NHS
North East & North Cumbria

Place Plan for Sunderland

Submitted by: Scott Watson, Place Director for Sunderland

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Summary Statement:
The Sunderland plan has been co-produced with local system-partners to create a clear and compelling document that consolidates national, regional and local ambitions for health and care integration, with specific alignment to the NENC Integrated Care Strategy ('Better Health and Wellbeing for All') and the Health and Wellbeing Strategy for Sunderland ('Sunderland's Healthy City Plan').

The plan sets a clear direction of travel for our partnership, supporting a progressive approach to integration that builds on both existing strengths, and fertile areas of opportunity to integrate services in a way that supports:

- Improved quality and equity of care
- Prioritisation of prevention
- A clear focus on reducing health inequalities
- More sustainable and innovative use of resource.

This document is a key part of our delivery plan for the overarching Healthy City Plan for Sunderland

The plan has been pulled together using a 4-stage process as outlined in the attached, which has included passage through key partnership boards and a system-wide 'check and challenge' workshop (08/03/2023).

The resulting plan is based around a 3-part prioritisation framework consisting of 4 priorities, 1 over-arching policy objective and 7 system enablers, as set out below:

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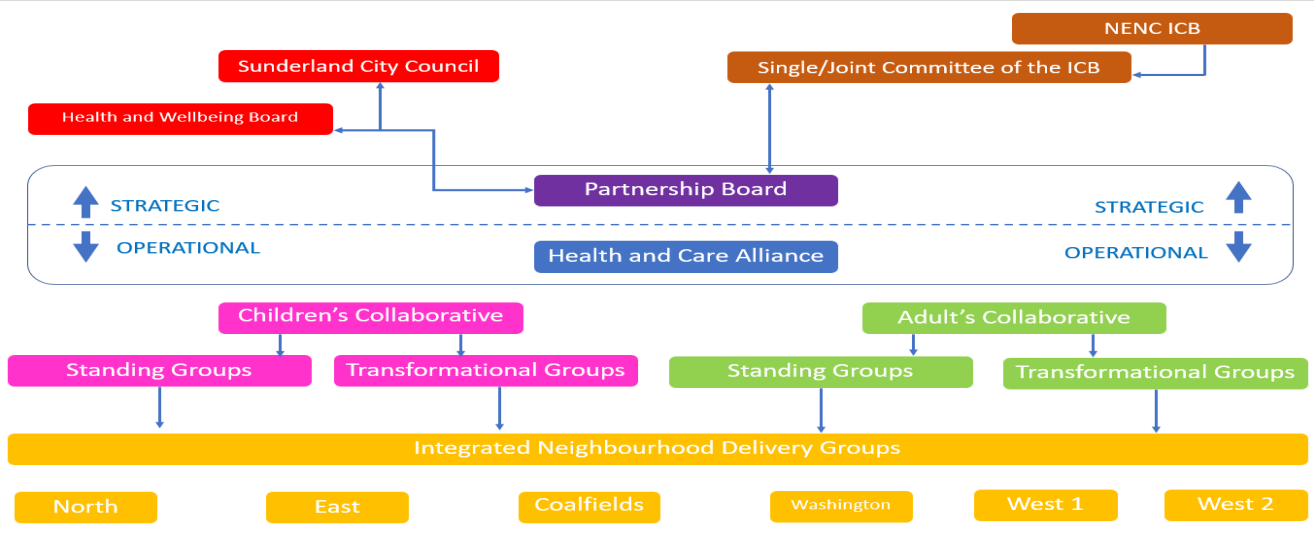
Governance and partnership working

Leadership and oversight of Sunderland's Place Plan will be provided by Sunderland's Single ICB-Committee and Partnership Board, which will replace Sunderland's Joint Consultative Forum as a committee-in-common from April 2023. Place-based accountability and reporting arrangements will align to Sunderland's place-based integration model (see page 3), which will include the necessary delegations to sibling adult and child collaboratives who will oversee the delivery of the place-plan objectives and deliverables.

Sunderland has commissioned Hill Dickinson LLP to oversee the development of a Section 75 partnership agreement between the ICB and Sunderland City Council, setting out how each party will jointly exercise their functions in respect to place plan objectives and how these arrangements will report into the Health and Wellbeing Board and wider statutory arrangements.

Critical to the delivery of the plan will be a determined focus on strong partnerships with people, communities and the VCSE. As such, community representation across all levels of place-based governance will be included to support shared decision-making and co-produced impact assessment and evaluation.



Key stakeholders

Key Partners	Key Boards & Wider Partnership Arrangements	Wider Stakeholders
People and communities	Integrated Care Board and Sub-Committees	Members
Integrated Care Board	Health and Wellbeing Board (and sub-groups)	Care Homes
Sunderland City Council	Cabinet	Schools, Colleges and Further Education
Sunderland Care and Support	All Together Better Executive	Housing Providers
Together for Children	Children's Collaborative	Combined Authority
South Tyneside and Sunderland NHS Foundation Trust	Local Safeguarding Partnership (Adults)	Media
Cumbria, Northumbria and Tyne & Wear Mental Health Trust	Local Safeguarding Partnership (Children)	
GP practices and PCNS	Safer Sunderland Partnership	
Lead Members	Carer's Strategy Board	
Community Pharmacy	Domestic Abuse and Violence Against Women and Girls Executive Board	
Sunderland Voluntary Sector Alliance		
Sunderland Health Watch		
Sunderland University		
Local Medical Committee		
Local Pharmacy Committee		

Priority Area 1: Strengthening primary and community care

Why is change needed?

Better integration and coordination of care is a key priority within NENC Integrated Care Strategy ('Better Health and Wellbeing for All'). A determined focus on neighbourhood integration - that builds on the development of primary care networks to ensure services are organised around the needs and voices of people and communities - is critical in transforming population health outcomes, reducing inequalities, and promoting sustainable and effective use of resource.

Objectives –

- Implement an integrated model of **personalised** care with a specific focus on embedding social prescribing within Core20Plus5 most deprived areas.
- Implement **anticipatory care** across integrated neighbourhood teams with an initial focus on frailty in those aged 65 years and over.
- Implement the 'Delivery Plan for **Recovering Urgent and Emergency Care Services'**, with a specific focus on building equitable community-based capacity through **integrated neighbourhood teams;** co-location of **Urgent Treatment Centre** (UTC) with **GP Out of Hours** (OOH); improved partnerships between health and **housing**; and protecting the **health of the workforce**.
- **Improve access to GP services** through implementation of the General Practice Access Recovery Plan with a specific focus on increasing equity of access
- Implement **direct GP access to diagnostic imaging** in-line with national guidance.
- Improve the effectiveness and efficiency of **care packages** for complex patients.
- Implement the ambitions of the national **Palliative** and **End of Life Care** framework
- Implement improvement action within the **Sunderland Carer's Strategy**, with a specific focus on improving the identification and support offered to carers, including strengthening links with Social Prescribing
- Engage with the public, patients, clinicians and pharmacy professionals across Sunderland to reduce the inappropriate use of medicines and overprescribing to support sustainable approaches to **medicines optimisation,** including driving targeted medicines actions in health inequalities improvement via Core20Plu5 approach

Goals –

- Regulated services across Sunderland are rated as good or outstanding by the Care Quality Commission
- Reduction in A&E attendance / Reduction in % of A&E attendance from most 20% most deprived areas
- Reduction in avoidable admissions / Reduction in % of avoidable admissions from 20% most deprived areas
- Increase % of adult social care users who have as much social contact as they would like (18+years)
- >90% of older people (65 or over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Reduction in the number of excess winter deaths / Reduction in % of excess winter deaths from 20% most deprived areas

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- Reduction in the number of staff vacancies and sickness absence across primary and community services
- Dementia diagnosis rate for people over 65+ in line with national recovery expectations
- Improvement in GP appointments data
- Increase in patient satisfaction in respect of GP services
- Every person offered a GP appointment within two weeks and offered a same/next day appointment for clinically urgent needs
- Achieve the ambitions of the Palliative and End of Life Care framework (as determined by a level 5 'fully achieving' score against each national ambition)
- Improved self-reported wellbeing in carers
- Reduction in prescribing costs for antidepressants
- Reduction in avoidable medicines-related harm
- Reduction in carbon footprint through inhaler device choice and appropriate disposal methods

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
1	**Personalised care:** Social Prescribing standards agreed in-line with Sunderland-wide Social Prescribing model									
2	**Personalised care**: Implementation and roll-out of a digital community supported self-management platform' for social prescribing									
3	**Personalised care:** Successful implementation of Phase 2 of Sunderland's Social Prescribing model									
4	**Personalised care:** Successful implementation of Phase 3 of Sunderland's Social Prescribing model									
5	**Anticipatory care** - Finalise the Anticipatory Care Model in each PCN / Neighbourhood area									
6	**Anticipatory care** - Implementation of the new Ageing Well Team in STSFT									
7	**Anticipatory care** - Implementation of Ageing Well Model across partners									
8	**Urgent and Emergency Care** - Implementation of integrated UTC/OOH model of delivery									
9	**Urgent and Emergency Care** - Refresh and refocus offer of the in-hours GP model within recovery at home service									
10	**Urgent and Emergency Care** – Undertake system-wide system diagnostic and transform community bed-based model for discharge									

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11	**Urgent and Emergency Care** - Review and Implement a refreshed Integrated discharge service model and transfer of care hub.									
12	**Urgent and Emergency Care** – Implementation of key actions within the Sunderland Housing and Homelessness Strategies, to support improved assessment of housing suitability and access to financial support for adaptations									
13	**Urgent and Emergency Care (placeholder)**									
14	**Improved access to GPs** - triage pilots evaluated and those that have evaluated well have been implemented across a wider footprint									
15	**Improved access to GPs** [Place holder for key deliverables within primary care recovery plan]									
16	General Practice Access – Improved patient satisfaction of use of General Practice services									
17	**Direct GP access to diagnostic imaging** - Deliver increased GP direct access to diagnostic imaging modalities									
18	**Care packages** - Identify fully-costed joint improvement plan for increasing the effectiveness and efficiency of care packages									
19	**Palliative and End of Life Care –** Undertake a self-assessment against the national palliative and end of life care ambitions and develop a cross-system improvement plan									
20	**Palliative and End of Life Care –** Achievement against each of the national and end of life care ambitions measuring level 4 (partially achieving) or higher									
21	**Palliative and End of Life Care -** Achievement against each of the national and end of life care ambitions measuring level 5 (fully achieving)									
22	**Carers Wellbeing –** Implement a standardised approach to the recording of carer status within General Practice									
23	**Carers Wellbeing** – Capacity-building programme in place to promote increase involvement of carers in decision-making and assessment of wider support needs									
24	**Carers Wellbeing** – Implementation of more streamlined access to social prescribing and ‘new to caring’ support pack									
25	**Medicines Optimisation** – Implementation of the NENC ICS Transformative Outcomes-Based Programme for medicines									

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Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
Personalised Care	X people across Sunderland benefiting from personalised care plans, with % uptake in Core20Plus5 most deprived population groups and x% uptake from carers	*TBC*	*X per 1,000 patients*	April 2024
Personalised Care	Improved wellbeing (ONS4)	*65%*	*TBC*	Ongoing improvement
Personalised Care	Increased Activation / Self-Management	*TBC*	*Overall Improvement*	Understanding measurement for this is ongoing.
Personalised Care	Additional performance measures are being led by the Research and Evaluation T and F group – for example University have HACT system to measure the social value of community based interventions.	*Ongoing evaluation*	*TBC*	TBC
Anticipatory Care	X% people aged over 65 who are at risk of frailty, benefiting from an anticipatory care plan	TBC	TBC	TBC
Anticipatory Care	Emergency Admission rates per older person with frailty and/or dementia	3 Month rolling average rate per 100,000 as at Dec 2022 = 210.60	None set – reduction	These are high level outcomes more work needed to agree targets and timescales
Anticipatory Care	Days disrupted for people with Frailty and / or dementia	3 Month rolling average rate per 100,000 as at Dec 2022 = 12.18	None set - reduction	TBC
Anticipatory Care	Pressure ulcers in older people with Frailty and / or dementia	3 Month rolling average rate per 100,000 as at Nov 2022 = 1.74	None set – reduction	TBC
Anticipatory Care	Serious falls in older people with Frailty and or dementia	3 Month rolling average rate per 100,000 as at Dec 2022 = 5.23	None set – reduction	TBC
Urgent and Emergency Care	Patients readmitted as emergency within 30 days of discharge (includes A% E attendances)	3 Month rolling average rate per 100,000 as at Dec 2022 = 49.71	None set – reduction	TBC

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Urgent and Emergency Care	UCR against 2 hour response	>70%	70%	April 2023
Urgent and Emergency Care	Sunderland AE Attendances compared to same period previous year	Jan 23 – 6240 Jan 22 - 5659	Overall Reduction	April 2024
Urgent and Emergency Care	No of face to face contacts (home visit) with specific timeframe (2hr and 6hr).	87%	95%	April 2024
Urgent and Emergency Care	Time to Treatment Seen within 60 Minutes within UTC	134 mins	60 mins	April 2024
Urgent and Emergency Care	Patients receiving a face-to-face consultation within their home residence within the specified period.	Avg. 22 per month for OOH GP	No Target - Dependant on patient circumstances and need.	April 2024
Urgent and Emergency Care	• More patients discharged to their usual place of residence • Discharge to same as admission destination • Discharge to Usual Place of Residence	No – 5.82%, Yes – 94.18% Not usual – 13.36%, Usual – 86.62	Overall increase	April 2025
Urgent and Emergency Care	% of discharges per pathway and against national standard / target	P0 – 79%, P1 – 15%, P2 – 4%, P3 – 0%	P0 - 50%, P1 - 45%, P2 - 4%, P3 - 1%	April 2025
Urgent and Emergency Care	LLOS/R2G summary reports Readmission rates per pathway with timeframes of 7, 14, 21 days	Overall 7 days – 7.0% 14 days 11.2%	Overall Reduction	April 2024 with ongoing increased improvement
Urgent and Emergency Care	at least 95% of patients attending A&E should be admitted, transferred or discharged within 4 hours	60-70%	>95%	April 2025
Urgent and Emergency Care	Improved access to Disability Facilities Grant	TBC	TBC	April 2024
Urgent and Emergency Care	2% improvement in staff retention across NHS workforce	TBC	>2% increase from baseline	April 2025
Improved access to GPs	Access to appointments in general practice *There are several measures with data gathered on a monthly basis - this is measured on a per practice basis*	*132,953 (based on January data)*	*Overall upward trend in appointment availability but no specific target*	April 2024

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Improved access to GPs	Patient experience of general practice services	*July GPPS results https://www.gp-patient.co.uk/surveysandreports*	*Increase on patient satisfaction on July 22 results (various measures)*	April 2024
Improved access to GPs	Number of patients calling NHS111 during core hours	*TBD*	*TBC*	April 2024
Improved access to GPs	Number of attendances at A&E and UTC for conditions that could be treated by General Practice	*TBD*	*TBC*	April 2024
Direct access to diagnostic imaging	Waiting times from referral to acquisition for specific diagnostic imaging modalities	Baseline to be established once modalities are agreed	Targets to be set once modalities are agreed	April 2024
Direct access to diagnostic imaging	Waiting times from referral to report for specific diagnostic imaging modalities	Baseline to be established once modalities are agreed	Targets to be set once modalities are agreed	April 2024
Care Packages	Number of patients discharged to own home with domiciliary care package in place	TBC	TBC	TBC
Care Packages	Number of patients who are discharged to a bed-based service in the community that should be at home	TBC	TBC	TBC
Care Packages	Increase in the number of joint packages of care	TBC	TBC	TBC
Palliative and End of Life	Number of outcome areas achieving level 4 or above within Palliative and End of Life self-assessment framework	TBC	95%	April 2024
Carers	Number of carers benefiting from social prescribing intervention	TBC	TBC	TBC
Carers	Number of carers benefiting from a Personal Health Budget	TBC	TBC	TBC
Carers	Number of carers supported to access direct payment support	TBC	TBC	TBC

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Medicines Optimisation	x% reduction in opioid prescribing	TBC	5% reduction	April 2024
Medicines Optimisation	x% of pressurised metered dose inhalers (pMDIs) as a % of all inhaler prescriptions	TBC	<X%	TBC

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Priority Area 2: Supporting people to live well

Why is change needed?

Supporting people to achieve a fairer, longer and healthier life are key commitments within the 'Better Health and Wellbeing for All Strategy' and 'Sunderland's Healthy City Plan'. Sunderland has lower life expectancy and healthier life expectancy at birth than the England average, with high levels of inter- and intra-area variations associated with deprivation, protected characteristics, geography and social exclusionary factors (e.g. homelessness; vulnerable migrants; Gypsy, Roma and traveller communities; sex workers; those with addictions, and people involved in the criminal justice system).

Improved integration of care supported by asset-based community development and underpinned by collaborative action on tackling wider determinants and prioritising prevention, will not only support people to live healthier, happier and more independent lives, but will reciprocally support inclusive and sustainable economic growth across Sunderland.

Objectives –

- Develop and implement a **High-Frequency User (HFU) strategy** for people with multiple complexity, underpinned by a comprehensive, multi-disciplinary personalised care approach.
- Undertake a population health management approach to improve prevention, screening, diagnosis and treatment of **cardio-vascular disease** with a specific focus on Core20Plus5 population groups
- Undertake a population health management approach to prevention, screening, diagnosis and treatment of **respiratory disease**, with an initial focus on COPD within Core20Plus5 population groups
- Undertake a population health management approach to improve prevention, screening, diagnosis and treatment of **type 2 diabetes** with a specific focus on Core20Plus5 population groups
- Undertake a population health management approach to improve prevention and **early diagnosis of cancer** with a specific focus on Core20Plus5 population groups
- Identify the core impacts of the **cost-of-living crisis** on health and care outcomes and implement a local action plan aligned to Sunderland's Financial Wellbeing Strategy

Goals –

- Increased life expectancy and healthy life expectancy in males
- Increased life expectancy and healthy life expectancy in females
- Reduced mortality rate from causes considered preventable per 100,000 population
- Reduce the gap in life expectancy for people in the most excluded groups
- Reduce smoking prevalence to 5% or below by 2030
- Reduce drug related deaths by at least 15% by 2030
- Reduction in under-75 mortality rate from cardiovascular disease considered preventable
- Reduction in under-75 mortality rate from liver disease considered preventable

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- Reduction in under-75 mortality rate from respiratory disease considered preventable
- Reduce alcohol related admissions to hospital by 20% by 2030
- Increase the number of adults with a healthy weight
- Increase the percentage of people diagnosed at the early stages of cancer (stage 1 and 2) to the national target of 75% by 2028
- Reduction in ambulatory-care sensitive admissions
- Reduction in the percentage of households experience fuel poverty
- Reduction in employment gap between those with long-term health conditions and the overall employment rate

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
1	**High Frequency Users** - Develop links in and out of hospital with supporting services	■	■							a
2	**High Frequency Users** - Develop a model to support those with complex, intermediate and low level needs	■	■							b
3	**High Frequency Users** - Develop and implement a HFU Strategy to sit alongside the health and care social prescribing strategy	■	■	■	■	■				all
4	**High Frequency Users** – Implement in-reach respiratory and cardiovascular screening within substance and alcohol service provision	■	■	■	■					
5	**High Frequency Users** – Establish and Implement 'Plus Pharmacy' model to high-traffic supervised consumption and needle exchange pharmacies					■				
6	**High Frequency Users** – Integrate the Individual Placement and Support offer into substance and alcohol treatment services	■	■	■	■	■				
6	**Cardiovascular Disease** – Align CVD Prevent tool to NHS Health Check programme to support more targeted approach to screening				■					
7	**Cardiovascular Disease** – Implement revised lifestyle intervention pathways for patients with a 20% risk of cardiovascular disease incidence within next 10 years			■	■					
8	**Respiratory Disease** – Delivery of a whole-system approach to the Targeted Lung Health Check programme, with a clear focus on reaching Core20Plus5 population groups	■	■	■	■	■	■	■		
9	**Diabetes** - Deliver contracted foot screening activity	■	■	■	■	■	■	■	■	
10	**Diabetes** - Deliver integrated diabetes service in general practice	■	■	■	■	■	■	■	■	
11	**Diabetes** - Integrate foot and eye screening services and deliver combined clinics	■	■	■	■	■	■	■	■	
12	**Diabetes** - Deliver effective weight management services	■	■	■	■	■	■	■	■	

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13	**Early Cancer Diagnosis** – Improve access to Primary Care for initial assessment and referral									
14	**Early Cancer Diagnosis** – Achieve compliance with NICE guidelines (NG12) across all practices									
15	**Early Cancer Diagnosis** – Increase cultural competence of practitioners who have contact with patients to increase uptake of screening in BaME communities									
15	**Cost of living** – Undertake a cost-of-living impact assessment across health and care services									
16	**All –** Implement the Sunderland Health Champions programme to support the capacity of VCSE									
17	**All** – Roll-out MECC training across health, care and key touchpoint services, with a specific focus on alcohol, obesity, smoking and substance misuse									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
High Users	Number of high frequency user attendances		*Overall reduction 40%*	April 2024
High Users	Increased referrals into UCR from all key routes, with a focus on maximising referrals from 111 to 999, and creating a single point of access where not already in place		*(national measure)*	TBC
High Users	Number of high frequency users with 10+ attendances in last 12 months		*Overall reduction 40%*	April 2024
High Users	Number of high frequency users proportion of all ED attendances		*Overall reduction 40%*	April 2024
High Users	% of eligible drug, alcohol and homelessness clients accessing NHS Health Check	TBC	*75% of eligible substance and alcohol patients with an up-to-date health check*	April 2025
High Users	% of eligible drug, alcohol and homelessness clients accessing mini lung-check	0%	*75% of eligible substance and alcohol patients with an up-to-date mini lung health check*	September 2024

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High Users	Reduction in the number of admission episodes for alcohol-related admissions	2,401 per 100,000	*1,979 per 100,000*	April 2026
Cardiovascular	% of eligible patients from 10% most deprived postcodes with an up-to-date NHS Health Check	TBC	50%	April 2025
Cardiovascular	% of patients accessing NHS Health Check who smoke setting a quit date with stop smoking services	TBC	45%	April 2025
Cardiovascular	% of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%	TBC	TBC	April 2024
Respiratory	% of eligible patients from 10% most deprived postcodes accessing lung health check	TBC	50%	September 2024
Respiratory	Reduction in the % of adult smokers	15.2%	5%	December 2030 (proxy for 2026)
Diabetes	Number of people receiving foot screening	10,713 YTD (Type 1 & 2)	Contracted activity	April 2024
Diabetes	Number of people receiving the 8 care processes	29.5% (Type 2 2021/22	targets not set yet	April 2024
Diabetes	Number of people meeting the 3 treatment targets	36.7% (Type 2 2021/22)	targets not set yet	April 2024
Diabetes	Number of people completing the NHSE Low Calorie Diet Pilot and losing weight	0	targets not set yet	April 2024
Diabetes	Number of people completing the National Diabetes Prevention Programme	0	targets not set yet	April 2024
Early Cancer Diagnosis	(Placeholder Screening targets in under-represented population for bowel, cervical and prostrate)	TBC	TBC	TBC
Early Cancer Diagnosis	Increase the % of cancers diagnosed at stage 1 and 2 inline with the 75% early diagnosis ambition by 2028	TBC	≥75%	March 2028
Cost-of-Living	Number of patients referred into financial wellbeing support	TBC	TBC	April 2024
All	Number of Health Champions/Core Connectors trained across Sunderland	12	50	April 2024
All	Number of MECC trained practitioners across health and care	TBC	TBC	April 2024

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Priority Area 3: Ensure the best start in life for children and young people

Why is change needed?

Ensuring all children and young people are given the opportunity to flourish and reach their potential is a key goal within the NENC Integrated Care Strategy ('Better Health and Wellbeing for All') and Sunderland's Healthy City Plan. Adversity in childhood can lead to long-term and/or life-long adverse health outcomes, with the first 1,001 days in particular (pregnancy to age 2) identified as a critical time for development.

Increased demand for children and young people's mental health support, Special Educational Needs and/or Disability (SEND) provision and therapeutic pathways (speech and language and occupational therapy), are experienced against the backdrop of high levels of deprivation, risk-taking behaviour and adverse childhood experiences, that collectively impact on the volume and complexity of met/unmet demand across the City and support the case for improved integration of primary and community care to better support the needs of children and young people.

Objectives –

- Establish a **Children's Collaborative to** oversee improved integration across key areas of children, young people and families provision.
- Improve access to robust **self-help, prevention and early intervention mental health offer** for children and young people
- Development of a **complex-needs commissioning** approach to support improved integration of health and care for children and young people with learning disability, autism and/or 3 or more ACEs
- Implement an equitable **family hub offer** to support effective early intervention and support in the first 1,001 days from pregnancy to age 2
- Improve the provision of **SEND support** to better meet the needs of children and young people with SEND and their families
- Strengthen proactive and co-produced **transitional arrangements** for young people with clinically or socially complex needs moving into adult services.
- Reduce avoidable, **unplanned hospital admissions** and A&E attendance in children and young people with a strong focus on targeted prevention and early intervention; proactive and coordinated support for children and young people with learning disability and/or autism; and implementation of **Core20Plu5** for children and young people
- Improved integration, capacity building and pathways into **neurodevelopmental support**
- Reduce overall **waiting times for assessment and treatment** in mental health services for children and young people

Goals –

- Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged groups
- % children eligible for free school means achieving a good level of development at the end of reception
- Increase the number of children and young people with a healthy weight
- Increase breastfeeding prevalence at 6-8 weeks
- Reduction in alcohol specific conditions in under 18s

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- Reduction in hospital admissions due to substance misuse (15-24 years)
- Reduction in smoking at the time of delivery
- Reduction in the percentage of school pupils with social, emotional and mental health needs
- Reduction in A&E attendances (0-4 years)
- Reduction in hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years)
- Reduction in hospital admission for asthma (under 19 years)
- Reduction in hospital admissions for mental health conditions (<18 years)

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
1	**Children's Collaborative** – Establish a cross-system children's collaborative with effective governance and reporting arrangements into Single ICB Committee & Place Partnership Board, including robust arrangements for embedding the voice of children and young people into place-based decision-making processes									
2	**CYP MH** - Scope current services and pathways									
3	**CYP MH** - Analyse data from across the system to understand demand and capacity									
4	**CYP MH -** Establish a CYP Mental health and Wellbeing Steering Group with associated workstreams aligned to the Thrive model									
5	**CYP MH -** Pilot the use of digital technologies (e.g., Lumi Nova)									
6	**CYP MH** - Work with schools and specialist CAMHS to develop an approach to supporting young people with anxiety, including those avoiding school									
7	**CYP MH** - Commission a VCSE provider to deliver a mentoring service for care experienced young people									
8	**CYP MH** - Commission a VCSE provider to employ two Community Connectors to work with young people aged between 16 and 25 to co-produce new activities, groups and events									
9	**CYP MH** - Work with Sunderland University to develop a Sunderland Parenting Course to be delivered by Early Help staff									
10	**CYP MH** - Commission a social prescribing service for young people who meet the thresholds for Community CAMHS but are awaiting a service									
11	**CYP MH** - Recruit and train young commissioners									
12	**CYP MH** - Establish a sub-group of the CYP Emotional Wellbeing Steering Group to consider innovative ways to reach and involve young people in commissioning									

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13	**CYP MH –** Implementation of young person's suicide prevention training									
14	**CYP MH** – Implementation of recommendations from Behavioural Insight Consortium for mental health review									
15	**Complex Commissioning** – Establish a working group to conduct a gap analysis of complex commissioning provision across Sunderland, to include children and young people with a diagnosis of learning disability, autism and/or 3 or more ACEs									
16	**Family Hub** – Implement Family Hub trailblazer programme across 5 areas of the city									
17	**SEND** - Undertake a review of pathways and processes across community equipment services, including those which are independently commissioned by schools to ensure families have a clear pathway to access, update and maintain equipment within home and education									
18	**SEND** - Complete a full joint commissioning review of speech and language therapy (SALT) to maximise opportunities for joint commissioning, ensure that resources are co-ordinated and there is sufficient provision to meet increasing demand in relation to: - SALT referrals for ASD diagnostic assessments - children with emerging speech and language issues in the early years.									
19	**SEND** - Relaunch Young Commissioners programme, with a focus on recruiting children and young people with SEND									
20	**SEND** - Recruit Transition Strategic Lead to co-ordinate pathways and processes for young people moving between children and adults services									
21	**Avoidable Admissions** - Care, Education and Treatment Review panel established									
22	**Avoidable Admissions** - Increased number of CETRs taking place preventing avoidable admission to Tier 4 services									
23	**Avoidable Admissions** - Review CETR findings to identify demand and gaps in service provision within Sunderland									
24	**Avoidable Admissions** - Ensure the DSR works collaboratively with the CETR process and informs/initiates CETRs to prevent avoidable admission to Tier 4 hospitals.									
25	**Avoidable Admission** – STSFT UNICEF accreditation pursued across community services									
26	**Avoidable Admissions** – Increased capacity and outreach provision within Young Person's Drug and Alcohol Programme in place									
27	**Avoidable Admissions** – Roll-out of Tobacco Dependency Pathway pilot programme within universal health visiting contacts									
28	**Avoidable Admissions** – Roll-out of regional Tobacco Dependency Pathways across maternity services									

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29	**Neurodevelopmental** - Meet with Autism Team, Community CAMHs, Education, CYPS, Parent/Carers to understand current systems and processes									
30	**Neurodevelopmental** - Mobilise a Family Support Service (initially as a pilot scheme)									
31	**Neurodevelopmental** - Explore support services that can be mobilised locally (sleep Scotland etc.)									
32	**Neurodevelopmental** - Create Neuro website for Sunderland with mythbusting, signposting, comms, contact information									
33	**Neurodevelopmental** - Review communications with parents/carers and professionals									
34	**Neurodevelopmental** - Redesign diagnostic pathway and assessment criteria.									
35	**Neurodevelopmental** - Build relationships with schools									
36	**Neurodevelopmental** - Development of a pre-specialist pathway									
37	**Neurodevelopmental -** Address 0-5 element of pathway									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
CYP MH	Number of people accessing mental health resources	0	80%	September 2024
CYP MH	Referrals to specialist CAMHS	TBC	20% reduction	June 2025
CYP MH	Change in child and parent reported outcomes, e.g., CORS and RCADS	TBC	TBC	TBC
CYP MH	Number of school days lost due to anxiety in participating schools	TBC	TBC	TBC
CYP MH	Number of schools participating in MHCM scheme	TBC	TBC	TBC
CYP MH	Number of families receiving a service from the MH workers alongside other support from early help	TBC	TBC	TBC
CYP MH	Number of families completing parenting course	TBC	TBC	TBC
CYP MH	Number of families reporting an improvement in their ability to meet their child's needs 6 months after the completion of the course	TBC	TBC	TBC

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CYP MH	Number of young people reaching the correct service at referral	TBC	TBC	TBC
CYP MH	Improvement in reported outcomes following treatment	TBC	TBC	TBC
CYP MH	Number of young people requiring a reduced service from CAMHS (shorter or no service compared to control group)	TBC	TBC	TBC
CYP MH	Number of young commissioners recruited and trained	TBC	TBC	TBC
CYP MH	Number of people trained in young person's suicide prevention	TBC	TBC	TBC
Family Hubs	Number of new family hubs across Sunderland in place	0	5	TBC
SEND	Reduction in admissions to Tier 4 provision for young people with autism and learning disabilities	TBC	TBC	April 2026
SEND	Reduction in waiting times for community equipment services	TBC	TBC	April 2024
SEND	Reduction in waiting times for therapy services	TBC	TBC	April 2025
SEND	Increased number of children with SEND involved in coproduction of services	TBC	TBC	April 2024
Avoidable Admissions	Reduction in avoidable admissions for children and young people with LD or autism	TBC	TBC	TBC
Avoidable Admission	Reduction in smoking status at time of delivery	14.6%	6%	April 2026
Avoidable Admissions	Breastfeeding prevalence at 6-8 week	27.6%	35%	April 2026
Avoidable Admissions	Reduction in admission episodes for alcohol specific conditions – under 18 (rate per 100,000)	76	70	April 2024
Neurodevelopmental	Increased involvement of CYP, families and carers in care planning	TBC	TBC	April 2024
Neurodevelopmental	Number of inappropriate referrals	TBC	TBC	TBC
Neurodevelopmental	Number of accessing support services	TBC	TBC	TBC

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Priority Area 4: Transforming mental health, learning disability and autism services to delivery improved outcomes

Why is change needed?

With demand for mental health services continually increasing, establishing place-based, multidisciplinary teams focused on prevention and tackling variations in mental health outcomes, is a critical component of health and care integration. As highlighted within the NENC Integrated Care Strategy ('Better Health and Wellbeing for All'), poor mental health is associated with reduced life expectancy and increased chances of physical illness, alongside adverse mental health outcomes which are currently impacted by long waiting lists and operational pressures.

The Sunderland Adult Mental Health strategy published in 2021 encapsulates our vision to making 'Everyone's mental health matter'. We have committed to empower people by supporting individuals, families, and communities to improve and maintain mental and physical health, so they can lead fulfilling and healthy lives. This will be achieved via three main priorities:

> ***An ounce of prevention is better than a pound of care:*** Strengthening and promoting lifelong mental health and wellbeing with a focus on prevention.
>
> ***Right Response, Right Time, Right Place***: Ensuring there is appropriate and timely access to flexible and inclusive mental health care services for all, focussing on the whole person.
>
> ***Working with you on what matters to you:*** Delivering care designed around the individual, without barriers across teams, services, and organisations.

In addition to the above, people with learning disability and/or autism are on average likely to die at a younger age, and experience poorer health outcomes. Strengthening community support and reducing reliance on specialist inpatient care is key to ensuring people with a learning disability and/or autism are supported to live a happy, healthy and independent lives, and to maximise their potential for employment and educational opportunities.

Objectives –

- **Community Mental Health Transformation**: Develop and deliver a community mental health transformation program with a determined focus on prevention and timely access to intervention for those from Core20Plus 5 population groups.
- Implementation of **Mental Health Hubs** to offer advice, guidance, signposting and low-level mental health support within neighbourhoods through co-located teams
- Implementation of **trauma and psychologically-informed** care across health and care services in Sunderland
- Delivery of the **Sunderland's Adult Mental Health Strategy**
- Improved uptake of physical health checks and targeted screening programmes for those with **Severe Mental Illness** (SMI) and **autism**

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- Transform the community provision for adults with **Learning Disability and/or Autism** to prevent crisis, avoid admissions and support the achievement of a happy, healthy and independent life.

Goals –

- Achieve a 5% year-on-year increase in the number of adults and older adults supported by community mental health services
- All patients with a learning disability, autism and/or those with serious mental illness have an up-to-date annual health check and action plan
- Reduction in suicide rate
- Reduction in excess under-75 mortality rate in adults with severe mental illness (SMI)
- Increase in the number of adults and older adults accessing Talking Therapies services through Sunderland's Single Point of Access
- Achievement the mental health investment standard (MHIS) at ICB level

Initiatives – Key deliverables

		23/24				24/25	25/26	27/28	28/29	Measure Reference
Item	**Deliverable description**	**Q1**	**Q2**	**Q3**	**Q4**					
1	**Community Mental Health Transformation**: Pilot the implementation of three community mental health hubs over 2023/24									
2	**Community Mental Health Transformation:** Evaluate success of mental health hubs and consider further city wide roll out									
3	**Community Mental Health Transformation**: Implement neighbourhood mental health MDT pilot over 2023/24									
4	**Community Mental Health Transformation:** Evaluate success of mental health MDTs and consider further city wide roll out									
5	**Community Mental Health Transformation:** Implement and evaluate a peer support network to support patients in engagement and attendance at appointments and are connected with appropriate services.									

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6	**Community Mental Health Transformation:** Support the implementation of the concordat in Sunderland to create a resilient community and supportive preventative activity.									
7	**Adult Mental Health Strategy**: promote mental health awareness, including promoting the help and support which is available to improve health and wellbeing and strengthen coping strategies									
8	**Adult Mental Health Strategy:** work in partnership with communities to identify priorities, understand barriers to access, and co-produce solutions in relation to mental health and wellbeing.									
9	**Adult Mental Health Strategy:** Improve accessibility of mental health care and support by working in partnership to co-produce and improve services.									
10	**Adult Mental Health Strategy:** Maintain an emphasis on co-production to quality assure and improve services									
11	**Adult Mental Health Strategy:** Implement and publish a mental health dashboard which demonstrates the delivery of the strategy									
12	**Mental Health Practitioners in Primary Care:** Further develop roles to maximise outcomes and ensure patients access the most appropriate service to meet their needs.									
13	**Crisis and Crisis Alternatives:** Review interdependencies and outcome measurements to maximise opportunities and ensure value for money									
14	**Suicide Prevention:** Support delivery of the Sunderland Suicide Prevention Action Group (SPAG) action plan to maximise preventative opportunities and reduce the number of attempted and completed suicides									
15	**Dementia:** Improve the dementia diagnosis rate by reviewing existing pathways and data recording and extraction mechanisms.									
16	**Severe Mental Illness:** Implement a system wide approach to increase engagement with and access to annual health checks to improve life expectancy									

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17	**Learning Disability and Autism:** Deliver an annual health check program for patients with autism									
18	**Learning Disability and Autism:** Develop and implement an autism strategy for Sunderland									
19	**Learning Disability and Autism:** Implementation of a Quality Framework for annual health checks for people with a learning disability, delivering the national expectations.									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
Community Mental Health Transformation	Increase in the number of Mental health hubs in Sunderland	0	3	March 2024
Community Mental Health Transformation	Increased number of referrals into Community Mental Health services	4,200	4,600 per quarter	March 2024
Community Mental Health Transformation	Increased access to talking therapies services	2,600 per quarter	2,900 per quarter	March 2024
Community Mental Health Transformation	Increased number of mental health MDTs in Sunderland	2	6	March 2025
Adult Mental Health Strategy	Reduction in the average days disrupted per person with mental health conditions	1.3	TBC	March 2025
Adult Mental Health Strategy	Increase the proportion of the population who are mentally healthy	67.6%	TBC	March 2028
Adult Mental Health Strategy	The number of completed suicides	TBC	Deteriorating	Ongoing
Severe Mental Illness	Improve uptake of annual health checks for patients with a Severe Mental illness to meet or exceed the national target of 60%	56%	60%	June 2023
Learning Disability and/or Autism	% of people aged over 14 on GP Learning Disability register in receipt of an annual health check and health action plan	73%	≥75%	March 2024

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Learning Disability and/or Autism	Improve in the number of autism health checks for patients with autism	40%	60%	March 2024
Learning Disability and/or Autism	Reduced reliance on inpatient care, to that by March 2024 no more than 30 adults with a learning disability and/or autistic per million adults are cared for in an inpatient unit	TBC	<30 per 1million	March 2024

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Enablers – what do you need in place for your full place-based plan?

1. Process – operational models that will require change as a result of this plan being delivered.

Integrated delivery arrangements in place, supported by ICT, data sharing and asset sharing
Improved GP access pathways to diagnostic imaging modalities in place
Establishment of Care, Education and Treatment Review panel for children and young people
New neuro diagnostic pathways for children and young people, including pre and post diagnostic support
Changes in how mental health services for children and young people are delivered via Thrive model
Consistent approaches to improving health literacy within Core20Plus5 population groups across health and care services
Consistent approaches to the assessment of equality impact and equitability of service provision with clear expectations (and support for) taking corrective action

2. Workforce

Increasing volume and diversity of the health and care workforce pipeline, including appropriate investment in VCSE-based delivery
Shared competency framework and workforce standards for personalised and anticipatory care (including VCSE and Social Prescribing capacity building)
Development of effective clinical, care and public health leadership and workforce strategy
Investment in workforce health and support (including cost-of-living support)
Investment in effective organisational development to support new ways of working and support the recruitment and retention of staff
Implementation of ARRS workforce plans and integration of the ARRS roles into the PCN and neighbourhood teams
Implementation of primary care workforce plan at place to support recruitment, retention and development of the primary care workforce and increase the number of placements of students and training places in primary care

3. Research and Innovation

Asset-based community development, community engagement and peer-leadership approaches to support improved patient and public involvement in decision-making and delivery
Digital and process innovation (horizon-scanning and improved engagement with digital and technology sector to identify innovation opportunity)
Behavioural insights and cultural norms research to support improved understanding of factors that impact on patient choices and decision-making, particularly in Core20Plus5 groups

4. Digital technology and Data.

Improved approaches to JSNA to support intelligence-led decision-making
Implementation of Sunderland's Population Health Management Strategy
Investment in digital tools to support self-care and remote monitoring
Quality and sharing of data to support risk stratification, MDT working, needs assessment and demand and capacity modelling
Digital infrastructure investment, including digital inclusion
Integrated approaches to technology enabled care
Development of Dynamic Support Register for children

5. Estates

Co-location needs to be supported by appropriate ICT infrastructure (family hubs, SRH UTC, mental health hubs, transfer of care hub)
Consideration of s106 funding at planning stages to align housing and health ambitions
Development of place based wider estates strategy, including improved collaboration between LA and ICB on estates planning

6. Finance

Mechanisms to support effective joint commissioning arrangements through improved use of pooled funds and risk share
Appropriate delegations are in place to support friction-less decision making at place-level

Risks

Risks	Mitigations
Appropriate place-based governance delegations not in place, reducing appetite to support integration across partnerships	Hill Dickinson LLP commissioned to provide strategic legal advice and support in the development of ICB Committee & partnership arrangement
Financial uncertainty impinging on risk appetite and investment opportunities	Develop robust risk share agreement within s75 arrangement | Identify a shared risk approach to key programmes and enabling infrastructure (inc estates)
Ongoing workforce issues (recruitment, pay-disputes) delaying or preventing progress against key deliverables	Investment in staff wellbeing initiatives and workforce strategy | Ability to test new ways of working through opportunistic innovation, inc digital innovations | Investment in VCSE and carers to build capacity and capability | Communication & engagement plan developed to support staff through change
Increased complexity and volume of demand delaying or preventing progress against key deliverables	Increased focus on prevention & targeted early intervention, including investment in population health approaches | Increased use of demand modelling and digital technologies to support planning & provision of care | Investment in research & development to promote improved evidence-based practice and innovation