SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 1) on Friday 16 May 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.

8.	**Sunderland Health and Wellbeing Strategy Implementation Plan Update** Report of the Executive Director of People Services (copy to be printed separately).	-
9.	**Health and Wellbeing Peer Review – Recommendations and Implementation Plan** Report of the Assistant Chief Executive (copy attached).	51
10.	**Health and Wellbeing Board Development Session and Forward Plan** Report of the Head of Strategy, Policy and Performance Management (copy attached).	67
11.	**Date and Time of the Next Meeting** The next meeting of the Board will be held on Friday 25 July 2014 at 12noon	

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

8 May 2014

Item No. 3

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 21 March 2014

MINUTES

Present: -

Councillor Paul Watson (in the Chair)	-	Sunderland City Council
Councillor Graeme Miller	-	Sunderland City Council
Councillor Mel Speding	-	Sunderland City Council
Councillor John Wiper	-	Sunderland City Council
Neil Revely	-	Executive Director of People Services
Dave Gallagher	-	Chief Officer, Sunderland CCG
Maureen Crawford	-	Director of Public Health
Ken Bremner	-	Sunderland Partnership
Lesley Ann Sutherland	-	Healthwatch Sunderland
Christine Keen	-	NHS England Area Team

In Attendance:

Councillor David Tate	-	Chair of Scrutiny Committee
Councillor Ronnie Davison	-	Sunderland City Council
Liz Highmore	-	DIAG
Helen Lancaster	-	Scrutiny Co-ordinator, Sunderland City Council
Jane Hibberd	-	Head of Strategy and Policy for People and Neighbourhoods, Sunderland City Council
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

HW53. Apologies

Apologies for absence were received from Councillors Smith and Kelly and Dr Ian Pattison.

HW54. Declarations of Interest

There were no declarations of interest.

HW55. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 24 January 2014 were agreed as a correct record.

HW56. Feedback from Advisory Boards

Adults Partnership Board

Councillor Miller informed the Board that the Adults Partnership Board had met on 4 March 2014 and the main issues considered had been: -

- Warm Up North
- Older People's Action Group
- Role of the VCS
- Better Care Fund update
- Transforming Care: A National Response to Winterbourne View Hospital
- Discussion Topic for Six Month Review and Forward Plan

In relation to Warm Up North, Councillor Wiper asked when the figures might be available for excess winter deaths to compare with previous years.

Councillor Miller advised that the presentation had dealt with deaths in 2012/2013 as it was too soon to discuss this year's figures. Nonnie Crawford highlighted that for the purposes of the NHS, winter ended in March and information would not be collated until after that date. She also said that excess deaths had increased nationally over the last two years, even though the winter temperatures had not been as low as previous years. There was a lot of work required to identify the reasons for this trend as it was not as simple as being the result of a cold, sharp winter.

Jane Hibberd commented that the Children's Trust were also focusing on child and family poverty and there was a need to join this up with Warm Up North project. Councillor Miller suggested that Jane liaise with Alan Caddick on this.

Christine Keen highlighted that Sunderland had been singled out as an example for good practice in relation to its partnership approach to the Winterbourne View concordat. Neil Revely added that despite the high profile of the Winterbourne View report, there were a number of areas which were behind the curve, so Sunderland's progress was particularly notable.

Neil Revely asked if Christine was able to help with the pharmacy issue which had been discussed at the Partnership Board and Christine stated that she understood a formal communication would be forwarded from the Health and Wellbeing Board and that she would provide a formal response.

Children's Trust

The Children's Trust had met on 11 March 2014 and the main issues considered had been: -

- Integrated Wellness Model for Children and Young People
- Children and Young People's Plan Refresh
- Sunderland Safeguarding Children Board
- Mental Health and Emotional Wellbeing Strategy for Children and Young People 2012-2015

The Chair expressed surprise that there was not already an existing integrated wellness model for children and Neil Revely stated that the work being done around the commissioning of adult services had flagged up a gap in respect of children and young people. The current review was looking at what was being commissioned, what was needed and what was not and when the service was in a position to commission for adults, it would do so on a whole life course basis. Engagement work was taking place early in 2014/2015 and would pan out in a three year rolling model.

The Chair asked how people were getting to work together at the current time and highlighted the need for those with the remit of dealing with children and young people to talk to one another. Neil advised at this stage the review was looking at what children wanted and there had been issues with some services not publicising other providers. The work would not cover the same ground as the Education Leadership Board but would look at issues such as activity and engagement and include areas such as emotional wellbeing and mental resilience.

It was noted that self image was something which was a huge issue, particularly when young people were subject to more marketing and merchandising than ever before. Neil commented that it was clear that what was being done now was not working and highlighted that the sexual health equity audit had been taken to the Place Boards recently and organisations were being advised to take account of local provision in Sunderland's areas and to provide sensitive and accessible services.

Councillor Speding highlighted that the CCG had presented the Mental Health and Emotional Wellbeing Strategy for Children and Young People to the Children's Trust. It was noted that the transition of mental health services over the last few years had impacted on results and the example of Highfield School was cited, where they have commissioned their own independent mental health services.

The Chair stressed the importance of using appropriate levers to take up best practice and Neil stated that a staged approach was currently being taken to the integration of children's services across the board. It was focused on a coordination approach and would also challenge schools to do the right thing for their children.

NHS Provider Forum

The NHS Provider Forum met on 7 February 2014 and the main issues considered had been: -

- Role and Function of the Group
- The Better Care Fund

The Chair asked if the role and function of the group had been agreed by all the providers involved and it was explained that the Local Medical Committee

representative was unable to commit to action on behalf of the GP practices as these were all individual. However, Dave Gallagher highlighted that there was an emerging entity of GP practices working together and a GP Federation had begun to form and currently included over half the practices in the city. There was some optimism that a consensus view from GPs could be achieved and practices understood that there was a time critical element to this process.

Dave explained that the CCG was maintaining a distance from this emerging federation as it was not a 'provider' and there was an overlap in membership between the CCG and Local Medical Committee. The Chair commented that it was important for this to be resolved with GPs as there was a need to involve other providers such as dentists and optometrists in the group.

The Board RESOLVED that the information be noted.

HW57. 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 group had held an initial meeting and the main items were linked to the Better Care Fund and the feedback from the NHS Area Team had been received and reported up through the Local Government Association (LGA).

The approach towards the Better Care Fund had been consistent across authorities and Sunderland was in as good a position, if not better than, most. There was a challenge in whether Sunderland was being ambitious enough in some areas and feedback would be taken on board. There had been positive feedback on the plan and that would be turned into action. There was also a common view that a condition of the Better Care Fund was to ensure that NHS providers were involved.

Everything was on track to develop the final submission for the first week in April 2014. There was a growing recognition that this would take time and not everything would be in place by April 2015, but the plan would be finalised, would be system wide and would be a five year unit of planning for the NHS. Finance officers from the Council and the CCG would also be considering and agreeing the financial rules over the next few weeks.

The Chair commented that at the recent LGA Executive meeting it had been noted that Sunderland was one of the 'big six' with a Better Care Fund proposal of over £100m and this fact had been remarked upon. Some areas had not grasped or demonstrated an understanding of integration and it was pleasing to note that Sunderland was doing so well in relation to this.

Dave Gallagher highlighted that the position that Sunderland was in reflected the positive starting point which the CCG and Council had, but there was always a risk that Sunderland was there to be shot down. It was about gaining the hearts and minds of partner organisations and to this end, an Accelerated Solutions Event was

going to be held on 5 and 6 June with the aim of creating a shared understanding and commitment to the health and social care integration agenda and its delivery. The event would be facilitated by Cap Gemini and would have an intensive approach with the intention of carrying out six months' work in two days. It was hoped to have as many stakeholders and Board Members as possible to attend in order to achieve a range of involvement and expertise.

Ken Brenner commented that he had attended these types of events in the past and they were intense but if details of the key questions which were to be answered were circulated well in advance, people would commit to the two days. It was noted that attendees would be a mix of those who made the decisions and those who did the work.

RESOLVED that the update be noted.

HW58. Update of the Scrutiny Function: Policy Review Recommendations 2013/2014 and Setting the Scrutiny Work Programme for 2014/2015

The Head of Scrutiny and Area Arrangements submitted a report providing the Board with an update on the key issues and developments within the council's Scrutiny Function.

Councillor Tate, Chair of the Scrutiny Committee, was in attendance at the meeting to formally present the report and to introduce the recommendations of the policy reviews.

Councillor Tate stated that reviews had been undertaken of Child Obesity and Alcohol and Licensing Policy by the Children's Services and City Services Scrutiny Panels and these were due to be presented to the Cabinet in April 2014. The recommendations of the reviews were set out within the report and the Board were also informed that there were four other policy reviews which were nearing completion.

The Public Health, Wellness and Culture Scrutiny Panel had undertaken a review of Patient Engagement and a full report on this would be brought to the next meeting of the Health and Wellbeing Board for consideration.

Members of the Board were invited to identify key issues or topics which were worthy of being the focus of a scrutiny policy review.

The Chair asked Councillor Tate to pass on thanks on behalf of the Board, to the Panel members and officers who carried out the reviews. Scrutiny was a tool to improve performance and he suggested that Neil Revely and Karen Graham feed into the process of setting the Scrutiny work programme for 2014/2015. Karen highlighted that the recommendations from the peer review into the Health and Wellbeing Board would be brought to the Board in due course and, following that discussion, the recommendations could be fed into the review topics for the next municipal year.

Councillor Miller commented that there was a great deal of scope within the remits of the Scrutiny Panels and every area could be looked at as part of a review. Neil added that the Board's three advisory groups should also be consulted on potential items for scrutiny reviews. He also noted that the peer review had commented that the embeddedness of the Health and Wellbeing Board across the Council was evidenced by scrutiny work.

Having considered the report, the Board: -

RESOLVED that: -

(i) the recommendations of the Children's Services and City Services Scrutiny Panels be noted;

(ii) an information item be received detailing the recommendations of the remaining policy reviews; and

(iii) consideration be given to potential topics and issues worthy of a scrutiny policy review in 2014/2015.

HW59. Draft Children and Young People's Plan

The Head of Strategy and Policy (People and Neighbourhoods) submitted a report presenting the latest draft of the Children and Young People's Plan and the associated three year delivery plan for consultation.

The Children's Trust had produced a 15 year plan for Children and Young People in 2010 and an associated three year delivery plan. It was now necessary to refresh the delivery and overarching plan and the Trust had agreed to create a slimmed down strategy with a focus on areas where the Trust believed it could add value. The four strategic objectives were: -

1. Improving the overall Health and Wellbeing of children, young people and families
2. Reducing the number of families with children living in poverty in the city
3. Improving educational outcomes and strengthening whole family learning
4. Improving safeguarding outcomes for children, young people and families.

It was highlighted that the child and family poverty arrangements had been collapsed into the Children's Trust and the design principles of the plan had been reviewed in the light of the Health and Wellbeing Strategy. Performance management of the plan would be carried out by the Children's Trust.

The Trust had also identified four priority areas for its 2014-2017 delivery plan, namely Child and Family Poverty, Best Start in Life, Child Obesity and Sexual Health (including teenage pregnancy). Information on each of these priorities was included within the draft plan but these would be further refined to ensure consistency. A review of governance had also been requested to ensure that the right groups were reporting back to the Children's Trust.

The next steps for the development of the plan would be consultation with the Sunderland Safeguarding Children Board, the Scrutiny Committee, the Children's Trust Advisory Network and the Area People Boards. The final Children and Young People's Plan and associated delivery plan would be presented to the Children's Trust for approval in May and also brought to the Health and Wellbeing Board for ratification. The Board was asked to consider if health impacts were being maximised in each of the delivery plans for the four priority areas.

Councillor Miller stated that the Safeguarding Adults Board should also be consulted as part of the next steps. All of the priorities were related to the family so adults' services needed to be involved.

Christine Keen raised the current arrangements for health visiting and the transfer of this to local authorities in 2015 and suggested that the Board might find it useful to have an update on this in the next few months. It was agreed that this would be very helpful.

The needs of children and young people with disabilities and parents with disabilities was highlighted and Jane Hibberd confirmed that the plan did reflect an equality analysis for decision making.

Neil Revely stated that consideration needed to be given to coordinating issues in a better way as there was a danger that some matters were included in more than one plan, for example 'better start in life' already featured in a number of strategies.

Nonnie Crawford commented that there were two priorities which there was a reasonable chance of doing something about but the other two were more problematic. There were a range of influences on child obesity but the amount which could be done at this stage was questionable. With regard to child and family poverty, there were issues around what was required in the economy and regional and national changes. Councillor Miller stated that he agreed with the logic around what impact which could be had on child poverty in Sunderland, given the national context, but there was still a need to consider this locally.

The Chair added that poverty was not always about being cash poor and was about a bigger picture than just not having enough money. 'Equity' was also a consideration and he observed that some people living in abject poverty across the world lived long lives. It was not just about money but about making the right decisions. The Chair was pleased to see 'Working Together' referenced and stressed the importance of the vision for people to do things collectively.

Councillor Miller made reference to the duty of the local authorities to address child poverty and Sunderland needed to be seen to be dealing with it. Jane Hibberd stated that the Child and Family Poverty Board had often talked about 'mitigating the impact' and this approach would continue to be maintained.

The Board RESOLVED that: -

(i) the four delivery plans (Child and Family Poverty, Best Start in Life, Child Obesity and Sexual Health) be noted; and

(ii) a final copy of the Children and Young People's Plan be received by the Board following agreement by the Children's Trust.

HW60. 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.

A development session would be held in June 2014 looking at making the links between housing and health and the opportunities for closer and more integrated working on areas of joint importance. The Housing Federation had been approached to facilitate the session.

With regard to the forward plan, it was noted that Christine Keen had suggested an update on the health visiting service and the Children's Trust had proposed that the Board received the annual report from the Sunderland Safeguarding Children Board. These would be added to the forward plan.

A schedule of meetings had been drafted for 2014/2015 and Board Members would be made aware of the dates for submission of items for the Board agenda.

Neil Revely commented that the session in June would be timely as the joint concordat with NHS England was due to be launched in June and the advice was that health and wellbeing boards should be sighted on this issue. The concordat would cover what national bodies hoped to do to facilitate better health on the ground. Housing partners would be invited to take part in the development session.

The Board RESOLVED that: -

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

(ii) the Forward Plan be noted.

HW61. Clinical Commissioning Group Two Year Operational Plan

Dave Gallagher delivered a presentation on the Clinical Commissioning Group's Operational Plan and reminded the Board of the requirement to develop a five year 'unit of planning' strategic plan from 2014-2019. The two year operational plan laid the foundations for the delivery of the five year strategic plan and the final submission of the five year plan would be made on 20 June 2014.

Dave directed the Board to the 'Plan on a Page' which was aimed at simplifying the plan for the CCG, stakeholders and the public. Under the overarching aim of 'Better Health for Sunderland', the plan outlined the objectives for transforming out of hospital care, transforming in hospital care, specifically urgent and emergency care and self care and sustainability. The targets to achieve this were: -

- Reduce emergency admissions by 15%
- Improve patient experience of out of hospital care above England average
- Reduce emergency re-admissions by 14%
- Increase number of people receiving treatment for IAPT (Improving Access to Psychological Therapies) from 12% to 16%
- Improve patient experience of hospital care above England average
- Improve health related quality of life for people with LTC (long term conditions) by 11%
- Reduce years of life lost by 7%
- Improve diagnosis of dementia from 62% to 68%

Dave also outlined the metrics, activity levels and the key transformational changes for the next five years. Detail was also given of the quality premium which was the mechanism by which targets would be agreed and if met, how funding would be pumped back into the CCG budget.

The presentation summarised the current position with the Better Care Fund and explained that the current proposal was to make the total health and local authority spend on 'out of hospital care' £168.5m for 2015/2016. The submission had been well received and it was commented that there was a clear vision but the metrics were too ambitious and governance arrangements needed to be strengthened. There was a huge issue nationally with workforce implications and there was a lot of work to do in getting employees and universities up to speed.

Liz Highmore noted that there was a lack of commitment to equality and diversity set out within the plan and asked if that was because it was assumed. She also commented on the plan to reduce growth in GP referrals and said that overall early diagnosis and referral was better. She also asked how GPs could be encouraged to follow best practice.

Dave stated that at this moment the plan was about commissioning but gave assurance that equality and diversity was part of the delivery process. The aim to reduce growth in referrals was more around the appropriateness of GP referrals and that these did not always have to be to hospitals. From the end of April 2014, all GPs would be using the same information system which would help to refine the referral process.

It was not possible to tell GP practices what to do but the CCG worked with and influenced them and the emerging GP Federation would also promote best practice. GPs were involved in commissioning through the CCG.

With regard to reducing the number of procedures with limited clinical value, Councillor Wiper asked if that could be expanded upon and Dave advised that these were procedures which were not going to have an impact on a person's life in a meaningful way.

RESOLVED that the presentation be noted.

HW62. Dates and Times of Next Meeting

The following schedule of meetings for 2014/2015 was noted: -

Friday 16 May 2014 at 12noon
Friday 25 July 2014 at 12noon
Friday 19 September 2014 at 12noon
Friday 28 November 2014 at 12noon
Friday 23 January 2015 at 12noon
Friday 20 March 2015 at 12noon.

(Signed) P WATSON
Chair

Item No. 4 (c)

SUNDERLAND HEALTH AND WELLBEING BOARD **16 May 2014**

UPDATE FROM THE NHS PROVIDER FORUM

Report of the Chair of the Provider Forum

The group met on the 7th May and discussed the following:

Better Care Fund

The Better Care Fund was discussed. It was agreed that there needs to be a better understanding of the financial implications of the integration of adult social care and health and that a meeting between the directors of finance of the foundation trusts, the CCG and the Council should be convened with urgency.

Provider Engagement

Provider engagement in groups and sub groups was discussed – including the urgent care board and working groups within this alongside the planning group for the forthcoming Accelerated Solutions Event. KG highlighted that an audit was underway to map the current system, and provider representation was to be included within this. This would be fed back to the next provider forum and to the HWBB and other advisory groups.

Accelerated Solutions Event

The ASE on the 5th & 6th June was discussed. It was agreed that there needed to be a broader understanding of the priorities of the event to make sure appropriate people could attend. Also it was important to have more details of the finance implications of restructuring in advance of the event to ensure discussions would be meaningful.

6 Monthly Broader Provider Engagement

As part of the establishment of this group it was agreed to hold 6 monthly broader engagement sessions. Invitees were discussed and it was agreed that anyone with a legitimate provider viewpoint would be welcome, but with targeted invitations to the VCS and organisations already commissioned. Karen to pull together a scope for the day and investigate venues and timing – but aiming for July.

HWBB is requested to suggest items for Provider Forum to investigate over next six months.

Sunderland City Council

NHS Sunderland Clinical Commissioning Group

INTEGRATION BOARD
Minutes of the meeting held
9.30am on Thursday 13 March 2014
Neil Revely's Office, Civic Centre

Present Karen Graham
Nonnie Crawford
Neil Revely
David Gallagher
Debbie Burnicle

Apologies Sarah Reed

1 Terms of reference

DG had circulated a draft Terms of Reference based on conversations and agreement at the Health & Wellbeing Board in January 2014. There was discussion around the wider context for this work, including interfaces potentially with the CCG 5 year Plan Stakeholder work. It was agreed that the Terms of Reference would be kept in draft for the moment while there was further clarification of some of the wider roles.

Action – KG agreed to draft a wider context discussion paper to share for comment.

2 **BCF Feedback update**

Feedback had been received by the CCG on the Sunderland BCF initial submission on 14 February 2014. This had been put together by colleagues at NHS England Area Team. There had also been input from LA representatives who, for the North East, were Dave Smith and Rachel Schimmin. There was discussion about the NHS England Area Team local interim deadline of 15 March and discussions about describing the level of expectation for this. It was AGREED that this should be submitted as very much a work in progress as was intended.

There was discussion about workforce which was a key theme, not just for Sunderland but for other areas, and a conversation about input into the LEP about the need for developing the H&SC workforce. NR commented that it was significant discussion about manufacturing and service industries, but not anything relating to BCF or Health and Social Care integration.

Ian Holliday was reviewing and would be resubmitting the BCF draft, largely looking at the trajectories and in conjunction with Graham King and Matt Thubron.

It was agreed that this should be included in the presentation to the Health & Wellbeing Board on 21st March, and there should also be some consideration of wider issues including if and when should children's services should be included in the integration model.

3 **Finance rules for the BCF**

After brief discussion it was AGREED that the three finance leads from the City Council, People's Directorate and CCG should be asked to get together to agree the finance rules and arrangements for the fund as a financial sub group.

Action – DG to instigate.

4 **System-wide Plan**

DB had shared the draft CCG system-wide plan for information. NR commented that this was complimentary to the work being undertaken within the council and around the "unit of planning" which had been agreed was Sunderland. There was a conversation about the need to understand and include the views of the local NHS Foundation Trust providers and DG agreed to write to the chief executive's to ask whether they could share their plans. This could also be covered at the next provider forum.

Action - DG

5 **Executive to Executive Meeting on 18 March**

There was some brief discussion about the agenda for this meeting which would include an update on the adult services peer review, extra care and the BCF.

6 **ASE event**

There was wide discussion about the proposed accelerated solutions event planned for the 30 April/1 May. Cap Gemini had provided an outline proposal and design for the event and there was some discussion about the timing of it, to ensure that there was sufficient time for relevant key people, including clinicians, to get it into their diary. Later dates including 6 weeks after the CCG event on the 26th March were suggested.

Action – DG to assess feasibility of later dates.

It was agreed the proposed event should be for approximately 100 people and should be focused on the issues outlined by Cap Gemini, including turning the vision for health and social services integration into design and then implementation. It was agreed that it was necessary to arrange for further initial dialogue with Cap Gemini by this group and then subsequent regular, possibly weekly, meetings with them in the run up to any event. It was agreed that DG would write out to key stakeholder Chief Executives asking for nominations for the event and that there would be one hour per week discussions with Cap Gemini.

7 **Date and time of next meeting**

Wednesday 30 April at 4pm in Dave Gallagher's office, Pemberton House

Item No. 6

SUNDERLAND HEALTH AND WELLBEING BOARD 16 MAY 2014

POLICY REVIEW 2013/14: PATIENT AND PUBLIC ENGAGEMENT IN HEALTH SERVICES

Report of the Public Health, Wellness and Culture Scrutiny Panel

1. Introduction

1.1 During 2013-14, the Scrutiny Committee commissioned the Public Health, Wellness and Culture Scrutiny panel to investigate the options for coordinating engagement activities and this report is a brief summary of the findings.

2. Background

2.1 In 2012-13, the Scrutiny Committee produced, on behalf of the Health and Wellbeing Board, a Protocol for working together between all of the member organisations of the Board.

2.2 The Protocol contained the following commitment:

Engaging with service users

All parties to this protocol recognise that they have both joint and separate approaches to engaging with service users and members of the public. Wherever possible all parties will ensure that such health, well-being and social care engagement activity is jointly planned and co-ordinated within the partnership, and individual frameworks of the parties, to ensure maximum coverage and capacity, to avoid duplication and 'consultation fatigue' and to ensure appropriate quality and outcomes.

3. Summary of Findings of the Scrutiny Panel

3.1 The Scrutiny Panel heard clear evidence that patient and public engagement (PPE) should be a strand of quality in its own right. However, PPE rarely has dedicated resources and for it to be embedded into an organisational culture of patient and public engagement is required. Further transformational work may be required to reach that stage.

3.2 A coordinated approach to PPE should be supported and informed by joined up strategy and planning. This makes good use of scarce resources and helps avoid the unnecessary proliferation of engagement infrastructure and 'engagement fatigue'.

3.3 A coordinated strategic approach goes alongside effective coordination of the data and intelligence already collected about front line services and should avoid seeking fresh collections of data for their own purposes. There is value in "piggy backing" on other public events/meetings that are being held.

3.4 It is considered by the Panel that a HWBB does not necessarily need to have its own public profile or its own resources for it to undertake its responsibilities for meaningful PPE. However, there is further scope for the Board to make known its activities to the public.

3.5 It should be noted that we concluded Healthwatch would not have the capacity to be responsible for delivering all public engagement activity, although there may be scope to carry out specific engagement activity on behalf of the Board.

3.6 The optimal solution seems to be to make use of available resources and expertise from member organisations including Healthwatch. Organisations represented on the Board have a separate responsibility for public engagement and PPE is also undertaken by agencies who are not members of the Board but part of the wider health system. This wider network for a 'whole-system' approach includes the voluntary sector, area forums, housing providers and police.

3.7 We are aware that each partner will have their own resource challenges. As such, they would find it challenging to initiate PPE on behalf of the Board where it does not fall into work that they would already be doing. However, there is a commitment from these organisations through their participation within the Board to offer guidance and leadership for the Board to meet its PPE obligations. As such, intelligence from individual engagement activity should be utilised to inform the Board's activities.

3.8 A unified approach to public engagement should link to the wider partnership approach to public engagement with a Communication Strategy and a unified Engagement Strategy which relates to the plans of member organisations and other strategic partners.

3.9 The Panel considered the points at which patients have the chance to provide information, including through complaints. Our evidence indicated that many people find complaints systems complicated and hard to navigate.

3.10 The Clwyd Review[1] identified that complaints should be treated like 'gold dust' as a source of information for decision-makers and evidence to the Review suggested that Clinical Commissioning Groups should play a vital role using their leverage to ensure that providers have good complaints systems in place, "*we are calling for CCGs and NHS England to provide clear information to patients and the public about their complaints process*."[2]

3.11 The Clwyd Review also recommended that the independent NHS Complaints Advocacy Service should be re-branded, better resourced, with protected funding, and better publicised.

[1] A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture Right Honourable Ann Clwyd MP and Professor Tricia Hart October 2013

[2] NHS Confederation evidence to the Clwyd Review

3.12 There is an important role for those organisations with responsibility for holding to account the robustness of engagement activity, for example, the role of scrutiny in determining whether the type and extent of engagement is sufficient and appropriate.

4. Patient and Public Engagement Framework

4.1 One of the main findings of all of the patient experience research we reviewed was that there is no "one size fits all" approach to improving experience and that what works really well in one setting might not work so well in another.

4.2 There are however, some key factors and themes that are important to consider, such as the need for a patient experience programme to be embraced throughout the health system, the role of staff experience, the power of stories and the need to make the experience strategy central to the core organisational vision, strategy, quality reporting and service improvement work.

4.3 Seven key principles to guide Health and Wellbeing Boards for effective PPE are recommended by the NHS Confederation as:[3]

1) Engagement should take place from the start of the life of the health and wellbeing board and be woven into the DNA of the board throughout its work.
2) There will be different types and levels of appropriate engagement depending on the situation.
3) Patient and public engagement is the business of every board member.
4) The board has a responsibility to ensure effective engagement is embedded within its day-to-day business and is taking place through the commissioning and delivery of services.
5) Patient and public engagement has made a difference.
6) Engagement activities should be based on evidence of what works.
7) The effectiveness of patient and public engagement needs to be rigorously evaluated involving local communities concerned.

4.4 The principles have been adapted into an operational framework for which evidence can be provided which tests the delivery of effective and coordinated engagement activity (See Appendix).A number of these principles can be supported through the existing activity of stakeholder organisations.

4.5 The principles proposed, based on the evidence of the Review, for the operation of a coordinated approach and to support the Board fulfilling its PPE responsibility are:

1) Patient and public engagement is a strand of quality in its own right
2) Member organisations coordinate and jointly plan their resources for PPE
3) Engagement will be embedded with the Board's day-to-day activities

[3] *Patient and Public Engagement: A Practical Guide for Health and Wellbeing Boards" (2012), NHS Confederation*

4) Meaningful engagement will be demonstrated through a range of approaches
5) PPE activity will demonstrate it has made a difference
6) The effectiveness of PPE will be evaluated

5. Conclusion

5.1 Patient experience of health services came into sharp focus with the publication of the Francis Report which highlighted the consequences of patient feedback not being acted upon.

5.2 Our evidence showed there is an extensive range of PPE although this can lead to public confusion and the need to convince people that their voices will make a difference across the system. People who may be considered 'hard to reach' may be less successful at navigating complex public service or complaints processes.

5.3 There is no doubt that it doesn't make sense to try to go it alone. Collaboration is essential in order to gather and make the best use of information. The outcome of the review is a proposed framework for patient and public engagement and establishing a statement of intent to inform activity. In the future, it is intended that this framework could support a co-ordinated approach to patient and public engagement by the whole local health economy so as to make best use of available resources.

6. Recommendation

6.1 The Scrutiny Committee is consulting on the draft Framework. The Board is requested to consider and comment on:

a) Whether the draft Framework could be adopted as an approach to coordinated patient and public engagement;
b) If so, how this could be developed over time as more unified ways of working are progressed.

PUBLIC HEALTH, WELLNESS AND CULTURE SCRUTINY PANEL

POLICY REVIEW 2013/14
PATIENT AND PUBLIC ENGAGEMENT IN HEALTH & WELLBEING

FINAL REPORT

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Foreword

We chose to explore the patient and public voice across health services in Sunderland partly because we had the impression that, while there was a lot of activity and opportunity, it could be very complex for people to negotiate their way through the maze.

We took evidence on how best to build on the strengths, eradicate duplication, how to ensure that patients and the public can access the system to have their voice heard and how to measure effectiveness and success.

The term ‘patient and public engagement’ is used within this report. In the view of the Panel, and for the purpose of this report, this encapsulates information sharing, consultation, feedback and engagement and all of the points at which people can express their views.

We are aware that there are times when organisations will have to make decisions that are unpopular about services. Sometimes there may be no alternatives but to close a service but, at the end of the day, people must feel that they have had the opportunity to express their voice on an issue, even if they disagree with the outcomes.

This review proposes an approach to patient and public engagement and consultation which includes the role of Health and Wellbeing Board incorporating the wider system of groups and partnerships that contribute to the delivery of patient and public engagement.

2. Introduction

2.1 In 2012-13, the Public Health, Wellness and Culture Scrutiny Panel produced, on behalf of the Health and Wellbeing Board a Protocol for working together between all of the member organisations of the Board.

2.2 The Protocol contained the following commitment:

> *Engaging with service users*
>
> *All parties to this protocol recognise that they have both joint and separate approaches to engaging with service users and members of the public. Wherever possible all parties will ensure that such health, well-being and social care engagement activity is jointly planned and co-ordinated within the partnership and individual frameworks of the parties, to ensure maximum coverage and capacity, to avoid duplication and 'consultation fatigue' and to ensure appropriate quality and outcomes.*

2.3 During 2013-14, the Scrutiny Panel, on behalf of the Board, investigated the options for coordinating engagement activities and this report is a summary of the evidence taken.

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

3. Aim of Review

3.1 To review the adequacy of services to meet the key requirement of meaningful engagement with patients, carers and their communities

4. Terms of Reference

4.1 The Panel agreed the following terms of reference for the review:-

a) To look at the core elements of engagement[1] with the intention of developing a collaborative framework[2];
b) To explore the roles, responsibilities and expectations of those with a duty to engage patients and the public with the intention of defining shared expectations;

[1] Engaging with patients and the public can happen at: Individual Level – 'my say' in decisions about my own care and treatment and Collective Level - 'our say' in decisions about the commissioning of services.

[2] A framework to support a collective approach to patient and public engagement from the whole health economy as a means to best utilise existing resources. This does not override individual duties, responsibilities and operating environments which vary for different parts of the NHS.

c) To explore how patient and public involvement enables an appropriate level of influence and where necessary leads to improved services;
d) To hear about the development of strategies for equality and how all people including children and young people and those from seldom heard groups can be heard.

5. Membership of the Scrutiny Panel

The membership of the Scrutiny Panel consisted of:

Councillors George Howe (Lead Scrutiny Member), Louise Farthing, Fiona Miller, Julia Jackson, Rebecca Atkinson, David Errington, Paul Maddison.

6. Methods of Investigation

6.1 The following evidence was taken at meetings of the Panel: North East Ambulance NHS Foundation Trust; NHS England; Sunderland Clinical Commissioning Group; South Tyneside Foundation Trust.

6.2 In addition, the Health and Wellbeing Board were invited to contribute, Sunderland Healthwatch provided support in relation to the involvement of children and young people and invited their membership to contribute, and the Care Quality Commission attended the Panel to provide advice on their regulatory role.

7. Findings of the Scrutiny Panel

7.1 Engagement as a Strand of Quality

7.1.1 The Francis Report[3] highlighted what can go wrong when patients, their families and the public struggle to have their voices heard. The Panel heard clear evidence that patient and public engagement (PPE) should be a strand of quality in its own right. However, we heard that PPE rarely has dedicated resources and for it to be embedded into an organisation, a culture of patient and public engagement is required. Further transformational work may be required to reach that stage.

7.1.2 It was clear that during the period of our review, organisations locally were embarking on ambitious programmes to transform the way that they engage with patients and the public.

7.1.3 For example, we took evidence from the Sunderland Clinical Commissioning Group (CCG) on the development of its PPE strategy. The strategy was being developed with comprehensive consultation using a stakeholder group and with particular interest groups that had historically been under-represented in the engagement practices of the Primary Care Trust. This work developed some clear overarching principles for public engagement and identified

[3]The Mid Staffordshire NHS Foundation Trust Public Inquiry – Robert Francis QC February 2013

appropriate variances in approach for a range of interest groups. The CCG engagement cycle will be done through the JSNA with annual priorities reviewed.

7.1.4 The Health and Wellbeing Board has a duty to engage the public in their work as defined in the Health and Social Care Act (2012). As a minimum requirement, the Board has a duty to involve local people in the preparation of the Joint Strategic Needs Assessment and the development of the Joint Health and Wellbeing Strategy.

7.1.5 The Board is therefore is the logical and best place to bring together and share insight about what matters to local people and communities.

7.1.6 It is clear that the Board's start-up phase has been a demanding time and PPE could feel like an additional burden, however the Panel took the view that it is while new policies and relationships are being formed, new cultures are developing and priorities are being decided that engagement needs to be embedded.

7.1.7 We were aware that the development and publication of the Sunderland Joint Health and Wellbeing Strategy for Sunderland was underpinned by extensive consultation and engagement with the public, partners and stakeholders, led by members of the Board to ensure the objectives, actions and outcomes were the right things for the population of Sunderland.

7.1.8 Furthermore, in taking forward the delivery of the strategy it was agreed by the Board to put in place a consistent approach to patient and public engagement accompanied by an action plan for communications.

7.1.9 Health and Wellbeing Board members participated in a development session in October 2013 to outline the principles of effective engagement in strategic priority setting. The Board was asked to consider some key questions around 'engagement aspirations'; limitations and possibilities in light of resourcing; and the scope for health commissioners and providers to co-ordinate engagement practices.

7.1.10 The general view from research and from our own evidence is that a Health and Wellbeing Board does not necessarily need to have its own public profile for it to undertake meaningful PPE. However, the Panel felt that there was scope for the Board to make known its activities to the public and the fact that meetings are held in public, possibly through a separate web page.

7.1.11 The Panel's evidence showed that a unified approach to PPE should be supported and informed by sharing intelligence, joined up strategy and planning and making use of existing intelligence and engagement activity. This makes good use of scarce resources and helps avoid the unnecessary proliferation of engagement infrastructure and 'engagement fatigue'. For example, this could involve the development of a calendar of engagement activities across the partners identifying what can be done together.

7.1.12 As new issues develop such as policy documents and governance arrangements there should be routine screening to reflect the Board's responsibility for patient and public engagement and to understand and assess how to involve people's interest, and then evaluate the success of the engagement exercise afterwards.

7.1.13 In delivering these ambitions for PPE, the Panel was aware that all partners face numerous difficulties including constraints in financial and human resources and organisational capacity.

7.1.14 Individual resource challenges will mean it is challenging for partners to initiate engagement activities on behalf of the Board that do not fall into work that they would otherwise already be doing. There is however, a commitment from partner organisations, through their participation within the Board, to offer guidance and leadership to the Board to develop appropriate engagement responses to respective elements of its work. In this way, findings from individual engagement activity will be utilised, along with the professional expertise of individual Board members.

7.2 **Accountability for PPE**

7.2.1 The overriding characteristic of the Mid Staffordshire events was that patients' accounts of their experiences were either not heard, or not understood or ignored. Performance management systems were recorded and explained in ways that made it difficult to be clear what was happening to patients – and concerns about operational performance were overshadowed by apparent strategic successes.

7.2.2 Accountability therefore is not just about publishing data – this is important but should be linked to mechanisms that bring a reality check to make sure that patient's experiences are properly reflected.

7.2.3 Robert Francis identified that it was difficult for anyone 'on the outside' to check what was happening in the hospital. Therefore, everyone with a role to hold the NHS to account needs to work together to make sure they combine their powers and the information they gather so that stronger lines of accountability are developed for strategic direction and operational performance.

7.2.4 Each partner organisation is formally accountable to different parts of the system and through the Board there is a shared responsibility for delivering shared objectives and being accountable to communities, and service users to deliver on the shared objectives including on patient involvement which should be integral.

7.2.5 Accountability of clinical commissioning groups will come through assessment by the NHS Commissioning Board for financial performance, quality of services, health outcomes and governance, and they will also have a collective responsibility as members of the Board for delivering the Joint Health and Wellbeing Strategy. There is also a Duty to Involve[4], and to publish an annual report.

7.2.6 Providers have their own in-house procedures. Foundation Trusts are regulated by Monitor which publishes quarterly reports and CQC could also carry out an inspection. Added to this the implementation of the Friends and Family Test is designed to help standardise the views on patients and relatives.

7.2.7 We heard that through NHS England, each Area Team will have a high level Quality Surveillance Group (QSG) which will share intelligence about health services thereby pooling PPE in one place. QSG's will look at early warning signs and their purpose will mainly be assurance with separate mechanisms for monitoring service improvement plans.

7.2.8 Scrutiny by local councillors is an important part of the framework of health service accountability, and their role is different from the Care Quality Commission (CQC) and local Healthwatch. Francis had clear messages about council scrutiny with specific recommendations:

43 - Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

147 - Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

149 - Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

[4]The Health and Social Care Act 2012 gives commissioners a statutory duty "to promote involvement of each patient". It states: "Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and their carers' and representatives (if any), indecisions which relate to—(a) the prevention or diagnosis of illness in the patients, or (b) their care or treatment. "The phrase "in the exercise of its functions" means "in everything it does".

150 - Scrutiny committees should have powers to inspect providers rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate rather than receiving reports without comment or suggestion for action.

7.2.9 The Francis Report identified that council scrutiny should have been more proactive about responding to local concerns and that it should have been less trusting of managements' explanations of performance.

7.2.10 The Panel felt that consideration should be given to establish more robust ways to monitor data or information about the experiences of people who use health and care services, alongside 'triggers to act' when things seem to be going wrong. Council scrutiny does not need to duplicate what others are doing but should maintain a wide network of intelligence so that it can use its powers effectively to hold the NHS account - having a clear understanding about the quality, safety and value of healthcare services and challenging providers and commissioners when it seems that good outcomes elsewhere are not being matched locally.

7.2.11 For example, there is a role for overview and scrutiny to review whether the type and extent of engagement is sufficient and appropriate. It also has a proactive role in bringing together representatives of key health bodies to work collaboratively and share learning of engagement processes. There are also opportunities to co-opt representatives of patient groups and the public, with no voting rights, to specific scrutiny panels when investigating key health issues.

7.2.12 A key point from the Francis Report is that council scrutiny should not passively accept responses from providers or commissioners but should seek to test these in light of what people who use services say about their experiences (relying only on results of Friends and Family tests and other formal surveys may not be effective enough).

7.3 Coordination and Jointly Planning for a Whole System Approach

7.3.1 Each representative on the Board has a separate and collective responsibility for public engagement and public engagement is also the responsibility of organisations who are not members of the Board but part of the wider system

7.3.2 We heard evidence of engagement aspirations and constraints in light of resourcing. Our evidence showed that, mostly, there are no dedicated resources for PPE, despite the fact that PPE is regarded as an aspect of quality in its own right. The challenge will be for PPE to become mainstreamed and integral to service developments.

7.3.3 Given the absence of a dedicated engagement resource, the optimal solution is to make use of available resources and expertise from partner organisations and the wider health network including the voluntary sector and

CASE STUDY 1: SHARED DECISION MAKING

Shared Decision Making is a process in which patients with current, clinical information relevant to their particular condition can be helped to work through any questions they may have, explore the options available, and take a treatment route which best suits their needs and preferences - *No decision about me, without me*.

To achieve this, NHS England will encourage the development of new relationships between patients, carers and clinicians, where they work together, in equal partnership, to make decisions and agree a care plan. This puts Shared Decision Making not only at the care level, but also at the strategic and commissioning level, with patients involved in the co-design, co-commissioning and co-production of healthcare. Without this change, the required transformational culture change of Shared Decision Making will not be achieved.

7.3.4 Healthwatch has a statutory responsibility to engage patients and the public on issues determined by the community as priorities for action to inform commissioning decisions. Healthwatch will work across the wider system for patient and public engagement, to gather evidence from the views and experiences of patients, service users and the public about their local health and care services and to provide feedback based on that evidence.

7.3.5 Clearly, public engagement cannot purely be the role and responsibility of the Healthwatch representative. Whilst Healthwatch may co-ordinate its efforts with existing decision-making and influencing structures (such as the Board) where it deems this to be appropriate to its own work plan, the expectation should not be that its work can be directed or instructed by a third party.

7.3.6 Requirements above and beyond planned activities may not be possible without additional resourcing. In terms of resources required, not all strategies will share the same expectations. If we mapped the activities requiring patient and public engagement across all partners and looked at what is required across the Board's activities to meet those expectations the challenge would be evident.

7.3.7 The Panel was informed that through the Health and Social Care Integration fund (now the Better Care fund) there is greater scope for a Joint Communication and Engagement Strategy for Sunderland. It is intended that this will maximise impact and have a joint agenda commissioning proposals and integrated ways of working.

7.3.8 The Panel concluded that a working definition of what the Board means by engagement covering the range of participatory activities from information to influencing decisions would support the Board in its role as the conduit of partner engagement information.

7.4 Information Gathering

7.4.1 The Panel heard that the data collected from patients can help organisations to make better decisions about how to improve services. The NHS Patient Engagement Framework is evidence-based which means that a large amount of evidence is collected in various ways to provide an overview of patient views. Evidence shows that if information is collected in isolation it often does not lead to service improvement.

7.4.2 We heard that organisations need a mixture of measures to provide immediate and recent data that is sufficiently detailed and meaningful to influence staff, managers and executives. As well as requiring different types of measure, the way that feedback is collected can also influence the type of information and what it is useful for.

7.4.3 Sunderland CCG informed us that the four main ways that they involve patients are: Governing Bodies held in public; measuring patient experience; community engagement and Locality Patient Groups. Locality Patient Groups are being established in the five areas with approximately 10-15 people registered with each group. In addition, each GP practice is encouraged to have a patient engagement group and some patient engagement will be through virtual meetings.

CASE STUDY 2: THE FRIENDS & FAMILY TEST

The Friends and Family Test (FFT) for acute in-patients and patients discharged from A&E became mandatory on 1 April. Now all providers of NHS funded acute inpatient and A&E services are asking patients:

> "*How likely are you to recommend our <ward/A&E department> to friends and family if they needed similar care or treatment?" with answers on a scale of extremely likely to extremely unlikely*."

The aim is to provide a simple headline metric which, when combined with follow-up questions, can drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users.

This quick, consistent, standardised patient experience indicator will provide organisations, employees and the public with a simple, easily understandable headline metric, based on near real-time experience.

It will mean that employees from 'boards to wards' will be informed and empowered to tackle areas of weak performance and celebrate and build on what's working well, using the results from this test and other sources of intelligence.

7.4.4 Other examples of engagement being undertaken by the CCG include work done at a secondary school giving information on primary care which raised lots of questions. Communication methods are being modified, for example, the CCG strategy is being developed to include a Digital Marketing Strategy. Use of Twitter and Facebook were being developed to add variety to the engagement tools. In addition, people can receive information on special areas of interest to them. Individuals can be invited to focus groups and events and surveys will be issued which are representative of the demographics of Sunderland.

7.4.5 We heard that patient stories are a powerful method of reflecting the views of service users. There is considerable value in staff hearing patients' stories directly.

7.4.6 The Patient Association has on several occasions told patients stories with dramatic effect, triggering task and finish reviews in to care standards and responses to those stories. Patient Opinion[5] is an example of an online review and response tool for patients to let providers know about their experiences and for providers to respond.

CASE STUDY 3: PATIENT STORIES

South Tyneside Foundation Trust is leading a piece of work with a focus on 'Transparency in Care'. This is a national initiative and measures are being developed in terms of what this should look like. The initiative requires the publishing of patient improvement stories every month. In the last 12 months 906 individual patient qualitative stories have been logged and also 3,738 patients were interviewed at the time of their care. The use of patient diaries is another tool to provide an account of experience and feelings. These can be useful in areas such as palliative care, whereby a patient would want to be left to sleep this would be honoured as part of the diary system. Using this approach, cases of pressure ulcers have been reduced by about 50%.

7.4.7 Patient information is also available from a variety of sources beyond that collected by member organisations. This includes the council's scrutiny panels, the council as a whole, CCG locality groups, voluntary agencies, and local Healthwatch. The council carries out a range of consultations and collects health-related activity data. Voluntary agencies have deep insight into the needs of particular groups and may have done work on groups that are hard to identify and access. The council's locality arrangements i.e. Area

[5]https://www.patientopinion.org.uk/

Committees and People and Place Boards and the network of Health Champions have access to a variety of information within localities.

7.4.8 The Panel also considered compliments and complaints in order to review options for using intelligence to improve services and inform commissioning. Compliments and complaints are important in ensuring good quality healthcare, helping an organisation to find out about what they're getting right and what can be improved.

7.4.9 There were over 162,000 complaints about NHS care in 2012/13. This amounts to 3,000 per week. Additionally, compliments tell an organisation when things work well, so they can make sure examples of good practice are followed across other services

7.4.10 One of the key themes of the Francis Inquiry is to improve the complaints system. The report found that the Board of Mid Staffordshire never saw information about complaints as they viewed them as operational not strategic. Francis wrote: "*A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment. A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service*."[6]

7.4.11 It was the Francis Report that prompted the Government to commission a review of NHS hospital complaints handling.[7] Although the review focused on acute hospitals, many of the reflections and comments could be as relevant to primary care, community services and social care as they are for acute hospitals. The review identified that complaints should be treated like 'gold dust' as a source of information for decision-makers.

7.4.12 Yet, our evidence indicated that many people find complaints systems complicated and hard to navigate. The charity Mencap, for example, referred to the findings of its two reports 'Death by Indifference' (2007 and 2012) on unnecessary deaths of people with learning disabilities. It said: "*Both reports stated that the complaints process was slow, bureaucratic and defensive*. *People told us that it was hard to find out who to complain to, what help they could get and what their legal rights were … We were also told that people found complaints forms very inaccessible*."

[6] Public Inquiry into the Mid Staffordshire NHS Foundation Trust, Volume 1, Chapter 3 pp 245-287 Mid Staffordshire Inquiry Report

[7] A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture Right Honourable Ann Clwyd MP and Professor Tricia Hart October 2013

7.4.13 Healthwatch England, the independent consumer champion for health and social care in England, summed up the experience by saying: "*The complaints system can be off-putting, complex and slow… There is limited confidence that making a complaint will lead to learning and change*."

7.4.14 The changes in NHS structures introduced by the Health and Social Care Act 2012 have had consequences for people making complaints. The NHS Confederation noted: "*We have serious concerns that following the NHS reforms the complaints system has become more difficult to navigate and risks leaving patients confused about who to complain to."*

7.4.15 The NHS Confederation in evidence to the Clwyd Review suggested that Clinical Commissioning Groups should play a vital role using their leverage to ensure that providers have good complaints systems in place, "*we are calling for CCGs and NHS England to provide clear information to patients and the public about their complaints process*."[8]

7.4.16 The NHS Complaints Advocacy Service started in April 2013 and is delivered by the Carers' Federation Ltd. The NHS Complaints Advocacy services are commissioned through consortia of the north eastern authorities. The service supports people who want to make an NHS complaint. The Clywd Review recommended that the independent NHS Complaints Advocacy Service should be re-branded, better resourced, with protected funding, and better publicised. It should also be developed to embrace greater independence and support to those who complain.

7.4.17 The Parliamentary Public Administration Committee (PASC) launched an Inquiry in March 2013 focusing on how complaints in the NHS are handled.[9]It is looking at whether the current complaints system delivers fairness, redress, and justice for people who complain, and to examine how departments and agencies use complaints as a source of information and challenge, to improve the delivery of public services

7.4.18 Evidence to the PASC Inquiry from the NHS Confederation stated, "*Having consistent national standards would be a very good place to start, partly because some of the regulation and oversight of the providers is now separated between NHS England from a national perspective, CCGs, and regulators, such as CQC. To have a set of national standards that everyone is working to would be a really good idea. To ensure we are then joining up the intelligence and the information-one of the problems with Mid Staffs was that we were not putting all the information in the same place-is going to be an important national function. Having the right sort of information technology to support that will be a national role*."

[8]NHS Confederation evidence to the Clwyd Review

7.4.19 The Panel felt that there needs to be more effective coordination of the data already collected about front line services and with the avoidance where possible of seeking fresh collections of data for their own purposes. There is value in "piggy backing" on other public events/meetings that are being held.

CASE STUDY 4: CARE CONNECT NHS

Care Connect is a new initiative designed to give patients a say in the delivery of NHS services in England.

The new service, currently being piloted in Newcastle and Gateshead, will enable patients to interact with the NHS in 'real time'.

The Care Connect system was inspired by the 311 hotline service in the US. Designed to make dealing with public bodies less frustrating, 311 services provide people with direct access to local services and information.

The service is just one element of a broader suite of digital initiatives that will be rolled out over the next few years.

Care Connect quickly puts people in touch with people in the NHS. The service has three main features, enabling patients to share an experience (whether good or bad), ask a question (answered within 24 hours) or report a problem with an NHS service.

Navigating through the NHS's different departments can be mind-boggling. This service makes it easy for people by having one single place to go to. The pilot, when rolled out, could provide an incredibly powerful tool in terms of giving patients a say in shaping the NHS. All submissions are collected and analysed and, over time, this information will become a powerful tool for change in the NHS.

7.4.20 The Panel concluded that, as part of a unified approach, findings from individual engagement activity must be utilised with all public consultations relating to health and wellbeing joined up and coordinated.

7.5 Involving Everyone

7.5.1 The Panel collected evidence on how and why organisations should involve a wide range of people. This includes groups who are likely to be vulnerable or marginalised either as a result of their medical condition or as members of a community whose voice is often not heard in service planning and improvement perhaps because of special requirements such as those for whom English is not their first language.

7.5.2 Members of the Panel were concerned that patient feedback should be representative of all patients' views and there is a risk of groups being dominated by vested interests. We were informed that, working with the North East Commissioning Service, CCG is conducting work to measure how representative the membership is using market research techniques.

7.5.3 As an example of the difficulties faced, the Panel was informed that different BME communities face different health problems from one community to another and from the general population. We heard of inequalities in access to, uptake of and satisfaction with health care services experienced by minority ethnic groups, which in turn have impact on poor health outcomes. Research at the Centre on Migration, Policy and Society (COMPAS) found key messages to inform the policy and research including the power of providing information and the need to consider how data gaps could be addressed.[10]

CASE STUDY 5: International Community Organisation of Sunderland

ICOS Sunderland works with all minority ethnic people but most members are recent economic migrants. This client group tends to lack the local knowledge and access to established support networks that the general population and the more settled communities may have.

In 2010 and 2011, ICOS worked with Sunderland LINk to establish the health needs of the Polish community, the largest new EU community both nationally and in Sunderland. Reports by Sunderland LINk confirmed that people do not have enough access to information, resulting in incorrect use of health facilities, for example, and over-reliance on A&E care to an even larger degree than the general population, non-registration with GP practices, and lack of awareness about help available with addiction/substance misuse issues. Difficulty in accessing information and services around mental and psychological health because of language barriers may also have a negative health impact.

7.5.4 It was apparent that within each strategy, organisations will need to analyse their equality performance against the objective of improving patient access and experience.

7.5.5 A review of Healthcare Commission national reviews and studies since 2006 highlights a need to improve the engagement of patients and their carers' in a number of specific NHS service areas, including:

a) People with learning difficulties
b) Young people
c) Older people, particularly those with dementia

[10] COMPAS The health status of migrants and access to health care in the UK

d) People from black and minority ethnic communities, particularly older people
e) Users of substance misuse services
f) Users of chronic obstructive pulmonary disease services

7.5.6 Studies identify some promising engagement practices in some services, such as the use of volunteers and advocates, and links with community groups.

CASE STUDY 6: HEALTHWATCH - ENGAGING CHILDREN AND YOUNG PEOPLE

Groundwork North East has engaged with 71 young people aged 13-24 over the last 3 months. This has involved face to face work with surveys and a focus group drawing out their views on health and social care and how they would like to be involved in Healthwatch.

The young people consulted had not been engaged in the development of health and social care services. They had never been asked to give feedback on a service they had used. Their involvement had been limited to sexual health guidance through schools or accessing health services for personal reasons.

The main way young people would like to be involved is through social media, Facebook or Twitter. They are particularly interested in the development of peer support. They are willing to share their experiences with people they have developed relationships with. This is vital to young people as issues around confidentiality are paramount to them engagement.

Work will continue with the Children's Trust Advisory Network (CTAN), Youth Parliament and the Change Council.

7.5.7 The Panel concluded that a single Communication Plan and a coordinated and holistic approach to engagement within the wider context of corporate engagement would allow for a unified approach. This approach could include specific engagement strategies for key groups such as children and young people.

7.6 Engagement that makes a difference

7.6.1 'No decision about us, without us' is the vision of empowered citizens participating as partners in decision making about their health and health services.

7.6.2 A legal duty to involve is a key element of the NHS Constitution and evidence of the Government's commitment to place patients and public at the heart of the NHS. There are related duties on Health &Wellbeing Boards and NHS providers. Beyond legal compliance, good involvement can add

7.6.3 We are aware that not everyone can be or will want to be involved in every decision, however, working in a smart, targeted way with relevant groups of patients and carers in co- designing services and approaches can help identify what may be decommissioned as well as commissioned; get the new services right first time; identify the culture and approaches that meet patients' preferences and are therefore more effective; make the overall case for the service change on the basis that the relevant patients who are most affected want it.

7.6.4 The 'ladder of participation'[11] model states that as you step up the ladder then the role of residents and interested groups becomes more meaningful. The more involved people are the more content they are likely to be with the final outcome.

7.4.21 The engagement cycle provides a valuable tool for planning and implementing involvement activity in the various stages of commissioning (see Appendix 2). Its importance in relation to the duty to involve (See Appendix 1) is to make explicit the requirement that involvement is required at all stages of commissioning - assessing needs, designing services, reviewing provision, deciding priorities, managing providers' performance and service evaluation.

7.6.5 The Panel heard that there can be a mismatch between the responsibilities for patient and public engagement and the low expectation that patients and the public may have about being able to influence commissioning decisions. It was clear that future strategies should deliver involvement in a way that does not make the production of a strategy an end in itself, but a cornerstone of good quality health care. Beyond the legal compliance to involve people, good involvement can add value and help unlock benefits including better value for money and getting new services right first time.

7.6.6 It was clear from the evidence collected that sufficient time should be built into consultations to allow for meaningful dialogue, with venues and access carefully planned to maximise appropriate participation. There is also scope for better use of social media to achieve wider reach amongst local people, including making good use of Facebook and Twitter accounts.

7.6.7 The Panel concluded that evidence should be collected that shows how the outcomes of engagement have informed business activity and it should be

[11]Often termed as "Arnstein's ladder", these are broadly categorized as: Citizen Power; Tokenism; Non-participation.

possible to demonstrate how service changes are directly linked to patient and public views being expressed.

7.7 Patient and Public Engagement Framework

7.7.1 While there may be no "one size fits all" approach to an effective engagement approach, there are some key factors and themes that are important to consider, such as the need for a patient engagement to be embraced throughout the health system, the role of staff experience, the power of stories and the need to make the engagement central to the core organisational vision, strategy, quality reporting and service improvement work.

7.7.2 Seven key principles to guide Health and Wellbeing Boards for effective PPE are recommended by the NHS Confederation as:[12]

1) Engagement should take place from the start of the life of the health and wellbeing board and be woven into the DNA of the board throughout its work.
2) There will be different types and levels of appropriate engagement depending on the situation.
3) Patient and public engagement is the business of every board member.
4) The board has a responsibility to ensure effective engagement is embedded within its day-to-day business and is taking place through the commissioning and delivery of services.
5) Patient and public engagement has made a difference.
6) Engagement activities should be based on evidence of what works.
7) The effectiveness of patient and public engagement needs to be rigorously evaluated involving local communities concerned.

7.7.3 A number of these principles can be supported through the existing activity of stakeholder organisations. The Panel has adapted these principles into an operational framework for which evidence can be provided which will test the delivery of effective and coordinated engagement activity (See Appendix 3).

8. Conclusion

8.1 Patient experience of health services came into sharp focus with the publication of the Francis Report which highlighted the consequences of patient feedback not being acted upon.

8.2 The Panel's evidence showed there is an extensive range of PPE activity although this can lead to public confusion. There is a need to convince people that their voices will make a difference across the system. Also,

[12]Patient and Public Engagement: A Practical Guide for Health and Wellbeing Boards" (2012), NHS Confederation

people who may be considered ‘hard to reach’ may be less successful at navigating complex public service or complaints processes.

8.3 A unified approach to patient and public engagement supports the council’s cooperative agenda and allows for creating capacity through sharing resources.

8.4 There is no doubt that it doesn’t make sense to try to go it alone. Collaboration is essential in order to gather and make the best use of information.

9. Recommendations

9.1 The Panel’s recommendation is for the Scrutiny Committee to endorse the Patient and Public Engagement Framework as set out in Appendix 3 for forwarding to the Health and Wellbeing Board.

10. Acknowledgements

10.1 The Panel is grateful to all those who have presented evidence during the course of our review. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

a) Sandra Sutton, Compliance Manager, CQC
b) Mark Cotton, Assistant Director of Communications & Engagement, NEAS
c) Lucy Topping, Assistant Director Patient Experience, NHS England
d) Bev Atkinson, Director Nursing & Patient Safety, Louise Burn, Strategic Lead Urgent Care, Denise Horsley, South Tyneside Foundation Trust
e) Ann Fox, Director of Nursing, Quality and Safety, Julie Whitehouse, Sue Goulding, Sunderland Clinical Commissioning Group
f) Alesha Aljeffri, Liz Greer, Sunderland Healthwatch

11. Background Papers

11.1 The following background papers were consulted or referred to in the preparation of this report:

a) Sunderland Joint Health & Wellbeing Strategy

b) Patient and Public Engagement: A Practical Guide for Health and Wellbeing Boards - NHS confederation 2012

Appendix 1

Duty to involve and consult

The 2006 NHS Act, section 242 (updated December 2007), places a statutory duty on all NHS trusts to proportionally involve (through informing, engaging or consulting) patients and the public on:

- planning services they are responsible for;
- developing and considering proposals for changes in the way those services are provided; and
- decisions to be made that affect the operation of those services.

Where there is a proposal for substantial development or variation of health services, Section 244 of the Act sets out the duty on NHS organisations to consult the local Scrutiny Board (Health).

In the revised Operating Framework 2010-2011 the Secretary of State for Health identified four additional key tests for service change, which are designed to build confidence within the service, with patients and communities. These require existing and future service change proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

Appendix 2

The Engagement Cycle

The NHS Institute for Innovation and Improvement has published an online resource for commissioners planning to engage patients, carers and the public in the decisions being made about health service provision.

Engaging with patients and the public can happen at two levels:

- Individual level – 'my say' in decisions about my own care and treatment
- Collective level – 'my' or 'our say' in decisions about commissioning and delivery of services

The Engagement Cycle is a strategic tool that helps commissioning teams to understand who needs to do what, in order to engage communities, patients and the public at each stage of commissioning.

It identifies five different stages when patients and the public can and should be engaged in commissioning decisions:

- Community engagement to identify needs and aspirations.
- Public engagement to develop priorities, strategies and plans.
- Patient and carer engagement to improve services.
- Patient, carer and public engagement to procure services.
- Patient and carer engagement to monitor services.

At each of these five stages (identify, develop, improve, procure, monitor) The Engagement Cycle provides simple advice on what to do in order to undertake high quality patient and public engagement (PPE) that will enhance and support the decisions that commissioners need to make.

Each stage of the cycle provides useful intelligence for the next (like a baton being passed on from one stage to another). The Engagement Cycle can help commissioners towards authorisation and beyond by helping to:

- Develop a shared understanding of what good engagement looks like
- Providing a strategic direction and basis for planning
- Clarifying relationships, accountabilities, roles and responsibilities.
- Clinical Commissioning Group Board Members (Chairs, Vice-Chairs, Clinical Leads for Patient and Public Engagement, Lay Members and other Board Members)
- Clinical Commissioning Group managers (e.g. Chief Operating Officers) and staff
- PPE Practitioners working with CCGs and other commissioners
- Commissioning support organisations.
- Local authorities
- Health and wellbeing boards
- Health and social care providers
- Voluntary sector, patient and community organisations
- HealthWatch

An operational framework for patient and public engagement

Principle 1 **Patient and public engagement (PPE) is a strand of quality in its own right, an integral and equal part of the Board's responsibilities**		
Action	**Evidence**	**Progress**
1. A public statement of intent has been made about engaging patients and the public	See attached example	
2. A definition is agreed by the Board of what it means by 'engagement'		
3. Resources are in place to support PPE, including evidence of joined-up resources		
4. All policies and strategies explain how local communities from different areas and groups will be engaged with		
5. PPE activity undertaken by member organisations, and the providers they commission services from,is used to inform the work of the Board		

Principle 2 **Member organisations coordinate and jointly plan their resources for PPE to achieve a whole system approach**		
Action	**Evidence**	**Progress**
6. Member organisations contribute their individual organisation's knowledge of local views from different areas.		
7. Findings from individual engagement activity will be utilised, along with the professional expertise of the board.		
8. The Board has taken an approach to how it will make use of information collected by Healthwatch as a representative of a coordinated consumer voice		
9. All local public consultations relating to health and wellbeing are joined up and coordinated		
10. Relationships exist with agencies who are not members of the Board but part of the wider community network. (e.g. VCS, the council's and CCGs locality arrangements i.e. Area Committees, People and Place Boards network of Health Champions)		
11. PPE will connect to a city-wide partnership approach to engagement		

Principle 3 **Engagement will be embedded within the Board's day-to-day business**		
Action	**Evidence**	**Progress**
12. PPE is reflected in the governance arrangements of the Board and partner agencies		
13. The Board's reports include meaningful information about patient engagement activity including where this has made a difference		
14. PPE is prioritised within key activities, including the JSNA, JHWBS, and decision-making.		
15. The JSNA and JHWB are co-designed and commissioned in collaboration with the local community in different areas, communities of interest and seldom heard groups as well as partner organisations.		
16. As a 'network of networks' Healthwatch ensures the local community's views are included in priority setting		
17. The Board should routinely screen new issues for PPE implications and actions.		

Principle 4 **Meaningful engagement will be demonstrated through a range of approaches**		
Action	**Evidence**	**Progress**
18. The Board has a unified Communication plan and is working towards a unified and holistic approach to Engagement including identifying how this relates to the plans of member organisations and other strategic partners[1]		
19. The Board has ensured through a unified approach that arrangements exist to engage with groups identified as 'seldom heard'		
20. Appropriate use is made of social media to achieve wider reach amongst local people, including making good use of the council's and CCGs Facebook and Twitter accounts		
21. Sufficient time for effective engagement to take place is built into the development planning for any issue		
22. Timings, venues and access to engagement activities will be carefully planned to maximise appropriate participation		

[1] A unified approach does not override the statutory duties of any organisation and is not enforceable in law

Principle 5 **Patient and Public Engagement activity will demonstrate it has made a difference**		
Action	**Evidence**	**Progress**
23. PPE is carried out at all points in the commissioning cycle (assessing needs, designing services, reviewing provision, deciding priorities, managing providers' performance and service evaluation)		
24. The outcomes of PPE inform business planning		
25. All plans specify how feedback to patients, their carer's and the public will be provided		
26. Local community expectations are managed by making clear the parameters of what is possible		
27. Local people feel they have had the opportunity to express their voice on an issue even if they disagree with the outcomes		
28. Service changes can be directly linked to patient and public views being expressed		

Principle 6 **The effectiveness of patient and public engagement will be evaluated**		
Action	**Evidence**	**Progress**
29. There is a clear understanding of current strengths and weaknesses of PPE		
30. There is awareness of any areas for further development of PPE		
31. The Board can clearly demonstrate 'reach' in its engagement activities, including seldom heard groups		
32. There is a willingness to experiment with new ways of engagement,in conjunction with local people, to help achieve greater reach		
33. Local people are involved in evaluating whether engagement activity has been a success		
34. There is evidence that PPE activities have been amended based on evaluation feedback		
35. There is shared learning between member organisations to promote best practice in PPE		

Statement of Intent

The Framework has been developed in recognition of the importance placed on a unified approach to patient and public engagement, recognising that there is a benefit in combining efforts to achieve greater capacity and ultimately, improved engagement activity for the residents of Sunderland. This statement and framework encompasses the following aspirations.

1. To build the culture, infrastructure and the processes needed to ensure that patients and the public are involved as partners in decision-taking;

2. To carry out meaningful engagement with patients, carers and their communities;

3. To support a co-ordinated approach to patient and public engagement by the whole local health economy;

4. listening and focusing on what matters most to patients is an integral part of health service provision
5. To make best use of available resources;

6. development of strategies for equality and how people from socially disadvantaged communities are listened to and have the opportunity to shape health and care services or To embrace equality in all aspects of engagement;
7. To ensure patient and public involvement enables an appropriate level of influence and where necessary leads to improved services

8. Opportunities amongst existing networks, resources across the city and the potential to share the approach, structures and methodologies.

9. Potential of people feeling more connected and in control of their health

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD 16 May 2014

SAFEGUARDING ADULTS IN SUNDERLAND

Report of the Independent Chair of Sunderland Safeguarding Adults Board

1. PURPOSE OF REPORT

1.1 The purpose of the report is to update HWBB on the work of the Sunderland Safeguarding Adults Board (SSAB), with a particular focus on a recent Peer Challenge.

2. BACKGROUND

2.1 The SSAB is the key mechanism for determining how organisations in Sunderland will cooperate to safeguard and promote the welfare of adults at risk.

2.2 The SSAB has well established relationships with key and relevant partner organisations, with the SSAB meeting on a regular basis to drive forward the safeguarding adults' agenda.

3. PEER CHALLENGE

3.1 In March 2014, the Council invited a Peer Challenge Team into the People Directorate to look at both the ambitions and vision of the People Directorate and to assess the current plans for safeguarding vulnerable adults and the effectiveness of the newly developed model for adult safeguarding in the city.

3.2 A key focus of the Peer Challenge process was the involvement of the SSAB and its members in interviews and observations. As with the Peer Review process, the Team produce a report which highlights the areas of strength and areas for consideration.

3.3 The attached presentation sets out these relating to Safeguarding Adults; and the actions being progressed as part of the response to the Peer Challenge.

4 RECOMMENDATIONS

4.1 Board members are requested to:

- Receive the Presentation as an update of the outcome of the Peer Challenge
- Agree to SSAB presenting an annual progress report
- Consider a Board development session on Safeguarding

Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 16 May 2014

HEALTH AND WELLBEING PEER REVIEW – RECOMMENDATIONS AND IMPLEMENTATION PLAN

Report of the Assistant Chief Executive

1. Purpose of Report

The purpose of the Report is to update the Board on the recommendation of the Peer Review and share the implementation plan for comment.

2. Background

Following the review to the health and wellbeing system that came with the Health and Social Care Act, the LGA developed a health and wellbeing system improvement programme which included a peer challenge for local systems based on the principles of sector led improvement. The Sunderland system volunteered itself for the challenge and this was delivered during February 2014.

3. The Findings of the Challenge

Overall the LGA report was positive, complimenting Sunderland on its approach to Health and Wellbeing, the strategic leadership of the Health and Wellbeing Board (HWBB), strong and stable partnerships between the Clinical Commissioning Group (CCG) and the Council, the innovative approach to the Health and Wellbeing Strategy (HWBS) and the strength of Area arrangements. The LGA letter is included as Appendix 1.

In terms of challenge, the Peer Team emphasised the need to build on the momentum of the HWBS by embedding the design principles throughout the system ensuring the vision is clear and bought into action by commissioners from all local organisations and by providers, regardless of size and sector (e.g. public, private, independent, voluntary and community). Areas for further work and development include developing a performance management framework, ensuring read across from strategic to operational level and embedding Public Health expertise into the whole system.

An improvement plan built on the recommendations from the review is included as Appendix 2 and 6 monthly updates on progress against this should be provided to the HWBB.

4. Recommendations

The HWBB is recommended to:

- Note the overall findings of the LGA Peer Review;
- Review the Implementation Plan; and

- Agree to receive 6 monthly updates on progress against the implementation plan

Sarah Reed,
Assistant Chief Executive
Sunderland City Council
Civic Centre,
Burdon Road,
Sunderland
SR2 7DN

19 March 2014

Dear Sarah,

Health and wellbeing peer challenge, 11-14 February 2014

On behalf of the peer team, I would like to say what a pleasure and privilege it was to be invited to Sunderland to deliver the health and wellbeing peer challenge as part of the LGA's health and wellbeing system improvement programme. This programme is based on the principles of sector led improvement, i.e. that health and wellbeing boards will be confident in their system wide strategic leadership role, have the capability to deliver transformational change, through the development of effective strategies to drive the successful commissioning and provision of services, to create improvements in the health and wellbeing of the local community.

Peer challenges are delivered by experienced elected member and officer peers from Councils, CCGs and other organisations. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Sunderland City Council (SCC) and its Health and wellbeing Board (HWB) were:

- Jamie Morris, Executive Director (Neighbourhood Services), Walsall Council
- Cllr Keith Cunliffe, Portfolio Holder (Health and Adult Social Care), Wigan Council
- Dr Jane Moore, Director of Public Health, Coventry City Council
- Dr Adrian Hayter, Clinical chair NHS Windsor, Ascot and Maidenhead CCG
- Sue Stevenson, Chief Operating Officer, People First Advocacy Cumbria
- George Leahy, Deputy Director, Department of Health
- Paul Clarke, Programme Manager, LGA

Scope and focus of the peer challenge

The purpose of the health peer challenge is to support Councils in implementing their new statutory responsibilities in health from 1st April 2013, by way of a systematic challenge through sector peers in order to improve local practice. In this context, the peer challenge has focused on three elements in particular: the establishment of effective health and wellbeing boards, the operation of the public health function, and the establishment of a local Healthwatch

Our framework for our challenge was five headline questions:

1. Is there a clear and appropriate approach to improving the health and wellbeing of local residents?
2. Is the Health and Wellbeing Board at the heart of an effective governance system? Does leadership work well across the local system?
3. Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?
4. Are there effective arrangements for evaluating impacts of the health and wellbeing strategy
5. Are there effective arrangements for ensuring accountability to the public?

You also asked us to comment on the following issues which we have sought to address within this report, encapsulated within the five headlines above:

- Test the leadership of the HWBB and the advisory group structure
- Test the extent to which the principles of the HWB Strategy are embedded throughout the system
- Examine the extent to which public health is influencing other council services
- Assess progress in bringing together social care and health resources
- Uncover any barriers to service integration/pooled budgets across the system
- Critically assess the engagement of patients and the public and the progress towards co-production
- Provide recommendations on the future direction of the HWBB that will enable it to affect a positive step change in residents health

It is important to stress that this was not an inspection. Peer Challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material that they read.

This letter provides a summary of the peer team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the peer team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress SCC and its HWB have already made whilst stimulating debate and thinking about future challenges.

Summary of feedback: overall observations and messages

Our overwhelming view as we departed Sunderland at the end of the peer challenge was that there is both a real passion and strong ambition within the council and its partners to make a fundamental difference to the health and wellness of Sunderland residents. This is perhaps best embodied in the strong and purposeful alliance that the council has with the Clinical Commissioning Group (CCG).

We saw a Health and Wellbeing Board (HWB) that was clearly providing system-wide leadership. The Board has, in our view, the 'right people at the table'. It is proactive and is investing in new ways of working to maximise its impact. The mix of formal meetings with regular development sessions has served to clarify the Board's ambitions and has promoted effective relationships amongst its members.

We were impressed with the Health and Wellbeing Strategy (HWBS). This has taken some time to develop but offers a coherent plan, emphasising an asset based approach to health and wellbeing and your ambitions for the city.

Your next challenge is to develop the narrative that underpins this strategy and promote this widely within the council and partner organisations to foster a shared understanding of the board's aims and the principles underlying the strategy. This will then enable you to move forward with the strategy's implementation plan, which is awaited by many stakeholders and is currently in embryonic form.

You recognise that the health and social care system will look very different in the future and through your joint plans, most recently evidenced within your Better Care Fund (BCF) submission, you are actively working on this now. This would be a very opportune time for the board to develop a "road map" with clear deliverables for this significant transformation and the steps that will be taken towards a more integrated system. This would help people understand the scale and direction of change ahead and also provide a high level plan for the board to evaluate progress.

You have excellent locality arrangements already in place. Your area committees provide a strong focus on localities with the emphasis on people and places. The area committees are a very effective vehicle for ensuring community aspirations are recognised and that local people have a say in matters affecting their area. In terms of health and wellness, local actions should also reflect your strategic aims. In this way area committees can be an important contributor to the achievement of city wide plans. But to do this local actions need to be based on strong evidence.

Finally, we saw at first hand the real opportunities for system-wide change to maximise impact on wider determinants of health. A good example of this is the Health Impact Assessment carried out on the council's Core Strategy. This should serve as an exemplar for a more systematic approach to health impact assessments in the local authority. It is an area which you recognise is 'work in progress' but an area which needs development at pace if you are to fully utilise the potential of the system you are leading and managing

1. **Is there a clear and appropriate approach to improving the health and wellbeing of local residents?**

There is a clear and collective understanding, among the key stakeholders in the system with whom we spoke, of the health and wellbeing of the communities in Sunderland. The Health and Wellbeing Strategy (HWBS) is a determined strategy based upon strong and compelling design principles with six clear objectives on how these will be improved:

- Promoting understanding between communities and organisations
- Ensuring that children and young people have the best start in life
- Supporting and motivating everyone to take responsibility for their health and that of others
- Supporting everyone to contribute
- Supporting people with long-term conditions and their carers
- Supporting individuals and their families to recover from ill-health and crisis

Health outcomes in Sunderland show the challenges the city faces. For example, although you can point to real improvements around school age children you remain an outlier around children and young people, as well as several other measures. As such it has been of fundamental importance for the HWB to focus its efforts upon creating the conditions for improvement.

The strategy uses an assets-based approach. This starts with a focus on the strengths within communities, not the risks and deficits. The approach is one which emphasises the need to understand local communities and build relationships and resilience, rather than devising interventions to fix problems. The strategy reflects Sunderland's model of area working and its approach to community leadership. We found that this approach was coherent and understood by partners.

We saw a clear 'read across' and alignment between the HWS and the CCG's priorities. There is a strong relationship between the council and the CCG with the latter now providing a coherent voice for GPs, which is welcome. It is plain that as one stakeholder told us 'we are on the same page'. We witnessed an integrated approach to local authority commissioning encompassing public health and plans to extend this with the CCG. All of this bodes well

Our only cautionary notes in relation to the above was that we believed there needed to be greater attention required on a .primary care commissioning plan as we did not in our short time see real evidence of this. Additionally, in our view there is a real opportunity to use the skills and work expertise across Public Health to create strong evidence based commissioning that incorporates co-design and co-production of the interventions with local communities. These things should be built upon

We had access to the draft Better Care Fund (BCF) submission which we believe is ambitious. It has an intention to pool significant budgets, establish an integrated commissioning structure as well as single NHS and social care system and invest in voluntary and community provision. This approach clearly reflects the priorities of the CCG and council.

In our view a next key step is to develop a compelling narrative for communicating the strategy with the workforces across the system, the areas across the city and its residents within them. You have a strong tradition of effective engagement and we believe that you will embrace this as a way of engaging 'hearts and minds'.

The implementation plan and performance framework of the strategy is still 'work in progress'. We have seen the fledgling infrastructure and draft plans that lie beneath the six core priorities of the strategy. Momentum now needs to develop to see these through into tangible plans. This should go hand in hand with the narrative outlined above.

Again in support of the narrative and the implementation plan referred to above we believe it would be very worthwhile to articulate and communicate what your 'system' will look like in the next say 5 years and beyond and how to make the transition. This will build upon the BCF submission and really help people see, understand and positively respond to a potentially very radically different health and wellness landscape.

The Health inequalities across the city are well understood and the JSNA (which is just about to be updated) provides a clear and evidence- based assessment of these. That rational understanding could perhaps be underpinned by a stronger user perspective, which didn't shine through as strong as we might have expected. We did report back in our feedback from Beverley, a user of care from Washington. Such stories help explain what the health needs are, how people are engaged effectively and what can be achieved. As Beverley said 'They weren't listening to our complaints 2 years ago so we started the 'here I am campaign'. We are now training doctors, nurses, and home care staff. There is a long way to go but now they are listening.

It is well understood that of the six key objectives referred to within the strategy all services within and across the system need to recognise their contribution to health improvement by influencing the wider determinants. We saw some important green shoots of this within the council itself, the HIA of the Core Strategy already referred to and the excellent extra care housing plans in place. However it was clear that to achieve the ambitions of the strategy these good examples need to be replicated across the council and the system. It's a challenge that should remain front and centre.

We came across a range of stakeholders holding the view that public health interventions had not worked, as evidenced by the continuing health inequalities in the city, and that radical change was therefore needed. As one interviewee put it, 'The old ways of doing things haven't worked'. However, what is perhaps more the case is that they haven't worked as well as you would have liked especially in relation to achieving benefits for those with the greatest need. It is therefore important that you do not underestimate the effectiveness of the interventions delivered whilst continuing the work started in the integrated wellness model to improve access and sustain change in those communities with the greatest need.

In terms of the above we found many schemes and approaches that have worked very effectively, but not always at the scale to achieve population-wide tangible

differences. The exercise referral programme has generated positive results though we acknowledge your concerns about areas of the service and the biased population using the service change. New approaches will certainly need to be explored given the pressure on resources and the scale of change needed, but there is good practice to build on. We commend the approach Public Health is taking to develop an integrated wellness model with a single point of access and a grounded approach to supporting the population. However, we would suggest given your concerns about health inequalities that you need to do more around the behavioural and cultural issues that underlie why people do not make changes or access services if you are to make progress

2. **Is the Health & Wellbeing Board (HWB) at the heart of an effective governance system? Does leadership work well across the local system?**

The HWB is recognised across the city as being at the heart of the system. The peer challenge team saw a strategic decision-making Board. The Board purposefully chose to base its membership on the statutory minimum. It has reporting to its three core advisory groups: a provider's forum, the Children's Trust and Adults Partnership Board.

The shared political leadership and involvement of key council portfolio members and indeed the leader of the council as part of the board emphasises its core relevance. This filters through the political management arrangements within the council and across the city. The fact that the CCG has structured itself to reflect the council's five core city areas reinforces the pervasive ownership of the health and wellness agenda at all levels.

The investment in development sessions for the HWB has led to a clear relationship of trust between board members which promotes good working relationships. It is a Board that challenges itself. We endorse the pragmatic approach to engaging with providers through a separate board to avoid conflicts of interest and applaud the HWB for responding to the need to do this as it is became an additional part of the governance architecture in 2013.

It was clear to us that there are effective links with the Adults and Children's Boards which provide opportunities for dialogue. Related to this we saw that the Overview and Scrutiny arrangements in place are providing an important challenge. All local authorities are mapping out the boundaries and inter-relationships between HWBs, cabinet and scrutiny and you are no different. We applaud the clear protocol developed in Sunderland to respond to this. It is a general but obvious observation to suggest that you should regularly review your working arrangements to ensure they are helping you deliver and in line with the general theme of this report communicate that well.

One of the phrases we heard quite regularly was that in terms of the Boards influence was that it was "early days…" in the same breath people would also describe the challenges to be faced and the speed at which they need to be tackled. Our key observation here is to be clear and consistent about the scale and pace at which you are and need to be travelling. A key question we have is how will the HWB

provide the leadership to ensure the system delivers transformation at pace? In truth this relates to the need to have in place the action plans that underpin the strategy and ensure that these outline important milestones for progress and the gauging of this.

We spent some time as a team questioning the current positioning of both the public health function and its influence in helping drive on behalf of the HWB, the level of change required to achieve the ambitions required. There was clear evidence of a desire within Public Health to respond to the challenges set by the HWB to deliver step changes in the health and wellbeing of the people of Sunderland. However, although there were good examples of Public Health involvement in working with people across the council and city already referred to herein, there were wider areas where Public Health could have a much greater impact (e.g. the role of Public Health in supporting a prevention/early intervention approach to the BCF and the potential of involving Public Health in areas such as regeneration, employment and other aspects of the 'Marmot' agenda). It was not always clear from the discussion across the three days how Public Health could leverage influence across the council or where it was seen as having a clear leadership role.

Finally, we also questioned whether there is a shared understanding of the provider role in delivering a step change in outcomes. One area that you could develop is the role of the NHS and Council as employers in delivering improvements in health outcomes. You are both aiming to be healthy workplaces that demonstrate your commitment to the importance of health and wellbeing at work and we believe this could be a key aspect of the Council's employment and regeneration agenda. However, wider than this, real step change is only going to be seen if service providers are committed to an agenda that places prevention and early intervention at its heart. This ranges from more emphasis on primary cares role, to considering how do health and social services, with the voluntary sector and others work with communities to empower them to develop models of support that recognise the importance of social models (the role of social isolation) as well as health models in ensuring people can maintain vibrant lives without the need for intensive service intervention. This recognises that a lot of the improvements will not come from specific Public Health interventions but a mind-set within providers around promoting early intervention and supporting people to maintain their lives within the community.

3. **Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?**

An overriding impression the peer team received from our time in Sunderland was the energy and commitment to the health and wellbeing agenda. This commitment was evident right from our first engagement, when amongst other key stakeholders, the leader and chief executive of the council and the chief officer from the CCG attended the planning meeting prior to the challenge itself. That commitment was maintained throughout. It is a top priority for Sunderland City Council and its partners.

The Area structures that underpin the council's ideology and ways of working are reflected also in the way the CCG arranges itself. The area committees have a strong focus on both a People and Place agenda. The very impressive Community

Leadership Programme places local councillors at the centre of community leadership. This coupled to its aims of creating partnerships for growth and reconfiguring local public services all bring the health and wellbeing agenda to life in real places and real communities. We witnessed this at first hand during our attendance at the Washington Area Committee where local projects to tackle obesity and the potential role of adult learning were both considered.

The area committees provide an opportunity for very diverse and locally responsive services and projects, which reflect the very different local communities in the city. However you need to ensure that local interventions are properly evidence-based and informed by professional judgements about what works. If these committees are used in conjunction with some of the consultation methods used on the healthy weight/integrated wellness model consultation you have a real opportunity to get real reach into your communities.

There was a clear realism about future resources available to the system and the implications this would have. At the same time there was a whole range of excellent approaches, programmes and activities that demonstrate the focus on delivering sound outcomes:

- Your Integrated wellness model which outlines your overall approach and pathway to wellness: It's development with people from your communities means it recognises the need for a stepped approach to support individual and group change via Universal opportunities->programme management-.Brief advice and signposting->responsive equitable delivery->supportive delivery->Direct delivery
- The range of Wellness Services you commission including components such as Wild Walks, Weight Management, Lifestyle Activity and Food.
- Sunderland Health Champions programme with over 600 fully trained health champions, including a number of elected members (More on this – it is much more significant that the commissioned wellness services above which everyone does).
- Extra Care Housing. You have an ambitious programme that will provide choice for people and reduce the use of more costly traditional and institutional options
- Creative approaches to Telecare
- VCS strength at a local level. We were enormously struck by the enthusiasm and energy that existed amongst those that we met from this sector. There was a depth of understanding about the real issue that need to be tackled and a recognition that these were reflected in the HWBS "it's what we do"

The coterminous arrangements at city and area level for the local authority and the CCG give real potential for a focussed approach to meeting people's health and wellbeing needs. As one key stakeholder said 'The stars have aligned-it's within our control now'. Essentially this was pointing to the right 'system' conditions being in existence on the ground now. The next significant step is to build upon the examples above and deliver the city wide tangible outcomes you seek.

Inevitably there are further areas which we feel you could address. A key focus from the peer team's point of view is to encourage you to use a sound performance framework for planning future activities. It is crucial in your strategic model that

evidence drawn from the strong data you possess is aligned with effective solutions delivered at a region, city or local level (as per your Integrated Wellness Model).

Not unique to your situation but crucial to it success will be developing a workforce plan for the future outlining the landscape and the skills, competencies and capabilities that will allow your workforce to thrive. This should build upon the narrative that is being developed now and embodied in your BCF submission.

Given your focus on building resilience and capacity at a local level your model will require greater capacity within the VCS) It may be helpful to review how the wealth of skills, experience and passion in this sector is resourced and supported, we are aware that there are many excellent activities taking place at grass roots level but heard that the sector would welcome an opportunity to learn how to better collate evidence of success and quantify improved outcomes. This would help to build up a picture of what works and therefore help to direct appropriate future commissioned activity.

Alluded to above in relation to performance management it is important to reflect upon how the area activity best support the delivery of the HWBS and begin to map in a locality how that might be done. Area structures are a significant strength but your next challenges are how you look beyond these to increase community engagement and empowerment. There is a recognition from many of the people we spoke to that area committees are not enough. They are a focal point for local decision making but need a wider range of approaches to give local people more of a say. The local voluntary sector forums are also important in this regard but you will also need to develop other approaches, including social media, to engage local communities.

We saw strong evidence of effective joint working across the system. However, to ensure that these build into effective delivery in the long term it is important that the roles of partners is clearly defined within MOUs and work plans. Some of this exists and works well, others we felt could benefit from additional work. For example, the role of the Public Health working with the CCG on commissioning and agreements to how the Council (Public Health), the area team and PHE will work together on Health Practitioner issues

4. **Are there effective arrangements for evaluating impacts of the health and wellbeing strategy**

As outlined already there is an emerging outcomes framework for ensuring the effective delivery of the strategy. One could be critical that these are essentially drafts only. However, we do applaud the HWB for seeking to create the necessary conditions to establish the concept, as one stakeholder put it of ‘form following function’. The acid test is whether those emerging plans hold true to this and both reflect the core purpose of the strategy but are also practically deliverable.

The council is at the forefront of developing a new and ground-breaking ‘Intelligence Hub’. The potential for the Hub is significant in providing a rich, empirical and ‘joined up’ data warehouse. This in turn will provide information to be translated into core

intelligence upon which to base future commissioning of services. We discussed the potential of this with senior council officers as a means of delivering real transformation within the council, across the city and importantly in relation to the wider health and Wellbeing system. .
The project is at a relatively early stage but already there is enthusiasm from within the council and partners about its potential. The HWB needs to explore how it would support the effective delivery of their strategy and additionally how the development of the hub could be informed by the expertise and knowledge of health partners and specifically how it can be informed by public health expertise in terms of content and analysis'.

A key development for the future is to ensure that there are robust evaluation approaches in place for area based initiatives. It is crucial that there is a focus on local delivery and we saw at first-hand how the area boards are setting programmes and activities in place. We were less certain about: how they related to the principles of the HWBS, how they impacted upon key health outcomes as evidenced through the JSNA and how they might be effectively evaluated.

A thorny but important issue is the whole question of the financing of public health across the council and system. We believe it would be a worthwhile exercise to measure the impact of the re-profiling of the Public Health Budget to assure yourselves that you were generating sufficient efficiencies but also gaining real effectiveness from it. This is of particular importance given in future Public Health funding will reflect progress in improving health outcomes.

Aligned to the above we also wondered whether you are using your
PH expertise to develop more evidence based evaluation? The scale of innovation you want to put in place is impressive however without effective evaluation you may struggle to deliver effective changes or to be able to demonstrate that the initiatives have delivered the change expected from them. We would suggest a real opportunity for Public Health expertise to be used to develop collaborations with PHE and local universities to deliver this

5. **Are there effective arrangements for underpinning accountability to the public?**

A key strength of Sunderland is the democratic engagement, through frontline councillors. This has ensured public input to the strategy. Equally, the breadth of the engagement with key groups and communities to build the commitment to the HWBS was first class. This signals a strong intent around accountability.

We have highlighted the work of scrutiny in supporting accountability and there were specific examples of the reviews of public engagement and adolescent self-harm. There is clear evidence of a scrutiny work plan that addresses the priorities within the HWS

Healthwatch is building on networks to increase engagement. It provides an independent mechanism to capture and analyse the experiences of people and is working on the philosophy that it is better to engage people where they already are rather than create new groups. This was a strength.

A further key development is the commissioning of customer insight studies to inform current initiatives in Public health. This will provide a richer picture and like Beverley's story outlined earlier in the report provide a stronger user perspective.

The area model and the new arrangements for People and Place Boards as part of this provide a real opportunity to highlight at a local level what is done and why. Also it is important that the public can see this. As part of this and the wider fabric of a performance framework for the delivery of the HWBS you could give further consideration to how best you share intelligence around health and wellbeing with the public and importantly the evidence base and analysis that informs your decisions as a consequence. You could develop an approach which demonstrated the 'value added' for the resources you commit to the wide range of activities that you commission.

Finally we felt that Healthwatch Sunderland can help to strengthen public accountability by providing a route for involving people in an iterative conversation of "you said, we did". People want to know that their comments have had an impact and there is an opportunity to use Healthwatch to increase transparency and thus public accountability

Moving forward

Based on what we saw, heard and read we suggest the Council and HWB consider the following actions. These are a range of things we think will help improve and develop your effectiveness and capacity to deliver future ambitions and plans and drive integration across health and social care. These are all included in this report and some are specifically highlighted below:

- Develop a strong and compelling narrative to underpin the HWBS and promote this widely within the council and partner organisations

- Increase the pace of the HWBS's implementation plan.

- Articulate and communicate what your Health and social care 'system' will look like in the next 5-10 years and within this develop a "road map" with clear deliverables for your integration transformation.

- Build upon your area arrangements to co-design effective consultation methods to achieve best reach into your communities

- Ensure there is a more systematic approach to embedding Health and wellness into the core of council and partners services so you fully utilise the potential of the system you are leading and managing

- Use the skills and experience of your Public Health expertise to create strong evidence based commissioning that incorporates co-design and co-production of the interventions with local communities

- Develop a shared understanding of how you will work with and utilise the provider role in delivering a step change in outcomes

- Ensure you have in place a use a sound performance framework for planning future activities

- Given your focus on building resilience and capacity at a local level your model will require greater capacity within the VCS and you should establish the ways and means to respond to this challenge

- Develop a workforce plan for the future outlining the landscape and the skills, competencies and capabilities that will allow your integrated workforce to thrive. This should build upon the narrative that is being developed now and embodied in your BCF submission

- Confirm how your intelligence hub will be informed by the expertise and knowledge of health partners and how the hub will support the effective delivery of the HWBS

- Consider measuring the impact of the re-profiling of the Public health Budget to assure yourselves that you are generating sufficient efficiencies but also gaining real effectiveness from it and the PH function

10. Next steps

The Council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how the Council wishes to take things forward. As part of the Peer Challenge process, there is an offer of continued activity to support this. We made some suggestions about how this might be utilised. I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Mark Edghill, Principal Adviser, is the main contact between your authority and the Local Government Association. Mark can be contacted mark.edghill@local.gov.uk (or tel 07747 636910) and can provide access to our resources and any further support.

In the meantime, all of us connected with the peer challenge would like to wish the Council every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely

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Local Government Association

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Health and Wellbeing Peer Challenge – Improvement Plan

ID	Improvement Actions	Lead	Timescale for completion
A	**Is there a clear and appropriate approach to improving the health and wellbeing of local residents underpinned by accountability to the public?**		
A1	Develop a strong and compelling narrative to underpin the Health and Wellbeing Strategy (HWBS) and promote this widely within the council and partner organisations.	Neil Revely	November 2014
A2	Increase the pace of the HWBS's implementation plan and ensure this includes important milestones and outcomes that will demonstrate progress.	Fiona Brown/Debbie Burnicle	November 2014
A3	Articulate and communicate what the Health and Social Care 'system' will look like in the next 5-10 years including: • a "road map" with clear deliverables for integration & transformation • a workforce plan • Primary Care commissioning plan.	Neil Revely & Dave Gallagher	November 2014
A4	Ensure there is a more systematic approach to embedding health and wellness into the core of council and partners services, to fully utilise the potential of the system.	Ken Bremner (LSP Chair)	November 2014
A5	Use Public Health expertise to create strong evidence based commissioning that incorporates the co-design and co-production of interventions with local communities.	Nonnie Crawford	May 2015
A6	Develop greater understanding around the behavioural and cultural issues that underlie why people do not make changes or access services, ensuring that: • evidence drawn from data is aligned with effective solutions • there is a robust process for sharing intelligence around health and wellbeing with the public • that public intelligence is added to the evidence base to inform decisions • the JSNA in underpinned with a stronger user perspective.	Sarah Reed/ Liz St Louis/ Nonnie Crawford/HealthWatch	May 2015
B	**Is the Health & Wellbeing Board (HWBB) at the heart of an effective governance system? Does leadership work well across the local system?**		

ID	Improvement Actions	Lead	Timescale for completion
B1	Strengthen the engagement of NHS providers to deliver a step change in outcomes, putting prevention and early intervention at the heart of plans	Ken Bremner/Mel Speding	November 2014
B2	Review the Public Health team's leadership role to ensure it is able to leverage influence across the council in order to respond to the challenges set by the HWBB.	Sarah Reed /Nonnie Crawford	November 2014
C	**Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?**		
C1	Support the VCS to respond to health and wellbeing challenges.	Charlotte Burnham	December 2015
C3	At an area level map how area activity best supports the delivery of the HWB Strategy ensuring that local interventions are properly evidence based and are informed by professional judgements about what works. Ensure that there are robust evaluation approaches in place for Area based initiatives.	Charlotte Burnham	November 2014
C4	Build upon Area arrangements to co-design effective consultation methods to achieve best reach into communities.	Charlotte Burnham/HealthWatch	November 2014
D	**Are there effective arrangements for evaluating impacts of the health and wellbeing strategy?**		
D1	Put in place a use a sound performance framework for planning future activities.	Neil Revely/Dave Gallagher	November 2014
D2	Ensure that the intelligence hub is informed by the expertise and knowledge of health partners and supports the effective delivery of the HWB Strategy.	Liz St Louis	December 2014
D3	Measure the impact of the re-profiling of the Public Health Budget to provide assurance that it is generating sufficient efficiencies but also gaining real effectiveness from it for the PH function.	Nonnie Crawford/ Sonia Tognarelli	November 2014
D4	Use Public Health expertise to develop collaborations with PHE and local universities to deliver the evaluation of the HWBS.	Nonnie Crawford/Sunderland University	November 2014

Item No. 10

SUNDERLAND HEALTH AND WELLBEING BOARD 16 May 2014

HEALTH AND WELLBEING 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 development session is to be held in June 2014.

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 2. To agree actions to be taken forward by all partners

3. Forward Plan

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

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

4. 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.

5. 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 (tbc)	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)	10 July (Thursday)	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)	4 September (Thursday)	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)	6 November (Thursday)	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)	5 March (Thursday)	26 Feb (Thurs)	9 March (Mon)	10 March – 2-3	12 March (Thursday)	13 March (Friday)	20 March 2015 (Friday)