# SUNDERLAND HEALTH AND WELLBEING BOARD

# AGENDA

## Meeting to be held in the Civic Centre (Committee Room No. 1) on Friday 25 July 2014 at 12.00noon

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




**Contact:** **Gillian Kelly, Principal Governance Services Officer Tel: 0191 561 1041**
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**Information contained within this agenda can be made available in other languages and formats.**

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|---|---|---|
| **9.** | **Care Act: The Local Response**<br><br>Report of the Executive Director of People Services (attached). | 107 |
| **10.** | **The Role of Pharmacies in Health**<br><br>Presentation by the Local Pharmaceutical Committee. | - |
| **11.** | **Adults Peer Challenge**<br><br>Report of the Executive Director of People Services (attached). | 133 |
| **12.** | **Health and Wellbeing Board Development Session and Forward Plan**<br><br>Report of the Head of Strategy, Policy and Performance Management (copy attached). | 141 |
| **13.** | **Date and Time of the Next Meeting**<br><br>The next meeting of the Board will be held on Friday 19 September 2014 at 12noon | |

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

16 July 2014

**Item No. 3**

# SUNDERLAND HEALTH AND WELLBEING BOARD

## Friday 16 May 2014

## MINUTES

**Present: -**

| | | |
|---|---|---|
| Councillor Mel Speding (in the Chair) | - | Sunderland City Council |
| Councillor Pat Smith | - | Sunderland City Council |
| Neil Revely | - | Executive Director of People Services |
| Dave Gallagher | - | Chief Officer, Sunderland CCG |
| Maureen Crawford | - | Director of Public Health |
| Kevin Morris | - | Healthwatch Sunderland |
| Christine Keen | - | NHS England Area Team |

**In Attendance:**

| | | |
|---|---|---|
| Councillor Steve Bonallie | - | Representing the Scrutiny Committee |
| Julie Walker | - | Gentoo |
| Karen Wilson | - | Pfizer |
| Andrew Swain | - | Pfizer |
| Karen Brown | - | Scrutiny Officer, Sunderland City Council |
| Karen Graham | - | Office of the Chief Executive, Sunderland City Council |
| Gillian Kelly | - | Governance Services, Sunderland City Council |

### HW63. Apologies

Apologies for absence were received from Councillors Kelly, Miller, Watson and Wiper and Ken Bremner, Dr Ian Pattison and Dr Gerry McBride.

### HW64. Declarations of Interest

There were no declarations of interest.

### HW65. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 21 March 2014 were agreed as a correct record subject to an amendment to the last paragraph on page nine to read: '…*Dave advised that these were procedures which were not going to have a positive impact on a person's condition*.'

## HW66. Feedback from Advisory Boards

### Adults Partnership Board

Councillor Speding informed the Board that the Adults Partnership Board had met on 13 May 2014 and the main issues considered had been: -

- Health and Wellbeing Board Agenda
- Integrated Wellness Model Update
- Affordable Warmth/ Fuel Poverty Update
- Better Care Fund Update
- Review of Adults Partnership Board – Terms of Reference and Membership

Kevin Morris asked if there had been any discussion around the Patient and Public Involvement Strategy when the Health and Wellbeing Board agenda was considered by the Board. Karen Graham advised that this had been brief because the full papers had not been available but the information would be provided to the Adults Partnership Board members after this meeting.

### Children's Trust

The Children's Trust had met on 8 May 2014 and the main issues considered had been: -

- Participation and Engagement Update
- Children and Young People's Plan Refresh
- Consultation on the Draft National Child Poverty Strategy 2014 – 2017
- Children's Trust Governance

Neil Revely commented that the Adults Partnership Board had also been looking at governance and it had been suggested that there was potential for some overlaps and joint working with the Children's Trust. Suggestions for how these boards could interface with other groups would also be welcome.

### NHS Provider Forum

Councillor Speding informed the Board that the NHS Provider Forum had met on 7 May 2014 and the main issues considered had been: -

- The Better Care Fund
- Provider Engagement
- Accelerated Solutions Event
- Six Monthly Broader Provider Engagement

Dave Gallagher informed the Board that the Accelerated Solutions Event would take place on 5 and 6 June. Expressions of interest had been requested and these would now be reviewed as there was a limited number who could attend and it was important to achieve a fair spread of interest groups. He asked that Members who had expressed an interest to keep the event in their diary.

Councillor Speding highlighted that six monthly provider engagement was always on the agenda for the Forum and Karen Graham had been asked to pull together a plan for a session in July.

Neil Revely commented that it was pleasing to see the specific mention of the voluntary and community sector in addition to the social care providers, as they would have a valuable contribution to make to the engagement session. Nonnie Crawford suggested that it might be worth considering an event at some stage with the broader health and wellbeing family rather than just health and social care.

Neil acknowledged that there was a broader group of contributors, not just providers to consider. Karen Graham added that the group had discussed voluntary and community sector providers and people who were already commissioned to provide services but would welcome suggestions on who else could be involved and ways of advertising the engagement sessions.

Kevin Morris asked if the Provider Forum would also be considering the Patient and Public Involvement Strategy and Christine Keen asked if the Forum had a work plan. Karen Graham advised that the Forum had discussed which topics and themes they wanted to look at which included the Better Care Fund, finance, the integration agenda, engagement and strategic planning. The group did not necessarily have a timetable for any of these matters.

Neil stated that groups needed to be aware of the potential for duplication of work and it was necessary to understand the responsibilities of each individual board. Councillor Speding commented that there was the opportunity to gain that understanding through the Accelerated Solutions Event.

Karen Graham advised that all of the advisory groups were looking at reviewing their systems and terms of reference and this would come back to the Health and Wellbeing Board for them to have ownership and oversight. It was planned to set out the relationship between the relevant boards and groups in a diagrammatic form and this would potentially be an item for a future agenda.

The Board RESOLVED that the information be noted.

**HW67. Update from the Integration and Transformation Board**

Neil Revely informed the Health and Wellbeing Board that the Integration and Transformation Board had been established as part of the transition to the Better Care Fund.

The Integration and Transformation Board had met on 30 April 2014 and the discussion had focused on the first steps towards integration. The Better Care Plan was in place but the Board were conscious that a good plan was not in itself sufficient and that they needed to move to make the plan happen.

The group were moving towards a vision of what an integrated commissioning team would look like and it was hoped that the Accelerated Solutions Event would

accelerate the thinking on this. Although the Better Care Fund would come on line on 1 April 2015, it was seen as a continually evolving process and it was intended to have as much of the mechanics as possible in place by then.

Dave Gallagher informed the Board that an event had been held at the Stadium of Light to consider the next stages of developing an integrated team. Finance leads had been commissioned to draw up examples of what this would look like in terms of pooled budgets and how it could operate.

Neil informed Members that the Health and Wellbeing Board would hold the Integration and Transformation Board to account for delivering the plans and would be implementing actions after the Accelerated Solutions Event.

Kevin Morris referred to Patient and Public Engagement Strategy and suggested that the strategy should be considered at the onset of any new arrangements. Dave stated that the public had very much set off this process and there would continue to be touch points throughout the transition.

RESOLVED that the update be noted.

**HW68. Policy Review 2013/2014: Patient and Public Engagement in Health Services**

The Public Health, Wellness and Culture Scrutiny Panel submitted a report to the Board outlining their work in investigating options for the coordination of engagement activities.

The Scrutiny Committee had been engaged to carry out this work, following the agreement of the Health Protocol, and had been investigating what organisations had been doing individually and how this could be brought together in a unified approach.

Based on the evidence of the Review, for the operation of a coordinated approach to Patient and Public Engagement and to support the Board in fulfilling its responsibility, the following principles were proposed: -

1. Patient and public engagement should is a strand of quality in its own right
2. Member organisations coordinate and jointly plan their resources for patient and public engagement
3. Engagement will be embedded with the Board's day to day activities
4. Meaningful engagement will be demonstrated through a range of approaches
5. Patient and public involvement activity will demonstrate it has made a difference
6. The effectiveness of patient and public engagement will be evaluated

The Scrutiny Committee had found that there was an extensive range of patient and public engagement and this could lead to confusion and that 'hard to reach' groups may be less successful at navigating complex public service or complaints processes.

The outcome of the review was a proposed framework for patient and public engagement and establishing a statement of intent to inform activity. In the future it was intended that the framework would support a co-ordinated approach to patient and public engagement by the whole local health economy so as to make the best use of available and existing resources.

Councillor Speding asked where the scrutiny function sat in relation to Healthwatch and Karen Brown stated that there was engagement with the public as part of scrutiny and they provided a check and balance for the Health and Wellbeing Board. The Scrutiny Committee was posing options to be borne in mind as matters moved forward, including a unified communication plan and noted that it was difficult to capture the evidence on making a difference.

Kevin Morris commented that it was about how information and feedback was collected and collated and at the moment, it did not seem that Healthwatch was receiving that information. Karen Brown highlighted that there was a huge amount of information in the system but it was very complicated with many routes in.

Nonnie Crawford said that it was a phenomenal aspiration to collate data in this way but it had to be considered what the reasons were for the patient and public engagement and how organisations would collate information around a theme or an activity. Kevin noted that it was difficult but this was no reason not to tackle it.

Dave Gallagher agreed with this and stated that it could be about feedback on existing services, looking at future services and different levels of strategic data. It was extremely complex but if it was joined together sensibly, it would be a great opportunity to get this right for the city of Sunderland.

Councillor Speding queried the difference between patient and public involvement and scrutiny and Karen Brown stated that the Health and Wellbeing Board had a responsibility to ensure that patient and public engagement informed their work.

Scrutiny was about understanding how things were done and how well they were being done. Neil Revely advised that there were a lot of facets to patient and public engagement, particularly to ensure that everything was being done to design principles and being embedded into the culture of health and wellbeing in Sunderland. There were still some statutory responsibilities for scrutiny in relation to health and these would be tested against the design principles of the Sunderland Health and Wellbeing Strategy.

Kevin Morris noted that the draft Framework would involve a considerable amount of work for Healthwatch and Karen Brown suggested that there needed to be some off line discussions with Healthwatch representatives on this. Dave Gallagher commented that the Council and the CCG would want to be involved in this as commissioners and that a collective set of words would be useful.

Councillor Bonallie informed the Board that he was there as a representative of the Scrutiny Committee who had considered the draft Framework in April and were now consulting on it. He was pleased to recommend the Framework to the Health and Wellbeing Board.

Having considered the report, the Board: -

RESOLVED that the draft Framework be adopted as an approach to coordinated patient and public engagement.

**HW69. Safeguarding Adults in Sunderland**

The Independent Chair of Sunderland Safeguarding Adults Board (SSAB) submitted a report and delivered a presentation to the Board updating Members on the work of the SSAB with a particular focus on a recent Peer Challenge.

Colin Morris, Chair of the SSAB, explained that he had been in post now for a few years and had been appointed following an inspection of safeguarding carried out by the Care Quality Commission. The SSAB was the key mechanism for determining how organisations in Sunderland would cooperate to safeguard and promote the welfare of adults at risk.

The SSAB had overseen the introduction of a centralised model for safeguarding through the establishment of the Safeguarding and Social Care Governance Team within the Council. The Peer Challenge which had taken place in the People Directorate in March 2014 had looked at the current plans for safeguarding vulnerable adults in the city and the effectiveness of this newly developed model for adult safeguarding.

The Peer Challenge identified a number of strengths: -

- Board Member relationships
- Evidence of impactful joint work across the CCG and Council overseen by SSAB
- Perception that new centralised model made safeguarding a safer and easier process
- Improved links between Sunderland Safeguarding Children Board and SSAB allowing better management of cross family cases
- Work has been progressed on SSAB Infrastructure
- Providers were experiencing appropriate training
- Awareness and understanding of Mental Capacity Act/Deprivation of Liberty was evidenced

Areas which had been identified for improvement included the need for Memoranda of Understanding with other boards and service user engagement and experience across the safeguarding agenda. Partner funding was also needed for the SSAB and robust case file auditing feeding into the Board was needed.

The Peer Challenge recognised the progress and ambition of the SSAB and felt that there was good work in process and a good platform to build upon. The SSAB would like to provide an annual report to the Health and Wellbeing Board and there was also an opportunity for a development session with members of both boards and potentially the Sunderland Safeguarding Children Board.

Councillor Speding commented that part of the benefit of a peer review was the relationship which was built up across partners and Nonnie Crawford suggested that the Safer Sunderland Partnership should be included in any joint work.

Christine Keen asked about the process for learning from audit and case reviews and Sharon Lowes replied that there had been evidence of some learning, but this was at an early stage and more needed to be done. It was noted that the Children's Safeguarding Board were further down the line on this and it was hoped to join up with some of this work.

Kevin Morris referred to the emerging Patient and Public Engagement Strategy and how this could work for the SSAB. Neil Revely highlighted that the Council was investing in an intelligence hub which would hopefully join some things together. If better intelligence was obtained then more intelligent decisions would be made. This would look at how something could be done once and then be made available for others. Neil endorsed the plan to have a development session on safeguarding.

Nonnie Crawford commented that as well as service users and carers, a public conversation needed to be had around safeguarding in the same way as the discussions around a dementia-friendly city.

Christine Keen noted that safeguarding was usually focused on a crisis point and this needed to be broader and was about getting a wider range of intelligence. Colin Morris highlighted that there was a balance to be achieved as they did not want the public to perceive that everything they touched was unsafe.

Having thanked Colin Morris for his presentation, the Board RESOLVED that: -

(i) the presentation be received and noted as an update on the outcome of the Peer Challenge;

(ii) the Sunderland Safeguarding Adults Board present an annual progress report to the Health and Wellbeing Board; and

(iii) a Board development session be held on the theme of safeguarding.

**HW70. Sunderland Health and Wellbeing Strategy Implementation Plan Update**

The Executive Director of People Services submitted a report advising the Board of the progress made in the implementation of the Health and Wellbeing Strategy and recommending the next steps in implementing the strategy and future reporting arrangements.

The Health and Wellbeing Strategy had been designed to take a whole systems and asset based approach to the improvement of health and wellbeing in Sunderland and there was an appreciation that the ethos of the strategy was impacting on the day to day work of partners across the city.

Six Objective Leads had been identified to progress elements of the six Strategic Objectives included in the strategy and this work was outlined at Appendix 1 to the report.

The next steps recommended by the Strategy Implementation Group were to have an extensive communication and engagement exercise or “big conversation”, which would be a joined-up and comprehensive process to increase the understanding of local people of the changes that were happening. This process needed to be ongoing and would seek to talk to people when they were well as well as when they were ill. Neil Revely emphasised that there was confidence amongst partner organisations that the system would be changed but if the public were not aware of this then they would do the same as they always did.

Consideration also had to be given to getting communications right and the Implementation Group would take this up on behalf of the Health and Wellbeing Board.

Neil referred to the arrangements for monitoring the progress of the strategy and the need to have something which was robust and systematic and this would be linked to a ‘plan on a page’ showing how monitoring activity was aligned across organisations.

It was proposed that the Board receive an annual Assurance Report which would demonstrate how all partners were delivering their core services and highlight any issues. The report would also detail additional action taken to address the strategy objectives and the difference it was making. It was also proposed that an Annual Statement be produced which would summarise the progress and any concerns expressed in the Assurance Report and this should be published.

Dave Gallagher stated that it made sense to put in a layer which would add value and that the “big conversation” was very important and reinforced the need to implement the strategy.

It was RESOLVED that: -

(i) the extensive public and organisational engagement exercise (“big conversation”) and the deepening of the Objective Sponsors and Leads role within this be agreed;

(ii) the development of a plan on a page to encapsulate wider plans be agreed; and

(iii) the introduction of an annual Assurance Report and Annual Statement be agreed.

## HW71. Health and Wellbeing Peer Review – Recommendations and Implementation Plan

The Assistant Chief Executive submitted a report updating the Board on the recommendations of the Peer Review and presenting the implementation plan. The Peer Review had taken place in February 2014 and the resulting report had been positive, complimenting Sunderland on its approach to Health and Wellbeing, the strategic leadership of the Board, strong and stable partnerships between the Clinical Commissioning Group and the Council, the innovative approach to the Health and Wellbeing strategy and the strength of Area arrangements. The Peer Team also outlined a number of challenges including: -

- The need to build on the momentum of the Health and Wellbeing Strategy by embedding the design principles throughout the system;
- Ensuring the vision is clear and brought into action by commissioners from all local organisations and by providers;
- The need to develop a performance management framework, ensuring read across from strategic to operational level; and
- Embedding Public Health expertise into the whole system.

It was important for the Board to own the actions listed in the Improvement Plan and an update report would be provided on a six monthly basis.

Councillor Speding commented that the process had shown the ability of strangers to work together effectively. Christine Keen noted that in relation to Improvement Action A3 and the Primary Care Commissioning Plan, it was difficult to take national policies and translate these to something useful locally. CCGs had aims and objectives but struggle to make changes because they are commissioners.

Dave Gallagher added that partners could all have different definitions of what primary care would be and that this should be considered as broadly as possible. Karen Graham suggested that Christine Keen be added as a lead on Improvement Action A3.

Neil Revely emphasised that the action plan should be cross referenced with work which was currently being done as many of the actions flagged up in the improvement plan were being picked up already.

Accordingly the Board RESOLVED that: -

(i) the overall findings of the LGA Peer Review be noted;

(ii) the Implementation Plan be noted; and

(iii) six monthly updates on progress against the implementation plan be received.

## HW72. Health and Wellbeing Board Development Session and Forward Plan

The Head of Strategy and Performance submitted a report informing the Board of the detail and scope of the next development session and the forward plan.

The next development session would look at the links between health and housing and the opportunities for closer and more integrated working on areas of joint importance, including the housing implications of the better care fund. Karen Graham advised that it might be necessary to re-arrange the date of this session but members would be kept informed of any changes.

Board Members were asked to contact Karen if they had any additional items for the forward plan. Details of the timetable for the Board and its advisory groups and deadlines for submission of reports were also provided for information.

The Board RESOLVED that: -

(i) details of the next development session be noted;

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

(iii) the timetable be noted.

## HW73. Date and Time of Next Meeting

The next meeting of the Board will be held on Friday 25 July 2014 at 12noon

(Signed) P WATSON
Chair

**Item No. 4 (a)**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

## FEEDBACK FROM THE ADULTS PARTNERSHIP BOARD

### Report of the Chair of the Adults Partnership Board

The meeting of the adults board took place on Tuesday 8th July

Under matters arising, the review of the partnership and its sub groups was discussed. It was agreed that over summer a joint workshop with the Childrens Trust be organised in order to progress the agenda and also to agree governance between the advisory groups and the Health and Wellbeing Board.

Graham Burt from the Carers centre updated the Board on 'Making it Real for Carers' – which is an assessment developed nationally by the Carers Trust and Association of Directors of Adults Social Services (ADASS) of how carers feel about 6 key topics leading to an action plan which is overseen in Sunderland by the Carers Strategy Implementation Group.

Graham King updated on the Peoples Services and Safeguarding Peer Challenge as per the HWBB agenda.

John Hall from Tyne & Wear Fire & Rescue Service provided a verbal report on Fire Related Deaths in Vulnerable Adults. They fit over 8,000 fire alarms a year to properties in Sunderland but see a need for a service linked to rapid response for vulnerable adults. In partnership with Age UK and Sunderland Care and Support they are marketing the link alarms as an 'insurance' as they can be used for fire, falls and intruders. They are also rolling out free training into identifying and referring vulnerable adults at risk of fires and agreed to follow up the offer of this training to all commissioned care providers.

Colin Morris updated the Board on Safeguarding Adults Partnership Board Update and his new joint role as chair of Childrens safeguarding. Attention was brought to a joint development session between the Health and Wellbeing Board, Adults and Children's Safeguarding which is to be held in October.

**Item No. 4 (b)**

**SUNDERLAND HEALTH AND WELLBEING BOARD 25 July 2014**

**FEEDBACK FROM THE NHS PROVIDER FORUM**

**Report of the Chair of the NHS Provider Forum**

The group met on the 8th July and discussed the following:

**Recruitment of GPs** – it was raised that staffing and resources is a big issue – especially in relation to GPs. If the move to community teams is to be successful there needs to be a coordinated approach to recruitment and manpower issues.

**Finance** – an update was given from both the CCG and local authority on financial planning for the next 5 years and the financial breakdowns behind the Better Care Fund.

It was reported that the CCG and City Hospitals finance managers had both met and agreed that although City Hospitals could not confidently sign off all of the efficiencies predicted, they were happy to sign up to reaching half of the £11million. The remainder has been included at risk.

Sunderland is fortunate in that it can double run systems for a few years using CCG surplus – so savings will not start to be accrued until year 3 at the earliest. The figures highlighted £15.6 million going into the system and £11million coming out through pathway reform, so there is still some investment being made.

In the CCG forward plan there was debate over the ring fenced £5 per head for GPs to deal with complex urgent care condition in the over 75s. There is agreement that the money needs to be ring fenced but less clarity on how this will be spent.

The question was raised – What if it doesn't work and efficiencies aren't seen? The approach would be to look at WHY investment was not delivering, look into the use of the CCG 0.5% contingency, re-examine planned investment, look at drawing down surplus (about £3million but it is unclear whether this can be used)

**Better Care Fund** – an update was provided on the resubmission date of 9th July and that Sunderland would be an early adopter. More clarity is still needed on the 6 mini-pools of funding that sit behind the headlines, namely

- Home based care
- Reduction in care homes
- Learning disabilities
- Locality working
- Intermediate care
- Reablement

There also need to be clear protocols drawn up and shared with providers regarding risk sharing and if efficiencies are made or over performance happens how this is attributed.

The total figure for Better Care Fund in Sunderland is £168million – but this might vary depending on contract negotiations with providers. The figures to 15/16 are based on existing contracts, but beyond this the figures are a best estimate. The overall figure might also expand if additional things are included such as Childrens services, primary care etc.

**6 Monthly Broader Provider Engagement –**a scope for the broader engagement session was circulated. Although the scope was agreed there was some concern that the number of potential invitees would be unmanageable. Forum members agreed to collate a list of commissioned providers and a plan for either a single event or a number of events focussed on specific groups such as GPs as providers, social care providers, VCS etc would be examined.

**Recommendation**
The HWBB is requested to suggest any items it would like the Provider Forum to investigate over next 6 months.

**Item No. 5**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

**Notes from the INTEGRATION BOARD held on 2 July 2014**

**Present** David Gallagher (DG)
Karen Graham (KG)
Nonnie Crawford (NC)
Neil Revely (NR)
Debbie Burnicle (DB)

**Apologies** Sarah Reed

**2. ASE Event**

DG updated on work following the recent ASE event. A letter of thanks to be written to all participants, materials and write up of the event had been received from Cap Gemini and at the event the sponsor team had made a commitment to share this information and to get the group together again in the autumn. There was discussion about the actions arising from the groups at the event and these were summarised as follows:

- Publish the model
- Commissioning delivery models
- Integrated teams
- Intelligence hub
- Data information sharing and potentially an information strategy
- Community connectors
- Engagement and communications
- Self help and early intervention
- Cultures and behaviours, including leadership of these

There was discussion around existing groups that could undertake this work and the need perhaps to develop new groups. DG agreed to summarise the discussion in a grid to be circulated to ask all of the Board members to complete/validate.

The Board agreed to plan towards an event in September/October as a follow-up to feedback on progress made and develop further work.

**Action : DG to circulate grid of work mapped to existing groups for comment**

There was also discussion around writing out with further information to participants, including sharing Cap Gemini materials and DG agreed to do this on behalf of the sponsor team.

**Action : DG**

## 3. Better Care Fund

DG and DB updated on a teleconference held earlier that day with colleagues from NHS England, CCGs, local authorities and the LGA. There were fourteen or fifteen health economies being looked upon to fast track their Better Care Fund applications to be held up as examples of good practice (including Sunderland). Submission of information to help with this process was required by 9 July 2014, and as part of the conversation bespoke feedback to each individual community health and social care community had been promised, including Sunderland, which was thought to be of value to the process.

DB updated on a discussion with Ian Holliday about the Better Care Fund and reported that there were around 20 schemes in Sunderland and the challenge was to map the benefits of these schemes and the impacts and how to articulate them.

Work was underway to complete the information requested by 9 July, recognising that this was not an end stop date, but part of an iterative process with a view to getting all BCFs in England signed off by September. It was agreed that the information to be submitted on 9 July would be circulated around close of play on 8 July for any final comment and ultimately for sign off. As part of the process an offer of support had been given by NHS England and the LGA but it was unclear as to what this would be and how this could be used.

It was agreed that the discussion around the BCF submission should be held with the Provider Forum on 8 July.

**Action: KG/DB**

## 4. Children's' Services

NR raised the need to bring Children's' Services into the integration work and it was agreed that this was helpful. The Health and Wellbeing Strategy includes Children's' services, as had the ASE event, which was based on pre-conception to grave.

Is the Integration Board oversees integration, is it the single group required to oversee the whole of integration, including Children's Services. It was agreed that this should be looked at along with governance arrangements for whole city integration and it was agreed that there was a need to get the right people around the table to ensure that this happened and provided governance links into the relevant statutory organisations.

## 5. WHO Healthy Cities

There was a brief conversation around the merits or otherwise of Sunderland's participation in healthy cities for phase VI. The council will progress with application for membership.

## 6. Date and time of next meeting

Thursday 7 August 2014 at 3pm at Sunderland Civic Centre

Item No. 6

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

# Health and Wellbeing Board Status Report

## Quarter 1 2014

Key activity undertaken in Healthwatch Sunderland during Q1 2014.

### Engagement Activity

The Healthwatch Sunderland Annual Update Event was held on 27th June to celebrate the successful first year of Sunderland Healthwatch, and deliver the Annual Report. The CCG presented their 'Plan on a Page' to Healthwatch members.

Monthly newsletters are sent to members to keep people up to date with local, regional, and national developments in health and care services. Our circulation list is currently 515and growing.

Two new members of staff have been recruited and will commence work with us in Q2 to support community engagement activity in line with our Workplan.

We have completed the training of six Information Champion volunteers, who will work closely with our new Community Engagement team.

We provide regular updates via Twitter and Facebook. Healthwatch Sunderland has over 450 Twitter followers with a reach of 70,000+

### Information and Signposting Activity

We have continued to develop our Information and Signposting service in Q1; establishing an effective logging system to monitor issues both locally and in alignment nationally with the Healthwatch England Hub system.

In addition, we have created robust monitoring and evaluation systems e.g. equality and diversity monitoring and satisfaction surveys, aligned to Healthwatch England monitoring.

The Information and Signposting role has ensured visibility of Healthwatch in Sunderland pending the recruitment of our Engagement officers in a comprehensive and diverse range of areas including Sunderland University Welfare Week; Gentoo Dementia Event; Sunderland library; BME Sunderland Royal Hospital Group.

During Q1, 14 issues from the public were raised with our Information and Signposting service, of varying complexity. We are using this information to feed into our Workplan, and will continue to raise the profile of this area with the intention of increasing activity.

A Complaints factsheet for health and social care has been developed and promoted on the Healthwatch Sunderland website.

## Focus for Quarter 2

Our Workplan is evolving in line with patient and member feedback and we are creating a detailed and specific Action Plan which will be the focus of our activity for the remainder of the year.

NHS
Sunderland
Clinical Commissioning Group

**Item No. 7**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

**Sunderland Health & Social Care System Strategic Plan**

## 1. Purpose

The purpose of this report is to provide the Health & Wellbeing Board with an update on the development of the 5 year strategic plan for the Sunderland Health and Social Care System.

## 2. Background

In December 2013, NHS England produced national guidance 'Everyone Counts: Planning for Patients 2014/15 – 2018/19. Within this guidance NHS England highlighted the fact that the healthcare system is facing the challenge of significant and enduring financial pressures and outlined the need to innovate and transform the way we deliver high quality services, within the resources available, to ensure that patients, and their needs, are always put first.

The guidance set out a framework outlining the need for commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all and maximise the best possible outcomes for local communities.

The guidance set out the need for CCG's to:

- Develop a two year CCG operational plan;
- Take the lead in developing a 5 year Strategic plan for the health and social care system in Sunderland;

In developing these plans a number of requirements were outlined:

- CCG's must have an outcomes focused approach, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them;
- Ensure citizen inclusion and empowerment to focus on what patients want and need;
- Ensure more integration between providers and commissioners;

- Ensure more integration with social care and ensure cooperation with Local Authorities on Better Care Fund planning;
- Ensure plans are explicit in dealing with the financial gap and risk and mitigation strategies. No change is not an option.

Initially there was a requirement to submit the final version of the 5 year strategic plan by 20th June 2014, however, NHS England have since advised that further time will be given for health and care systems to work through their 5 year strategic plan with a final version being submitted in Autumn 2014.

## 3. Current Position

NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care;
- Wider primary care, provided at scale;
- A modern model of integrated care;
- Access to the highest quality urgent and emergency care;
- A step change in the productivity of elective care;
- Specialised services concentrated in centres of excellence.

The Strategic plan is focused around these six characteristics highlighting both examples of good practice currently in place across the Sunderland health and care system as well as key programmes of work identified as a priority going forward across the whole system.

In line with this approach, a 5 year health and care system plan on a page for Sunderland has been developed which outlines the key programmes of work being undertaken across Sunderland including the 10 transformational changes identified by the CCG as a priority for the next two years and the key BCF schemes This can be found at Appendix 1 for ease of reference, however the full Plan also accompanies this report.

Through the sharing of organisational plans via the Transformation Board, it has also been possible to identify the financial savings required to be made across the system, outlined in the table below:

| | 14/15 £M | 15/16 £M | 16/17 £M | 17/18 £M | 18/19 £M |
|---|---|---|---|---|---|
| NHS SUNDERLAND CCG | 2.9 | 3.9 | 6.0 | 3.0 | 3.0 |
| SUNDERLAND CITY COUNCIL (Peoples) DIRECTORATE | 10.7 | 12.0? | 10 | 10 | 10 |
| CITY HOSPITALS SUNDERLAND NHS F.T | 16.3 | 14.1 | 18.5 | 15.6 | 15.5 |
| SUB TOTALS (MAINLY SUNDERLAND) | 29.9 | 30 | 34.5 | 28.6 | 28.5 |
| NORTHUMBERLAND TYNE & WEAR NHS F.T | 11.3 | 10.8 | 10.7 | ?? | ?? |
| SOUTH TYNESIDE NHS F.T. | 13.8 | ?? | ?? | ?? | ?? |
| NORTH EAST AMBULANCE SERVICE F.T | 6.0 | ?? | ?? | ?? | ?? |
| SUB TOTALS (Will include an element of Sunderland) | 31.1 | ?? | ?? | ?? | ?? |

From the table above it can be seen that the organisations whose focus is “mainly” on Sunderland need to save in excess of £150m over the life of the strategic plan. Other organisations that also provide services into Sunderland will need to deliver efficiencies so it is feasible the wider “public” sector economy in Sunderland will need to save circa £175m in the next 5 years. The detailed figures for Sunderland CCG are highlighted in the “financial plan on a page”, however from the table above the context for the wider public sector economy can be seen.

Fundamental to the successful delivery of the savings above, will be the need to transform “pathways of care” from traditional secondary care settings where appropriate into community / primary care settings. At the heart of our plans is the expectation that non elective admissions can be reduced by 15% over the life of the plan. For the CCG and our main acute providers this impacts from 2016/17 onwards whereas for some economies the need is now. Sunderland does have the time to

work through with partners the granularity of its plans to deliver its Vision and three strategic objectives and ensure 'universal' sign up.

Underpinning the pathways of reform work will be the need to finance non recurrent projects and double running costs. Sunderland CCG is in a fortunate position given its sound financial situation which will be used to support the "reform" agenda. We have signalled a phased "draw down" of the financial surplus reported by the CCG at the end of 13/14, commencing in 15/16 which gives the wider economy a unique advantage to finance change effectively.

In addition to the phased draw down of the surplus delivered at the end of 13/14, Sunderland has also reviewed its short term plan for 14/15 and will increase its planned surplus by a further £2m. Following all these adjustments the planned surplus for each year will be as follows:

| | 14/15 £,000 | 15/16 £,000 | 16/17 £,000 | 17/18 £,000 | 18/19 £,000 |
|---|---|---|---|---|---|
| Original Plan Surplus (13/14) | 16,987 | 16,987 | 16,987 | 16,987 | 16,987 |
| Add Surplus Delivered in 14/15 | 2,000 | 2,000 | 2,000 | 2,000 | 2,000 |
| Draw down of Surplus | | (3,000) | (3,000) | (3,000) | (3,000) |
| **Revised Plan Surplus** | **18,987** | **15,987** | **12,987** | **9,987** | **6,987** |

The "draw down" of surplus is controlled at a national level following discussion between Treasury and NHS England. We will not know if our plans are agreed until later in the year when the plans of all CCG's have been scrutinised and the "planned" level of draw down is known.
Using this money wisely is key to success going forward. Failure to do this will result in a missed opportunity which is unlikely to come around again.

## 4.Next Steps

- Receive Health & Wellbeing Board feedback on the content of the strategic plan;
- Receive further partner and provider feedback on the strategic plan and key initiatives within this;
- Agree further key programmes of work to be funded via the operational resilience and planning process and amend the plan to reflect these;
- Assess the impact of the LA efficiencies to be made from the LA contribution to the pooled Better Care Fund and agree the risk sharing arrangements for the pool
- Further develop the vision for each of the six characteristics
- Further review of the financial savings in the latter three years of the plan for those organisations currently not outlined in the table below;
- The final version of the strategic plan will be submitted in Autumn 2014.

## 5.Recommendations

The Health & Wellbeing Board is recommended to:

- Provide feedback to inform the continuing development of this plan

**Lynsey Caizley / Chris Macklin**
Authors

**Debbie Burnicle & Chris Macklin**
Sponsors
**10th July 2014**

# Sunderland Health & Care System 2014/15 – 2018/19

All together Sunderland!

## Vision: Better Health for Sunderland

| Transforming Out of Hospital care (through Integration and 7 day working) | Transforming In Hospital Care, specifically Urgent & Emergency Care (7 day working) | Enabling Self Care and Sustainability |
|---|---|---|

## Outcomes

| | | | | | | |
|---|---|---|---|---|---|---|
| Reduce years of life lost by 7% by 2019 | Improve health related quality of life for people with LTC by 8.9% by 2019 | Reduce Emergency Admissions by 14% by 2019 | Increase the proportion of older people living independently at home following discharge from hospital by 5% by 2015 | Improve patient experience of hospital care by 7.2% by 2019 | Improve patient experience of out of hospital care by 8% by 2019 | Make significant progress towards eliminating deaths in hospitals* |

| High Quality Sustainable System Characteristics | Key Initiatives |
|---|---|
| Citizens fully included in all aspects of service design and change and fully empowered in their own care | Communications & Engagement Strategy (including My NHS)<br>Shared decision making<br>Personal health budgets<br>Intelligence Hub<br>Wellness Service |
| Wider Primary Care, provided at scale | GP Alliance<br>Proactive and personalised Primary Care programme<br>Alignment of IT systems across Primary , Community & Secondary Care |
| A modern model of integrated care | Community integrated locality teams<br>Community Connectors model<br>Intermediate care hub 24/7<br>Improving health care in care homes in all localities<br>Implementation of deciding right initiatives in practices<br>Dementia Friendly Communities<br>NEAS Advanced Practice Paramedic (TBC) |
| Access to the highest quality urgent & emergency care | GP Led Urgent Care Centres<br>City Hospitals Sunderland Urgent Care Centre 'Big Front Door'<br>GP Out of Hours service |
| A step change in the productivity of elective care | Surgery & Theatres Efficiencies programme (STEP)<br>New Endoscopy Unit at City Hospitals Sunderland<br>Improved community mental health pathways |
| Specialised services concentrated in centres of excellence | City Hospitals Sunderland's position as a recognised provider of complex care in the North East developed in line with national strategy for specialised services |

| Enabled by | Governed by | Measured by | Values and Principles |
|---|---|---|---|
| Localities / Joint Commissioning / Contract Management (CQUIN) / Medicines Optimisation / Evidence based Approach / Research & Development | System Wide Transformation Board<br>Health & Wellbeing Board<br>CCG Governing Body<br>Integration Board | Quality & Safety of Services<br>Achievement of Outcome ambitions<br>Delivery of £150m efficiencies across the system | One system for Health and Social Care<br>Patient Centred<br>Parity of Esteem<br>7 day services<br>Team based working across Sunderland |

*Zero Tolerance MRSA. At least 10% increase in the reporting of medication errors. Achievement of Cdifficile nationally set trajectory

All together Sunderland!

NHS
Sunderland
Clinical Commissioning Group

# Sunderland Health & Care System

## Strategic Plan 2014-2019

Version 1.0

Better health for Sunderland

# Contents

# Introduction

## 1.0 Sunderland Health & Care System

Sustainable system wide change requires a system wide approach. This strategic plan outlines the desired state for the Sunderland Health and Care system by 2018/19 and has been developed in Sunderland for Sunderland. The key partners of which, outlined below, are all represented at the Sunderland Transformation Board, chaired by the CCG.

| Organisation | Role in the Health and Care System |
|---|---|
| **Sunderland Health & Wellbeing Board** | A statutory board where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. |
| NHS Sunderland Clinical Commissioning Group | The statutory body responsible for planning, purchasing and monitoring the delivery and quality of most of the local NHS healthcare and health services for the people of Sunderland. |
| **GP Member Practices** | The 53 GP practices across Sunderland are members of Sunderland CCG. |
| Sunderland City Council | Sunderland City Council secures and influences a wide range of services, either directly through their staff or by commissioning services from outside organisations. They also have responsibility for the economic, social and environmental 'wellbeing' of Sunderland. |
| City Hospitals Sunderland NHS NHS Foundation Trust | City Hospitals Sunderland is the main acute healthcare provider in Sunderland, operating from Sunderland Royal Hospital, Eye Infirmary and the Children's Centre. |

| | |
|---|---|
| | They have a number of intermediate specialist services and Sunderland Eye Infirmary is a leading regional eye treatment centre. |
| South Tyneside NHS Foundation Trust | South Tyneside FT are both an acute and community services provider. They are the main provider of community services in Sunderland. |
| Northumberland, Tyne and Wear NHS Foundation Trust | Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest Mental Health and Disability Trusts in England and the main provider of mental health services in Sunderland. |
| North East Ambulance Service NHS Foundation Trust | The North East Ambulance Service provides a number of NHS services including 999 response and patient transport services for the people of Sunderland. |
| healthwatch Sunderland | The aim of Healthwatch Sunderland is to strengthen the collective voice of citizens and communities in influencing local health and social care services to better meet their needs. It also supports people to find the right health and social care services for them by providing appropriate information, advice and signposting. |
| NHS England | NHS England is an executive non-departmental public body of the Department of Health and oversees the budget, planning, delivery and day-to-day operation of the NHS in England. Also responsible for the commissioning of primary care and specialised services at a local level. |

# 2.0 Our Vision and Strategic Objectives

## 2.1 Our Vision for 2018/19

Our Vision is to achieve **Better Health for Sunderland**

We will deliver this through:

- **Transforming out of hospital care (through integration and 7 day working)**
- **Transforming in hospital care, specifically urgent and emergency care (including 7 day working)**
- **Enabling Self Care and Sustainability**

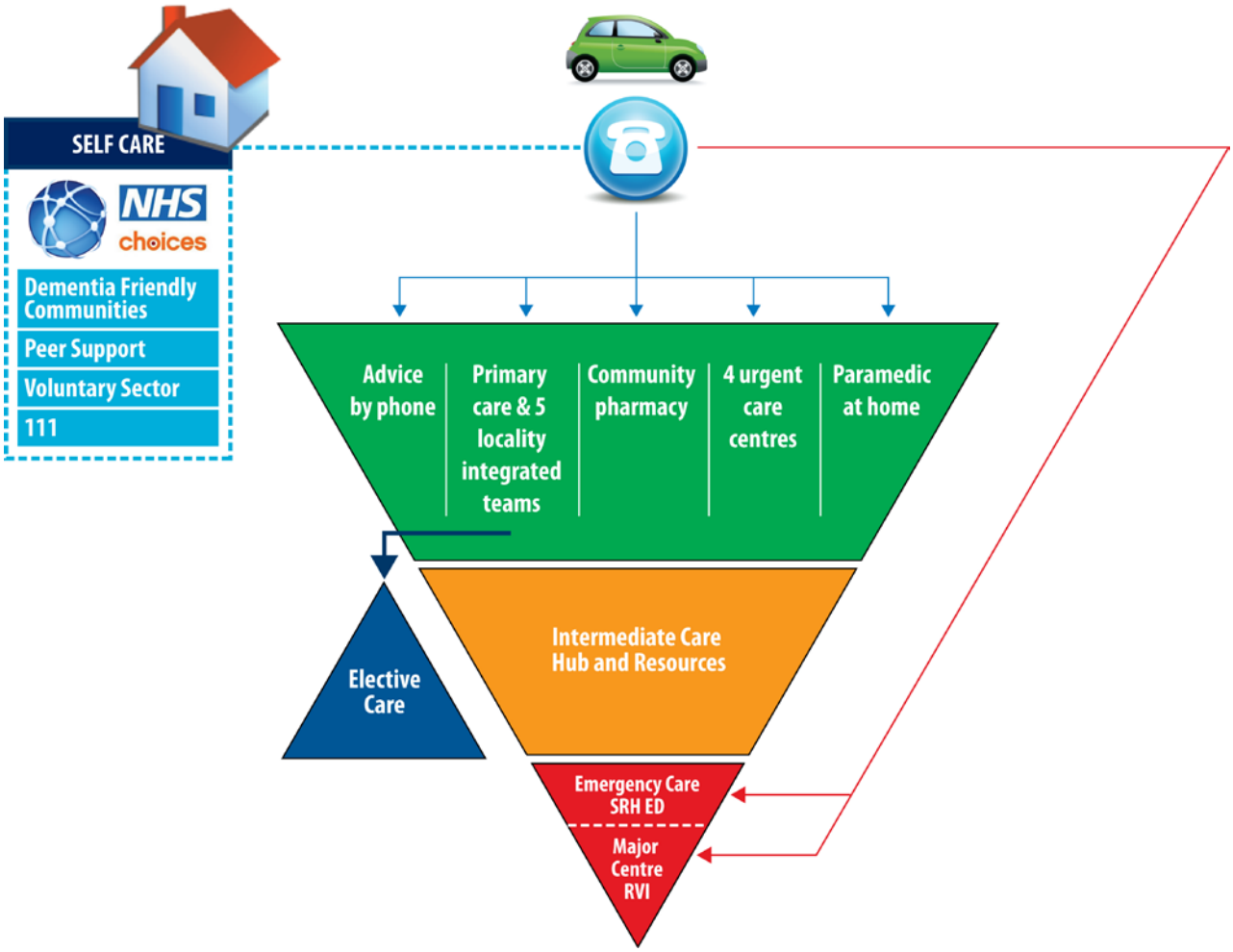
We will do this by having a whole system approach working closely with citizens, patients, carers, providers and partners.

## 2.2 Our Strategic Objectives

| 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 |
|---|---|---|
| ▪ Right Care; Right Place; Right Time<br>▪ System wide approach with one common vision<br>▪ Multi-disciplinary teams in localities working together with people, adults and children with long term conditions / complex needs to improve their lives / meet their needs<br>▪ Improved overall quality of care for the elderly<br>▪ Reduced variation in primary care<br>▪ Patient centred<br>▪ A system which is simple to navigate<br>▪ Reduced emergency admissions to hospital as people are cared for effectively in the community | ▪ Equality of access across the City to urgent care<br>▪ 24/7 hub<br>▪ Reduced handoffs in the system<br>▪ Reduction in emergency admissions | ▪ Local people influence and understand the system<br>▪ A city that actively supports / enables people to be and stay healthy, well and happy<br>▪ Improved public health outcomes<br>▪ Managing demand<br>▪ Using community assets |

## 2.3 What will the future look and feel like?

The following diagram shows the future state by 2019 for the health and social care economy in Sunderland:



The table below outlines how the future state will feel from different stakeholder perspectives:

<table>
<tr><th colspan="3">Citizens (Adult, Child, Older Person, Carer)</th></tr>
<tr><td colspan="3">▪ People are educated to self-manage where possible with the necessary support if required;<br>▪ Easily accessible advice;<br>▪ Once diagnosed someone co-ordinates the care you require and there is only one record which is shared with those who need it;<br>▪ Best use of Information technology to enable this to happen;<br>▪ Responsive providers;<br>▪ As local as possible.</td></tr>
<tr><th>Member Practices</th><th>A&E Consultant</th><th>District Nurse</th></tr>
<tr><td>▪ Feel part of a system which is efficient and joined up<br>▪ Belonging to a community / locality<br>▪ Able to use their time effectively to influence change in the system</td><td>▪ Only see accidents and emergencies<br>▪ Have great communications with primary care, social care and the rest of the system<br>▪ Make best use of skills<br>▪ Provide ‘remote’ advice via technology<br>▪ Trust in the system<br>▪ Wait for patients to arrive</td><td>▪ Will be part of a multidisciplinary team (24/7) in the community<br>▪ Have a relationship with GP Practices<br>▪ Make use of all skills<br>▪ Specialist knowledge / advice to call upon<br>▪ Understand how the system works</td></tr>
</table>

# 3.0 Values and Principles

## 3.1 Core Values

We have identified a set of core values which will continue to shape and underpin all of the work we undertake to deliver our vision. These seven core values are outlined below around our vision:


## 3.2 System Principles

The following system principles have been agreed:

- Our approach will be one of a single system for health and social care across Sunderland;
- Mental and physical health will be equally important, recognising both impacts on each other;
- To develop, as a principle, a team based working approach across the city.

- To share learning and approaches around demand management across the health and social care sector, but also wider public sector e.g: Sunderland City Council;
- The establishment of a single Transformational Programme Board to oversee this work (now in place);

We will also work closely with our partners in neighbouring CCGs where our patients use services in these areas.

# 4.0 Meeting the needs for local people

## 4.1 Big Challenges for Sunderland

We serve a population of around 275,700 people in Sunderland, with an increase of 8,100 (3%) forecast over the next 20 years. Large increases are predicted in the elderly, and particularly the very elderly, populations which has significant implications for health care over the next five, ten and twenty years. Even if the general levels of health in these age groups continues to improve, the shape and structure of health services will need to change to meet the needs of this growing population, particularly as older people use services more often, have more complex needs and stay longer in hospital.

The main health challenges facing Sunderland are:

- **Mental Wellness as demonstrated by our poor outcomes in relation to depression and self-harm**
- **Excess deaths, particularly from cancer, respiratory and circulatory disease;**
- **Health which is generally worse than the rest of England;**
- **A growing population of elderly people with increased care needs and increasing prevalence of disease who need to be supported to live independently;**
- **An over-reliance on hospital care;**
- **Services which are fragmented and lack integration.**

## 4.2 Key messages from the Sunderland Joint Strategic Needs Assessment

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

The Sunderland JSNA has undergone a major refresh to broaden the coverage of wider determinants of health; takes account of Marmot priorities; updates the analysis of health and wellbeing information; gives greater insight into expressed needs of local people; identifies where effective interventions to address needs are available but not taking place; and includes equality impact assessments as they are developed.

The JSNA refresh has used a structured process with clear criteria, which continues to involve partners and the public. We are in a time of economic uncertainty and major system change which make it crucial that JSNA recommendations are clear regarding priorities based on a one Sunderland

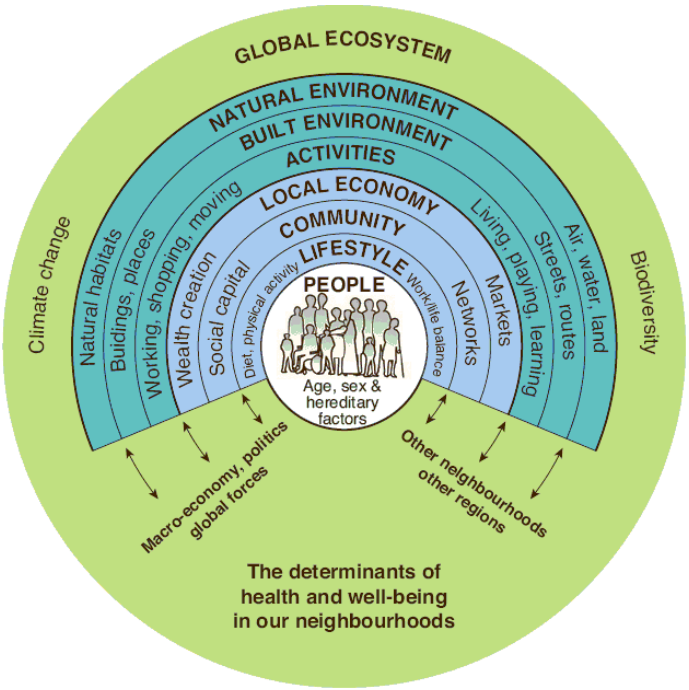
strategy; what needs can be met and how we can mitigate against unintended consequences from changes in funding and organisational arrangements over the next 3-5 years.

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

- Increasing life expectancy and reducing health inequalities through focusing on addressing the causes of premature morbidity and mortality;
- A tiered approach to prevention, risk management and early intervention;
- Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;
- Identifying those who would benefit from wraparound health and social care services;
- Integration of services, whether NHS, social care or other services which affect health (e.g. spatial planning, housing, transport, libraries, wellness services, addressing fuel poverty, mitigating the impacts of welfare reform etc.);
- Reducing health inequalities by focussing on giving children the best start in life and strengthening ill health prevention as well as addressing the wider determinants of health, including deprivation, employment, education, housing, social isolation, environment and by identifying neighbourhoods to target;
- Commissioners and providers engaging with individuals, families, neighbourhoods, and communities in order to deliver on all the above to build resilience at all levels to enable greater levels of self care.

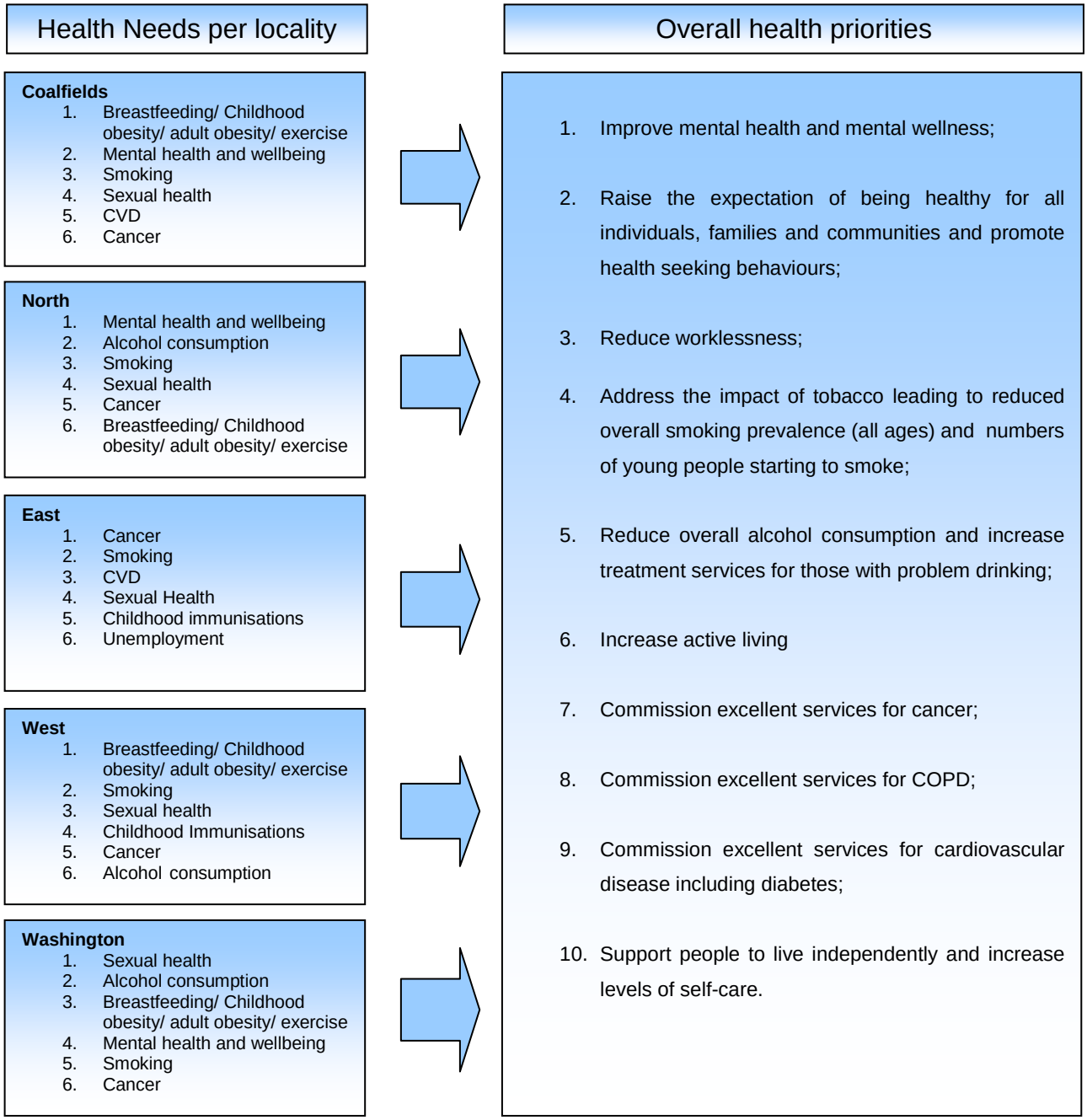
We have traditionally focused on treating illness but to improve health, we need to move, as represented by the following diagram, out into the concentric circles working with a broader range of partners, delivering our direct responsibilities and influencing partners to deliver theirs.

**The main determinants of Health and Wellbeing**



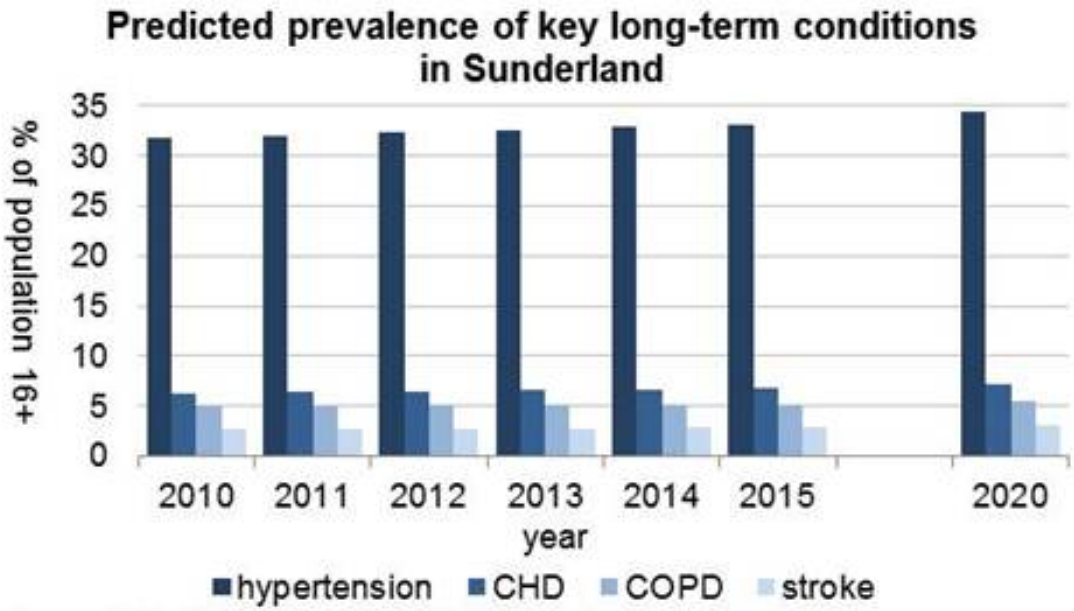

*Ref: Hugh Barton and Marcus Grant (2006), drawing on Whitehead and Dahlgren (1991) and Barton (2005).*

The JSNA is set out using profiles to highlight the needs of individual health groups and community area profiles and we continue to work closely with public health colleagues to identify health needs. The top 6 health needs per locality are outlined below along with the top ten priorities to improve health in Sunderland.



## 4.2.1Expected disease prevalence

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



Source: Public Health England (2011) Disease prevalence models

## 4.2.2 Life expectancy challenge

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

| | England Average Life Expectancy | Sunderland Life Expectancy | Gap (%) * |
|---|---|---|---|
| Males<br>Females | 79.2<br>83.0 | 77.0<br>80.7 | -2.8%<br>-2.8% |

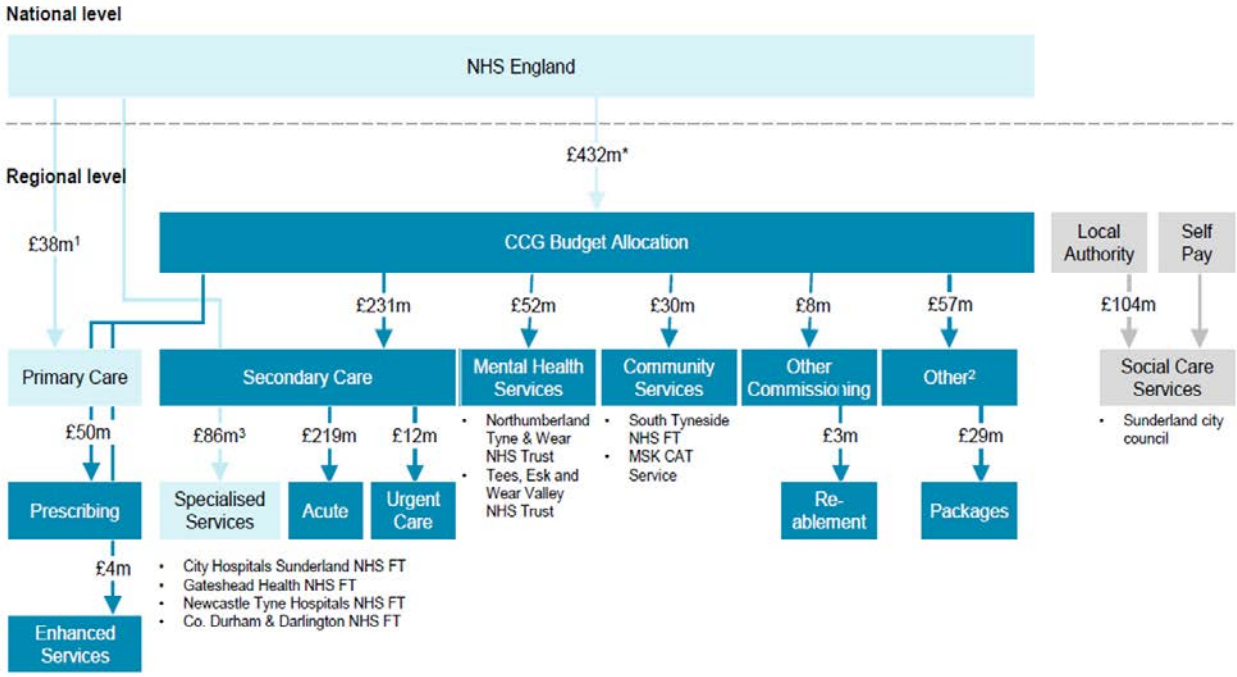
**Life expectancy gap expressed as a percentage of the England life expectancy.*

Over 60% of the gap is caused by cancer, respiratory diseases and CVD and to address this, we have built on previously identified "High Impact Interventions" to deliver an effective approach to improving health and transforming care which our commissioning and work with partners and our GPs will contribute to:

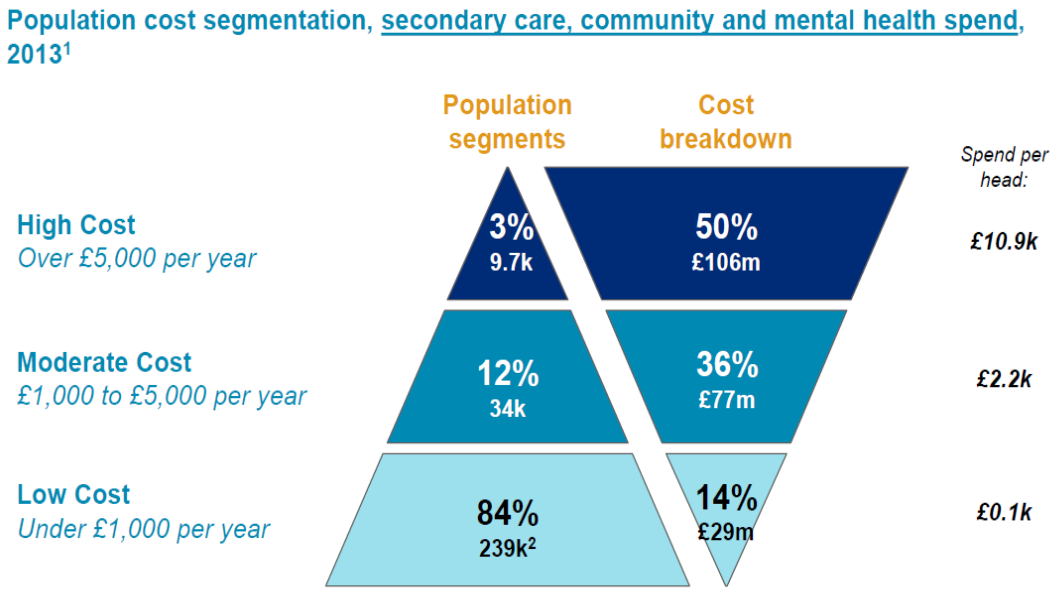
- Use of Health Checks to identify asymptomatic hypertensives age 40–74 & start them on treatment;
- Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;
- Systematic cardiac rehabilitation;
- Systematic COPD treatment;
- Develop & extend diabetes best practice with appropriate local targets;
- Cancer early awareness and detection;
- Identification and management of Atrial Fibrillation thus avoiding vascular dementia;
- Develop best practice in relation to dementia and falls to support people to live independently;
- Implement new approaches to people living in care homes and extra care facilities;
- Support people to manage their own health conditions where appropriate.

## 4.2.3 The Current Health & Care System in Sunderland

A range of organisations commission and provide care services in Sunderland. The approximate spend for each is outlined below:




Further analysis has found that the top 3% of patients in Sunderland drive 50% of the cost of health and care services:



Frail elders have diverse needs and use all care settings heavily. They have complicated care needs, which are difficult to coordinate:

## Average Frail Elder without Cancer or Specialist Dementia care

(2,000 patients in segment – 73% of Frail Elders)

### Details

**Name** 65+, 2+ co-morbidities no Cancer or Specialist Dementia

**Age** 79 (avg.)

### Health

**Top Comorbidities**
- COPD (49%)
- Myocardial Infarction (39%)
- Diabetes (38%)

**Top Risk Factors**
- Hypertension (70%)
- Addictions (14%)
- Obesity (4%)

### Service utilisation

| | | 2013[1] Utilisation | 2013[1] Spend |
|---|---|---|---|
| **Primary[2]** | Appointments | >10 | £500 |
| **Inpatient** | Spells | 3 | £7,300 |
| **Outpatient** | Episodes | 9 | £900 |
| **A&E** | Attendances | 2 | £300 |
| **Mental Health** | Clusters | 0 | £200 |
| **Community** | Visits | 55 | £2,000 |
| **Social** | Visits | *Expected high user of social care* | |
| **Total** | | **87** | **£11,200** |

**Reasons for admission (Top Primary Diagnosis CCS Codes)**
- 87 – Retinal detachments; defects; vascular occlusion; and retinopathy (7%)
- 122 – Pneumonia (except that caused by tuberculosis or sexually transmitted disease) (6%)
- 127 – Chronic obstructive pulmonary disease and bronchiectasis (5%)
- 159 – Urinary tract infections (5%)
- 108 – Congestive heart failure; nonhypertensive (3%)

Source: Sunderland CCG secondary, community care and mental health data, Oliver Wyman analysis
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community care
2 – Estimates based upon previous work

Frail elders with Dementia typically use a large amount of community care:

## Average Frail Elder with Specialist Dementia Care but not Cancer

(200 patients in segment – 6% of Frail Elders)

### Details

**Name** 65+, 2+ co-morbidities, Specialist Dementia, no Cancer

**Age** 83 (avg.)

### Health

**Top Comorbidities**
- Dementia (100%)
- COPD (34%)
- Diabetes (33%)

**Top Risk Factors**
- Hypertension (61%)
- Addictions (11%)
- Obesity (1%)

### Service utilisation

| | | 2013[1] Utilisation | 2013[1] Spend |
|---|---|---|---|
| **Primary[2]** | Appointments | >10 | £500 |
| **Inpatient** | Spells | 2 | £7,200 |
| **Outpatient** | Episodes | 4 | £400 |
| **A&E** | Attendances | 3 | £300 |
| **Mental Health** | Clusters | 1 | £1,100 |
| **Community** | Visits | 65 | £2,300 |
| **Social** | Visits | *Expected high user of social care* | |
| **Total** | | **94** | **£11,700** |

**Reasons for admission (Top Primary Diagnosis CCS Codes)**
- 159 – Urinary tract infections (9%)
- 122 – Pneumonia (except that caused by tuberculosis or sexually transmitted disease) (7%)
- 127 – Chronic obstructive pulmonary disease and bronchiectasis (4%)
- 211 – Other connective tissue disease (4%)
- 226 – Fracture of neck of femur (hip) (3%)

Source: Sunderland CCG secondary, community care and mental health data, Oliver Wyman analysis
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community care
2 – Estimates based upon previous work

# 5. Improving Quality & Outcomes

We currently monitor our CCG performance against a nationally prescribed delivery dashboard which covers all 5 domains of the NHS Outcomes Framework. An overview of performance at the end of 2013/14 against this framework is outlined below along with key risks to delivery:

| Domain | Current Position | Risks to Delivery |
|---|---|---|
| 1: Are local people getting good quality care? | Amber/ Green | Performance against health associated infections (MRSA and CDifficile). |
| 2: Are patient rights under the NHS Constitution being promoted | Amber / Green | A&E 4 Hour waits at Sunderland Royal Hospital is the main area of risk. |
| 3: Are health outcomes improving for local people? | Amber / Red | Performance against healthcare associated infections, mortality indicators, health related quality of life for people with long term conditions. |
| 4: Are CCG's commissioning services within their financial allocations | Green | |
| 5: Are conditions of CCG authorisation being addressed and removed (where relevant) | Green | |

# 6.0 Our Success so far

An example of some of our successes so far include:

- Improved quality of healthcare and resident / family experience in care homes in the Coalfields Locality via an enhanced primary and community proactive approach for residents of residential, nursing and extra care.
- Implementation of a joint action plan with City Hospitals Sunderland and have instigated a clinical discussion process for each case of a health associated which has been recognised nationally as best practice. 2014/15 will implement this process in the community.
- Implementation of a GP extended hours pilot within the East Locality to provide patients with greater GP access and will use lessons learned in our approach to urgent care.
- Significant work undertaken in relation to diabetes including Human Insulin Training, Implementation to Insulin Passport, 100 % participation in the National Diabetes Audit 2012, Implementation of the North East Diabetes Network Foot Pathway, Introduction of CQUIN in Diabetes and reviewed new therapy – Dapagliflozin;.
- Delivered significant improvements in mental health pathways such as:
    - The implementation of fully operational pyschotherapy services, enhanced in 2013/14 to address the psychological needs of persons with long term conditions and carers;
    - Comprehensive memory protection services ensuring early diagnosis and support;
    - Re-commissioned CAMHS Tier 3 services including services at Tier 2 for youngsters in special circumstances;
    - Continued transformation of community services supported by an innovative initial response team, augmenting crisis services;
    - Introduction of a rapid assessment interface discharge (RAID) team into A&E / acute hospital performing exemplary liaison services;
    - New build capital projects creating world class inpatient environments for dementia and serious mental illness.

- Increased the number of people diagnosed and supported with dementia;
- Significant work on cancer including city wide lung cancer audit, Cancer peer review of seven specialties, incorporated the Hamilton Risk score into two week waits for lower gastro intestinal LGI referral, Communication to GPs about early diagnosis and referral pathways;
- Focused work within localities to significantly increase the number of COPD referrals to the pulmonary rehabilitation programme to 27.3% against a locally set target of 22.3%;
- Put in place a Carers Innovation scheme to improve the identification, registration and support offered to carers within the GP practice and encourage onward referral as appropriate. The outcome of the scheme is to ensure carers are adequately supported in their caring role. 51 GP practices delivered the scheme in 2013/14, resulting in improvements in carers registers, how practices identify carers, awareness training for staff, and a better referral system to Sunderland Carers Centre;
- Development of a Telehealth text service to support Smoking Cessation Pathways in collaboration with Public Health, Durham and Darlington Foundation Trust and NHS England;
- Telehealth established as part of Pregnancy Pathways (Mild Hypertension and Gestational Diabetes) which has gained national and international interest;
- Considerable work was carried out within SCCG practices, supported by the Medicines Optimisation Team in order to retain patients on Repeat Dispensing and to initiate new patients. For March 2014 the figure had reached 29.3% exceeding the SCCG target of 27.5%. Recently released annualised national figures indicate that from April 2013 to March 2014 the CCG was in the top 10 performers for "Percentage of all items prescribed as electronic repeat dispensing as a proportion of all electronic prescriptions" (39.0%) and for "Percentage of repeat dispensing items compared to all prescribing" (27.6%).

# 7. Enablers of Change

In 2013/14 NHS England outlined five offers which were seen to be the key enablers of change:

1. NHS services, seven days a week
2. More transparency, more choice
3. Listening to patients and increasing their participation
4. Better data, informed commissioning, driving improved outcomes
5. Higher standards, safer care

The NHS Outcomes Framework remains the focus to demonstrate improvement in outcomes with the introduction of seven critical indicators of success against which CCG's should track their progress:

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

In addition to these 7 critical indicators, NHS England also expect to see significant focus and rapid improvements against the following three measures:

- Improving Health
- Reducing Health Inequalities
- Parity of esteem (between mental and physical health)

In July 2013, NHS England along with national partners launched *A Call to Action* which sets out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. Specifically outlining the need to raise the quality of care for all in our communities to the best international standards while closing a potential funding gap of around £30billion by 2020/21.

In order to meet these challenges, NHS England have identified that any high quality, sustainable health and care system in England will have the following six characteristics in 5 years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care;
- Wider primary care, provided at scale;
- A modern model of integrated care;
- Access to the highest quality urgent and emergency care;
- A step-change in the productivity of elective care;
- Specialised services concentrated in centres of excellence.

Our response to these national drivers is set out in the following sections.

# 8. Our Outcome Ambitions

Through delivery of our transformational programmes we expect to make significant progress against the critical indicators of success outlined by NHS England and have been ambitious in setting outcomes for the future:

| Critical Indicator of Success | Outcome Ambition by 2019 |
|---|---|
| Securing additional years of life for the people of England with treatable mental and physical health conditions | Reduce years of life lost by 7% |
| Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions | Improve quality of life for those with long term conditions by 8.9% |
| Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital | Reduce emergency admissions by 14% (composite measure) |
| Increasing the proportion of older people living independently at home following discharge from hospital | 5% increase by March 2015 |
| Increasing the number of people with mental and physical health conditions having a positive experience of hospital care | Improve patient experience of hospital care by 7.2% |
| Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community | Improve patient experience of out of hospital care by 8% |
| Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care | Increased reporting of medication errors;<br>MRSA Zero tolerance;<br>Achievement of Cdifficile nationally set trajectory |

# 9.0 Better Care Plan

The £3.8billion Better Care Fund has been introduced nationally to encourage transformation in integrated health and social care. This fund is a single pooled budget to support health and social care services to work more closely together to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

Better Care plans must deliver on the following national conditions:

- Protecting social care services;
- 7 day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional.

The Better Care development has been seen as a real opportunity within Sunderland to drive change through a system wide approach with a pooled budget of £24.778m identified in 2014/15, in comparison to the minimum required value of £12.052m, and up to £169m identified moving forward into 2015/16, in comparison to the minimum required value of £24.778m.

The joint initiatives within the Sunderland Better Care plan are set out in the Sunderland Health and Care System plan on a page, which can be found on Page 46.

# 10.0 Ensuring we have a high quality sustainable healthcare system by 2019

In identifying our priorities over the next five years, we have considered the six characteristics of a high quality and sustainable system outlined by NHS England.

Over the last few years much attention has been given locally to planned care and acute services and our system is generally performing well in relation to the NHS Constitution requirements

Our main focus over the first two years of our plan will be to focus on four of the six characteristics, namely:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care;
- Wider primary care, provided at scale;
- A modern model of integrated care;
- Access to the highest quality urgent and emergency care;

We have also considered the key messages we have heard from a Call to Action specifically outlining the need to raise the quality of care for all in our communities to the best international standards while closing the funding gap of potentially around £30billion nationally by 2020/21, approximately £150m locally for Sunderland, and identified those transformational changes which will provide us with the biggest impact in terms of improving quality whilst making significant savings over the next five years.

With all this in mind we have outlined our response against each of the six characteristics of a high quality and sustainable healthcare system for the next five years. This includes the 10 Transformational programmes of work which will be undertaken in the first two years which will lay the foundations to ensure we achieve our 5 year vision and strategic objectives.

## 10.1 A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care

By 2019 we will ensure patient experience is central to service development and that patients, carers, and the public are actively and systematically involved in all aspects of service design and change. We will also ensure that patients are fully empowered to make informed choices regarding their own care.

## Public Participation

Being patient centred is one of our 7 core values. This really means ‘no decision about me, without me’ for patients and their own care. The same goes for the design of health and social care services. We are making sure we have effective ways to always involve patients and the public when identifying their needs, the plans we develop to meet these needs and evaluating whether services are meeting them.

The majority of GP practices in Sunderland have their own patient groups and localities will explore the most effective ways of bringing these voices together to enhance their knowledge of the patient and public perspective at a local level.

As a health and social care system we will continue to proactively engage with the wide range of local partners including the business community, community and voluntary sector and clinicians to ensure both our short and long term plans reflect local need and that partners play a key role in change for local people.

We will also continue to seek the views and opinions of local people, patients, voluntary and support groups about the services we provide through a wide

range of activities including surveys, focus groups, formal consultations and events. My NHS' will be proactively populated to represent Sunderland demographics and engagement opportunities, related to interest, actively marketing using this tool.

We will use the Local Engagement Board every 2 to 3 months which anyone is welcome to attend and is advertised in the local press. These now meet in the localities to update on key developments and seek views about proposals.

We have also developed a good working relationship with Healthwatch, the new local independent body, required by law to ensure the views and experience of people who use health and social care services are heard and taken seriously by statutory bodies such as Sunderland CCG. Healthwatch are a key member of the Health and Wellbeing Board and our Sunderland wide Transformation Board.

We will continue to work with our service providers to upon feedback from the Friends and Family Test in hospitals and are able to demonstrate the action we have taken from this feedback including plans to work with providers on further roll out from 2014/15.

We review feedback on patient experience from a wide variety of sources, especially that feedback collected via our providers and this forms part of our assessment of the quality of those services and is used in contract meetings with those providers to ensure a focus on safety, good patient experience and effective services.

We will be using new technologies and communication methods, such as Twitter and Facebook, to reach all parts of our society to listen to what is important to them in improving local health services.

## Individual Participation

Enabling self care and sustainability is one of our three strategic objectives and we are committed to have a focus on helping individuals to better manage their own health and heathcare needs.

We will continue to invest in empowering local people through effective care navigation, peer support, mentoring and self-management programmes to maximize their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

Through our work in developing locality integrated community teams, we will ensure that every person in Sunderland with a long term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.

We will also ensure that any person who would benefit from it will have access to their own personal health budget.

## 10.2 Wider Primary Care, provided at scale

By 2019 we will have a high quality, safe, sustainable primary care system fully integrated within a whole health and social care system, operating within available resources to improve health and provide timely access to appropriate services for the population of Sunderland.

Primary care services are currently commissioned by NHS England who have a key focus on the following areas over the next two years:

| Objective | Key Initiatives |
|---|---|
| Improving Health | Focus on cancer, CVD, respiratory and mental health |
| | Engaged and empowered citizens |
| | Access to primary medical services |
| | Access to primary dental services |

| | |
|---|---|
| | Access to ophthalmic services |
| | Ensuring maximum use of community pharmacy services |
| Reducing health inequalities | Focus on cancer, CVD, respiratory and mental health |
| | Implementation of GMS contractual requirements for over 75's |
| | Facilitate development of integrated community care systems to support vulnerable patients |
| Financial Management | Review impact of changes in MPIG |
| | Develop a strategy for PMS service reviews |
| | Review general dental access – shifting resource to address areas of under capacity |

From 1st April 2014, GP Practices have been offered the opportunity to take part in an enhanced service, which is designed to reduce avoidable unplanned admissions by improving services for the most vulnerable patients and those with complex, physical or mental health needs. The key components of the enhanced service will be for practices to:

- Ensure that other clinicians can easily contact the practice by telephone to support decisions relating to hospital transfers or admissions;
- Carry our regular risk profiling to identify at least 2% of adult patients – and any children with complex needs who will benefit from more proactive care management;
- Provide proactive care and support for at-risk patients through developing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care co-ordinator;
- Work with hospitals to review and improve discharge processes and undertake internal reviews of unplanned admissions / readmissions.

All of these elements, taken together, will lead to GP's being more clearly accountable for co-ordinating the care of patients with more complex needs.

In addition to this the CCG have identified £5 per patient from its 2014/15 allocation to support practice plans for improving services for over 75yrs and complex patients.

In addition to the priorities outlined by NHS England, the key findings from 'Improving General practice – A Call to Action' have also been considered with the following findings of particular interest in Sunderland:

- Alignment of IT systems across primary and secondary care;
- Consideration of pooling / federating of GP practice resources;

In order to ensure alignment of IT systems across primary and secondary care the following programmes of work are currently underway:

- City wide rollout out of EMIS Web GP clinical system – to improve data sharing and system integration across Providers;

- Development of CQUIN schemes within local Providers to improve integration and delivery of clinical correspondence directly into GP systems;

- Development and implementation of data extraction tools across primary care to integrate GP Practice data alongside secondary and community care data.

- Potential roll out of EMIS Community to enable community nursing to read practice information.

In order to better enable integrated working, 26 GP practices across Sunderland have expressed a desire to pool their resources to create a GP Alliance. The benefits to Sunderland are to:

- Strengthen clinical governance and improve the quality and safety of services;
- Develop training and education capacity;
- Strengthen the capacity of practices to support, develop and tender for new services outside of hospital;
- Make efficiency savings, economies of scale, for example in back office services or the procurement of practice services;
- To improve local service integration across practices and other providers.

The CCG is working with NHS England to support the development of at scale providers of primary medical and nursing care.

The key role which community pharmacy can play in supporting patients with minor illness, promoting health and helping people to both avoid hospital admission and re-admission, has been recognised by all stakeholders and it is timely to challenge the current role and model of community pharmacy and consider a broader role for pharmacists as caregivers.

There are 61 community pharmacies in Sunderland and our aim is to improve access for patients, carers and the public to a broader range of services and care from pharmacy than the traditional dispensing and supply of medicines. This could include pharmacists working more closely with patients and healthcare colleagues in outreach teams, patients' homes, residential care, hospices, and general practice, as well as in community pharmacies, helping people to manage illness, providing health checks, supporting best use of medicines, and detecting early deterioration in patients' conditions.

NHS England has given all CCG's the opportunity to co-commission Primary care services. We have therefore expressed an interest in undertaking co-commissioning in support of our self care and out of hospital strategic objectives through the following activities:

- Supporting workforce recruitment and development in primary medical and nursing care;
- Enabling extended primary medical and nursing care at scale;
- Influencing pharmacy and dental provision;
- Co-commissioning enhanced services.

## 10.3 A Modern Model of Integrated Care

By 2019 people will receive the right care, for the right people, in the right place at the right time from people with the right skills.

Integration of health and social care services within Sunderland is based on a vision that has been formed by what the people of Sunderland have told us they need from health and social care services. There is a desire amongst people in Sunderland for a safe, integrated, effective and timely response that meets their individual needs.

People want choice and control, support to continue living in their own homes and communities with services that are co-ordinated to meet their individual needs at times which they require. At the heart of the vision is the ambition to deliver the right care and support, at the right time, in the right location with the right people to meet the needs of the individuals, their carers and families living within Sunderland.

The Sunderland vision for integration identifies 5 priority elements within the Integration programme:

- An overall integrated operating model;
- Locality integrated teams across health and social care;
- Integrated commissioning processes;
- Shared intelligence processes;
- Enhanced user focus both in terms of engagement and influencing behavior to manage demand.

The vision for integrated services will be built around bringing together social care and primary / community health resources into co-located, community focused, multi-disciplinary teams, linking seamlessly into hospital based services.

Those who require health and social care services will receive the right care and support in their own homes and communities through the development of community integrated locality teams organised around GP practices which will ensure:

- Services are co-ordinated around individuals and targeted to meet specific needs;
- Outcomes are improved for individuals;
- Improvements in the care experienced by individuals, their families and carers;
- Independence is optimized, by providing the right support in a timely manner, focusing on a re-ablement approach;
- People have high quality, tailored support which focuses on people staying out of hospital;
- People's care is co-ordinated and managed, with the GP at the heart of organising the care, avoiding unnecessary admissions to hospital and care homes – enabling people to regain skills and independence after episodes of ill health and / or injuries.

At the heart of this programme is the commissioning approach which is focused on defined locality populations, rather than by specific service.

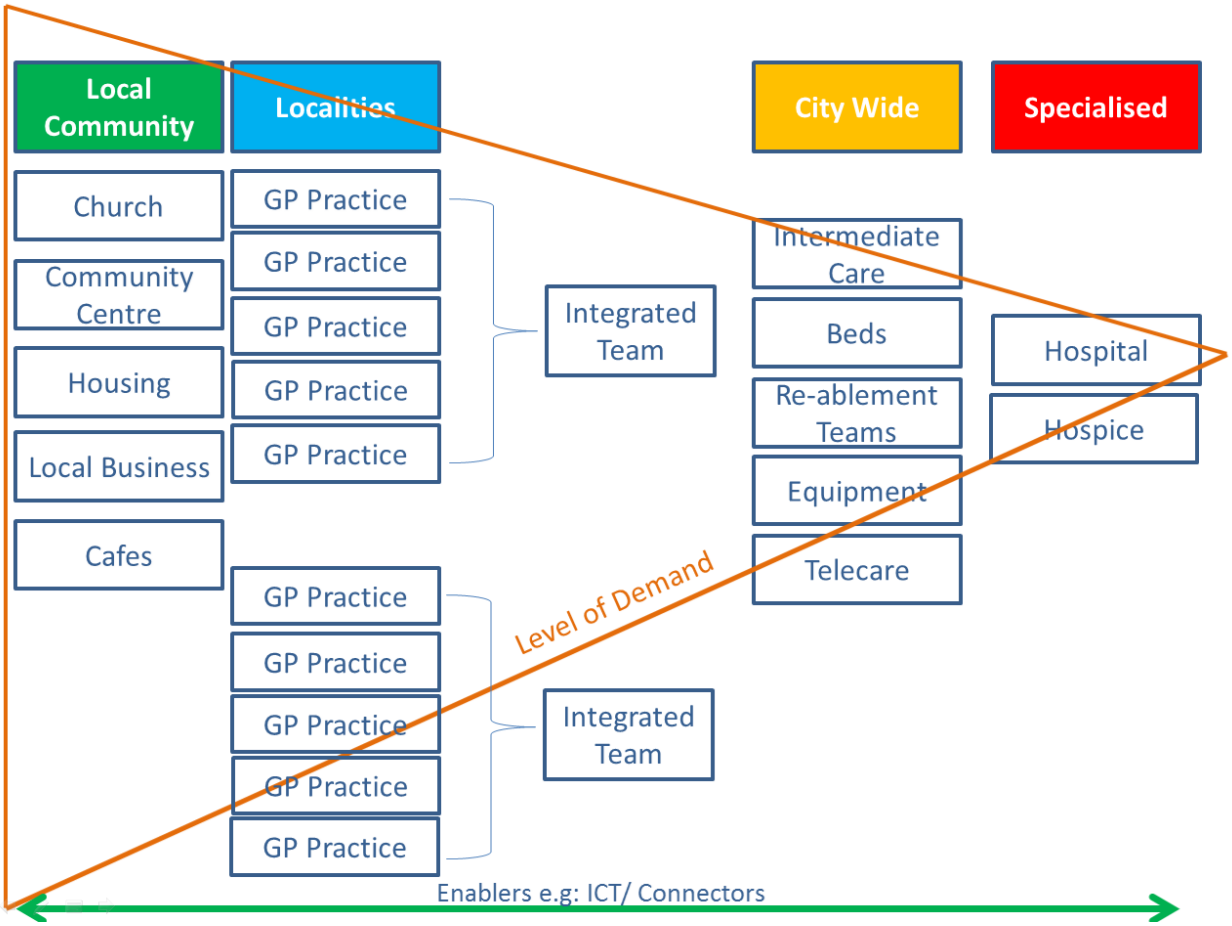
Within Sunderland it is recognised that integration of health and social care services needs to involve mental health services. Within NTW (Mental Health Trust) there has been significant work to integrate pathways of care for people using their services. It is expected that, where appropriate, mental health resources will be linked into the locality integrated teams through the Person centred co-ordinated care programme, especially in relation to supporting people with dementia symptoms and avoiding the need for admissions to residential care.

To ensure the system we are working within enables, and not hinders integrated care, the CCG and Local Authority will be commissioning jointly focusing on improving outcomes for individuals.

On the 5th & 6th June, the CCG and local authority took the lead in working with partner organisations across health, local government and the voluntary sector to further develop the health and social care integration agenda and create a shared understanding and commitment to how the agenda will be delivered. This was undertaken via an Accelerated Solutions Event with over 100 attendees from all partners including Healthwatch and the Voluntary sector. The objectives set for the event were:

- Reaffirm the vision and outcomes for Sunderland and the financial context in which this needs to be delivered;
- Understand and define HOW the health and social care integration agenda will support the achievement of these outcomes over the next 2 years
- Discuss and shape a tangible plan that will take us forward in the short, medium and long term including agreement on how to measure our success;
- Engage all key stakeholders in the programme to gain feedback on proposed service changes and identify how we will work together to drive greater quality, value and sustainability.

The Integration Board, who were sponsors for the event, felt the objectives were largely achieved. For example a model for integration, which is the overall integrated operating model was developed which is shown, in its simplest form overleaf and supports the future state set out on Page 7 of this Strategic Plan.




The aim being to enable self care in the community as far as possible, supported by local people who act as informal connectors to information / local activities and self care messages. At the other end of the spectrum to ensure only those who really need acute / specialist intervention access this level of support. Along the spectrum in between to make sure those with long term conditions and / or complex needs are identified and receive proactive person centred care from formal connectors and care coordinators who consider their overall health and wellbeing rather than only the 'sickness' aspect of their lives. Citywide intermediate services will provide the scaffolding to support the locality based teams, ensuring a rapid response to emergency issues and supporting both step up and step down care.

This model is based on a real person centred approach and takes account of national and international evidence which identifies the resulting major impact in terms of improved individual patient outcomes and reduction in health and care resources. The focus of our integrated teams will be on the top 3% of the population who currently account for 50% of the health and care spend.

This focus will over the course of this plan start to impact on the next 12% of patients with long term conditions who account for 36% of the spend.

More detailed work also took place on the commonly agreed key aspects of the model which will inform and refine current plans including the following areas:

- Prevention, early intervention and self help
- Engagement and Comunication
- Culture & Behaviours
- Joint Commissioning  or Making the whole model work
- Shared information and data insight
- Connectors
- Integrated Teams – Roles & Skills
- Service Co-ordinator

These key aspects from the city wide model will be informed and supported by some of the current CCG transformation programmes over the next 2 years including:

- Improving healthcare in care homes for all localities
- Implementation of end of life ‘deciding right’ initiatives in practices
- Extension of the intermediate care hub
- Development of Dementia friendly communities.
- Once this infrastructure and person centred model is in place the focus will then move to improving clinical pathways for conditions such as CVD, Diabetes, Cancer and COPD, often the conditions that lead to 3% of people  in the high risk / complex segment of the population.

In delivering Community Integrated Locality teams as well as the further transformational changes above, we will not only significantly increase the quality of care for patients, but also release savings of approximately £7.92m by 2019.  This target is a prudent target based on modelling undertaken using both the national Anytown Tool and the Torbay Local Government Value Case and has also been corroborated by further modelling using the Future Forum finding s in relation to the International Extensivist and Extended Primary care patient centric models.

## 10.4 Access to the highest quality Urgent and Emergency Care

By 2019 there will be equality of access across Sunderland to an urgent care response. From a citizens or patients perspective, urgent care services will be accessible and responsive, and provided in the most part close to home. Only patients requiring specialist urgent care & emergency care will navigate into those services.

The main acute trust in Sunderland, City Hospitals Sunderland FT, faces a continual increase in demand for urgent and emergency care services and the need to transform the whole system to deliver seamless and joined up emergency care has never been more pressing.

Whilst significant transformation in out of hospital services is underway, it is still recognised within Sunderland that transformation of the existing Urgent and Emergency Care services are required.

Over the next two years the focus will be to develop the City Hospitals Sunderland Emergency Department Urgent Care Centre outlining an integrated way to access hospital services and wider local health service provision. This relies on a whole system approach being taken in order to create an effective and efficient delivery vehicle, from preventative medicine to social support frameworks. An integrated “front door”, as well as bed space management, will help to avoid admissions, reduce length of stay and improve recovery time.

In addition to this we have procured a provider to operate three GP Led Urgent Care Units across the city. The overarching objectives of the Urgent Care Centre service are to:

- Provide comprehensive, accessible and high quality GP led treatment to both adults and children presenting with a minor illness or injury;
- Improve access of services for patients and reduce unnecessary Emergency Department attendance and admission to hospital;
- Ensure more people have access to a minor illness and injury service close to home;
- Help people to access the right service for their need at the right time;

- Adopt a shared triage tool across all Urgent Care Units and the ED/OOH service, providing consistency to patients and ensuring the same patient outcome are achieved across all services;
- Promote the use of the 111 service to help patients and the public with any future unscheduled care need;
- Work collaboratively with the 111 provider to enable the 111 service to book direct patient appointments into the Urgent Care Units;
- Reduce inappropriate admissions at the Emergency Department.

The third key element of the transformation of Urgent and Emergency care is the re-procurement of existing GP out of hours services to ensure robust interfaces across the urgent and Emergency care system and to deliver GP extended hours.

Each of our urgent care partners have, or are in the process of, being commissioned to work in collaboration with each other to support delivery of the urgent care strategic objective.

There will also be a range of resources available to citizens to enable them to navigate to the appropriate urgent care services. Resources such as 111, NHS Choices, community pharmacy support, emergency health care plans and GP telephone consultations.

Through the navigation resources available to Sunderland residents, patients will be deemed to be appropriately managed by primary and community services until proven otherwise.

GP services (including any at scale GP provider) will provide access to telephone consultations, home visits, booked appointments at surgeries or urgent care centres. The primary care urgent care services will provide 24/7 accessible & responsive clinical services working closely with pharmacies and emergency care paramedics, integrated adult & paediatric community team and the community geriatrician service. These services will deliver see, assess & manage health and social care services for those patients most at risk of hospital admission.

Patient groups such as those with long term conditions or frailty, or those at end of life, will require intensive packages of care and will be the priority patient groups for these services.

Urgent care for acutely ill children will be provided through GP services, and in urgent care centres. Children requiring specialist urgent & emergency care will access it through the Emergency Department / Urgent Care Centre at City Hospitals Sunderland.

A range of intermediate care services, including community beds & services, will be available for primary care and community services to access to support people to remain at independent for as long as possible. The 24/7 intermediate care hub will navigate patients into the most appropriate services.

Between 2014-2019, the development of urgent and emergency care pathways will be focused on ensuring the right care is provided in the right place at the right time. Patients will experience safe, timely and effective care within the financial resources available in Sunderland. Health and social care urgent care services will be accessible 365 days a year and through 24 hours:

- Patients accessing health care directly through 999 or 111 will be triaged through established mechanisms and appropriately transported or booked into emergency care;
- When patients are deemed to require specialist urgent & emergency care, they will be navigated by primary, community & paramedic staff into specialist care. They will be pulled back into primary and community care as soon as practicable;
- Primary & community services will refer into ambulatory care pathways services to see, assess & manage patients within more specialist health care pathways such as neurology, cardiology, abdominal pain & COPD, and pull them back into primary and community services as soon as appropriate;
- Patients presenting directly at CHS will be triaged through the Big Front Door, diverted into the GP led urgent care service, ambulatory care pathways or into emergency care services as appropriate.

## 10.5 A step-change in the productivity of elective care

By 2019 we will deliver high efficiency care in a convenient setting with increased patient choice, improved scheduling and a higher level of quality resulting in improved outcomes.

Over the last few years much attention has been given locally to planned care and acute services and we remain committed to ensuring the rights and pledges outlined in the NHS Constitution are consistently met across Sunderland.

As a whole system, however, we have agreed that we now need to refocus our energies on the transformation of out of hospital care.

Our main providers will continue to review their potential to improve productivity and we will review the potential opportunities for a step change in the productivity of elective care each year.

City Hospitals Sunderland FT have commenced a Surgery and Theatres Efficiencies' programme (STEP) which aims to deliver a change in the productivity of elective care. The programme will have a key focus on efficient and effective scheduling and reducing waste at all stages of the patients pathway. This should maximise and make more effective use of the existing capacity and reduce waits for surgery. The use of standardised procedures and processes and elimination of bottle necks and consecutive processes will improve utilisation of theatres and improve the outputs and outcomes for patients.

The trust is also building a new state of the art endoscopy unit which will be in operation in July 2015. The unit will be the first of its type in the UK and will be built on the concepts employed by the Virginia Mason Production System to provide high quality, efficient care with an outstanding patient experience.

In addition to this, the trust will be completing a Day of Surgical admissions (DOSA) area for Urology as part of its drive to provide day case surgery wherever clinically appropriate.

Significant improvements in mental health pathways have been implemented over recent years to increase access and reduce waiting times as identified in the earlier section on improvements to date. A further £3m will be invested over the next two years and Northumberland, Tyne & Wear (NTW) FT, will continue to transform their mainstream services with a specific focus on the following mental health pathways:

- Attention deficit hyperactivity disorder (ADHD)
- Personality disorders
- Autism
- Psychosexual disorders

## 10.6 Specialised services concentrated in centres of excellence

Work is currently being undertaken to develop a national strategy which will set out the case for maximising quality, effectiveness and efficiency in the delivery of specialised services, and a draft will be published for consultation later this year. It is recognised that services currently designated as specialised are provided from a high number of sites across England and work is ongoing to review the portfolio of activity which is set out annually in the Manual for Prescribed Specialised Services.

City Hospitals Sunderland FT is a centre of excellence in a number of areas such as Bariatric surgery, Urology, ENT, neonatology and ophthalmology and is looking to further develop vascular services. The Northern Strategic Clinical Network has recently produced a report which demonstrates the need to remodel vascular services in the North East. The case for change, based on quality service provision and AAA screening requirements is broadly accepted by local clinicians who support the principle of reorganisation of services. Discussions are ongoing with clinicians across Sunderland and Durham/Gateshead which has resulted in agreement to work collaboratively.

The vision for specialised services in the Sunderland area will be for network or hub and spoke models which ensure local provision of services where possible (outpatients and daycases) whilst at the same time still ensuring immediate input and access to expertise from specialist teams 24/7.

Supported by the CCG, City Hospitals Sunderland will focus on consolidating and further developing the range of complex services which it provides, in line with the NHS England strategy and with appropriate alignment of investment in the workforce, technology, equipment and capital plans as required.

## 10.7 Valuing Mental Health equally with Physical Health

Parity of Esteem will continue to be at the heart of our health and care plans and we will value mental health equally with physical health addressing mental health issues with the same energy and priority as we address physical illness:

- Mental health as well as physical health are assessed at GP registration and in annual health checks
- There is ongoing mental health training to GP's and practice nurses across Sunderland
- Patients can now access treatment in secondary care within 4 weeks
- All appropriate mental health staff have been trained to ensure they are able to provide NICE evidence based psychological therapies
- There is equality of access to psychological therapies across Sunderland
- Patients are prescribed medicines safely and helped to take them well with appropriate guidance, leaflets and contact for advice
- Care plans include effective interventions to ensure people recover and get employment
- In the event of mental health crisis, there is an initial response service (Single point of contact) who will assess the level of need
- There is a mental health rapid assessment interface discharge (RAID) team in A&E
- Families are well supported in caring for their loved ones with carers included in care plans and carers champions in place
- Recovery Colleges provide peer support to enable people to self manage and continue to be part of the community
- We have evidence that service users of mental health services in Sunderland are very happy with the service they receive

As detailed in section 10.5, we have continued to make significant improvements in mental health pathways over recent years to increase access and reduce waiting times.

## 10.8 Sunderland Health & Care System Plan on a Page

The Sunderland health and care system plan on a page, shown overleaf, summarises the following:

- System Vision
- Strategic Objectives
- Outcome ambitions
- Key characteristics of a high quality, sustainable healthcare system
- Key enablers
- Governance arrangements
- How our success will be measured
- Values and principles

# Sunderland Health & Care System 2014/15 – 2018/19

All together Sunderland!

## Vision: Better Health for Sunderland

| Transforming Out of Hospital care (through Integration and 7 day working) | Transforming In Hospital Care, specifically Urgent & Emergency Care (7 day working) | Enabling Self Care and Sustainability |
|---|---|---|

## Outcomes

| | | | | | | |
|---|---|---|---|---|---|---|
| Reduce years of life lost by 7% by 2019 | Improve health related quality of life for people with LTC by 8.9% by 2019 | Reduce Emergency Admissions by 14% by 2019 | Increase the proportion of older people living independently at home following discharge from hospital by 5% by 2015 | Improve patient experience of hospital care by 7.2% by 2019 | Improve patient experience of out of hospital care by 8% by 2019 | Make significant progress towards eliminating deaths in hospitals* |

| High Quality Sustainable System Characteristics | Key Initiatives |
|---|---|
| Citizens fully included in all aspects of service design and change and fully empowered in their own care | Communications & Engagement Strategy (including My NHS)<br>Shared decision making<br>Personal health budgets<br>Intelligence Hub<br>Wellness Service |
| Wider Primary Care, provided at scale | GP Alliance<br>Proactive and personalised Primary Care programme<br>Alignment of IT systems across Primary , Community & Secondary Care |
| A modern model of integrated care | Community integrated locality teams<br>Community Connectors model<br>Intermediate care hub 24/7<br>Improving health care in care homes in all localities<br>Implementation of deciding right initiatives in practices<br>Dementia Friendly Communities<br>NEAS Advanced Practice Paramedic (TBC) |
| Access to the highest quality urgent & emergency care | GP Led Urgent Care Centres<br>City Hospitals Sunderland Urgent Care Centre 'Big Front Door'<br>GP Out of Hours service |
| A step change in the productivity of elective care | Surgery & Theatres Efficiencies programme (STEP)<br>New Endoscopy Unit at City Hospitals Sunderland<br>Improved community mental health pathways |
| Specialised services concentrated in centres of excellence | City Hospitals Sunderland's position as a recognised provider of complex care in the North East developed in line with national strategy for specialised services |

| Enabled by | Governed by | Measured by | Values and Principles |
|---|---|---|---|
| Localities / Joint Commissioning / Contract Management (CQUIN) / Medicines Optimisation / Evidence based Approach / Research & Development | System Wide Transformation Board<br>Health & Wellbeing Board<br>CCG Governing Body<br>Integration Board | Quality & Safety of Services<br>Achievement of Outcome ambitions<br>Delivery of £150m efficiencies across the system | One system for Health and Social Care<br>Patient Centred<br>Parity of Esteem<br>7 day services<br>Team based working across Sunderland |

*Zero Tolerance MRSA, At least 10% increase in the reporting of medication errors, Achievement of Cdifficile nationally set trajectory

# 11.0 Ensuring Quality and improved outcomes

We are committed to delivering quality improvement across the three areas of quality, namely patient safety, clinical effectiveness and patient experience and have reviewed the recommendations from the Francis 2, Berwick and Clwyd Hart reports and the Keogh review and whilst we have not identified any specific risks currently, we have developed an overarching Quality Action Plan to ensure continuous improvement. One of the key lessons from events at both Mid-Staffordshire NHS Foundation Trust and Winterbourne View hospital is that a fundamental culture change is needed to put patients at the centre of the NHS. As an organisation we are committed to ensuring truly clinically led commissioning, ensuring quality and outcomes drive everything we do.

Examples of the range of actions we will continue to take include:

- Develop and maintain relationships with providers to ensure continuous dialogue on quality;
- Secure and use quality assurance information from a broad range of sources both external and local;
- Identify areas for improvement, respond to areas of concern in relation to quality and monitor accordingly;
- Maximise use of contractual levers to secure quality improvement e.g. use of quality indicators and Commissioning for Quality and Innovation (CQUIN) schemes;
- Promote the implementation of national guidance and standards with all providers;
- Work with associate/lead commissioners, including local authority, to maximise quality assurance/improvement in commissioned services;
- Summarise quality assurance reports to CCG Board as the accountable body.

### 5.2.3 CQUIN

There are robust arrangements in place for the review of incident reporting in general as well as a process to manage serious incident reporting, reviewing and determining lessons learned. Each provider at the Quality Review Group meetings report on progress of internal action plans with regard to incident reporting (low / near misses) as well as identification and implementation of lessons learned and changes to practice. These principles also apply to lessons learned from the safeguarding environment i.e.: serious case reviews.

Each provider also provides assurance that the six action areas of the Compassion in Practice implementation plans are a core theme throughout workforce development initiatives and this is reflected in the reports provided to the Quality Review Group meetings and ongoing discussions.

There is a Sunderland Safeguarding Children Board (SSCB) and Sunderland Safeguarding Adults Board (SSAB) in place with representation on both by the CCG Director of Nursing, Quality and Safety and the Head of Safeguarding. The CCG Safeguarding Team also support Partnerships which interface with the SSCB and SSAB, for example the Safer Sunderland Partnership and the Strategic Domestic Violence Partnership.

The CCG has effective arrangements in place to support the Serious Case Review process and offers supervision to health providers in the writing of their Individual Management Reviews. The CCG has established a process of ensuring the NHS England Area Team has oversight of all Primary Care Management Reviews to ensure recommendations are endorsed and monitored. There are established processes regarding dissemination of lessons learned from reviews, both within the CCG and across the health economy.

A Strategic Safeguarding Group has been established which monitors safeguarding activity and compliance with statutory processes across the health economy. Contractual arrangements regarding safeguarding have been strengthened and made more explicit in all commissioned services.

The CCG have secured the expertise of a range of doctors and nurses who make up the “Safeguarding Team” and who fulfil the statutory roles outlined in “Working Together to Safeguard children “(2013). In addition they have also employed a Designated Nurse for Safeguarding Adults and a Named GP Safeguarding Adults. The CCG has a named Mental Capacity Act lead.

We will also ensure that Commissioning arrangements for Safeguarding Adults support the implementation of statutory requirements resulting from the Care and Support Bill.

We will work together across the health and care economy to ensure that the Prevent requirements set out in the NHS National contract from 2013 onwards are embedded in practice and that staff in primary care have access to appropriate Prevent WRAP training as well as ensuring that Prevent is effectively integrated into local safeguarding arrangements.

# 12.0 Joint Working with other health economies

Sunderland will work with a variety of other health economies and these will differ subject to patient flows and contracts. We particularly work closely with South Tyneside as we share a number of joint priorities including the development of integrated teams and the configuration of acute services.

The two main acute trusts have worked together in a number of areas to date including the development of an integrated service that provides 24/7 cardiology cover and an equitable revascularisation service for all patients across Sunderland and South Tyneside.

We are also part of the Northern Forum of CCG's, meeting monthly with the aim of sharing practice and issues, and wherever possible, agreeing a whole health economy approach where it makes sense to do so for all parties.

# 13.0 Workforce Implications of our plans

As a health and care economy we will continue to ensure that appropriate levels of staff and skills are in place across Sunderland. This will support the delivery of safe and effective care whilst also considering the workforce implications of our plans moving forward and being open and transparent with all partners, in relation to what this means for individual organisations.

At this early stage, impact analysis undertaken on our key transformational changes, using the Any Town model and LGA toolkit and modelling using the extensivist and extended primary care models and associated analytical support have been shared across the economy and we continue to work together as further detail develops.

We will also strengthen relationships with Health Education England, the new national leadership organisation responsible for ensuring that education, training, and workforce development drives the highest quality public health

and patient outcomes, to ensure security of supply of a competent, compassionate and caring workforce to provide excellent quality health and patient care.

We are already in discussions with our Area Team and Health Education England North East colleagues regarding a career start programme for healthcare assistants in primary care. This programme will support development of the primary care workforce and provide a standard of competence and skill mix across the city.

In addition, we are closely involved with the primary care workforce scoping exercise being undertaken by Northumbria University on behalf of Health Education England North East.

# 14.0 Financial Sustainability

The current Chancellor of the Exchequer presented his “Spending Round” paper / proposals to Parliament in June 2013. In this document he outlined the Governments plans for public sector spending for the 2 financial years commencing 2014/15 and 2015/16 alongside some longer term projections for the overall economy going through to 2017/18. The Chancellors intention in publishing firm 2 year allocations for the public sector was to give some certainty over the remaining life of the existing parliament alongside projections for the future, however the document was very clear that it would be the new government who would ultimately decide and agree on the overall public sector finances for the years commencing 2016/17.

Following publication there was widespread agreement amongst the main stream political parties that irrespective of the makeup of the new government following the May 2015 general election the need for continuation of a strict fiscal policy would be paramount in maintaining the upturn in the economy. This is the context that the CCG has used in preparing its financial plans for the years commencing 2016/17.

Whilst central government decide on the overall public sector budgets (including the NHS) it is NHS England who agree the distribution of the total sum amongst the various sectors i.e. CCGs, Area Teams and Central Budgets. Allocations to CCGs were agreed by NHS England in December 2013 covering the 2 years commencing 2014/15. Rather than tackle the variances in actual spend to formula proposal, they decided all CCGs would receive growth funding in 14/15 and 15/16 with floor or minimum levels of 2.14% and 1.7% respectively. Putting this in context which is relevant to future years funding, NHS Sunderland's budget at the end of 2015/16 puts it at 11.54% "distance from target" (DFT). Basically the CCGs budget at the end of 15/16 is £43.9m greater than its "fair share" of the national cake as outlined in the formula. This also has a bearing on assumptions used by the CCG in formulating its financial plans for years 3 to 5 of the strategic plan.

The Chief Financial Officer of NHS England (Paul Baumann) wrote to CCGs in February 14 and outlined some potential "allocation growth assumptions" for the 3 years commencing 2016/17 which were based upon GDP deflators of 1.8%, 1.7% and 1.7% respectively. CCGs could use these figures in their plans as a "maximum", however local discretion is allowed to use "lower" growth assumptions if it is felt warranted. Given NHS Sunderland's closing DFT (+11.54%) at the end of 15/16 it was agreed to set "prudent" growth assumptions of 0.5% for each of the 3 years commencing 16/17. CCGs who are under there DFT's are already facing financial pressure and we feel this could give rise to an accelerated national "pace of change" policy targeting organisations who are 5% or greater DFT. Using some of the national assumptions in the Paul Baumann letter if NHS Sunderland were to receive growth of 0.5% it would still be approximately 8.5% DFT at the end of 2018/19. Although not covered in the life of this plan Sunderland CCG has looked at the years commencing 2019/20 to inform a "10 year" financial strategy which is being developed.

## What does this mean for Sunderland?

The CCG does not work in isolation and needs the support of fellow commissioners i.e. the Local Authority, NHS England and all Providers to assist in delivery of the local system vision. Knowing this we have attempted to quantify the potential efficiency / savings requirements across the economy given the national / local fiscal scenario outlined above.

## Public Sector (Health & Social Care) Savings Targets 2014/15 to 2018/19

| | 14/15 £M | 15/16 £M | 16/17 £M | 17/18 £M | 18/19 £M |
|---|---|---|---|---|---|
| NHS SUNDERLAND CCG | 2.9 | 3.9 | 6.0 | 3.0 | 3.0 |
| SUNDERLAND CITY COUNCIL (Peoples) DIRECTORATE | 10.7 | 12.0? | 10 | 10 | 10 |
| CITY HOSPITALS SUNDERLAND NHS F.T | 16.3 | 14.1 | 18.5 | 15.6 | 15.5 |
| SUB TOTALS (MAINLY SUNDERLAND) | 29.9 | 30 | 34.5 | 28.6 | 28.5 |
| NORTHUMBERLAND TYNE & WEAR NHS F.T | 11.3 | 10.8 | 10.7 | ?? | ?? |
| SOUTH TYNESIDE NHS F.T. | 13.8 | ?? | ?? | ?? | ?? |
| NORTH EAST AMBULANCE SERVICE F.T | 6.0 | ?? | ?? | ?? | ?? |
| SUB TOTALS (Will include an element of Sunderland) | 31.1 | ?? | ?? | ?? | ?? |

From the table above it can be seen that the organisations whose focus is "mainly" on Sunderland need to save in excess of £150m over the life of the strategic plan. Other organisations that also provide services into Sunderland will need to deliver efficiencies so it is feasible the wider "public" sector

economy in Sunderland will need to save circa £175m in the next 5 years. The detailed figures for Sunderland CCG are highlighted in the “financial plan on a page”, however from the table above the context for the wider public sector economy can be seen.

Fundamental to the successful delivery of the savings above, will be the need to transform “pathways of care” from traditional secondary care settings where appropriate into community / primary care settings. At the heart of our plans is the expectation that non elective admissions can be reduced by 15% over the life of the plan. For the CCG and our main acute providers this impacts from 2016/17 onwards whereas for some economies the need is now. Sunderland does have the time to work through with partners the granularity of its plans to deliver its Vision and three strategic objectives and ensure ‘universal’ sign up.

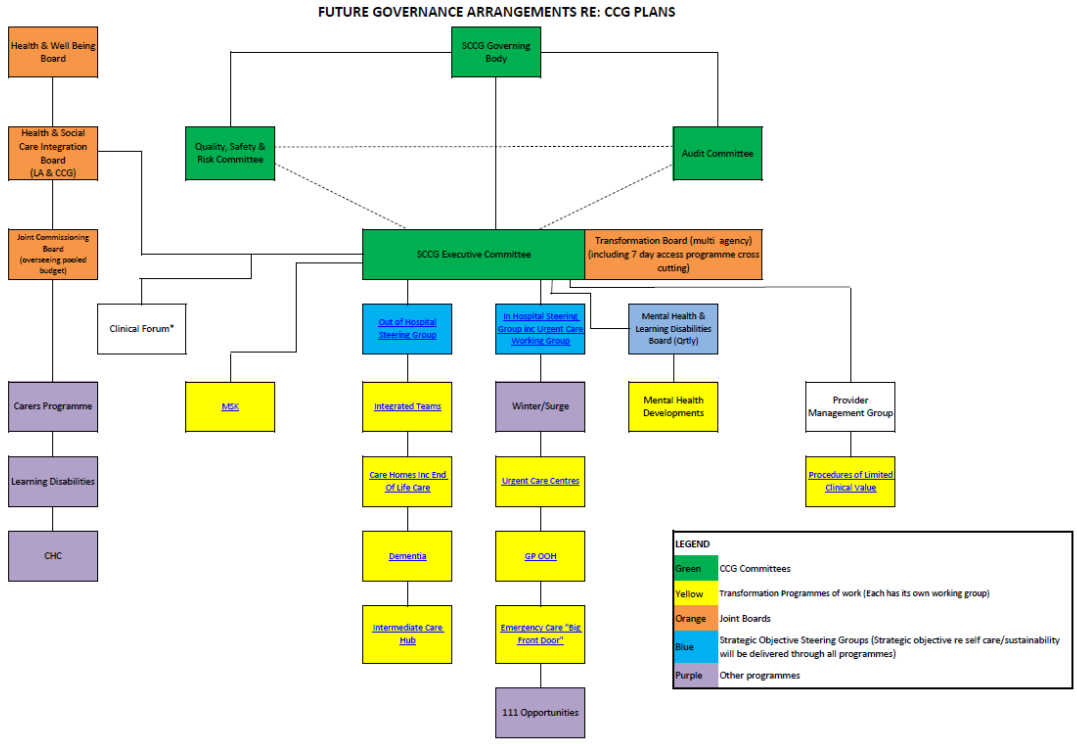
Underpinning the pathways of reform work will be the need to finance non recurrent projects and double running costs. Sunderland CCG is in a fortunate position given its sound financial situation which will be used to support the “reform” agenda outlined above. We have signalled a phased “draw down” of the financial surplus reported by the CCG at the end of 13/14, commencing in 15/16 which gives the wider economy a unique advantage to finance change effectively. Using this money wisely is key to success going forward. Failure to do this, will result in a missed opportunity which is unlikely to come around again.

# 15.0 Delivery of our plan

## 15.1 System Ownership and Alignment

As a Health and Social Care System, we have set in place a framework and structure to ensure that all of the components of this strategic plan are efficiently and effectively implemented including a comprehensive performance management regime and governance framework.

A Transformation Board, with senior representation from all key partners, has been established to ensure system ownership and alignment overseeing the delivery of this plan and a robust multi agency programme board structure, outlined below, has been established to drive delivery of key transformational changes.




NB: The clinical forum will be focused on clinical pathways to inform variation in care, however, there are also GP Executive Leads on each Programme Board.

## 15.2 Organisational Development

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people; it is often termed as the “oil that keeps the engine going”. In Sunderland we fully embrace this philosophy and the concept of continuous improvement and development. This strategic approach is critical as we continue to develop and grow as an organisation.

As the CCG is still in its infancy we have developed an Organisational Development Plan in order to:

- Support the delivery of the 5 Year Strategic Plan and 2 Year Operational Plan to deliver our vision and transformational changes to improve health outcomes;
- Ensure a system wide approach with partners to organisational learning;
- Ensure the actions we take in the shorter term support delivery of our longer term objectives;
- Ensure that the organisational enablers for delivery are in place and are being progressed;
- Establish a cross-cutting approach by connecting our efforts, skills, experiences and competencies to develop a more effective system of commissioning.

As a clinically led organisation, the CCG will add value and continue to use appropriate mechanisms to seek feedback on our performance as leaders of the local health economy.

We are working with our partners to address our shared priorities and challenges and ensure our approach to organisational development across the health economy provides a strong platform to deliver our vision.

As an organisation we promote organisational learning and are committed to promoting a learning culture to ensure that all staff are developed to provide safe and effective care and to achieve their full potential.

## 16. Equality and Diversity

An Equality Impact Assessment has been carried out on this strategic plan. There is no evidence to suggest that the plan has an adverse impact in relation to race, disability, gender, age, gender reassignment, marriage and civil partnership, pregnancy and maternity, sexual orientation, religion and belief or infringe individuals' human rights. The plan is accessible to everyone regardless of age, disability, race, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health.

The CCG buys support for managing the Equality Delivery System from the North of England Commissioning Service (NECS) and an in-depth consultation exercise was undertaken by NECS on behalf of the CCG with local stakeholders from the nine protected characteristics groups. This feedback, along with existing feedback from a prior consultation exercise undertaken in 2012, was used to inform the development of the CCG's equality objectives.

The objectives were reviewed by the Executive Committee and formally approved by the Governing Body in October 2013. An action plan has also been developed to support the delivery of these objectives and process established to monitor progress via the Executive Committee, with formal reporting to the Governing Body on a six monthly basis.

Full Equality Impact Analysis scoping will continue to take place on each programme of work to ensure that the needs of all local communities are fully reflected in the design, planning, implementation and evaluation of services.

**Item No. 8**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

**REPORT OF THE SUNDERLAND TOBACCO ALLIANCE**

## 1. Purpose of the Report

To provide Board Members with an update from the Sunderland Tobacco Alliance.

1) Update the HWB on the results of CLeaR, which is an assessment which allows local government and its partners to review the existing approach to tackling tobacco and challenge the existing tobacco control services and local leadership.
2) Update the HWB on the standardised tobacco packaging consultation.
3) Update the HWB on Making Smoking History in the North East Partnership strategic aim to reduce tobacco related harm and reduce smoking to below 5%

## 2. Background

Over the past 5 years, smoking prevalence has been falling in nationally, regionally and locally, but it still remains the single biggest preventable cause of premature deaths and preventable disease in Sunderland. According to the Health Profile in 2014, the rate of smoking related deaths was 405, worse than the average for England. This represents 596 deaths per year[1]. According to Public Health England's Segment Tool [1] the biggest contribution to the largest gap in life expectancy between Sunderland and England was due to excess deaths caused by lung cancer, other cancers and COPD.

## 2.1 National

To set the context it is important to consider action in relation to tobacco on three levels; national, regional and local. In March 2011, the Government published, Healthy Lives, Health People: a Tobacco Control Plan for England. The plan has three ambitious goals:

- to reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015 (from 21.2 per cent)
- to reduce rates of regular smoking among 15 year olds in England to 12 per cent or less (from 15 per cent) by the end of 2015
- to reduce rates of smoking throughout pregnancy to 11 per cent or less (from 14 per cent) by the end of 2015 (measured at time of delivery)

[1] Public Health England; Segmenting Life Expectancy Gaps by Cause of Death; www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

## 2.2 Regional

In 2005, Fresh - Smoke Free North East was formed as the first dedicated regional programme to tackle smoking related illness and death. Since 2005, the North East has seen the adult smoking rate fall at twice the national average. Fresh brings together a wide range of partners to deliver a coordinated approach to making tobacco less attractive, less accessible and less affordable.

## 2.3 Sunderland

**Adult smoking rates in Sunderland**
Smoking prevalence has been falling in Sunderland over recent years from 29.7% to 23.4%[2]. This compares to 19.5% nationally. Locally this rises to 33.6% among people employed in routine and manual occupations. This compares to 29.7% nationally.

**Smoking rates in young people in Sunderland**
No national data set is available for rates of regular smokers among 15 year olds. A survey showed that in the North East the average age for starting smoking was 15 years old[3]. The Sunderland Health Related Behaviour Survey in 2012 reported that 8% of year 10 boys and 14% of year 10 girls smoked occasionally or regularly, which is an average of 11%. According to the Sunderland College Survey in 2013, this increases to 20% smoking, with a quarter of these starting at college.

**Smoking rates throughout pregnancy in Sunderland**
The Integrated Household Survey data shows that over the past 5 years Sunderland has reduced smoking in pregnancy from 23.4% to 18.6%[4]. This year we have seen an increase to 19.9%. This compares to 12% nationally.

## 3. CLeaR – Sunderland Tobacco Alliance

Sunderland's Tobacco Alliance formed in 2003, is a multi-agency group which leads on the strategic overview of reducing tobacco smoking locally. The Alliance, chaired by Public Health, delivers a coordinated approach with key partners. The remit of the group is to develop a local action plan which supports the national aspiration goals and the eight key strands of Fresh. A three year action plan for Sunderland is in place for 14/17.

**3.1** In March 2014 the Alliance undertook a voluntary peer assessment visit called CLeaR. CLeaR is an improvement model providing local government and its partners with a structured, evidence-based approach to achieving excellence in tackling tobacco harm. The assessment team reviewed the existing approach and provided objective feedback on Sunderland's performance against the model. (An executive summary can be found in appendix 1)

[2] Integrated Household Survey; July 2014
[3] YouGov 2014
[4] Integrated Household Survey; July 2014

Overall the Alliance was congratulated in reducing smoking prevalence, demonstrated effective leadership, demonstrated effective partnership working and had strong relationships across the local tobacco alliance/ partners.

The CLeaR review suggested opportunities for development through:

- setting a longer term vision for reducing smoking prevalence
- engaging with a broader range of strategic leaders for tackling tobacco harm across the City
- Strengthening the Alliance with clinical leadership through the CCG, GPs and secondary care.
- Engaging clinical champions in prioritising tackling smoking across the NHS particularly within City Hospitals and across secondary and primary care

### 3.2 Standardised tobacco packaging consultation

On 26th June, the draft regulations for standardised packaging were published for consultation. This is a short consultation of 6 weeks, and will close on 7th August. The draft regulations for standardised packaging can be downloaded on: www.gov.uk/government/consultations/standardised-packaging-of-tobacco-products-draft-regulations

The introduction of standardised tobacco packaging will support local efforts to reduce the number of young people who smoke, removing one of the few remaining opportunities the tobacco industry has to market their products to children. Tobacco packaging is designed to be attractive to young people. Evidence shows that standardised packaging with health messages is less attractive to young people. A polls show that 81% of teenagers in the North East think we should introduce standardised packaging. Support for standardised packaging is at an all-time high with 69% of people in the North East in favour[5] and only 9% opposing.

In Sunderland most smokers are keen that their children do not to start, and support initiatives such as smokefree play areas and smokefree cars. During August 2013, public health carried out a survey of 347 local people in parks across the City 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.

In the original consultation Sunderland City Council submitted the results of a focus group held with a year 7 class at a Sunderland school. The group rated the standardised packs as being more harmful to health and less attractive to young people than branded packs. Below are some young people's comments around standardised packaging:

*"I think that the plain packages is great idea as there is dark and gloomy colours and what could happen to them if they do smoke"*

[5] YouGov 2014

*"If cigarette are in a fancy packet people would want to buy them but if they have warnings and horrible pic's people would think twice about buying them"*
*"I think packaging will make a difference as it will put people off and make them think twice about buying them"*

### 3.3 Making Smoking History in the North East Partnership strategic aim to reduce tobacco related harm and reduce smoking to below 5%

Whilst the North East and Sunderland have made significant progress in the last decade in reducing adult smoking rates, it is clear that rates amongst priority groups (routine and manual workers, pregnant women, and people with mental health issues) are significantly higher than in the general adult population. Over the last two years smoking rates appear to have stagnated in the North East at around 20-22% and are yet to break through the 'magical' 20% barrier.

At the March 2013 Fresh conference, delegates felts that planning now needs to take into account longer term goals to ensure that a short term perspective does not allow any sense of 'mission accomplished to set in,' e.g. to set longer term aspirations around the concept of 'making smoking history' and imaging a time when smoking is essentially becomes 'a thing of the past'.

Fresh are coordinating a new regional strategic group called Making Smoking History in the North East Partnership. The aim of the partnership is to reduce tobacco smoking in the North East to below 5% in adult smoking rate by 2025. Whilst there are risks to setting an ambitious aim and then not achieving this, on the basis of the North East vision to 'make smoking history' and to significantly improve health and wellbeing across all communities and localities, setting a target of 5% adult smoking by 2025 could have significant benefits (appendix 2 for full report from Fresh)

.

## 4. Issues Where HWB Could Add Value

1) Board to support the opportunities for development identified through the CLeaR review such as setting a longer term vision for reducing smoking prevalence, engaging with a broader range of strategic leaders, strengthening the Alliance with clinical leadership and engaging clinical champions in prioritising tackling smoking across the NHS particularly within City Hospitals and across secondary and primary care
2) Board to support and submit a response to the standardised packaging consultation
3) Board to support the aspirational aim for a 5% adult smoking rate by 2025.

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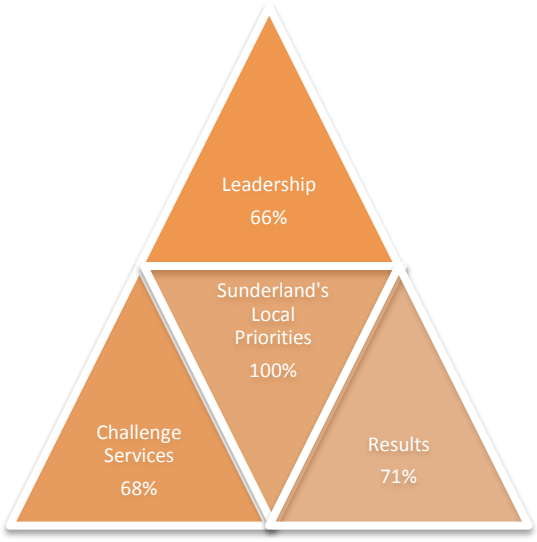
# CLeaR Thinking

## CLeaR Model Assessment for Excellence in Local Tackling tobacco harm

**Sunderland**

**5th March 2014**




Sunderland's CLeaR scores as a % of the total available in each domain

## CLeaR Context

CLeaR is an improvement model which provides local government and its partners with a structured, evidence-based approach to achieving excellence in local tackling tobacco harm.

The model comprises a self-assessment questionnaire, backed by an optional challenge and assessment process from a team of expert and peer assessors. The purpose of the assessment is to test the assumptions organisations have made in completing the questionnaire and provide objective feedback on performance against the model.

The report also provides a number of recommendations (CLeaR Messages) and the assessors suggestions for revised scores accompanied by detailed feedback on specific areas of the model (CLeaR Results). In addition we suggest some resources you may find useful as you progress your work on tackling tobacco harm (CLeaR Resources).

## CLeaR in Sunderland

Local Public Health Leads Julie Parker-Walton and Liz Parkes invited the CLeaR team to validate the CLeaR self-assessment process in Sunderland as a benchmarking exercise for the local authority and tackling tobacco harm alliance.

The CLeaR team for the visit was:

- Andrea Crossfield, Chief Executive, Tobacco Free Futures (lead assessor)
- Lisa Surtees, Business Manager, Fresh Smoke Free North East
- Paul Christer, Environmental Health Team Leader, Gateshead Council

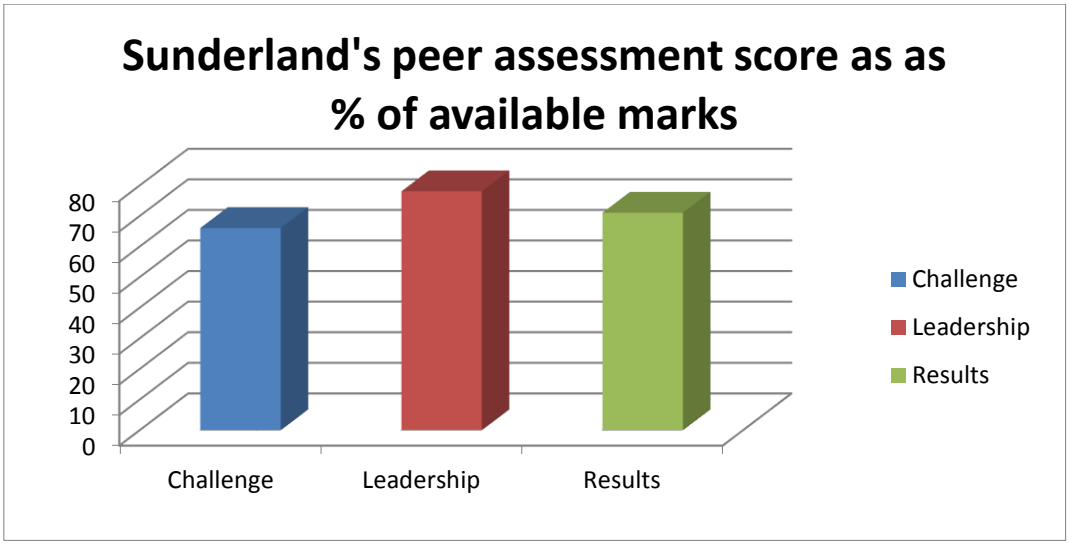
This report summarises conclusions of the CLeaR Assessment team following their visit and a series of interviews held on 5th March 2014. It sets Sunderland's challenge in context, providing information on the economic impact of smoking in Sunderland.

In carrying out the CLeaR assessment we built on the locality's insights into areas for improvement, as recognised through their own self-assessment questionnaire.

Special thanks go to Julie Parker-Walton and Liz Parkes for their assistance in co-ordinating responses to the self-assessment and organising the assessment visit and making the assessment team feel so welcome. Thanks also go to all those who gave their time to participate in the workshop led by the CLeaR team; their willingness to engage with the process, honesty and integrity were greatly appreciated:

- Councillor John Kelly
- Christine Bulmer
- Gemma Handley
- Gillian Gibson
- Gillian Lund
- Jo Dickinson
- Joanne Turns
- Julie Parker-Walton
- Laura Cassidy
- Liz Parkes
- Michael Chappell
- Nonnie Crawford
- Richard Reading
- Rose Peacock
- Sam Meredith
- Sheila Rundle
- Susan Goodchild
- Helen Pearce

## CLeaR Messages




| CLeaR Domain | Max score | Self-assessment score | CLeaR Assessment score |
|---|---|---|---|
| Challenge Services | 78 | 57 | 53 |
| Leadership | 60 | 41 | 40 |
| Results | 28 | 21 | 20 |

**Your insights:**

- **Tackling tobacco harm is a high priority for you as part of a wider Wellbeing agenda. It is clearly embedded in the Health and Wellbeing Strategy and links into the broader strategic priorities through the *Sunderland…for a better future Strategy 2008-2025* and into the Sunderland CCG's *Better Health for Sunderland Plan* priorities. However, you recognise there is much more work to do to fully engage all local NHS partners in this agenda.**

- **While there has been a focus on 4 week quit targets and smoking at time of delivery targets, prevalence targets are also clearly articulated in the Health and Wellbeing Strategy and stopping young people from starting to smoke is also a real priority. Reducing exposure to secondhand smoke in homes and cars also remains a local priority.**

- **There has been no local authority scrutiny of tackling tobacco harm for some time, however there is an intention that the CLeaR report will be shared with the Health and Wellbeing Board.**

- **Your alliance is well established and has diverse membership: chaired by Julie Parker-Walton, it reports directly to your Adult Partnership Board, which in turn reports into the Health and Wellbeing Board. The Adult Partnership Board received a full update report on progress to tackle tobacco from the Alliance in November 2013.**

- **SATOD rates significantly remain higher than the England and regional average although rates have fallen and tackling this is a priority for you to give every child the best start in life. You are doing this through the implementation of babyClear in partnership with Fresh Smoke Free North East.**

- **Some concerns were expressed that while recent falls in smoking prevalence had been significant, a "hard core" of smokers less willing or able to quit had now been reached (it is important to note that there is no research evidence to support this).**

**Your strengths:**

- Your local and collaborative work has resulted in a significant and sustained fall in adult smoking prevalence over recent years which is far greater than the England average prevalence drop. This would be expected to follow through into improved health outcomes for your local population in coming years reducing the burden of smoking related disease and death and importantly through reducing adult prevalence, also reducing youth uptake. The NICE Tobacco Return on Investment Model (http://www.nice.org.uk/ROItobacco) demonstrates clearly that such reductions in prevalence will also deliver short, medium and long term economic returns on investment benefiting not only the local health economy, but also the local authority directly, with additional significant immediate returns to the local business economy. This is a real achievement.

- There is political commitment to tackling tobacco harm in Sunderland: demonstrated by member engagement with the CLeaR process and real leadership and engagement with the tobacco agenda; the longstanding support for the local tobacco alliance; and support for the collaborative Fresh Smoke Free North East programme.

- Transition does not yet appear to have had a significant negative impact on the prioritisation of tackling tobacco harm and the dedication, professionalism and personal passion of the staff tasked with coordinating this work as an element of their role was evident to assessment team. Nor does it yet appear to have had any significant negative impact on the funding for the delivery of various initiatives, both local and collaborative, albeit that some concerns were expressed about continuing capacity and resource when all services may be subject to review given pressures on local government budgets.

- Existing excellent relationships between the public health team and elected members and senior local authority officers have supported successful transition, as well as embedding the focus on improving public health and Wellbeing.
- Good links have been established between the communications and marketing team and public health which greatly enhanced Stoptober coverage locally and ensured the local authority was able to fully engage its own employees. The leadership and personal commitment of Councillor Kelly in the Stoptober campaign was exemplary.
- The systematic and strategic approach to public health communications planning, alongside the collaborative investment in marketing communications through Fresh Smoke Free North East has resulted in excellent local media coverage on tobacco issues.
- There is a demonstrable commitment to tackling smoking related inequalities and to engaging communities through projects like the St Chad's Project. Equally there was a recognition that such initiatives need to be sustained and rolled out into other communities where smoking prevalence is significantly higher than average.
- There is a realistic understanding of the role that smoking cessation services can play in overall prevalence reduction. The re-commissioned service provides an increased range of access points for people to access community support to quit with significantly improved overall performance data.
- There are strong relationships across the local tobacco alliance/partnership. Alliance members demonstrate effective leadership and partnership and a strong drive to make things happen plus a willingness to work together.
- Sunderland made a significant contribution to the effort in the North East to make the case for standardised packaging, acting as a role model for other localities as to how proactively engage local communities.
- There was recognition of the added value and greater impact of local working within a wider geographical footprint and the locality works well with partners such as the Association of North East Councils (ANEC), Fresh Smoke Free North East and the North East Trading Standards Association (NETSA).
- The CLeaR team was impressed by quality of leadership for tackling tobacco harm in Sunderland and recognised the value provided by a level of consistency in key leadership figures over the several years including during transition. Leadership qualities were prominent at all levels of the partnership at strategic, management and delivery levels.

**Opportunities for development:**

- As part of your wider Wellbeing approach, it would be useful to further explore a longer term 'vision' around tackling tobacco harm in Sunderland so that long term as well as medium term prevalence aspirations could be further considered. The Sunderland Strategy does contain a 2025 target for smoking prevalence of 15% with an ambition that there would be no difference in prevalence between wards, however this did not seem to be well understood. There is also an ambitious target of 5% smoking at time of delivery. As local authorities across the North East now consider how they will turn their declared shared aspiration to *'Make Smoking History'* into a reality, that is to reach 5% prevalence by 2025 , it will be important to consider what this might mean for different communities and priority groups. There was minimal discussion from partners around this longer term vision and this is an area for development as it could help with making the continued case around local authority resourcing of tackling tobacco harm, as well as bringing on board the investment of human and financial capital from NHS partners.

- It could be useful to engage with a broader range of elected members from across the council and to work to build up a wider network of strategic leaders more generally for tackling tobacco harm issues across the city. There is an opportunity to consider using the Local Government Declaration on Tobacco Control as well as your existing membership of the Smokefree Action Coalition as a profile raising opportunity within the council. There is also an opportunity to increase awareness of the local authority's responsibilities under the WHO Framework Convention on Tobacco Control to protect public health policy from tobacco industry interference.

- There are opportunities to engage communities in ongoing advocacy issues e.g. standardised tobacco packaging, where communities in Sunderland have already been engaged and also in the visioning discussions around 'making smoking history' and engaging local communities around their aspirations around this for example exploring their desire to 'turn off the tap' of a generation of new young smokers.

- It would be useful to use the updated NICE return on investment model for tobacco control (http://www.nice.org.uk/ROItobacco) which is available on application to NICE and assess the current allocation of funds to tackle tobacco harm including supporting people to quit.

- The local tobacco alliance could be further strengthened by the engagement of clinical leadership, in particular through CCGs, GPs and secondary care. The alliance and the delivery of its work plan would also benefit from some dedicated coordination support. Concerns about the ongoing capacity to support and deliver an ambitious programme of work across services which are subject to review should be considered and the possible reallocation of existing resource explored.

- Given the excellent relationship the locality has with Fresh Smoke Free North East from which it commissions tobacco social marketing, campaigns and communications, there may be opportunities to uplift or develop existing regional campaigns and brands, to ensure the locality is able to create the maximum value from its collaborative investment and to achieve increased campaign impact.
- Engaging clinical champions in prioritising tackling smoking across the NHS particularly within City Hospitals and across secondary and primary care was recognised as a priority and could be taken forward by key leaders on the Health and Wellbeing Board.
- Lack of adequate IT infrastructure, particularly within regulatory services but also for stop smoking services, is preventing the effective and efficient delivery of services. A review of the IT systems and infrastructure for regulatory services, both Trading Standards and Environmental Health Services, and implementation of a suitable system is recommended.

**Appendix 2**

**Paper One: Discussion paper on 5% adult smoking rate strategic aim for the Partnership – November 2013**

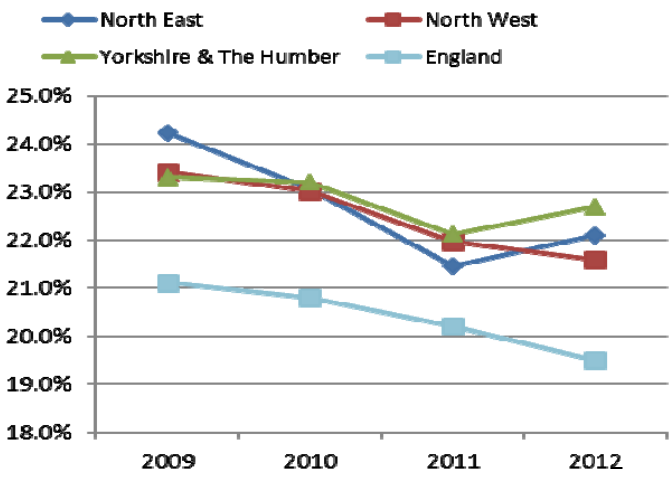
**Background and purpose of paper:**
The draft terms of reference for the 'Making Smoking History in the North East Partnership' state that: "*The strategic aim of the partnership is to reduce tobacco related harm and ultimately to reduce tobacco smoking to a suggested level of below 5% through shifting the social norms of tobacco use to make it less accessible, less affordable and less attractive".*

This strategic aim was agreed at the inaugural meeting of the Partnership in August 2013; however no timeline to achieve the aim has yet been agreed. The intention was that the Partnership would discuss this at the next meeting and this paper aims to inform discussion around what a realistic aim may be and why it would be useful for the Partnership to articulate a level of ambition around this. This paper is not a worked up strategy on end game planning but it does introduce some concepts around this and clearly the Partnership will have an active interest in this over the forthcoming months and years.

**Current North East and England position on prevalence:**
Whilst the North East and England have made significant progress in the last decade in reducing adult and youth smoking rates, it is clear that rates amongst priority groups such as routine and manual workers, pregnant women, and people with mental health issues are significantly higher than in the general adult population. The overall North East adult smoking rates declined from 29% in 2005 to 21% in 2011. This was the largest overall regional decline in England over this time period. Over the last two years, as measured by the General Lifestyle Survey, the traditional data set used to measure regional smoking prevalence; smoking rates appear to have stagnated in the North East at around 20-22% and are yet to break through the 'magical' 20% barrier.

We now also have the Integrated Household Survey for tracking national, regional and local prevalence and these are currently experimental statistics. The current position of the North East in comparison to the other Northern regions and England is shown below:

Table 1- North of England and England current prevalence from Integrated Household Survey



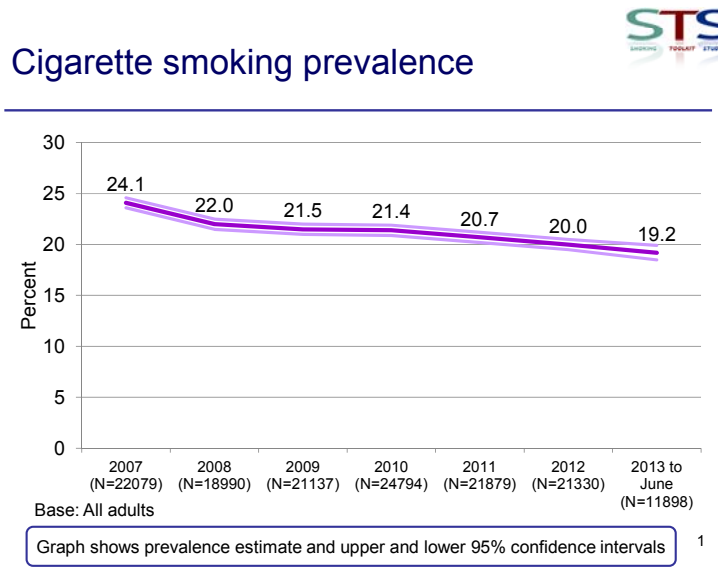

The ‘increase’ in the last IHS figures from 2011-2012 is of concern to Fresh and whilst noting that the figures are still ‘experimental statistics’, there is no room for complacency and that these are challenging times in terms of making further progress.

The local figures are not yet available, but clearly the North East figure reflects the collective progress across all 12 localities and the 2011 data showed that some localities are making much quicker progress in reducing prevalence than others and this is something that needs to be investigated further once the 2012 data is available. There are useful reports from Fresh on all 12 localities using 2011 data available at www.freshne.com

In terms of the current North East prevalence figures, a number of factors have probably influenced this including:  the impact of the economic recession on the region, reductions in the budget for mass media campaigns nationally, impact of the public health transition on service delivery, price discounting by the tobacco companies around key budget brands, 40% reduced funding to the regional tobacco control programme since 2011, amongst others, could all have an influence on the North East position.

What is reassuring however, is that nationally, there has been a return to the same levels of motivation to quit and levels of quit attempts as around the time of the smokefree legislation and for the first time England as a whole has gone below the 20% barrier (based on the findings from Professor Robert West’s Smoking In England toolkit (http://www.smokinginengland.info/).

Table 2- England prevalence 2007-2013 based on Smoking in England toolkit




**Thinking around setting an 'end game' target:**
Despite the good progress made in the North East, in both reducing smoking rates and also in making significant progress in reducing mortality rates from smoking related diseases, the reality is that smoking remains *the* key contributor to health inequalities and premature mortality within the region and still accounts for 15 deaths a day in our region.

Concerns have been expressed e.g. by delegates at the March 2013 Fresh conference, that planning now needs to take into account longer term goals to ensure that a short term perspective does not allow any sense of 'mission accomplished to set in,' e.g. once rates reduce to 20% or 15%, that the North East, and England, should look to set longer term aspirations around the concept of 'making smoking history' and imaging a time when smoking is essentially becomes 'a thing of the past'.

In terms of the academic and tobacco control community, this has been called 'end game' thinking and the discussions internationally have been largely focused around the idea that it is necessary to move beyond a focus on tobacco *control* (and its subsequent assumptions that tobacco is here to stay and that regulating the time, place and manner of its use is the policy objective) toward one focused on how to actually reach a *tobacco-free future.*

Research shows that even if smoking uptake entirely ceased and cessation increased beyond any targets reached to date, there would still be several decades of high healthcare costs attributable to smoking. Without additional measures, these costs and the preventable suffering they represent will extend even further into the future.

In terms of what is going to help us to achieve a tobacco free future, there will clearly be an on going role to continue to implement the significant evidence base of complimentary key strands of tobacco control into the future e.g. reducing tobacco

promotion and marketing, vital role of hard hitting mass media campaigns, supporting smokers to stop and the central role that price and taxation can play.

There is also an emerging need for consideration of potential new measures to add into the already established comprehensive suite of interventions e.g. the role that a tobacco registration/licensing system could play; maximizing the role of tobacco harm reduction and potentially switching smokers onto cleaner forms of nicotine delivery; further extension of smokefree legislation into private vehicles, multiunit dwellings, outdoor areas; reducing the profitability of the tobacco industry; increasing the legal liability of the tobacco industry; restrictions on availability of tobacco e.g. through 'sinking lid' ideas of product availability and also age of sale restrictions; increased product regulation such as standardised packaging and improved harder hitting pictorial warnings and clearer consumer labeling; bans on tobacco additives; adult certification for smoking in movies amongst other ideas.

The following two links provide an excellent overview to endgame thinking:
The Tobacco Endgame- Open access supplement of the journal Tobacco Control, May 2013, Volume 22, supply 1. From dramatically reducing nicotine to total abolition of cigarette sales, the series of articles includes six endgame strategies and a number of essays written to encourage public debate.
Tobacco Control: The End-Game - April 2013 presentation by Prof K Srinath Reddy, President, Public Health Foundation of India, and of the World Heart Federation and Bernard Lown Professor of Cardiovascular Health, Harvard School of Public Health

**International discussions on 'end game targets' (click on links for more information):**
Endgame initiatives are being discussed globally and some countries regarded as tobacco control leaders are instituting endgame planning. A snap shot of these discussions is provided below including what targets have been discussed.

WHO: WHO Director-General considers the tobacco endgame Dr Margaret Chan, Director-General of the World Health Organization, Keynote address at the International Conference on Public Health Priorities in the 21st Century: the Endgame for Tobacco, New Delhi, India.

FINLAND 2040: The Tobacco Act of 2010 declared that it would put an end to the use of tobacco products in Finland. There was no target date but Savuton Suomi, a civil society movement for a tobacco-free Finland, challenged the Finnish government to make it 2040 and they accepted the goal.

NEW ZEALAND 2025: In New Zealand, the Tupeka Kore (tobacco-free) vision was launched by a range of concerned NGOs and advocacy groups in 2009. This proposed a target and a series of interventions to achieve close to zero tobacco smoking prevalence by 2020. Subsequently, the Māori Affairs Parliamentary Select Committee released a report recommending that New Zealand should be smokefree by 2025, and the Government has since affirmed support for this goal

SCOTLAND 2034: *'Whilst the Scottish Government has long made clear its aspiration for a tobacco-free Scotland, this Strategy sets the date by which we hope to realise*

*this ambition. This is not about banning tobacco in Scotland, or unfairly stigmatising those who wish to smoke. Our focus is on doing all we can to encourage children and young people to choose not to smoke. By so doing, we hope to create a tobacco-free generation of Scots by* 2034*. To achieve this goal – defined here as a smoking prevalence among the adult population of 5% or lower – we need to continue to promote the shift in social attitudes so that choosing not to smoke is the normal thing no matter who you are or where you live.'* Creating a tobacco-free generation - A Tobacco Control Strategy for Scotland (March 2013) 258kb)

IRELAND 2025: The Irish Government tobacco strategy contains 60 recommendations to significantly reduce smoking over the next 12 years. They define a "tobacco-free" Ireland as one where less than five per cent of the population smoke. Tobacco-free Ireland (October 2013)

**Discusssions in England:**

In England, the current National Tobacco Plan runs from 2011-2015 and the Department of Health current focus is on the key outcome of smoking in pregnancy which is not on trajectory to 2015. This particular short term national priority focus will be of clear benefit to the North East given the challenges we have faced around smoking in pregnancy. However, we will also in parallel encourage the Department of Health to start to develop ideas for a new cross Government National Tobacco Plan, particularly so that momentum can be increased and then maintained following the 2015 general election.

Cancer Research UK will be publishing a report in December 2013 called 'Tobacco Control Endgames' and we await its publication with interest and Fresh will be participating in a roundtable discussion with its author in December.

ASH is also starting the development of a new 'Planning the Endgame' report and Fresh has been invited onto the Advisory Panel for this. Given the significance of ASH's previous 'Beyond Smoking Kills' http://www.ash.org.uk/beyondsmokingkills report this is a very welcome development and will undoubtedly be of huge benefit to the UK and internationally.

What is clear is that any long term target setting must not distract from the work that is vital in the immediate, short and medium terms. Anydiscussions around endgame need to be centred in the reality of the now, for example the tobacco industry is fighting aggressively against much needed measures such as standardised packaging.

**What is a realistic timeline for the 5% aim of the Partnership for smoking in the North East?**

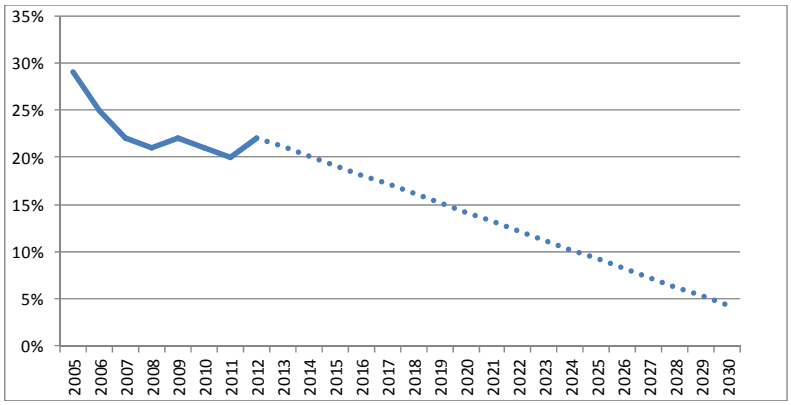
It is obvious that whatever long term aspirational aim the Partnership agrees on for the North East, this will only be successful if the local and regional work is coupled with effective national and international action. Central to this should be the focus on narrowing health inequalities so that all communities and population groups benefit.

We need to consider what the ultimate aim is. Are we looking to reduce prevalence to 5% or to end all smoked tobacco use and therefore potentially have a minority of the adult population using nicotine in a non-combustible form? This is where the emerging discussion and debates, for example on the role of “clean medicinal nicotine,” may play a role.

If we view the current thinking in its simplest form about reducing all adult smoking rates to 5% (noting that there should be further discussions around key priority groups e.g. pregnancy, young people) then based upon recent years’ data, the North East would take a significant time to achieve this level. Three different trajectories are presented below.

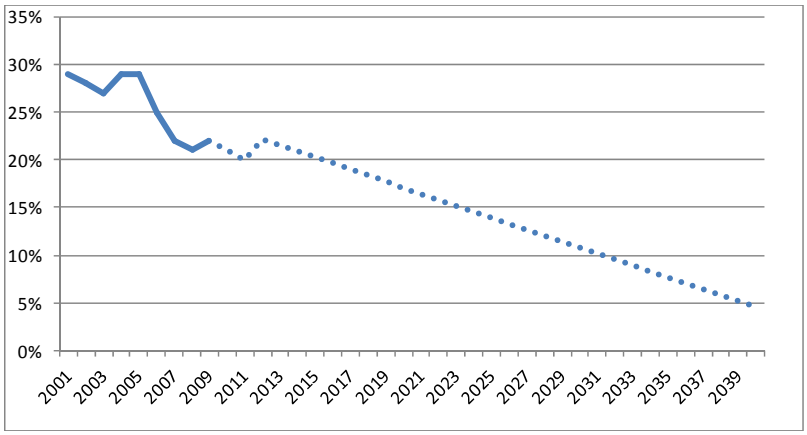
In total since 2005 (when the regional tobacco control programme was launched) adult rates have fallen by 0.986% annually.

Table 3- North East trajectory to 5% based on 2005-2012 experience- we get to 5% by 2030



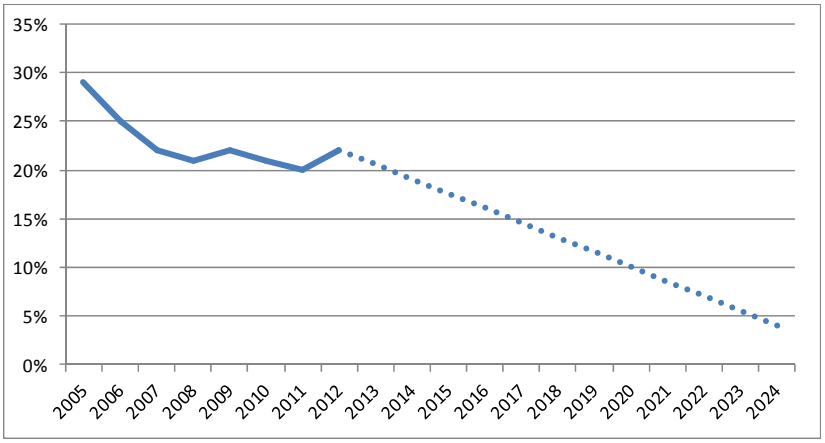

If we look at the experience from the last decade, the trajectory for the 5% looks even longer.

Table 4: North East 5% trajectory based on the 2000-2012 experience- we get to 5% by 2039



If we view the recent IHS figure showing an increase in 2012 as a statistical 'blip' and think positively of the overall trend decline from 2005 to 2011 the trajectory based on these figures looks more positive and in line with Ireland.

Table 5: North East 5% trajectory based on the 2005-2011 experience- we get to 5% by 2024




Whilst there are risks to setting an ambitious aim and then not achieving this, on the basis of the North East vision to 'make smoking history' and to significantly improve health and wellbeing across all communities and localities, setting a target of 5% adult smoking by 2025 could have significant benefits. It could help to focus efforts on: taking action on an industrial scale; helping to make the case for adequate funding so that investment levels were based upon earlier experience; help with making the case for more effective national and international action; and set out a strong statement that the region wished to follow the lead set by Ireland, which currently has prevalence higher than the North East.

Localities are also having discussions about their long term aspirational targets, e.g. Durham County Council has recently approved the tobacco alliance plan to have 5% smoking in adults/10% routine and manual workers by 2030 whilst Gateshead Council has had a 5% target by 2020 as part of its Vision 2030 for a number of years.

**Summary:**
Achieving a 5% smoking rate is ambitious and successful jurisdictions such as California have not yet declined below 10% so consideration of new policy levers are likely to be needed. Whilst a rate of 5% by 2025 may seem unrealistic on the basis of where things are in 2013 - such as challenges to local government and the NHS from funding allocations, lack of national decision making on vital regulatory issues,

pressures from other public health challenges e.g. obesity - the Partnership aspiring to this as part of the wider discussions around ‘Making Smoking History’ would send out a strong message across the North East and beyond around the scale of our collective ambition.

It will be vital over the next few months and years that the North East is closely involved in the emerging and vital discussions about ‘end game’ thinking. We can achieve this by supporting partner organisations such as ASH in planning and influencing of the national and international agendas. Coupled with this there needs to be a continued local and regional focus on the full range of tobacco issues. This will include new and emerging areas such as electronic cigarettes and new novel nicotine containing products. In the absence of regulation the latter will be undoubtedly challenging but also has the potential to be beneficial for population level public health.

The ‘end game’ discussion and planning is one that will continue over the next decade and one that the Partnership can play an active part in. Recent focus groups held by Fresh in planning our Spring campaign has highlighted that smokers are receptive to the idea of ‘making smoking history’. Crucially this would need not to be seen as a form of forced government prohibition, but would happen incrementally, evolve over the next decade, coupled with support for smokers to stop. Support from North East smokers to doing more to stop a new generation of young people from starting to smoke is high (over 80%) so discussions can be framed within overall positive public opinion.

How these discussions are framed will be important and whilst the Partnership can explore ‘end game’ thinking over new next months, this term is probably not appropriate for the public at this time and this is something we can consider in future discussions.

**Recommendation:**
For now, the Partnership is asked to consider whether aspiring to aim for a 5% adult smoking rate by 2025 is acceptable to them and to be included within the Partnership terms of reference. Further work will be undertaken, alongside our discussions with ASH et al, around aims for other key priority groups, broader ‘end game’ ideas and also on the fundamental discussion around the role of nicotine use within society as opposed to the role of tobacco.

**Item No. 9**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

**CARE ACT: THE LOCAL RESPONSE**

**Report of the Executive Director of People Services**

## 1. REPORT PURPOSE

1.1 This report provides Health & Wellbeing Board Members with brief details of the Care Acts scope, and of the developing local response to the significant changes and challenges that the Act poses.

1.2 Additional information is provided in the accompanying appendices. These comprise

- Briefing Note - Care Act ( Part 1 ) Implications
- Programme Board ( Care Act and Children & Families Act ) Governance Outline
- Department of Health Consultation Overview

1.3 Together this information is intended to provide further context for Board Members and to support the recommendations made in part 4 of this report.

## 2. BACKGROUND – CARE ACT

2.1 The Care Act received Royal Assent on 14 May and its provisions both update and extend obligations for the council, Health Services and for a range of other organisations.

2.2 The Care Act is in 5 parts.

- Part 1 - Care and Support
- Part 2 - Care Standards
- Part 3 - Health
- Part 4 - Health & Social Care (Integration Fund)
- Part 5 - General

2.3 **Part 1** updates and extends councils' responsibilities with regard to the assessment, financial assessment, and the provision of social care services for residents with social care needs, market shaping and the development of

universal services ( including an advice and information service) for local residents.

2.4 **Part 2** provides the legislative framework for the government's response to unacceptable failings in health and social care provision, primarily in relation to the responsibilities, independence and oversight of the Care Quality Commission. Part 2 also covers licence conditions for NHS Foundation Trusts, and the appointment of trust special administrators.

2.5 **Part 3** covers the establishment and responsibilities of Health Education England and the Health Research Authority. These bodies will be responsible respectively for health care worker training and ensuring there is sufficient supply of these workers, and health and social care research.

2.6 **Part 4** covers the increased integration of health and social care but from the NHS 'end' by making amendments to the National Health Service Act 2006.

2.7 In June the Department of Health (DH) issued over 500 pages of draft Statutory Guidance and Regulations as part of a major consultation exercise linked to Part 1 of the Act. The consultation only covers the changes due for implementation in April 20153 and will be followed up by final guidance and regulations this October. A consultation on funding reforms due for implementation from April 2016 is not expected until later this year

2.8 The consultation exercise closes on 15 August, and includes 84 questions / calls for evidence. An initial overview of the response and some key questions is attached as Appendix 3

## 3. THE LOCAL RESPONSE

3.1 In order to manage the requirements of the Care Act, and to ensure that the proposed responses align and support other corporate and city priorities, People Services Directorate have established a combined Programme Implementation Board (PIB).

3.2 The Boards remit is to oversee the development and successful implementation of a Care Act Programme Plan and also a separate Children & Families Act Programme Plan.

3.3 The Boards high level governance outline is attached as Appendix 2 and this also covers the project (cluster) areas that report to it. This include several areas where the activity and responses cover both the Care Act and the Children & Families Act

3.4 Individual Project plans are being finalised , and a high level mapping exercise has been undertaken to fully capture both current on-going activity , and where / what additional activity is required

3.5 The intention is to have full project plans and a Care Act Programme Plan in place by the end of July. It should be noted that much of the activity is already underway and priorities within the Programme Plan have been identified and are being addressed as priorities

3.6 The main priority projects concern

- Engagement. This underpins and better enables the delivery of a number of other projects. While a number of Care Act Workshops have been held or have been arranged already , the development and implementation of a more comprehensive Care Act Engagement Plan / Strategy – as part of wider All Together Sunderland engagement activity is therefore crucial
- Performance & Data – This project is intended to build on existing intelligence to better identify the Acts potential additional demands / costs. This information is needed in order for the programme and projects to identify and better plan resource requirements and / or the need to reconfigure current service delivery mechanisms

3.7 This local response to the challenges posed by the Care Act is similar in scope to that to that being developed across the majority of local authority areas, although governance arrangements and project configurations vary quite widely.

3.8 These local responses can now finally be stepped up a gear due to the issue of the statutory guidance / regulations. These are in the process of being reviewed by the relevant service areas as well as by the Councils Legal Services with aim of

- Identifying the scope and nature of the changes required – if any , in order to inform on-going options with regard to project and programme plans
- Developing responses (if needed ) to some of the key consultation questions

3.9 The volume of legislation and the resulting activity required to properly analyse it is significant and means that a comprehensive response to the majority of consultation questions (if required) will take some time to prepare

3.10 A consultation overview and outline responses to some key questions has been included however as Appendix C. This is based on feedback from a Regional DH / ADASS /LGA Consultation Event (2nd July) and initial feedback from service areas, legal services and from the regional Financial Assessment Officers Group

## 4 Recommendations

4.1 Health and Wellbeing Board Members to note the contents of this report and appendices and to confirm;

4.2 Whether Board members require any additional Care Act information at this point or just future quarterly updates.

4.3 Whether the Board wishes to submit a formal response to the DH Consultation Exercise and if so;

- Whether there are any more key questions / areas that they would like addressing ( in addition to those identified in Appendix 3)
- Whether they would like a workshop arranging for Board Members , in order to help inform and facilitate a formal response
- Their timescales for either receiving a more detailed response / response to more questions and/ or for attending a workshop ( in the event that Board members do require either of these)
- Whether individual questions should still be responded to / clarification sought from the DH ASAP by the services currently looking at the guidance / regulations, given the challenging timescale being worked to

## 5 Additional Papers

- Appendix 1 : Briefing Note - Care Act ( Part1 ) Implications
- Appendix 2 : Programme Board ( Care Act and Children & Families Act ) Governance Outline
- Appendix 3 : Department of Health Consultation Overview

**APPENDIX 1**

## BRIEFING NOTE - CARE ACT IMPLICATIONS

## BRIEFING PURPOSE

This briefing is intended to provide additional detail about the Care Act and some of the potential impacts / implications.

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### Part 1- Care & Support

Part 1 is by far the largest part of the Act (80 of 129 sections) and together with schedules 1-4, updates and extend councils' responsibilities with regard to;

- The assessment and provision of social care services for residents with social care needs,
- Market shaping services for residents with minimum eligible social care needs and increasingly for those without those needs levels
- The development of universal services for local residents – together with a much improved Information, Advice & Guidance service / offer

These responsibilities include;

- Working to new assessment criteria and being required to offer services to those that meet new national minimum eligibility thresholds
- Improving the assessment processes and resulting 'offers' for carers and also for young people involved with Children's Services
- Delaying or reducing the need for care and support by commissioning preventative services
- Increasingly integrating care / support services and assessments with the NHS
- Better joining up and cooperation between children's, adults, housing and public health services
- Providing a universal and accessible Advice & Information Service for all residents – not just those with social care needs
- Promoting diversity and quality in the local care / support services market to enable more residents , as well as those with social care needs to receive the help that they need
- Updating all charging policies and financial assessment processes to reflect funding reforms , and also being required to offer a new Deferred Payment Process
- Brokering Services for those without minimum levels of eligible need, but that request this help
- Improving Safeguarding , and putting Safeguarding Adults Boards on a statutory basis
- Mitigating against provider failure by meeting more adults needs when care providers collapse, and revised working arrangements with the Care Quality Commission

Not all of these responsibilities are new – some update existing legislation, some reflect best practice and some are simply business as usual.

Taken together with increasing demand, increasing expectations and increasingly restricted funding however, the Act is projected to have major implications for councils / partners. These implications include additional assessments being required, improving a range of provisions / services, additional cost pressures as well as changes to on-going commissioning arrangements with partners.

Central Government additional funding to help with integrated working and with implementation costs is not new money and is unlikely to be sufficient .In addition turnaround times between the issue of final legislation and their implementation are tight;

Some of the main changes / implications of the Care Act are detailed below;

- Consolidation and replacement of most social care legislation and charging legislation – with individual well being considered as the main driving force for the provision of care and support.
- Clear legal entitlements to care and support, and with minimum eligible needs that must be met, with these suggested as being linked broadly to the current FACS ‘Substantial’ level.
- More carers to receive support - they must be assessed in their own right and more customers will count as carers due to the carer definition being relaxed.
- The implementation of a £72,000 cap on most customers care costs, with liability after that towards daily living costs only. As this cap includes any contribution the council itself makes towards the customers care services so people could pay much less. Others could pay more as the cap is also based on what it would cost the council to procure such services itself rather than the higher actual costs self-funders may face
- Self-funders or potential self-funders will be able to request a ‘care needs’ assessment simply in order to establish the costs of their care – and will receive a notional budget ( Care Account) based on this to allow their contributions to be tracked towards the Contributions ( Care ) Cap.
- Councils to have increased statutory duties linked to the provision of information /advice for all potential customers, preventative services, market shaping, and to support more integrated working with Health.
- A strengthened requirement for the on-going review of care / support plans and of the information that must be provided to customers that have been assessed.
- All customers with eligible needs will have a right to a Personal Budget / Direct Payment.
- Self-Funders, including people that are adjudged to have insufficient eligible needs, will have the right to ask councils to arrange their care and support services for them.
- Councils will have a duty to offer Deferred Payments to more customers, subject to safeguards

- .The potential for customers to be able to ‘appeal  to an existing statutory body about decisions on their assessments / decisions made about their contributions
- Increased safeguarding responsibilities – with Statutory Safeguarding Adults Boards being established in every area.
- Significant workforce considerations, including retraining and embedding additional capacity. These are to manage changing legal requirements as well as managing expected increased demands in some areas.

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**Part 2 -  Care Standards**

The second part of the Act relates to care standards, providing the Government’s legislative response to the Francis Inquiry into the failings at Mid-Staffordshire hospital.

- It provides for an extended ‘failure regime’ for NHS healthcare providers by: enabling the Care Quality Commission (CQC) to issue warning notices to NHS Trusts and NHS foundation trusts; extending Monitor’s powers to impose additional licence conditions on foundation trusts; and enabling Monitor to make an order authorising the appointment of a trust special administrator for foundations trusts on quality grounds.
- It introduces Ofsted-style ratings for hospitals and care homes, empowering the new Chief Inspector of Hospitals at the (CQC) to identify problems with care quality and then take action.
- It makes it a criminal offence for care providers to give false and misleading information about their performance.

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**Part 3 - Health**

The third part of the Act covers the establishment and responsibilities of Health Education England and the Health Research Authority

- The establishment of Health Education England as a body designed to supervise education for healthcare professionals only has been seen as a missed opportunity to bring together the training of health and care professionals and to develop a workforce with a common culture and a more integrated approach across health and social care.

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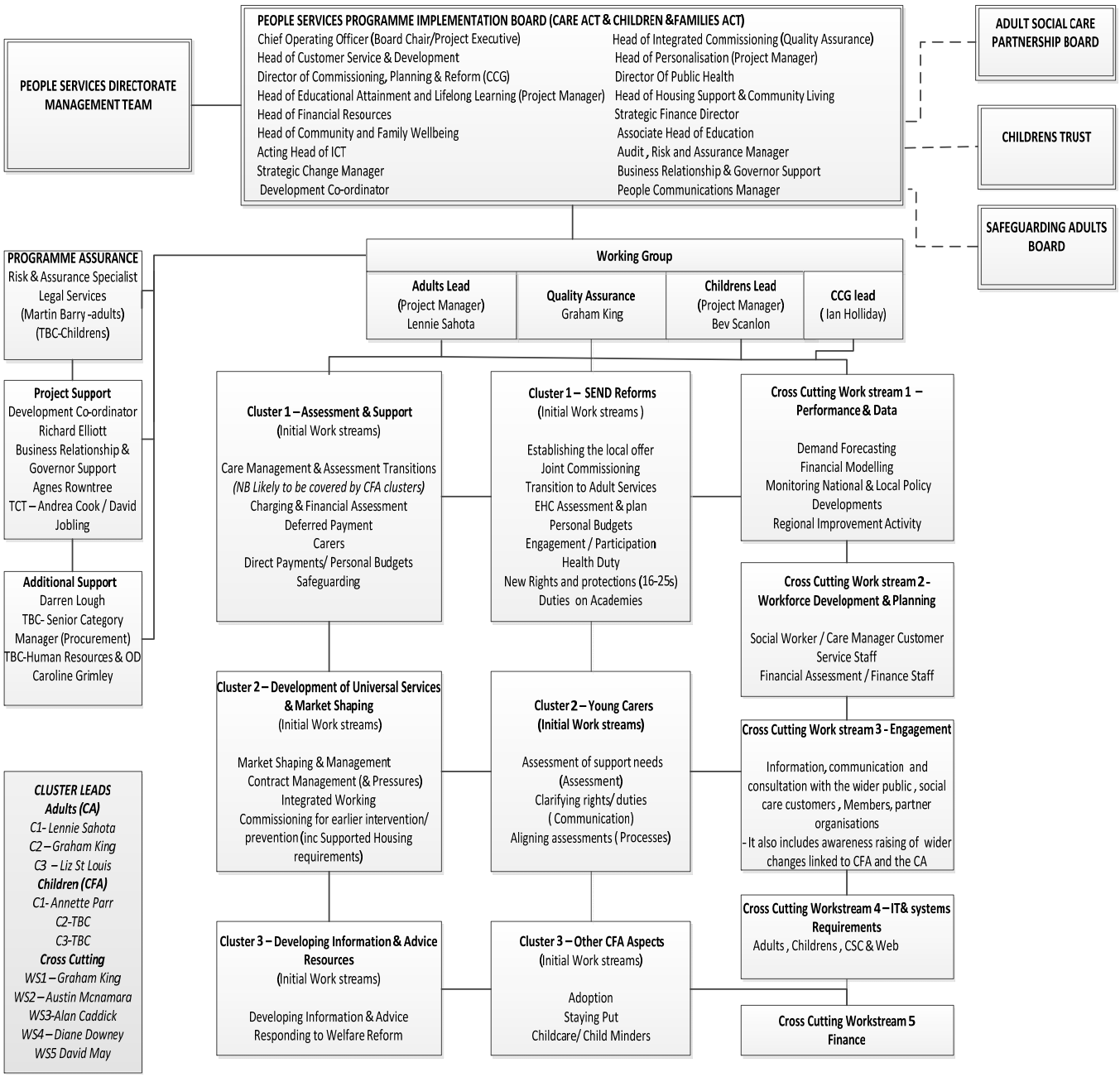
**Parts 2 & 3**

- The draft provisions in the Bill which dealt with the NHS failure regime had become highly controversial, since it was realised that the powers of the trust special administrators appear to allow them to make wide-ranging decisions about reconfiguring health services in the area of an NHS trust in administration, including closing hospitals. Following a campaign by MPs, pressure groups and trust representative bodies, the Government adopted an amendment which will allow local commissioners not directly involved with failing trusts to respond to proposals made by trust special administrators. This amendment does not, however, significantly reduce the contentious powers conferred on the administrators by the Act.

**Appendix 2**

# PROGRAMME IMPLEMENTATION BOARD (CARE ACT - CHILDREN & FAMILIES ACT) GOVERNANCE OUTLINE

## Schematic



**Programme Implementation Board (Care Act – Children & Families Act) (PIB)**

The Programme Board is responsible for ensuring that the Programme identifies and then delivers the changes / improvements required by both the Care Act (CA) and the Children & Families Act (CFA). The Board is made up of senior representatives from the organisations / services that will be required to implement significant changes. The Boards responsibilities are;

- Creating the environment where the Programme (comprising CA and CFA work plans ) can succeed in delivering the changes necessary to realise the Programmes defined objectives/ outcomes
- Setting the direction for the Programme (work plans) and to approve key milestones. These include approving the Programme Plan and individual Project (Cluster) Mandates.
- Ensuring that the programme / clusters and work streams are appropriately resourced – or made available when required
- Making decisions as necessary during the period covered by the Programme Plan
- Providing authority for the Project Managers, Cluster Leads and cross cutting work stream leads to manage their areas of the programme on a day to day basis

**Programme Working Group (PWG)**

The Working Group consists of the Project Managers, (Adult and the Children's Leads) and Quality Assurance Lead; with support provided by the Development Coordinator, TPP Project Manager (and Cluster Leads when necessary). Additional Specialist Support is also available to progress issues if required.

The Working Group is intended to progress / drive agreed improvement activity and to respond to instructions from the PIB. While most day to day activity will be driven by Individual Cluster Leads (Heads of Service) the working group will work to overcome more serious issues with regard to progression and dependencies that are not able to be resolved within the clusters themselves.

Responsibilities include;

- Attendees being aware of progress in each cluster , towards overall objectives, and of barriers to their achievement
- Ensure that dependencies / delivery of transition plans ,agreed via separate Project ( Cluster) Mandates for individual cluster areas do not adversely impact on other cluster areas own delivery ( outputs / timescales)
- Identify / develop cross cutting information and joint solutions to inform and improve on-going overall programme and cluster delivery

- While all clusters are likely to include dependencies , the four separate Performance & Data, Workforce Development , Engagement and IT Work Streams are essentially cross cutting in scope and intended delivery

**Individual Roles and Responsibilities**

**Board Chair (Project Executive)**

- Owning the Programme Plan and being ultimately accountable for achievement of the programmes required objectives / outcomes
- Ensuring that all key stakeholders are committed to the Programme, Programme Plan , and appropriately represented in its organisational structure
    - Ensure that budget /resource holders are committed to the programme and that resources are made available when required
    - Ensure that Implementation Board Members understand their own roles and the commitments needed , in order to realise the Programmes agreed objectives
    - Brief Senior stakeholders on current / forecast programme status
- Ensuring that the Programmes governance arrangements are fit for purpose

**Board Members**

- Agree the Programme Plan and/ or suggest required changes
- Commit to making the agreed changes within their own organisations / service areas in accordance with the Programme Plan and Project (Cluster area) transition plans
- Commit resources from their own organisations / service areas as detailed in the agreed Programme Plan
- Participate in the on-going decision making process
- Attend board meetings
- Inform the Board of any issues / risks that could affect delivery of the Programme Plan
- Monitor development and delivery of relevant Cluster / work streams within their service area / organisation , and ensuring that these are fit for purpose and meet the relevant Programme Plan objectives
- Analyse and respond to update reports from the Working Group, Cluster Lead or in some cases from individual Work stream leads and provide appropriate support to enable them to manage any issues that would impact on potential delivery objectives / improvements.

**Project Managers (Adults and Children's Leads)**

The Project Managers provide leadership and direction to the work programmes They will work through the project support (including the Development Coordinator and TPP Project Manager) to ensure that agreed project outcomes are achieved within identified constraints ( timescales, quality and cost ) The main responsibilities include

- Designing the adults and children's & families work plans( that will make up the Programme Plan) and governance arrangements for agreement by the PIB and Project Office
- Supporting the development of the Project ( Cluster) Mandates and Cross Cutting Work stream Mandates for agreement by the PIB
- Monitoring a Risk Register for their work plan
- Monitoring progress against the work plan including links and dependencies,
- Identifying and taking action to deal with actual / potential exceptions that might prevent delivery of the Programmes objectives / outcomes. This may be notifying / supporting other PWG members, Cluster Leads or escalating issues to the Board Chair (Project Executive )
- Agreeing monthly / quarterly Programme Progress Reports for Directorate Management Team, to include Programme Updates and Risk Register

**Cluster Leads**

Designated Cluster Leads are all Heads of Service in order to lever in additional capacity and allow them to better drive day to day activity across their own cluster area, and resolve more issues without recourse to the PIB/PWG. Responsibilities include;

- To develop the outline Project ( Cluster) Mandates to cover work streams needed , resources required , timescales necessary to identify and implement the necessary changes ( objectives / outcomes), and any identified dependencies
- Developing a clear understanding of the independencies between their cluster area and the areas covered by the other Cluster Leads
- Managing the delivery of their own agreed cluster transition plan ( including all work streams) and reporting monthly on progress / lack of progress to the Working Group including any risks / issues that might prevent the delivery of the Programme(s) objectives
- Supporting the monitoring / measuring of delivered improvements across their cluster area

## Governance Arrangements

### Meeting/Reporting Framework

| Who to | Frequency | Report and Source | From |
|---|---|---|---|
| Adult Social Care Partnership Board<br><br>Children's Trust<br><br>Safeguarding Adults Board | Quarterly | Programme Plan Update – high level summary across both work programmes | Programme Implementation Board |
| People Services Directorate Management Team | Monthly ( after the board) | Programme Plan Update – high level summary across both work programmes | Project Managers (Adult & Children's Leads/TPP Project Manager |
| Board | Monthly | Work Plan Update ( Adults and Childrens & Families) - summary of progress across the two work plans | Development Coordinator/ TPP Project Manager |
| | | Cluster Progress Summaries and escalated issues | Project Managers (Adult & Children's Leads)<br><br>Cluster Lead /TPP Project Manager |
| Working Group | Monthly | Detailed Progress and Escalation reports<br><br>Issues Log | Development Coordinator/ TPP Project Manager<br><br>Cluster Leads |

### Other Meetings

| Who | Frequency | Purpose |
|---|---|---|
| Cluster meetings<br><br>(Cluster Lead and Work stream Leads) | As necessary – as determined by each Cluster Lead | Look at cluster progress<br>Links and dependencies |
| Cluster Lead and individual work stream leads | As necessary- as determined by each Cluster Lead | Progress work streams and deal with issues |

## Programme Support

The Development Coordinators role is to support the governance and delivery of the programme which includes coordinating the additional resources available to support the programme (TCT Project Managers and Business Relationship and Governor Support)

Between them the programme support will:

- Work with project managers to create two work plans that will meet the needs of the adults and Children & Families agendas
- Use these work plans to create a single high level programme plan that includes cross cutting activity and a timeline for programme activity and roll out of product deliverables
- Facilitate the governance arrangements around the PIB and Working Group
- Support Cluster Leads to develop the outline Project (Cluster) Mandates and Cross Cutting Work stream Mandates for agreement by the PIB. These will include individual cluster timelines
- Develop and monitor the Risk Register for the work plans and Programme
- Monitor progress against the Work Plans and Programme Plan, including links and dependencies,
- Identify actual / potential exceptions that might prevent delivery of the Programmes objectives / outcomes. This may be notifying / supporting a Project Managers, Working Group Members or Cluster Leads
- Support the Cluster leads to monitor progress of each cluster and work stream,
- Prepare monthly / quarterly Progress Reports and Programme Updates

## Additional Controls

The Programme Boards Programme of Work (comprising two Work Plans) will conform to the updated Corporate Management Standards in order to provide stakeholders with the necessary levels of assurance

In addition the Care Act Cluster development is being informed by regional/ national improvement activity- such as that provided by the Care & Support Reform Programme Board. This is a combined LGA, ADASS and Department of Health resource for councils specifically to tackle the Care Bill.

| | |
|---|---|
| **Version** | 3 |
| **Status** | Draft – for approval by PIB |
| **Comments** | Updated version - includes additions to personnel and to individual responsibilities |
| **Date** | 26 June 2014 |

**APPENDIX 3**

## DEPARTMENT OF HEALTH CONSULTATION AND OVERVIEW

### 1 Background

The Department of Health (DH) launched 10 week consultation exercise on 6 June (ending on 15 August). This can be accessed via the following link https://www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

The consultation is about Part 1 of the Care Act which primarily concerns council led responsibilities, and centres on changes to be implemented from April 2015

There are over 30 areas offered for people to feedback/ respond to and grouped under 8 main headings

- General Duties and Universal Provision
- First contact and identifying needs
- Charging and financial assessment
- Person Centred Care and Support Planning
- Integration and Partnership Working
- Adult Safeguarding
- Moving between areas – inter local authority and cross border issues residence
- Other areas

The consultation includes

- 76 page consultation guide
- 430 + pages of statutory guidance
- 100+ pages of regulations
- 167 page Impact Assessment
- 84 consultation questions / calls for evidence ( these are included in this paper as Appendix A ) together with details of the Care Act Clusters that will be considering the changing requirements)

The intention is that final regulations and guidance, based on feedback to this exercise, are issued / available from October 2014 in order to allow councils time to finalise plans and implement required changes from April 2015

## 2 Consultation Overview

While the consultation only covers the 2015 implementation areas these comprise the majority of the changes to be implemented, and therefore guidance and regulations require close scrutiny.

The scale of the consultation exercise, combined with the extremely short timescale for turnaround before final regulations are issued (June – October) give rise to a number of issues / concerns - including;

- Whether the regulations / guidance in some areas are sufficiently clear and unambiguous to support the Care Acts aspirations
- The wording in a number of areas still seems to allow for misinterpretation – significant differences in interpretation and therefore may not provide the hoped for improvements with regard to increased consistency and minimising anomalies between different council areas with regard to social care provision and wider universal offers . For example the 2nd draft of the eligibility criteria – and wording used within the tests still appears extremely subjective , and therefore has already interpreted differently by people / councils as being potentially the equivalent of the current substantial , moderate, or low
- A numbers of potential contradictions between the guidance aims and the regulations in some areas ( Charging and Deferred Payments ) – which when coupled with the technical nature of these changes will require clarification from the DH - as well as comment
- Whether the questions being asked are the correct ones – though this links more to whether the Act will achieve its broad aims without additional funding being provided nationally

A number of people, including attendees at regional consultation events have questioned whether the short time period does actually allow for;

- The level of in depth consideration and scrutiny required by interested parties
- The DH to respond effectively where the need for improvement is recognised , by updating the draft legislation / guidance

  While it is accepted that the Governments direction of travel is unlikely to change without this scrutiny and improvement there is increased potential for badly drafted legislation and / or unintended consequences leading to increased and costly court actions actually providing the required clarity and interpretation.

The DH have accepted that this consultation has a challenging timescale and have requested that responses be made individually and as soon as it is possible to do so , in order to give them the maximum length of time to make any changes they deem as being necessary

Taking this into account the next section provides some brief potential responses to specific questions in the event that the Health & Wellbeing Board wish to respond on these questions now – as well as to potentially respond on a larger scale and to more questions closer to the time that the consultation is due to close, and with the benefit of further and more detailed examination of the guidance/ regulations being undertaken by the service areas identified in Appendix A.

## 3 Suggested Consultation Responses

| |
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| **Q 1. Does the draft guidance provide local authorities with the information they need to embed wellbeing into the way that they work?**<br><br>Yes – at both a strategic and operational level. |
| **Q 3. Is the description of prevention as primary, secondary or tertiary, a helpful illustration of who may benefit from preventative interventions, when and what those interventions may be?**<br><br>Yes as it shows the steps from early intervention options to what can be considered as eligible need provision in the delay or tertiary section ….i.e. what you may receive as eligible services once you leave intermediate/reablement services |
| **Q 4. Is the list of examples of preventative 'services, facilities or resources' helpful? What else should be included?**<br><br>It is adequate but as the Guidance states it is non-exhaustive, and this will still be the case even with more examples added |
| **Q 6. Does the guidance provide sufficient clarity about the active role that the local authority should play to support people's access to financial information and advice that is independent of the local authority, including regulated financial advisors?**<br><br>Yes and improving peoples access to a range of information and advice is something that the Sunderland organisations are committed to and it is accepted that there will be a need to develop the current offer and/ or commission additional provision<br><br>The guidance however requires that councils facilitate access to Independent Financial Advice which could be achieved by signposting or referral to available / approved providers (as well as by commissioning)<br><br>We do not think that this extends to any requirement on councils to commission Regulated Financial Advice. Any requirement to do so would be a concern given the technical nature of the advice, the need for advisors to understand both Care Act Requirements and its interaction with Pension Reforms, and above all the increased potential scope for future complaints coming back to the council in the event that people are badly advised and / or incur financial loss. |

Should this be a requirement we would welcome a template / minimum specification being provided for councils to work to and / or a potential national tendering exercise

**Q 14.Do the draft eligibility regulations, together with powers to meet other needs at local discretion, describe the national eligibility threshold at a level that will allow local authorities to maintain their existing level of access to care and support in April 2015? If you believe they don't please explain your reasons for this.**

There is an argument to say that the proposed national threshold is at par with the current Low level FACS banding in that the inability to carry out one or more basic care activities (including domestic tasks) seems to be a very low threshold.

While those council's with provision that currently cover all 4 FACS bands may see little change those on substantial and critical bands will have to have a culture change to the preventative outcome based approach of the new act and lower their level of access to care and support

**Q 15. Do you think that the eligibility regulations give the right balance of being outcome- focused and set a threshold that can be easily understood, or would defining "basic care activities" as "outcomes" make this clearer?**

It appears irrelevant as the description of basic care activities is clear. It is the interpretation of whether or not a person is then subsequently "*unable to achieve an outcome*" and the council's view of that in the assessment process as opposed to the person's view of the same outcome that will give rise to disagreement and challenge.

Unless further clarity / objectivity can be provided with regard to achieving outcomes only time and legal action will determine whether they are being applied correctly

**Q18. Does the guidance adequately describe what local authorities should take into consideration during the assessment and eligibility process? If not, what further advice or examples would be helpful?**

The Guidance is comprehensive in terms of describing what should be taken into account during both the assessment and eligibility process. The issues appear to be the still considerable discretion that councils have when taking account of the factors which will be considered in the overall view

This is made exacerbated by terms within the guidance such as significant *impact…..appears to have…… not being unable to achieve an outcome…..may* …..and *should*…… all being used.

These are all wide open to discretion and therefore for councils to reach different results. If these require testing judicially and / or via the still to be determined new challenge mechanism these lead to both;

- Customers not achieving their required outcomes and increased customer dissatisfaction
- An increased call on stretched resources to deal with what is effectively failure demand.

| Area | Care Act Sections | Regulations - Guidance- Both (R/ G / B) | Cluster ( and service Areas / leads) | Consultation Questions |
|---|---|---|---|---|
| **General Duties** | | | | |
| Wellbeing<br><br>http://careandsupportregs.dh.gov.uk/category/wellbeing/ | 1 | G | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 1: Does the draft guidance provide local authorities with the information they need to embed wellbeing into the way that they work?<br><br>2: Can you suggest some examples to illustrate how the wellbeing principle could be applied? |
| Preventing , reducing and delaying needs<br><br>http://careandsupportregs.dh.gov.uk/category/prevention/ | 2 | G | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 3: Is the description of prevention as primary, secondary or tertiary, a helpful illustration of who may benefit from preventative interventions, when and what those interventions may be?<br><br>Question 4: Is the list of examples of preventative 'services, facilities or resources' helpful? What else should be included? |
| Information & Advice<br><br>http://careandsupportregs.dh.gov.uk/category/info/ | 4 | G | CA2 & CA3<br><br>Integrated Commissioning<br><br>Customer Services | 5: Views are invited about how local authorities should coordinate and target information to those who have specific health and care and support needs.<br><br>6: Does the guidance provide sufficient clarity about the active role that the local authority should play to support people's access to financial information and advice that is independent of the local authority, including regulated financial advisors? |
| Market Shaping& Commissioning<br><br>http://careandsupportregs.dh.gov.uk/category/market-shaping/ | 5 | G | CA2<br><br>Integrated Commissioning | 7: Does the statutory guidance provide a framework to support local authorities and their partners to take new approaches to commissioning and shaping their local market?<br><br>8: Are there any further suggestions of case studies or tools that can assist local authorities in carrying out their market shaping and commissioning activities? |
| Managing Provider failure and other market interruptions<br><br>http://careandsupportregs.dh.gov.uk/category/provider-failure/ | 19<br>48-57 | B<br>3 sets of regs ( see left) | CA2<br><br>Integrated Commissioning | 9: We invite views on the entry criteria to the market oversight regime, and whether and how they should be made simpler for residential care providers.<br><br>10: We invite views on the approach to defining business failure by reference to insolvency situations.<br><br>11: We also invite views on the insolvency situations listed, for example, are they appropriate and clear. Should other situations be covered? |

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| | | | | 12: In particular, are the listed insolvency situations appropriate and relevant to the various legal forms registered care provider can take (including providers registered in respect of establishments or agencies under the relevant legislation in/Wales and Northern Ireland |
| **1ST Contact & identifying Needs** | | | | |
| Needs assessment and carers assessments<br><br>http://careandsupportregs.dh.gov.uk/category/assessments/ | 9-13 | B<br>link to regs (see left) | CA1<br><br>Personalisation | 13: What further circumstances are there in which a person undergoing assessment would require a specialist assessor? Please describe why a specialist assessor is needed, and what additional training is required above the requirement for the assessor to be appropriately trained to carry out the assessment in question? |
| Eligibility<br><br>http://careandsupportregs.dh.gov.uk/category/eligibility/ | 9-13 | B<br>link to regs<br>(see left) | CA1<br><br>Personalisation | 14: Do the draft eligibility regulations, together with powers to meet other needs at local discretion, describe the national eligibility threshold at a level that will allow local authorities to maintain their existing level of access to care and support in April 2015? If you believe they don't please explain your reasons for this.<br><br>15. Do you think that the eligibility regulations give the right balance of being outcome-focused and set a threshold that can be easily understood, or would defining 'basic care activities' as 'outcomes' make this clearer?<br><br>16. Does the current definitions of 'basic care activities' include all the essential care tasks you would expect? If not, what would you add?<br><br>17. Are you content that the eligibility regulations will cover any cases currently provided for by section 21 of the National Assistance Act 1948?<br><br>18. Does the guidance adequately describe what local authorities should take into consideration during the assessment and eligibility process? If not, what further advice or examples would be helpful? |
| Independent advocacy<br><br>http://careandsupportregs.dh.gov.uk/category/advocacy/ | 67-68 | B<br>Link to regs ( see left) | CA1 & CA2<br><br>Personalisation<br>Integrated Commissioning | 19. We would welcome views on further specific circumstances where the advocacy duty should apply. In particular, we welcome views on the potential benefits and disadvantages of providing independent advocacy for people for people receiving care jointly from adult social care and the NHS |
| **Charging & Financial Assessment** | | | | |
| Charging for care & support<br><br>http://careandsupportregs.dh.gov.uk/category/charging/ | 14, 17 , 69-70 | B<br>Link to regs ( see right) | CA1<br><br>BIAS | http://careandsupportregs.dh.gov.uk/2014/05/16/charging-for-care-and-supportquestion21/<br><br>20. Do the regulations and guidance provide a clear modern framework for charging that will enable local authorities to maintain existing flexibilities in how people contribute to the cost of meeting their care needs? Are there any particular areas that are not clear? |

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| | | | | 21. Is there anything from the current rules that has not been re-created that you feel should have been? If so, please list along with a brief explanation of why. |
| 12 week property disregard<br><br>http://careandsupportregs.dh.gov.uk/category/property-disregard/ | | NA – questions based on guidance | CA1<br><br>BIAS | 22. Do you agree that we should adjust the operation of the 12-week property disregard to better support those most at risk?<br><br>23: Would you prefer to see the current approach retained?<br><br>24: Do you agree that this proposal is cost neutral for local authorities? If it is not, please provide evidence |
| Other disregards<br><br>http://careandsupportregs.dh.gov.uk/category/other-disregards/ | | NA – questions based on guidance | CA1<br><br>BIAS | 25. Do you think these bonds should be taken account of in the financial assessment? What are the risks and costs to local authorities and individuals?<br><br>26 Should pre-paid funeral plans be disregarded and if so should there be a limit to the size of plan that can be disregarded? If so, how much? |
| Choice of accommodation and additional payments http://careandsupportregs.dh.gov.uk/category/choice-of-accommodation/ | 14, 17 , 69-70 | B – link to regs( see left) | CA1<br><br>BIAS | 27. Does the guidance need to particularly cover these types of accommodation? If so, what would it be helpful to discuss?<br><br>28: What are the risks of the expansion of the additional cost provisions so that the person can meet this cost themselves (to both local authorities and the person)? How can any risks be mitigated by regulations and guidance? |
| Pension reform<br><br>http://careandsupportregs.dh.gov.uk/category/pension-reform/ | NA | Neither | CA1<br><br>BIAS | 29: What do you think the impact of the increased pension flexibilities might be for social care charging for people and local authorities? How can any risks be mitigated via regulations and guidance?<br><br>Link to separate DWP Pension consultation<br>• Details of the proposed reforms can be found here and the consultation is open until 11 June 2014. |
| Deferred payment agreements<br><br>http://careandsupportregs.dh.gov.uk/category/deferred-payments/ | 34-36 | B<br>link to regs(see left) | CA1<br><br>BIAS<br><br>Transactional Finance | 30: Should the eligibility criteria for deferred payment agreements be extended to include people in extra care housing or supported living arrangements? Do you have evidence of the likely demand for deferred payment agreements from people whose needs are met in these types of accommodation?<br>31: Do you think we should seek to introduce a scheme which is compliant with Sharia law at a later date?<br><br>32: Do you agree that the maximum LTV for deferred payment agreements should fall between 70% and 80%? Do you have any evidence to support a particular amount within that range?<br><br>33: Do you agree that people should be able to keep a proportion of any rental |

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| | | | | income they earn on a property they have secured a deferred payment agreement on? Are there other ways people could be incentivised to rent out their houses?<br><br>34: Do you have any views or evidence to suggest how much rental income people should be able to keep to incentivise them to rent their property out?<br><br>35: Do you agree that local authorities should be required to accept any legal charge on a property as security for a deferred payment agreement when they are required to enter into one and not just a first charge?<br><br>36: In line with the recommendations of the Independent Commission on Funding of Care and Support, do you agree that the interest rate should be set so that it is reasonable for people, cost neutral to local authorities and as such that it does not create incentives for people to apply for deferred payments when they are not needed?<br><br>37: Do you agree that there should be a different interest rate for deferred payment agreements made at the local authority's discretion? If so, what should the maximum rate be? |
| **Person Centred and Support Planning** | | | | |
| Care & Support Planning<br><br>http://careandsupportregs.dh.gov.uk/category/care-and-support-planning/ | 24-25 | G | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 38: Does the guidance on personalisation fully support and promote a care and support system that has personalisation at its heart?<br><br>39: Does the guidance on personalisation support integration of health and care (and any other state support)?<br><br>40: Does the guidance support care and support workers to do their job effectively? |
| Personal Budgets<br><br>http://careandsupportregs.dh.gov.uk/category/personal-budgets/ | 26 | B ( regs on exclusion of costs – see link left) | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 41: Is this definition clear and does it conform to your understanding of intermediate care and reablement? Is there any way it can be improved?<br><br>42: Does excluding the cost of reablement/intermediate care from the personal budget as defined above: Create inconsistencies with the way that reablement/intermediate care is provided in NHS personal health budgets? Affect the provision of reablement/intermediate care for people with mental health problems?<br><br>43: Are the ways in which different personal budgets can be combined sufficiently clear? |
| Direct Payments<br><br>http://careandsupportregs.dh.gov.u | 31-33 | B | CA1<br><br>Personalisation | 44: Will the easing of the restriction to pay family members living in the same household for administration/management of the direct payment increase uptake of direct payments? Will this create implementation issues for local authorities? |

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| k/category/direct-payments/ | | | NB Care & Support Sunderland may also offer a view | 45: The draft direct payment regulations decreases the time period to conduct a review of the direct payment from 12 months to 6 months – is this workable?<br><br>46: The draft regulations seek to ensure choice is not stifled and the direct payment is not monitored excessively – is it strong enough to encourage greater direct payment use, but workable for local authorities to show effective use of public monies? |
| **Integration and partnership working** | | | | |
| Integration, cooperation and partnerships<br><br>http://careandsupportregs.dh.gov.uk/category/integration/ | 3,6,7, 22,23, 74, Sch 3 | B Regs listed under the questions from the link | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 47: Does the draft statutory guidance provide a framework that will support local authorities and their partners to make integration a reality locally?<br><br>48: Are there any ways the guidance can better support cooperation locally? |
| The boundary with the NHS<br><br>http://careandsupportregs.dh.gov.uk/category/boundary-nhs/ | 3,6,7, 22,23, 74, Sch 3 | B | CA2<br><br>Integrated commissioning | 49: Is the description in the guidance of exceptions to provision of healthcare (which effectively sets out the boundary between NHS and local authority responsibilities) sufficiently clear and does it maintain the current position on the boundary?<br><br>50: Is there any danger that the legal barrier could be interpreted as a barrier to integration? Are there specific examples where it would be helpful to clarify? |
| Delayed transfers of care<br><br>http://careandsupportregs.dh.gov.uk/category/delayed-transfers/ | NA | B | CA1& CA2<br><br>Personalisation | 51: Will any of these changes affect the working of delayed discharge processes in ways not discussed in the guidance?<br><br>52: Can you provide any best practice examples or guidance relating to hospital discharge for people with care and support needs? |
| Working with Housing Authorities and providers<br><br>http://careandsupportregs.dh.gov.uk/category/working-with-providers/ | 3,6,7, 22,23, 74, Sch 3 | G | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 53: Could local authorities' duties in relation to housing be described more clearly in the guidance?<br><br>54: Are the links to prevention, integration, co-operation, information and advice, market shaping and assessments adequate? |
| Working with employment and welfare services<br><br>http://careandsupportregs.dh.gov.uk/category/employment-welfare/ | 3,6,7, 22,23, 74, Sch 3 | G | CA2& CA3 Integrated Commissioning<br><br>BIAS | 56: Are there any good practice examples of local authorities working with their partners, including health, education, employment and housing? |
| Transition to adult care and support | 58-66 | B | CA1 / CFA 1-2 | 57: Is the guidance clear enough that the term 'significant benefit' is about the timing of the assessment? Is the guidance precise enough to ensure that |

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|---|---|---|---|---|
| http://careandsupportregs.dh.gov.uk/category/transition/ | | | Personalisation | 'significant benefit' is not open to misinterpretation and that people who should be assessed are assessed at the right time for them?<br><br>58: Are the descriptions in the guidance of people's rights to transition assessments and continuity of care beyond 18 sufficiently clear? |
| Prisons , approved premises , and bail accommodation<br><br>http://careandsupportregs.dh.gov.uk/category/prisons-and-bail-accommodation/ | 76 | G | CA1- CA2<br><br>Personalisation<br><br>Integrated commissioning<br><br>(Likely irrelevant within Sunderland) | 59: We would welcome views and transferable good practice examples about the application of care and support to custodial settings, in particular about information and advice, advocacy, financial assessment, personal budgets and joint commissioning arrangements between custodial establishments, local authorities and health services.<br><br>60: When delivering care and support in custodial settings, how should local authorities go about reflecting the high prevalence of mental ill health, substance misuse and learning disabilities?<br><br>61: How might these be best provided in custodial settings and how might responsibility for provision best be identified?<br><br>62: How could the initial assessment of a prisoner's care and support needs be best constructed to be useful in supporting proportionate reassessment and planning to meet any eligible care and support needs in subsequent custodial settings throughout the person's sentence? Are there triggers, particularly which might be identified in the health assessment which all prisoners receive on entering prison, which could help prison staff and/or health care partners to identify when it would be appropriate to refer a prisoner for a care needs assessment? |
| Delegation of local authority functions<br><br>http://careandsupportregs.dh.gov.uk/category/delegation/ | 79 | G | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 63: Are there any core principles or requirements that local authorities should always place on contractors when delegating care and support functions<br><br>64: Some stakeholders have mentioned that a 'model contract' would be helpful. What would be included in a model contract? Can you give any examples of a good model contract when delegating statutory care and support functions |
| **Adult Safeguarding** | | | | |
| Adult safeguarding<br><br>http://careandsupportregs.dh.gov.uk/category/adult-safeguarding/ | 42-47, 68 | G | CA1 & CA2<br><br>Personalisation<br><br>Integrated Commissioning | 65: Are there any other types of behaviour that should be explicitly stated in the guidance? Are there any that should be removed?<br><br>66: Are there additional possible members of Safeguarding Adults Boards that we should add?<br><br>67: Are there additional aspects of the Safeguarding Adults Board's work that we should highlight? |

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|---|---|---|---|---|
| | | | | 68: Would it be useful to append a draft template for the strategic plan for Safeguarding Adult Boards to use if they wish? |
| **Moving Between Areas- Inter local authority and cross border issues** | | | | |
| Ordinary residence<br><br>http://careandsupportregs.dh.gov.uk/category/ordinary-residence/ | 39-41 | B (Links to both within questions) | CA1<br><br>Personalisation | 71: Are the definitions of the types of accommodation as cited in the regulations too wide? Are they workable and clear?<br><br>72: Do the guidance and regulations about ordinary residence disputes provide enough clarity to settle ordinary residence disputes between two or more local authorities? Are there other scenarios that it would be helpful for the guidance to consider?<br><br>73: Which authority should be responsible for meeting the needs of an adult or carer when two authorities are in dispute, or another authority cannot come to an agreement on who should be the lead authority? Do you agree with the regulations as currently set out? |
| Continuity of care<br><br>http://careandsupportregs.dh.gov.uk/category/care-continuity/ | 37-38 | B (Links to both within questions) | CA1<br><br>Personalisation | 74: What further circumstances should be considered when carers and people with care and support needs want to move? |
| cross –border placements<br><br>http://careandsupportregs.dh.gov.uk/category/cross-border/ | 39, Sch 1 | B (Links to both within questions) | CA1<br><br>Personalisation | 75: Do the regulations provide for an effective dispute resolution procedure?<br><br>76: In particular, in setting out the process for local authorities to follow when making a cross-border residential care placement, are there any gaps or omissions in the guidance in terms of key issues that need to be addressed before a placement can successfully take place?<br><br>77: With regard to the arrangements for managing a placement once it has commenced, can you envisage issues other than those identified? Specifically, what are these and how should they be addressed?<br><br>78: Would it be helpful for the guidance to be supplemented by best practice guidance? If so, what issues and scenarios will it be important for best practice guidance on these placements to cover? |
| **Other areas** | | | | |
| Registers<br><br>http://careandsupportregs.dh.gov.uk/category/registers/ | 77 | B (Links to both within questions) | WS1<br><br>Performance & Data | 79: Should certification of CVIs be extended to senior ophthalmologists, or should this continue to be carried out by consultant ophthalmologists as is currently the case?<br><br>80: Should we seek the patient's consent to pass their contact details to RNIB, as well as to the local authority, as part of the CVI process in order for RNIB to |

| | | | | |
|---|---|---|---|---|
| | | | | offer advice and support? |
| Transition to the new legal framework<br><br>http://careandsupportregs.dh.gov.uk/category/transitional-newlegal/ | All | G | Legal Services / all | 81: Are there other considerations around preparation for implementation of the April 2015 elements of the Care Act on which national guidance would be helpful?<br><br>82: Are there other considerations around preparation for implementation of the April 2016 elements of the Care Act on which national guidance would be helpful? |
| Monitor licensing regime and social care organisations<br><br>http://careandsupportregs.dh.gov.uk/category/monitor/ | N/A | R | CA2<br><br>Integrated Commissioning | 83: Do you think that providers of NHS continuing healthcare and NHS-funded nursing care should continue to be exempt from the requirement to hold a licence from Monitor?<br><br>84: Should providers NHS continuing healthcare and NHS-funded nursing care services be subject to those services being designated Commissioner Requested Service? |

**Item No. 11**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

**ADULTS PEER CHALLENGE**

**Report of the Executive Director of People Services**

## 1 Introduction

1.1 The purpose of the report is to set out the outcome of the Local Government Association (LGA) Peer Challenge, which took place in March 2014. It highlights the key messages and next steps.

## 2. Background

2.1 Following the removal of national targets and assessments, councils are working through the opportunities and challenges of self regulation, improvement and innovation in adult social care. The LGA is working with partners to develop a programme for sector led support, which will focus on promoting excellence and harnessing the skills of local authorities. Its core elements – regional working, robust data, annual self reporting and peer challenge – are consistent with the sector's wider approach to improvement.

2.2 In March 2014, the People Directorate invited a Peer Challenge Team to undertake an assessment of progress and potential relating to the following scope:

- Provide an objective forward looking assessment of the ambition and vision of the People's Directorate within Sunderland City Council and the opportunities this presents for enhanced outcomes for vulnerable adults
- Assess the current plans for safeguarding vulnerable adults and the effectiveness of the newly developed model for adult safeguarding in the city

2.3 Through a process of internal and external stakeholder engagement, the Peer Challenge Team spent four days in Sunderland and on day five, reported key messages to officers and partners who had participated in the review process. This was followed by a written report.

## 3. Key Findings

3.1 The Peer Challenge Team reported that the People's Directorate is well placed to secure enhanced outcomes for vulnerable adults through:

- The ambitious and clear vision in place
- It's good service and organisational platform
- Well respected relationships and partnerships
- Continued use of performance data

3.2 The Team also identified the following areas of consideration, in relation to the People's Directorate:

- Continue to embed changes and 'get the job done' before moving onto the next challenge.
- Consider the management capacity across the whole directorate.
- Delivery against 4 major programmes (Better Care Fund, Sunderland Care and Support, Personalisation and Prevention) is fundamental and they are interdependent for success.
- Mitigating the narrowing resource base will be a challenge, if gains do not arrive quickly enough.

3.3 In relation to Safeguarding Adults, the Peer Challenge Team identified that the newly developed model is a significant advance on the former service. It was acknowledged that things were at an embryonic stage and there was still work to do, in order to reach its full potential.

3.4 In particular, they identified that the relationships at the Sunderland Safeguarding Adults Board are mature and trusting and there is evidence of proportionate, timely, joined up and person-centred responses to safeguarding concerns.

3.5 Better understanding and use of metrics is required, improved access to safeguarding information on the Council's website is a must and a focus on service user and carer engagement and understanding experiences across safeguarding processes is required.

## 4. Next Steps

4.1 In response to the feedback presentation, the Directorate has developed an action plan (attached) based on the specific areas for consideration identified. The areas linked to the People's Directorate will be incorporated into existing transformation programmes underway.

4.2 In relation to the areas linked to safeguarding, the specific action plan was discussed at the Sunderland Safeguarding Adults Board in May, where all Partners agreed to the proposed actions and will be receiving regular reporting on progress against actions.

## Adult Social Care and Adult Safeguarding Peer Challenge Action Plan – May 2014

| Ref | Area for Consideration | Lead Officer | Action Required/Underway | Timeframe |
|---|---|---|---|---|
| 1. | **People Directorate: Vision, Strategy and Leadership** | | | |
| 1.1 | Embed a Council wide approach to deliver the transformation agenda | N Revely | Ensure that People Directorate 'Plan on a Page' is central to LA and partners Transformation Programme. | July 2014 |
| 1.2 | Communicate the vision of prevention and demand management, via community capacity and co-design and structure of the People's Directorate | F Brown | Use extended SLT to enhance plan on a page and ensure senior ownership. Review structure within extended SLT and other elements of council to ensure capacity exists to focus on this area. (linked to 1.5) | September 2014 |
| 1.3 | Make better use of evidence based data to inform the strategic direction and drive the change via delivery plans. | G King | Review current data sets, review suite of performance & intelligence information available, agree refresh of JSNA with DPH. Council to implement Intelligence Hub. | September 2014 |
| 1.4 | Review and simplify governance structure to ensure appropriate reporting mechanisms to provide assurance and avoid duplications | F Brown | Governance review underway. Implement quarterly performance and governance clinics with each HoS. Rationalisation of planning groups with health and council partners. Agree approach to interface with People / Place Boards | August 2014 |
| 1.5 | Ensure adequate management capacity is available to deliver change | N Revely | Use available intelligence through Core Assets, PWC , Peer Challenge to review structure of 2nd and 3rd tier to deliver both business as usual and transformation plans. | August 2014 |
| **2.** | **People Directorate: Resource and Workforce Management** | | | |
| 2.1 | Commissioning strategies must interlink with financial savings targets | G King | Link with 1.3 to ensure composite picture of performance, finance and commissioning is available. DMT to consider revised governance arrangements for co-ordinating plan on a page and integration with health. | July 2014 |
| 2.2 | Ensure the local authority trading company can diversify and change services quickly enough | G King | Review 3 year business plan and sign off via Board for LATC alongside plan for mutualisation. | September 2014 |

## Adult Social Care and Adult Safeguarding Peer Challenge Action Plan – May 2014

| Ref | Area for Consideration | Lead Officer | Action Required/Underway | Timeframe |
|---|---|---|---|---|
| 2.3 | Ensure there is a robust training needs analysis and workforce development plan around future changes / structures, eg BCF | L Sahota | Workforce development and planning is a work stream of Care Bill and Children and Families Act Programme Board and will be similarly considered in the work on the Customer Journey and the BCF. | On-going |
| **3.** | **People Directorate: Service Delivery and Effective Practice** | | | |
| 3.1 | Incorporate into a sustainable prevention strategy further work around co-located and virtual teams building on current practice in mental health, dementia, virtual wards, etc | L Sahota | The development of Integrated Locality Teams will go a long way towards addressing this recommendation. The Care Homes / Extra care and Closer Working with GPs pilots areearly examples of effective preventative work through partnership working. | COMPLETE |
| 3.2 | A front-facing, accessible resource directory will be critical around advice, information and signposting | L St. Louis | Prototype IAG directory now available on the web. Agreement needed on future requirements in light of Care Bill and Children & Families Act. Governed via the Care Bill Board | On-going |
| 4. | **People Directorate: Commissioning and Managing the Market** | | | |
| 4.1 | Creation of Provider Forums to facilitate discussion around SCC strategic intentions | S Lowes | Market engagement strategy to be embedded within revision of MPS& Social housing | May 2014 |
| 4.2 | Refresh Market Position Statement in light of future demand and a surplus residential care market | S Lowes | Revision to be completed with 13/14 activity/demand | May 2014 |
| 4.3 | The model for contract review and provider management needs to be embedded in the commissioning directorate | G King/S Lowes | The Integrated Commissioning Service will have a separate contract and performance function - which will embed the learning from recent Audits of the current process | April 2014 |
| 4.4 | Stronger engagement with services users in service redesign and co-production | L Sahota | ? link with 5.2 and 2.1<br>Some arrangements already in place – LD Partnership Board, Self- directed Support User Group, Older Families Carers Group, Sunderland People First and Carers Management Group. | COMPLETE |

## Adult Social Care and Adult Safeguarding Peer Challenge Action Plan – May 2014

| Ref | Area for Consideration | Lead Officer | Action Required/Underway | Timeframe |
|---|---|---|---|---|
| | | | We do need to more routinely capture service user experience feedback (?link with 4.3) and for this to be used in service redesign.<br>Engagement is a Work stream of the Care Bill and Children and Families Programme Board | |
| 5. | **Safeguarding: Local Safeguarding Board** | | | |
| 5.1 | MOU needs to be agreed to clarify role and responsibilities and arrangements with SAB and other Boards | S Lowes | MOU drafted which sets out the expectations of SSAB and other Boards – discussion is required regarding next steps for the MoU | June 2014 |
| 5.2 | Immediate attention should be given to service user engagement and experience across the safeguarding agenda& safeguarding carers group | L Arbon | Recent appointment of post holder who will be focussing on developing engagement processes within operational safeguarding procedures – work programme to be developed including annual sample of cases within safeguarding process; focussed work with individuals and their families | Recruitment – completed<br>Work Programme – May 2014 |
| 5.3 | Partner funding needs to be secured as the SAB becomes statutory | S Lowes | Discussion to take place at May Board regarding the funding of the SSAB infrastructure– CCG funding is secured for 14/15 | May 2014 |
| 5.4 | There needs to be a more consistent use of metrics and outcomes by SAB | J Akehurst/S Lowes | Safeguarding dashboard is being developed – to be discussed at May Board | May 2014 |
| 5.5 | Seek better co-ordination between the SAB and LSCB whilst ensure the two very different development priorities of these boards are completed | M Boustead | Review of subcommittees has commenced with view to understand the future co-ordination of the SSAB and SSCB priorities | June 2014 |
| 5.6 | In the light of being an outlier, the SAB needs to understand the profile of SCC with regards to safeguarding data and associated benchmarking | J Akehurst/S Lowes | Safeguarding Dashboard will support the Board to better understand the profile in Sunderland – comparative analysis will be built into the dashboard | May 2014 |
| 5.7 | The provider market risk particularly around CQC/Care | S Lowes | Included in Forward Programme of Work | COMPLETED |

## Adult Social Care and Adult Safeguarding Peer Challenge Action Plan – May 2014

| Ref | Area for Consideration | Lead Officer | Action Required/Underway | Timeframe |
|---|---|---|---|---|
| | Homes should be reported to SAB | | | |
| 5.8 | The current status of the Business Management Group and its terms of reference should be clarified to ensure how it links with the SAB | S Lowes | Reviewed ToR – outcomes explicit within the ToR; minutes of BMG will be shared with SSAB at each meeting | COMPLETED |
| 5.9 | Review SAB membership including director level attendance | N Revely | Membership reviewed – appropriate representation at NHS Partners at Director level. Executive Director of People Services (Council) is committed to attend | COMPLETED |
| 5.10 | Consider the creation of a robust Case File Audit process that feeds into SAB to provide assurance about effective frontline safeguarding activity | L Arbon/J Akehurst<br>G King & L Sahota | Case File Audits are part of the Quality Assurance subcommittee work programme; process is being progressed.<br>Agree data sharing in IT systems<br>Review Case File Audit Tool | May 2014 – to report to SSAB<br><br>July 2014 |
| 5.11 | SAB to carry out a baseline audit of need in preparedness for the Care Bill | S Lowes | Added into Forward Programme of Work – part of development day agenda | September 2014 - part of SSAB Development Day |
| 5.12 | Establish formal links between regular DV reporting and the SAB | S Douglass | Reporting from Safer Sunderland Partnership – seeking assurances from safeguarding perspective is built into Forward Programme of Work | July 2014 – to report at SSAB |
| 5.13 | A robust process needs to be developed to ensure that the SAB is able to learn from audit reviews and SCRs | D Lagun | Proposal to revise ToR of the Case Review Subcommittee to embed learning and improvement | May 2014 |
| 5.14 | Consider co-location of adult safeguarding teams to promote a better service user experience | BMG | Establish Options Appraisal. Combine 'business units' to support LCSB and SSAB | September 2014 |
| 6. | **Safeguarding: Delivery and Effective Practice** | | | |
| 6.1 | Continue to embed understanding of the new safeguarding thresholds with a view to reviewing within one year of implementation | L Arbon | Review of Thresholds to be built into Operational Safeguarding Service work programme | Review – November 2014 |
| 6.2 | Be clearer on the definitions and language used in safeguarding to ensure a consistent understanding and application of the process | L Arbon/J Akehurst | To be discussed at Quality Assurance Subcommittee – as procedures and processes all have common language/definitions – the | June 2014 |

## Adult Social Care and Adult Safeguarding Peer Challenge Action Plan – May 2014

| Ref | Area for Consideration | Lead Officer | Action Required/Underway | Timeframe |
|---|---|---|---|---|
| | | | application of the common language requires monitoring | |
| 6.3 | Ensure adequate recording throughout the safeguarding process | L Arbon/J Akehurst L Sahota | This is built into the new operational procedures; requires monitoring by the Quality Assurance Subcommittee | June 2014 |
| 6.4 | Inadequate access via SCC website in relation to safeguarding needs urgent attention | S Lowes/K Dimmock | Meeting arranged with Corporate Communications to progress | April 2014 |
| 6.5 | SCC to consider the offer to carers of support and counselling and advocacy to service users in safeguarding cases | L Sahota & G King | Re-tendering exercise for Advocacy Services is underway, which will ensure services are in place; operational procedures need to reflect the offer available to family carers | July 2014 |
| 7 | **Case File Audit: People's Experiences of Safeguarding** | | | |
| 7.1 | IT systems supporting safeguarding are under-developed | L Arbon/G King | Upgrade to Version 28.2 of AIS (IT System used across care management and safeguarding); enhanced safeguarding capabilities will be available | August 2014 |
| 7.2 | Little analysis displayed in case management files and risk assessment, these are substantial in safeguarding work – identification of indicators of risk of abuse needs structured approach | L Sahota Jim Usher | Review documentation used in safeguarding investigations and staff training to be rolled out | September 2014 |
| 7.3 | Outcomes for individuals are not yet used in a consistent and structured way – this makes assessment of impact and progress difficult | L Sahota/L Arbon<br><br>J Akehurst | Review operational procedures to understand how outcomes for individuals are documented within the safeguarding process<br><br>Use of case file audit tool to monitor progress | June 2014<br><br>June 2014 |
| 7.4 | Strategy meeting minute taking and availability of minutes is problematic | F Brown Head of Transactional services | Review of business support arrangements for operational safeguarding is currently underway | June 2014 |

**Item No. 12**

**SUNDERLAND HEALTH AND WELLBEING BOARD** **25 July 2014**

**BOARD DEVELOPMENT SESSION AND FORWARD PLAN**

**Report of the Head of Strategy, Policy and Performance Management**

## 1. PURPOSE OF THE REPORT

To inform the Board of the date and scope of the next development session and the forward plan.

## 2. MAKING THE LINKS – HEALTH AND HOUSING

The session will look at the links between housing and health and the opportunities for closer and more integrated working on areas of joint importance, including the housing implications of the better care fund.

It will be facilitated by the national housing federation and will have presentations from local partners including the northern housing consortium.

The Aims and Objectives of the session are as follows.

| Aims | Objectives |
|---|---|
| To bring together partners to agree a way forward around activity to link health and housing | 1. To explore the key joint topics<br>2. To agree actions to be taken forward by all partners |

## 3. MAKING THE LINKS – SAFEGUARDING

Following the report to the HWBB in May a safeguarding development session is proposed for October 10th 12 – 2.

## 4. FORWARD PLAN

| **Health and Wellbeing Board Agenda - Forward Plan 2014 – 15** | | |
|---|---|---|
| | 25th July 2014 | 19th September 14 |
| **Standing Items** | • Update from Advisory Groups<br>• Development Sessions Briefing<br>• Integration and Transformation Board | • Update from Advisory Groups<br>• Development Sessions Briefing<br>• Integration and Transformation Board |

| | | |
|---|---|---|
| **Joint Working** | • HealthWatch Update (KM)<br>• Care Bill (NR)<br>• CCG 5 year plan | • H&WB Strategy – Implementation and Engagement Update<br>• Integrated Impact Assessment – HIA of the Core Strategy (NC/VT)<br>• DPH Annual Report – Healthy City – Healthy Economy (NC)<br>• WHO Healthy Cities<br>• Health Visiting contracts (NHS E) |
| **External Links** | • Tobacco Alliance Peer Review | • Pharmacy and Links to HWBB<br>• Update on APB review topic – housing and fuel poverty |

## 5. BOARD TIMETABLE

Attached as appendix 1 is the Board timetable showing the deadlines for agenda items, papers and the provisional times for the advisory groups.

## 6. RECOMMENDATIONS

The Board is recommended to

- note the next development session
- note the forward plan and suggest any additional topics
- note the timetable

**SUNDERLAND HEALTH AND WELLBEING BOARD**

**MEETINGS 2014/15**

| Call for Agenda Items | 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 26 March (Weds) | 9 April (Weds) | 13 May (Tuesday) | 8 May (Thurs) | 7 May (Weds) | 24 April (thurs) | 5 May (Mon) | 6 May 9-10 | 8 May (Thursday) | 9 May (Friday) | 16 May (Friday) |
| 21 may (Weds) | 4 June (Weds) | 8 July (Tuesday) | 9 July (Weds) | 8 July (Tuesday) | 2 July (weds) | 14 July (Mon) | 15 July 9-9.30 | 17 July (Thursday) | 18 July (Friday) | 25 July (Friday) |
| 23 July (Weds) | 6 August (Weds) | 9 September (Tuesday) | 11 September (Thurs) | 2 September (Tuesday) | 21 August (thurs) | 8 September (Mon) | 10 Sept 9-10 | 11 September (Thursday) | 12 September (Friday) | 19 September (Friday) |
| 24 sept (Weds) | 8 October (Weds) | 4 November (Tuesday) | 13 November (Thurs) | 5 November (weds) | 5 November (weds) | 17 November (Mon) | 19 Nov 2-3 | 20 November (Thursday) | 21 November (Friday) | 28 November (Friday) |
| 3rd Dec (Weds) | 17 Dec (Weds) | 6 January (Tuesday) | 13 January (Tues) | 8 January (Thursday) | 6 Jan (tues) | 12 January (Mon) | 13 Jan – 2-3 | 15 January (Thursday) | 16 January (Friday) | 23 January 2015 (Friday) |
| 28 Jan (Weds) | 11 February (Weds) | 3 March (Tuesday) | 5 March (Thursday) | 3 March (Tuesday) | 26 Feb (thurs) | 9 March (Mon) | 10 March – 2-3 | 12 March (Thursday) | 13 March (Friday) | 20 March 2015 (Friday) |