drafted for SSCB on six monthly basis	October 2015

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

GENERAL PRACTICE STRATEGY FOR SUNDERLAND

Report of the Clinical Commissioning Group

1. Purpose

The purpose of this report is to provide the Health and Wellbeing Board with an update on progress in relation to the development of a Strategy for General Practice across Sunderland.

2. Background

The Five Year Forward view, published in October 2014, sets out a clear vision for the future of the NHS.

It outlines that transformation is required to meet the changing needs of current and future patients and advises that there is a shared understanding of the extent and nature of the gap between where we are and where we need to be, including: the 'financial' context. The Forward view also outlines a range of care models that could deliver transformation (the what) identifying actions required at the local and national level to support delivery (how).

The Forward view acknowledges the severe strain on general practice and outlines the foundation of NHS care will remain list-based primary care. It promises to "stabilise core funding for general practice nationally over the next two years" and offers a new deal for primary care.

The Forward view also outlines the following expectations of primary care:

- Proactive and personalised care for most complex patients;
- Extended hours / 7 days;
- Integrated primary care (with secondary care providers) to enable more community based care;
- Reduced variation in quality and cost of primary care;
- Investment in the workforce;
- Alignment of IT systems across primary and secondary care;
- Consideration of pooling / federating of GP practice resources;
- Contractual obligations e.g.: named and accountable GP for all patients.

3. Progress Update

Work continues to progress well in developing the strategy for General Practice.

Feedback from a TITO event in June was shared with all practices along with an online survey asking practices to confirm if the key themes identified were

an accurate reflection of the discussions on the day and also offering the opportunity for individuals to provide further comments.

There were 39 responses to the survey, 35 of which felt that there was nothing missing from the key themes identified. The report with additional comments can be found at *Appendix 1*.

Engagement with patients and the public has commenced with on street surveys being undertaken and a focus group held on 23rd August 2015. Online surveys have also been shared with all practice patient groups via Practice Managers.

Engagement with stakeholders has also been undertaken, mainly via the Transformation Board as this includes all key stakeholders but has also been supplemented with additional opportunities for the GP Federations; the Local Medical Committee and local Councillors. All Councillors were invited to 2 open events (evening and day time) w/c 7.9.15 and the information gained will be used at the next TITO event with Practices outlined later in this report.

The general practice group (GPG) under the Vanguard programme have now prioritised the key initiatives identified from the June TITO session, please see *Appendix 2* for the full results. In summary the initiatives which scored most highly in terms of impact vs do-ability are outlined below:

	Impact	**Do-ability**
Consider inclusion of budgets for staff development	36	9
Review of all enhanced services	33	6
Staff Development including succession planning	31	7
Development of city wide training programme for all staff	31	6
Improve consultation times to enable a holistic and pro-active approach	31	6
Improve integration with community services and secondary care – seamless	30	6
Consider implementing a local QoF	30	5
Explore options to work closer with pharmacy	29	7
Review of capacity in primary care	29	7
Undertake review of secondary care services which could be delivered in primary care	29	5
Consider options to improve access	28	5
Review of existing roles including GP, Nurse Practitioners	27	7
Shared records across all main services	26	8

Development of a Self Care awareness programme including the education of school children	26	6
Direct access to diagnostics	25	6
Work with public health to review existing lifestyle services	25	6

This information will be shared with all practices for comment by 4th September 2015.

A further TITO session will be held on the 16th September.

The key questions the groups will be asked to consider are:

1. Considering the views of patients, public, partners and GP representative groups, should there be any changes to the initiatives we have prioritised?
2. If yes, what changes do we need to make and why?
3. Do you feel there is anything missing? If yes, please provide details…
4. Following the TITO session, further work will be undertaken on developing the strategy document. An additional Governing Body development session is now planned for 6th October and it is anticipated that the focus will be:

- Review of general practice aim and objectives;
- Review of key themes from patients, partners and the public;
- Review of prioritised initiatives;
- Review proposed investment plan.

4. Next Steps

Key dates moving forward are outlined below:

11th September – PPI Report from NECS
16th September – TITO Event
30th September – First draft of strategy
6th October – Governing Body Development Session (special am session)
6th October – Executive Committee
27th October – Governing Body Development session – part of time for business item to sign off strategy

5. The Health and Wellbeing Board is recommended to:

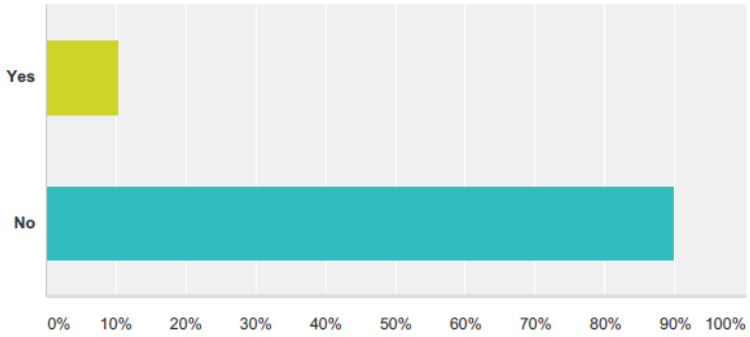
- Note the progress on developing the general practice strategy
- Agree to receive further update reports

Sunderland Clinical Commissioning Group

General Practice Strategy TITO Analysis – Confirmation of Key Themes

Q1 In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…

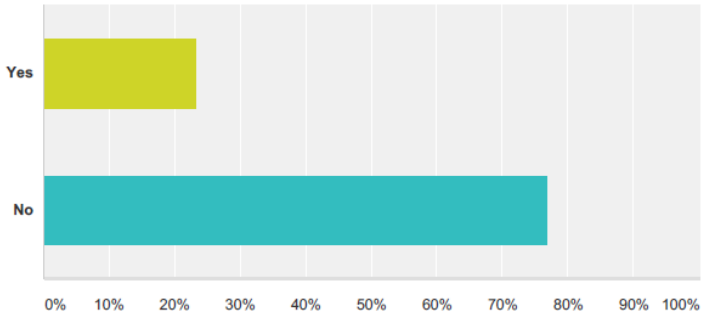
Answered: 39 Skipped: 0



Answer Choices	Responses	
Yes	10.26%	4
No	89.74%	35
Total Respondents: 39		

Q2 Are there any other comments you wish to make in relation to the strategy for general practice?

Answered: 39 Skipped: 0



Answer Choices	Responses	
Yes	23.08%	9
No	76.92%	30
Total Respondents: 39		

#2

COMPLETE

Collector: Web Link (Web Link)
Started: Monday, July 20, 2015 6:56:21 PM
Last Modified: Monday, July 20, 2015 6:57:10 PM
Time Spent: 00:00:48
IP Address: 86.181.138.175

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) We must keep our member practices involved each step.

#7

COMPLETE

Collector: Web Link (Web Link)
Started: Tuesday, July 28, 2015 12:19:20 PM
Last Modified: Tuesday, July 28, 2015 12:24:48 PM
Time Spent: 00:05:28
IP Address: 194.176.105.6

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) It is a bit strange that SCCG was asking general questions about how we want general practice to go forward in the first few question then there was a specific question about federation in question 5. This implies that the SCCG has already made up its minds regarding this option and I wonder if this was just a paper exercise and the decision about federations has already been made. Thanks

#13

COMPLETE

Collector: Web Link (Web Link)
Started: Tuesday, July 28, 2015 12:45:58 PM
Last Modified: Tuesday, July 28, 2015 1:11:01 PM
Time Spent: 00:25:03
IP Address: 194.176.105.6

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	Yes, Comments What tangible incentives can the CCG provide to support practice collaboration/merging
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) What plans does the CCG have for practices which will end up in 'special measures' or cannot recruit any GPs?

#15

COMPLETE

Collector: Web Link (Web Link)
Started: Tuesday, July 28, 2015 1:59:08 PM
Last Modified: Tuesday, July 28, 2015 2:08:35 PM
Time Spent: 00:09:27
IP Address: 194.176.105.6

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) We all know resources are limited and so more than ever, we have to use them efficiently. That means that the right person (with the right qualification and hence appropriate resource attached to them) sees the right patients at the right time - for example, GPs see patients with complex issues, multiple co-morbidity; NPs see patients with less complex issues; PNs see patients with chronic diseases; community pharmacists see patients with minor ailments and so on. Most importantly, patients have to be educated to utilize the various services appropriately. Then the services have to be set up so that there is less confusion, less duplication and hence achieving more efficiency. What is the point of having GP-led WICs, OOH services, extended access services etc all doing more or less the same thing but each needing to be commissioned in thousands and thousands of public money?

#16

COMPLETE

Collector: Web Link (Web Link)
Started: Tuesday, July 28, 2015 2:13:33 PM
Last Modified: Tuesday, July 28, 2015 2:20:41 PM
Time Spent: 00:07:07
IP Address: 194.176.105.6

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) Strategy is one thing but living in the real world is another. I/ve been in this business for nearly 30 years and have seen many changes and adapted but this is different. i understand the need for change and working smarter but without bodies on the ground and with moral at at all time low I'm really not sure if it can be achieved. Although I feel guilty for considering abandoning a sinking ship, I'm personally looking at an exit strategy in the next few years. on another note a member of my family applied for the Northern GP scheme and was rejected twice. he has now been offered jobs to fill in posts not filled as the scheme has only recruited half the places!. it makes absolutely no sense at all. if i were him I'd go back to Australia where he was treated with respect.

#23

COMPLETE

Collector: Web Link (Web Link)
Started: Tuesday, July 28, 2015 11:29:14 PM
Last Modified: Tuesday, July 28, 2015 11:31:28 PM
Time Spent: 00:02:14
IP Address: 86.180.212.90

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No, Comments I think everything was covered and there appears to have been similar opinions expressed in the different localities.
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	No

#24

COMPLETE

Collector: Web Link (Web Link)
Started: Tuesday, July 28, 2015 11:43:50 PM
Last Modified: Wednesday, July 29, 2015 12:15:43 AM
Time Spent: 00:31:52
IP Address: 86.130.57.54

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	Yes, Comments 1) Capacity needs to be increased, not reviewed. The huge reduction in primary care funding over the last five years is at the heart of this problem. We need a local funding solution for Sunderland. Only then can real change in the way services are delivered take place. 2) All other workforce elements are irrelevant to the current crisis.
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) 1) There is absolutely no capacity currently or in the foreseeable future for any further shift of services from secondary care. 2) 93% of patients in Sunderland expressed satisfaction with access to appointments. Why is this listed as a major issue. 3) Succesful change requires leadership, and above all else, vision. There has been a complete absence of this since the inception of the CCG. CCG leaders need to tell us what, if any, is their vision for the future of general practice in Sunderland, specifically how they intend to deal with the workforce crisis, how to deal with the funding crisis in primary care, how to resource the huge shift of secondary care services that has taken place over the last five years and how to reduce the explosion of bureacracy that has swamped practices. So far the silence has been deafening and this document just adds white noise.

#25

COMPLETE

Collector: Web Link (Web Link)
Started: Wednesday, July 29, 2015 7:32:53 AM
Last Modified: Wednesday, July 29, 2015 7:37:13 AM
Time Spent: 00:04:19
IP Address: 84.43.103.150

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	Yes, Comments You mention activity based contract. This is controversial and i think the majority of gps and the national bodies are in favor of outcome based contract . would you please clarify as this may have significant implications. We maybe a combination of both to reward practices with high activity for various reasons but ensure those who have worked hard to be effective and educate patients are also rewarded
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) Succession planning and enabling the forward thinking gps to take us forward. We have had enough of the old negative thinking generation who has driven us to the ground. We need energy innovation and new ideas without the baggage !

#33

COMPLETE

Collector: Web Link (Web Link)
Started: Wednesday, July 29, 2015 7:01:40 PM
Last Modified: Wednesday, July 29, 2015 7:03:32 PM
Time Spent: 00:01:51
IP Address: 194.176.105.6

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	Yes, Comments How would you want to the future CCG should be shaped? What are the steps to be taken to question CCG board?
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	No

#34

COMPLETE

Collector: Web Link (Web Link)
Started: Thursday, July 30, 2015 7:30:35 AM
Last Modified: Thursday, July 30, 2015 7:34:16 AM
Time Spent: 00:03:41
IP Address: 194.176.105.6

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) We need to continue highlighting how unacceptable political attitudes are towards general practice.

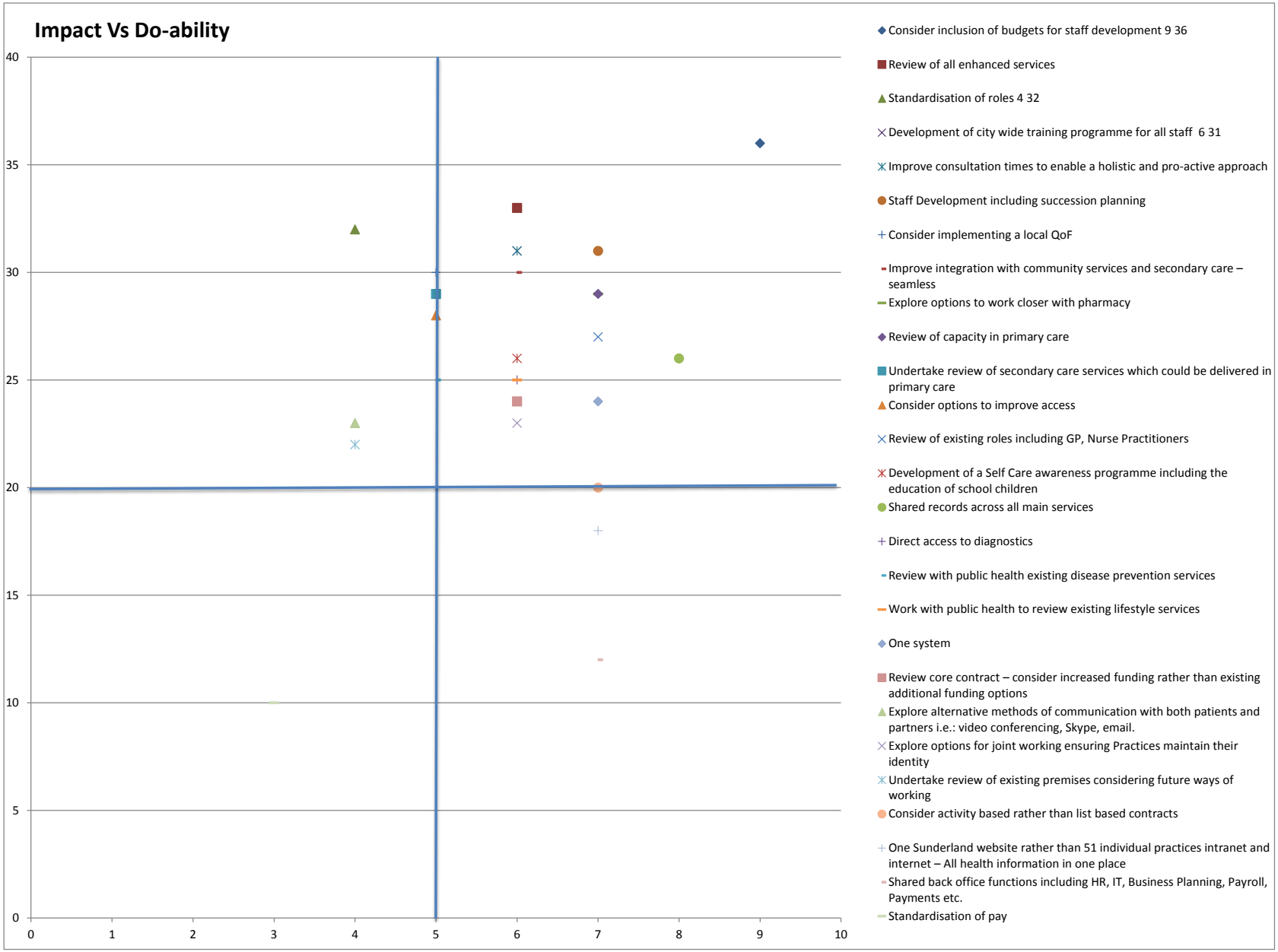
#37

COMPLETE

Collector: Web Link (Web Link)
Started: Thursday, July 30, 2015 11:42:53 PM
Last Modified: Friday, July 31, 2015 12:42:55 AM
Time Spent: 01:00:02
IP Address: 2.97.144.151

PAGE 1

Q1: **In terms of the long list of key themes, do you feel that there is anything missing? If so, please provide details…**	No
Q2: **Are there any other comments you wish to make in relation to the strategy for general practice?**	Yes, Other (please specify) The strategy discussions at TITO were very good. This comment is about priority. Comparison of international health systems shows how excellent the NHS is at solving problems, how poor at achieving healthy living and preventing lifestyle related problems. Most of our health care already deals with the consequences of unhealthy choices and inequity in health is huge. With massive local authority public health cuts and a government not focusing on inequity it needs a change in direction to prevent our NHS from smothering under increasing care needs. Sunderland is at the receiving end of this issue. Only one in five of our our citizens have a healthy weight and our children are the most obese in England. We are amongst the England binge drinking champions and my impression is that depression rates are also soaring. I don't want to sound pessimistic, as much is preventable, GPs are aware, our CCG is well placed to buck the trends, we're vanguard, we've got the vision and spirit for this journey and there are lots of opportunities. GPs and schools seem to be at the heart of potential solutions as they relate to virtually all citizens - but this is preluding. We do need to invest into developing the methodology, identifying opportunities and learning to use the principles the best we can, in our (joint) commissioning as well as our primary care and general practice development.


Impact Vs Do-ability
40
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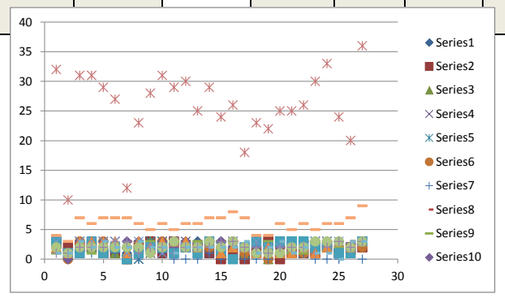
8
9
10
Consider inclusion of budgets for staff development 9 36
Review of all enhanced services
Standardisation of roles 4 32
Development of city wide training programme for all staff 6 31
Improve consultation times to enable a holistic and pro-active approach
Staff Development including succession planning
Consider implementing a local QoF
Improve integration with community services and secondary care – seamless
Explore options to work closer with pharmacy
Review of capacity in primary care
Undertake review of secondary care services which could be delivered in primary care
Consider options to improve access
Review of existing roles including GP, Nurse Practitioners
Development of a Self Care awareness programme including the education of school children
Shared records across all main services
Direct access to diagnostics
Review with public health existing disease prevention services
Work with public health to review existing lifestyle services
One system
Review core contract – consider increased funding rather than existing additional funding options
Explore alternative methods of communication with both patients and partners i.e.: video conferencing, Skype, email.
Explore options for joint working ensuring Practices maintain their identity
Undertake review of existing premises considering future ways of working
Consider activity based rather than list based contracts
One Sunderland website rather than 51 individual practices intranet and internet – All health information in one place
Shared back office functions including HR, IT, Business Planning, Payroll, Payments etc.
Standardisation of pay

Summary of Prioritised Initiatives	Do-ability	Impact
Consider inclusion of budgets for staff development	9	36
Review of all enhanced services	6	33
Staff Development including succession planning	7	31
Development of city wide training programme for all staff	6	31
Improve consultation times to enable a holistic and pro-active approach	6	31
Improve integration with community services and secondary care – seamless	6	30
Consider implementing a local QoF	5	30
Explore options to work closer with pharmacy	7	29
Review of capacity in primary care	7	29
Undertake review of secondary care services which could be delivered in primary care	5	29
Consider options to improve access	5	28
Review of existing roles including GP, Nurse Practitioners	7	27
Shared records across all main services	8	26
Development of a Self Care awareness programme including the education of school children	6	26
Direct access to diagnostics	6	25
Work with public health to review existing lifestyle services	6	25
Review with public health existing disease prevention services	5	25
One system	7	24
Review core contract – consider increased funding rather than existing additional funding options	6	24
Explore options for joint working ensuring Practices maintain their identity	6	23
Standardisation of roles	4	32
Explore alternative methods of communication with both patients and partners i.e.: video conferencing, Skype, email.	4	23
Undertake review of existing premises considering future ways of working	4	22
Consider activity based rather than list based contracts	7	20
One Sunderland website rather than 51 individual practices intranet and internet – All health information in one place	7	18
Shared back office functions including HR, IT, Business Planning, Payroll, Payments etc.	7	12

Standardisation of pay	3	10

General Practice Strategy Prioritisation Criteria																			
		Impact of the Initiative (Compare each initiative against each of the requirements below. What impact will the initiative have on this requirement - Score 0-3)														**Do-ability (How do-able is this initiative? Is it value for money, how much effort will it take and what are the risks involved in doing, or not doing, the initiative - Score 0-3)**			
		CCG Strategic Objectives			**CCG 5 Year Outcome Ambitions**				**Sunderland Future State for General Practice**										
Proposed Initiative		Transforming out of hospital care through integration and 7 day working	Transforming in hospital care, specifically urgent and emergency care and 7 day working	Enabling self care and sustainability	Improve health related quality of life for people with long term conditions	Improve patient experience of out of hospital care	Reduce emergency admissions	Reduce years of life lost	Sustainable general practice	Appropriate access (Right person, right place, right time for right condition)	Consistent and high quality	Self Care	Appropriate skill mix	System working	**Impact Score**	VFM & Financial Sustainability	Effort	Risk	**Do-ability Score**
Workforce	Standardisation of roles	3	3	3	3	3	2	2	2	1	2	3	2	3	32	2	1	1	4
	Standardisation of pay	1	2	1	1	1	0	1	0	0	0	1	1	1	10	1	1	1	3
	Staff Development including succession planning	3	2	3	3	1	3	1	3	2	3	1	3	3	31	2	2	3	7
	Development of city wide training programme for all staff	3	2	2	3	2	2	1	3	1	3	3	3	3	31	2	2	2	6
	Review of capacity in primary care	3	1	1	3	1	3	1	3	3	3	1	3	3	29	2	2	3	7
	Review of existing roles including GP, Nurse Practitioners	2	1	1	3	2	2	1	2	2	2	2	3	3	27	2	3	2	7
Ways of Working	Shared back office functions including HR, IT, Business Planning, Payroll, Payments etc.	1	0	1	0	0	0	0	3	2	3	0	1	1	12	2	3	2	7
	Explore options for joint working ensuring Practices maintain their identity	2	2	1	0	0	2	0	3	3	3	1	3	3	23	2	1	3	6
	Consider options to improve access	3	3	3	1	3	2	1	1	3	2	2	2	2	28	1	2	2	5
	Improve consultation times to enable a holistic and pro-active approach	2	1	3	3	3	3	1	3	3	3	2	3	1	31	2	2	2	6
	Undertake review of secondary care services which could be delivered in primary care	3	3	2	2	2	2	0	3	3	2	1	3	3	29	3	1	1	5
	Improve integration with community services and secondary care – seamless	2	2	3	3	2	2	0	3	3	3	2	3	2	30	2	2	2	6
	Direct access to diagnostics	3	2	2	1	2	2	0	3	3	2	1	2	2	25	2	2	2	6
	Explore options to work closer with pharmacy	1	1	3	1	2	2	1	3	3	3	3	3	3	29	3	2	2	7
IT Infrastructure	One system	3	0	2	2	2	2	0	3	3	3	1	1	2	24	2	3	2	7
	Shared records across all main services	3	1	2	3	2	3	0	3	2	2	0	2	3	26	3	3	2	8
	One Sunderland website rather than 51 individual practices intranet and internet – All health information in one place	2	0	1	1	1	1	0	2	2	2	2	2	2	18	2	2	3	7
	Explore alternative methods of communication with both patients and partners i.e.: video conferencing, Skype, email.	1	1	3	2	2	1	0	2	2	2	3	1	3	23	1	2	1	4
Premises	Undertake review of existing premises considering future ways of working	3	3	0	1	2	0	0	3	3	1	2	2	2	22	1	1	2	4

Prevention and Self Care	Work with public health to review existing lifestyle services	3	0	3	3	1	2	2	2	1	2	3	1	2	25	1	2	3	6
	Review with public health existing disease prevention services	3	1	3	3	2	1	1	2	1	2	3	1	2	25	2	2	1	5
	Development of a Self Care awareness programme including the education of school children	3	1	3	2	1	1	1	3	1	3	3	2	2	26	2	2	2	6
Contractual / Financial	Consider implementing a local QoF	3	1	3	3	3	1	0	3	3	3	2	1	3	30	3	1	1	5
	Review of all enhanced services	3	2	3	3	3	2	0	3	3	2	2	2	3	33	3	2	1	6
	Review core contract – consider increased funding rather than existing additional funding options	3	1	1	2	2	1	0	2	2	3	1	3	3	24	3	3	0	6
	Consider activity based rather than list based contracts	1	2	2	1	2	1	1	3	1	1	1	2	2	20	2	2	3	7
	Consider inclusion of budgets for staff development	3	2	3	3							3	3	3	36	3	3	3	9



Key
Impact - Score each initiative 0-3 (Total Score = 42) ***NB: Sustainability is weighted x 2***
0 - Initiative does not link to that requirement
1 - Initiative loosely links to that requirement
2 - The initiative has a clear link to that requirement
3 - The initiative strongly links to that requirement
Do ability - Score each initiative 0-3 (Total Score = 9)
0 - Initiative uses too much of that aspect - ie: initiative is too costly, risk is too great, too much effort
1 - Initiative uses a significant amount of that aspect
2 - Initiative uses a fair amount of that aspect
3 - Initative uses very little of that aspect ie: cost is very small, very little risks and small amount of effort to deliver

Impact													
	CCG Strategic Objectives			CCG 5 Year Outcome Ambitions				Sunderland Future State for General Practice					
	Transforming out of hospital care through integration and 7 day working	Transforming in hospital care, specifically urgent and emergency care and 7 day working	Enabling self care and sustainability	Improve health related quality of life for people with long term conditions	Improve patient experience of out of hospital care	Reduce emergency admissions	Reduce years of life lost	Sustainable general practice	Appropriate access (Right person, right place, right time for right condition)	Consistent and high quality	Self Care	Appropriate skill mix	System working
Governing Body Comments in relation future state for general practice	N/A			N/A	N/A	N/A	N/A	To ensure sustainability of general practice to realise economy and benefits; Ensure equity of access and patients are able to access all services available at every practice / cluster.	Patients want appointments with their GP in a reasonable timeframe; If we do not deliver appropriate access and patients are not seen within reasonable timescales evidence shows they will use other healthcare facilities.	Too much variation at the moment - not equitable; Need a cost effective gate keeper model.	There is evidence showing inappropriate use of services; Self care supports longer term health benefits and needs for individuals; Self care will support other parts of the system to deliver.	Currently capacity is a huge issue in general practice; Appropriate use of skills and resources will provide value for money and ultimately better care for patients; Appropriate use of skills will provide staff satisfaction and patient satisfaction.	Recognition that general practice is also part of the solution to deliver integration - without being part of the full system this will fail; Integration will increase the volume of patients waiting to be seen - this needs to be evidence based with informed opinion and input; Huge risk is disconnect in the system and integration agenda is not delivered.
Further definitions	Right Care; Right Place; Right Time; Right Skills; System wide approach with one common vision; Multi-disciplinary teams in localities working together with people, adults and children with long term conditions / complex needs to ensure person centred co-ordinated care; Improved overall quality of care for the elderly; Reduced variation in primary care Patient centred; A system which is simple to navigate; Reduced emergency admissions to hospital as people are cared for effectively in the community.	Equality of access across the City to urgent care; 24/7 hub; Reduced handoffs in the system; Reduction in emergency admissions	Local people influence and understand the system; A city that actively supports / enables people to be and stay healthy, well and happy; Improved public health outcomes; Managing demand Using community assets.	Average health status (EQ-5D*) scores for individuals aged 18 and over reporting that they have a long-term condition. It assesses whether health-related quality of life is increasing over time for the population with long-term conditions, while controlling for measurable confounders (age, gender, disease mix etc). The overarching indicator (together with complementary improvement indicators) provides a picture of the NHS contribution to improving the quality of life for those affected by long-term conditions.	Patient experience of GP out-of-hours services, measured by scoring the results of one question from the GP Patient Survey (GPPS) The indicator is based on the percentage of people responding 'Good' or 'Very Good' to the following question: 'Overall, how would you describe your experience of out-of-hours GP services?'	Directly age and sex standardised rate of emergency admissions for acute conditions that should not usually require hospital admission. Preventing conditions such as ear, nose or throat infections, kidney or urinary tract infections, or heart failure from becoming more serious. Some emergency admissions may be avoided for acute conditions that are usually managed in primary care. Rates of emergency admissions are therefore used as a proxy for outcomes of care.	Directly age and sex standardised potential years of life lost to conditions amenable to healthcare in the respective calendar year per 100,000 CCG population. Causes considered amenable to health care are those from which premature deaths should not occur in the presence of timely and effective health care. The concept of 'amenable' mortality generally relates to deaths under age 75, due to the difficulty in determining cause of death in older people who often have multiple morbidities. The Office for National Statistics (ONS) produces mortality data by cause, which excludes deaths under 28 days (for which cause of death is not classified by ICD-10 codes). These indicators therefore relate to deaths between 28 days and 74 years of age inclusive.	Definition of sustainable: maintainable, viable, supportable.	Definition of appropriate: suitable, correct, applicable, right.	NHS England have a single common definition of quality which encompasses three equally important parts: •Care that is clinically effective– not just in the eyes of clinicians but in the eyes of patients themselves; •Care that is safe; and, •Care that provides as positive an experience for patients as possible	NHS Choices describe self care as outlined below: Self care means looking after yourself in a healthy way, whether it's brushing your teeth, taking medicine when you have a cold, or doing some exercise. If you have a long-term condition, there are extra things you may need to consider, such as making changes to your diet, different types of exercise or different types of medication you may need to take. Self care also means staying active by doing things that are important to you, such as gardening, seeing friends and family, going on holiday, or continuing to work, if possible. It involves looking at what you can do and want to do, rather than what you can't do. Living a healthy lifestyle is an important part of self care for everyone. Self care doesn't mean you get less help from your doctor.	NHS England outline this is about having the right staff with the right skills in the right place.	There is much talk about taking 'a whole systems approach' to planning. This is not just about getting the different parts of the system round a table and understanding their roles,it is about gathering local intelligence to understand the impact of changes in one part of the system on everything else.

Do-ability			
	VFM & Financial Sustainability	Effort	Risk
Further guidance notes	Consider how much implementing the initiative will cost. Will the initiative provide cost to save opportunities? General guide re scoring: 0 = initiative is very costly and will provide no savings 1 = initiative is costly but has potential to save £100 - £499k 2 = initiative is costly but has potential to save £500 - £999k 3 = initiative is costly but has potential to save in excess of £1m	Consider how much effort will be needed to implement the initiative. General guide re scoring: 0 = initiative requires unrealistic amount of effort 1 = initiative requires sigificant effort to implement 2 - Moderate effort to deliver initiative 3 - Effort to deliver initiative is minimal	Consider the risks in implementing the initiative. General guide re scoring: 0 = the risks to implement the initiative significantly outweigh the benefits 1 = the risks to implement the initiative are significant however there are benefits which can be identified 2 = there are moderate risks to delivery of this initiative but these are outweighed by the benefits 3 = there are minimal risks and benefits are significant

	Do-ability	Impact
Consider inclusion of budgets for staff development	9	36
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Standardisation of roles	4	32
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Consider implementing a local QoF	5	30
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Explore alternative methods of communication with both patients and partners i.e.: video conferencing, Skype, email.	4	23
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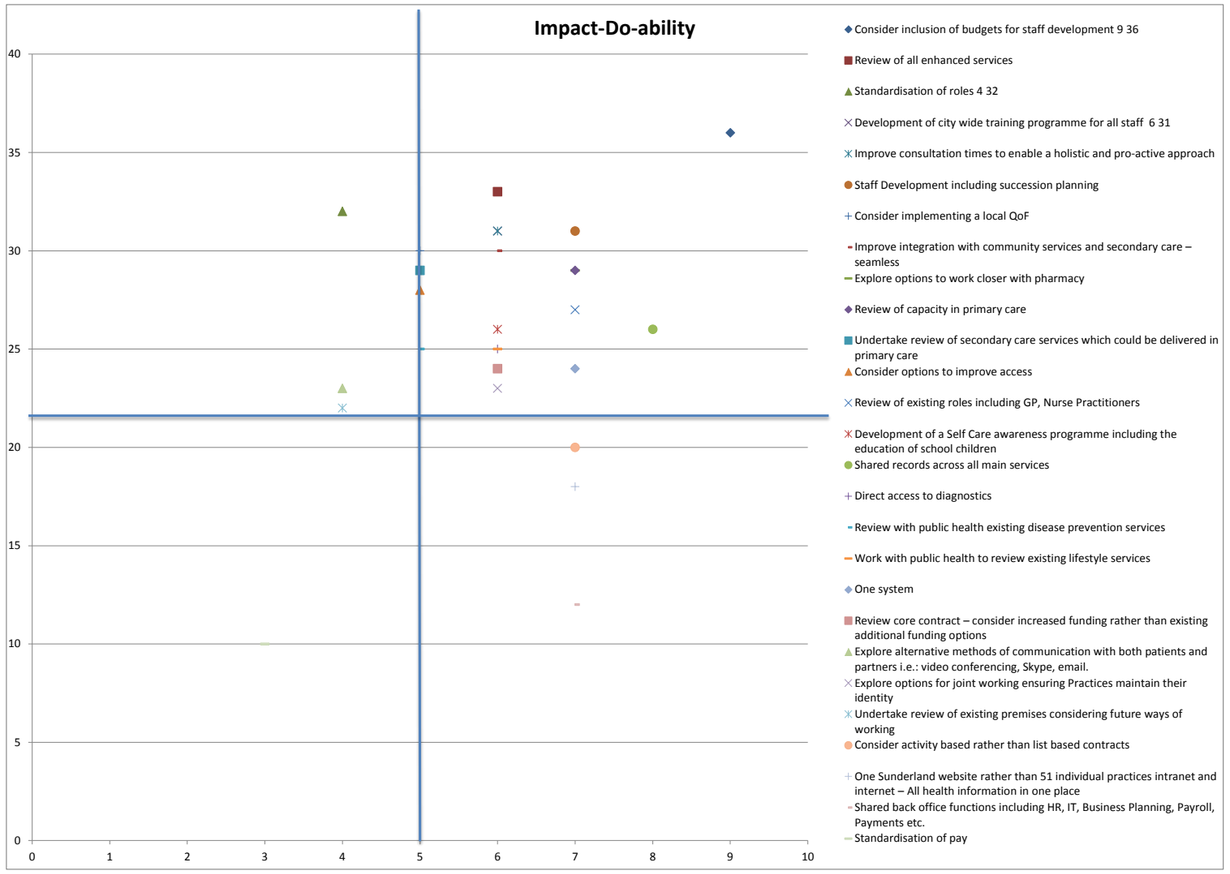
Consider activity based rather than list based contracts	7	20
One Sunderland website rather than 51 individual practices intranet and internet – All health information in one place	7	18
Shared back office functions including HR, IT, Business Planning, Payroll, Payments etc.	7	12
Standardisation of pay	3	10



Item No. 8

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Report of the Chief Officer, Sunderland CCG

1. Purpose of this Report

The purpose of this report is to:

- Set out NHS England guidance for local NHS teams - CCGs working closely with their health and wellbeing boards and partners on the development of Local Transformational Plans to support improvements in children and young people's mental health and mental health and wellbeing
- Set out the current position, self-assessment and proposed areas for development
- Seek member support for the CCG approach to developing plan

2. Background

2.1 The recent report of the Children and Young People's Mental Health Task Force *Future in Mind,* jointly chaired by NHS England, and the Department of Health establishes a clear direction and some key principles about how to make it easier for children and young people to access high quality mental health when they need it.

2.2 The document describes an integrated whole systems approach to driving improvements in children and young people's mental health outcomes with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together to:

- o place the emphasis on building resilience, promoting good mental health and wellbeing, prevention and early intervention;
- o deliver a step change in how care is provided – moving away from a system defined in terms of the services organisations provide towards one built around the needs of children, young people and their families;
- o improve access so that children and young people have easy access to the right support at the right time and as close to home as possible. This includes implementing clear evidenced based pathways for community based care to avoid unnecessary admissions to in-patient care;
- o deliver a joined up approach: linking services so care pathways are easier to navigate for all children and young people;
- o sustain a culture of continuous evidence based service improvement delivered by a workforce with the right mix of skills, competencies and experience

- improve transparency and accountability across the whole system – being clear about how resources are being used in each area and providing evidence of collaborative decision making.

2.3 The report sets out a clear national ambition to transform the design and delivery of local services for children and young people with mental health needs. These include prioritising investment in those areas that can demonstrate strong leadership and ownership at a local level through robust action planning and engagement with all partners and NHS England Specialised Commissioning to develop publicly available agreed **Local Transformational Plans for Children and Young People's Mental Health and Wellbeing.**

2.4 Extra funding to support the transformation of mental health services for children and young people was announced in the autumn statement (December 2014) and Budget (March 2015). These announcements align with recommendations set out in the *Five Year Forward View* and are designed to build capacity and capability across the system so that by 2020 there is measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health.

3. Local Transformational Plans for Children and Young People's Mental Health and Wellbeing

3.1 Required Actions for Local Areas;

Local areas can decide what is included in the local transformational plan. It is recognised that the timescales to develop plans is tight and the expectation is that the plan will be a living document that local areas will wish to review and develop in year and within the mainstream planning process from 2016/17.

Local plans will need to demonstrate that they:

- Have been designed with, and are built around the needs of children, young people and families;
- Are based on the mental health needs of children and young people within the local population
- Provide evidence of effective joint working both within and across the sectors including NHS, public health, LA, social care, youth justice, education and voluntary sector
- Include reference to other improvement initiatives including the crisis care concordat
- Include evidence the plans have been developed collaboratively with NHS Specialised Health and Justice Commissioning teams
- Promote collaborative commissioning approaches within and between the sectors
- Clarify status within the CYP IAPT Programme

- Include the level of investment by all partners commissioning children and young people's mental health services for the period April 2014 to March 2015
- Include spend on services directly commissioned by NHS England on behalf of the CCG population
- Will be published on websites for the CCG, Local Authority and any other local partners
- Are based on delivering evidence based practice and focused on demonstrating improved outcomes
- Make explicit how equality is being promoted and health inequalities are being addressed
- Will be monitored by multi-agency boards for delivery supported by local implementation/ delivery groups to monitor progress against plans including risks
- Include baseline information for April 2014-March 2015 on referrals made, accepted and waiting times
- Include workforce information, numbers of staff including whole time equivalents, skills and capabilities
- Include measurable, ambitious KPIs
- Have been costed and are aligned to the funding allocation that will be received
- Take into account the existing different and previous funding streams including MH resilience funding (parity of esteem)

3.2 **Headline Timelines and Proposed Local Action**

3.2.1 Actions to Date

- March 2015 – Publication of Future in Mind CAMHS Partnership review of Mental Health and Emotional Well Being Strategy for Children and Young People against Future in Mind Recommendations and initial priority setting

- July 2015 – Opportunity to bid for CAMHS / Schools Pilot Programme CCG work with partners to produce and submit expression of interest in CAMHS/ Schools pilot

- August 2015 – Publication of Transformational Planning and Eating Disorder commissioning guidance with initial allocation of Eating Disorder Monies

- Circulation of completion of CAMHS Transformation self-assessment by partner organisations

- CCG produce draft self-assessment, proposed future actions and state of readiness based on partner responses and priorities identified within the CAMHS Partnership (see Appendices 1 and 2)

- Initial discussion with specialist commissioning team in relation to the development of CAMHS transformational plan

- CCG receive notification from NHS England that the Sunderland CAMHS/Schools bid was successful

- ***September 2015***

  Consultation with health and wellbeing board on proposed process, self assessment and emerging priorities

3.2.2 Proposed Future Actions (in line with requirements set out by NHS England

- September 2015 - CCG collaborate with NHS England Specialised Commissioning and partners including local CAMHS Partnership to develop draft Transformational Plan in line with self-assessment, priorities identified within the CAMHS strategy and emerging from self-assessment.

- Completed self-assessment, Transformational Plan and completed tracking template will be circulated to partners, including members of the Health and Wellbeing Board for comment, revised documents to be signed off by the CCG Chief Operating Officer on behalf of the Health and Wellbeing Board by 30th September 2015

- 16th October 2015 - Submit transformational plan, competed self-assessment and competed tracking template checklist to NHS England for assurance at regional level (this is the second window for submission of plan)

- First week of November 2015 – CCG notified of outcome of assurance process with three possible outcomes:

  - Transformational plan meets the assurance criteria in full and CCG receives all funds allocated
  - Transformational plan needs minor clarification or amendment the CCG will be asked to resubmit showing that the clarification and amendments have been made and funding will be allocated
  - Plans are not aligned to the requirements set out in this guidance – further funding will not be released until the plans are satisfactory. A support mechanism will be put in place to support the CCG in developing plan

- November

Local Transformation Plan published

- Q3 and Q4 2015/16

Transformational Plans inform 2016/17 commissioning intentions

- 2016 onwards

Review and development of Transformation Plans embedded in mainstream planning process across partner agencies

3.3 Allocation of Additional Funds

The additional funds allocated to Sunderland are as follows:

- Initial Allocation for Eating Disorders and Planning for 2015/16 - £173,762
- Additional Funding following assurance of Transformational Plan - £434,966
- Minimum uplift 2016/17 onwards following assurance - £608,737 (equates to Eating Disorder +Transformational monies)

4. Current Position : CAMH Service Provision

There has been significant work to improve the range and quality of CAMH Service provision over the last 10 years.

This has resulted in the development of the CCAMH Service, the review and re provision of regional services, the review and re provision of community services to include integrated CAMHS and learning disability services, extended CAMH services for vulnerable children including those with complex behavioural, mental health and social care needs, the development of community based eating disorder services and the establishment of Intensive home treatment services.

The current range of services to support Children and Young People (CYP) with mental health needs across Sunderland these are as follows:

4.1 National Services

NHS England currently commissions Tier 4 services for children with highly complex, severe or persistent mental health needs (0.075%). These are predominantly in-patient services and are provided by the two major mental health trusts in the region as follows:

- Tees Esk and Wear Valley (TEWV) Regional Eating Disorder Service for Children and Young People

- Northumberland Tyne and Wear Mental Health Foundation Trust (NTW) Regional CAMHS and Learning Disability Services including intensive care, in-patient and Neuro-Development Disorder Service

NHS England operates a national bed management system and meet with CCG commissioners on a regular basis to monitor activity.

4.2 Local Services

NTW Children and Young Peoples Service (CYPS) Tier 3

Working in partnership with Sunderland City Council (SCC), Sunderland CCG commission NTW CYPS to provide specialist services to support children, young people and their families with severe and complex mental health needs (2% of population).

In addition NTW CYPS have been commissioned to provide a broad range of services that include:

- Intensive Home Treatment Services for children, young people and families with acute or highly complex and severe mental health needs - to prevent hospital admission
- Multi Systemic Treatment Services - to support children, young people and their families with complex behavioural, mental health and social care needs
- Support for children, young people and families in special circumstances with moderate levels of mental health need (Tier 2+) including those:
    - Who have learning disabilities
    - Who are or have been looked After or accommodated including those who have been adopted
    - Who have been neglected or abused or are part of a child protection plan
    - Who have a learning or physical disability
    - Who have chronic, enduring or life limiting illness
    - Who have substance misuse issues
    - Who are at risk of, or have been involved in offending
    - Who are homeless or who are from families who are homeless
    - Whose parents have problems including domestic violence, illness, dependency or addiction

In addition the service offers training, consultation, in-reach, outreach and opportunities for joint working with targeted service providers e.g. Youth Offending Service (YOS) and Looked After Children (LAC), substance misuse services, paediatrics.

The CYPS service have continued to develop their model of care to improve access and waiting Times to meet the increasing demands in referrals.

As a result of this, by March 2016, the maximum wait from referral to treatment will be 12 weeks for 95% of children and young people. In addition at least 50% of children and young people will wait less than 9 weeks. Within this, children and young people with severe and complex needs are seen more urgently, using their Urgent and Priority guidelines and processes to ensure that urgent cases are seen as set within 24, 72 hours and priority cases within 4 weeks.

This compares favourably to the 18 week national target that is currently being proposed for CAMH services to ensure mental health waiting time standards mirror physical health waiting time standards.

South Tyneside Foundation Trust (STFT) Community Child and Adolescent Mental Health Service (CCAMHS) Tier 2

Working in partnership with Sunderland City Council and with some additional funding from SCC, Sunderland CCG commission the CCAMH Service to provide services for children, young people and their families with moderate levels of mental health needs (7% of the population).The service provides:

- Individual and group work, brief intervention, parenting support, talking therapies and counselling

- Training, consultation and joint work to increase the capacity of universal service providers to meet the mental health needs of children, young people and their families.

Working with commissioners the service undertakes a process of improvement most recently this has included :

- The successful bid and implementation of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme.
- The recruitment of a wide range of posts financed via investment awarded as part of the CYP IAPT programme.
- Implementation of electronic care record
- Maintenance of less than 12 week waiting times.

In line with the CYPS, the CCAMHS are reporting increasing numbers of referrals which is creating waiting time pressures from 6 – 10 weeks.

Universal and Targeted Services Tier 1

There are a broad range of services that have responsibility for mental health promotion for ALL children, young people and their families (100%) and providing support for children, young people and their families with mild to moderate levels of mental health need (15%) These include:

- Midwifery Services (commissioned by CCG)
- Health Visitor and Family Nurse Partnership Services (commissioned by LA)
- Children's Centres, Nurseries and Early Years Settings (commissioned / provided by LA)
- Schools, Colleges and Training Providers
- Services for young people e.g. youth services (commissioned by LA)
- School Nursing Service (commissioned by LA)
- General Practitioners (commissioned by CCG from April 2015)

In addition targeted and specialist service providers have a responsibility to support the mental health needs of CYP these include: paediatric services, strengthening families, children social care and youth offending service.

5. Summary Self-Assessment and Proposed Actions

5.1 **Resilience, prevention and early intervention for the mental health and emotional wellbeing of children and young people – self assessment actions 1-5**

5.1.1 Current Position

There are mechanisms in place in maternity and health visitor services there in place to identify early warning signs of mental health distress and access to support as required.

CAMH Services are commissioned to deliver a range of training, consultation and support to maternity, early years and health visitor services in addition to providing a broad range of evidence based programmes to promote attachment and early years mental health and well being

There are a broad range of services to promote attachment and provide evidence based programmes of intervention for parents to improve early years mental health Sunderland offers priority access to psychological therapies in the peri natal period

There have been high levels of investment and sustained support to schools to promote mental health and emotional wellbeing. CCAMS provides a broad range of training, consultation and support for schools to meet the mental health needs of children and young people including counselling, peer support, whole class and group approaches.

Sunderland successfully implemented the targeted mental health and schools programme with a significant number of schools across the city resourced to provide therapeutic spaces and with identified mental health leads with significant additional training.

Statutory and non-statutory CAMHS organisations adopt a co-ordinated approach to provide anti-stigma awareness training and targeted anti-stigma activities to promote mental health.

Department of Health are considering the development of a national branded web based portal to provide high quality information and on line support for children, young people and their families.

Locally the CAMHS partnership is working to strengthen the well-being guide and CAMH Services are beginning to use digital technology to support engagement and reduce DNA’s (FLORENCE)

5.1.2 Priority Actions

Increase the capacity of the universal work force to appropriately recognise and address identified mental health needs

Improve perinatal community support including the further development of specialist perinatal mental health clinician role

Develop CAMHS Partnership arrangements to include a robust mechanism to work with schools to consider their contribution to meeting the mental health needs of children, young people and their families

Consider the contribution of the school nursing service to support the mental health needs of children, young people and their families as part of the Healthy Child Programme

Further develop the mental health lead role within schools aligned to the development of link professional within CAMHS

Build on current best practice to develop and provide evidence based programmes including the development of Mindfulness in schools

5.2 **Improving access to effective support – self assessment actions 6-19**

5.2.1 Current Position

CAMH services are configured in a way that is aligned either to universal (schools) services or to targeted and specialist services e.g. LAC, YOS with the CYPS service providing integrated CAMHS and learning disability provision across the Tiers (2-4)

CAMH Services support locally agreed models of working. They participate in the current Strengthening Families Model to support a co-ordinated response to meeting the needs of children, young people and their families and CCAMH service is provided from Childrens Centres and Extended Service Schools

There are single point of access into both CCAMH Service provision and the CYPS Service. CAMH services work collaboratively to ensure that children and young people receive the most appropriate service to meet their level of mental health need.

Sunderland CCG in partnership with CCAMHS, CYPS, SCC and the voluntary sector have been successful in bidding to become a pilot site for a joint training programme between CAMHS and 10 schools. Over 40 nursery, primary, secondary, mainstream and special volunteered to become involved in the pilot.

There are a range of peer support services for children, young people and their families available in mainstream and specialist settings

There are identified strategic leads for SEND and mental health in both the LA and CCG

CAMHS are commissioned to provide input into the SEND care planning process.

Sunderland locality has a crisis care concordat plan in place which includes children and young people.

A range of services are available to prevent inappropriate use of police cells as a place of safety. This includes street triage, ICTS, 136 Suite, A&E, local authority and mental health provision.

Children and young people have access to intensive care and treatment services as well as out of hour's mental health services.

CAMH Services are commissioned to work flexibly with adult mental health services to support smooth transition. It is expected that transition planning should begin at least 6 months before transfer and may include CAMHS and AMHS working jointly with CYP before and after their 18th birthday.

CAMH Services are commissioned to deliver services to a 6 week waiting standard. Currently the CCAMH services has 6-12 week waiting time and the CYP service has an action plan in place to reduce waiting time to no longer than 12 weeks by April 2015

Both CAMH services have seen a 50% increase in referrals over the last 2 years

CAMH services are required to have clear DNA policies in place and operate from a value base of "no giving up on families and will use a number of different, innovative approaches to engagement. This may include partnership working in reach, outreach, and joint working to support engagement

5.2.2 Priority Actions

Establish named point of contact within CAMH services for schools, GP;s and other services for children in particular services for vulnerable children, young people and their families.

Extend the CAMHS Schools pilot at a local level to work with all schools who wished to become involved in joint training with CAMHS and the development of mental health lead in schools aligned to CAMHS support.

Develop the mental health lead role in other services for children, young people and their families including developing skills and expertise to support mental health needs in services for vulnerable children and young people

Establish an audit tool to provide a baseline of current range, type and effectiveness of peer support being offered across the City and develop a framework to support good practice.

Strengthen the coordination of strategic planning arrangements for SEND and mental health

Develop capacity within CAMHS to effectively support the Educational Health and Care Planning process

Improve the diagnostic pathway for Autistic Spectrum Disorders to ensure NICE compliance and consistency. Develop support for children, young people and their families with Autistic Spectrum Disorder.

Develop innovative and bespoke models of integrated multi-disciplinary support for children with learning disabilities including those with challenging behaviour to avoid preventable admission to inpatient services

Develop innovative and bespoke models of integrated multi-disciplinary support for children with complex behavioural, mental health and social care needs that include

children and young people in crisis and those with challenging behaviours to reduce the number of young people in out of area placements

Monitor effectiveness of street triage, 136 detentions, A&E, RAID and police custody to support ongoing service development and future commissioning

Strengthen pathways and communication between inpatient and community services

Develop and improve integrated models of service provision for children and young people across the City including one stop shop approach. CAMH services should be integral to the planning and delivery of new models of integrated service provision.

Commissioners and CAMH Service providers to continue to reduce waits to local waiting time standard of 6 weeks

Improve the capacity of universal and targeted services to effectively address the mental health needs of CYP and their families at an earlier stage to reduce increasing levels of referrals to specialist services.

The partnership is continuing to develop a more integrated approach and joint working between partner organisations to ensure better engagement with CYP and their families in particular those CYP who find services difficult to access.

5.3 **Caring for the most vulnerable – self assessment actions 20-29**

5.3.1 Current Position

CAMHS services are commissioned to proactively work alongside other organisations to engage children, young people and families. The services are expected to provide creative and imaginative models of service delivery to ensure that they are accessible to those whom may find engaging with services difficult.

The CYP service is commissioned to provide a broad range of services for vulnerable children and young people experiencing psychological distress to ensure that acceptance criteria is based on presenting need and not clinical diagnosis. The expectation is that the service provides imaginative, integrated models of care including co-location of staff, dedicated in-reach or outreach support, joint or collaborative and named contact for service.

The CYP Service is commissioned to deliver an integrated model of integrated CAMHS and Learning Disability provision ensuring that children and young people with learning disabilities are able to access a full range of CAMH Service provision

The CYP service is commissioned to provide the following services to support looked after children:

- Advice and training on identifying children and young people with mental health needs including use of the SDQ (Strengths and Difficulties Questionnaire)
- Training consultation and advice for foster carers, residential home staff and social workers
- Creative partnership working to ensure that children and young people have disclosed receive psychological support
- Psychological support for children and young people not in a stable placement

- Assessment of parenting to support effective placement
- Post adoption support for parents
- “Risk sharing” for children and young people with complex needs including taking clinical responsibility and providing support to manage behaviour and minimise risks
- Adopting a flexible approach to meet the needs of children and young people
- Flexibility in supporting children and young people placed in Sunderland who are from other areas and for children and young people from Sunderland who are placed Out of Area

The CYP service is commissioned to provide services for vulnerable children and young people, including homelessness, young offenders, substance misuse and those of parents with problems including domestic violence. Services to support the mental health needs of young offenders should include:

- Advice and training on identifying children and young people with mental health needs including use of the ASSETT
- Provision of direct support to young people
- Provision of consultancy advice including contribution to risk plan
- Ensuring continuity of provision, transition planning for young people entering and leaving custody

CAMH Service have practitioners with the necessary skills to understand the impact of trauma on the mental health of children, young people and families.

CAMH Services are commissioned to be an integral part of service to support children and young people who have been sexually abused or at risk of exploitation.

CAMH services are required to have clear DNA policies in place and operate from a value base of "no giving up on families and will use a number of different, innovative approaches to engagement. This may include partnership working in reach, outreach, and joint working to support engagement.

CAMHS collect data to enable them and commissioners to identify and address any inequalities as they arise e.g. under-representation of specific groups accessing services

5.3.2 Priority Actions

Sunderland locality is continuing to develop a more integrated approach and joint working between partner organisations to ensure better engagement with CYP and their families. In particular those CYP who find services difficult to access

Promote more effective working between CAMHS and other services for vulnerable children.

5.4 **To be accountable and transparent – self assessment sections 30-39**

5.4.1 Current Position

Sunderland has a well-established model of joint commissioning to support the implementation of agreed CAMHS strategic priorities based upon assessment of need.

The CCG lead on the commissioning of CAMH Services on behalf of the CAMHS partnership which has recently refreshed the Mental Health and Emotional Well Being Strategy for Sunderland to reflect National Policy and Guidance including Future in Mind document published by DoH and NHS England in 2015

The partnership reports to the Mental Health Programme Board and to the Health and Wellbeing Board via the CCG Chief Operating Officer. This will be reviewed as the Children and Young Peoples Strategic Partnership is re-established.

There has been extensive work across the NE to develop a complimentary model of inpatient and community services for children and young people

Services are commissioned in line with national standards in relation to access, waiting times and outcomes

CAMHS collect data in line with the national CAMHS minimum data set as well as CORC, IAPT and locally agreed data to inform service planning, commissioning and delivery

5.4.2 Priority Actions

The JSNA, H&W strategy and partnership arrangements need to be strengthened in relation to the health and wellbeing needs of CYP. This includes the establishment of a CYP strategic partnership and a refresh of the CYP Plan to include the mental health of children and young people

Ensure that developments to improve mental health outcomes for CYP and their families are considered within the CAMHS Partnership and are aligned to the strategy and transformational plan

Strengthen the membership of the CAMHS Partnership and more effectively engage with schools

Complete local financial mapping exercise detailing the current level of spend on mental health and emotional wellbeing across all partners including public health, education, social care and youth justice This will support a transparent, coherent approach to future funding decisions

Further develop collaborative working between local and specialist commissioning and in-patient and community services to ensure continuity of care

The commissioning of all services for children and young people should include the requirement to provide an agreed data set to demonstrate service impact on mental health outcomes for children, young people and their families

5.5 **Developing the workforce – self assessment sections 40-45**

5.5.1 Current Position

Sunderland CAMH Services have recently completed CYPS IAPT Transformation Programme.

CAMHS are commissioned to provide a significant amount of training in evidenced based approaches to universal, targeted and specialist services for children, young people and their families.

CAMHS Commissioner has completed National CAMHS Leadership Programme

5.5.2 Proposed Action

Audit current mental health training provided across the locality.

Produce an educational framework to ensure the delivery of high quality, evidence based training and the most effective and efficient use of training resource across the City

6. Summary

6.1 The planning, commissioning and delivery of services to improve mental health and emotional wellbeing outcomes for children and young people needs to be an integral part of wider partnership planning of integrated delivery of services for children and young people.

6.2 Sunderland has a broad range of commissioned services to meet the needs of children with mental health problems however there is increasing referral pressure on these services.

6.3 Some priority needs to be given to developing services to support peri-natal mental health and working with universal and targeted service providers to promote mental health and emotional well being and deliver support and intervention to children, young people and families with mild to moderate levels of mental health need – Proposed priority area

6.4 CCAMH and CYP service should continue to work pro-actively to continue to reduce waiting times and improve access to services as agreed with commissioners - – Proposed priority area

6.5 CAMHS Partnership should continue to support the implementation of evidence based interventions with particular consideration given to the potential impact of mindfulness in increasing resilience and supporting mental health – Proposed priority area

6.6 The development of mental health lead role in schools (and in other services for children and young people) alongside identified CAMHS practitioners to link with schools, GP's and targeted service providers needs to continue to be developed – Proposed priority area

6.7 Pathways to support children with special educational needs and disabilities need to continue to be developed with CAMH services including diagnostic and intervention pathways for Autistic Spectrum Disorder- Proposed priority area

6.8 Innovative models of integrated multi-disciplinary support for children with complex behavioural, mental health and social care needs that include children and young people with challenging behaviours to be developed to multi-systemic / wrap around services for children and young people children as an alternative to specialist placements-Proposed priority area

7.1 Recommendations

Members are asked to:

7.1.1. Consider the contents of this report

7.1.2. Approve proposed process to produce the CAMHS Transformational Plan as detailed in Section 3.2.2

7.1.3. Agree to receive regular progress updates

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Sponsor: Debbie Burnicle, Deputy Chief Officer, NHS Sunderland Clinical Commissioning Group

8th September 2015

NHS
East Midlands Strategic Clinical Network

Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing

Self Assessment Tool: This self assessment tool was developed by Associate Development Solutions to enable organisations to assess readiness to meet the recommendations laid out in the 'Future in mind' document published by Department of Health and NHS England in 2015.

Name of Organisation: **Example Self Assessment**

Contents (by tab):

Background Info:	Lists all summary actions from the 'Future in mind' document and aligns them with their associated sections from within the document
Self-Assessment:	This is the section that organisations populate with your perceived readiness to address the recommendations of the 'Future in mind' report* **Although not all recommendations made within the report are aimed directly at the organisations using this assessment tool, they will all impact the organisation in some manner were they to be agreed or actioned. Where this is the case, it is the intention of this document for organisations to determine their ability or readiness to respond once these recommendations were to be acted upon.*
Readiness_Sort:	Sorts all recommendations and sub-recommendations by the organisations determined readiness to address
Task Rating_Sort:	Sorts all recommendations and sub-recommendations by the combined size and complexity of each task as determined by the organisation
Graphs:	Provides a high level graphical representation of the organisations current position

associate development **solutions**

Current or Future	ACTION
	Resilience, prevention and early intervention for the mental wellbeing of children
Current	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.
Current	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.
Current	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.

Future	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidencebased programmes of intervention and support.
Future	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers.
Current	**Improving access to effective support – chapter 5 summary**
Current	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.
Current	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.
Current	8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.

Current	9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.
Current	10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).
Current	11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.
Current	12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.
Current	13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
Current	14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.
Current	15. Promoting implementation of best practice in transition, including ending arbitrary cutoff dates based on a particular age.

Future	16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.
Future	17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.
Future	18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.
Future	19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.
Current	**Caring for the most vulnerable – chapter 6 summary**

Current	20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.
Current	21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.
Current	22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.
Current	23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.
Current	24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.
Current	25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.
Current	26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.
Future	27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.

Future	28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.
Future	29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.
Current	**To be accountable and transparent – chapter 7 summary**
Current	30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.
Current	31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.

Current	32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.
Current	33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions
Current	34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.
Current	35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.
Current	36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.
Current	37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.
Current	38. Making the investment of those who commission children and young people's mental health services fully transparent.
Future	39. Committing to a prevalence survey being repeated every five years.
Current	**Developing the workforce – chapter 8 summary**

Current	40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments
Current	41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.
Current	42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.
Future	43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.
Future	44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.
Future	45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.
	Making Change Happen – chapter 9 summary
Current	46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.

Current	47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.
Current	48. Enabling more areas to accelerate service transformation.
Future	49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.

Associated Paragraph in 'Future in Mind'
and young people
Current action to improve early support for parents, carers and children from birth (1 and 4) • The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support. • The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician. • The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives. • Public Health England is publishing an update of the evidence base for the Healthy Child Programme37 (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s). • Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem. • In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to
4.15 We encourage all schools (including those in the independent sector) to continue to develop whole school approaches to promoting mental health and wellbeing (2). This will build on the Department for Education's current work on character building, PSHE and counselling services in schools (see box for details). The named mental health lead for schools proposed in chapter five would also make an important contribution to leading and developing whole school approaches.
4.19 To this end, the Taskforce proposed there could be a major national branded social marketing campaign with a mechanism for dialogue so it is a genuine two-way conversation – driven by children, young people, parents and carers (3). Options include building on the Time to Change campaign (www.time-to-change.org.uk/youngpeople) as well as looking for opportunities to address mental health and wellbeing issues with the Public Health England Rise Above44 campaign.

Current action to improve early support for parents, carers and children from birth (1 and 4)

• The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.

• The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician.

• The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College
of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.

• Public Health England is publishing an update of the evidence base for the Healthy Child Programme37 (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s).

• Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.

• In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to

4.24 We propose that the Government asks the National Information Board to work in close partnership with the Government Digital Service and young people themselves to develop a single framework for harnessing the power of digital technology and protecting young people from mental harm (5). Within this framework, we propose that Government considers incentivising the development of new apps and digital tools; and also whether there is a need for some form of kite-marking scheme based on research evidence to guide

Models could and should be different in different types of locality; for example, a model which works well in rural Devon may fail to meet need if applied in inner-Manchester, and vice versa. This is why we have not dictated the local offer but been clear about the national ambition (6).

There is a pressing need to develop these approaches more widely (7 and 16). Common features of a single point of access system include:

• One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.

• Initial risk assessment to ensure children and young people at high risk are seen as a priority.

• Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).

• Young people and parents are able to self-refer into the single point of access.

Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stopshop services, based in the community (7 and 16).

Create an expectation that there is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices (8 and 16). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers. ii. Create an expectation that there should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (8 and 16). This individual would make an important contribution to leading and developing whole school approaches.

Develop a joint training programme for named individuals in schools and mental health services to ensure shared understanding and support effective communications and referrals (9).
Ensuring there is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND) (10). This should be matched by involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)
Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with. It is proposed that further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider
For children and young people experiencing mental health crisis, it is essential that they receive appropriate support/intervention as outlined in the Crisis Care Concordat, including an out-of-hours mental health service (12). The challenge of supporting a child or young person in a crisis includes ensuring that there is a swift and comprehensive assessment of the nature of the crisis. There are examples around the country of dedicated home treatment teams for children and young people, but these are not universally available. Some children and young people end up in A&E, where access to appropriate and timely psychiatric liaison from specialist child and adolescent mental health services is not always available. Some are placed (not always appropriately) on paediatric or general adult hospital wards. The national development of all-age liaison psychiatry services in A&E Departments with targeted investment over this and the next financial year, as set out in the joint Department of Health and NHS England publication, Achieving Better Access to Mental Health Services by 2020, should mean that appropriate mental health support in A&E is more readily
There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision. This can provide clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care (13).
This work (response to Bubb report) will involve people with learning disabilities and their families and include: • robust admission gateway processes for those with learning difficulties; • a challenge process to check that there is no alternative to admission; and • the agreement of a discharge plan on admission.
The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care. (15)

5.6 Therefore, at the heart of any good local system should be cross-sector agreement to ensure clarity in respect of how services are accessed. Many areas are already using a single point of access to targeted and specialist mental health services through a multi-agency 'triage' approach, including areas working within the CYP IAPT programme such as Liverpool. There is a pressing need to develop these approaches more widely (7 and 16). Common features of a single point of access system include:

• One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice,
consultation, assessment and onward referral.

• Initial risk assessment to ensure children and young people at high risk are seen as a priority.

• Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).

• Young people and parents are able to self-refer into the single point of access.

5.7 We propose the following to improve communication and access:

i. Create an expectation that there is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices (8 and 16). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers.

ii. Create an expectation that there should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (8 and 16). This individual would make an important contribution to leading and developing whole school approaches.

iv. Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop shop

5.8 NHS England has committed to developing access and waiting time standards in mental health. By 2020, the aim would be to provide a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services. This applies to children and young people who will benefit in
the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. It is important that children and young people are taken fully into account as further access and waiting time standards are considered, subject to resource availability. Careful consideration will need to be given to which conditions are prioritised, working with experts, services and commissioners and building on

5.13 As we established in the previous chapter, children and young people and many parents and carers are digitally literate and told us they wanted better and more use made of the web. This could be expressed in a number of ways, but must be informed by the views and preferences of children and young people to be effective. The Taskforce believes a future government should look at options enabling children, young people, parents and carers to access high quality and reliable online information and support. One such option could be a national branded web based portal established using NHS Choices, in line with the recently published National Information Board framework. (18) It could build on the successful MindEd website (www.minded.org.uk) aimed at professionals to provide national information about mental health and wellbeing in an engaging and reliable format. The NHS Choices content on adult mental health should link to the children and young people equivalent – the Youth Wellbeing Directory (youthwellbeingdirectory. com)

5.17 For some children and young people, their route into specialist services is more extreme and is through detention by the police, under Section 136 of the Mental Health Act. Those who exhibit such distress and risk to themselves or others that a section 136 detention becomes warranted will need further support, which may not be purely from mental health services. There is broad support for legislating to ensure that no child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.(19) It is also important to develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning. CQC should be asked to carry out routine assessments of places of

Not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up (this can apply to all children and young people – see also paragraph 5.10) (20).
Some children, young people and families find the formal setting of a clinic offputting and are unwilling to attend. This can lead to them saying that they do not wish to be referred or not turning up – particularly for some highly vulnerable groups, such as those involved with gangs or those who have been sexually exploited. As a consequence, some services experience high rates of children, young people and families not attending appointments. It is important that services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer (see also paragraph 6.2). It may be necessary

There is a clear need for appropriate and bespoke care pathways that incorporate new models of providing effective, evidence based interventions to vulnerable children and young people to provide a social and clinical response to meeting their needs (21).
6.17 Whilst the health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes (21).

The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern (22)

Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse. For young people aged 16 and above, as part of the Government's response to the concerns arising about child sexual exploitation, routine enquiry in line with NICE guidelines63 (whereby every young person is asked during the mental health assessment about violence and

Those children and young people who have been sexually abused and/or exploited should receive a comprehensive specialist initial assessment, and referral to appropriate services providing evidence-based interventions according to their need. There will be a smaller group who are suffering from a mental health disorder, who would benefit from referral to a specialist mental health service (24).

Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs which should be used more extensively to identify those at high risk who would benefit from referral at an earlier stage (25).

Children and young people in vulnerable groups are amongst the most complex seen in specialist services. Systems such as appointing a lead professional through a Common Assessment Framework (CAF), Team Around the Child or Family, or the Care Programme Approach (for those with severe mental health problems) already exist in many places. For some, the consistent application of these needs to be improved – particularly for vulnerable children and young people with complex needs who require care that is well-planned and coordinated with information shared effectively. A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way (26). This role could be allocated through a number of multi-agency processes, including the CAF or Team Around the Child or Family

6.7 Enhanced training for staff working with children and young people would lead to greater professional awareness of the impact of trauma, abuse or neglect on mental health (27). This should be coupled with effective treatment

6.9 Applying an approach whereby specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties is already best practice in some areas, for some very specific and highly vulnerable groups. Consultation and liaison teams can be used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved. These services would offer advice, troubleshooting, formal consultation and care planning, or assessment and intervention in cases where this is required above and beyond the level of existing cross-agency provision (including specialist services). There would need to be an identified specialist point of reference, including a senior clinician with specific expertise within mental health services. The roll-out of such teams could be piloted

6.10 Young people who are amongst the most excluded from society, such as those involved in gangs, those who are homeless and/or looked-after children, need support from people they trust. This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel **(29)**. The embedded worker can develop a relationship with the young people through youth-led activities so that they are then able to respond as a familiar, trusted adult as the need arises, working with more specialist or intensive services as required. They can also impart basic mental health skills to frontline staff. This approach has been successfully developed by MAC-UK's INTEGRATE model (see www.mac-uk.org) which also incorporates the necessary governance structures essential for success. INTEGRATE requires a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across

7.6 There was strong support from many members of the Taskforce to make it a requirement at the local level for there to be a lead accountable commissioning body to co-ordinate commissioning and the implementation of evidenced-based care (30). Many members of the Taskforce also favour the creation of a single, separately identifiable budget for children's mental health services. These proposals build on the learning from those areas which are already jointly commissioning children's mental health services between Clinical Commissioning Groups and local authorities, in some cases with pooled budgets. We envisage in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements

7.8 The work of the lead commissioner should be based upon an agreed local plan for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/ carers (30). The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health. Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing. As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of

7.9 Key drivers for the quality of any local offer should be the local Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The JSNA should address children and young people's health and wellbeing, including mental health (31). Health and Wellbeing Boards, supported by the local government-led health and wellbeing system improvement programme and Public Health England, should ensure that both the JSNA and the Joint Health and Wellbeing Strategy address children and young people's mental health needs effectively and comprehensively.

7.12 There is a particular need to coordinate the commissioning of community health and inpatient services (32). Within the current statutory system, the former is the responsibility of local commissioners and the latter the responsibility of the national commissioner, NHS England. If we are serious about moving away from a tiered model, then this commissioning needs to be joined up. This need for co-commissioning has been recognised by NHS England. At the same time, however, we want to avoid the mistakes of the past where we ended up with a patchwork quilt of intensive community crisis support and inpatient services.

7.13 The National Institute for Health and Care Excellence has a crucial role to play in framing a national ambition through the development of Quality Standards as well as guidance for health and social care, which are commissioned by the Secretaries of State for Health and Education (33). The quality standards will need to describe cost-effective evidence-based practice. They should provide clear descriptions of high priority areas for quality improvement. They will help organisations by supporting comparison of current performance, using measures of best practice to identify priorities for improvement. Though not mandatory, they are an important driver for change in the new arrangements for commissioning and service delivery in health and social care. It would be helpful if their recommendations could include further advice regarding

7.14 In supporting implementation and delivery of high quality care, we consider that CQC and Ofsted – with their distinct roles and responsibilities in health and education – should develop a joint cross inspectorate view of how the health, education and social care systems are working together to improve children and young people's mental health outcomes and how this area should be monitored in future (34).

7.15 [part] Measurement is crucial to support continuous improvement. Support and services should be based on high quality, accurate data, but there are significant gaps in relation to children's mental health. The last children and young people's mental health prevalence survey was done over a decade ago, although the Department of Health has just started the process of commissioning the next one (35).
7.17 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidencebased interventions to support evaluation of the effectiveness of the care commissioned (35). To build on this work, it is important that routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-

7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (36 and 37).

7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (36 and 37).

7.16 At the same time, levels of investment in mental health services for children and young people should be transparent. Accurate information on current levels of spend on children's mental health across agencies is a key gap. NHS England is working to improve the quality of data on adult mental health spend from April 2015 so that it will be able to identify the overall spend in primary and community care as well as mental health services and specialist commissioning. This has been built into the NHS planning process at CCG level. We propose that, in the future, this activity is extended to cover children's mental health spend by the NHS. It is also proposed that further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment (38).

We propose the commissioning of a regular prevalence survey of child and adolescent mental health every 5 years, giving particular consideration to including under-5s and ages over 15 (39).

8.3 Professionals across health, education and social care services need to feel confident to promote good mental health and wellbeing and identify problems early, and this needs to be reflected in initial training and continuing professional development across a range of professions (40).
Professionals need to be trained to be able to:
• Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.
• Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.
• Identify mental health problems early in children and young people.
• Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.
• Refer appropriately to more targeted and specialist support.
• Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.

For schools, the Carter Review of Initial Teacher Training (ITT) reported in January. It recommended commissioning a sector body to produce a framework of core content for ITT which would include child and adolescent development (41)

8.17 Traditionally, especially in the NHS, investment in training has focused on the provision of services. There is, however, no recognised standard training programme for commissioners of children's services or mental health services for children and young people. The recent mental health commissioning and leadership programme developed by NHS England and Academic Health Science Networks is organised around the principles of: data for commissioning, the use of the evidence base and leadership. All programmes include a module on child and adolescent mental health provision, and attendance at these accredited courses should be a requirement for all those working in commissioning of children and young

8.10 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum. All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability. This was considered in detail by the Vulnerable Groups and Inequalities Task and Finish Group. In addition, there are skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE. The CYP IAPT programme was commissioned with a modest budget to deliver training for a limited range of therapies to a prescribed group as a part of its transformation role. There are gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings. Counsellors working in schools and the community have asked for further training to improve evidence-based care (43).

The CYP IAPT programme currently works with partnerships covering 68% of the 0-19 population. The Service Transformation programme includes training for existing service leaders, supervisors and therapists in the NHS, social care and voluntary sector in a range of evidence-based programmes, with a Mandate commitment for both Health Education England and NHS England to plan further roll-out (44).

8.16 It is proposed that the Department of Health and Department for Education should work together with HEE, the Chief Social Worker for children and others, to design and commission a census and needs assessment of the current workforce working across the NHS, local authorities, voluntary sectors and independent sector as the first stage in determining a comprehensive cross-sector workforce and training

9.8 This will require local leadership and ownership. We therefore propose the development and agreement of Transformation Plans for Children and Young People's Mental Health and Wellbeing which will clearly articulate the local offer (46). These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well

9.14 The transformation of our national and local approach to children and young people's mental health and wellbeing will take time, at least the period of the next Parliament, aligning with the timescales of the Five Year Forward View. Change at the national level will need co-ordination across policy, investment, commissioning, regulation, training and inspection. Local areas will need ongoing support and guidance. It represents a complex and difficult journey and it will need strong political will combined with senior level leadership to see it through and be successful. Our closing proposal is therefore that there should be some clear governance at the national level to oversee the transformation of children's mental health with clear
9.12 At the same time, NHS England and the Department of Health have recently invited proposals from CCGs to lead and accelerate co-commissioning arrangements for children and young people's mental health. The national response to this invitation was hugely encouraging and indicative of the potential to be harnessed by this report. Although only a limited number of areas could be chosen, as these projects develop, they will provide good examples of what can be achieved, alongside other relevant initiatives such as the Social Care Innovation Fund and the Department for Education's Voluntary and Community Sector
9.3 If we are continuously to improve the mental health care and wellbeing of children and young people, we need data and evidence with which to do so (49). Good information is the foundation for commissioning; to understand need, to plan, secure and monitor services. In some areas, evidence is weak or entirely lacking as to the best interventions. Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers' money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation.

	Example Self Assessment	Readiness Rating:	Complexity:	Size:	Rat
	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.	2. Partially Implemented	3. Medium	3. Medium	9
	1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.	2. Partially Implemented	3. Medium	3. Medium	9
	1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.	2. Partially Implemented	2. Simple	2. Small	4
	1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.				0
	1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents				0
	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.	2. Partially Implemented	4. Complex	5. Very Large	20
	2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.				0
	2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.				0
	2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.				0
	2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.	2. Partially Implemented	3. Medium	3. Medium	9
	2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.				0
	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.	2. Partially Implemented	3. Medium	4. Large	12
	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.	2. Partially Implemented	3. Medium	4. Large	12
	4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.				0
	4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.				0
	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.				0
	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.	2. Partially Implemented	3. Medium	3. Medium	9
	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.	2. Partially Implemented	4. Complex	4. Large	16
	7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.	2. Partially Implemented	3. Medium	3. Medium	9
	7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.	1. Fully Implemented	*n/a*	*n/a*	0

	7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).	2. Partially Implemented	3. Medium	3. Medium	9
	7.4 Young people and parents are able to self-refer into the single point of access.	2. Partially Implemented	2. Simple	2. Small	4
	7.5 Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop shop services, based in the community .	2. Partially Implemented	3. Medium	3. Medium	9
	8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.	2. Partially Implemented	4. Complex	5. Very Large	20
	8.1 There is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices.	2. Partially Implemented	2. Simple	2. Small	4
	8.2 There should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals.	2. Partially Implemented	2. Simple	2. Small	4
	9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	2. Partially Implemented	4. Complex	4. Large	16
	10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).	2. Partially Implemented	3. Medium	4. Large	12
	10.1 There is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND)	1. Fully Implemented	2. Simple	2. Small	4
	10.2 There should be involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)	2. Partially Implemented	3. Medium	3. Medium	9
	11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.	3. Changes Agreed but Not Started	3. Medium	3. Medium	9
	11.1 Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with	2. Partially Implemented	3. Medium	3. Medium	9
	11.2 Further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision.	3. Changes Agreed but Not Started	2. Simple	3. Medium	6
	12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.	2. Partially Implemented			0
	12.1 CYP experiencing mental health crisis receive appropriate support/intervention as outlined in the Crisis Care Concordat	2. Partially Implemented	3. Medium	2. Small	6
	12.2 There is an out-of-hours mental health service available for children and young people experiencing mental health crisis	1. Fully Implemented	*n/a*	*n/a*	0
	12.3 Supporting a CYP in a crisis includes a swift and comprehensive assessment of the nature of the crisis.	2. Partially Implemented	2. Simple	2. Small	4
	12.4 There are dedicated home treatment teams for children and young people.	1. Fully Implemented	*n/a*	*n/a*	0
	12.5 The national development of all-age liaison psychiatry services in A&E Departments should mean that appropriate mental health support in A&E is more readily available.	2. Partially Implemented	2. Simple	2. Small	4
	13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.	2. Partially Implemented	3. Medium	3. Medium	9
	13.1 There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision.	2. Partially Implemented	2. Simple	3. Medium	6
	13.2 This are clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care	2. Partially Implemented	3. Medium	2. Small	6
	14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.	2. Partially Implemented	2. Simple	2. Small	4
	14.1 There is a robust admission gateway processes for CYP with learning difficulties	1. Fully Implemented	*n/a*	*n/a*	0
	14.2 There is a challenge process that checks that there is no alternative to admission for CYP with learning disabilities and/or challenging behaviour.	2. Partially Implemented	2. Simple	2. Small	4

	14.3 The creation of an agreed discharge plan on admission for CYP with learning disabilities and/or challenging behaviour is standard practice.	2. Partially Implemented	2. Simple	2. Small	**4**

Example Self Assessment

Readiness Rating: **Complexity:** **Size:**

Resilience, prevention and early intervention for the mental wellbeing of children and young people

Our aim is to act early to prevent harm, by investing in the early years, supporting families and those who care for children and building resilience through to adulthood. Strategies should be developed in partnership with children and young people to support self-care. This will reduce the burden of mental and physical ill health over the whole life course.

Readiness Rating: **Complexity:** **Size:**

	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.			
	1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.			
	1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.			
	1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.			
	1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents			
	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.			
	2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.			
	2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.			
	2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.			
	2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.			
	2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.			
	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.			
	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.			

	4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.			
	4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.			
	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

Improving access to effective support – chapter 5 summary

Our aim is to change how care is delivered and build it around the needs of children and young people and families. This means moving away from a system of care defined in terms of the services organisations provide to ensure that children and young people have easy access to the right support from the right service at the right time.

		Readiness Rating:	**Complexity:**	**Size:**
	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.			
	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.			
	7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.			
	7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.			
	7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).			
	7.4 Young people and parents are able to self-refer into the single point of access.			
	7.5 Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop shop services, based in the community .			
	8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.			
	8.1 There is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices.			
	8.2 There should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals.			
	9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.			
	10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).			

	10.1 There is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND)			
	10.2 There should be involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)			
	11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.			
	11.1 Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with			
	11.2 Further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision.			
	12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.			
	12.1 CYP experiencing mental health crisis receive appropriate support/intervention as outlined in the Crisis Care Concordat			
	12.2 There is an out-of-hours mental health service available for children and young people experiencing mental health crisis			
	12.3 Supporting a CYP in a crisis includes a swift and comprehensive assessment of the nature of the crisis.			
	12.4 There are dedicated home treatment teams for children and young people.			
	12.5 The national development of all-age liaison psychiatry services in A&E Departments should mean that appropriate mental health support in A&E is more readily available.			
	13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.			
	13.1 There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision.			
	13.2 This are clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care			
	14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.			
	14.1 There is a robust admission gateway processes for CYP with learning difficulties			
	14.2 There is a challenge process that checks that there is no alternative to admission for CYP with learning disabilities and/or challenging behaviour.			
	14.3 The creation of an agreed discharge plan on admission for CYP with learning disabilities and/or challenging behaviour is standard practice.			
	15. Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.			
	15.1 There is flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care.			

	16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.			
	17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.			
	18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.			
	19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.			
	19.1 No child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.			
	19.2 Develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning.			
	19.3 CQC should carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.			

Supporting Information:

Theme Readiness Rating:

#N/A

Caring for the most vulnerable – chapter 6 summary

Current service constructs present barriers making it difficult for many vulnerable children, young people and those who care for them to get the support they need. Our aim is to dismantle these barriers and reach out to children and young people in need.

		Readiness Rating:	**Complexity:**	**Size:**
	20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.			
	20.1 Not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up			
	20.2 Services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer			
	20.3 It may be necessary to find alternative ways to engage the child, young person or family.			
	21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.			
	21.1 Health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes			
	22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.			

	23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.			
	24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.			
	25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.			
	26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.			
	26.1 A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way.			
	27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.			
	28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.			
	28.1 Specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties.			
	28.2 Consultation and liaison teams are used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved above and beyond the level of existing cross-agency provision (including specialist services).			
	28.3 There is an identified specialist point of reference, including a senior clinician with specific expertise within mental health services.			
	29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.			
	29.1 This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel. This model shall incorporate the necessary governance structures essential for success.			
	29.2 Develop a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across the team members.			

Supporting Information: **Theme Readiness Rating:**

	#N/A

To be accountable and transparent – chapter 7 summary

Far too often, a lack of accountability and transparency defeats the best of intention and hides the need for action in a fog of uncertainty. Our aim is to drive improvements in the delivery of care, and standards of performance to ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.

		Readiness Rating:	Complexity:	Size:
	30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.			
	30.1 There is a lead accountable commissioning body to co-ordinate commissioning and the implementation of evidenced-based care.			
	30.2 There is a single, separately identifiable budget for children's mental health services.			
	30.3 The work of the lead commissioner should be based upon an agreed local plan for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/ carers.			
	30.4 The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health.			
	30.5 Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing.			
	30.6 As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children's Partnership Boards.			
	31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.			
	32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.			
	33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions			
	34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.			
	34.1 CQC and Ofsted should develop a joint cross inspectorate view of how the health, education and social care systems are working together to improve children and young people's mental health outcomes and how this area should be monitored in future (34).			
	35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.			
	35.1 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidence based interventions to support evaluation of the effectiveness of the care commissioned (35).			
	35.2 Routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.			

	36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.			
	36.1 The introduction of the first ever waiting time standards in respect of early intervention in psychosis.			
	36.2 Access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes.			
	37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.			
	38. Making the investment of those who commission children and young people's mental health services fully transparent.			
	38.1 NHS England will be able to identify the overall children's mental health spend by the NHS.			
	38.2 Further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment.			
	39. Committing to a prevalence survey being repeated every five years.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

Developing the workforce – chapter 8 summary

It is our aim that everyone who works with children, young people and their families is ambitious for every child and young person to achieve goals that are meaningful and achievable for them. They should be excellent in their practice and able to deliver the best evidenced care, be committed to partnership and integrated working with children, young people, families and their fellow professionals and be respected and valued as professionals themselves.

		Readiness Rating:	**Complexity:**	**Size:**
	40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments			
	40.1 Professionals trained to be able to: Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.			
	40.2 Professionals trained to: Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.			
	40.3 Professionals trained to be able to: Identify mental health problems early in children and young people.			
	40.4 Professionals trained to be able to: Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.			
	40.5 Professionals trained to be able to: Refer appropriately to more targeted and specialist support.			
	40.6 Professionals trained to be able to: Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.			
	40.7 Professionals trained to be able to: Work in a digital environment with young people who are using online channels to access help and support.			

	41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.			
	42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.			
	42.1 Attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people's services			
	43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.			
	43.1 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum.			
	43.2 All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability.			
	43.3 Skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE shall be addressed.			
	43.4 Skills gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings shall be addressed.			
	43.5 Counsellors working in schools and the community will receive further training to improve evidence-based care			
	44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.			
	45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

	Making Change Happen – chapter 9 summary	**Readiness Rating:**	**Complexity:**	**Size:**
	46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.			
	46.1 Develop agreed Transformation Plans for Children and Young People's Mental Health and Wellbeing which will clearly articulate the local offer. These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.			
	47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.			
	48. Enabling more areas to accelerate service transformation.			
	49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

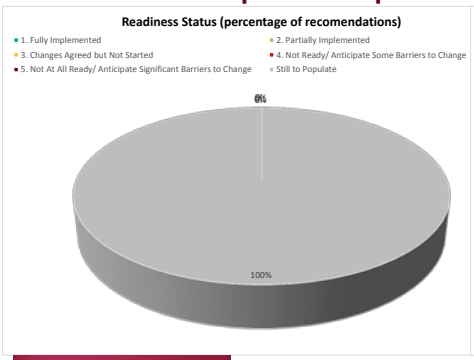
	Example Self Assessment	Complexity:	Size:	Rat
	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.			0
	1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.			0
	1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.			0
	1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.			0
	1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents			0
	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.			0
	2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.			0
	2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.			0
	2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.			0
	2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.			0
	2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.			0
	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.			0
	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.			0
	4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.			0
	4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.			0

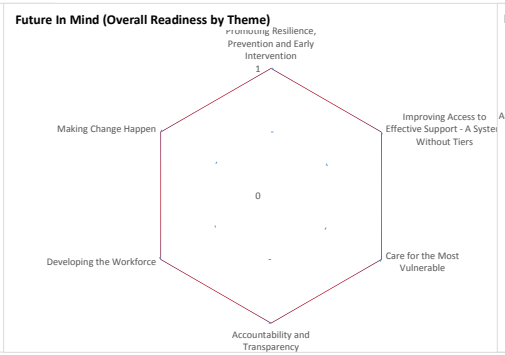
	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.			**0**
	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.			**0**
	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.			**0**
	7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.			**0**
	7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.			**0**
	7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).			**0**
	7.4 Young people and parents are able to self-refer into the single point of access.			**0**
	7.5 Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop shop services, based in the community .			**0**
	8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.			**0**
	8.1 There is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices.			**0**
	8.2 There should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals.			**0**
	9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.			**0**
	10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).			**0**
	10.1 There is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND)			**0**
	10.2 There should be involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)			**0**
	11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.			**0**
	11.1 Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with			**0**
	11.2 Further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision.			**0**
	12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.			**0**

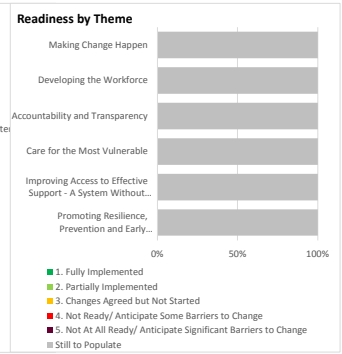
	12.1 CYP experiencing mental health crisis receive appropriate support/intervention as outlined in the Crisis Care Concordat			0
	12.2 There is an out-of-hours mental health service available for children and young people experiencing mental health crisis			0
	12.3 Supporting a CYP in a crisis includes a swift and comprehensive assessment of the nature of the crisis.			0
	12.4 There are dedicated home treatment teams for children and young people.			0
	12.5 The national development of all-age liaison psychiatry services in A&E Departments should mean that appropriate mental health support in A&E is more readily available.			0
	13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.			0
	13.1 There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision.			0
	13.2 This are clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care			0
	14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.			0
	14.1 There is a robust admission gateway processes for CYP with learning difficulties			0
	14.2 There is a challenge process that checks that there is no alternative to admission for CYP with learning disabilities and/or challenging behaviour.			0
	14.3 The creation of an agreed discharge plan on admission for CYP with learning disabilities and/or challenging behaviour is standard practice.			0

Graphs: Example Self Assessment

10/09/2015







Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

SMOKEFREE PLAY AREAS

Report of the Sunderland Tobacco Alliance

1. Purpose of the Report

To update the Health and Wellbeing Board on smokefree play areas in Sunderland and present members with the rationale for these proposed changes and feedback from a consultation exercise.

2. Background

Although there has been a legal ban on smoking in all enclosed public places in the UK since July 2007, there is no legal basis to formally ban smoking in open public areas. The Government's Tobacco Control Plan for England published in March 2011 states; "Local communities and organisations may also wish to go further than the requirements of smokefree laws in creating environments free from secondhand smoke, for example in children's play areas." Initiatives such as these can also help to shape positive social norms and discourage the use of tobacco, and reduce the likelihood of them becoming smokers in the future.

2.1 Rationale for Smokefree children's play areas in Sunderland

Smoking is a childhood addiction and most smokers in the North East start aged 15. Tobacco use is the leading cause of preventable death and disease and is the leading cause of health inequalities. Young people most at risk of becoming smokers themselves grow up in communities where smoking is the norm. Furthermore, exposure to secondhand smoke, particularly amongst children, can also lead to conditions including asthma, wheeze, chest and ear infections and, at its worst, cot death. Appendix one includes the evidence base.

One key action Sunderland City Council could take is to make children's outdoor play areas free from tobacco smoke. It is not intended that the smokefree play areas initiative is perceived as a smoking "ban". The scheme will be promoted as a polite request for adults to voluntarily refrain from smoking in and around children's play areas and would bring about several benefits:

- Decreasing the opportunity for children to see adults smoking around them
- Creating an environment in which smoking is not seen as the norm thus potentially motivating smokers to cut down or to quit
- Protecting the environment and saving local authorities money by reducing tobacco-related litter
- Offering further protection from the harmful effects of secondhand smoke.

2.2 Public opinion in Sunderland

During August 2013 the Locality Public Health team in Sunderland carried out a survey of 347 local people in various parks across the borough to seek local views on whether 'Smoking should be banned in outdoor children's play areas in Sunderland'. 98% said that they agreed or strongly agreed with this statement indicating the very strong support for this position to be considered in Sunderland. (37% of those completing the survey were smokers or ex-smokers). Appendix two includes a detailed breakdown of findings)

2.3 Examples of implementation

There are now many examples of areas where smokefree play areas have been introduced. In this region, Gateshead Council, Durham County Council, Redcar and Cleveland Borough Council, Stockton Borough Council, Newcastle City Council Middlesbrough and Hartlepool Borough Council have all installed signs across each of their parks.

3. Recommendation

The Health and Wellbeing Board is recommended to support the voluntary code to make Sunderland children's play areas Smokefree

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Appendix One - Evidence Base

Making play areas smokefree decreases the opportunity for children to see adults smoking around them. Children are influenced by what they see, and young people are most at risk of becoming smokers themselves if they grow up in communities where smoking is the norm. The most effective way to prevent young people from becoming smokers is to encourage adult smokers to quit and to remove young people's exposure to smoking behaviours. Increasing the number of smokefree areas can have a positive effect on youth smoking rates: smokefree play areas are associated with lower levels of adolescent smoking[1].

Making tobacco use less acceptable plays a key role in motivating current smokers to cut down or to quit. A key aim of tobacco control is to change the social norms around tobacco use by creating a social and legal climate which challenges the perception that smoking is a normal and acceptable behaviour[2]. Making play areas smokefree will help to change community norms as part of broader tobacco control strategies.

Smokefree play areas will also offer further protection from the harmful effects of secondhand smoke. The effects of secondhand smoke indoors, and the need to protect people from it, are well-known and form the basis of England's smokefree legislation. But there is growing evidence that secondhand smoke outdoors can also cause harm[3].

Signs installed in parks to indicate there is a smokefree code in place can help people to challenge someone who lights up in a play area and can point those who want to quit to services that can help them. This is especially important for parents who smoke, as their children are more likely to start smoking than those of non-smoking parents[4].

If smoking no longer takes place in play areas it follows that there will a reduction in tobacco-related litter which will not only help to protect the environment but will mean that local authorities will need to spend fewer resources on cleaning up. Cigarette butts are the most common type of litter found in the UK[5]. According to an Environmental Campaigns study, tobacco-related litter was found in 78% of locations investigated, and the cost of clearing cigarette butts is estimated at £342 million each year.

Whilst the number of smokers in the borough is decreasing Sunderland's rate of early deaths caused by smoking remains significantly higher than the national average. Reducing the rates of illness and death caused by smoking remains one of Sunderland's key Public Health priorities. To achieve this objective there is a need to

[1] Wakefield MA Chaloupka FJ, Kaufman NJ, Orleans CT, Barker DC, Ruel EE (2000): "Effect of restrictions on smoking at home, at school and in public places on teenage smoking: cross sectional study", in British Medical Journal, 32 (7257): 333-337.
[2] http://www.ncbi.nlm.nih.gov/pubmed/20382647
[3] http://tobaccocontrol.bmj.com/content/22/3/172.abstract
[4] Leonardi-Bee, J, Lisa Jere, M, Britton, J (2011), "Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis", in Thorax International Journal of Respiratory Medicine, thorax.bmj.com/content/66/10/847.abstract
[5] http://www.policyexchange.org.uk/images/publications/cough%20up%20-%20march%2010.pdf

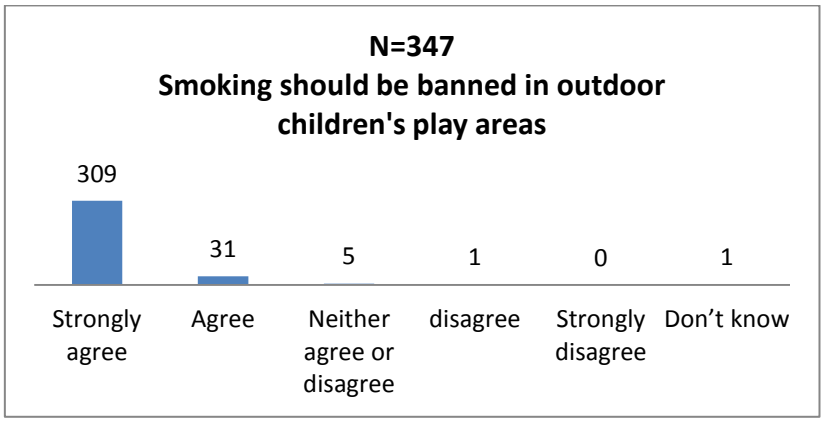
reduce the number of people who smoke. It can be notoriously difficult for existing smokers to stop, so it is critical that we help to reduce the numbers of people who start to smoke. This includes initiatives that help prevent children in Sunderland from becoming the next generation of smokers.

According to the Health Related Behaviour Survey in 2012, 98% of 8 to 10 year olds said they had never smoked at all, but 13% said they would smoke or maybe smoke when they are older, this rises to 19% in 12 to 15 year olds.

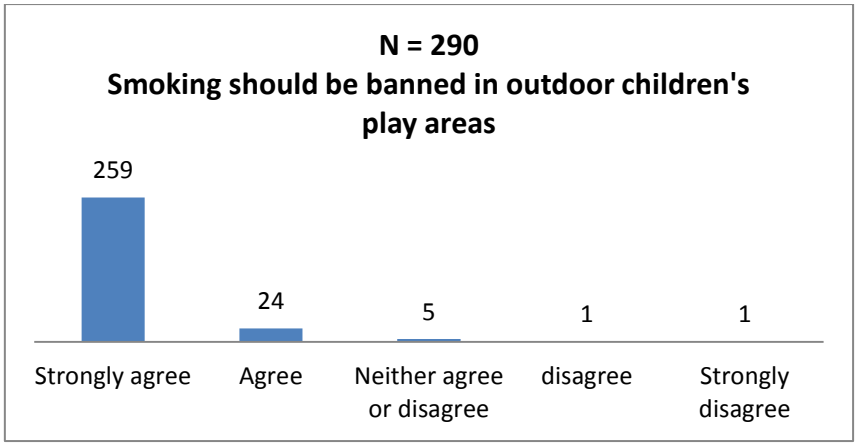
Appendix Two – Consultation

Smokefree Play Areas – Sunderland
During August 2013 the Locality Public Health team in Sunderland carried out a survey in various parks across the City to seek local views on whether 'Smoking should be banned in outdoor children's play areas in Sunderland'.

All Responses - Of the 347 responses collected 290 (84%) of them were residents of Sunderland. 98% said that they strongly agreed or agreed with the following statement '**Smoking should be banned in outdoor children's play areas in Sunderland'** indicating the very strong support. (37% of those completing the survey were either smokers or ex-smokers). Only 53% of these people had heard about either the smokefree homes or smokefree cars campaign.



Sunderland only responses - Of the 290 responses collected from Sunderland residents, 98% said that they strongly agreed or agreed with the following statement '**Smoking should be banned in outdoor children's play areas in Sunderland'** indicating the very strong support in Sunderland. (39% of those completing the survey were either smokers or ex-smokers). Only 54% of these people had heard about either the smokefree homes or smokefree cars campaign.



Summary
Our experience in Sunderland of talking to smokers on this issue suggests most smokers are very keen for their children not to start, and support initiatives such as smokefree play areas and smokefree cars. During August 2013 the locality Public

Health team in Sunderland carried out a survey of 347 local people in various parks across the borough to seek local views on whether ‘Smoking should be banned in outdoor children’s play areas in Sunderland’. 98% said that they agreed or strongly agreed with this statement indicating the very strong support for this position to be considered in Sunderland. (37% of those completing the survey were smokers or ex-smokers)

Item No. 10

SUNDERLAND HEALTH AND WELLBEING BOARD 18 September 2015

HEALTH AND WELLBEING BOARD FORWARD PLAN AND TIMETABLE

Report of the Head of Strategy and Policy

1. PURPOSE OF THE REPORT

To inform the Board of the forward plan and Board timetable.

2. FORWARD PLAN

Health and Wellbeing Board Agenda - Forward Plan 2015-16			
	Friday 18 September 2015	Friday 20 November 2015	Friday 15 January 2016
Standing Items	• Update from Advisory Groups • Health and Social Care Integration Board • Closed Board Sessions and Forward Plan	• Update from Advisory Groups • Health and Social Care Integration Board • Closed Board Sessions and Forward Plan	• Update from Advisory Groups • Health and Social Care Integration Board • Closed Board Sessions and Forward Plan
Joint Working	• Development of General Practice Strategy (DG) • Ofsted Inspection – Childrens Safeguarding (CM) • CAMHS Transformation Planning (JS) • Smoke Free Play Areas	• JSNA update from working group • Behaviour Change Pilots update (JH/KG/WH?) • Final GP Strategy for General Practice • Transforming Care for people with learning disabilities and/or autism – Fast Track (AC) • HWBB Priority Setting Update (VT/GG)	• Update on NHS National Planning Requirements
External			• Age Friendly Status Update

3. BOARD TIMETABLE

The Board timetable is attached for information.

The dates for future Board meetings are:

- Friday 20 November 2015
- Friday 15 January 2016
- Friday 11 March 2016

4. RECOMMENDATIONS

The Board is recommended to

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

SUNDERLAND HEALTH AND WELLBEING BOARD SCHEDULE 2015/16

Notification of Agenda items	Adults Partnership Board	Children's Trust	Provider Forum	Integration Board	Deadline For Board Papers (to KG)	Chairs Briefing	Publication Deadline	Members briefing	HWBB Meeting Date
20 April (Mon)	5 May 2015			Thursday 9 April 2015 Thursday 14 May 2015	18 May (Mon)	21 May	21 May (Thursday)	22 May (Friday)	Friday 29 May 2015
15 June (Mon)	7 July 2015		1st July	Thursday 25 June 2015 Thursday 23 July 2015	13 July (Mon)	14 July	16 July (Thursday)	17 July (Friday)	Friday 24 July 2015
10 August (Mon)	8 September 2015		25th Aug	Thursday 10 September 2015	7 September (Mon)	9 Sept	10 September (Thursday)	11 September (Friday)	Friday 18 September 2015
12 October (Mon)	10 November 2015		30th Oct	Thursday 15 October 2015 Thursday 12 Nov 2015	9 November (Mon)	10 Nov	12 November (Thursday)	13 November (Friday)	Friday 20 November 2015
7 Dec (Mon)	5 January 2016		15th Dec	Thursday 10 December 2015 Thursday 7 January 2016	4 January (Mon)	7 Jan	7 January (Thursday)	8 January (Friday)	Friday 15 January 2016
1 February (Mon)	1 March 2016		18th Feb	Thursday 4 February 2016 Thursday 3 March 2016	29 Feb (Mon)	1 March	3 March (Thursday)	4 March (Friday)	Friday 11 March 2016