**Item No. 3**

**SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD** **27 JULY 2011**

**DEVELOPMENT OF THE HEALTH AND WELLBEING BOARD**

**Report of Executive Director Health, Housing and Adult Services**

## 1.0 PURPOSE OF THE REPORT

1.1 To provide board members with an overview of the health and wellbeing board.

1.2. To set out proposals for the development of the board in Sunderland.

## 2.0 BACKGROUND

2.1 The Health and Social Care Bill states that each local authority must establish a Health and Wellbeing Board (H&WB) for its area. The Bill also states that the H&WB will be a committee of the local authority. It brings together key NHS, public health and social care leaders in each local authority area to work in partnership.

2.2 Sunderland Council endorsed the creation of an Early Implementer Health and Wellbeing Board at its Cabinet on the 22nd June 2011 which was ratified by full Council on the 20th July which confirmed the elected member representation for the board with the Leader of the Council as chair of the board.

2.3 As an early implementer Sunderland will be able to trial new working arrangements before the establishment of the formal shadow board form in 2012 and then subject to Parliamentary approval, the establishment of full boards from 2013.

2.4 The report to full Council endorsing the earlier Cabinet decision set out the Membership of the Early Implementer Board. Subsequent to the drafting of that report the Sunderland GP Consortium has been formally established, and recognising the desire for strong and clear linkage between the Boards it is recommended that in addition to the Chair of the Consortium Board, a further GP Board Member be co-opted to the Early Implementer Health and Wellbeing Board. The complete membership of the Board will be reviewed prior to the establishment of the formal Shadow Board in 2012.

2.5 Many local authorities have become early implementers of health and well being boards and there are a number of learning networks in place that share the evolving thinking and development of boards. At a regional level there is an ANEC task and finish group for elected members and a NHS North East Health Transition Programme Board.

It is also the intention that an officer level regional community of interest is established to develop learning. Nationally a Department of Health online early implementer learning network has been established. Learning from these networks will be reported to the Board.

## 3.0 PROPOSAL FOR THE SUNDERLAND BOARD

3.1 The early implementer board is intended to be a developmental board that will use the remainder of the year to develop an approach that is suitable for Sunderland. This means considering future membership on the group, development of terms of reference and operational arrangements.

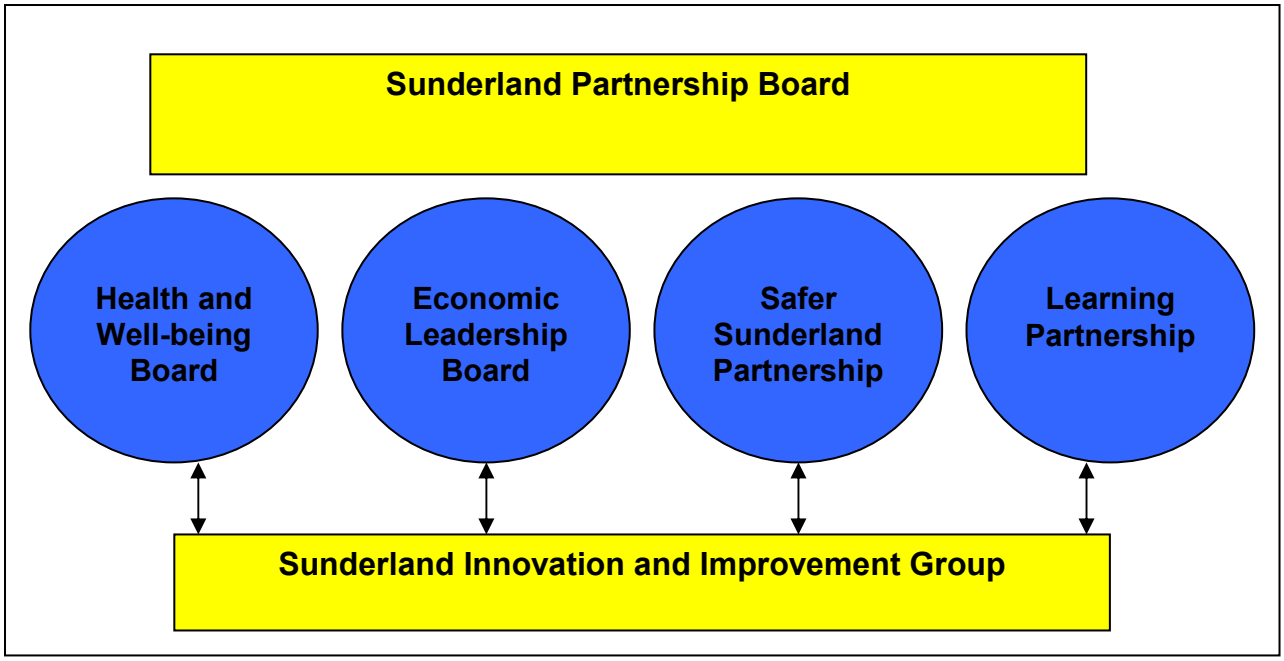
The following proposals have been put forward and the board is asked for their comments:

3.2 The current thinking is that the new board is a decision-making and shaping board which works closely with its "advisory" boards which are the existing Children's Trust and Adults Partnership Board as highlighted in Appendix 1. This relationship needs to be developed to ascertain how best to engage these boards both in feeding into the overarching board and dealing with actions from the board. Currently there is also an officer group that meets on a monthly basis to support the transition of arrangements.

3.3 Consideration will also need to be given as to how best to ensure all stakeholders are fully engaged and actively involved in the development of the arrangements. This especially applies to the role of providers – consideration could be given to a provider forum, a clinical senate or other groupings of partners. The potential of the Sunderland Innovation and Improvement Group to fulfil the broader engagement role could also be examined. In addition consideration needs to be given to the role of the Community and Voluntary Sector in terms of these arrangements.

3.4 It is intended that the overarching board meets on a formal bi monthly basis and minutes and papers to these meetings will be posted on the council's public Committee Management Information System. There is also the opportunity for additional meetings or developmental sessions.

3.5 Although the board is a council "committee" it is a key partnership board and in relation to the wider Sunderland Partnership arrangements in the city, it will be a key component of the partnership going forward. It will be autonomous from the overarching Sunderland Partnership but the work on health will contribute to the overarching Sunderland Strategy (2008 – 2025) which is currently being refreshed and overseen by the Sunderland Innovation and Improvement Group.




3.6 As the arrangements develop there are a key number of activities that will be required to be undertaken by the end of March 2012. This includes the following which will also need to be reflected in the Terms of Reference for the board as well of those for the two advisory boards.

- To assess the broad health and wellbeing needs of the local population and lead the statutory citywide needs assessment, known as the Joint Strategic Needs Assessment (JSNA)

- To develop a new joint high-level health and wellbeing strategy (JHWS) that spans NHS, social care, public health and the wider health determinants such as housing and child and community poverty

- To promote integration and partnership across areas through promoting joined up commissioning plans across the NHS, social care, public health and other local partners

- To ensure a comprehensive engagement voice is developed as part of the implementation of Healthwatch.

(For the JSNA and the implementation of Healthwatch more detail is covered in other reports for this board meeting)

3.7 The health and well being strategy will reflect the assessment made through the JSNA and consideration will also need to be given to other key priority areas from across the city, reflecting also the needs of providers in the city. The board will be responsible for delivering key parts of the Sunderland Strategy and these strategies need integration. The strategy will identify the key priorities to making significant

improvement and provide the overarching direction to all stakeholders and provide leadership for its implementation.

3.8 To support this overall work programme (See Appendix 2) it is important that the new board identifies what success will look like by the end of March 2012 to provide strategic direction. This could include:

- To have aligned commissioning intentions from all partner organisations to improve Health and Wellbeing outcomes
- To have an established plan for the engagement of VCS, providers and wider partners
- To have an established plan for the engagement of the broader community and users.
- To have engaged with the GP Commissioning Board and seen progress towards authorisation
- To have a plan for the transition of the public health function to the City Council including finance implications
- To have a final draft of the Health and Wellbeing Strategy to include outcome measures
- To make progress on greater integrated service provision at a locality level across the city

## 4.0 RECOMMENDATIONS

4.1 Early Implementer Health and Wellbeing Board is requested to receive this report and provide comments and suggestions.

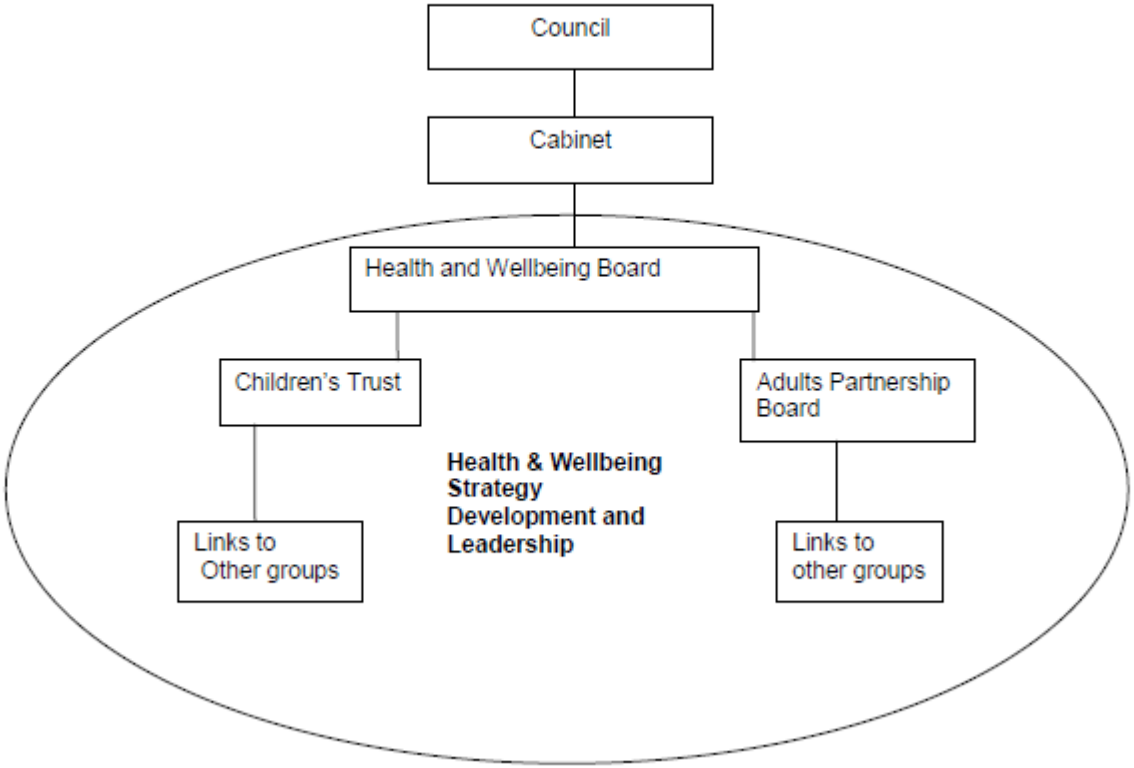
4.2 Early Implementer Health and Wellbeing Board is requested to agree to the proposal to co-opt a second Board Member from the GP Consortium.

4.3 Early Implementer Health and Wellbeing Board is requested to agree the next steps, reflecting the discussions on the work programme and the role of advisory groups.

4.4 Early Implementer Health and Wellbeing Board is requested to agree to receive regular updates**.**

Appendix 1

# Health and Wellbeing Board Structure



**Appendix 2**

**Health and Wellbeing Board Draft Agenda Forward Plan**

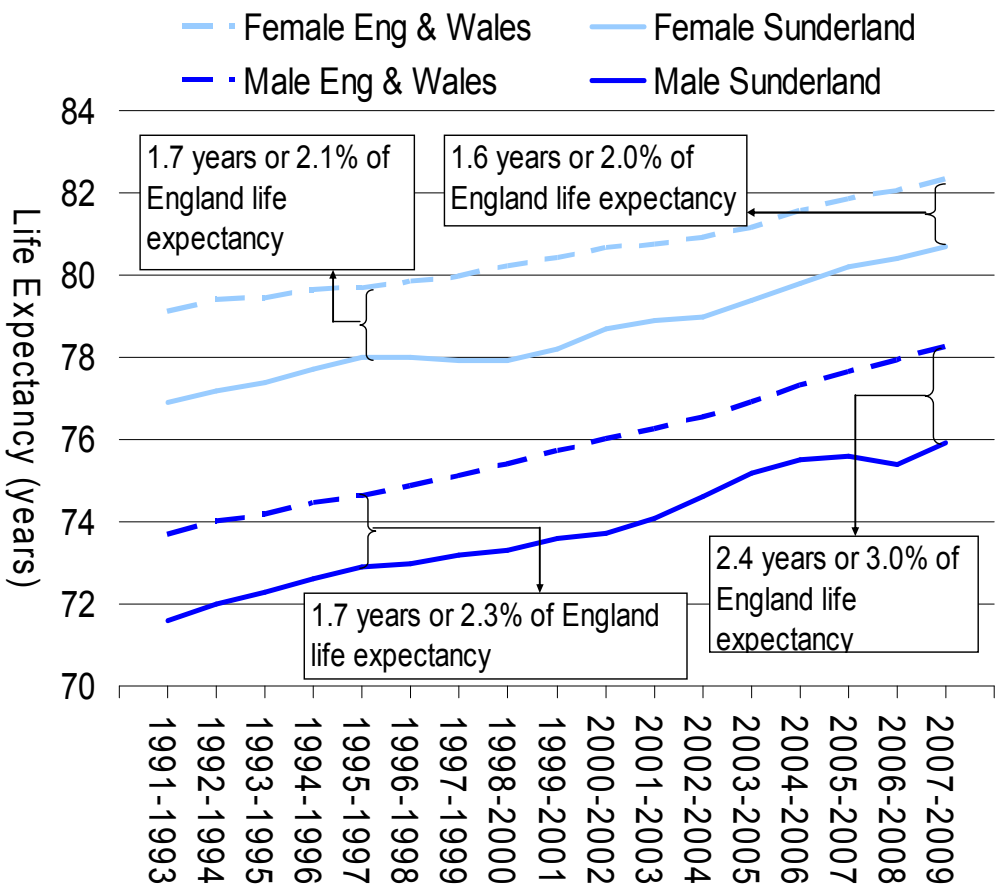
| | | |
|---|---|---|
| 27th July 2011 | 1. Apologies<br>2. Welcome from the Chair<br>3. Establishing the HWB<br>4. The Health of the City<br>5. JSNA and the link to commissioning<br>6. Development of Health Watch<br>7. GP Commissioning Pathfinder Bid | <br>Leader<br>NR<br>NC<br>NC<br>NR<br>IP |
| September 2011 | 1. Agree JSNA priorities including deep dive commissioning<br>2. Public Health transition plan<br>3. NHS change<br>4. Feed in from Children's & Adult's Boards<br>5. Council Directorate 3 year plans<br>• Marmot & Best Start<br>• Families and Neighbourhoods<br>6. ISOP Refresh<br>7. Engagement and involvement | NC<br><br>SR/NC<br>JC<br>NR&KM<br>RO/KM/NR<br>KM<br>RO<br>DH<br>SW? |
| December 2011 | 1. Stakeholder analysis – non members<br>2. Update on JSNA priorities<br>3. Decisions following deep dive findings<br>4. Health Watch update<br>5. Feed in from Children's & Adult's Boards<br>6. Commissioning Intentions | VT<br>NC<br>NR<br>NR/SW<br>NR&KM<br>All |
| February 2012 | 1. Agree structure & membership of shadow board<br>2. Agree work plan for shadow board<br>3. Report on impact of commissioning/decommissioning against JSNA<br>4. Draft Health and Wellbeing Strategy<br>5. Feed in from Children's & Adult's Boards | NR<br><br>NR<br>NC<br><br>VT<br>NR&KM |
| April 2012 | 1. Establish Shadow Board<br>2. Health and Wellbeing Strategy<br>3. Feed in from Children's & Adult's Boards | NR<br>VT<br>NR&KM |

# Overview of Health and Wellbeing in Sunderland 2011

## Introduction

The links between deprivation and poor health outcomes have been well documented over the last thirty years. Sunderland has some of the worst areas of deprivation in England, with over 40% of the population living within the most disadvantaged areas as identified by the Index of Multiple Deprivation. Some of the consequences of this on people's health are detailed below. In addition, the impact on health of significant economic and social inequalities that exist within Sunderland is very apparent.

The good news is that overall life expectancy for people in Sunderland is increasing and that mortality from heart disease and cancer has decreased significantly over the last 15 years.




So the bad news is that the life expectancy gap between Sunderland and England as a whole is not decreasing; the gap between life expectancy for men and women in Sunderland is not decreasing- for men, the gap is increasing. Sunderland is behind schedule to achieve a 10% reduction in the life expectancy gap between ourselves and England among both males and females between 1996 and 2010. Between 1995-97 and 2007-09 there was a **31% increase**

in the gap among males and an **8% reduction** in the gap among females. The gap among females is very close to the trajectory required to reach the 10% reduction by 2010

We know that Sunderland comprises 65 natural neighbour hoods and last year we carried out some analysis to establish what life expectancy in those neighbourhoods looked like:22 out of the 65 neighbourhoods have an all people life expectancy that's significantly different from the average for Sunderland people, 13 higher than and 9 lower than the average. The most health deprived neighbourhoods in Sunderland, where life expectancy is lowest, are as follows; City Centre, Port and East End, Hendon, Thornhill, Hetton Downs and Warden Law, Southwick, Witherwack, Marley Potts and Thorney Close. All these areas have high levels of health deprivation with Hendon and Southwick being the most marked.

We have included the detail of neighbourhood life expectancy in Appendix 1 and they demonstrate that whilst we frequently quote a 2 year difference in life expectancy between people in Sunderland and England there is much greater variation within the City. Within Sunderland wards, a man living in Washington South could live 14 years longer than a man living in Hendon, and a woman could live 8 years longer in Fulwell than a woman living in Hendon, when we look at the difference between women in the neighbourhoods with highest life expectancy and men in neighbourhoods with lowest life expectancy- we can be speaking of over 20 years.

We need to continue to deliver continuously improving universal services across the city as we need to continue to drive life expectancy up for all Sunderland's residents, but if we and our partners cannot find a way to a different engagement with people in these 9 neighbourhoods, we will not deliver a reduction in inequalities.

**Determinants of health inequalities**

According to the Marmot Report health inequalities result from social inequalities, which start before birth and accumulate throughout life. In order to reduce health inequalities action must start before birth and be followed through the life course of the child.

Recently Marmot indicators of the social determinants of health, health outcomes and social inequality have been published. When using these indicators the population in Sunderland was shown to be significantly worse than England in:

- Life expectancy at birth
- Inequality in life expectancy
- Inequality in disability-free life expectancy
- Young people not in employment
- People living in a household in receipt of means tested benefit
- Inequality in people in receipt of a means tested benefits

Further good news for the future was that some of the social determinants indicators, including child development aged 5 years, shows a picture of improvement, with the average being above the England standard.

The national policy change of moving responsibility for health improvement and reducing health inequalities to local authorities as part of NHS transitions recognises that the NHS is unable to tackle the social causes of ill health; action must come from communities, families, schools, employers and local government. Interventions need to take account of the inequalities suffered by most of the population but a greater focus needs to be given to those areas experiencing greatest need – what Marmot refers to as "proportionate universalism".

Good quality neighbourhoods can make a significant difference to quality of life and health; this is both physical environments such as more green spaces to the social environment to support communities in their physical and mental wellbeing. The majority of Sunderland, 95%, is classified as urban areas, with only 5% being classified as town / fringe or hamlet / isolated dwelling, including parts of Hetton and Shiney Row. However this does not necessarily result in better health, as both Hetton and Shiney row fall into the most disadvantaged and 3rd most disadvantaged area across the England. A refresh of the approach to healthy urban planning, possibly under the direction of the proposed Place Board, is required.

We also have a high proportion of unemployed at 5.4% with the national average being 4.7%. The larger numbers of unemployed fall within Hendon, Pallion, Sandhill and Southwick areas. In those that do work the average weekly income is £398.6, which is £40.20 less than the North East Average and £92.60 less than the England average. This then links to the situation where, dependent on which definitions we apply between 14500-24000 childrens and young people are living in poverty: the approach to addressing this may fall between the Health and Wellbeing Board and the Economic Leadership Board but care must be taken in partnering arrangements to ensure it does not slide into a 'gap' in our strategic thinking and planning.

**Health Inequalities throughout the life course**

***Children***

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations are laid in early childhood and what happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status. One quarter of all pregnant women smoke during their pregnancy up to the time of delivery compared to 14% nationally, impacting on the child's long term health. Low rates of breastfeeding are an issue locally with only 51.1% of mothers initiating breast feeding compared to 73.6% nationally. There is a strong correlation locally of mothers who don't breastfeed and smoke during pregnancy.

We have high rates of children classified as either obese or overweight: 21.1% of year 6 children within the Sunderland area. This is higher than the North East prevalence (20.6%) and England (18.7%). The areas which have higher levels of obesity are Millfield, Sandhill, Hetton, Castletown and Washington Central. Sandhill is of particular concern as it is currently

the only ward within Sunderland where a quarter of children in the reception years are overweight or obese, significantly higher than the Sunderland average.

Teenage pregnancy rate (less than 18 years old) is 54.9 per 100,000 compared to a figure of 40.2 nationally. The areas significantly above average are Castletown, Grindon, Hendon and Hetton. Teenage pregnancy indicates poor outcomes for both child and mother and is also an indicator of unsafe sexual practice.

To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking. The benefits of early intervention are seen not only improve educational outcomes and attainment at GCSE but reduce problems with emotional health and wellbeing and impact on a range of council, health and partners services.

***Adults***

Whilst all cause mortality rates have fallen over the last 10 years, we have demonstrated that life expectancy still lags England considerably. The three most influential conditions that contribute to the reduced life expectancy in Sunderland are Cancer, especially lung cancer, Cardiovascular Disease (CVD) and Coronary Obstructive Airways Disease (also know as COPD). The impact of these three diseases on local health is described below followed by an analysis of the three main lifestyle-associated risk factors for these conditions: obesity, alcohol and tobacco.

*Cardiovascular Disease (CVD)*

Early deaths from heart disease and stroke have fallen and are reducing faster than England as a whole, but CVD in Sunderland still remain worse than the national average. In Sunderland the number of deaths for circulatory disease is 853, which is a rate of 88.9 per 100,000 of the Sunderland population. Whilst the England average is 74.8 per 100,000 of the population, indicating that there are 14.1 more deaths in Sunderland per 100,000 per year from circulatory disease. Circulatory disease is prevalent throughout the city but peaks in Hendon with 178 deaths per year, closely followed by Hetton and Redhill with 112 and 110 deaths respectively.

*Cancer*

Amongst males, all cancers account for a much larger proportion of the life expectancy gap when compared to the average Local Authority, with 33% of the life expectancy gap being attributed to all cancers and half of this was the result of higher mortality rates due to lung cancer.

Wider health inequalities due to cancer among the Sunderland population and among males make it more important to engage with these groups. Early deaths from cancers nationally are

falling, but in Sunderland it has started to increase since 2005 and we are now significantly worse than the England average.

In 2007 trends in mortality rates due to cancer in Sunderland have fallen over the past 10 years. However, almost a quarter of all deaths are due to cancer. Compared to the England average, mortality in Sunderland is significantly higher with the highest rates being in the Hendon and Millfield wards. Six types of cancer make a major contribution to all cancer mortality amongst males and females, lung cancer, colorectal cancer, breast cancer, prostate cancer, stomach cancer and oesophageal cancer. Together these six cancers account for nearly 60% of all cancer deaths in Sunderland.

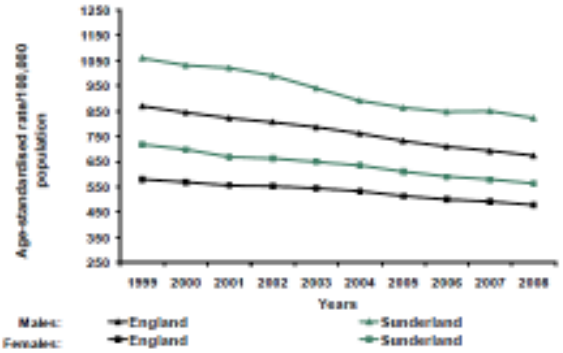
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

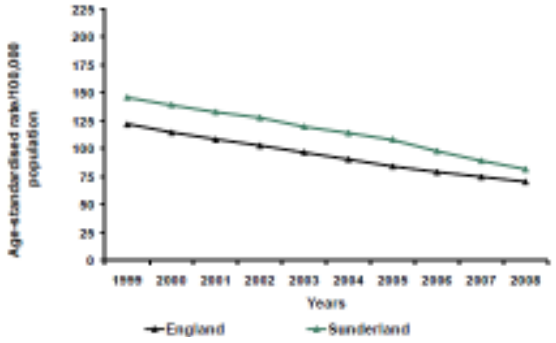
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

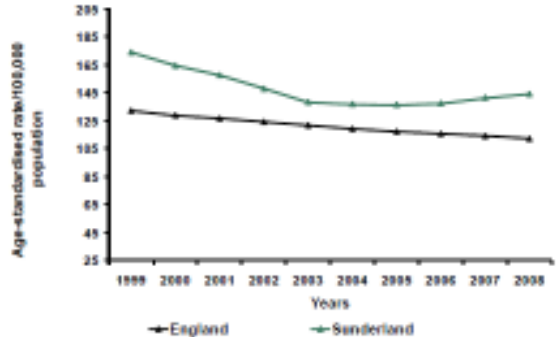
**Trend 1:**
**All age, all cause mortality**




**Trend 2:**
**Early death rates from heart disease and stroke**




**Trend 3:**
**Early death rates from cancer**




*Chronic Obstructive Airways Disease (COPD)*

COPD currently affects 8,000 people in Sunderland which accounts for 5.3% of all people aged 16 and over, this equates to 12,400 residents on GP lists. The prevalence is rising and has been predicted to rise to 5.9 therefore could affect between 13,500 and 13,700 people. The rates of admission for COPD are highest in Redhill, Southwick, Pallion and Sandhill. One of the most important risk factors for COPD is smoking; Sunderland has higher than average smoking rates, with an overall smoking prevalence of 21% although we know in a number of wards and neighbourhoods this rises to almost 50%. Tackling tobacco control and smoking

locally is the ultimate priority in order to reduce illness and premature death for local people of all ages. Helping young people not to start needs to be a significant part of our plans.

*Obesity*

Current levels of obesity within Sunderland are higher than the national average. The national level of obesity for males is 24.1% and females 24.9%. The highest rates of obesity occur in 35 – 44 years for males and 55 – 64 for females. This indicates that almost a quarter of adults living in Sunderland are overweight or obese, the highest prevalence lies within Silksworth, Millfield, Pallion, Redhill and Washington North. We already know the causal links between obesity and heart disease and stroke but are acquiring more evidence of links to cause between obesity and cancer, and for pregnant women between obesity and poor foetal health and wellbeing.

*Alcohol*

Levels of alcohol consumption are of significant concern within Sunderland. According to our 2008 Health and Lifestyle Survey, the majority of harmful and hazardous drinking occurs in those areas in the 'mid deprivation' category (IMD third Quintile), this includes Houghton, St Michaels, St Peters, Shiney Row and Washington East and North. The consumption of alcohol in Sunderland overall is above the recommended safe weekly limits. The levels of consumption are highest amongst 18-24 year old males with nearly 60% reporting that they drink above recommended levels each week, closely followed by 25-34 year olds. 29.8% of 18 – 24 year old females reported drinking over the safe weekly limits. 32.8% of people drinking above the recommended weekly safe limits are people living in social housing with uncertain employment in deprived areas.

The Local Alcohol Profiles for England (LAPE) continue to indicate that alcohol remains a significant problem with Sunderland being in the worst 10% in the country for:

- months of life lost - males
- alcohol specific mortality – males
- alcohol attributable mortality – males
- alcohol specific hospital admission – under 18s
- alcohol specific hospital admission – males
- alcohol specific hospital admission – females
- alcohol attributable hospital admission – males
- alcohol attributable hospital admission – females
- hospital admission for alcohol related harm (NI39)
- claimants of incapacity benefits – working age
- Binge drinking (synthetic estimate)

In Sunderland the rates of hospital stays for alcohol harm related admissions are 8310 per year, a rate of 2,581 admissions per 100,000 population per year. The England average rate is 1,743 per 100,000 per year.

*Tobacco*

Smoking rates are higher than the national average. The proportion of smokers within England is currently 21.7% (23.7% males and 19.9% female) compared to 25% in Sunderland (27.6 % male and 22.7% female). Within Sunderland ward areas the prevalence of smoking variations are even greater, with wards such as Pallion (33.6%), Redhill (31.3%) and Sandhill (30.1%) being significantly higher than the Sunderland average.

Rates of smoking related deaths are higher than the England average with an average of 636 people dying each year from smoking related causes (308.1 per 100,000 compared to an England rate of 216.0 per 100,000). In our lifestyle survey, the age band with the highest proportion of smokers was among 24-34 year old males and females.

***Older people***

Life expectancy is rising over time, and it is forecast in Sunderland that the number of people above 65 years of age will rise from 46,000 in 2009 to 68,000 in 2030, an increase of 46%. The number of people in Sunderland aged over 85 years, those with greatest care needs will more than double over the same period. We also know that whilst in 2010 the numbers of people with Dementia are estimated at 3100, by 2025 we are likely to have 4600 people aged 65 years and over with a diagnosis. This has profound implications spanning health, social care, housing and a range of significant services.

Sunderland has 15.1 % of its older population living independently, an estimated 17578 of the total household population. We are seeing a significant increase in lone person households (accurate figures to be released from 2011 Census). Further relatively good news comes in relation to excess winter deaths (which are related to fuel poverty, poor housing and deprivation); locally excess winter deaths are below the national average. Sunderland has an average of 142 deaths per year- 15.4 deaths per 100,000, whilst the England average is 18.1 per 100,000.

**Summary**

In summary it is obvious that Sunderland has clear and problematic health indices, however within the NHS locally, we have a vision to improve health across the life course. This includes increasing opportunities to allow children to have a ‘better start in life’ by reducing childhood obesity, increasing breast feeding, and reduce smoking in pregnancy; improving long term health conditions by reducing smoking in people with long term conditions and reducing hypertension in people with TIA/Stoke and reducing CVD and Cancers deaths by early diagnosis and intervention.

As a Health and Wellbeing Board we will need to establish our strategy to improve health and wellbeing for local people, considering social and other determinants of health and illness. Our activity will need to be placed in the context of requirements over the next 3 to 5 years, the next 5-10 and for 10 plus years. The high level areas have already been defined within the Sunderland Strategy and where our challenge lies is how in our current circumstances we can be flexible and responsive and demonstrate different and improved partnering arrangements to address those goals and priorities.

We will also need to consider the range of priority areas where our partners in the Economic Leadership Board and in the Place Board will play their part in driving prosperity and other health determinants to realise the City's vision.

| Vision | Strategies | Objectives | Outcome aspirations | Programmes | Initiatives |
|---|---|---|---|---|---|
| Better health<br>Excellent patient experience<br>Using your money wisely | Prevention | **Reduce CVD & cancer deaths** | Increase life expectancy by: men 2.0%, women 1.1% | **Obesity** | • Evaluate new obesity services<br>• Referral to lifestyle packages |
| | | | Reduce health inequalities by 5.2% | **Smoking** | • Evaluate new alcohol services<br>• Promote positive drinking culture |
| | | | Stop the rise in alcohol-related admissions | **Alcohol** | • Re-balance stop smoking services<br>• Deliver smoke free schools |
| | | **Better start in life**<br>Children's health<br>Maternity services | Reduce childhood obesity by 10% | **Child health** | • Child health promotion<br>• Children's risk and resilience model<br>• Increase breastfeeding<br>• Review maternity staffing skill mix<br>• Identify & manage high risk women |
| | | | Increase breastfeeding by average 89% | | |
| | | | Reduce smoking in pregnancy by average 26% | **Maternity** | |
| | Long term conditions | **Long term conditions**<br>Identification & management<br>Better rehabilitation | Reduce smoking in people with LTC by 29% | **CVD risk** | • CVD identification & management<br>• Early cancer identification - awareness, screening |
| | | | | **Cancer** | |
| | | | Reduce hypertension in people with TIA/stroke by 4% | **LTC & rehabilitation** | • Wider LTC reform<br>• Reform stroke rehab<br>• Reform neuro rehab<br>• Reform intermediate care |
| | Safe, quality services, close to home, no waste | **Reform urgent care**<br>for adults and children - more provided outside hospital | Reduce ambulatory care sensitive admissions by 44% | **Sick & injured child** | • Reform care of sick and injured child<br>• Single point of access<br>• Integrate pathways across organisations<br>• Diagnostic services in community<br>• Telehealth |
| | | | | **Urgent care** | |
| | | **Reform planned care**<br>more provided outside hospital | Increase in planned procedures in primary & community settings | **Planned care** | • Reform programme shifting care out of hospital utilising PCCs<br>• Rheumatology modifying drug monitoring in primary care<br>• Carpal tunnel out of hospital |
| | | **Reform mental health care**<br>more provided outside hospital | Earlier access to dementia diagnosis & interventions | **Mental health** | • New model of mental health care Implement dementia strategy<br>• New model of CAMHS<br>• Autism national strategy |
| | | | Increase in psychological therapies | | |
| | | **A better death**<br>greater choice | Increase deaths outside hospital by 5% | **End of life care** | • 24/7 services in all settings<br>• Review & redesign services using Marie Curie Choice programme |

Appendix **1:Life Expectancy in Sunderland Neighbourhoods**

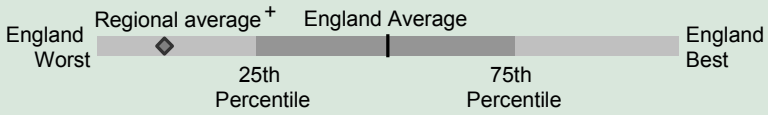
| Neighbourhood | Male Life Expectancy | Female Life Expectancy | Persons Life Expectancy | |
|---|---|---|---|---|
| Albany & Blackfell | 78.6 | 81.4 | 80.4 | |
| Ashbrooke | 70.7 | 80.0 | 75.1 | |
| Ayton, Lambton & Oxclose | 79.5 | 81.0 | 80.3 | |
| Barmston & Columbia | 75.0 | 77.9 | 76.6 | |
| Barnes | 75.2 | 81.1 | 78.1 | |
| Burnside & Sunniside | 74.4 | 82.9 | 78.3 | |
| Carley Hill | 79.9 | 79.1 | 79.2 | |
| Castletown & Hylton Castle | 73.8 | 80.4 | 77.1 | |
| Chilton Moor & Dubmire | 79.0 | 80.7 | 80.0 | |
| City Centre | 66.6 | 74.6 | 69.7 | < |
| Concord, Sulgrave & Donwell | 75.7 | 81.0 | 78.4 | |
| Downhill & Redhouse | 76.0 | 80.2 | 78.2 | |
| Doxford | 76.9 | 81.9 | 79.5 | |
| Elstob Farm & Queen Alexandra Road | 83.9 | 85.8 | 84.8 | |
| Farringdon | 73.2 | 79.5 | 76.4 | |
| Fatfield & Mount Pleasant | - | 87.7 | 88.5 | |
| Fencehouses | 76.0 | 82.5 | 79.2 | |
| Ford & Pallion | 73.0 | 79.0 | 76.0 | |
| Fulwell & Seaburn Dene | 79.9 | 83.8 | 81.7 | |
| Grangetown | 75.7 | 84.1 | 79.9 | |
| Grindon & Hastings Hill | 74.4 | 83.0 | 78.5 | |
| Hall Farm & Chapel Garth | 76.9 | 84.8 | 80.7 | |
| Hendon | 68.9 | 77.8 | 73.3 | < |
| Hetton | 77.7 | 81.6 | 79.7 | |
| Hetton Downs & Warden Law | 69.0 | 77.4 | 72.8 | < |
| High Barnes | 79.2 | 82.7 | 81.2 | |
| Hillview | 71.8 | 83.5 | 77.5 | |
| Hollycarrside | 75.8 | 85.5 | 80.3 | |
| Houghton | 76.4 | 81.3 | 78.9 | |
| Humbledon & Plains Farm | 77.2 | 85.0 | 80.9 | |
| Marley Pots | 69.3 | 75.9 | 72.5 | < |
| Middle & East Herrington | 81.2 | 86.0 | 83.6 | |
| Millfield | 76.0 | 77.3 | 76.7 | |
| Monkwearmouth | 77.1 | 83.4 | 79.8 | |
| Moorside | - | 83.8 | 81.0 | |
| Moorsley & Easington Lane | 73.8 | 80.6 | 77.2 | |
| New & West Herrington | 84.9 | 76.6 | 78.2 | |
| Newbottle | 75.5 | 80.4 | 77.9 | |
| Nookside | 72.9 | 77.8 | 75.4 | |
| Old Penshaw & Cox Green | 74.7 | 78.6 | 77.2 | |
| Pennywell | 70.7 | 81.6 | 76.1 | |
| Penshaw & Shiney Row | 76.6 | 81.8 | 79.3 | |
| Port & East End | 67.0 | 76.0 | 70.8 | < |
| Rainton | 74.3 | 107.0 | 78.9 | |
| Rickleton & Harraton | 76.9 | 80.0 | 78.8 | |
| Roker | 75.7 | 79.1 | 77.4 | |
| Ryhope | 77.5 | 76.3 | 77.0 | |
| Seaburn & South Bents | 83.8 | 92.4 | 88.2 | |
| Silksworth | 76.4 | 81.9 | 79.2 | |
| South Hylton | 76.0 | 81.2 | 78.4 | |
| Southwick | 71.8 | 78.1 | 74.9 | < |

# Health summary for Sunderland



The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average




+ In the South East Region this represents the Strategic Health Authority average

| Domain | Indicator | Local No. Per Year | Local Value | Eng Avg | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|---|
| Our communities | 1 Deprivation | 119430 | 42.5 | 19.9 | 89.2 | | 0.0 |
| | 2 Proportion of children in poverty | 14760 | 25.0 | 20.9 | 57.0 | | 5.7 |
| | 3 Statutory homelessness | 166 | 1.37 | 1.86 | 8.28 | | 0.08 |
| | 4 GCSE achieved (5A*-C inc. Eng & Maths) | 1812 | 52.6 | 55.3 | 38.0 | | 78.6 |
| | 5 Violent crime | 4027 | 14.3 | 15.8 | 35.9 | | 4.6 |
| | 6 Long term unemployment | 1408 | 7.6 | 6.2 | 19.6 | | 1.0 |
| Children's and young people's health | 7 Smoking in pregnancy | 665 | 22.3 | 14.0 | 31.4 | | 4.5 |
| | 8 Breast feeding initiation | 1476 | 51.1 | 73.6 | 39.9 | | 95.2 |
| | 9 Physically active children | 20141 | 57.5 | 55.1 | 26.7 | | 80.3 |
| | 10 Obese children (Year 6) | 556 | 21.1 | 18.7 | 28.6 | | 10.7 |
| | 11 Children's tooth decay (at age 12) | n/a | 1.1 | 0.7 | 1.6 | | 0.2 |
| | 12 Teenage pregnancy (under 18) | 302 | 54.9 | 40.2 | 69.4 | | 14.6 |
| Adults' health and lifestyle | 13 Adults smoking | n/a | 29.8 | 21.2 | 34.7 | | 11.1 |
| | 14 Increasing and higher risk drinking | n/a | 26.6 | 23.6 | 39.4 | | 11.5 |
| | 15 Healthy eating adults | n/a | 19.4 | 28.7 | 19.3 | | 47.8 |
| | 16 Physically active adults | n/a | 12.3 | 11.5 | 5.8 | | 19.5 |
| | 17 Obese adults | n/a | 28.6 | 24.2 | 30.7 | | 13.9 |
| Disease and poor health | 18 Incidence of malignant melanoma | 27 | 9.4 | 13.1 | 27.2 | | 3.1 |
| | 19 Hospital stays for self-harm | 1059 | 382.2 | 198.3 | 497.5 | | 48.0 |
| | 20 Hospital stays for alcohol related harm | 8310 | 2581 | 1743 | 3114 | | 849 |
| | 21 Drug misuse | 1444 | 7.7 | 9.4 | 23.8 | | 1.8 |
| | 22 People diagnosed with diabetes | 12788 | 5.63 | 5.40 | 7.87 | | 3.28 |
| | 23 New cases of tuberculosis | 20 | 7 | 15 | 120 | | 0 |
| | 24 Hip fracture in 65s and over | 304 | 517.1 | 457.6 | 631.3 | | 310.9 |
| Life expectancy and causes of death | 25 Excess winter deaths | 142 | 15.4 | 18.1 | 32.1 | | 5.4 |
| | 26 Life expectancy - male | n/a | 75.9 | 78.3 | 73.7 | | 84.4 |
| | 27 Life expectancy - female | n/a | 80.7 | 82.3 | 79.1 | | 89.0 |
| | 28 Infant deaths | 11 | 3.52 | 4.71 | 10.63 | | 0.68 |
| | 29 Smoking related deaths | 636 | 308.1 | 216.0 | 361.5 | | 131.9 |
| | 30 Early deaths: heart disease & stroke | 260 | 81.5 | 70.5 | 122.1 | | 37.9 |
| | 31 Early deaths: cancer | 459 | 143.9 | 112.1 | 159.1 | | 76.1 |
| | 32 Road injuries and deaths | 104 | 37.1 | 48.1 | 155.2 | | 13.7 |

**Indicator Notes**

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009 For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide. You may use this profile for non-commercial purposes as long as you acknowledge where the information came from by printing 'Source: Department of Health. © Crown Copyright 2011'.

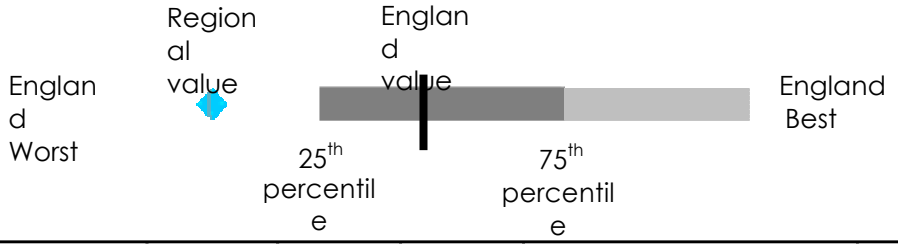
## Appendix 3 Marmot Indicators for Local Authorities in England

Fair Society, Healthy Lives

London Health Observatory

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value
for this local authority is shown as a circle, against the range of results for England, shown as a bar.

- Significantly better than England value
- Not ssignificantly different from England value
- Significantly worse than England value




## Sunderland

| | Indicator | Local Authority Value | Regional Value | England Value | England Worst | Range | England Best |
|---|---|---|---|---|---|---|---|
| | **Health outcomes** | | | | | | |
| | ***Males*** | | | | | | |
| 1 | Male life expectancy at birth (years) | 75.9 | 76.8 | 78.3 | 73.7 | | 84.4 |
| 2 | Inequality in male life expectancy (years) | 10.6 | 11.5 | 8.8 | 16.6 | | 2.7 |
| 3 | Inequality in male disability-free life expectancy (years) | 12.6 | 14.1 | 10.9 | 20.0 | | 1.8 |
| | ***Females*** | | | | | | |
| 4 | Female life expectancy at birth (years) | 80.7 | 80.9 | 82.3 | 79.1 | | 89.0 |
| 5 | Inequality in female life expectancy (years) | 6.6 | 8.3 | 5.9 | 11.5 | | 1.8 |
| 6 | Inequality in female disability-free life expectancy (years) | 10.2 | 11.8 | 9.2 | 17.1 | | 1.3 |
| | **Social determinants** | | | | | | |
| 7 | Children achieving a good level of development at age 5 (%) | 58.2 | 54.9 | 55.7 | 41.9 | | 69.3 |
| 8 | Young people not in employment, education or training (NEET) (%) | 10.1 | 10.1 | 7.0 | 13.8 | | 2.6 |
| 9 | People in households in receipt of means-tested benefits (%) | 21.2 | 19.3 | 15.5 | 41.1 | | 5.1 |
| 10 | Inequality in people in receipt of means-tested benefits (% points) | 42.0 | 41.9 | 30.6 | 61.3 | | 2.9 |

## Appendix 4 Health Profile of Sunderland

| | Now | In the future | | | |
|---|---|---|---|---|---|
| Age(years) | 2009 | 2020 | | 2030 | |
| All ages | 282 | 285 | ∅ | 289 | ∅ |
| 0-14 | 46 | 47 | ∅ | 45 | 𝔼 |
| 65+ | 46 | 56 | ∅ | 68 | ∅ |

If the way services are delivered remains the same, an aging population will lead to an increased demand for health and social care services.

Population by ethnic group, 2009 ('000s) [2]

| | White British | BME | % BME |
|---|---|---|---|
| Sunderland | 262 | 19 | 7 |
| England | 42,900 | 8,900 | 17 |

BME = Black and minority ethnic groups

### Society, economy and environment

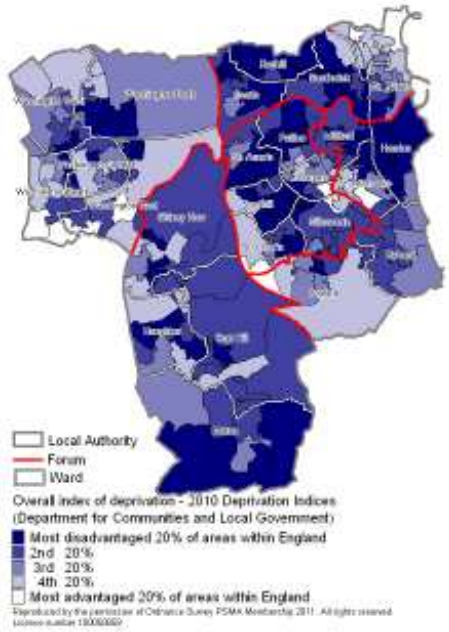
There are 390 children in care under 18 years of age resident in Sunderland[3]. This is above the average rate per 10,000 children across England.

24,000 children under 16 years of age (51% of all children) live in low income families[4]. Across England, 42% of children live in low income families.

9,400 adults of working age or 5% of this population group claim Jobseekers' Allowance (JSA)[5]. Across England 4% claim JSA. The proportion of JSA claimants in Sunderland is above the N.E. average.

### Society, economy, environment (cont.)

37% of the population of Sunderland lives in areas that are among the 20% most disadvantaged across England[6].




### Child Health and Lifestyle

| | Sunderland | | England | |
|---|---|---|---|---|
| Infant mortality rate[7] | 3.5 | 𝔼 | 4.7 | 𝔼 |
| Teenage conception rate[8] | 53 | – | 38 | 𝔼 |
| Breastfeeding continuation[9] | 25% | – | 46% | ∅ |
| Smoking during pregnancy[10] | 22% | – | 14% | 𝔼 |
| Smoking Yr 10[11] | 12% | 𝔼 | 15% | 𝔼 |

### Child Health and Lifesty

NHS South of Tyne and Wear

| | Sunde | | | |
|---|---|---|---|---|
| Alcohol Yr 10[12] | 40% | – | 33% | 𝔼 |
| Obesity Yr 6[13] | 21% | – | 19% | ∅ |
| Uptake of MMR vaccination at 5 years[14] | 87% | ∅ | 83% | ∅ |

### Adult Health and Long Term Conditions

| | Sunderland | | England | |
|---|---|---|---|---|
| Male life expectancy[15] | 76 | ∅ | 78 | ∅ |
| Female life expectancy[16] | 81 | ∅ | 82 | ∅ |
| Early mortality heart disease/ stroke[17] | 82 | 𝔼 | 71 | 𝔼 |
| Percent diagnosed with heart disease[18] | 5.2% | 𝔼 | 3.4% | 𝔼 |
| Early mortality all cancers[19] | 144 | ∅ | 112 | 𝔼 |
| Percent diagnosed with diabetes[20] | 5.6% | ∅ | 5.4% | ∅ |
| Coverage of breast screening[21] | 79% | 𝔼 | 77% | ∅ |
| Coverage of cervical screening[22] | 81% | ∅ | 79% | 𝔼 |

∅ rising trend, 𝔼 falling trend, – constant trend; ■ significantly worse than England value at 95% confidence, ■ not significantly different, ■ significantly better

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References: 1. Office for National Statistics, mid-year 2009; 2. Office for National Statistics, mid-year 2009; 3 Department for Education, 2010; 4. HM Customs and Revenue, 2006 taken from Child Poverty Toolkit, Child Poverty Action Group; 5 Department for Work and Pensions, June 2010, published by NOMIS at www.nomisweb.co.uk; 6. 2010 Deprivation Indices, Department for Communities and Local Government; 7. Deaths among infants under 1 year per 1,000 live births, 2007-2009, National Centre for Health Outcomes Development; 8. Conceptions among females under 18 years per 1,000 females 15-17 years, 2009, Department of Health; 9. Proportion of mothers partially or completely breastfeeding at the 6 to 8 week infant health check, 2010/11, Department of Health; 10. Proportion of mothers who report smoking at time of delivery, 2010/11, Department of Health; 11. Proportion of Year 10 children that report smoking, School Health Education Unit; 12. Proportion of Year 10 children that report having consumed alcohol in the past week, School Health Education Unit; 13. National Childhood Measurement Programme, 2009/10, NHS Information Centre; 14. 2009/10, Department of Health; 15. and 16. 2007-2009, Office for National Statistics; 17. Age-standardised mortality rate due to all circulatory disease among people under 75 years per 100.000 population, 2007-2009, National Centre for Health Outcomes Development; 18. Prevalence of coronary heart disease, 2009/10, Quality and Outcomes Framework, NHS Information Centre; 19. Age-standardised mortality rate due to all cancers among people under 75 years per 100.000 population, 2007-2009, National Centre for Health Outcomes Development; 20. Prevalence of diabetes, 2009/10, Quality and Outcomes Framework, NHS Information Centre; 21.Percent of eligible women 53 to 70 years who have been screened in the past three years, 2009/10, NHS Information Centre; 22 Percent of eligible women 25 to 64 years who have had an adequate smear in the past five years, 2009/10, NHS Information Centre.

**SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD** **27 July 2011**

# PRODUCTION OF THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) FOR 2011

**Report by the Director of Public Health**

## 1. Purpose

This brief note sets out proposals for the development of the 2011 JSNA which will be initiated through a project management approach.

## 2. What is a JSNA?

The Joint Strategic Needs Assessment (JSNA) is an ongoing process that identifies current and future health and wellbeing needs of the local Sunderland population. This informs decisions not just about how we design, commission and deliver services (both now and in the future), but also about how the urban environment is planned and managed. Our aim is to improve and protect health and wellbeing across the city while reducing health inequalities.

.

Sunderland's JSNA baseline report was published in 2008, with an update released in 2009. These reports described some of the key health and wellbeing issues for the local population, and looked into the future to predict how these might change, and what the implications of these changes might be in terms of service planning. This was used to inform strategic documents, such as the Sunderland Strategy; PCT's 5 year Strategic Plan; the Director of Public Health's Annual Report; the Council's 15 year Commissioning Framework for the Directorate of Health Housing and Adult Services; and the Children and Young People's Plan. It is not clear that the JSNA directly supported and underpinned prioritisation and commissioning decisions and it is this aspect of the process which we need to enhance during the 2011 refresh

## 3. Change Drivers

There have been many national policy and economic changes in the past 12 months. A key issue impacting on both Councils and all public sector and private partners is the financial impact of the global economic downturn, in which public-sector organisations are expected to manage within a much more restricted financial settlement. This will mean a greater targeting of resources towards identified priorities.

In view of this rapidly changing national (political and economic) policy context, this year's JSNA has taken a different approach from previous years and as well as supporting the delivery of the Health and Wellbeing Strategy also focuses on:

**The need to better support decision-makers (commissioners) during this period of austerity and change.**

There are some clear priority areas which we have focused on in Sunderland over the last 3-5 years (eg the areas selected within our Local Area Agreement and the Sunderland Strategy) and which were covered in the previous JSNA. However as part of the refresh a group of Officers have submitted a range of priority areas for consideration by the Board as those for which we will provide refreshed analyses by the end of September to support commissioning rounds. In addressing these priority areas through the People Place Economy strategic model, the aim is to reduce inequalities for local people. The list is attached as Appendix 1.

## 4. Project Approach

As always there are time and resource constraints on the delivery: i.e. JSNA analysis is needed to inform the Health & Well-Being Board's strategic responsibilities; and partners' commissioning prioritisation during the 11/12 commissioning cycles. To counter this, it is proposed the project develops in a number of phases to widen participation and interaction in the JSNA with a range of stakeholders including health and social care commissioners, other health and Council professionals and Third Sector partners as well as service users, carers and the wider public. Available resources currently include some coordination and intelligence capacity within the Strategy, Policy and Performance Management function as well as capacity from Directorates (Commissioning Leads) and colleagues from Public Health in the TPCT.

A significant advantage is that many (albeit not all) of the areas which will be under consideration are not new priorities for Sunderland and much intelligence is available. An overall JSNA Data Annex which confirms to Department of Health Guidance has already been produced and is available on both the PCT and Council websites.

The first stage of the refresh should be completed by the end of September 2011 in that a draft of the chapters with high level recommendations for commissioners is produced for provisional agreement by the Health and Wellbeing Board. We also need to consider the best approach to take to additional user involvement and community engagement. Chapters would include the most up to date user/carer/public involvement information gained from the continuous process of engagement and involvement work that is carried out as part of our usual systems. A communication and consultation period of three months would allow for a broad range of stakeholders to feed in their views on the work that had been delivered. We anticipate that by the end of December 2011 the Board will have signed off this year's JSNA.

It is anticipated that the final list of priority areas will be allocated to commissioning leads and they with assistance from SSPM staff will populate the standardised template which will then be the JSNA chapter for that subject. An Executive Summary will be produced for each Chapter. We recognise that even with the information already available there will be 'gaps' e.g. where spend on a

particular area is subsumed within a larger financial envelope or spread across a number of partners.

The expectation is that allowing for these issues each commissioning lead/policy officer combination should be able to deliver an analysis of their topic area ensuring the H&WB Board have sufficient information for consideration of Sunderland commissioning decisions over the next 3-5 years (investment and disinvestment). Where there are some significant changes coming e.g. the definition of the Public health Ring fenced Budget, the nature of the continuous process of JSNA will allow for further refining and analysis.

## 5. Project Team

A Project Board has been established to oversee this major refresh with coordination function given to a much smaller project team. Members of the Board include Senior Officers from the Council (Childrens Services, City Services, Health Housing and Adult Services and the Office of the Chief Executive as well as from the TPCT and the Sunderland Clinical Commissioning Group. In reality Board Members will be significantly involved in the completion of the task as each will have responsibility for the completion of topic areas relating to their area. Officers have been asked to submit their suggestions for a 'first trawl' of priority areas and a 'prioritisation' into first and second level importance will be available for the H&WB Board to consider.

## 6. Alignment

The Health and Wellbeing Board is asked to approve this report and agree:

- The JSNA approach and timelines (draft for provisional approval end September, public engagement and Final Approval December 2011)
- The Refreshed JSNA Priority List

**Maureen Crawford**
**Director of Public Health**
**18 July 2011**

**Appendix 1 – JSNA Priorities List (Officer Group Prioritisation will be provided in advance of 27th)**

**Proposed JSNA Priorities**

***People***

Life Expectancy
Quality of life and wellbeing
**Start in life (incl. parenting, breastfeeding, readiness for school)**
Literacy and educational attainment
Carer support (esp. young carers)
Sexual health (incl. teenage pregnancy)
Emotional resilience
**Obesity**
Physical activity
**Substance misuse (esp. alcohol)**
**Tobacco** (incl. smoking in pregnancy)
**Early identification and management of cancer, CVD and COPD**
Preventing hospital admissions
Social isolation
Domestic violence

***Place***

Access to services which impact on health
Homelessness/availability of affordable housing
Housing (physical condition)
Affordable warmth
Accidents
**Healthy urban planning and access to green space**
Low carbon
Crime/perception of safety

***Economy***

**Poverty (esp child poverty)**
Training (reduction in NEETs)
Income/financial resilience
**Access to good quality work**
Access to lifelong learning

***Cross-cutting***

Digital City
Increased aspirations
Individual and community resilience
Democratic engagement

**HHAS**
- Supporting adults to live independently in the community through improving their choice & control of care, support and daily living options
- Improving support and recovery for people with mental illness
- Improving access to accommodation solutions for socially disadvantaged individuals

**Scrutiny-Related Topics**
- Children's start in life
- Care closer to home (support on discharge to avoid re-admission, intermediate care, re-ablement and other rehabilitation pathways)
- Safeguarding children and adults

**City Services**
- Lifestyle Factors - particularly obesity, smoking cessation and alcohol misuse (but potentially other things too)
- Supporting Older People to live independently
- Healthy Urban Planning

**NC/PA**
**20th July 2010**

**SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD** **27 JULY 2011**

**HEALTHWATCH TRANSITION PLAN**

**Report of Executive Director Health, Housing and Adult Services**

## 1.0 PURPOSE OF THE REPORT

1.1 To provide board members with information on the Government's Healthwatch Transition Plan.

1.2. To set out proposals for the Healthwatch Transition in Sunderland.

## 2.0 BACKGROUND

2.1 The HealthWatch Transition Plan was published on 29th March 2011. The document is the first in a series of transition documents being produced by the Department of Health (DH) primarily for LINks, their Host organisations and local authorities.

2.2 The aim of HealthWatch is to strengthen patient and public voice at both local and national levels. To do this, HealthWatch England will be established and LINks will become local HealthWatch organisations.

2.3 Local authorities (LAs) that were interested in becoming HealthWatch pathfinders were invited, in partnership with their LINks, to submit their plans to the DH by May 2011. Subject to parliamentary approval both HealthWatch England and local HealthWatch will be introduced by July 2012.

## 3.0 PROPOSED NEW ROLES OF LOCAL HEALTHWATCH

3.1 At least one representative of local HealthWatch will be a statutory member of the health and wellbeing board, helping to ensure that the consumer voice is integral to the wider, strategic decision-making across local NHS services, adult social care and health improvement.

3.2 For this reason it is very important for local HealthWatch to develop strong relationships with key partners to develop a shared understanding of the needs of the local population with the purpose of agreeing the best strategy to meet those needs within the collective resources available to the local community.

3.3 Local HealthWatch organisations will be funded via LAs and will be accountable to LAs for operating effectively and providing value for

money. LAs will have responsibility for putting in place different arrangements if a local HealthWatch organisation is not operating effectively.

3.4 The following proposals have been put forward:

- The role of LINks will evolve to become local HealthWatch which will have an expanded range of functions.
- Local HealthWatch will be statutory organisations
- LAs will commission local HealthWatch with freedom to decide how to do this
- The DH will make additional funding available to LAs to support local HealthWatch
- Local HealthWatch will have a seat on the LA health and wellbeing board, to ensure consumer voice is integral to decision-making.
- From April 2013, LAs will commission NHS complaints advocacy from any suitable provider, including local HealthWatch, and the service will be accessed through local HealthWatch.

3.5 LAs will be commissioners and funders of local HealthWatch organisations, and will also be subject to scrutiny from them in respect of their adult social care services. LAs and local HealthWatch will be partners on health and wellbeing boards. The DH acknowledges that this is a complex set of relationships and recommends that LAs begin to think about how they will manage these with their local HealthWatch organisation.

## 4.0 HEALTHWATCH ENGLAND

4.1 HealthWatch England will provide leadership, support and advice for local HealthWatch organisations, creating greater consistency across the country.

4.2 Healthwatch England will be a subcommittee of the Care Quality Commission.

4.3 HealthWatch England will be able to advise the Secretary of State for Health, the NHS Commissioning Board, LAs and Monitor as well as the Care Quality Commission (CQC) about concerns raised by local HealthWatch organisations.

4.4 HealthWatch England will be able to request that the CQC carries out an investigation if it has evidence of poorly performing services.

## 5.0 BUILDING ON WHAT IS BEST

5.1 The DH sets out what an effective local HealthWatch organisation would be like and questions that LINks will need to consider when preparing to transition to HealthWatch.

5.2 While local HealthWatch will take forward LINks' responsibility for gathering people's views and making those views known to the people responsible for commissioning, providing or scrutinising local services, they will also take on the responsibility for supporting individuals directly.

5.3 From July 2012 local HealthWatch will have a role supporting individuals to access information which, in turn, will help them to make informed choices about the health and care and treatment options available to them.

5.4 From April 2013, LAs will take on responsibility for commissioning local NHS complaints advocacy services for people requiring support to make a complaint. These services will be accessed through, and in some cases may be provided by, local HealthWatch.

5.5 Local HealthWatch will also have direct involvement in local commissioning decision-making processes through their role on the LA health and wellbeing board: this is different from the role of LINks in using feedback to influence decision-makers. Concerns exist within Sunderland LINk that one place on the Health and Wellbeing Board for local HealthWatch may not be enough to genuinely influence the commissioning process.

5.6 Through their relationship with HealthWatch England, local HealthWatch will be able to ensure that people's concerns about services are brought together and acted on nationally.

## 6.0 TRANSITION

6.1 For LINks, this transition year needs to address two key challenges:

- All LINks being supported to operate at the level of the best
- A smooth transition to local HealthWatch

6.2 For LAs the transition year needs to address:

- What effective and valuable local HealthWatch arrangements would look like
- The level of investment required in local HealthWatch arrangements.

6.3 The Centre for Public Scrutiny, supported by the Local Government Association and the Patient's Association, is undertaking a review of LINks' progress and good practice which will also be shared. The Centre is expecting to publish results in May.

6.4 LINks and their hosts, with peer support where this would be helpful, will be able to assess what their current level of effectiveness is, as compared to the best performing LINks, with a critical but non-judgemental approach based on the available guidance and feedback from their stakeholders.

6.5 Concerns exist within Sunderland LINk that this approach does not take account of local differences between LINks. What works in one area may not necessarily be successful elsewhere.

6.6 The DH acknowledges that there will have to be a degree of learning together as GP consortia pathfinders; early implementer local authority health and wellbeing boards; and HealthWatch pathfinders, increasingly establish their identity and understand their individual roles and how they relate to each other.

6.7 Implementation of the Government's proposals for establishing HealthWatch is being overseen by a national programme board. It is the Board's role to provide strategic advice to the development and implementation.

**Action Learning Sets**

6.8 The DH encourages the establishment of action learning sets to build momentum through peer learning and sharing and to facilitate continuous improvement for all LINks. This will increase consistency where this is desirable, and build sustainability. The learning from this work will be shared via web publications and, where opportunities arise, via regional or national events.

6.9 Participants of action learning sets would set their own terms of reference, which would include bringing issues to the table for discussion and some clear products to enable others to learn. Such products can be, for example, a set of tools for use in HealthWatch that would enable it to gather diverse, collective views from its local community.

6.10 The action learning sets will decide their own aims and will need to commit to a programme of activity that helps them to improve, to report on their progress, and to share any outputs of the activity for the benefit of all LINks.

6.11 The DH will commission support for the action learning network and build momentum to give LINks an opportunity to engage with the

evolutionary process. This will begin creating a 'network of networks' towards a sustainable future for local HealthWatch.

6.12 The Chair of Sunderland LINk is part of the action learning network but is awaiting further guidance on how the system will work.

**Pathfinders**

6.13 A joint letter from David Behan, Director General for Social Care Local Government and Care Partnerships, and Joan Saddler, National Director for Patients and the Public was issued on 7th March 2011. The letter invited LAs and LINks to submit a funded plan by 12th May 2011 to become a HealthWatch pathfinder.

6.14 Initial discussions were held at a regional level around submitting a joint bid (South Tyneside, Gateshead and Sunderland) to become a local HealthWatch pathfinder.

6.15 A decision was taken in Sunderland not to bid for the opportunity to become a pathfinder. This decision was based on:

- Uncertainty of national availability to support the bid
- Discussions with the Sunderland LINk host, who raised concerns about the extra work that becoming a pathfinder would place on the LINk Co-ordinator and volunteers.

6.16 Learning events will be held from October 2011 and February 2012 using information from the evaluation of the pathfinders and the HealthWatch development programme.

**The DH and CQC HealthWatch Programme Board and Advisory Group**

6.17 Implementation of the Government's proposals for establishing HealthWatch is being overseen by a national HealthWatch Programme Board, supported by a HealthWatch Advisory Group, of which the Chair of the Sunderland LINk is a member.

6.18 The Advisory Group will be supplemented by one-off workshop events and a CQC online forum. Comments from the forum will be used to create reports to the Advisory Group and the Programme Board for consideration. The notes of the Advisory Board and Programme Board meetings will be accessible via the forum along with other information and updates.

**The DH and Local Government (LG) Transition Board**

6.19 This is a new Board chaired by David Behan, Director General for Social Care Local Government and Care Partnerships and includes representatives from DH and local government.

6.20 The Board will ensure system alignment moving forward into the new architecture – and this will help give HealthWatch a greater profile

6.21 It will work closely with a number of other governance mechanisms, in particular the Public Health England Programme Board and the HealthWatch Programme Board. The DH and Local Government Programme Board will provide additional advice and oversight to ensure the policy is developed and implemented in line with the broader goals of the wider reforms around local democratic legitimacy.

## 7.0 COMMUNICATIONS AND BRANDING

7.1 During 2011/12 LINks Exchange (www.lx.nhs.uk) will remain DH's primary route for sharing information, developments and opportunities for participation with LINks (and others).

7.2 DH will produce regular newsletters, including information on the progress of the legislation.

7.3 DH is also talking to other stakeholders both to ensure consistency of messaging and to make use of their wider communications channels for example CQC's online HealthWatch pages and the Local Government Group's newsletters/ bulletins.

7.4 Work to design the HealthWatch 'brand' (nationally and locally) will draw on initial work to define the HealthWatch vision. This work is being led by CQC who expect that the branding information will be available in draft form by October 2011. Meanwhile, the Department is taking steps to register the trademark. CQC hope to publish the final version in December 2011.

7.5 From Autumn 2011 onwards, a programme of local communication is planned. The focus will be on using local media and the programme will draw on successful promotional methods already used by LINks. CQC will prepare some simple promotional material that can be adapted locally by LINks and, in future, local HealthWatch.

7.6 During 2011 CQC will also consult on plans for the HealthWatch England website. CQC expects to launch the website in April 2012. In addition, during 2011 the CQC website will contain information pages on HealthWatch England.

## 8.0 NATIONAL ASSOCIATION OF LINK MEMBERS (NALM) – PREPARING FOR HEALTHWATCH

8.1 NALM has produced a report detailing information received from almost every local authority in the country around their first steps in the

development of HealthWatch. The full report is available at http://nalm.croftonite.co.uk/nalm_pdf/FIRST_STEPS_REPORT.pdf

8.2 NALM have produced a checklist which allows LAs and LINks to measure their progress towards HealthWatch. This will inform the Sunderland Workstream Plan.

## 9.0 LISTENING EXERCISE

9.1 On 6 April 2011 the Government announced that it would take advantage of a national break in the legislative timetable to "pause, listen and reflect" on the modernisation plans.

9.2 An eight week NHS Listening Exercise was announced with four core themes

- Choice and competition
- Clinical advice and leadership
- Patient involvement and public accountability
- Education and training

9.3 In relation to Healthwatch Transition the outcomes of the Listening Exercise included:-

- New requirements that the Care Quality Commission to respond to its Healthwatch England Subcommittee
- The Secretary of State will be required to consult Healthwatch England on the mandate to the NHS Commissioning Board
- An explicit requirement that local Healthwatch membership is representative of different users, including carers.

9.4 The principles of patient and public involvement at individual, local, community and strategic level were strongly emphasised throughout the Listening Exercise. The involvement included shared decision making at every opportunity.

## 10.0 NEXT STEPS

10.1 The DH plans to publish supporting documents to the Transition Plan through working collaboratively to co-produce useful material with LINks, local authorities and representative organisations, to support the successful establishment of HealthWatch from July 2012.

10.2 Consultation will be carried out in Sunderland over the transition year in order to engage diverse individuals and groups in the design and development of Local HealthWatch.

10.3 A dedicated Healthwatch transition workstream has been established. The transition will be led by Sue Winfield, Chair of Sunderland Teaching Primary Care Trust supported by Jean Carter, Deputy Executive Director, Health, Housing and Adult Services.

10.4 The workstream will include development of a workstream team including Sunderland LINks, Age UK as the host organisation and other key stakeholders in the city.

## 11.0 RECOMMENDATIONS

11.1 Early Implementer Health and Wellbeing Board is requested to receive this report for information.

11.2 Early Implementer Health and Wellbeing Board is requested to agree the proposed next steps

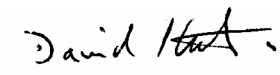
11.3 Early Implementer Health and Wellbeing Board is requested to agree to receive regular updates as the transition progresses.

NHS North East

# General practice commissioning consortia pathfinder programme application

## Contact details

| | |
|---|---|
| **Name of group of GP practices / GP consortium:** Sunderland Commissioning Consortium | |
| **Lead GP contact details:** | |
| **Name** | **Dr Ian Pattison** |
| **Designation** | **Chair** |
| **E-mail address** | **SCC@sotw.nhs.uk** |
| **Telephone number** | **0191 5297039** |
| **Signature of lead GP on behalf of group/consortium**  | |

| | |
|---|---|
| **PCT Lead Director contact details:** | |
| **Name** | **David Hambleton** |
| **Designation** | **Director of Commissioning Development** |
| **E-mail address** | **David.hambleton@sotw.nhs.uk** |
| **Telephone number** | **0191 5297907** |
| **Signature of PCT Lead Director**  | |

## GP practices Group / Consortium details

| | |
|---|---|
| **Number Practices within the group / consortium:** | 54 |
| **Patient population :** | 284, 618 |
| **Brief description of populations served:** | Sunderland is an ageing community and has some of the worst areas of deprivation in the UK and comes in at 33 on the list of all 354 local authorities in the UK. On average people in Sunderland die eight years earlier than people who live in the healthiest parts of England. 51% of children live in low income families. Nine areas have the highest health deprivation whilst Hendon and Southwick are the worst. |

| Local Authority | Practice Code | Practice Name | Practice List Size @ 01/01/11 | Number of GPs |
|---|---|---|---|---|
| Sunderland | A89001 | Dr Owen & Partners | 14458 | 8 |
| Sunderland | A89002 | Dr Bhate & Partner | 3252 | 2 |
| Sunderland | A89003 | Dr Vakharia & Hegde | 5757 | 2 |
| Sunderland | A89004 | Dr H Pepper & Partners | 12008 | 8 |
| Sunderland | A89005 | Dr Brigham | 5796 | 5 |
| Sunderland | A89006 | Dr Shetty & Partner | 6418 | 4 |
| Sunderland | A89007 | Dr Brown & Partner | 9920 | 5 |
| Sunderland | A89008 | Dr Reddy & Partners | 5334 | 3 |
| Sunderland | A89009 | Dr Lilley And Partners | 6833 | 5 |
| Sunderland | A89010 | Dr Stephenson & Partners | 12255 | 6 |
| Sunderland | A89011 | Dr Joshi & Partner | 3860 | 4 |
| Sunderland | A89012 | Dr Dixit & Partner | 4922 | 2 |
| Sunderland | A89013 | Dr J S Partington | 5552 | 1 |
| Sunderland | A89014 | Dr Mair | 1889 | 1 |
| Sunderland | A89015 | Dr Rutherford & Partners | 9265 | 6 |
| Sunderland | A89016 | Dr Ford & Partners | 7603 | 7 |
| Sunderland | A89017 | Dr Wright And Partners | 13035 | 10 |
| Sunderland | A89018 | Dr Parry & Partners | 5016 | 3 |
| Sunderland | A89019 | Dr Cloak & Partners | 9779 | 8 |
| Sunderland | A89020 | Dr Spagnoli & Partners | 8232 | 6 |
| Sunderland | A89021 | Dr Mishreki & Partners | 8934 | 8 |
| Sunderland | A89022 | Dr Mazarelo And Partners | 5320 | 4 |
| Sunderland | A89023 | Houghton Medical Group | 7594 | 4 |
| Sunderland | A89024 | Dr Mekkawy And Partners | 5652 | 5 |
| Sunderland | A89025 | Encompass Health Care | 4689 | 6 |

| | | | | |
|---|---|---|---|---|
| Sunderland | A89026 | Dr Ray | 3243 | 2 |
| Sunderland | A89027 | Dr Sharma And Partners | 6337 | 5 |
| Sunderland | A89028 | Dr Wallace & Partners | 6704 | 5 |
| Sunderland | A89029 | Dr Singh | 2115 | 2 |
| Sunderland | A89030 | Dr Hubbard | 6846 | 3 |
| Sunderland | A89031 | Dr Al-Khalidi & Partners | 5323 | 3 |
| Sunderland | A89032 | Dr K Stephenson And Partner | 5314 | 2 |
| Sunderland | A89034 | Drs Mackrell And Joseph | 3822 | 2 |
| Sunderland | A89035 | Dr Pattison & Partner | 5211 | 4 |
| Sunderland | A89036 | Drs Dhar And Kaul | 2307 | 0 |
| Sunderland | A89038 | Barmston Medical Centre | 4719 | 2 |
| Sunderland | A89040 | Dr Crummie | 2249 | 2 |
| Sunderland | A89041 | Dr Weaver | 4778 | 1 |
| Sunderland | A89042 | Church View Medical Centre | 6311 | 3 |
| Sunderland | A89603 | Dr O'bonna | 2240 | 1 |
| Sunderland | A89604 | Dr Weatherhead | 3494 | 3 |
| Sunderland | A89610 | Dr M C Hipwell | 3104 | 2 |
| Sunderland | A89611 | Dr Chhabra | 2279 | 2 |
| Sunderland | A89612 | Dr Nathan | 2172 | 1 |
| Sunderland | A89614 | Dr Widdrington & Partner | 3883 | 2 |
| Sunderland | A89616 | Dr Aiyegbayo | 1965 | 1 |
| Sunderland | A89617 | Dr Thomas | 2118 | 2 |
| Sunderland | A89618 | The Wearside Practice | 2019 | 2 |
| Sunderland | A89620 | Dr Thomas & Dr Joseph | 2805 | 2 |
| Sunderland | A89621 | Pennywell Medical Centre | 2990 | 3 |
| Sunderland | A89623 | Dr El Safy | 2597 | 1 |
| Sunderland | A89624 | Dr Bhatt | 2289 | 2 |
| Sunderland | A89625 | Maritime Practice | 1187 | 2 |
| Sunderland | Y02647 | Encompass GP Practice Two | 824 | 6 |

**Proposed date for consortium to start commissioning: 1.7.11**

## Description

**Please describe how the group/consortium will work and the scope of commissioning activities to be undertaken to benefit patients.** (This will include, for example, the organisational structure, the management arrangements and the working arrangements with the PCT during the transition)

**VISION**

Sunderland Commissioning Consortium is made up of 54 constituent practices led by a Board of 6 GPs elected by their peers. The Consortium has brought together 3 previous PBC groups. We are committed to providing excellent health outcomes for its patient population. We are passionate that these outcomes will be best achieved by developing closer and more effective working relations between primary and secondary care whilst integrating the health needs with the social and community needs of our patients.

It is envisaged that this vision aligns well with the results of the pause in the White Paper that suggest better integration of services is a driving factor to improving patient outcomes. The subsequent Pathfinder plan will ensure the development of the Consortium and it is envisaged our Pathfinder work will assist in our assurance to statutory status.

We will work in collaboration with the PCT, local providers, the Local Authority and patients to ensure that our vision is targeted via a whole system approach. We will work within the Sunderland Integrated Strategic and Operational Plan (ISOP) and also the Joint Strategic Needs Assessment. We are committed to delivering collaboratively on the local QIPP agenda and we have ensured our plans are aligned.

**PATIENT AND PUBLIC INVOLVEMENT**

We are committed to excellent patient care and it is essential that strong communication and relationships are maintained with our patient population.

We have appointed a Board lead who will actively develop a range of patient and public involvement mechanisms, working closely with a dedicated public involvement officer with experience in developing effective and productive communication methods.

The Board will be leading their first patient, public and stakeholder event in mid July, both to introduce ourselves to the Sunderland community and also to begin to ask the questions on how the public would like to be involved with the Board in contributing to future health decisions.

The Consortium members are cognisant of their unique position in communicating with patients on a daily basis and relish the opportunity of harnessing this experience in developing strong and effective ties within the community.

Our current discussion regarding possible methods of public involvement and engagement reflect our wish to ensure that public opinion is integral to our work and that the community we serve feels we are accessible and responsive to their views.

Many of our Practices have active patient groups and we are exploring the potential for these groups to supplement Board decision making processes with a geographical focus. We would anticipate these measures would be supported and extended with respect to representing communities of interest and in addressing issues of diversity and inclusivity.

**ORGANISATIONAL STRUCTURE**

A Consortium Constitution which regulates the relationship of the GP Practices with their elected leads is in development and builds on that developed by the North East Advisory Group (NEAG). An individual Practice level agreement setting out expectations of Practices as part of the Consortium has also been drafted and is about to be shared with all Practices.

The Board met with all the Practices on May 15th in an Organisation Development facilitated event to discuss our vision and organisational structure. The event was attended by multidisciplinary staff from all but three smaller practices – the most for over eight years to date. The clear consensus amongst Practices was to support the development of a sub structure of 5 geographically-based groups, co-terminus with Local Authority regeneration areas. This was identified by the Practices as aligning with our vision and provided the potential for more integrated working between primary and community health and social care. The event also identified the need for Practice Manager and Nurse representation on a Pathfinder Committee.

The five geographical groups will be accountable to the elected board and a designated Board member has been identified as the link with each group to facilitate dialogue and promote inclusiveness.

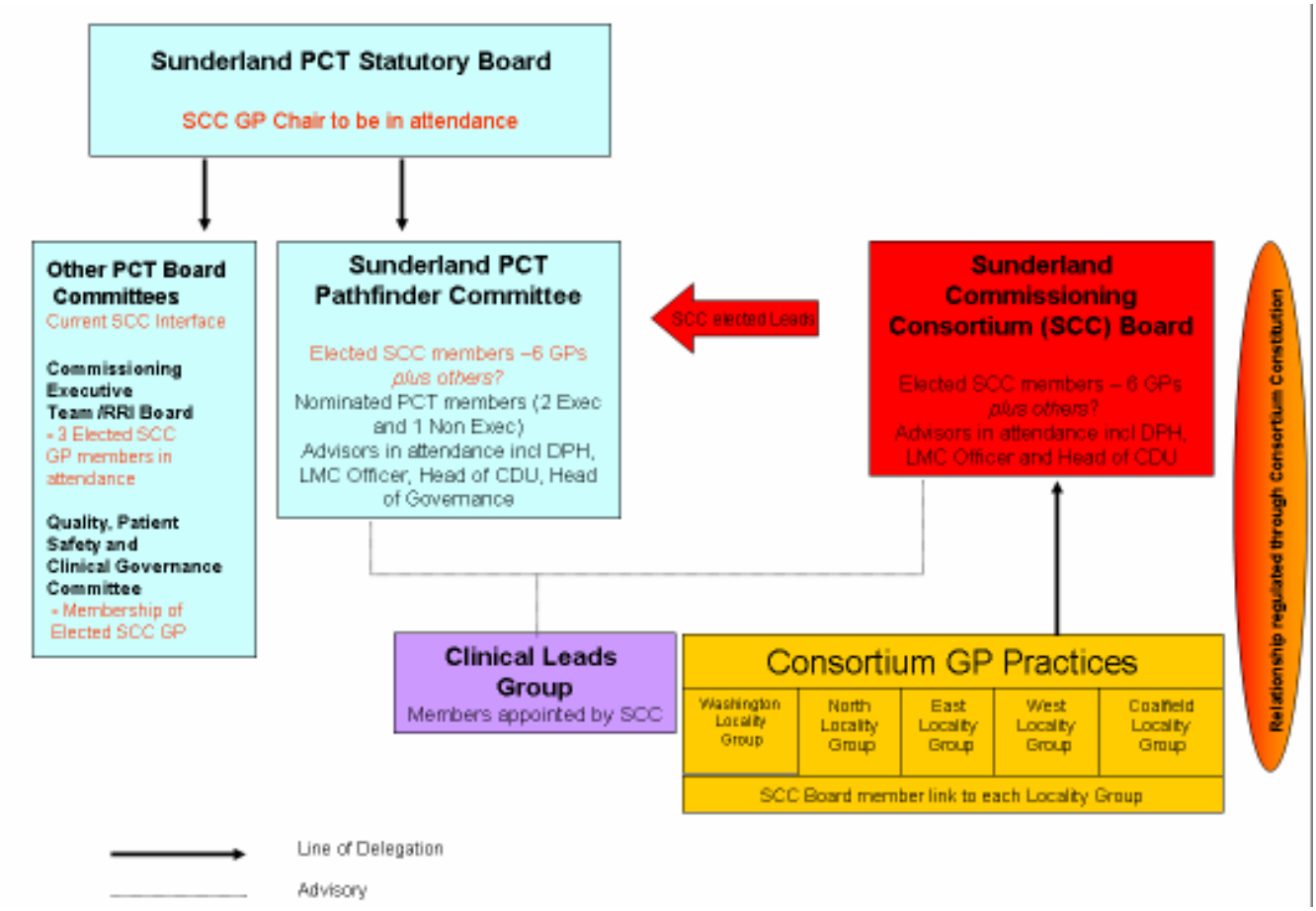
The Board has already held two protected development sessions to scope the Pathfinder application and discuss its evolution. An Organisation Development (OD) Plan is under preparation as a result and will be supported by regular board development sessions and leadership development opportunities for all Board members supported by the aligned PCT OD lead

Whilst the Director of Public Health (joint appointment with the LA), an LMC Officer and the PCT Head of Commissioning Development are in attendance at the current Board, any further extension is on hold until further information is known following the DoH response to the NHS Future conclusions. The Board however, understands and are supportive of the need to become a committee of the PCT in order to deliver the commissioning responsibilities that will be delegated by the PCT Board. The membership of the committee will include the elected GPs together with nominated PCT executive and non executive directors. Further members of advisors will be assessed in the light of the further information following the DoH response to the NHS Future conclusions. Terms of reference for the Pathfinder Committee are in a draft form building on the NEAG work to date.

The Board also supports the essential role of clinical leads with clear job roles/ objectives and clinical sub groups to support clinically led commissioning. Such roles may assist in contributing to clinical senates going forward.

We have representation on the Sunderland Early Implementer Health and Wellbeing Board which will act as a key driver for health and social care integration and ensuring the needs of local populations and vulnerable people are met. Our commissioning plans will be aligned to the City wide health and wellbeing strategy.

A skill matrix and city wide expressions of interest have been sought to support delivery of the Pathfinder application and Integrated Strategic and Operational Plan. In the interim we have supported the continuation of any historical clinical groups until they can be reviewed. All Pathfinder work streams have an aligned SCC Board lead.




The Consortium is supported by the aligned Sunderland Commissioning Development Unit within the PCT. Board members are also informing the development of the Commissioning Support Unit within SOTW and have liaised with the SHA and PCT both for the transition period and beyond.

The Chair and Vice Chair are members of the PCT Commissioning Executive team meeting on a weekly basis, along with membership of the RRI Programme Board overseeing the QIPP delivery plans.

Current GP membership of the Sunderland Contracting group (representatives from the 3

previous PBC groups) is being reviewed, recognising the new Consortium, the importance of the forthcoming contracting round, the Northeast wide review and the development path for the Consortium. Contract quality and activity reports are presented on a regular basis to the Commissioning Executive Team and the Chair has met with the Sunderland lead contracting manager to plan a way forward with any immediate pressures in the interim. To date the Chair and Vice Chair have contributed to the current years CQUIN and Penalty schedules for all major providers.

**WORKING WITH THE PCT DURING TRANSITION**

As part of the transition, we expect to be authorisation ready by July 2012 and authorised to take on statutory responsibility for commissioning no later than March 2013. To be authorised, the Consortium will need to go through due and proper process.

In terms of interim delegation of responsibility for the overall commissioning budget until we become a statutory body, the proposed timetable is set out in Figure 1 below. The total budget amount excludes the current PCT budget on areas such as primary care, specialised services and public health which will transfer to other bodies.

Figure 1 also includes a high level overview of the programme/service areas which will become the delegated responsibility of the Consortium to commission and the suggested timetable for that transfer of delegated responsibility. Day to day responsibility for service areas will be agreed with indicative amounts over time and this will increase in % terms as outlined in Figure 1. This needs to align with PCT's scheme of delegation and standing orders.

The Pathfinder sub committee of the PCT (with both executive, non executive and SCC membership) will be the committee that assures the PCT statutory board during transition.

**Figure 1** (note the budget figure is indicative, based on 10/11 and does not include any corporate budgets)

| Timeline: July 2011 | Aug 11 | Sept 11 | Oct 11 | Nov 11 | Dec 11 | Jan 12 | Feb 12 | March 12 | April 12 | July 12 | April 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Service: (none) | Prescribing | | Urgent Care | | Planned Care | | Community | | Mental Health | Authorisation Ready July | |
| Commissioning Budget transferring to GPCC: | | | | 25% (100M) | | 50% (£201M) | | | 100% (£402M) | | Authorised Consortia |

**Our initial focus and where we are currently ready to take a leadership role and responsibility will be:**

- **Improving the whole system Urgent Care response**
- **Improving the quality of care for people with COPD across the whole system as a key step to taking on more responsibility for patients with a range of LTCs**
- **Improving the quality and reducing the cost of prescribing**
- **Addressing clinical effectiveness in primary care**

This focus follows work with the Health Inequalities National Support team and the Director of Public Health to identify the factors contributing to the significant life expectancy gap in Sunderland and the worsening position for men in particular. Over 60% of the gap is as a result of Cardio-vascular disease, Cancer and respiratory diseases. Eight high impact interventions have been agreed and we will lead on four of these. All align to the QIPP agenda.

- Consistent use of beta blockers, aspirin, ACE inhibitor and statins following a circulatory event
- Systematic treatment for COPD
- Cancer awareness and early detection
- Identification and management of atrial fibrillation

The initial focus is on delivery of the 4 areas above as these are priority health requirements for the people of Sunderland and achievable within the pathfinder timeframe.

The Consortium is mindful of the target reduction of 1,388 emergency admissions in 11/12 for the Urgent Care system (equating to a saving of 2.84m) and the target reduction of 674 emergency admissions in 11/12 for the Long Term Conditions programme (equating to a saving of £2m). We will contribute to a reduction in the rising trend through the work streams outlined below. This equates to every Practice avoiding 1 inappropriate emergency admission a week.

The Consortium is also aware of the need to move towards the SHA average spend per head of population, currently 5% above average costs and will contribute to the system aim of being 3% above average for 2011/12 and 1.5% above by the end of 2012/13.

There is an imperative to improve the early diagnosis of Lung Cancer and we will contribute to the planned 10 % improvement compared to the 10/11 baseline, following NIHCE guidance. This will contribute to the NE Cancer Network target of saving 1,000 lives.

**1. IMPROVING THE WHOLE SYSTEM URGENT CARE RESPONSE.**

Urgent Care and Long Term Conditions are interdependent. People with long term conditions often present with urgent care needs at hospital. The urgent issues could have been prevented if they had access to better management and a wider range of services in the community.

We want to place a major focus on people with LTC, particularly those with COPD as well as focusing on ensuring all patients receive the right care at the right time and in the right place. This will require close working with key providers in the city, including the local Foundation Trust, South Tyneside Foundation Trust as the provider of community health services, the Out of Hours service and the primary care community.

Whilst there are a number of work streams to support the Urgent Care/LTC vision the golden thread is the need for an integrated community/primary care service, easily accessible and understandable to all.

Our vision identifies the need to move away from the current fragmentation of teams and the subsequent confusion for Clinicians and more importantly for Patients. The priority is the need for integrated pathways with secondary care and our community partners.

National policies and local pressures have led to the creation of a number of separate community teams and disintegration with primary care. However, we have started conversations with the current provider of Community Health Services, sharing our vision and clear intent for an integrated community and primary care service.

At this stage it is not envisaged that this will require any formal procurement. The intention is to work with the existing provider; building on the lessons learned from initiatives developed by the Provider, by Primary Care through PBC and via the PCT led Urgent Care and LTC networks. This work will represent a significant opportunity for clinical commissioning. Clinicians will be leading the change building on their understanding of patient need, experience of current services on the ground and a common belief that what unites Clinicians is a better deal for patients.

The current policy changes provide a major opportunity to drive forward this vision, which has a sense of urgency from all parties and is clearly recognised in the Sunderland Strategic and Operational Plan.

Sunderland Local Authority is currently and will continue to be engaged in this work and where appropriate align support services and commissioning intentions to enhance the urgent care response.

The work streams to be led by the Consortium are outlined below and are part of the Sunderland Integrated Strategic and Operational plan and Urgent Care Network plans:

- **Standard Assessment process**

  It is recognised that GPs locally are only responsible for some twenty percent of emergency admissions via A/E. However, in those cases it has been agreed that all GPs within Sunderland will follow the standard assessment process, building on the pilot developed by one of the Sunderland PBC Clusters. The outcomes from this work stream will mean that more patients who would have been referred to A/E by a GP are referred to alternative community health services. Those that do need to be seen in hospital will only arrive after having had a standard assessment including an early warning score to assist seamless care. This standard assessment process will also ensure clarity of whether the patient is being referred for advice only or admission. We expect to see some early success in this area as a result of Board leadership and the engagement of Practices.

- **Community based service for Cellulitis**

  This will enable the provision of IV antibiotics in the community. Currently patients have to be admitted to hospital for treatment principally due to lack of availability of I-V antibiotics in the community. It is envisage that we will work with current providers to allow development of a care pathway to prevent avoidable admissions.

- **Community based service for the assessment and diagnosis of suspected DVT**

  This will both improve the quality and cost effectiveness of treatment received. The pathway for suspected DVT currently involves patients attending the hospital to exclude a diagnosis of DVT. This often involves multiple attendances in order to have blood tests, administer drugs and ultrasound to exclude the diagnosis.

- **More integrated response to patients with COPD** – see section on LTC later

  We expect to see early success in this area as a result of SCC leadership and potential to engage practices.

The role of secondary care is also significant in achieving the overall vision and the Consortium through the Chair and supported by the Urgent Care Network, will lead the **remodelling of A/E** services in collaboration with City Hospitals Sunderland.

We equally recognise the role Primary Care needs to play in improving the overall outcomes for patients and the focus on people with LTC. The two key products from this work, which will be led by the Vice Chair will be:

- **Rolling out the Standard Admission Assessment to all GP Practices** including the Out of Hours Service adopting the same standard. This roll out will also provide an audit mechanism for potential future work on improving access to primary care.

- **Identification and treatment of people with AF at risk of a stroke**. The first stage of this development will be to launch the Grasp – AF toolkit across all Practices. This will enable the identification of patients at risk of a stroke who would be better managed on warfarin therapy. This will take place via partnership working with City Hospitals Sunderland (current provider of a warfarin service) responding to the increased numbers and as a result the treatment needs of those new patients will be met. The second stage will be to explore alternative ways of providing the service to improve the patient experience i.e. a community based initiation and monitoring service. This could also lead to a community based treatment for patients with DVT in addition to the assessment. We expect to see early success in this area as a result of Board leadership and the potential to engage Practices.

In summary we intend to take over the leadership of the Sunderland Urgent Care Network in the next few months with the Consortium Chair becoming the Chair of the Network

Sub measures which will help monitor our contribution to the whole system target of reducing emergency admissions will be agreed as part of the Pathfinder Delivery Plan. They will include for example: increased referrals and activity into community teams, percentage of admissions avoided due to DVT service, increased activity in warfarin clinics and a baseline to measure the impact of the Grasp AF tool on the prevention of strokes.

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## 2. IMPROVING THE QUALITY OF CARE FOR PEOPLE WITH COPD ACROSS THE WHOLE SYSTEM

We intend to be focussed on a number of key priorities as a key step to taking on more responsibility for patients with a range of LTCs. The concept of whole system working is paramount to our vision especially in relation to LTCs. The COPD work will:
:

- **Monitor and improve the quality of care provided to COPD patents in a primary care setting, reducing variation between practices. This will be over and above the requirements of QoF**

- **Improve the training and education of primary care staff**

- **Reduce avoidable emergency activity in relation to COPD through for example post-exacerbation reviews of all COPD admissions and the use of the combined predicative model to identify patients at risk of admission**

- **Improve identification of patients with undiagnosed COPD and support patients in self management**

We expect to see early success in these areas as a result of Board leadership and the potential to engage Practices

Developmental work will include the Consortium working with the PCT to ensure other services to support COPD patients are commissioned, including pulmonary rehabilitation, non invasive ventilation/oxygen and early discharge schemes

The LTC Board Lead, as a member of the LTC Programme Board will work with the PCT to deliver these changes, setting a steer and gradually taking the lead for delivering the change as appropriate. The approach will look to build on the current health/local authority project utilising assisted technology for the management of long term conditions.

Sub measures which will help monitor our contribution to the reduction in emergency admissions will be developed as part of the Pathfinder Delivery Plan. These will include for example the percentage of patients with severity recorded; uptake of influenza vaccination in patients with COPD; referrals to community teams; percentage of patients having post exacerbation reviews, number of practice staff attending training sessions; and length of stay for copd patients. Targets can be extrapolated for these measures as a result of the COPD improvement made by one of the previous PBC Clusters in 10/11.

## 3. IMPROVING THE QUALITY AND REDUCING THE COST OF PRESCRIBING

We recognise considerable potential exits for local prescribing to maximise both cost effectiveness in prescribing and in optimising the use of appropriate medicines to enhance health outcomes for patients.

The Consortium Board has appointed a Clinical Lead with delegated authority for this area of work supported by the PCT Medicines Management team. The Pathfinder will address four

key prescribing areas with early priorities and successes being repeat dispensing, and the prescribing of four drugs post MI.

- **Repeat dispensing:**

The uptake of repeat dispensing is variable across Sunderland. We plan to increase the repeat dispensing rates across Sunderland (currently 9% average) with all Practices to be doing at least 10% of all items via repeat dispensing by the end of 2011/12 and 20% by the end of 2012/13. All Practices will need to demonstrate continued uptake.

We will do this through the development of a consistent approach to materials and communication and by working with community Pharmacists to ensure that there is a streamlined patient journey. The Prescribing lead has recently participated in a RPIW on this issue and is committed to taking the agenda forward.

Evidence suggests that in addition to improving patient care, the repeat dispensing process reduces waste medicines. Patients are, when stable, ideally suited to the repeat dispensing process. Whilst it is not possible to quantify this impact in advance it clearly aligns with the QIPP agenda.

This initiative will be monitored by the number of prescribed items dispensed via repeat dispensing as a proportion of all items dispensed on an individual Practice basis.

- **Four Drugs Post-MI: aspirin, beta-blocker, statin and ACEI**

Sunderland has higher than average morbidity and mortality from cardiovascular disease. Working with our public health partners it was highlighted that only 57% of post-MI patients currently receive all four drugs indicated which impacts on quality of life and life expectancy. 18% have apparent contraindications and the remaining 25% are on 3 drugs or less.

We believe the rate of contraindications is overly high and aim to increase numbers treated appropriately at Practice level. The improved quality of care resulting from this measure will not be immediate but is predicted to have an effect as early as 2-3 years hence.

The work can be achieved by Practice staff in conjunction with Pharmacy Support teams and will be overseen by the Prescribing Lead helping Practices understand their baseline and level of improvement. We aim to have a minimum of 80% of patients on all four drugs. And the new QOF indicator will act as the outcome measure for monitoring purposes.

We expect to see early success in both these initiatives because of Board leadership and the potential to engage Practices.

- **Moving spend per head of population**

The average spend per head of population within the Sunderland area is higher than Gateshead, South Tyneside and the Strategic Health Authority average. It has been estimated that there is the potential to free up around £2 million over the next 4 years (QIPP target) by moving towards more cost effective drug choices within Sunderland. These savings may be reinvested within the drug budgets for patients who need to have medication prescribed without compromising the drug budget or having to draw on other areas of

expenditure for support.

Supported by the PCT Prescribing Advisor we will develop a cross Sunderland action plan that can be delivered through the geographical groups to ensure implementation and peer review of prescribing.

Measures are available at an individual Practice level relating to spend per head of population and spend on specific drugs and or drug groups which may be useful in the case of outliers.

- **Care Homes Review**

CHUMS (Care Homes Use of Medicines Study 2009) reported on the high incidence (~70%) of prescribing errors in care homes (prescribing, dispensing, administering and monitoring).

Prescribing errors are also a common reason for hospital admissions in this vulnerable group. Work has already been done by a previous PBC group with the aim of reducing waste and encouraging safe and efficient medicines management. Consequently significant savings were generated.

At present there is no existing system for the remaining care home population in Sunderland. We want to consider this issue an area for development over the next few years, recognizing there will be a need to maximise the productivity of the Pharmacy Support team and ensure good communication with Practices. The work is likely to be linked to a Practice incentive scheme. Key measures to monitor progress would be the number of reviews undertaken and the number of interventions recommended which are fully acted on. Once we have a better picture of the numbers across Sunderland, targets will be set as part of the Pathfinder Delivery Plan.

This work will be enhanced by working with Sunderland Local Authority as the main commissioners of care home provision**.**

**4. TAKING A LEAD ROLE IN ADDRESSING CLINICAL EFFECTIVENESS IN PRIMARY CARE**

Clinical Effectiveness is defined as clinical intervention which can result in improving heath and securing the greatest possible health gain from the available resources.

A clinical effectiveness programme can be divided into three sections:- Inform, Change and Monitor

Inform: - Identifying information on clinical effectiveness and evidence based practice and sharing the information with local Practices

Change:- Changing practice to comply with well founded information
e.g. to reduce the variation between Practices and achieving higher standards

Monitor:- Assessing improvement against the set standards

Clinical effectiveness is a key component for whole system working and seamless patient pathways. It also has a partnership role with education and can help support professional

development.

The focus for the Pathfinder year will be:

- Four drugs post MI (as noted under the prescribing section)
- COPD treatment (as noted under the COPD section)
- Early identification of lung cancer.

Lung cancer is one of the commonest causes of cancer death and accounts for high death rate among males. One year survival rate is below 30% and late presentation is common, hence low resection rates. There are identifiable barriers to early diagnosis including access to primary care, GP awareness and belief about lung cancer, referral for Chest X Ray, safety netting, continuity of care, mechanisms to follow abnormal results and dealing with unresolved symptoms.

Early priorities are:

- Raising awareness of lung cancer among patients over 50 yrs attending COPD, CVD and Smoking Cessation clinics
- Education event with all Practices about early diagnosis of lung cancer
- Following NICE guidance to refer a new cough lasting over 3/52 weeks

As a result of the above interventions, we anticipate an improvement of diagnosing early disease, contributing to the 10 % system target.

Supporting measures to measure the our contribution to the achievement of the high level indicator will be developed in the Pathfinder Delivery Plan but are likely to include:

- 80% of those attending COPD, CVD and Smoking Cessation clinics are given national "Be Clear On Cancer" Campaign/ local Health Promotion leaflets to be measured through Practice read codes
- 100% Practice attendance of education events
- Increased number of Chest X Rays carried out by 5% in 2011/12
- Increased number of appropriate two week referrals for suspected lung cancer by 10% in 2011/12
- Reduced number of emergency presentations for lung cancer by 10% in 2011/12
- Increased number of T1 or T2 Lung cancer staging by 5% in 2011/12

We expect to see early success in these initiatives because of Board leadership and the potential to engage Practices.

**ENGAGEMENT OF PRACTICES**

The engagement of practices in all our objectives will be the responsibility of the Consortium Board Leads, working with their 5 geographical delivery groups and encouraging peer support in the groups. They will be supported by the synergy created from directing the new Quality and Productivity Indictors wherever possible to the goals we want to achieve as a Pathfinder. For example the new emergency admissions indicator 11 could be used to support the use of the standard assessment tool and integrated community teams. We will also use the local commissioning incentive scheme; the local prescribing incentive scheme; and educational opportunities through the protected learning time bi monthly programmes.

## Local GP leadership and support

**Please describe evidence of existing local GP leadership and support (or how this will be achieved if this is not in place)**

The LMC facilitated the approach to the development of the Consortium. The process started in September 2010 with a large open meeting for GPs and Practice Managers. Meetings also took place with all the previous PBC Groups along with consultation with local and national GP colleagues. This activity also involved close working with the PCT. All Practices were kept fully informed throughout. The LMC then organized a survey in December/January 2010 to all GP Practices on the future of GP Commissioning. The survey included a range of questions including the level of interest in forming one single Commissioning Consortium for Sunderland and the process for securing the Board. The response indicated clear support for the direction of travel recommended by the LMC which included the desire for one Consortium and an election process for GPs.

Following the survey, the LMC sought nominations from GPs to the Board. There were 12 candidates for 6 vacancies and the election saw a 63% response rate. The first meeting of the Board took place late March 2011.

As a result the Board is made up of the following elected GPs:

- Dr Ian Pattison (Chair)
- Dr Iain Gilmour (Vice Chair)
- Dr William Arnett
- Dr Jacqui Gillespie
- Dr Henry Choi
- Dr Gerry McBride

The first event with all Practices in mid May had 180 attendees (the most popular protected learning event to date). Excellent feedback was received on our initial work and a lot of interest in continuing communication with Practices. This was followed up with a full afternoon event on the 15th June with all Practices. The event sought further engagement in the Pathfinder proposals and in developing a joint vision for the Consortium through exploring the potential for commissioning. It was also an opportunity to bring the Practices together for the first time in their geographical groups.

195 people attended and heard from each of the Board members about the Pathfinder proposals and developments within Prescribing. The feedback was again excellent with Practices keen to engage with the Consortium to deliver our vision and early priorities. The Practices were equally keen to influence the commissioning of a range of services including community nursing and mental health.

Each of the Board members has leadership experience along a spectrum. Three of the members have led previous PBC groups and worked with the current PCT Executive team, one of whom was a PEC member and part of the WCC assurance process. The remaining three members have occupied roles as Clinical Leads, leading service change in particular pathways including LTC; Cancer, Diabetes, CVD and Prescribing. One member is also a GP

tutor supporting the education and training of fellow GPs. Two others are members of NE Networks e.g. Cancer and CVD. Each is also keen to explore their own personal development needs in relation to corporate and leadership roles.

The Board is also supported by two others in attendance, including the LMC Secretary and the Director of Public Health for Sunderland. Both contribute a lot of leadership experience, with the LMC Secretary having previously been a PCG Chair and a Chair of a PBC Group. The DPH is a member of the PCT Commissioning Executive team and the Local Authority Sunderland leadership team.

The Chair participates in the NEAG and is a member of the NE Transition Board influencing the direction of travel and accessing support for the Consortium. The Chair also meets with the other two GPCC Chairs in the SOTW area and the LMC and PCT Chief Executive, Medical Director and Director of Commissioning Development on a monthly basis to support the transition.

We are keen to access support via the PCT and are working closely with its aligned development team, OD lead and strategic leads for strategic priorities, accessing specialist support from PCT teams where required e.g. the medicines management team and prescribing support. This will further develop over the transition to April 2013 and the dissolution of the PCT as we are keen to retain the knowledge, skills and experience of particular PCT teams.

## Local authority engagement

Please describe evidence of existing local authority engagement（or how this will be achieved if this is not in place)

A fundamental part of the development of our Consortium is the establishment of the 5 geographical delivery groups.

Whilst a number of options for such groups were presented by the Board to its constituent Practices, our preference was to link with the Local Authority Area Regeneration Frameworks. This was supported by the Director of Health, Housing and Adult Services. Whilst this number and make up provide a manageable delivery mechanism for the Board, one of the key reasons it was suggested is the potential it provides for closer working with the Local Authority in neighborhoods and for more integrated responses to patients from front line primary and community teams – the key vision for the Consortium.

The geographical groups are just forming, however, the intention is to discuss further with the Local Authority, extending the membership to their staff and community staff. Equally to consider Practice representatives engaging with the Area Regeneration committees, informing the local area generation plans. This approach recognizes achieving a number of key health outcomes will require the joint efforts of both the Local Authority and Health bodies.

In addition the Chair of the Board has met both the Leader of the Council and the Director of Health, Housing and Adult Care on an informal basis and is due to meet with both parties and the Chief Executive on the 20th June. A further meeting is being planned with the Director of Children's Services.

Meetings have also taken place with the Deputy Director of Health, Housing and Adult Services, along with the Head of Personalization and the Head of Care and Support to explore opportunities for joint working and synergy in the delivery of the Pathfinder objectives. Our vision was positively received, building on the positive experience of the Unique Care Project – a joint project between Social Services, Community Services and one of the PBC Clusters.

Information is being shared about Board Leads for geographic groups and Social Services leads for assessment and support teams are profiling the pattern across the geographic groupings. This will include children's services who are also organizing around the Area Regeneration frameworks.

The Director of Public Health has been a key influence on the Pathfinder particularly the need to focus on health outcomes and as a joint Local Authority/PCT appointment has also brought the Local Authority perspective to our Board.

The Chair is also a member of the Chief Officer Group established to oversee the development of the Sunderland Early Implementer Health and Wellbeing Board. Wider GP involvement in this group is expected.

The Chair and Vice Chair of the Health Scrutiny Committee have also been briefed about the development of the Consortium and the Commissioning Development Unit and the Director of Public Health interface with the Committee on a regular basis.

A six month stock take meeting between the PCT, the Consortium and the Local Authority to discuss progress with the Integrated Strategic and Operational Plan including RRIs is also being planned, following on from the recent joint meetings.

## Delivery of the local quality, innovation, productivity and prevention (QIPP) agenda

**Please provide evidence that the group / consortium has taken greater responsibility and involvement in the QIPP agenda**

The Chair and Vice Chair are members of the Commissioning Executive Team meeting which oversees key commissioning decisions and business including keeping an overview of the Integrated Strategic and Operational Plan deliverables/ QIPP agenda. Once a month the meeting takes on the role of the Programme Board for the specifics of the QIPP programme, monitoring progress on targets and lessons learned.

Whilst the Strategic Plan needed to be submitted by mid March just as our Board members were being elected, four events were held with Clinical Leads including all those up for election. The Leads supported the direction of travel within the Strategic Plan including the Sunderland QIPP proposed savings and investments. Half of our current Board members participated and all Board members have since had an update on the QIPP agenda for Sunderland as part of our Board Development day.

The Board also recognises the need to work with the PCT on the transition to April 2013. To date our priority has been to form the Sunderland wide Consortium, keeping Practice engagement in this, recognising the historical fragmentation of primary care in Sunderland.

More recent Board focus has been on the key work streams within the Pathfinder and how they contribute to the QIPP agenda (described below). However we are aware that our future clinical leads will need to engage with all the current priorities in the Strategic Plan as part of the transition arrangements.

We are aware of the contribution made to this agenda by the previous three PBC groups and have built on the lessons learned particularly the refocused PBC Plans from the last two quarters of 2010/11. These Plans targeted the rise in emergency admissions. For example one of the three groups made significant headway in standardising the copd pathway in primary care leading to a 12% reduction in emergency admissions over the year.

Another PBC group piloted the Unique Care programme and saw a slower rise in emergency admissions that the rest of the Practices across Sunderland. The third PBC group required all Practices to actively review their emergency admissions. The findings which included best practice are currently being considered by the Sunderland Urgent Care Network and the LTC/Urgent Care Commissioning group and have informed this expression of interest.

Board members are also members of the SOTW strategic LTC and Urgent Care programme Boards and the Sunderland wide Prescribing Board

**Please describe proposals to contribute to the QIPP agenda in your locality**

Our four work streams all align to the local QIPP agenda as can be seen in our contribution to the high level KPIs noted earlier.

In relation to reducing the trend in emergency admissions (Urgent Care and LTC QIPP programmes), it is recognized that our initial priority work streams in this area will not be responsible for achieving the whole of the target. It would be unwise to try to allocate a proportion of the target as the agenda in these areas is complex. The priority is that our activity has been agreed as a crucial part of the Network activity due to our engagement of primary care. In addition over the next year we will take on clinical leadership of the Urgent Care Network.

We also recognise the Local Authority contribution to this particular aspect of the QIPP agenda in the form of reablement services and intermediate care provision which are a large part of the Sunderland health and social care provision.

In relation to prescribing, currently Sunderland is experiencing 5% cost growth against uplift of 2% (£1.5m gap) over and above the QIPP target of 500k for this year. A number of PCT led plans are in place to address the growth, including the four initiatives we will be leading. However the Consortium will also be a key mechanism to wider Practice engagement in all the prescribing initiatives. As a result we will be contributing to the overarching aim to move the spend per head of population nearer to the SHA average and this includes the £500m QIPP programme.

In relation to the Lung Cancer high level indicator, this work is not part of the QIPP programme on Planned Care for 11/12, as the QIPP initiatives in 11/12 focus on outpatient reviews. However, Board members have informed the outpatient work as part of the Contracting Group with the PCT and further work is due to take place on the Planned Care QIPP programme for 12/13.

We are also working with the PCT on a proposal to change the monthly SOTW RRI Programme Board meeting into a Sunderland specific meeting as part of the Consortium Board meeting on a regular basis. This will support our commissioning development and the transfer of responsibility for the QIPP programme.

Further information is outlined below as evidence of how our priority work streams will inform the current QIPP progammes:

- Evidence suggests that in addition to improving patient care, the repeat dispensing process reduces waste medicines as a result of the proactive intervention of community pharmacy. The potential to decrease the number of days supply of medication, also means unnecessary medicines wastage should be reduced

- A cross Sunderland prescribing action plan supported through the 5 geographical groups will ensure implementation and peer review of prescribing activity. The savings generated will support the Medicines Management QIPP programme for Sunderland. The work in Care Homes to reduce prescribing errors building on a pilot last year, will generate significant savings and reduce the number of hospital admissions in this vulnerable group

- The treatment of AF with warfarin reduces the risk of stroke by 50—70% which is projected will equate to 64 stokes per year in Sunderland. The estimated cost per stroke due to AF is £11,900 in the first year after stroke occurrence (of which 4k is the cost of the emergency admission). The total cost of maintaining one patient on warfarin for one year including monitoring is £383. The current pathway for suspected DVT patients involves patients attending the hospital to exclude a diagnosis of DVT. Patients often have 0-1 day length of stays to be diagnosed which costs from £413, within primary and community teams this cost could be greatly reduced

- Use of the standard assessment/admission process and form by all Sunderland GPs will enable faster turn around of patients by A/E. This will also mean avoiding admission when advice only is required and saving time when early warning scores are already available

- The whole system work to reconfigure A/E supported by the review of MIUs and integration of the community teams will ensure GPs are more likely to use the community services. This will also enable more appropriate use of A/E leading to a reduction in emergency admissions and length of stay. Effective and appropriate urgent care is also key to providing a whole system approach to patients with long term conditions

- People in Sunderland are 51% more likely to be admitted to hospital with COPD than the national average. Sunderland also has the 6$^{th}$ highest rate of COPD prevalence in the UK and length of stay is higher than the UK average (7-8 days longer). COPD is also the 2$^{nd}$ most common cause for emergency admissions. The LTC/COPD work will enable a more preventative approach, maximizing self management and joined up care. It will also enable the identification of high risk patients and implementing appropriate and personalized care plans, all of which will lead to less hospital admissions, readmissions and reduced length of stay

- Earlier diagnosis of lung cancer will result in reducing the burden of disease and increase life expectancy. Productivity will be increased by maximizing the opportunities of current COPD, CVD and Smoking Cessation clinics where 80% of those with lung cancer will attend

**Please complete and return to Richard Barker, director of commissioning development at North East Strategic Health Authority**
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