Appendix 1

NHS
North East &
North Cumbria

Programme/Workstream plan:	Sunderland Place Plan
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Date:	May 2023

Summary: Please outline the scope of the plan, the longer-term ambition, and what you plan to achieve. Also summarise the key deliverables and impact in support of the NENC ICP Health and Care Strategy and national guidance where relevant, e.g. the NHS long term plan. ** no more than 500 words**)

The Sunderland Place Plan has been co-produced with local system-partners to create a clear and compelling document that consolidates national, regional and local ambitions for health and care integration, with specific alignment to the NHS Long-term Plan, NENC Integrated Care Strategy ('**Better Health and Wellbeing for All'**) and the Health and Wellbeing Strategy for Sunderland ('**Sunderland's Healthy City Plan'**). The overarching vision for this plan reflects Sunderland's ambition to ensure that:

"Everyone in Sunderland will have healthy, happy lives, with no one left behind"

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

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

Priorities

Sunderland's priorities are:

- **Strengthening primary and community care**
- **Enabling people to live and age well**
- **Ensuring the best start in life for children and young people**
- **Transforming mental health, learning disability and autism services**
- **Delivering place-shaping innovation and sustainability through investment in critical system-enablers**

These priorities are supported by an overarching policy objective to **prioritise NHS action on prevention and tackling of inequalities, with a specific focus on delivering Core20Plus5**. This has been included as an over-arching policy objective to ensure prevention and a determined focus on tackling inequalities is considered across all priority areas in-line with the **NHS Long-Term Plan** and **Better Health and Wellbeing for All Strategy**. This will additionally support a more systematic approach to prevention and inequalities with key system partners, as set out within Sunderland's **Healthy City Plan**.

Key Deliverables

As a result of delivering on Sunderland's Place Plan, Sunderland residents and health and care system can expect:

- More streamlined access to **community-centred** and **asset-based care** that places **equal value on mental and physical health.**
- Increased access to **proactive and personalised care**, effectively managed through multi-disciplinary team working that puts the patient at the centre.

- A joint-up, community-led approach to the prioritising of **prevention, tackling health inequalities** and influencing the **wider determinants of health.**
- A **skilled, compassionate and sufficient health and care workforce** that benefits from inclusive and diverse employment opportunities, strong system leadership, dynamic learning and development opportunities, and improved access to workplace health and wellbeing.
- Improved use of **digital technology, integrated commissioning, research and intelligence, and integrated estates,** in the delivery and development of sustainable health and care innovation.

Partnership working – please describe how partners have been engaged in developing the plan, the partnership working structure and where applicable the current governance, and how this might further mature or strengthen, e.g. ICS work streams or place based committees.

Sunderland's Place Plan has been co-produced with a wide range of multi-sector partners with a shared ambition to deliver on Sunderland's vision for health and wellbeing. The plan was developed with the support and leadership of **Sunderland's Health and Wellbeing Board**, and benefits from input across health, social care, public health, housing and the voluntary and community sector.

Leadership and oversight of Sunderland's Place Plan will be provided by the newly-establish **Sunderland Place-Committee**, which will meet monthly 'in-common' with the **Sunderland Health and Care Partnership Board** to provide strategic oversight of key deliverables that require shared delegations and joint exercising of functions with Local Authority partners. The leadership function is supported both strategically and operationally by two **collaboratives** for both adults and children's health and care integration, as set out in fig 1 (below). Each priority area has been assigned to a transformational group within the adult and children's collaborative arrangement, to ensure there is operational oversight of each priority area.

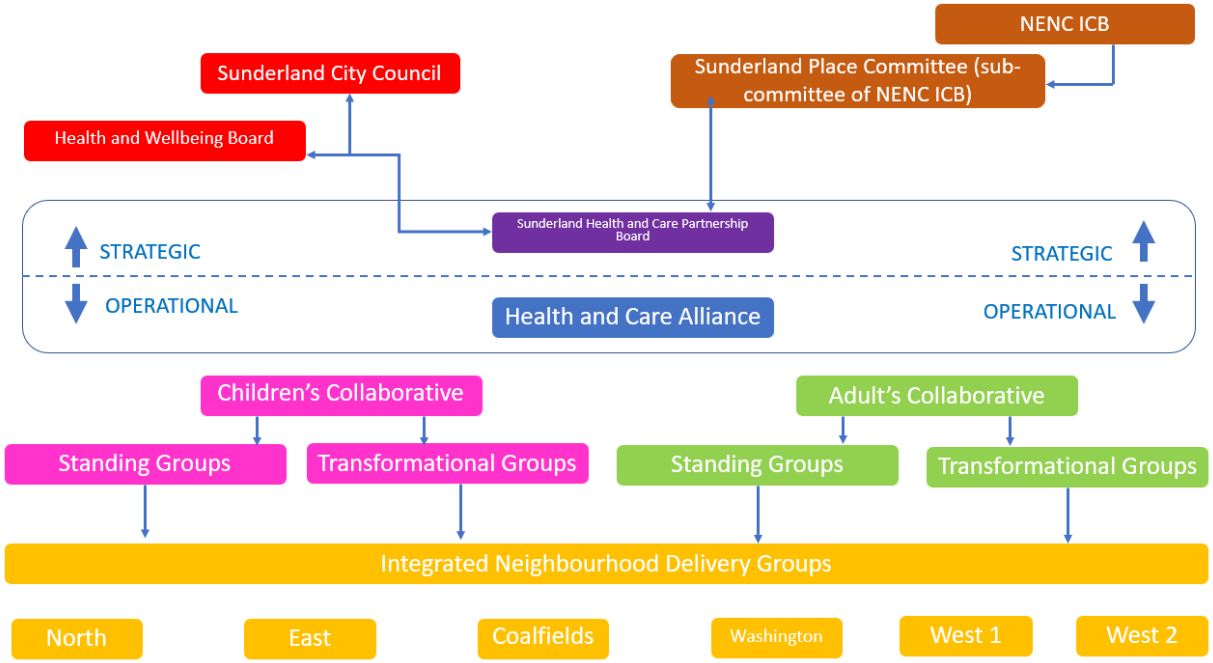

Fig 1.1: Sunderland's Place-based Governance Model

The Sunderland Place-Committee will lead on the oversight of the Sunderland Place Plan, which is supported by a Place Committee work programme that includes:

- monthly and quarterly reviews of Place Plan deliverables and KPIs (respectively)
- periodic 'deep dive' reviews of priority themes – applying a person, place and population lens to each priority area in order to strengthen action on community co-production and asset-based development
- annual Place Plan refresh
- associated learning and development opportunities

Alongside place-level governance, Sunderland's Place Plan will be supported by strategic ICP and ICB sub-committee arrangements to support system-level working and promote increased place-level assurance as set out below:

Priority	ICB Sub-Committee Alignment	Strategic ICP
Priority 1: Strengthening primary and community care	• Primary Care Strategy and Delivery • Medicines Optimisation • Healthier and Fairer Advisory Group ○ Health Care Inequalities	**Central Area ICP**

Priority 2: Enabling people to live and age well	• Healthier and Fairer Advisory Group
	  ○ Health Care Inequalities
	  ○ Prevention	

Priority 3: Ensuring the best start in life for children and young people	• Healthier and Fairer Advisory Group
	  ○ Health Care Inequalities
	  ○ Prevention
	• Mental Health Learning Disabilities and Autism	

Priority 4: Transforming mental health, learning disability and autism services	• Mental Health Learning Disabilities and Autism • Healthier and Fairer Advisory Group ○ Health Care Inequalities	

Priority 5: Delivering place-shaping innovation and sustainability through investment in critical system enablers	• Research and Innovation Steering Group
	• Healthier and Fairer Advisory Group
	  ○ NHS support to broader social economic disparities
	  ○ Population Health Management (enabling programme)
	  ○ Community Asset-Based Approach (enabling programme)
	  ○ Workforce Development (enabling programme)	

Key stakeholders - please list the groups/types of stakeholders that are important in jointly developing and delivering the plan.

Strategic Planning and Delivery Partners	Assurance/Accountability	Wider Stakeholders
NENC ICB Executive	NENC ICB Executive (and respective sub-committees)	Members
All Together Better Executive	Sunderland Health and Wellbeing Board	Care Homes
Sunderland City Council	Sunderland Cabinet	Schools, colleges and further education
Sunderland Care and Support	Safer Sunderland Partnership	Housing Providers
Together for Children	Carers Strategy Board	North-East Combined Authority
Sunderland Voluntary Sector Alliance	Patient participation Group	Media/press
South Tyneside and Sunderland NHS Foundation Trust		
Cumbria, Northumbria and Tyne and War Mental Health Trust		
GP Practices and Primary Care Networks		
Lead Members/Portfolio Leads		
Sunderland Health Watch		
Sunderland University		

Priority 1 – Strengthening Primary and Community Care

Why is change needed?

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

Through a stronger and more integrated primary and community care offer, Sunderland residents will benefit from key deliverables outlined in section 1, as part of a localised approach to the implementation of the Fuller Stocktake recommendations and national delivery plan for recovering access to primary care and key elements of the recovering urgent and emergency care services plan. This will be heavily supported by Sunderland's **Better Care Fund** plan and associated trajectories for reducing preventable admissions, better managing the transfers of care and promoting improved integration between health and housing.

A strengthened primary and community care system will bring care closer to home and reduce preventable and avoidable demand within elective, emergency and long-term care provision, enabling people to stay healthier, happier and more independent for longer.

As with the totality of the Sunderland Place Plan, action on strengthening primary and community care will be underpinned by a determined focus on prevention and tackling health inequalities - ensuring variation in demands and outcomes are systematically addressed through place-level action to increase service capacity and choice, and new opportunities to promote self-directed care. This will be supported by cross-cutting enabling priorities outlined in priority 5 of the Sunderland Place Plan.

Objectives –	
Objective 1	Implement an integrated and equitable model of **personalised care** with a specific focus on embedding the Sunderland '**Links for Life' Social Prescribing model** across the City.
Objective 2	Support local implementation the '**Delivery Plan for Recovering Urgent and Emergency Care Services'**, with a specific focus on building equitable community-based capacity through **integrated neighbourhood teams** and co-location of **Urgent Treatment Centre** (UTC) with **GP Out of Hours** (OOH)
Objective 3	To develop and implement local plans to support the national '**Delivery Plan for Recovering Primary Care'**, and the recommendations of the Fuller Stocktake, to support improved access and experience of general practice for our citizens.
Objective 4	Support the successful achievement of the **Sunderland Better Care Fund** priority metrics, with a specific focus on implementing high impact change approaches for: **managing the transfers of care**, **preventing avoidable admissions** and strengthening the links between **health and housing**
Objective 5	Engage with the public, patients, clinicians and pharmacy professionals across Sunderland to reduce the inappropriate use of medicines and overprescribing to support sustainable approaches to **medicines optimisation,** including driving targeted medicines actions in health inequalities improvement via Core20Plu5 approach

	Goals – These should be the measure, in numbers, of an improvement to deliver the objective. The description of the goal means the definition of what is being measured, for example 'improve waiting times for X service', or 'improve the dementia diagnosis rate' or 'reduce inappropriate prescribing of antibiotics'. Where are you now is the most recent baseline. The target is the numerical level you want to achieve, 5% improvement or 10% reduction. When you aim to get there is simply the date you intend to achieve the target. Using the mental health objective above the goal might be 'increase the number of mental health school support teams from (x) number to (y) number by the end of 2025/26.

	Description of Goal	**What is being measured?**	**Where are you now?** Baseline, with a date.	**What is the target?** Number or percentage	**When do you aim to get there?** A date
Goal 1 – Personalised Care	Improved access into **social prescribing** support	Percentage of patients referred into a Social Prescribing Service	Baseline to be conformed in 2023/23	10% year-on-year increase in access	Annual increase in access to be observed each year
Goal 2 – Recovering Urgent and Emergency Care	Reduced number of **preventable admissions**	Indirectly standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patients	271 per 100,000 (average 21/22)	TBC	2025/26
Goal 3 – Recovering Primary Care	Improved **access into GP** practices	Percentage of patients accessing appointments, with a suitable clinician, in a timeframe that best fits their needs	Baseline to be established 2023/24	>95%	2025/26

Goal 4 – Delivering BCF ambitions	Discharge to usual place of residence	Percentage of people, who are discharged from acute hospital to their normal place of residence	89.2%	91%	2024/25
Goal 5 – Medicines Optimisation	Reduction in antibiotic prescribing	Percentage reduction in antibiotic prescribing	Baseline TBC	Target to be set regionally	Target to be set regionally

Initiatives – Key deliverables. Please list the key improvements you intend to deliver, and indicate whether this will be in Q1, 2, 3 or 4 of 2023/24 or in subsequent years. This should be a tangible milestone, using the mental health example above under objectives a milestone might be roll out of mental health school support teams in x and y Place in 2024/25.
As far as possible please avoid process measures, like we will agree terms of reference for our sub group, these are important but we are looking for genuine deliverables.

		23/24				24/25	25/26	27/28	28/29
Item	**Deliverable description**	**Q1**	**Q2**	**Q3**	**Q4**				
1.1.1	**Personalised Care:** Implementation of the digital community supported self management platform for social prescribing and wider community-based referrals								
1.1.2	**Personalised Care:** Successful implementation of Phase 2 of Sunderland's Links for Life Social Prescribing model								
1.1.3	**Personalised Care:** Successful implementation of Phase 2 of Sunderland's 'Links for Life' Social Prescribing model								
2.1.1	**Recovering Urgent and Community Care:** Implementation of integrated UTC/OOH model of delivery								
2.1.2	**Recovering Urgent and Community Care:** Implementation of new in-hours GP model within recovery at home service								

2.1.3	**Recovering Urgent and Community Care:** Implementation of new community bed-based model for discharge								
2.1.4	**Recovering Urgent and Community Care:** Implementation of transfer of care hub								
3.1.1	**Recovering Primary Care:** Agree alternative delivery model for same day access hub, at-scale provision of services and improved continuity of ongoing care								
3.1.2	**Recovering Primary Care:** Local implementation of Primary Care Recovery Plan (placeholder subject to development via regional working group)								
3.1.3	**Recovering Primary Care:** Implement approach to increase GP to Pharmacy Consultation Service								
3.1.4	**Recovering Primary Care:** Roll-out of communication toolkit to support patients to access and navigate primary care locally								
4.1.1	**Better Care Fund:** Obtain annual Health and Wellbeing Board sign-off of Sunderland's BCF plan								
4.1.2	**Better Care Fund:** Agree (and annually renegotiate) a section 75 partnership arrangement with Sunderland City Council to underpin pooled budget and joint delegations within the Sunderland BCF (2023/24-2024/25)								
5.1.1	**Medicines Optimisation:** Implement the NENC ICS Transformative Outcomes-Based Programme for Medicines								

Priority 2 – Enabling People to Live and Age Well

Why is change needed?

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

The UK population is anticipated to grow to over 74 million by 2039, with an increased proportion of older people. Sunderland's JSNA demonstrates that long-standing health issues translate into Sunderland residents living shorter lives with more years in poorer health than other parts of the country. Preventable deaths (including cardiovascular, respiratory, cancer and excess winter deaths), alongside social isolation and fuel poverty, are unequally distributed across Sunderland, requiring more **proportionate-universalist** approaches to prevention, early intervention and screening.

The ICB has a unique role to play in regard to focused action on **secondary** and **tertiary prevention -** maximising opportunities to support early identification and health promoting intervention to address key contributors of poorer health outcomes, such as tobacco, alcohol, substance misuse, unhealthy weight and delayed diagnosis. Using the **Core20Plus5** framework, alongside specific action on **dementia diagnosis**, **frailty** and **palliative** and **end of life care**, Sunderland aims to support more **personalised** and **anticipatory care** approaches to reduce avoidable demand and - more crucially - support people to remain healthier and more independent for longer.

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

Objectives –	
Objective 1	Implement the ambitions of the national **Palliative** and **End of Life Care** Framework
Objective 2	Implement **anticipatory care** across integrated neighbourhood teams with an initial focus on frailty and those aged 65 years and over
Objective 3	Undertake a population health management approach to improve prevention, screening, diagnosis and treatment of **cardio-vascular** and **respiratory disease, cancer** and **type 2 diabetes** with a specific focus on **Core20Plus5** population groups
Objective 4	Develop and implement a **High-Frequency User (HFU) strategy** for people with multiple complexity, underpinned by a comprehensive, multi-disciplinary **personalised care** approach.
Objective 5	Identify the core impacts of the **cost-of-living crisis** on health and care outcomes and implement a local action plan aligned to Sunderland's Financial Wellbeing Strategy

Goals					
	Description of Goal	**What is being measured?**	**Where are you now?**	**What is the target?**	**When do you aim to get there?**
Goal 1: Palliative and End of Life Care	Improved quality of **palliative** and **end of life** care provision	Percentage of outcomes within the palliative and end of life framework scoring a level 4 or above	TBC	100% Level 5	2025/26

Goal 2.1: Anticipatory Care	Reduction in length of hospital stays as a result of improved access to **anticipatory care**	Percentage point reduction in patients with weighted average hospital stay of 14+ days	11.59%	9%	2025/26
Goal 2.2: Anticipatory Care	Reduction in falls admissions as a result of improved access to **anticipatory care**	Emergency hospital admissions due to falls in people aged 65 and over	2,710	2,100	2025/26
Goal 3.1 CVD	Reducing preventable **CVD** mortality	Reduction in under-75 mortality rate from **cardiovascular disease** considered preventable	34.6	30	2025/26
Goal 3.2 Respiratory	Reducing preventable **respiratory** related mortality	Reduction in under-75 mortality rate from **respiratory disease** considered preventable	33.5 per 100,00	TBC per 100,000	2026/27
Goal 3.3 Cancer	Increase in **early cancer diagnosis**	Increase the percentage of people diagnosed at the early stages of cancer (stage 1 and 2) to the	51.6%	>75%	2027/28

		national target of 75% by 2028			
Goal 3.4 Cancer	Reduction in **cancer** mortality considered preventable	Under 75 mortality from cancer considered preventable	73.7 per 100,000	TBC per 100,000	2026/27
Goal 3.4 -Diabetes	Reduction in undiagnosed **Diabetes**	Estimated prevalence of undiagnosed diabetes in Sunderland as a proportion of overall prevalence	Est 17% (3,476)	<10%	2027/28
Goal 4 High Frequency Users	Reduction in **emergency hospital admissions** for alcohol related conditions	Admission episodes for alcohol-related conditions	840 per 100,000	TBC per 100,000	2026/27
Goal 5: Cost-of-Living	Number of **poverty proofed** Core20Plus5 pathways	Number of Core20Plus5 clinical domain pathways that have been update inline with Sunderland's Financial Wellbeing recommendations	0	5	2025/26

Initiatives – Key deliverables.

		23/24				24/25	25/26	27/28	28/29
Item	**Deliverable description**	**Q1**	**Q2**	**Q3**	**Q4**				
1.1	**Palliative and End of Life Care –** Undertake a self-assessment against the national palliative and end of life care ambitions and develop a cross-system improvement plan								
1.2	**Palliative and End of Life Care –** Achievement against each of the national and end of life care ambitions measuring level 4 (partially achieving) or higher								
1.3	**Palliative and End of Life Care -** Achievement against each of the national and end of life care ambitions measuring level 5 (fully achieving)								
2.1	**Anticipatory care** - Finalise the Anticipatory Care Model in each PCN / Neighbourhood area								
2.2	**Anticipatory care** - Implementation of the new Ageing Well Team in STSFT								
2.3	**Anticipatory care** - Implementation of Ageing Well Model across partners								
3.1	**Cardiovascular Disease** – Align CVD Prevent tool to NHS Health Check programme to support more targeted approach to screening								
3.2	**Cardiovascular Disease** – Implement revised lifestyle intervention pathways for patients with a 20% risk of cardiovascular disease incidence within next 10 years								
3.3	**Cardiovascular Disease** – Implement in-reach cardiovascular screening to substance and alcohol services								
3.4	**Respiratory Disease** – Delivery of a whole-system approach to the Targeted Lung Health Check programme, with a clear focus on reaching Core20Plus5 population groups								
3.5	**Respiratory Disease –** Implement in-reach lung check screening and substance and alcohol services								
3.6	**Early Cancer Diagnosis** – implement GP direct access to diagnostic imaging								

3.7	**Early Cancer Diagnosis** – Achieve compliance with NICE guidelines (NG12) across all practices								
3.8	**Early Cancer Diagnosis** – Increase cultural competence of practitioners who have contact with patients to increase uptake of screening in BaME communities								
3.9	**Diabetes** - Implement integrated diabetes service in general practice								
3.10	**Diabetes** – Implement an effective weight management service for T2D patients								
4.1	**High Frequency Users** - Develop a personalise care model to support those with complex, intermediate and low level needs								
4.2	**High Frequency Users** - Develop and implement a HFU Strategy to sit alongside the health and care social prescribing strategy								
5.1	**Cost-of-Living** – Work with Public Health to poverty proof CVD screening, diagnosis and treatment pathways via ICS Health Inequalities funding								
5.2	**Cost-of-Living –** Work with Public Health to poverty proof lung-health check programme via ICS Health Inequalities funding								

Priority 3: Enabling the Best Start in Life for Children and Young People

Why is change needed?

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

Specific health challenges identified within Goal 3 (Best Start in Life) of the NENC **Better Health and Wellbeing for All Strategy**, identified the need to strengthen the **voice of the child** within health and care planning and delivery. Priority 5 identifies some specific actions related to the way in which children and young people's services are commissioned – supporting more child and young person centred approaches and creating new opportunities to involve children and young people in co-producing services.

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

Objectives	
Objective 1	Ensure children and young people have timely and equitable access to effective mental ill-health prevention, early intervention and support through system-wide roll-out of **Sunderland's Thrive model**, with a determined focus on **Core20Plus** populations
Objective 2	Support the development of a health-promoting **family hub** offer through effective alignment of health care resource that addresses the 5 clinical areas of health inequalities outlined in the **Core20Plus5** framework
Objective 3	Contribute to improved provision of **SEND support** through personalised and tailored care that promotes greater choice and control over packages of care and ensures children in transition to adult services have a clear progression pathway.
Objective 4	Support improved integration, capacity building and needs-led pathways into **neurodevelopmental** support.
Objective 5	Reduce avoidable, **unplanned hospital admissions** and A&E attendance in children and young people with a strong focus on targeted prevention and early intervention of **Core20Plus5** clinical domains.

Goals					
	Description of Goal	**What is being measured?**	**Where are you now?**	**What is the target?**	**When do you aim to get there?**
Goal 1.1 Mental Health	Improved access into **mental health** support for children and young people	Reduction in average waiting times for children and young people entering treatment (defined as two contacts with CYPMHS)	80 days	<30 days	2025/26

Goal 1.2 Mental Health	Reduction in adverse mental health outcomes for children and young people	Reduction in in-patient admissions rate (per 100,000) for mental health conditions in under 18 year olds	118 per 100,000	TBC	2025/26
Goal 2 Family Hub	Increased access to health support through **family hub** provision	Number of families accessing health-related support through family hubs	Baseline TBC	10% year-on-year improvement in access	Annual increase in access to be observed each year
Goal 3 SEND	Improved access to therapies for children and young people with **SEND**	% of children and young people with a SEND reporting improved access into therapies provision	Baseline TBC	85%	2025/26
Goal 4 Neurodevelopmental	Improved access to **neurodevelopmental** support	% of children and young people referred for neurodevelopmental assessment seen within 3 months of referral	Baseline TBC	>95-100%	2025/26
Goal 5 Unplanned Admissions	Reduction in **unplanned hospital admissions**	Indirectly standardised rate of emergency admissions for specified Ambulatory Care Sensitive Conditions per	TBC	TBC	2025/26

		registered patients <18 years			

Initiatives – Key deliverables.

		23/24				24/25	25/26	27/28	28/29
Item	**Deliverable** description	Q1	Q2	Q3	Q4				
1.1	**Mental Health** Implement findings from mental health services review and pilot programmes to support full roll-out of Sunderland's Thrive programme								
1.2	**Mental Health** Roll-out and evaluate digital support pilot for 'Getting Help' element of the Thrive programme								
1.3	**Mental Health** Pilot and review findings of social prescribing support within the 'Getting Help' element of the Thrive programme								
2.1	**Family Hub** Scope and implement potential health offer to support Sunderland's Family Hub development, based on 5 clinical areas of health inequalities (Core20Plus5)								
3.1	**SEND** Undertake a full review of SEND equipment and therapies provision and implement a need-led support offer through joint commissioning arrangements								
4.1	**Neurodevelopmental** Undertake a full review of neurodevelopmental pathways and implement a revised integrated, needs-led model based on recommendations								
5.1	**Avoidable Admissions** Roll-out regional Tobacco Dependency Pathways across maternity services								
5.2	**Avoidable Admissions** Establish a Care, Education and Treatment Review panel for Sunderland								
5.3	**Avoidable Admissions** Develop and implement a Core20Plus5 action plan for the 5 clinical area of child health inequalities								

Priority 4*:* Transforming mental health, learning disability and autism services

Why is change needed?

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

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

- ***An ounce of prevention is better than a pound of care:*** Strengthening and promoting lifelong mental health and wellbeing with a focus on prevention.

- ***Right Response, Right Time, Right Place***: Ensuring there is appropriate and timely access to flexible and inclusive mental health care services for all, focussing on the whole person.

- ***Working with you on what matters to you:*** Delivering care designed around the individual, without barriers across teams, services, and organisations.

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

Objectives	
Objective 1	Develop and deliver a **community mental health transformation program** with a determined focus on prevention and timely access to intervention for those from **Core20Plus5** population groups
Objective 2	Ensure collaborative delivery of the **Sunderland Adult Mental Health Strategy,** through increased provision of timely, person-centred and prevention-focused care
Objective 3	Review **dementia** pathways and data recording to support improved dementia diagnosis rate.
Objective 4	Improved uptake of physical health checks and targeted screening programmes for those with **Severe Mental Illness** (SMI)
Objective 5	Transform the community provision for adults with **Learning Disability and/or Autism** to prevent crisis, avoid admissions and support the achievement of a happy, healthy and independent life

Goals					
	Description of Goal	**What is being measured?**	**Where are you now?**	**What is the target?**	**When do you aim to get there?**
Goal 1.1: Community Mental Health Transformation	Improved access into **community mental health** services for adults and older adults	Number of adults and older adults supported by community mental health services	Baseline TBC	5% year-on-year increase	Annual 5% increase from 2024/25 – 2028/29
Goal 1.2: Mental Health Hubs	Improved access to low-level **community**	Number of adults and older adults	Baseline TBC	5% year-on-year increase	Annual 5% increase from 2024/25 to 2028/29

	mental health support through mental health hubs	accessing mental health hub support			
Goal 2.1: Mental Health Strategy	Reduction in hospital admissions for **intentional self-harm**	Directly aged standardised rate of emergency hospital admissions for intentional self-harm	183 per 100,000	TBC	2025/26
Goal 3: Dementia	Improved **dementia** diagnosis rate	Estimated dementia diagnosis rate (aged 65 years and over)	60.5%	66.7%	2024/25
Goal 4.1: Health of people on SMI register	Improved physical health of people on **SMI** register	Percentage of patients on SMI register with an up-to-date health check	TBC	>75%	2024/25
Goal 5: Learning Disability and Autism	Improved physical health of people with **learning disabilities**	Percentage of patients on learning disabilities register with an up-to-date health check	35.3% (2019/20)	>75%	2024/25
Goal 5: Learning Disability and Autism	Improved physical health of people with autism	Percentage of patients with autisms with an up-to-date health check	Baseline to be established in 2024/25	>75%	2025/26

Initiatives – Key deliverables

		23/24				24/25	25/26	27/28	28/29
Item	**Deliverable description**	**Q1**	**Q2**	**Q3**	**Q4**				
1.1	**Community Mental Health Hubs:** Pilot the implementation of three community mental health hubs								
1.2	**Community Mental Health Transformation**: Implement neighbourhood mental health MDT pilot								
1.3	**Community Mental Health Transformation:** Review findings from community mental health hub and neighbourhood MDT pilot and make recommendations for future commissioning of community provision								
1.4	**Community Mental Health Transformation:** Support the implementation of the concordat in Sunderland to create a resilient community and supportive preventative activity.								
2.1	**Mental Health Strategy:** Implement and publish a mental health dashboard which demonstrates the delivery of the strategy								
2.2	**Mental Health Strategy:** Further develop mental health ARRS roles to maximise primary care outcomes and ensure patients access the most appropriate service to meet their needs								
2.3	**Mental Health Strategy:** Support delivery of the Sunderland Suicide Prevention Action Group (SPAG) action plan to maximise preventative opportunities and reduce the number of attempted and completed suicides								
3.1	**Dementia Diagnosis:** Undertake review of dementia pathways and data recording and extracting mechanisms to support development of a dementia diagnosis improvement plan								
4.1	**SMI and Learning Disability Health Checks**: Implement a system-wide approach to increase engagement with and access to annual SMI health checks								
4.2	**SMI and Learning Disability Health Checks:** Implementation of a Quality Framework for annual health checks for people with a learning disability, delivering the national expectations.								

5.1	**Learning Disability and Autism:** Deliver an annual health check program for patients with autism								
5.2	**Learning Disability and Autism:** Develop and implement an autism strategy for Sunderland								

Priority 5: ***Delivering place-shaping innovation and sustainability through investment in critical system-enablers***

Why is change needed?

Investment in key system enablers, including **workforce capacity and development**; **integrated commissioning infrastructure**; **digital and tech innovation**; **research and intelligence**; and future-proofed **estates**, are critical success factors in delivering sustainable, evidence-based and innovative solutions to best meet the current and future health and care needs of Sunderland's residents. Prioritisation of enabling infrastructure within Sunderland's Place Plan, additionally creates opportunities to nurture the place-shaping potential of localised health and care partnerships, helping to create new social, economic and environmental value for Sunderland and maximising use of the Sunderland pound.

In 2023/24 Sunderland will additionally develop it's **community-led**, **co-production** approach to health and care commissioning, creating new opportunities for people, place and communities to become more meaningfully involved across the commissioning cycle. In addition, key actions to develop the role of the **voluntary and community sector** will be leveraged through the newly established Sunderland Voluntary Sector Alliance, creating a more coherent and sustainable strategy for community-led provision.

Increased accountability and oversight of Sunderland's implementation of the enabling objectives within the **NHS Long-Term Plan**, Integrated Care Strategy ('**Better Health and Wellbeing for All'**) and thematic areas of the **NENC Joint Forward Plan**, will additionally support a more coordinated, learning approach that can leverage the potential of joint-system resource to move further, faster on key enabling strategies that support improved health and care outcomes and more efficient system-level working. This includes extracting maximum **health value** from NHS investment and ensuring **financial balance**, through increased investment in prevention and more strategic integrated commissioning approaches that harness the potential of pooled-budget arrangements in furthering ambitions for population health management.

Objectives	
Objective 1	Build a skilled, compassionate and sufficient **health and care workforce**
Objective 2	Synthesise the NENC ICB **Digital Strategy** and Sunderland Smart City Plan objectives to create a place-shaping digital innovation approach
Objective 3	Create an **integrated commissioning** infrastructure that promotes, transformational, community and intelligence-led commissioning, including development of a Sunderland s75 Partnership Board and Children and Adult Collaboratives
Objective 4	Increase Sunderland's health and care **research intensity** through local implementation of the ICS research strategy
Objective 5	Maximise opportunities for **health and care estates** to further Sunderland's ambition for integrated care closer to home
Objective 6	Maximise **health value** from NHS investment and ensuring **financial balance** through a full review of current investment portfolio and applying an allocative efficiency approach to longer-term financial planning.

Goals					
	Description of Goal	**What is being measured?**	**Where are you now?**	**What is the target?**	**When do you aim to get there?**
Goal 1.1 Workforce	Reduction in health and care **workforce** vacancy rate across Sunderland	Health and care vacancy rate in Sunderland	Baseline TBC	50% reduction	2030

Goal 1.2 Workforce	Percentage of **ARRS workforce** investment maximised across Sunderland PCNs	% of ARRS budget utilised	Baseline TBC	>98%	2024/25
Goal 2.1 Digital and Technology	Using **digital capabilities** to improve GP access through implementation of the 'Modern General Practice Access' approach	Percentage of patients who know how their request will be handled on the same day as request being made	n/a	100%	2025/26
Goal 2.2 Digital and Technology	Using **technology-enabled care** to increase the proportion of older people living independently at home following discharge from hospital	Reduction in the rate of long-term support needs of older people (aged 65 years and over) met by admission to residential and nursing care homes, per 100,000 population	1170.1	TBC	2025/26
Goal 3 Integrated Community-Led Commissioning	Increased **integration of health and care commissioning** to support person, place and population-centred care across Sunderland	Increased proportion of Sunderland ICB funding invested in a pooled budget with one or more partners	Baseline to be established in 2023/24	Target TBC	2025/26

Goal 4 Research and Intelligence	Develop a community asset-based **research** programme to support the development of a sustainable, strengths-based approach to improve plus population access to health screening	Percentage improvement in residents with substance and/or alcohol addiction accessing NHS Health Checks	TBC	50% improvement	2025/26
Goal 5 Estates	Improved patient access and experience as a result of person-centred **estates** provision	Percentage of patients rating access to services good or above	TBC	>90%	2027/28
Goal 6 Financial Balance	Achieving financial balance in a way that delivers allocative efficiency	Percentage of efficiency targets achieved	£tbc	30% (£tbc)	2024/25

Initiatives – Key deliverables

		23/24				24/25	25/26	27/28	28/29
Item	**Deliverable description**	**Q1**	**Q2**	**Q3**	**Q4**				
1.1	**Workforce:** Development of a joint workforce strategy across health and care that encompasses joint training and development opportunities to support improved retention and career progression								
1.2	**Workforce:** Develop (and annually renegotiate) an annual work programme for Sunderland Place Committee that supports effective place-based leadership and embeds a culture of compassion, inclusion and collaboration across the local health and care system								
2.1	**Digital and Tech:** All practices moved over from analogue to digital telephony								
2.2	**Digital and Tech:** All practices completing digital tools and care navigation training for Modern General Practice Access								
2.3	**Digital and Tech:** Complete two home monitoring pilots and make recommendations for future commissioning of Lily and Guardian technology to support more proactive and independent care.								
2.4	**Digital and Tech:** Undertake an options appraisal of LUSCII and alternative technical products to support long-term roll-out of tech-enabled virtual ward and home first approach across Sunderland								
3.1	**Integrated Community-Led Commissioning:** Mobilisation and implementation of adult refreshed adult collaborative, based on All Together Better alliance model								
3.2	**Integrated Community-Led Commissioning:** Mobilisation and implementation of a children's collaborative arrangement								
3.3	**Integrated Community-Led Commissioning:** Sign-off a s75 partnership arrangement between the ICB and LA for all elements of pooled and aligned health and care integration, including the development of a formal partnership board arrangement to meet in common with the Sunderland Place Committee								

3.4	**Integrated Community-Led Commissioning** Roll-out community-led commissioning development programme (via Collaborate for Social Action) to create a system-wide approach to improved community co-production, including patient and public involvement and VCSE development								
4.1	**Research and Intelligence:** Conduct a 2-year asset-based research programme with NENC ARC to develop a strengths-based, trauma informed approach to Plus Population commissioning								
4.2	**Research and Intelligence:** Publish a joint Population Health Intelligence Strategy and delivery plan with Local Authority								
5.1	**Estates:** Develop a local estates strategy utilising SHAPE to support improved integration of health and care estates based on population health approaches								
6.1	**Financial Balance:** Undertake a review of current investment and identify a robust efficiency plan that delivers long-term financial sustainability								
6.2	**Financial Balance:** Undertake a review of pooled budget arrangements and identify opportunities for risk sharing system-level pressures through s75 arrangements								

Enablers – what do you need in place in order for you to deliver your plan
1. Process – operational models that will require change as a result of this plan being delivered
2. Workforce
3. Research and Innovation
4. Digital technology and Data
5. Estates.
6. Finance

Risks – Please summarise the key risks <u>specific</u> to your action plan, and how these might be mitigated.

Risks	**Mitigations**