HEALTH AND WELLBEING SCRUTINY COMMITTEE

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 1) on Wednesday 11th April, 2018 at 5.30 pm

Membership

Cllrs Chequer, Davison, D. Dixon, Fletcher, Heron, Hodson, Johnston, Leadbitter, McClennan, Middleton, D. Trueman and G. Walker

Contact: **David Noon Principal Governance Services Officer** **Tel: 561 1008**
Email: david.noon@sunderland.gov.uk

Information contained in this agenda can be made available in other languages and formats on request

6.	**Annual Work Programme 2017/2018** Report of the Head of Member Support and Community Partnerships (copy attached)**.**	64
7.	**Notice of Key Decisions** Report of the Head of Member Support and Community Partnerships (copy attached)**.**	67
	Part C – Health Substantial Variations to Service No Items	-
	Part D – CCFA/Members Items/Petitions No Items	-

E. WAUGH,
Head of Law and Governance,
Civic Centre,
SUNDERLAND.

3rd April, 2018

HEALTH AND WELLBEING SCRUTINY **11 APRIL 2018**

COMMISSIONING OF A MULTISPECIALITY COMMUNITY PROVIDER (MCP).

REPORT OF NHS SUNDERLAND CCG

1. Purpose of Report

1.1 The purpose of the report is to provide members with an update of progress realising the local strategic ambition of a Multi-specialty Community Provider (MCP) leading, developing and delivering an effective integrated Out of Hospital Care model in Sunderland.

1.2 Members are invited to note the CCG Governing body decision following the MCP engagement activities previously shared with members at their November 2017 meeting.

2. Background

2.1 Since May 2013 Sunderland CCG has been working towards delivering a vision for the future of out of hospital services with the aim of moving from fragmented service provision to more integrated service provision.

2.2 As a Vanguard we have been testing and developing an MCP (Multi-Speciality Community Provider) based care model over the last 3 years with a range of services. The underlying principle of this approach is to enable GPs, nurses and other health and care professionals within the community and voluntary sectors to come together and plan and deliver person centred co-ordinated care that leads to better outcomes for people.

2.3 Following the success of this approach to integration within the tested services the CCG agreed a business case to enhance the scope of services to be integrated to include all out of hospital services the CCG commission, up to £240m in value.

3. Engagement Activities

3.1 Over the last few months we have been exploring how best to secure the integrated care model with the full scope of out of hospital services for the long term. To develop the MCP model further has involved engaging with GP Practices, the public and the market. We have engaged via sharing our draft Prospectus which set out the MCP Care Model, the proposed business model to support it, the scope of services and what we would expect from any provider.

3.2 Following that engagement, the MCP Care Model is largely unchanged because the majority of the feedback supported the model and the CCG Governing Body signed off the Final Prospectus at the February 2017 meeting. However there were a number of comments about the proposed business model which required further debate and consideration by the Governing Body. The options and considerations are set out in the Commissioning Strategy – the outcomes of which are set out in section 4 below.

3.3 Our final Prospectus therefore reflects our final care model and scope of services including the intended outcomes we expect to achieve. In effect the final Prospectus

sets out WHAT we want to commission. (Appendix 2). In terms of HOW we intend to commission the MCP i.e. what business model we should use – the final Prospectus briefly explains the options but the detail behind these are set out in the Commissioning Strategy for the MCP which was also considered by the CCG Governing Body at its February 2017 meeting. This is not a public document due to commercially sensitive information from the market engagement, however the summary of each of the options and the recommendation is in the covering report which is available on request and summarized in section 4 below.

3.4 The outcomes of the engagement can be found on the CCG website including the:

- Public Engagement Report
- General practice engagement report and
- The final Prospectus

http://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/

4. CCG Governing body Decision

4.1 On the 27th February 2018 the CCG Governing Body came to a decision about how to secure the MCP Care Model for the future. Our decision follows careful consideration of the feedback from the public, general practices, the local authority, other stakeholders and potential and current providers of healthcare services gathered during the engagement period. This feedback also informed our review of the benefits and challenges of the different business/contracting models available to secure an MCP set out in our Commissioning Strategy.

4.2 The Governing Body decision (subject to some further and ongoing assurance on achievement of appropriate pace of change and robust governance arrangements) was to secure the MCP via a **Collaboration business model, supported by an Alliance Agreement.**

4.3 Whilst either of the business models: Accountable Care Organisation or Collaboration could deliver the MCP Care model, our preference was to continue to build on the success arising from the more joined up approach over the last few years between the current providers, working collaboratively with commissioners.

4.4 The key features of the MCP Alliance will be:

- Organisations in a system **acting and behaving as though they are one**, whilst maintaining statutory and contractual responsibilities of individual organisations – **both Commissioners and Providers.**
- Formalised by **an alliance agreement which overlays underlying commissioning contracts**
- **Collaborative and pro-active management of resources**
- Delivers, **by collaboration**, any changes to models of care and integration

4.5 This will redefine the relationship between commissioner and provider with the ultimate aim of:

- Improving the quality of care for local people
- Improving health outcomes and wellbeing for local people
- Improving the sustainability of the local health and care system.

4.6 Our aim will be to have an MCP Alliance Agreement and supporting governance arrangements in place with existing providers over the next few months and a programme of further transformation agreed by the autumn in readiness for the MCP Alliance to be operating effectively from April 2019. This work will include a CCG contracting strategy to manage future procurements for those contracts where services are included within the MCP Alliance Agreement and are due to expire over the coming years.

4.7 The ability of the collaboration approach to deliver the pace and transformation required, will be kept under review over the next year and we reserve the right to commission the MCP using a different business model if the ongoing review concludes the collaboration approach is not able to deliver the further transformation and pace required.

4.8 A communications plan has been implemented to ensure that the decision has been effectively communicated to key stakeholders including a stakeholder brief (Appendix 1). We want to thank all those who took part in the engagement and contributed to this key next stage in transforming the out of hospital healthcare system in Sunderland.

5. Recommendation

5.1 The Committee is recommended to note the report for information.

5.2 Members are invited to note the contents of the Stakeholder Brief and the Final Prospectus

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Author: Penny Davison, Senior Commissioning Manager, Sunderland CCG

Sponsoring Director: Debbie Burnicle, Deputy Chief Officer, Sunderland CCG

29.3.18

APPENDIX 1

MULTI-SPECIALITY COMMUNITY PROVIDER (MCP)
BRIEFING FOR All STAKEHOLDERS
9.3.18

Since May 2013 Sunderland CCG has been working towards delivering a vision for the future of out of hospital services with the aim of moving from fragmented service provision to more integrated service provision.

As a Vanguard we have been testing and developing an MCP (Multi-Speciality Community Provider) based care model over the last 3 years with a range of services. The underlying principle of this approach is to enable GPs, nurses and other health and care professionals within the community and voluntary sectors to come together and plan and deliver person centred co-ordinated care that leads to better outcomes for people.

Following the success of this approach to integration within the tested services the CCG agreed a business case to enhance the scope of services to be integrated to include all out of hospital services up to £240m in value.

Over the last few months we have been exploring how best to secure the integrated care model with the full scope of out of hospital services for the long term.

To develop the MCP model further has involved engaging with GP Practices, the public and the market, sharing our draft Prospectus which set out the MCP Care Model, its scope and what we would expect from any provider.

Following that engagement, the MCP Care Model is largely unchanged because the majority of the feedback supported the model. Our final Prospectus reflects our intended outcomes and what we want to commission. However further work has taken place on the options for securing the model.

On 27th February 2018 our Governing Body came to a decision about how to secure the MCP Care Model for the future. Our decision follows careful consideration of the feedback from the public, general practices, the local authority, other stakeholders and potential and current providers of healthcare services gathered during the engagement period. This feedback also informed our review of the benefits and challenges of the different business/contracting models available to secure an MCP.

The Governing Body decision (subject to some further and ongoing assurance on achievement of appropriate pace of change and robust governance arrangements) was to secure the MCP via a **Collaboration business model, supported by an Alliance Agreement.**

Whilst either of the business models : Accountable Care Organisation or Collaboration could deliver the MCP Care model, our preference was to continue to build on the success

arising from the more joined up approach over the last few years between the current providers, working collaboratively with commissioners.

The key features of the MCP Alliance will be:

- Organisations in a system acting and behaving as though they are one, whilst maintaining statutory and contractual responsibilities of individual organisations – both Commissioners and Providers.
- Formalised by **an alliance agreement which overlays underlying commissioning contracts**
- **Collaborative and pro-active management of resources**
- Delivers, **by collaboration**, any changes to models of care and integration

This will redefine the relationship between commissioner and provider with the ultimate aim of:

- Improving the quality of care for local people
- Improving health outcomes and wellbeing for local people
- Improving the sustainability of the local health and care system.

Our aim will be to have an MCP Alliance Agreement and supporting governance arrangements in place with existing providers over the next few months and a programme of further transformation agreed by the autumn in readiness for the MCP Alliance to be operating effectively from April 2019. This work will include a CCG contracting strategy to manage future procurements for those contracts where services are included within the MCP Alliance Agreement and are due to expire over the coming years.

The ability of the collaboration approach to deliver the pace and transformation required, will be kept under review over the next year and we reserve the right to commission the MCP using a different business model if the ongoing review concludes the collaboration approach is not able to deliver the further transformation and pace required.

We want to thank all those who took part in the engagement and contributed to this key next stage in transforming the out of hospital healthcare system in Sunderland.

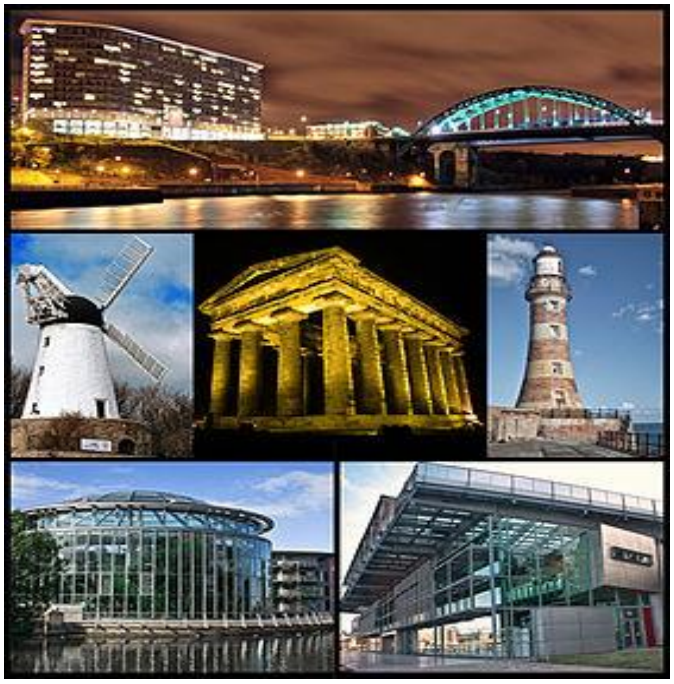
Further information including the Public Engagement report, GP Engagement report and final Prospectus can be found at http://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/

Appendix 2

NHS Sunderland Clinical Commissioning Group

NHS Sunderland Clinical Commissioning Group

The Multi-Specialty Community Provider (MCP) Prospectus



Version Final 23.2.18

Contents

Statement from CCG Chair and Chief Officer

Sunderland is a vibrant city with great energy, proud history and plenty of opportunity which is actively recovering from the loss of its past position as a world leader for mining, shipping and heavy industry.

Sunderland in general has poorer health outcomes than the rest of the country with significant pockets of deprivation. However Sunderland has risen to the challenge of improving those health and care outcomes with a population and workforce committed to tackling those challenges by embracing all opportunities for improvement. It is within this context and ambition that the health and care system has developed the new care model for the out of hospital system

Our community health and care system has some fantastic services, many innovative others traditional but strong with a highly skilled, experienced and committed workforce of fantastic quality.

The MCP will ensure that our care system is fit for the future meeting Sunderland's needs and delivering the effective, efficient and seamless care that the people of Sunderland expect.

We move forward together as always under our "All Together Better" vision.

Dr Ian Pattison
Chair, Sunderland CCG

David Gallagher
Chief Officer, Sunderland CCG

Executive Summary

Closer integration between services in the community is a fundamental part of both national policy and of local strategy with the aim of promoting health and wellbeing, delivering quality care for patients/service users, and ensuring sustainability of the local system.

Since May 2013 Sunderland CCG has been working towards delivering a vision for the future of out of hospital services with the aim of moving from fragmented services to more integrated services, providing more effective person-centred co-ordinated care. This led to Sunderland's selection to join the NHS England vanguard programme with the intention to develop a new care model – the multi-speciality community provider (MCP) model.

The All Together Better (ATB) Sunderland Vanguard Programme has been in place since 2015 and, has had significant success making major progress with the development and implementation of an integrated out of hospital care model.

The CCG now wishes to enhance the care model and secure it for the longer term. In so doing, the CCG believes there is benefit from including and integrating all out of hospital services it commissions into the MCP model of care. This increases the scope and value of the services from the current Vanguard, resulting in up to 240m worth of out of hospital services which need to be integrated in order to deliver the model of care described below responding to the 4 levels of population need.

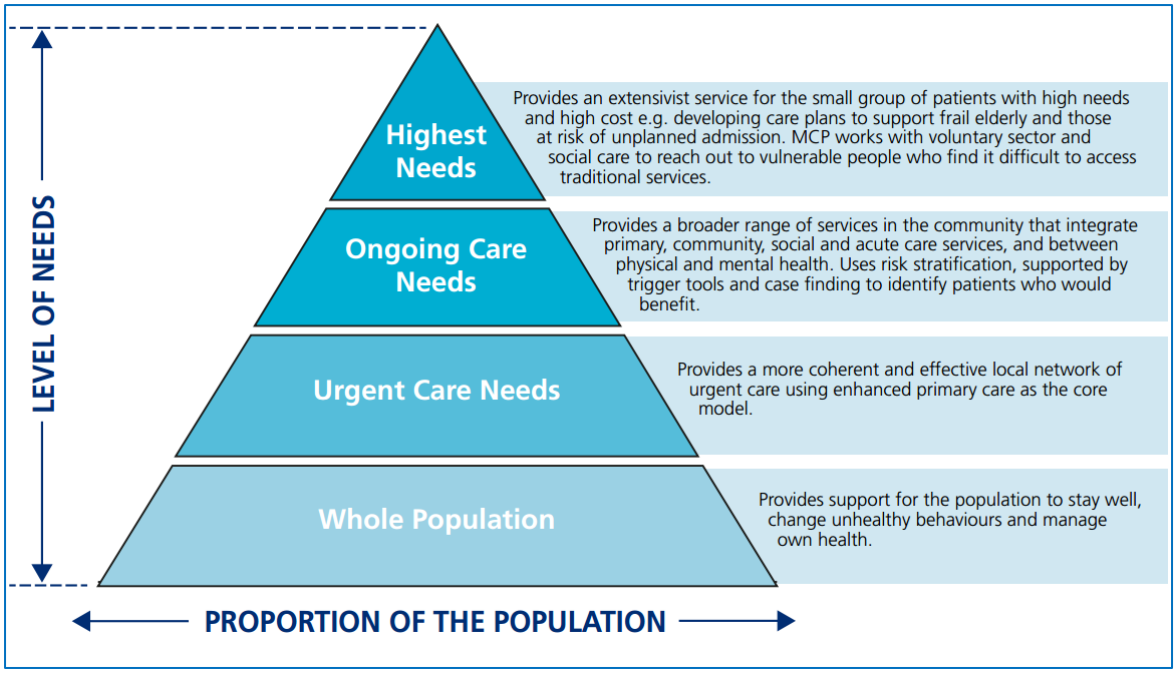


Diagram 1: MCP Framework

The intention is therefore to secure the MCP Care Model for the long term to in order to realise the local strategic ambition of an MCP leading, developing and delivering an effective integrated out of hospital care model in Sunderland.

The underlying principle of the development is that it will enable GPs, nurses and other health and care professionals with the community and voluntary sector to come together

and plan and deliver person centred co-ordinated care that leads to better outcomes for people.

The CCG wishes to work with potential provider(s) who share the vision for our care model and consider that they have the right capacities and capabilities to respond to the challenge ahead.

This will redefine the relationship between commissioner and provider with the ultimate aim of:

- Improving the quality of care
- Improving health outcomes and wellbeing
- Improving the sustainability of the health and care system.

This document goes on to describe:

- What the CCG requires from any Provider(s) delivering the MCP care model, including our design principles,
- Development of the out of hospital model to date
- How the model continues to be developed
- Scope of services included in the MCP
- Outcomes to be achieved
- Findings from public engagement and
- Our Commissioning Strategy to secure the MCP

From November to December 2017 the CCG undertook a market and public engagement exercise with general practices, potential providers, stakeholders and the local community regarding the commissioning of an MCP in Sunderland using the Draft Prospectus. The findings from this engagement have informed this final Prospectus

Background

Closer integration between care services in the community is a fundamental part of both national policy and of local strategy and commissioning intentions the aim being to promote health and wellbeing, delivering better outcomes for patients/service users, promoting ease of access and ensuring sustainability of the local system.

The planning for closer integration between health services and social care in Sunderland began in May 2013, when both the new clinically led CCG with the local authority as Commissioners agreed a vision for the future of community services and was supported by the main local providers. The aim being of moving from fragmented services to integrated services providing more effective person centred co-ordinated care. This led to a range of local developments which together provided the evidence to support Sunderland's application and selection to join the NHS England Vanguard programme with the intention to develop a new care model – the Multi-Speciality Community provider model (MCP).

The **All Together Better (ATB) Sunderland Vanguard Programme** has been in place since 2015 and, through the unified vision and combined efforts of both health and social care commissioners and providers, has had significant success making major progress with the development and implementation of an integrated Out of Hospital Care Model.

The CCG now wishes to secure the Out of Hospital Care Model for the longer term. In so doing, the CCG believes there is benefit from including all out of hospital services it commissions in an MCP care model.

This prospectus describes the CCG's vision to commission an MCP care model.

From November to December 2017 the CCG undertook a market and public engagement exercise with general practices, potential providers, stakeholders and the local community regarding the commissioning of a MCP in Sunderland using the Draft Prospectus. The findings from this engagement have informed the final Prospectus.

Population to be served (Sunderland)

The MCP care model will support the care for all adult patients registered with all Sunderland practices and non-registered adult patients resident in Sunderland. The MCP will cover 43 (as at 1st January 2018) practice populations and along with non-registered patients which will in effect cover the whole adult population of Sunderland The CCG works with the practices in five groupings, split by area described as localities. They are Coalfield, Sunderland East, Sunderland North, Sunderland West and Washington. The relevant practices and localities are set out in Appendix 1.1.

Joint Strategic needs assessment

Sunderland had a resident population of 277,000 in 2015 which is predicted to rise to 285,000 by 2030, with a CCG Registered population of 284,133 at 1st January 2018. It has an ageing population and is much less ethnically diverse than the England average but is becoming more ethnically diverse (See JSNA and Health profile link provided below).

The population profile of Sunderland is changing with a rapidly ageing population and a declining younger population. The key messages are set out below with some further detail in later paragraphs:

- The population is forecast to grow by 3,000 to 2020 – a 1.1% increase compared to 4.7% nationally.
- The 65+ population is growing at a higher rate than the under 65 population which is a significant concern given the typical healthcare service utilisation of this segment of the population
- More people are living with complex health conditions.

Population forecasts

The Sunderland population is expected to **increase** over the next 10 years by 1.8% and by 3.0%[1] over the next 20 years. Although the population is expected to increase marginally overall over the next 10 to 20 years, the rate of growth in particular age groups is of significant concern. It is expected that the under 65 year old population is expected to **decrease** over this period by 2.5% and 5.1% respectively whist the over 65 population is expected to **increase** by 20.2% by 2027 and 37.5% by 2037 which is a significant concern given the healthcare utilisation of this segment of the population. The belief is that as the population increases in the over 65 age group, then the healthcare utilisation will almost certainly increase.

Health issues and concerns

The health of people in Sunderland is varied compared with the England average. Sunderland is one of the 20% most deprived districts/unitary authorities in England and about 26% (12,600) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 10.1 years lower for men and 8.2 years lower for women in the most deprived areas of Sunderland than in the least deprived areas.

The rate of alcohol-related harm hospital stays (adults) is 948 per 100,000 population, worse than the average for England. This represents 2,592 stays per year. The rate of self-harm hospital stays is 180 per 100,000, which is better than the average for England which is 191.4. This represents 499 stays per year. The rate of smoking related deaths is 423 per 100,000, worse than the average for England. This represents 648 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average.

Around 79,000 people in the City of Sunderland have at least one long term condition, and one in four adults report some form of long term illness, health problem or disability. Long term conditions become more common with age and Sunderland has an aging population. Approximately 80% of local people between the age of 70 and 79 have at least one long term condition.

Key additional messages from the JSNA for localities compared to Sunderland as a whole:

[1] Based on 2014 population estimated provided by the Office of National Statistics (ONS)

- Coalfields – a higher proportion of older people;
- Sunderland East – a higher proportion of people from black and minority ethnic groups;
- Sunderland North – more communities that experience high levels of disadvantage;
- Sunderland West – more communities that experience high levels of disadvantage;
- Washington – a higher proportion of families with children.

The MCP will be expected to take account of the JSNA and ensure awareness of and deliver services in a way that meets the needs identified.

https://www.sunderland.gov.uk/article/13880/Joint-Strategic-Needs-Assessment

https://www.sunderland.gov.uk/media/18724/Joint-Strategic-Needs-Assessment-Summary/pdf/Joint_Strategic_Needs_Assessment-_Summary_.pdf

Multi-speciality Community Provider (MCP)

Vision for Multi-speciality Community Provider (MCP)

Our vision for the MCP is to provide:

A focus on person centred proactive and coordinated care which will support appropriate use of health and care services, will improve patient and carer experience and outcomes, ensuring people will live longer with better quality of life

This vision is underpinned with the high-level ***outcomes*** *below*:

- ***To Improve Care Quality including safety, clinical effectiveness & patient experience***
- ***To improve Health and Wellbeing***
- ***To improve Sustainability creating a sustainable health and care system***

The CCG want to commission an MCP model of care that is holistic and addresses all patients' needs in the community and covers the 4 levels of need and using the high level care model identified in the MCP national framework set out below.

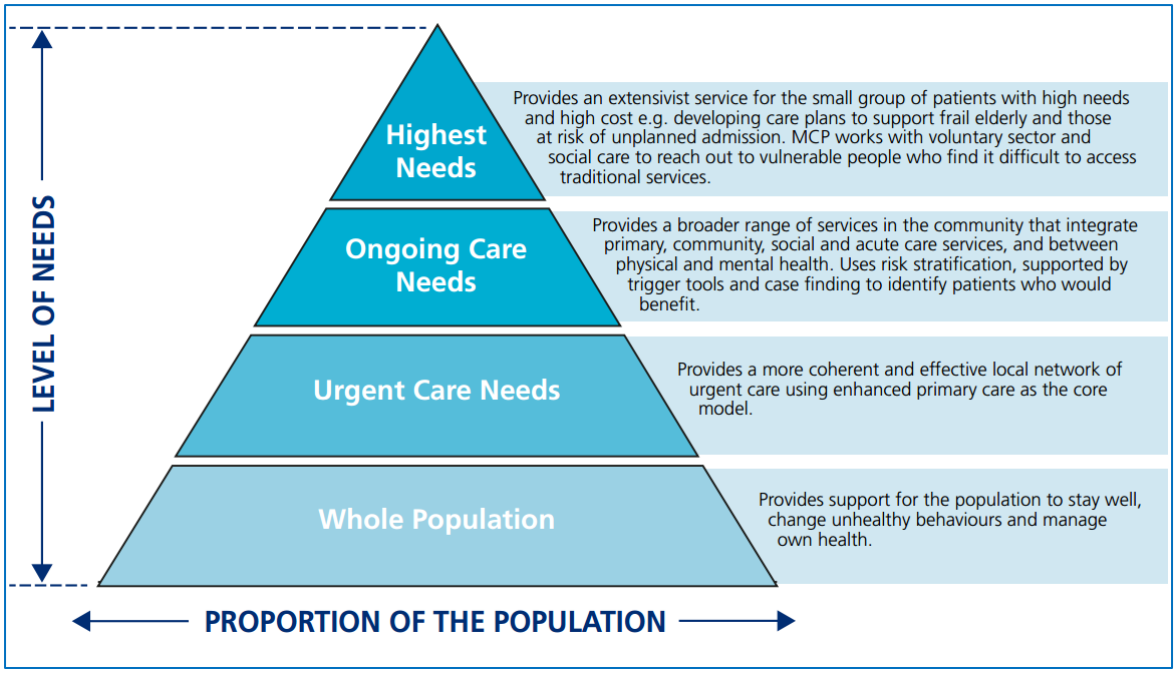


Diagram 1: MCP Framework

An MCP is expected to be a new type of integrated provision. It should bring together the delivery of primary care and community-based health and care services. They can incorporate a much wider range of services and specialists wherever that is the best thing to do. This is likely to mean provision of some services currently based in hospitals, such as some outpatient clinics or care for frail older people as well as some diagnostics; integrating mental as well as physical health services; and social care and public health provision together with NHS provision wherever possible.

An MCP is a place-based model of care. It will serve the whole population, with the offer of decision-making rights to deploy the integrated budget flexibly, so the provider can reshape the local care delivery system around what really works best for different groups of patients.

The MCP care model operates at four different levels:

- at the whole population level, the MCP aims to reduce future healthcare demand. It aims to address the wider determinants of health, such as low income levels and unemployment, and tackle inequalities. It builds upon social capital by mobilising citizens, local employers and the voluntary sector;
- for people with self-limiting conditions, the MCP helps build and forms part of a more coherent and effective local network of urgent care;
- for people with ongoing care needs, it provides a broader range of services in the community that are more joined-up between primary, community, social and acute care services, and between physical and mental health; and
- for small numbers of patients with very high needs and costs, it delivers an 'extensive care' service with more proactive and co-ordinated care due to the complexity involved.

In addition we have set out some specific local design principles we would expect and MCP Provider(s) to take account of when delivering the above care model. These are set out below. –

Our Design Principles

We have described what is important to us as Commissioners in Sunderland through a series of Design Principles which are set out below following engagement with our clinical leaders, member practices and our executive members. These are illustrated at Appendix 2.1 and described below.

Design Principles	
1	Integrated and holistic approach to care to include physical and mental health integrated with social care
2	Conduct population health needs assessment and develop strategies to improve the health and wellbeing of the population and reduce health inequalities
3	To provide a proactive and patient centred approach that empowers patients and carers and addresses people's needs
4	To provide a consistent and standardised offer of care to the population whilst maintaining the national standards of quality and safety
5	Strategic leadership Role for General Practice within an MCP - Strong GP leadership in the Governance arrangements of the MCP with a Clinical majority (clinical majority in widest sense) on the Board and clear GP leadership throughout all levels of the MCP
6	Strong clinical operational leadership, recognising the role of the GP as the expert generalist and the value of continuity of care
7	Protect existing budgets for general practice and identify additional resource in line with the national ambition to increase investment in general practice
8	To support the delivery of more enhanced and specialised services in the community where appropriate by ensuring a flexible, responsive and sustainable workforce without increasing the workload for General Practice
9	Sustain and support the development of the whole Practice workforce as well as assist the recruitment and retention in areas of scarcity - GPs and Practice Nurses
10	Locality focus (c 50,000 patients) for delivery of services where appropriate whilst wrapped around patients and closely aligned to General Practice

Design Principles	
11	Develop and implements an estates strategy that protects and improves the community and GP estate
12	To provide an intermediate and urgent care system that is responsive to patient needs and integrated within the model of care
13	Ensuring patients and carers have access to high quality services when needed within a simplified system
14	To work closely with the community and the voluntary sector
15	Focus on self-care and prevention to promote independence and reduce pressures on the health and social care system
16	To ensure continuous and effective patient and staff involvement where service changes are proposed, ensuring consultation in line with legislation and best practice
17	To improve the quality and efficiency of services through sharing records, data and information including integrating information management and technology
18	To maximise the agreed outcomes within the resources available
19	To contribute to sustaining and transforming General Practice to ensure the provision of high quality primary medical care delivering improved health outcomes for local people now and in the future.

Table 1: Design Principles

The MCP Provider(s) will need to deliver its services taking account of the design principles and success will be linked to its ability to demonstrate how it will take account of the design principles in service delivery.

Whilst we have set out the care model including the key design principles we aim to measure progress increasingly based on achievement of key outcomes. This combination of vision, care model including design principles and outcomes is anticipated to be our approach, rather than detailed service specifications and specified inputs.

The MCP will be community based serving the local Sunderland population, its success, in part, will be based upon the development of strong local relationships with and trust from the community it serves.

Our model rests upon the unique position of general practice starting with the person registered with the practice. The MCP will need to be population-based, linked to the registered lists of the GP practices across Sunderland.

Provider(s) will have to demonstrate how the operating model will be designed to ensure that the foundation of NHS care will remain list-based primary care. The model of care will

be unable to be delivered fully without some form of integration with GP Practices. This includes both ensuring that service delivery starts from the practice as well as ensuring that the patient medical records held by the GP form the basis of the medical records for the MCP. The role of the Practice is therefore fundamental and this is reflected in a number of the service design principles in Table 1.

The underlying principle of the development of the MCP care model is that it will enable GPs, nurses and other health professionals to come together and work with social care and the community and voluntary sector, to plan and deliver integrated care that leads to better outcomes for people. This means that when people do need support from public services it is delivered close to home with hospitals only needed for specialist care, so making best use of the limited resources available. Equally a key principle will be that the MCP will need to develop strong partnership working with the acute sector developing shared clinical pathways and joint working

The local Vanguard (ATB Programme) has helped to shape the national guidance documents on What Good Looks Like, and we would expect any providers of the MCP care model to be familiar with and demonstrate how they will deliver the key service components which align with our Design Principles. We would also advise any providers to consider the ways that the service components could be delivered as described in the good practice guidance – What Good Looks Like.

Delivery of the Out of Hospital Care Model

Delivery of the MCP care model for some of the services in scope has gone a long way to being fully implemented by the delivery of the All Together Better (ATB) Programme, as part of the new care Models programme since 2015.

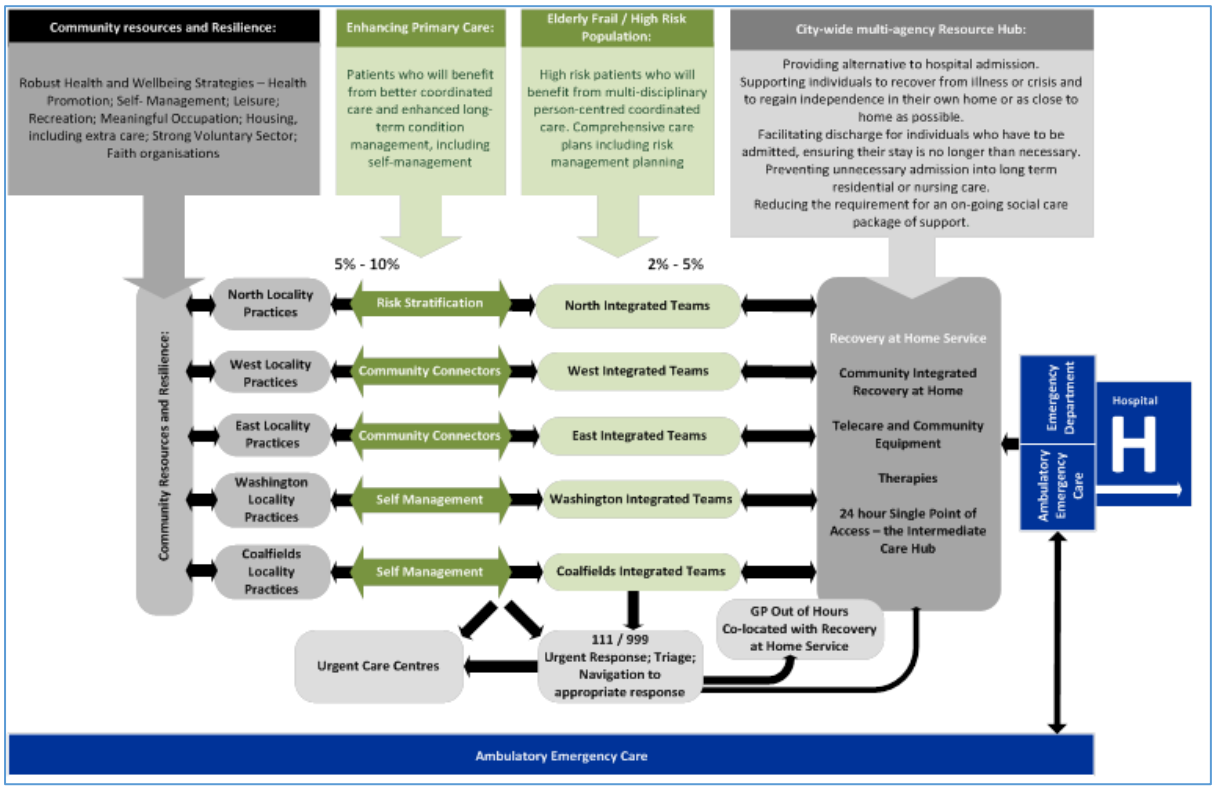


Diagram 2: The current Sunderland Out of Hospital Model

The model, which Provider(s) will be expected to build firmly upon through the wider scope, comprises four key elements. These are:

- **More effective prevention** – through enhancing community resources and resilience. Delivering proactive care which is holistic and preventive, empowering people to play a central role in managing their own care, preventing onset or decline of care needs or health conditions. Bringing health and care services together in one coordinated care response that is underpinned by prevention, self-care, early intervention, re-ablement and rehabilitation can avoid long term treatment and life-long service dependency.

- **Delivering integrated care more effectively** – enhanced Primary Care will be targeted towards people who have one or more long term health conditions, and who depend on support, but who are not counted among the frailest in the city.

- **A locality-based, community-focused delivery model** - All Together Better (ATB) has demonstrated the importance of better co-ordination of care across teams and organisations. The multi-disciplinary approach adopted by our Community Integrated Teams (CITs) and the Recovery at Home Service, working closely with Enhanced Primary Care has enabled a marked shift away from reactive care to proactive care. The CITs will create holistic health care plans with patients and carers, which are tailored to the needs of the person, and these are supported by their own GP, who will lead clinical decision-making to ensure that the medical, social and emotional needs of their patient are taken into account.

- **An approach to care that seeks to maintain stability and prevent escalation** to more acute levels of care with greater use of the third sector as well as recovery at home services to promote this change. Living Well Link Workers connect people to local community resources, whilst the city-wide multi-agency resource hub (Recovery at Home), both home and bed based, has been created to provide alternatives to hospital admission where patients needs have deteriorated placing them at real risk of serious decline in their condition and / or being admitted as an emergency to hospital. There will, of course, always be a need for reactive care, but the balance must continue to move towards proactive care if we are to improve outcomes for patients and maintain safe, sustainable and affordable care services.

To date, the ATB programme has delivered significant improvements to the care and support of individuals in the community following practice risk stratification, resulting in tangible benefits including a reduction in emergency admissions and A&E attendances for patients identified through this risk stratification and supported by Multi -disciplinary teams and care plans. This has also led to a reduction in delayed transfers of care and fewer permanent admissions to care homes.

Now the model has seen significant progress on implementation with improvements and some gaps in provision addressed with continuous refinement, it provides a solid foundation to enable further transformation in relation to the full scope of services intended to be in the MCP and the wider population. This transformation will be expected to be delivered using the same principles of addressing fragmentation; duplication and the lack of co-ordination

and creating integrated care pathways across the wider system, including mental health pathways as well as integration with social care where this is deemed to add value.

It is proposed that these additional services will be brought into the MCP Care Model over a two year period from April 2019. (The detailed scope can be found in Appendix 3.1).

Further Development and Delivery of the MCP Care Model

In line with local system plans, there are key programmes of system transformation linked to efficiencies required over 17/18 and 18/19 currently in progress. These may recommend enhancements/variations to some of the services that will be in the scope of the MCP model of care. Equally they may represent more detailed work on the operating model needed to deliver elements of the overarching MCP Care Model. These changes cannot wait for the MCP care model to be secured due to the pressures associated with them. However, once the MCP model of care is secured, the provider(s) will need to take account of these developments and ensure the more detailed operating models described below are delivered as part of the MCP model of care.

These include:

Mental Health Learning Disabilities and Autism

Significant transformation of Mental Health, Learning Disabilities and Autism has taken place in Sunderland over the past 8 years. The provider led Principle Community Pathways transformation programme has resulted in care now being delivered through a series of service pathways which do not distinguish between community and inpatient care. The CCG wishes to protect this pathway approach to the delivery of these services whilst at the same time expecting further integration within the MCP model of care for Sunderland. This might be achieved either through the current pathways delivered by the MCP provider(s) with integrated mental provision; or through a subcontracting arrangement with a specialist mental health provider.

Urgent care

We are currently working on the transformation of urgent care services in Sunderland in line with our Urgent Care strategy. Urgent Care refers to the care of people who do not have life threatening illness or injury but who have mental or physical health needs that require same day advice, diagnosis and treatment.

We are working with partners and stakeholders across the city so that the residents of Sunderland receive care within a joined up system, where services are not delivered in isolation but are wrapped around the individual needs of each person.

We have developed a vision for Urgent Care in Sunderland with stakeholders and partners to ensure that UC provision is fit for the future and sustainable in light of increased healthcare demand in Sunderland. This vision is set out in the following five design principles which will guide the redesign of Urgent Care services across Sunderland:
1. Increase self-care through access to appropriate clinical advice
2. Ensure appropriate access to treatment as close to home as possible

3. Simplify access by improving integration across health and social care and reducing duplication of services
4. Meet mandated requirements
5. Be safe, sustainable, and provide responsive, high quality care.

We have undertaken engagement activities with members of the public and patients and people have told us the current system of Urgent Care is too complicated and they don't know where to go to get the healthcare they need. The CCG wants to simplify the system so it is easier for people to access the care they need, enabling people to get the right service to meet their needs, first time and every time. To make the system easier to navigate the CCG wants to reduce duplication where there are different services open at the same time offering the same service, as people have said this is confusing.

We want to enable people to care for themselves and their families, where this is appropriate, reducing inappropriate use of services and thus enabling the targeting of resources where they will make a real difference to peoples' health. We also want to shift urgent care access away from the Emergency Department (ED) and closer to people's homes. This would mean that people only need to attend the ED if their condition is life threatening.

People have also said they want to be able to see a GP when they have an urgent care need, and if they have a long term conditions they want continuity of care because their needs are more complex.

Work is also underway to develop an Emergency Department Interface model, where out of hospital and in hospital services meet. Staff are starting to work in new ways across this interface to deliver effective and efficient care with an emphasis on getting people home where this is more appropriate than a hospital stay.

We need to ensure our Urgent Care provision meets the requirements set out by NHS England, including the new service specification for Integrated Urgent Care (111), the standards for Urgent Treatments Centres, and requirements to deliver Extended Access in General Practice. The urgent care clinical model will also build upon the out of hospital reform already undertaken in Sunderland

We have worked with stakeholders to co-design a proposed potential urgent care clinical model. During spring and early summer 2018 we will take this proposed potential model and clinical scenarios to formal public consultation. The feedback from this consultation will be used to inform the final urgent care clinical model. This clinical model is completely in line with the MCP Model of Care and with the Design Principles.

Ambulatory Care

Ambulatory Emergency Care (AEC) is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed. It is a transformational change in care delivery and has the potential to be as significant to emergency care as day case surgery is to elective care.

AEC is a key priority for Sunderland as it's acknowledged that this way of working will support the sustainability and delivery of the urgent and emergency care system.

AEC has been developed with partners across the system, particularly the acute trust and is commended by the National AEC Network for its whole system approach. Sunderland's shared purpose for AEC is as follows:

"Clinical discussion between key partners to ensure the right patients benefit from AEC, in the right place, time and by the right professional thus providing a simple and seamless pathway to patients across different sectors - AEC is not a location but a philosophy of care"

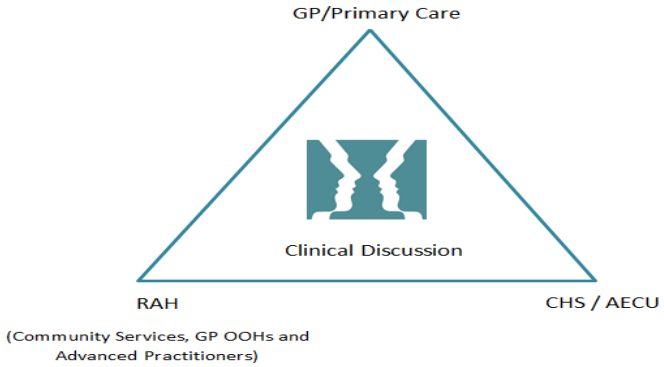


Diagram 3: Ambulatory Emergency Care

AEC has delivered successful outcomes to date, supporting more people to be managed without needing to stay in hospital and an AEC strategy is currently being developed in 2018 to continue to support the whole system manage unscheduled care over the next 3 years. The strategy will need to align with the high level model of care and design principles

Therapies

As part of the ATB programme a review of the provision of most physiotherapy and occupational therapy services providing out of hospital care, to ensure consistency and timeliness of access, is taking place. It is anticipated that this review is expected to recommend a future operating model of delivery that will be in line with the high level care model and design principles.

Falls

A multi-agency falls steering group, under the umbrella of the ATB programme, has undertaken the development of a new Sunderland Falls Strategy. The strategy aims to encourage better health and promote independent living through raising awareness of falls prevention. It aims to deliver new ways of cross agency working and improve patient access for those at risk of falling. The implementation of the strategy will include a new operating model of delivery.

Integrated Rehabilitation

There was evidence to show that there are elements of duplication and fragmentation across rehabilitation services in Sunderland. There was also evidence to show that some services are funded to a greater capacity than they were fulfilling, and that the level of need at a population level (prevalence) was much greater than any contract activity level of any condition/clinical pathway. At the same time referral levels remained low and referrers

found the system complicated to navigate. Patient engagement indicated room for improvement in accessibility and the range of support to be included.

A service re-design event was undertaken. A new model was developed to achieve the scalability required to deliver the outcomes and impact required, and maximize the potential that is possible for individual patients and their lifestyles.

Mobilisation is currently underway, and it is anticipated that the new service will be implemented from April 2018.

Community Bed Based services

A recent audit of patients in community beds has gathered strong evidence to suggest that there is significant scope for improvement in how the beds are accessed, who uses them, and for how long. If improvements in these areas could be made, it suggests that we may not need as many community beds in Sunderland as there are currently. There is also evidence to suggest that a different staffing model could be used in community bed facilities. Work is ongoing to understand the community bed requirements for Sunderland and the outcomes will inform enhancements to the MCP model of care.

Enhanced Care in Care Homes

The ATB programme has undertaken a review of the approach to supporting Care Home patients, in line with the national framework for enhanced health in care homes (2016);

https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

A deep dive and stakeholder workshop took place into care home support and further work is underway to refine the operating model to ensure it is fit for the future, recognising higher numbers of emergency admissions tend to come from care homes.

An action plan has been developed to support this work. This will be supported by the refocussed MDT guidance with practices to include all care home patients into the risk stratification process. This is supplemented by the continued realignment of practices to care homes. A group has been mobilised to oversee this work, led by a senior operational sponsor that has system wide knowledge of the current care home issues/plans. .

Packages of Care

We are leading a programme of reform on the future delivery of Continuing Health care (CHC), for Sunderland. A multiagency group is overseeing a programme of work which aims to ensure care packages are delivered in the most sustainable way. This includes people funded by CHC and Section 117. The programme has four main objectives which are:

1. Overseeing implementation of a new CHC Policy for sustainability
2. The review of high cost care packages
3. Effective application of CHC criteria
4. Efficient delivery of the operational model for CHC assessment.

The programme aims to ensure the basis for a more sustainable delivery of care packages is in place and outcomes will inform enhancements to the model of care the MCP provider(s) will be expected to deliver. The programme is attempting to ensure the same

principles of sustainability are applied across Health and Social Care regardless of the funding stream that pays for the care package.

The new CHC policy has been operational since the 1 September 2017 and has been well received by front line staff, a review policy has been agreed with the Local Authority in respect of high cost care packages and work has been commenced in respect to the application of the CHC criteria which would appear to be successful with the Multi – Disciplinary Team conversion rate falling more in line with the National average in Quarter 3. Site visits have taken place to view alternative operational models for CHC assessment with the aim of establishing greater control of the CHC assessment process.

This work stream is in place until summer 2018 with ongoing plans yet to be agreed; however it is likely that they will include a programme of efficiencies.

Treatment Room Services.

There is current variation across the city on the provision of treatment rooms for General Practices. The current community health services provider provides complex treatment services for all Practices whilst the non-complex care is provided to different degrees in light of the fact that some practices are now providing their own services. Work is underway to address this variation.

Prescribing

We currently have one of the highest prescribing costs per ASTRO-PU and cost growth compared to other CCGs within the North East and Cumbria area. A medicines optimisation work plan includes an extensive improvement programme to bring these figures in line with the area average. This includes:

- The cessation of community pharmacy managed repeats. Incident reports from GP practices have identified that with managed repeats patients may receive medication which is not required. This can be a risk to patient safety and lead to medication waste.
- Changing the method of provision of items such as wound care, incontinence appliances and oral nutritional supplements; currently supplied by the established prescription route.
- Increasing the clinical role of pharmacists in general practice taking a steer from the evaluation of the current NHSE pilot project running in twelve practices.
- Supporting medicines optimisation for patients in care homes and vulnerable patients as part of the integrated teams
- Focusing on deprescribing – encouraging patient-focused, holistic medication reviews, stopping inappropriate and ineffective medication and sharing the decision-making with people about which medicines are beneficial to them.
- Supporting medicines work streams within the NHS right care programme to reduce inappropriate variation and optimise patient care
- Working with secondary care providers to develop and implement a joint formulary of medicines for use in Sunderland
- Supporting patient safety in relation to medicines use in primary care
    - Promoting antimicrobial stewardship in primary care to reduce high antibiotic prescribing levels
    - Monitoring the prescribing of controlled drugs

- Promoting patient safety in relation to medicines including monitoring medicines patient safety incidents and supporting implementation of MHRA alerts

Other

Work is taking place to explore the potential for transformation of:

- **Diagnostic Services**, including community diagnostics. This could entail the development of a Community Diagnostic Centre that deals with, outpatient and non-urgent GP direct access. The community elements are within the scope of the MCP care model.
- **Outpatient** attendances are not currently within the scope of the MCP care model. We plan to incorporate a much wider range of services and specialists wherever that is the best thing to do. The vast majority of outpatient based services are currently carried out in an acute setting but it is acknowledged that some of this activity could be delivered in alternative settings and through the use of technology. Working with general practice and other services, the ability to transform outpatient care will be a key development of the care model and any MCP provider(s) could be expected to provide some of the services needed as a result of the review.

Integration with General Practice

The integration approach with general practice is central to the delivery of the MCP; there is no MCP without General practice. Our aim would be for any MCP Provider(s) to work in an integrated way with all the practices, and with a minimum of 100,000 of the practices population. What this means for General Practice related funding will depend on the level of integration they choose (voluntary for the Practice) and the business model that will be selected by the CCG to secure the MCP care model. Whichever business model is selected, how the Practice chooses to integrate or chooses not to integrate is up to each Practice.

There are 3 levels of integration:

- Full – putting the GP Contract into an Accountable Care Organisation(ACO)
- Partial – signing an integration agreement with an ACO whilst keeping the core contract
- Virtual – being part of a Collaboration of providers.

Integration with Local Authority

Sunderland CCG and Sunderland City Council are developing a plan setting out how health and social care will be integrated by 1 April 2020, in accordance with national requirements. Any MCP provider(s) will need to be engaged in the delivery for achieving this plan.

The CCG would expect any MCP provider(s) to recognise the value and promote the role of social care and social work in the delivery of the service model and the contribution both can make to overall health and wellbeing. The provider(s) will need to forge a successful relationship with Sunderland City Council, in order to determine and achieve a level of integration or as a minimum working arrangement to enable effective joint working between operational staff on the ground, where the needs of local people require a joint approach.

The Council at the current time does not intend to put its commissioning budgets into the MCP. However, there are some services they commission where it would provide added

value to have a working arrangement and/or integration agreement between the Council and MCP provider(s).

The areas are:

- Locality Integrated Teams including Living Well Link Workers
- Recovery at Home including Therapies and Equipment
- Community Equipment Services
- Mental Health and Learning Disability
- Packages of Care – NHS CHC, s.117 MH Act, Joint Packages

The Scope of the Services

Proposed Scope of Services

The proposed scope includes services that are commissioned by the CCG from over 40 organisations (including NHS, Local Authority, Community Interest Company, private, voluntary and charitable) and a current total of 43 general practices.

Fundamentally, the proposed scope of the MCP encompasses everything that is, can or should (taking into account medical, wellbeing, safety and quality matters) be delivered outside of a hospital environment.

In order to establish such a level of detail we met reviewed every service line currently commissioned on a recurrent basis and a decision made on each as to the suitability for it to be potentially included within the scope of the MCP.

In addition to the 'In/Out' status of each of the service lines an extra layer of information was added as to where we viewed the services would become a 'live' element of the MCP.

Our view is that between the commencement of year one (April 2019) and the end of year two (March 2021) all services will be enveloped by the MCP care model.

This scoping was undertaken with the view that it wasn't exclusively developed in a commissioner silo but also required input from the existing providers who have been collaborating on the development of this model of care for several years. Following broad agreement by further commissioner clinical input and approval from a Governing Body perspective the indicative level of scope was shared with the main current providers (for their areas of current provision) to comment and aide in the development.

The scope was then further developed during the market and public engagement phase between November 2017 and December 2017. The main changes made are the reduction of the phasing from 3 years to 2 years, moving GP and Care Packages from year 3 to year 1 to enable alignment with other services, the removal of some hospital services, and services that would no longer be commissioned by 2019.

Adoption of services

Year One

Enhanced Primary Care, CCG health funded elements of both the Community Integrated Teams and the Recovery at Home service established and developed through the All Together Better (ATB) programme. The general medical services (GMS) and personal medical services (PMS) contracts with general practices across Sunderland are within scope along with the responsibility for the general practice prescribing budget. In addition, GP extended access, recovery at home community beds, palliative care services, MSK and physiotherapy, speech and language therapies, dietetics, community equipment services, carers and continuing healthcare assessment, along with other services shown in table 2

A full list of services currently identified as being in scope for the first year are presented in Appendix 3.1.

Services to be incorporated into year 1
Acute and Community Ambulatory Care
Acute and Community Dietetics Services
Acute and Community Occupational Therapy
Acute and Community Podiatry Provision
Acute and Community Speech and Language Therapy
Acute Physiotherapy Services
Audiology Services
Biomechanics
Carers Service
Carers Services – Council
Carers Services - LIS
Community Based Anticoagulation Stabilisation, Monitoring and Dosing Service for Non-Complex Patients
Community Depression and Anxiety Social Network Services
Community Dermatology and Minor Operations
Community Diabetes
Community Equipment Services
Community Falls Services
Community Geriatrician
Community Integrated Teams
Community Lymphodema Care
Community Matrons
Community Musculo-skeletal and Physiotherapy Services
Community Nursing Support to General Practice
Community Optometry Services
Community Service for Acquired Brain Injuries
Community Stroke Rehabilitation
Community Therapies
Community Tissue Viability Provision
Community Urgent Care and Out of Hours Services
Community X Ray provision including urgent care
Continence Assessment and Provision of Products

Continuing Healthcare Assessment
Diabetic Foot Screening
District Nursing
DMARD Monitoring
Enteral Feed Services
General Practice Extended Access
General Practice Funding (including enhanced services and QOF)
General Practice Infrastructure - IT and Premises
General Practitioner Workforce Support
GP Direct Access Radiology
Healthcare Packages of Care
Home Oxygen Assessment and Review Service (including provision of Gas)
Hospital Discharge Support Service
Intermediate Care Hub Provision
Living Well Link
Long Term Conditions Rehabilitation Services
Medicines Optimisation to Care Homes and Vulnerable Adults
Medicines Optimisation to General Practice
Out of Hours Pharmacy Provision
Outpatient Therapy Services
Palliative Care Services 24/7 (including estate)
Patient Transport Services
Patient Transport Services - Renal
Planned Nursing Care
Primary and Community Care Interpreting/Language Services
Primary Care Prescribing (includes Central Drugs, excludes PADMs)
Recovery at Home
Recovery at Home - Community Beds
Stoma Review Services
Telehealth Services
Tier 3 Weight Management

Table 2: Services to be incorporated in Year 1

Year Two

During the second year of operation the remaining out of hospital services will be brought into the MCP care model. These include a large number of mental health, learning disability and autism services, along with other services, as listed in Table 3.

Services to be incorporated into year 2
Acute and Community Learning Disabilities Services
Acute and Community Mental Health Services
Community Counselling Services
Community Dementia Services
Community Psychiatric Nursing
Mental Health Liaison Services

Mental Health Social Care Services
Outpatient and Community Neuro-rehabilitation Services
Outpatient Botulinum Dystonia and Spasticity Services
Regional Disability Team

Table 3: Services to be incorporated in Year 2

Out of Scope

A number of other services have been considered for inclusion, but for several reasons (including complexity, risk, efficiency and co-dependency on other services) have been classed as out of scope for the foreseeable future. These include urgent care transport (999 ambulances) and the 111 service, and maternity pathways. In addition following engagement with providers, outpatients have been removed from the scope in their current form, whilst recognising the outcomes of current Local Health Economy work to transform outpatients may impact on the MCP in the future e.g. the MCP may need to provide services that are currently provided in the hospital but following transformation could be provided in the community.

MCP Outcomes framework

Outcomes have been developed through a process of engagement with commissioners, including CCG and Local Authority staff. The results of the market and public engagement exercise, provided support for the use of the suggested high level outcomes, but that we needed a more detailed framework that measures impact over time. Suggestions for measurements for the MCP included: measure patient experience; develop measurements for physical and mental health separately; develop measurements for self-care; incorporate carers into MCP.

We now intend to continue to take a collaborative approach with stakeholders and MCP provider(s) to develop a more detailed outcomes framework including the set of measures needed to ensure we are assured the MCP provider(s) are delivering the outcomes and not simply relying on existing available measures. We have engaged a specialist organisation in this work. They will facilitate the completion of the Outcomes Framework. This work will begin in March 2018 and fully conclude, by March 2019.

The current **high-level *outcomes are***:

- ***To Improve Care Quality including safety, clinical effectiveness & patient experience***
- ***To improve Health and Wellbeing***
- ***To improve Sustainability creating a sustainable health and care system***

Delivery of these outcomes will be underpinned with a range of measures as follows:

Outcome	Benefits	Example Measures
To Improve Care Quality	• Evidence based effective and safe care pathways	• Proportion of people feeling supported to manage their

Outcome	Benefits	Example Measures
including safety, clinical effectiveness & patient experience	• Accessible services including advice and information which communicate effectively with each other • Patient centred care through shared decision making and integration of services • Excellent patient and carer experience • Identification of and support to vulnerable people to reduce inequality, improve health and wellbeing and keep them safe • Proactive engagement of patients with high health and social care needs and of those projected to have those needs • Patients empowered to be more in control of their care and wellbeing and better able to self-manage, and maximise independence. •	condition • Improving functional ability in people with Long Term Conditions • Reablement after 91 days • Patient experience of GP Services • Proportion of people dying in preferred place of death
To improve Health and Wellbeing	• People are enabled to maintain control over their own lives but know how to access support when they need it • Helping older people to recover their independence after illness or injury • Agreed care pathways will identify and address the needs of people with physical and/or mental health disability and ensure that all patients are treated equitably.	• Potential years of life lost from causes considered amenable to healthcare • IAPT access and recovery standards • Health related quality of life for carers
To improve Sustainability creating a sustainable	• Effective use of resources to meet need and maximise value • Effective use of skill mix	• Reductions in emergency admissions • Reductions in delayed transfers of care

Outcome	Benefits	Example Measures
health and care system		• Increased use of personal health budgets

Table 5 Outcomes, benefits and example measures

Public Engagement

Putting people at the heart of our planning and commissioning is fundamental to what the CCG are trying to achieve. A significant amount of engagement has already been carried out prior to and through the Sunderland Vanguard programme All Together Better. For example, Age UK Sunderland was commissioned to undertake the All Together Better engagement and with Sunderland Carers' Centre, they conducted a series of formal engagements with diverse groups across the City of Sunderland. This raised awareness of All Together Better as well as gained comprehensive feedback regarding the model of care including the publics' recent experience of services culminating in an insightful report in March 2016

We then carried out a communication and engagement exercise between 8 November and 13 December 2017 with stakeholders and the local community regarding the commissioning of a Multi-Specialty Community Provider (MCP) in Sunderland, sharing the Draft Prospectus. The engagement focused on asking people what they thought about the 19 principles for the MCP, as well as the outcomes for the MCP within the MCP Draft Prospectus (available at http://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/).

The key findings of the exercise were that the majority of people agreed with the nineteen principles for the MCP and the three outcomes. The Executive summary, full report and a control sheet illustrating how we have used the key findings in relation to this Prospectus can be found at:
http://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/

Commissioning Strategy

This Prospectus sets out the MCP care model for delivery, regardless of the business model chosen for securing the MCP. Our Commissioning Strategy sets out the various business models that could be used to secure an MCP care model and includes an analysis of the strengths, opportunities, weaknesses and threats (SWOT) of each business model that could be used to secure the MCP care model for the longer term. The SWOT has been informed by the outcomes of the engagement described below.

From November to December 2017 the CCG undertook a market and public engagement exercise with general practices, potential providers, stakeholders and the local community regarding the commissioning of a MCP in Sunderland using the Draft Prospectus.

The preferred business model to support the care model will be decided by the CCG Governing Body at the end of February 2018. In summary the potential business models are:

- Accountable Care Organisation (using the new ACO contract). The ACO may be fully or partially integrated with General Practice
- Collaboration with existing contracted providers including general practices (using an Alliance Agreement)

The intention is therefore to commission the MCP care model by using the CCG preferred business model, in order to realise the local strategic ambition of a Multi-specialty Community Provider (MCP) leading, developing and delivering an effective integrated Out of Hospital or Community Care model in Sunderland.

The CCG will need to ensure that provider(s) have the capacity and capacity to bring together and integrate the range of services that are in the scope of the Sunderland MCP care model.

The complexity of this development will require a robust assurance process prior to and during the implementation of the preferred business model for securing the MCP.

This will redefine the relationship between commissioner and provider with the ultimate aim of delivering better, more integrated care and reducing health inequalities.

We do wish to secure the model for the long term. The MCP provider(s) will be expected to have a clear strategy for managing and delivering clinical, patient and service user outcomes. They will need to demonstrate the highest level of commitment to service quality and patient safety, with a payments approach that supports integration across the service scope, delivering outcomes in line with our care model and design principles.

The MCP provider(s) will need to operate in accordance with the requirements of the Public Services (Social Value) Act 2013 and identify opportunities to secure wider social, economic and environmental benefits from its activities.

We are developing our financial framework for the MCP business model, taking account of the national and local requirements. Assessments of the scope, put this potential total current value (17/18 costs) between c£209m to c£240m depending on the level of integration of general practices. The intention is for this overall budget to be used by the MCP provider(s) in a way that enables the MCP Care Model to be delivered and the outcomes achieved.

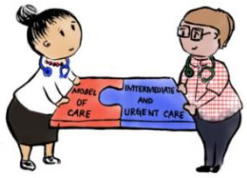
The CCG and senior leaders from provider organisations have undertaken an initial gain / share loss simulation exercise (based on a fictitious scenario) to understand and inform the potential framework, the outputs of this exercise are available.

We are also developing a contracting strategy which will aim to ensure that the current spectrum of contracts which we commission for services which are within the scope of the MCP are aligned to the timescales outlined within the scope and phasing into the MCP.

The CCG wishes to work with provider(s) who share the vision for our new care model and consider that they have the right capability and capacity to respond to the challenge ahead.

NHS Sunderland CCG – List of practices		
Locality	**Code**	**Name of Practice**
Coalfield	A89028	Grangewood Surgery
Coalfield	A89009	Herrington Medical Centre
Coalfield	A89004	Hetton Group Practice
Coalfield	A89023	Houghton Medical Group
Coalfield	A89021	Kepier Medical Practice
Coalfield	A89030	Westbourne Medical Group
East	A89018	Ashburn Medical Centre
East	A89001	Deerness Park Medical Group
East	A89034	Park Lane Practice
East	A89002	Dr S M Bhate & Dr H El-Shakankery
East	A89612	Dr Nathan
East	A89035	Southlands Medical Group
East	A89013	New City Medical Centre
East	A89005	Villette Surgery
North	A89036	Castletown Medical Centre
North	A89015	Fulwell Medical Centre
North	A89040	Dr Gellia & Dr Balaraman
North	A89008	Red House Medical Centre
North	A89019	Drs Cloak, Choi And Milligan
North	A89603	Dr. R. Obonna
North	A89604	Dr Weatherhead & Associates
North	A89016	St Bedes Medical Centre
West	A89031	Hylton Medical Group
West	A89017	Millfield Medical Group
West	A89007	Pallion Family Practice
West	A89006	Wearside Practice
West	A89623	Chester Surgery
West	A89032	New Silksworth Medical Practice
West	A89041	Happy House Surgery
West	A89011	Village Surgery
West	A89614	South Hylton Surgery
West	A89027	Springwell Medical Group
West	A89024	Broadway Medical Practice
West	A89020	Forge Surgery
Washington	A89022	Concord Medical Practice
Washington	A89025	Sunderland GP Alliance Medical Practice
Washington	A89617	Harraton Surgery
Washington	A89616	Rickleton Medical Centre
Washington	A89012	Galleries Medical Practice

NHS Sunderland CCG – List of practices		
Locality	**Code**	**Name of Practice**
Washington	A89620	Dr Thomas
Washington	A89026	Victoria Medical Practice
Washington	A89624	Dr. N.J. Bhatt & Dr. H.M. Benn
Washington	A89010	Dr Stephenson & Partners

DESIGN PRINCIPLES	 **1**. Integrated and holistic approach to care to include physical and mental health integrated with social care	 **2.** Conduct a population health needs approach in developing strategies to improve the health and wellbeing of the population and reduce health inequalities	 **3.**Proactive and patient centred care that empowers patients and carers and addresses people's needs
 **4.** Consistent and standardised offer of care to the population whilst maintaining the national standards of quality and safety	 **5.**Strategic leadership Role for General Practice throughout all levels of the MCP	 **6.** Strong clinical operational leadership, recognising the role of GP as the expert generalist and the value of continuity of care	 **7.** Protect existing budgets for general practice and identify additional resource in line with national ambition to increase investment in general practice.
 **8.** Support the delivery of more enhanced and specialised community services where appropriate without increasing the workload for General Practice	 **9.** Sustain and Transform General Practice and Primary Care by assisting the recruitment and retention of staff and ensuring a responsive, flexible and highly skilled work force.	 **10.** Locality focus (c 50,000 patients) for delivery of services where appropriate whilst wrapped around patients and closely aligned to General Practice.	 **11.** Develops and implements an estates strategy that protects and improves the community and GP estate.
 **12.** Integrate the intermediate and urgent care system with the model of care to ensure responsiveness to patient needs	 **13.** Ensuring patients and carers have timely access to high quality services within a simplified system	 **14.**To work closely with the community and the voluntary sector	 **15.** Focus on self-care and prevention to promote independence and reduce pressures on the health and social care system
 **16.** To ensure continuous and effective patient and staff involvement where service changes are proposed.	 **17.** To improve the quality and efficiency of services through sharing records, data and information including integrating information management and technology	 **18.** Maximise the agreed outcomes within the resources available	 **19**. To sustain and transform General Practice to ensure the provision of high quality primary medical care delivery improved health outcomes for local people now and in the future

Current services proposed to be in the scope of the multispecialty community provider (MCP) Please note that these services are those services currently commissioned by Sunderland CCG	
Services in the scope of year 1	
Service Line	**Provider**
Acute and Community Ambulatory Care	City Hospitals Sunderland NHS Foundation Trust
Acute and Community Dietetics Services	City Hospitals Sunderland NHS Foundation Trust
Acute and Community Occupational Therapy	City Hospitals Sunderland NHS Foundation Trust
Acute and Community Podiatry Provision	Multiple Providers
Acute and Community Speech and Language Therapy	City Hospitals Sunderland NHS Foundation Trust
Acute Physiotherapy Services	City Hospitals Sunderland NHS Foundation Trust
Audiology Services	Multiple Providers
Biomechanics	City Hospitals Sunderland NHS Foundation Trust
Community Based Anticoagulation Stabilisation, Monitoring and Dosing Service for Non-Complex Patients	Multiple Providers
Community Dermatology and Minor Operations	South Tyneside NHS Foundation Trust
Community Diabetes	City Hospitals Sunderland NHS Foundation Trust
Community Equipment Services	Sunderland Care and Support
Community Falls Services	South Tyneside NHS Foundation Trust
Community Geriatrician	City Hospitals Sunderland NHS Foundation Trust
Community Lymphodema Care	South Tyneside NHS Foundation Trust
Community Matrons	South Tyneside NHS Foundation Trust
Community Musculo-skeletal and Physiotherapy Services	South Tyneside NHS Foundation Trust
Community Optometry Services	Primary Eyecare Ltd
Community Service for Acquired Brain Injuries	Multiple Providers
Community Stroke Rehabilitation	Multiple Providers
Community Therapies	Sunderland City Council
Community Tissue Viability Provision	South Tyneside NHS Foundation Trust
Community Urgent Care and Out of Hours Services	Multiple Providers
Community X Ray provision including urgent care	City Hospitals Sunderland NHS Foundation Trust
Continence Assessment and Provision of Products	South Tyneside NHS Foundation Trust
Continuing Healthcare Assessment	South Tyneside NHS Foundation Trust
Diabetic Foot Screening	City Hospitals Sunderland NHS Foundation Trust
District Nursing	South Tyneside NHS Foundation Trust
DMARD Monitoring	City Hospitals Sunderland NHS Foundation Trust
Enteral Feed Services	South Tyneside NHS Foundation Trust
General Practice Infrastructure - IT and Premises	North of England CSU
GP Direct Access Radiology	City Hospitals Sunderland NHS Foundation Trust
Home Oxygen Assessment and Review Service (including provision of Gas)	Multiple Providers
Hospital Discharge Support Service	Age UK
Intermediate Care Hub Provision	South Tyneside NHS Foundation Trust
Long Term Conditions Rehabilitation Services	Multiple Providers
Medicines Optimisation to Care Homes and Vulnerable Adults	Intrahealth Ltd
Medicines Optimisation to General Practice	Multiple Providers
Out of Hours Pharmacy Provision	Multiple Providers
Outpatient Therapy Services	City Hospitals Sunderland NHS Foundation Trust
Palliative Care Services 24/7 (including estate)	South Tyneside NHS Foundation Trust
Patient Transport Services	Multiple Providers
Patient Transport Services - Renal	NERAMS
Primary and Community Care Interpreting/Language Services	Multiple Providers
Primary Care Prescribing (includes Central Drugs, excludes PADMs)	Prescribing
Stoma Review Services	Securicare
Telehealth Services	Various Providers
Tier 3 Weight Management	City Hospitals Sunderland NHS Foundation Trust
Planned Nursing Care	Marie Curie
Community Depression and Anxiety Social Network Services	Age UK
Community Integrated Teams	Multiple Providers
Recovery at Home	Multiple Providers
Recovery at Home - Community Beds	Multiple Providers
General Practitioner Workforce Support	Multiple Providers
Community Nursing Support to General Practice	South Tyneside NHS Foundation Trust
General Practice Extended Access	General Practice
Healthcare Packages of Care	Multiple Providers
Carers Service	Sunderland Carers Centre
Carers Services - Council	Budget
Carers Services - LIS	Budget
Living Well Link	Age UK
General Practice Funding (including enhanced services and QOF)	General Practice

Current services proposed to be in the scope of the multispecialty community provider (MCP) Please note that these services are those services currently commissioned by Sunderland CCG	
Services in the scope of year 2	
Service Line	**Provider**
Acute and Community Learning Disabilities Services	Multiple Providers
Acute and Community Mental Health Services	Multiple Providers
Community Psychiatric Nursing	Northumberland, Tyne and Wear NHS Foundation Trust
Mental Health Liaison Services	Northumberland, Tyne and Wear NHS Foundation Trust
Outpatient and Community Neuro-rehabilitation Services	Northumberland, Tyne and Wear NHS Foundation Trust
Outpatient Botulinum Dystonia and Spasticity Services	Northumberland, Tyne and Wear NHS Foundation Trust
Community Dementia Services	Multiple Providers
Community Counselling Services	Multiple Providers
Regional Disability Team	Northumberland, Tyne and Wear NHS Foundation Trust
Mental Health Social Care Services	Multiple Providers

Item 4

HEALTH & WELLBEING SCRUTINY COMMITTEE **28 FEBRUARY 2018**

ORAL HEALTH IN SUNDERLAND

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

1. Purpose of the Report

1.1 The purpose of this report is to:

- Raise awareness with the Health and Wellbeing Scrutiny Committee about the poor state of oral health in people in Sunderland (this paper focuses on oral health outcomes of five year olds);
- Notify the Health and Wellbeing Scrutiny Committee that the public health team has increased the priority afforded to addressing this issue and will be working to put in place a strategy to tackle poor oral health that makes use of all key evidence based interventions;
- Start a conversation about the role that water fluoridation could play in Sunderland;
- Offer the opportunity for members of the Health and Wellbeing Scrutiny Committee to comment on plans for addressing this issue.

2. Background

2.1 Oral health is an important part of general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example due to pain or social embarrassment[1]. Oral health problems include gum (periodontal) disease, tooth decay, tooth loss and oral cancers.

2.2 In some cases, poor oral health may be indicative of dental neglect and wider safeguarding issues. The persistent failure to meet someone's basic oral health needs can result in the serious impairment of the person's oral health and general health; in the case of children, dental neglect can also impair development.

2.3 Tooth decay is the most common oral disease affecting children and young people. In England it is the most common reason for hospital admission in children aged 5-9 years[2]; this may not be the case in Sunderland which has generally high rates of hospital use but also has high levels of untreated dental disease.

2.4 Tooth decay is largely preventable and, whilst levels have reduced over time, it remains a serious problem and a significant cause of health inequalities.

[1] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE

[2] Public Health England 2013. Local Authorities improving oral health: commissioning better oral health for children and young people.

2.5 Children who have toothache or who need treatment may have pain, infections and difficulties with eating, sleeping and socialising. Adults with tooth decay, missing teeth or poorly fitting dentures can become socially isolated, lose their confidence and experience reduced employment opportunities.

2.6 Dental treatment under general anaesthesia presents a small but real risk of life-threatening complications for children and can lead to significant morbidity.

2.7 There are educational and economic impacts arising from poor oral health. School absence may occur when a child needs to attend a dentist or hospital appointment. Working adults may need to take time off work for their own dentist or hospital appointments or when their child needs dental treatment.

2.8 Everyone who has teeth is at risk of tooth decay. The range of risk factors, many of which are also risk factors for common long term conditions, includes:

- Poor diet;
- Poor oral hygiene;
- Smoking;
- Alcohol use;
- Stress; and
- Trauma.

2.9 Children are more at risk of developing tooth decay if they are:

- Eating a poor diet;
- Brushing their teeth less than twice per day with fluoride toothpaste;
- From deprived backgrounds.

2.10 Children with high levels of disease in their primary (milk) teeth have an increased risk of disease in their permanent teeth. If treated, these teeth will require long term maintenance.

2.11 Adults are at increased risk of poor oral health if they:

- Are from lower socio-economic groups;
- Live in a disadvantaged area;
- Have a physical or mental disability;
- Smoke;
- Drink above recommended levels;
- Are a substance misuser;
- Have a poor diet.

2.12 As oral health outcomes have improved over time, more adults are now likely to keep some of their teeth throughout their lives; however, if they do, they are likely to need complex dental care to restore and maintain their teeth.

3. The Current State of Oral Health in Sunderland

3.1 Public Health England, through its National Dental Epidemiology Programme for England, undertakes intermittent surveys into the oral health of five-year-old children. These surveys provide information on the prevalence and severity of dental decay for local authority areas.

3.2 The most recent survey for which data are available was undertaken in 2015, though a larger sample was available in the 2012 survey. A further survey was undertaken during 2017 and, as Sunderland City Council asked for a "full census", the sample size should be large enough to provide updated ward level data. Results from this are expected to be published during March 2018.

3.3 Sunderland performs extremely poorly in relation to measures of prevalence of tooth decay in 5 year olds. Results from the 2015 survey show that:

- 59.9% of 5 year olds examined were free from tooth decay; the remaining 40.1% of 5 year olds had tooth decay. Equivalent figures for England are 75.2% free from decay and 24.8% experiencing decay.
- The prevalence of tooth decay is significantly higher than the England average and is the 11th highest of all upper tier local authorities in England.
- Sunderland benchmarks poorly compared to both regional (figure 1) and statistical (figure 2) neighbours.

3.4 Sunderland also performs poorly in relation to measures of severity of tooth decay in five year olds. Results from the 2015 survey show that:

- The average number of teeth affected by decay (decayed, missing or filled teeth) was 1.5 compared to 0.8 across England. Sunderland benchmarks poorly compared to statistical neighbours (figure 3) in relation to measures of severity of tooth decay.
- The major contributor to the average number of affected teeth is obvious untreated decay with an average of 1.2 decayed teeth compared to 0.7 across England.
- The average number of missing teeth is 0.2 compared to 0.1 across England and the average number of filled teeth is 0.1 compared to 0.1 across England.
- 4.8% of Sunderland five year olds had had at least one tooth extracted, compared to 2.5% across England.
- When limited to children experiencing some decay, the average number of teeth affected by decay (decayed, missing or filled teeth) was 3.8 compared to 3.4 across England.
- The Care Index shows that only 8.3% of decayed teeth were filled, compared with 12.0% across England. This may indicate lower use of restorative activity by local dentists, though it should be noted that evidence of the benefits of filling primary (milk) teeth is not clear.
- 8.3% of 5 year olds had sepsis (e.g., a dental abscess) compared to 1.4% across England resulting from the dental decay process or, in some cases, from traumatic injury of the teeth.

Figure 1:

4.02 - Proportion of five year old children free from dental decay 2014/15 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	84,100	75.2	75.0	75.5
North East region	–	2,016	72.0	70.4	73.7
Hartlepool	–	198	84.6	79.9	89.4
North Tyneside	–	196	81.7	76.7	86.7
Newcastle upon Tyne	–	160	77.5	71.7	83.4
Gateshead	–	130	76.2	70.1	82.2
Stockton-on-Tees	–	184	74.7	69.6	79.8
Northumberland	–	216	74.3	69.4	79.2
South Tyneside	–	153	74.0	68.0	80.0
Redcar and Cleveland	–	177	72.9	67.2	78.7
County Durham	–	153	64.9	58.8	71.1
Darlington	–	149	64.6	58.6	70.6
Middlesbrough	–	159	61.2	55.6	66.7
Sunderland	–	141	59.9	53.8	66.1

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Figure 2:

4.02 - Proportion of five year old children free from dental decay 2014/15 Proportion - %

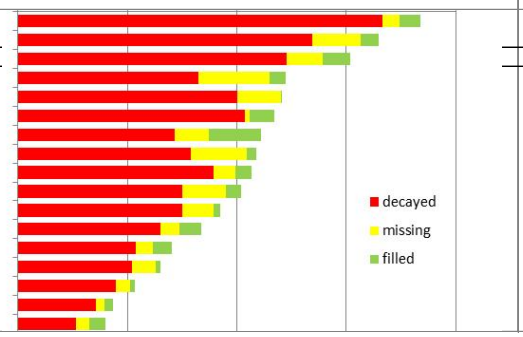
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
Plymouth	–	2	328	84.7	80.9	88.4
Hartlepool	–	6	198	84.6	79.9	89.4
North Tyneside	–	3	196	81.7	76.7	86.7
Gateshead	–	4	130	76.2	70.1	82.2
South Tyneside	–	1	153	74.0	68.0	80.0
Halton	–	13	159	73.3	67.1	79.6
Redcar and Cleveland	–	5	177	72.9	67.2	78.7
Rotherham	–	12	1,284	71.1	69.1	73.2
Stoke-on-Trent	–	7	213	70.7	65.4	76.1
St. Helens	–	9	112	70.3	63.2	77.4
North East Lincolnshire	–	10	712	70.1	67.3	73.0
Tameside	–	11	305	68.6	63.7	73.6
Knowsley	–	8	215	67.5	62.4	72.5
Wakefield	–	15	134	63.5	56.6	70.3
Sunderland	–	-	141	59.9	53.8	66.1
Salford	–	14	182	49.0	43.7	54.2

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Figure 3:

Average number of decayed, missing and filled teeth among five year old children, 2014/15

	mean decayed teeth	mean missing teeth	mean filled teeth	dmft	95% Confidence Interval	
Salford	1.67	0.08	0.09	1.84	1.53	2.14
Wakefield	1.35	0.22	0.08	1.65	1.20	2.09
Sunderland	1.23	0.16	0.13	1.52	1.17	1.87
Knowsley	0.82	0.33	0.07	1.22	0.95	1.49
Stoke	1.00	0.20	0.00	1.21	0.91	1.50
Tameside	1.04	0.02	0.11	1.17	0.93	1.41
Redcar and Cleveland	0.72	0.15	0.24	1.11	0.78	1.44
St Helens	0.79	0.25	0.05	1.09	0.73	1.45
North East Lincolnshire	0.89	0.10	0.07	1.07	0.93	1.21
Rotherham	0.75	0.20	0.07	1.02	0.92	1.12
Halton	0.75	0.14	0.03	0.93	0.62	1.23
ENGLAND	0.65	0.09	0.10	0.84	0.83	0.85
South Tyneside	0.54	0.08	0.08	0.70	0.49	0.92
Gateshead	0.52	0.11	0.02	0.65	0.45	0.86
North Tyneside	0.45	0.06	0.02	0.54	0.36	0.71
Plymouth	0.36	0.04	0.04	0.44	0.30	0.58
Hartlepool	0.27	0.06	0.07	0.40	0.24	0.56

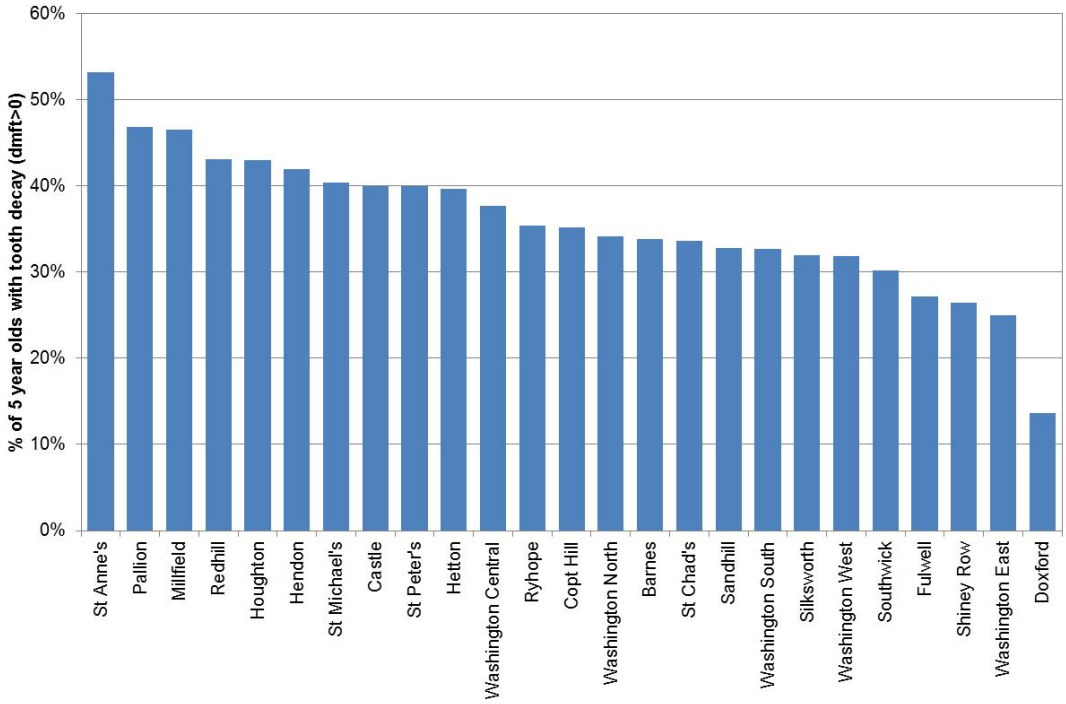


- 6.5% of five year olds had substantial amounts of plaque compared 1.7% across England indicating that teeth are rarely or never brushed.
- 11.5% of five year olds had dental decay affecting one or more incisor (front teeth) compared to 5.6% across England. This is an aggressive form of decay which can be rapid and extensive. It is associated with long term bottle use and prolonged exposure to sugar sweetened drinks. Children with incisor decay tend to have more teeth affected than those with general decay, so tackling this issue could lead to greater overall benefits.

3.5 In addition to the high prevalence and high severity of tooth decay affecting five year olds in Sunderland, there is wide variation in the levels of tooth decay experienced by children living in different parts of the city. Based on data from the 2012 survey, the prevalence of tooth decay in five years olds ranged from 53.2% in St Anne's to 13.6% in Doxford (figure 4).

Figure 4:

Proportion of children with dental decay, Sunderland wards, 2012



3.6 Both prevalence and severity of tooth decay are strongly linked to deprivation. Whilst levels of tooth decay have reduced over time, inequalities in tooth decay have not reduced.

3.7 In 2015/16 across England, there were 9,306 admissions for tooth extractions in children aged under five years; 7,926 of these were specifically identified as being due to tooth decay. In Sunderland there were 29 admissions for tooth extractions in children aged under five years; 21 of these were specifically identified as being due to tooth decay.

4. What Does this Cost?

4.1 Despite being largely preventable, dental disease places a significant cost burden on the NHS. In 2014, it was estimated that the costs of NHS dental treatment for persons of all ages were £3.4bn with an estimated further £2.3bn in the private sector.

4.2 In 2015/16 across England, the cost of tooth extractions in children aged 0-19 years was approximately £50.5 million; this was for tooth extractions for any reason, but the majority (65%) were for tooth decay. For Sunderland, the cost of tooth extractions in children aged 0-19 was approximately £160k.

4.3 In 2015/16 across England, the cost of tooth extractions in children aged under five years was approximately £7.8 million. In Sunderland the cost of tooth extractions in children aged under five years was approximately £24k.

5. How Can We Improve?

5.1 Improving child oral health requires a whole systems approach with action across sectors, from national and local policy, the food and drink industry, healthcare organisation and professionals, to families and individuals. Whilst, local authorities have a statutory role in improving the oral health of their local population, everyone has a part to play. All interventions will need to be underpinned by staff training and development.

5.2 There are a number of cost effective interventions to prevent tooth decay that can save money in the long term and reduce the number of children needing time off school because of tooth decay.

5.3 Key interventions to <u>prevent</u> tooth decay are as follows:

- **Advice and support to parents** for breastfeeding, bottle and cup feeding, and weaning.
- **Reducing sugar consumption in the diet** in line with national recommendations that for all persons aged 2 years and over no more than 5% of total dietary energy intake should come from “free” sugars.
- **Twice daily tooth brushing with a fluoride toothpaste** including last thing at night and using the “spit, don’t rinse” approach; young children should be supervised by an adult.
- **Early access to a dentist**, beginning when the first tooth erupts and regularly thereafter.

5.4 Key interventions to <u>improve dental health</u> are as follows:

- **Targeted supervised tooth brushing** within a suitable supportive environment (e.g., nurseries, schools) teaches children to brush their teeth from a young age and encourages support for home brushing. These approaches are particularly important in areas where children are at high risk of poor oral health. For every £1 invested, the return on investment is £3.06 after 5 years, rising to £3.66 after 10 years.

- **Toothbrushes and toothpaste by post schemes** targeted to areas with highest levels of tooth decay and delivered in a timely way (at around the time when the first tooth erupts) can encourage parents to adopt good oral health practices and reduce oral health inequalities. Strong engagement from health visitors can make the programme more cost effective. This could be delivered as part of the 3-4 month developmental check by the health visitor. For every £1 invested, the return on investment is £1.03 after 5 years, rising to £1.54 after 10 years. With strong health visitor engagement these figures are £4.89 and £7.34.
- **Fluoride varnish schemes** targeted at children of all ages with tooth decay or those at high risk of developing it can strengthen tooth enamel making it more resistant to decay. The process involves painting a varnish containing high levels of fluoride onto the surface of the tooth every six months. For every £1 invested, the return on investment is £2.29 after 5 years, rising to £2.74 after 10 years.

5.5 A key structural intervention that does not require behaviour change is as follows:

- **Water fluoridation** provides a universal programme which can result in a 28% reduction in the prevalence of tooth decay and 55% fewer hospital admissions in very young children for tooth extraction and a reduction in oral health inequalities. Decisions about water fluoridation are a local authority responsibility and offer them the opportunity to take decisive action to improve oral health. Any authority considering water fluoridation will be met with claims that it does not work and that it causes harm. Both statements are untrue. For every £1 invested, the return on investment is £12.71 after 5 years, rising to £21.98 after 10 years.

6. Water Fluoridation

6.1 Water fluoridation is the only oral health improvement intervention that does not require behaviour change by individuals. As such it provides a universal programme. Fluoridation is safe and effective and has particular benefits for those at increased risk of tooth decay, those from deprived communities and those from vulnerable groups (i.e., it can reduce health inequalities).

6.2 Fluoride is widely present in the environment and occurs naturally in virtually all water, and is typically at a concentration of 0.1 to 0.2 mg/l (the unit of measurement of mg/l are sometimes referred to as parts per million or ppm). The optimal level of fluoride to reduce the risk of tooth decay and minimise its severity is 1.0 mg/l (or 1ppm). Areas such as Hartlepool, and indeed some of the ground water stations within Sunderland's water supply area, have water which is naturally fluoridated at about 1.0 mg/l.

6.3 Where the natural fluoride level is too low to provide dental health benefits, a community water fluoridation scheme can be implemented to raise and maintain fluoride levels at the optimum of around 1.0mg/litre.

6.4 Parliament expressly permits the deployment of water fluoridation as a public health measure, and this is enshrined in legislation and regulation[3]. Decisions about water fluoridation are to be made at local level. The Health and Social Care Act 2012 amended the Water Industry Act 1991, returning responsibility for those decisions to local authorities with public health responsibilities.

6.5 Such decisions must be made by following a rigorous process which is defined in legislation and set out in regulation. This includes:

- Upper tier and unitary local authorities proposing and making the decision to implement new schemes and working jointly with other local authorities affected by any proposed/agreed scheme. Decision making processes would include public engagement and consultation. The local system would need to provide ongoing revenue costs for any scheme, and Public Health England has estimated that these will be in the order of 50p per head of population benefitting from the scheme per annum, when delivered at scale.
- Water companies advising on the technical feasibility of schemes and, when requested to do so, implementing and operating them in accordance with the legislation and regulations.
- The Secretary of State for Health determining whether the arrangements that would result from a local authority's proposal for a community water fluoridation scheme would be operable and efficient. The Secretary of State for Health also provides the capital funding for new schemes.

6.6 Durham County Council has been exploring the possibility of introducing a community water fluoridation scheme. Due to the water supply network, this would have an impact on Sunderland and South Tyneside. Sunderland City Council has been approached to assess interest in introducing a community water fluoridation scheme that would fully cover the local water supply network and our residents. There is a strong case for this, and we have political support from our Portfolio Holder to explore this.

6.7 With the permission of our Portfolio Holder, we have agreed to work with Durham County Council and South Tyneside Council to commission a detailed engineering feasibility study from Northumbrian Water Ltd. Durham County Council will act as the lead commissioner. There is an in principle agreement that NHS England will make a significant contribution to costs of the study; at this stage Sunderland's contribution to the cost of the feasibility study is expected to be in the order of £8.5k. We anticipate that this work will be undertaken between May and December 2018.

6.8 The return of responsibility for water fluoridation to local authorities offers us the opportunity to take much needed decisive action to improve oral health in Sunderland. Any authority considering fluoridation will be met with claims that it does not work and that it causes harm. Both statements are untrue. A summary of Public Health England's findings from a review of the evidence in response to concerns about alleged side effects is included at Appendix 1.

[3] SI 2013 No 301. The Water Fluoridation (Proposals and Consultation) (England) Regulations 2013.

7. What We Wish To Do

7.1 It is our intention to put in place a strategy to tackle poor oral health that makes use of all key evidence based interventions.

7.2 We want to ensure that a strong focus on prevention and giving every child the best start in life is embedded into our strategy to tackle poor oral health. Whilst some oral health promotion interventions had already been included within the specification for the 0-19 children's public health services, we took the opportunity of a pause and rewind in the procurement process to review and significantly strengthen the focus on oral health within the service specification (see Appendix 2). This included adding an additional £50k to the contract value.

7.3 We have commenced the process of Oral Health Needs Assessment to gain a more complete picture of levels of need within the population. Whilst we already have enough evidence of the need to act, this process will help us to target interventions more effectively and work with a range of commissioners and providers to include consideration of oral health within a "make every contact count" approach and to ensure that oral health is addressed in a range of settings. We have access to the expertise of a Specialty Registrar in Dental Public Health to help us with this work.

7.4 We would wish to give serious consideration to the introduction of a community water fluoridation scheme, in concert with Durham County Council and South Tyneside Council. At this stage we have agreed to commence the commissioning of a detailed engineering feasibility study from Northumbrian Water Ltd. We are interested in the Committee's views about the role that water fluoridation could play in Sunderland. We also plan to raise and discuss the issue with the Health and Wellbeing Board.

8. Conclusion

8.1 Sunderland's children have poor oral health and experience stark oral health inequalities. We can and should do more to improve children's oral health as part of our broad strategy to give children the best start in life. The full needs assessment will help us to identify other key population groups with oral health needs which will inform the need for further interventions.

8.2 It is our intention to put in place a strategy to tackle poor oral health that makes use of all key evidence based interventions. This will start with interventions focussed on children and young people and will be developed as we complete the needs assessment.

8.3 We have already increased priority for oral health within the public health team's work programme, have support from key Portfolio Holders and have gained commitment from COG for cross council action that would be required to support this work.

9. Recommendations

9.1 Members of the Health and Wellbeing Scrutiny Committee are asked to:

(i) Note the poor state of oral health in people in Sunderland.
(ii) Note that the public health team has increased the priority afforded to addressing this issue and will be working to put in place a strategy to tackle poor oral health that makes use of all key evidence based interventions.
(iii) Consider and provide any comments they have regarding the plans for addressing this issue in general and on fluoridation in particular.

Contact Officers:

Gillian Gibson
Director of Public Health

Kath Bailey
Registered Public Health Specialist

APPENDIX 1: SUMMARY OF PHE'S FINDINGS FROM A REVIEW OF THE EVIDENCE[4]

Health Condition	Evidence
Dental health of 5-year olds	On average, five-year olds in fluoridated areas are 15% less likely to have had tooth decay than those in non-fluoridated areas. When deprivation and ethnicity (important factors for dental health) are taken into account, five-year olds in fluoridated areas are 28% less likely to have had tooth decay than those in non-fluoridated areas.
Dental health of 12-year olds	On average, 12-year olds in fluoridated areas are 11% less likely to have had tooth decay than those in non-fluoridated areas. When deprivation and ethnicity are into account, 12-year olds in fluoridated areas are 21% less likely to have had tooth decay than those in non-fluoridated areas.
Impact of dental health inequalities	The reduction in tooth decay in children of both ages in fluoridated areas appears greatest among those living in the most deprived local authorities.
Hospital admissions of children aged one to four	In fluoridated areas there are 45% fewer hospital admissions of children aged one to four for dental caries (mostly for extraction of decayed teeth under a general anaesthetic) than in non-fluoridated areas.
Dental fluorosis (mottles or flecks on teeth caused by fluoride)	Children in a fluoridated area were more likely than those in a non-fluoridated area to develop fluorosis of any level. The proportion with moderate or greater fluorosis is very low (1% in the fluoridated area compared to 0.2% in the fluoridated area). Children in the fluoridated area had less tooth decay than those in the non-fluoridated area.
Hip fractures	There was no evidence of a difference in the rate of hip fractures between fluoridated and non-fluoridated areas.
Kidney stones	There was evidence that the rate of kidney stones was lower in fluoridated areas than non-fluoridated areas.
All-cause mortality	While there was some evidence that the rate of deaths from all recorded causes was lower in fluoridated areas than non-fluoridated areas, the size of the effect was small.
Down's syndrome	There was no evidence of a difference in the rate of Down's syndrome in fluoridated and non-fluoridated areas.

[4] Public Health England, 2014. Water fluoridation - Health monitoring report for England 2014: Executive summary.

Health Condition	Evidence
Bladder cancer	There was evidence that the rate of bladder cancer was lower in fluoridated areas than non-fluoridated areas.
Osteosarcoma (a form of bone cancer) among under 25-year olds	There was no evidence of a difference in the rate of osteosarcoma between fluoridated and non-fluoridated areas.
Osteosarcoma (a form of bone cancer) among people aged 50 and over	There was no evidence of a difference in the rate of osteosarcoma between fluoridated and non-fluoridated areas.
All cancer	There was no evidence of a difference in the rate for all types of cancer between fluoridated and non-fluoridated areas.

(iv) Ensuring that access to information and advice through community provision includes a focus on oral health alongside information on developmental milestones, healthy weight, breastfeeding, weaning and feeding, sleep, toilet training and minor illness;

(v) Ensuring the universal service key visits focus on oral health promotion alongside other healthy living messages and that these are supported by behaviour change approaches;

(vi) Ensuring that conversations about sugar reduction are included at every contact with the potential to influence nutrition, healthy weight and oral health;

(vii) Ensuring that universal plus services include expert help and advice on oral health in response to identified needs;

(viii) Ensuring that the oral health status of parents and grandparents is established and monitored through family health assessment undertaken at each key developmental visit;

(ix) Ensuring that personal information collected by the service can be shared (with consent) with professionals and organisations providing dental care and that referral are made to dental care, where appropriate;

(x) Making the following additions to the requirements of the antenatal visit: dietary advice relating to sugar reduction, establishing whether previous children have experienced oral health issues, and reinforcing the importance of early access to a dentist and regular dental check-ups.

(xi) Making the following additions to the requirements of the 6-8 week developmental visit: providing oral and dental health promotion information and provision of advice and support for safe weaning;

(xii) Making the following additions to the requirements of the 3-4 month and 9-12 month developmental visits: providing oral and dental health promotion advice including cup feeding, promotion of regular dental check-ups, use of dummies, undertaking a fluoride toothpaste review and providing dental packs;

(xiii) Making the following additions to the requirements of the 9-12 month developmental visit: reviewing weaning and eating, and reinforcing the importance of discontinuing use of bottles and dummies by one year and introducing drinking cups;

(xiv) Making the following additions to the requirements of the 24-30 month and 42-54 month visits: providing oral health promotion information and support including promotion of attendance at regular dental appointments,

provision of dental packs, and recording date of the most recent dental review;

(xv) Ensuring that the Family Nurse Partnership develops referral pathways with key services, including those providing dental care;

(xvi) Ensuring that services for children and young people in educational settings develop and maintain a register of those who are vulnerable or potentially vulnerable, including those who lack access to dental care.

(xvii) Ensuring that the health assessments undertaken at commencement of education, in Year 6 and at the transition between Years 9 and 10 include a review of access to dental care and promote attendance at regular dental appointments, where this is not in place;

(xviii) Ensuring the school drop-ins for children aged 11 to 19 include advice on dental health and support for referral to dental care if required;

(xix) Ensuring that nursing support to YOS and YDAP includes the provision of advice, information and support on dental health alongside other issues such as exercising and healthy lifestyles, eating disorders, safe sex, speech and language needs, and parental substance misuse.

(xx) Setting out the range of functions to be delivered under the banner of oral health promotion including: partnership working with dentists, supporting the development of oral health strategies and approaches, implementing tooth brushing schemes, supporting clinical referrals for oral health interventions, providing training, and developing dental packs.

Item 5

HEALTH AND WELLBEING SCRUTINY COMMITTEE 11 APRIL 2018

MANAGING THE MARKET

REPORT OF THE EXECUTIVE DIRECTOR PEOPLE SERVICES

1. Purpose of the Report

1.1 This report provides information relating to the care and support provider market in Sunderland, including the on-going work undertaken by the Commissioning Team with regards to working with and developing a diverse care and support market, and an update on quality and adult safeguarding matters. The report is one of a series of regular updates to Scrutiny Committee.

2. Current Position

2.1 The Council currently operates a range of commissioning arrangements for the provision of adult care and support services. The Council's preferred method of securing services is via a formal procurement process whereby the Council enters into a contractual arrangement with care and support providers. There are services that are commissioned that sit outside of a formal contracted arrangement whereby services have been arranged on an individual basis. Individuals are also able to commission services directly with providers via Direct Payment arrangements.

2.2 The Commissioning Team is responsible for facilitating market development, management of demand and supply, and ensuring the quality of services provided by the market are of a high standard, appropriate and flexible to the needs of the individuals being supported.

2.3 Within Sunderland there are different provider markets which support the health and social care agenda. These can be broken down into the following:

I. **Accommodation based services for older people** – Residential and Nursing Care; Extra Care Accommodation
II. **Accommodation based services for people with disabilities** – Residential Care; Independent Supported Schemes; Core and Cluster Schemes.
III. **Accommodation based services for people with mental health needs** – Residential Care; Independent Supported Living Schemes; Core and Cluster Schemes.
IV. **Community services** – Care and Support into people's homes; Day Care/Opportunities; Preventative Services.

3. Market Facilitation and Development

3.1 As outlined in previous updates, there are a number of ways in which the Commissioning Team engages with the provider markets and looks at patterns of demand, to determine how the markets need to develop to respond to future need and commissioning intentions. These include the following activities, which are the core business of the Commissioning Team:

- Contract Management Processes
- Provider Forums
- Individual Provider Meetings
- Quality assurance and service improvement processes
- Supported Accommodation Commissioning Forum
- Monitoring capacity within older persons care homes
- Regional collaborations and networks
- Customer engagement
- Fee Negotiations
- Publications and guidance, benchmarking and identifying best practice
- The use of performance and intelligence data
- Individual social care team meetings to input on the needs of users

4. Current Position

4.1 OP Care homes

4.1.1 There are 47 **older person's care homes** in the city that deliver a mixture of general and dementia residential care, general and dementia nursing care, support for younger people with dementia and people with enduring mental health needs. In terms of beds, based on information gathered from the care homes as at 1 March 2018, there were 1,985 beds with an average occupancy of 85% (1,733 beds occupied). Four homes were operating 100% occupancy.

4.1.2 66% of the care home market is rated as good (31 Homes); 30% Requires Improvement (14 homes); 2% as Inadequate (1 home) and 1 home (2%) has not yet been inspected. Since the last update report, the following homes have been inspected (and reports have been published) by the Care Quality Commission (CQC):

Service Name – OP Residential/ Nursing	**Report publication date**	**Rating**
Highcliffe Care Centre (North locality)	December 2017	Requires Improvement

Care Homes Based on Locality

Locality	Total number of homes	Total number of beds	Residential Care Only	Nursing Care Only	Dual Registered Residential and Nursing
Coalfields	11	451	5	0	6
Sunderland East	8	235	5	2	1
Sunderland North	11	463	4	0	7
Sunderland West	12	584	6	0	6
Washington	5	252	3	0	2

4.1.3 Members were updated in the last report that Paddock Stile Manor (Coalfields locality), operated by Indigo, made the decision to remove its nursing care registration. This was following concerns raised with both the Council and CQC regarding the staffing levels within the home not being sufficient to support individuals with complex nursing care needs. The Council are still continuing to work closely with the service to ensure that the service improves in accordance with their service improvement plan and CQC requirements.

4.1.4 Members were updated in the last report that there had been media reports about the national care home operator, Four Seasons Health Care, going into liquidation. At the time, the Commissioning Team liaised with the organisation to seek confirmation of the company's position and we were assured that there were no concerns in relation to services operated in Sunderland or nationally. There have been no further reports to indicate that there are any concerns that the Council needs to be aware of and there have been no changes to any of the four homes operating in Sunderland.

4.1.5 A new care home opened in December 2017. Blossom Hill Care Home, operated by Crystal Care Services, based in the North of the city offering 40 beds to individuals aged over 18 years, with needs including dementia, sensory impairment and physical disabilities.

4.1.6 The Commissioning Team is still in the process of undertaking quality monitoring visits of care homes which have been running from November and will be completed by end of April 2018. The outcome will be that homes will be given a quality rating which is linked to their CQC and internal monitoring rating and which determines their fee levels. Of the homes that have been monitored, there are no indicators of any concerns or areas for improvement that would require immediate action from the Commissioning Team.

4.1.7 For those homes operating in the city that have been rated as Requires Improvement and the one home rated as Inadequate by CQC, assurances have been gained via the monitoring visits that have taken place by the

Commissioning Team, feedback from Adult Social Care and Community Health colleagues that there have been improvements made since the point of the CQC inspection and these are being monitored via the regular meetings the Commissioning Team have with the providers.

4.2 Care and Support at Home

4.2.1 There are in excess of 30 agencies providing care and support at home located in the Sunderland area and more taking into account those located outside of Sunderland but who provide services into the city.

4.2.2 The Council currently has a framework contract in place with 14 care providers who are commissioned to provide care and support at home to all service user groups including adults with complex needs and there are 4 non-contracted providers who are frequently utilised as a back-up to the contracted providers.

4.2.3 Of the18 contracted and non-contracted home care providers that are accessed the most by Adult Social Care, 13 (72%) are rated Good; 4 (22%) are rated Requires Improvement and 1(6%) service has not yet been rated by CQC.

4.2.4 The following services have been inspected by CQC since the last update report:

Service Name – Care and Support at Home	**Report publication date**	**Rating**
Dimensions	December 2017	Good

4.2.5 The care and support at home market appears quite stable in terms of quality with no specific service improvement activity being taken forward by the Commissioning Team.

4.2.6 Common issues that providers feedback via the provider forum and contract management include workforce recruitment and retention and collective discussions are taking place locally and regionally about this continuing concern.

4.2.7 As part of the Councils quality assurance and contract management function, a programme of quality monitoring visits has commenced with care and support at home providers. Of the services that have been monitored to date, there have not been areas or providers identified that require immediate input or action from the Commissioning Team.

4.2.8 The Commissioning Team are progressing with the engagement and planning process in relation to commissioning a new care and support at home contract that will be operational from early 2019.

4.3 Extra Care

4.3.1 There are currently 12 Extra Care schemes in the city providing 847 apartments. The average occupancy for each provider is shown in the table below:

Provider	**Total number of schemes**	**% occupancy**
Abbeyfield (West locality)	1	50%
Gentoo (Coalfields and East)	2	98%
Housing & Care21 (Coalfields; East, North and West localities)	8	97%
Riverside (Washington locality)	1	100%

4.3.2 The new extra care scheme, Abbeyfield, located in Silksworth is now open and is registered with CQC.

Extra Care Schemes based on Locality

Locality	**Total number of homes**	**Total number of apartments**
Coalfields	2	91
Sunderland East	3	165
Sunderland North	2	183
Sunderland West	3	290
Washington	2	118
Total	**12**	**847**

4.3.3 Overall, 75% (9 Schemes) of the Extra Care market has been rated as good. Two Extra Care schemes inspected by CQC in December 2017 and January 2018 have both been rated as Requires Improvement. Although Abbeyfield is CQC registered it has yet to have an inspection carried out.

Service Name – Care and Support in extra care schemes	**Report publication date**	**Rating**
Cherry Tree Gardens, Gentoo (Coalfields locality)	December 2017	Requires Improvement
Haddington Vale, Gentoo (East locality)	January 2018	Requires Improvement

4.3.4 There are two main providers of Extra Care one of which provides their own care and support into the schemes and one who has an agreement in place with a home care provider to deliver the care and support into their schemes. The other two schemes both provide their own care and support into the scheme.

4.3.5 Sunderland Home Care Associates (SHCA) is the care provider in the two extra care schemes that are owned by Gentoo and have recently been rated by CQC as Requires Improvement. Both schemes were found to be requiring improvement across all five domain areas: Safe; Effective; Caring; Responsive and Well-led.

4.3.6 The Commissioning Team have met with SHCA and Gentoo to discuss the service improvement actions that need to take place and the timescales for completing the required work. Regular meetings are in place with all parties to monitor the progress achieved against the actions.

4.3.7 SHCA have appointed a Compliance Officer who is now responsible for the review and maintenance of the quality assurance processes and systems in the organisation. Progress has also been made in relation to staff training, care plan reviews, introduction of a more robust a care plan audit process, redesign of risk assessments and a review of the organisation's medication policy.

4.3.8 The care provider has also taken forward a consultation exercise with all tenants and family members who receive a service from them to gather views and feedback about their service delivery. The outcome of this exercise has supported organisational reform work they are taking forward and has resulted in a scheme manager being appointed to each scheme as opposed to one manager covering both schemes which were the previous arrangements.

4.3.9 There have been safeguarding and service concerns in respect of one of the Extra Care schemes in which there was evidence of significant poor care practices. The Council have been working very closely with one of the Directors in the Provider organisation to ensure that these concerns are investigated and corrective actions taken to ensure the safety of all tenants. The investigation remains on-going and police investigations have now commenced. The Provider has interviewed over 30 staff which has resulted in a number of staff having action taken against them (from verbal warnings to dismissal). An action plan is in place to progress the investigation and any identified areas for improvement. As result of the concerns all of the other schemes have been subject to quality monitoring by the Council and the Council remains assured that the concerns are not organisation wide. Formal safeguarding proceedings remain in place.

4.3.10 Two Extra Care schemes experienced intermittent heating issues during the recent adverse weather conditions with loss of heat in various rooms and communal corridors. Due to previous heating issues the Provider had already requested the contractor to rectify the problems. The Provider has now confirmed that the rectification programme, which included the plant room, has been put in place. In future each scheme will have its own specific contractors in the hope of reducing the number of reoccurring issues.

4.4 Domestic Abuse Services

4.4.1 The Directorate has in place a contract for the provision of Crisis Refuge Accommodation and Specialist Domestic Abuse Outreach Support including Independent Domestic Violence Advisors (IDVA) Provision and this has been in place since July 2017. The current service provides a 10 bed refuge service; a Domestic Abuse Specialist Outreach Support and an IDVA linked to Sunderland Royal Hospital. The service continues to operate 3 refuges and demand remains constant, with 94 referrals being received for refuge places within the period, which is slightly less than last quarter. Referrals into the specialist outreach and IDVA provision have increased since last quarter. Self referrals into the service are the highest referral route and the Police are the main referring partner agency.

4.5 Independent Advocacy

4.5.1 Total Voice Sunderland are the contracted provider of advocacy support in the city and the two providers who work as part of the consortium arrangement are Voiceability and Mental Health Matters. There were a total of 289 new referrals to the service between October and December 2017 (quarter 3), compared to 366 in the previous period, July to September.

4.5.2 The total number of active cases at the end of quarter 3 for all advocacy provision was 820, compared to 869 at the end of quarter 2 (a decrease of 49).

4.5.3 The total number of hours being delivered at the end of quarter 3 for all advocacy provision was 3,844, compared to 3,753 at the end of quarter 2 (increase of 91 hours)

4.5.4 Whilst there has been a decrease in referrals for Relevant Persons Representative (RPR) provision from 182 in quarter 2 to 132 in quarter 3, this remains the highest demand, followed by Independent Mental Health Act advocacy.

4.5.5 The total number of RPR active cases during the period October to December 2017, including new referrals from the period and ongoing cases was 394. There was 1,624 hours being delivered at the end of the quarter.

4.5.6 The average length of time that clients are on the waiting list is 57 days, this will be monitored in the forthcoming periods using a new data collection tool, along with measures being taken by the service to manage demand.

4.5.6 At the recent quarter 3 contact monitoring meeting the Team Manager representing Adult Social Care provided very positive feedback from Assessment and Review Officers and Social Workers regarding work completed by Voiceability.

4.5.7 Voiceability, as part of their organisational service development, are exploring alternative accommodation which could be more cost effective to their current building.

4.6 Accommodation for families with multiple and complex needs

4.6.1 The Council has commissioned a wraparound service to families with multiple and complex needs and is delivered from a building with 8 core self-contained units. There are a further 6 satellite properties within this service that provides a pathway through the service with families moving from the Core services into these properties, staff maintain an outreach support function and support families to move through the pathway and into their own tenancy. The provider continues to promote the service with partner agencies both statutory and voluntary. Demand for the service remains constant and the service has supported 5 families to move into an independent tenancy within the period.

4.7 Care and Support Services (Sunderland Care and Support Ltd)

4.7.1 The Council has extended the Services Agreement with Sunderland Care and Support (SCAS) up until 30 November 2018. SCAS provide a range of care and support services, including community based services for people with learning disabilities and mental health needs, community equipment services, Telecare and reablement.

4.7.2 Since the last update report, Blackwood Road has been inspected in March by CQC. The overall rating was good, with an outstanding rating in the domain of ‘responsive’:

SCAS: Blackwood Road – overall rating Good;

- The service ensured that people received exceptional end of life care.
- The service ensured processes were in place so that people were supported at the end of their life to have a comfortable, dignified and pain-free death.
- The service recognised the connection between those receiving care and the people supporting them. The service provided care for the family, giving practical and emotional support before and after the death of the person.
- People received personalised care which was responsive to their needs.

4.7.3 There are no reported quality concerns with the services provided by SCAS.

4.7.4 The Council is continuing to work closely with SCAS in relation to a programme of reform work.

4.8 Accommodation of People with Learning Disabilities/Mental Health Needs

4.8.1 The Council has arrangements in place with providers for the provision of care and support and accommodation for people with learning disabilities and mental health needs, known as Supported Living and Registered Services. Sunderland Care and Support Ltd is the largest provider of this type of support in Sunderland, however there are also a number of other providers that are commissioned on an individual level to provide this type of support.

4.8.2 There have been no services inspected by CQC since the last update report, however as a point to note, the following services have achieved an outstanding rating in one domain in their most recent CQC inspection.
Scope: Laverneo – Overall rating Good; rated Outstanding in Caring in September 2017

- The service was extremely caring.
- People who used the service, their relatives and external professionals provided consistently exceptional feedback regarding the caring attitudes of staff and the homely nature of the service.
- People were supported to develop their independence and all people we spoke with agreed the continuity of care provided by staff was key to achieving better health and wellbeing outcomes.
- People were supported to grieve for the loss of a friend and take part in their memorial service, in a dignified, respectful and celebratory manner.
- Staff demonstrated an excellent knowledge of people's needs, preferences, life histories and relationships.

ESPA: Beechwood – Overall rating Good; rated Outstanding in Responsive in July 2017

- The service was Outstanding.

- People said they had “great” quality of life at Beechwood.
- People received very personalised support. The service enhanced their skills, independence and lifestyle.
- People felt they had been supported to find meaningful occupations in the community which they found fulfilling, purposeful and enjoyable
- and there are no significant quality issues within this area of the market.

4.8.3 The Commissioning Team are no dealing with any service related concerns with this provider market.

4.8.4 The demand for accommodation care and support for individuals is monitored via the Council’s internal Supported Accommodation Partnership, which includes the Commissioning Team and Adult Social Care working together to monitor demand and determine future need for accommodation based services.

4.8.5 A scoping exercise is currently been undertaken across all learning disability and mental health service areas involving the Commissioning Team and Adult Social Care to explore alternative models of care and support that are cost effective and that supports individuals to maximise independence. This will be supported by the use of up to date assistive technology solutions where appropriate.

5. Safeguarding Activity

5.1 Performance in the first 3 quarters of 2017/18 has followed previous years in terms of the continued increase in safeguarding concerns received which are anticipated to exceed the number received for the full year 2016/17. The progression and timeliness of safeguarding concerns has changed in 2017/18, with 44.4% (834) concerns received in 2017/18 progressing to enquiry compared with 94.6% (1986) in 2016/17. A decrease was anticipated as the revised safeguarding concern form was rolled out, however further audit work continues to validate and test process for effectiveness and quality.

5.2 The timeliness of decision making on the progression of a concern received has decreased to 71.1% in 2017/18 from 96.6% in 2016/17, with a decision within 5 days. This is reflective of the team working with referrers to gather further information in order to make an informed decision on the concern received rather than progressing to enquiry to undertake the fact finding at that stage.

5.3 Generally agreed threshold levels are improving between operational safeguarding and the referring agency particularly regarding those concerns submitted that are deemed low risk. The agreed levels reduce the more significant the risk is identified as. This is an area that has been identified for further audit and interrogation activity to ensure understanding is maintained and any additional training or support required is identified and provided across the partnership.

5.4 Females aged 75 and over with a primary support reason of physical disability continue to be the group for whom the highest volume of concerns are received with the alleged category of abuse being physical or neglect. The partnership and operational safeguarding continue to address these concerns but also look at ways in which the situations/incidents can be prevented.

5.5 The removal or reduction of risk remains the priority for all clients and for those enquiries completed in the year to date April – December 2017/18 92.5% of individuals who had a completed enquiry had the risk reduced or removed.

5.6 The Partnership through the Board and supporting committees continues to strengthen its collective position progressing multi agency and single agency training and communication opportunities to raise awareness regarding Adult Safeguarding and embedding it into standard operating procedures.

6. New Services

6.1 The Commissioning Team are taking forward the following service developments:

6.1.1 Continued work with a national care home provider to discuss the potential to develop two new services in Sunderland. This includes the acquisition and extensive refurbishment of a currently unoccupied care home which has been closed for the past 2 years and also the development of one of the providers existing services. The provider has confirmed the refurbishment and remodelling costs to the currently closed care home and are engaging with the Council regarding next steps.

6.1.2 Very early discussions are taking place with a developer and care provider about a potential supported housing development in Washington. Scoping is underway to identify the need and demand for provision in this area and this will inform any further discussions.

6.1.3 Work continues with three Housing Associations to develop the following schemes:

- One housing provider has purchased a 3 floor property with Thornhill area of Sunderland with the purpose of converting it into supported accommodation for 5 people with disabilities and complex needs, 3 of whom are part of the Transforming Care Programme. The support element to the service will be a blended model using assistive technology and a local contracted care provider has been identified to provide the care and support. The housing provider has submitted applications to the planning department in the Council and they are awaiting the final decision.

- A current supported living scheme in the Washington area has an empty building on its grounds that could be converted into accommodation for

someone with disabilities, autism and/or complex needs. Following discussions with the Clinical Commissioning Group (CCG, the housing and social care provider, a bid for capital monies was made via the CCG. The bid was successful and consequently, the housing providers will now start developing the building to accommodate the specific requirements of the individual identified for the property, who is part of the Transforming Care Programme.

- A housing provider has purchased land in Grindon and planning permission was granted in March 2017 that has enabled them to build a housing scheme that will accommodate over 55 units for general needs and the potential for 7 or 8 units/apartments for people with learning disabilities. The housing provider has been on site since March 2017 and there is a planned completion date of April 2018. The Commissioning Team have been working closely with SCAS and Adult Social Care to identify people to move into the apartments allocated for people with a learning disability with an assessed housing and support requirement.

7. Recommendations

7.1 Scrutiny Committee is requested to receive this report for information.

7.2 Scrutiny Committee to agree to receive regular updates from the Commissioning Team in relation to the market position.

Contact Officer:
Ann Dingwall – Strategic Commissioning Manager
Ann.dingwall@sunderland.gov.uk

Item 6

HEALTH & WELLBEING SCRUTINY COMMITTEE — 11 APRIL 2018

ANNUAL WORK PROGRAMME 2017-18

REPORT OF THE HEAD OF MEMBER SUPPORT AND COMMUNITY PARTNERSHIPS

1. Purpose of the Report

1.1 The report attaches, for Members' information, the current work programme for the Committee's work during the 2017-18 Council year.

1.2 In delivering its work programme the committee will support the council in achieving its Corporate Outcomes.

2. Background

2.1 The work programme is a working document which Committee can develop throughout the year. As a living document the work programme allows Members and Officers to maintain an overview of work planned and undertaken during the Council year.

3. Current position

3.1 The current work programme is attached as an appendix to this report.

4. Conclusion

4.1 The work programme developed from the meeting will form a flexible mechanism for managing the work of the Committee in 2017-18.

5 Recommendation

5.1 That Members note the information contained in the work programme.

6. Glossary

n/a

Contact Officer: Nigel Cummings, Scrutiny Officer
nigel.cummings@sunderland.gov.uk

HEALTH AND WELLBEING SCRUTINY COMMITTEE – WORK PROGRAMME 2017-18

REASON FOR INCLUSION	**28 JUNE 17** D/L:15 June 17	**12 JULY 17** D/L:29 June 17	**6 SEPTEMBER 17** D/L:24 August 17	**4 OCTOBER 17** D/L:21 Sept 17	**1 NOVEMBER 17** D/L:19 Oct 17	**29 NOVEMBER 17** D/L:16 Nov 17	**3 JANUARY 18** D/L:21 Dec 17	**31 JANUARY 18** D/L:18 Jan 18	**28 FEBRUARY 18** D/L:16 Feb 18	**11 APRIL 18** D/L:29 March 18
Policy Framework / Cabinet Referrals and Responses										
Scrutiny Business	Care & Support Provider Market Update(G King) CQC GP Inspection Annual Report (Sunderland CCG) The state of GP Practice in Sunderland (Sunderland CCG) Teenage Pregnancy – Proposal to establish a working group	Housing and Care 21 Schemes – update (G King) CCG Operational Plan 17/18 (Sunderland CCG)	School Nursing Update (G Gibson) Alcohol & Substance Misuse Service Update (G Gibson)	Care & Support Provider Market Update(G King) Telecare (G King/J Usher) Urgent Care Strategy incl. The big Front Door(Sunderland CCG)	Care and Support Annual Report (P Foster) Sunderland Care and Support Ltd, Financial Update (F Brown/B Scarr) Better Care Fund 2017-19 (G King/Ian Holliday)	Adult Safeguarding Board Annual Report (G King) CCG End of Life Plan (Sunderland CCG) MCP Engagement Activity (CCG/NECS)	Care & Support Provider Market Update (G King) Healthwatch Annual Report 16/17 (Margaret Curtis – Healthwatch)	Pharmaceutical Needs Assessment (G Gibson/K Bailey) Breast Service Update (Sunderland CCG) North East Ambulance Service (M Cotton) Joint Health Scrutiny Committee – Update (N Cummings)	Urgent Care Update (Sunderland CCG – Helen Fox) Consideration of the Decision of South Tyneside and Sunderland Joint Health Scrutiny Committee to refer the 'Path To Excellence' Decisions to the Secretary of State for Health (N Cummings) Annual Report (N Cummings)	MCP Update – (CCG) Managing the Market (G King) Oral Health in Sunderland(G Gibson)
Performance / Service Improvement										
Consultation/ Information & Awareness Raising	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18	Notice of Key Decisions Work Programme 17-18

Items to be scheduled
Speech and Language Therapy
Dementia Friendly City

HEALTH AND WELLBEING SCRUTINY COMMITTEE

28 MARCH 2018

NOTICE OF KEY DECISIONS

REPORT OF THE HEAD OF MEMBER SUPPORT AND COMMUNITY PARTNERSHIPS

1. PURPOSE OF THE REPORT

1.1 To provide Members with an opportunity to consider the items on the Executive's Notice of Key Decisions for the 28 day period from 20 February 2018.

2. BACKGROUND INFORMATION

2.1 Holding the Executive to account is one of the main functions of Scrutiny. One of the ways that this can be achieved is by considering the forthcoming decisions of the Executive (as outlined in the Notice of Key Decisions) and deciding whether Scrutiny can add value in advance of the decision being made. This does not negate Non-Executive Members ability to call-in a decision after it has been made.

2.2 To this end, the most recent version of the Executive's Notice of Key Decisions is included on the agenda of this Committee. The Notice of Key Decisions for the 28 day period from 20 February 2018 is attached marked **Appendix 1**.

3. CURRENT POSITION

3.1 In considering the Notice of Key Decisions, Members are asked to consider only those issues where the Scrutiny Committee or relevant Scrutiny Panel could make a contribution which would add value prior to the decision being taken.

3.2 In the event of Members having any queries that cannot be dealt with directly in the meeting, a response will be sought from the relevant Directorate.

4. RECOMMENDATION

4.1 To consider the Executive's Notice of Key Decisions for the 28 day period from 20 February 2018.

5. BACKGROUND PAPERS

- Cabinet Agenda

Contact Officer : Nigel Cummings, Scrutiny Officer
0191 561 1006
Nigel.cummings@sunderland.gov.uk

28 day notice
Notice issued 27 March 2018

The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012

Notice is given of the following proposed Key Decisions (whether proposed to be taken in public or in private) and of Executive Decisions (including key decisions) intended to be considered in a private meeting:-

Item no.	Matter in respect of which a decision is to be made	Decision-maker (if individual, name and title, if body, its name and see below for list of members)	Key Decision Y/N	Anticipated date of decision/ period in which the decision is to be taken	Private meeting Y/N	Reasons for the meeting to be held in private	Documents submitted to the decision-maker in relation to the matter	Address to obtain further information
170810/205	To approve the freehold acquisition of a property to provide children's services accommodation.	Cabinet	Y	During the period 25 April to 30 June 2018.	Y	The report is one which relates to an item during the consideration of which by Cabinet the public are likely to be excluded under Paragraphs 3 of Schedule 12A of the Local Government Act 1972, as amended, as the report will contain information relating to the financial or business affairs of any particular person (including the authority holding that information). The public interest in maintaining this exemption outweighs the public interest in disclosing the information.	Cabinet report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
170927/212	To approve in principle the establishment of a new police led Road Safety Partnership (Northumbria Road Safety Partnership) embracing the Northumbria Force area.	Cabinet	Y	During the period 25 April to 30 June 2018.	N	Not applicable	Cabinet report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk

Item no.	Matter in respect of which a decision is to be made	Decision-maker (if individual, name and title, if body, its name and see below for list of members)	Key Decision Y/N	Anticipated date of decision/ period in which the decision is to be taken	Private meeting Y/N	Reasons for the meeting to be held in private	Documents submitted to the decision-maker in relation to the matter	Address to obtain further information
180103/235	To seek approval for the procurement and award of contracts to providers for local welfare provision	Cabinet	Y	During the period 25 April to 310 June 2018	N	Not applicable	Cabinet Report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
180103/237	To seek approval of the Active Sunderland policy position and themes until 2021, ensuring that the policy is relevant to both corporate priorities and Sport England outcome framework.	Cabinet	Y	25 April 2018	N	Not applicable	Cabinet report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
180205/244	To seek Cabinet approval of the Housing Allocations Policy which has been revised in line with the Homelessness Reduction Act 2017.	Cabinet	Y	25 April 2018	N	Not applicable	Cabinet report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
180308/245	To seek approval for the sale of land at former Southwick School.	Cabinet	Y	During the period 1 to 30 June 2018	N	Not applicable	Cabinet report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk

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180313/246	To approve : a)2018-19 Highway Maintenance(Including Bridges) Programme. b) 2018-19 Integrated Transport Capital Programme. c) Amendments to 2017-2018 Programme	Executive Director of Economy in consultation with the Deputy Leader and Portfolio Holder for City Services	Y	During the period 25 to 30 April 2018	N	The responsibility for this decision is delegated to the Chief Officer and Portfolio Holder in this instance.	Report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
180319/247	To approve property seizure pursuant to The Control of Waste (Seizure of Property) Regulations 2015 for property involved in the commission of relevant environmental crimes	Cabinet	Y	25 April 2018	N	Not applicable	Cabinet report and qualifying Regulations	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
180323/248	To seek approval to commence consultation on the Publication draft of the Core Strategy and Development Plan and Planning Obligation SPD.	Cabinet	Y	30 May 2018	N	Not applicable	Publication draft of the Core Strategy and Development Plan Planning Obligation SPD	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk

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180326/249	To seek approval for the procurement of a Framework Agreement for care and support provision, including the procurement of care and support within two extra care housing schemes and the subsequent award of contract	Cabinet	Y	25 April 2018	N	Not applicable	Cabinet Report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk
180326/250	To seek Cabinet approval and agreement to the Unauthorised Encampment Policy.	Cabinet	Y	25 April 2018	N	Not applicable	Cabinet report	Governance Services Civic Centre PO BOX 100 Sunderland SR2 7DN committees@sunderland.gov.uk

Note; Some of the documents listed may not be available if they are subject to an exemption, prohibition or restriction on disclosure.
Further documents relevant to the matters to be decided can be submitted to the decision-maker. If you wish to request details of those documents (if any) as they become available, or to submit representations about a proposal to hold a meeting in private, you should contact Governance Services at the address below.
Subject to any prohibition or restriction on their disclosure, copies of documents submitted to the decision-maker can also be obtained from the Governance Services team PO Box 100, Civic Centre, Sunderland, or by email to committees@sunderland.gov.uk

Who will decide;
Cabinet; Councillor Henry Trueman – Leader; Councillor Michael Mordey – Deputy Leader/City Services; Councillor Mel Speding – Cabinet Secretary; Councillor Louise Farthing – Children's Services: Councillor Graeme Miller – Health, Housing and Adult Services; Councillor John Kelly – Public Health, Wellness and Culture; Councillor Cecilia Gofton – Responsive Services and Customer Care

This is the membership of Cabinet as at the date of this notice. Any changes will be specified on a supplementary notice.

Elaine Waugh
Head of Law and Governance **27 March 2018**