Item No. 2

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

Held in the Wessington Room, Bunny Hill Centre on Wednesday 27 July 2011

MINUTES

Present:

Councillor P Watson (Chair)	-	Sunderland City Council
Councillor D Allan	-	Sunderland City Council
Councillor R Oliver	-	Sunderland City Council
Councillor P Smith	-	Sunderland City Council
Councillor M Speding	-	Sunderland City Council
Neil Revely	-	Executive Director, Health, Housing and Adult Services, Sunderland City Council
Ron Odunaiya	-	Executive Director, City Services, Sunderland City Council
Keith Moore	-	Executive Director, Children's Services, Sunderland City Council
Nonnie Crawford	-	Director of Public Health, Sunderland TPCT
Dr Ian Pattison	-	Chair of Sunderland Clinical Commissioning Group

In Attendance:

Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Warnes	-	Governance Services, Sunderland City Council

HW1. Apologies

Apologies for absence were received from David Hambleton, Sue Winfield and Sarah Reed.

HW2. Welcome from the Chair

Councillor Paul Watson welcomed those present to the first meeting of the Early Implementer Health and Wellbeing Board and thanked them for their attendance.

HW3. Establishing the Health and Wellbeing Board

The Executive Director of Health, Housing and Adult Services submitted a report setting out the proposals for the development of the Health and Wellbeing Board in Sunderland.

The Health and Social Care Bill stated that each local authority must establish a Health and Wellbeing Board for its area which would bring together key NHS, public health and social care leaders. The Department of Health had endorsed Sunderland becoming an early implementer and this would enable new working arrangements to be trialled and lessons learned prior to the formal Shadow Board being established in 2012. It was proposed that a full review of the membership and functioning of the Board be undertaken prior to the changeover to the Shadow Board.

The Early Implementer Board was intended to be a decision-making and shaping body which would work closely with 'advisory' groups such as the Children's Trust and Adult Social Care Partnership Board. The Board would meet on a bi-monthly basis and the papers would be made available through the Council's website.

The Board was formally a Committee of the Council but was also a key partnership for the city and its work on health would contribute to the overarching Sunderland Strategy. There were a number of key activities which will need to be reflected in the Terms of Reference including assessing the broad health and wellbeing needs of the local population, leading the Joint Strategic Needs Assessment (JSNA), developing a new high-level health and wellbeing strategy, promoting integration and partnership across areas through promoting joined up commissioning plans and ensuring a comprehensive engagement voice is developed as part of the implementation of Healthwatch.

It was important for the Board to identify what success would look like by the end of March 2012 and it was suggested that this may 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 to have 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

It was highlighted that the GP Commissioning Consortium was currently a pathfinder body and was yet to take on full statutory responsibilities. It was proposed that a second GP consortium member be co-opted onto the Board to allow more flexibility

and a continuum of engagement from the group. This proposal would have to be considered by a full meeting of Sunderland City Council. At this point the Board also stated its intention to be inclusive and to hear views from everyone, whether they be members of the Board or not.

Following consideration of the report it was: -

RESOLVED that: -

(i) the Early Implementer Health and Wellbeing Board agree the proposal to co-opt a second Board Member from the GP Consortium;

(ii) that the next steps be agreed and regular updates received on the work programme.

HW4. The Health of the City

The Director of Public Health presented a report providing an overview of health and wellbeing in Sunderland in 2011.

Nonnie Crawford highlighted some of the main issues observed in the health profile of Sunderland including in inequalities in life expectancy, child development, rates of breastfeeding, cancer statistics and alcohol related illnesses.

The Board paid particular attention to the life expectancy differences shown in the different neighbourhoods within the City, the list showed 22 neighbourhoods which had significant differences from the Sunderland average. It was apparent that thought needed to be given to which services should be offered universally and where specific focus was needed in certain areas.

Dr Pattison commented that take up of services did vary on the ground and it tended to be people in more deprived areas who did not take up the opportunities for follow up and review appointments, when they were often in the greatest need. It was a challenge for the city as a whole to engage these groups of people and there would be opportunities for engagement and outreach to work differently through HealthWatch.

This also needed to be looked at as a long term process, the investment in children's centres was now showing dividends in terms of child health and this needed to continue through to adulthood.

Councillor Watson referred to the Marmot report on health inequalities which stated that it was natural in society to have some unfairness. Improvements had to be made to the health of those statistically at the bottom but as they moved higher up the scale so would those already at the top. It was a matter of improvement for everyone.

Dr Pattison commented that a pattern was developing on increased alcohol consumption amongst the 'non-deprived' communities and the impact on health

would filter through to the statistics in the next few years. A discussion then ensued around the reasons for the increase in drinking by the more affluent communities and comparisons were made with the efforts to tackle smoking which have led to a reduction in tobacco consumption over a number of years.

The Board talked about how they might identify the top ten health priorities for the city and through area arrangements develop individual priorities for a locality and specific need. The system in place at the present time, which was engaged with commissioning, would allow service providers to differentiate responses on this. Consideration also had to be given to how and where GP services could be delivered in the future.

Following discussion, it was: -

RESOLVED that the content of the report be noted.

HW5. JSNA and the Link to Commissioning

The Director of Public Health presented a report setting out proposals for the development of the 2011 Joint Strategic Needs Assessment (JSNA).

The JSNA was an ongoing process which identified current and future health and wellbeing needs of the local Sunderland population. The baseline report was published in 2008 and updated in 2009. The process of refreshing the assessment for 2011 had begun and the aim was to develop a list of priority indicators and identify an officer to lead on each one. It was intended to bring the priority list back in December when organisations were considering their commissioning intentions for the following year.

A proposed Priorities List was presented as part of the report and the Board were asked their views on the list and the draft format for reporting on each priority.

The Board agreed that the JSNA priorities had to be owned by everyone and consideration had to be given to how these would fit into planning for the pathways of people's lives. It was felt that categorising issues under People, Place and Economy was the correct way forward, especially as elected Members would have to present this in political fora.

The need to obtain views from GPs at an early stage was highlighted and Dr Pattison stated that GPs could add value in being able to identify which elements had been problematic and where things could be improved. Nonnie advised that this was the first time that the list had been shared with anyone and that members may want to take it back and have discussions with colleagues to identify any issues that were missing. Safeguarding was noted as something which was missing from the list of priorities.

A Project Board made up of Senior Officers from the Council, the TPCT and the Clinical Commissioning Group, had been established to oversee the refresh of the

JSNA. A smaller project team would co-ordinate this and it was noted that it would be useful to have a clinical commissioning representative on this group.

It was emphasised that the methods for GP engagement had to be clarified at the outset and Board Members reassured that the processes were robust. Neil Revely advised that the process was ongoing and Board Members would have the opportunity to review the arrangements for the project group when the JSNA was brought back to a future meeting of the Early Implementer Health and Wellbeing Board.

Fully engaging with the process of joint commissioning would enable organisations to see where plans were cross cutting, leading to coherence across the public, and eventually the private, sector.

Having considered the report, it was: -

RESOLVED that: -

(i) the JSNA approach and timelines be approved; and

(ii) the refreshed JSNA Priority List be noted.

HW6. HealthWatch Transition Plan

The Executive Director of Health, Housing and Adult Services presented a report outlining details of the Government's HealthWatch Transition Plan and the proposals for the transition in Sunderland.

Healthwatch aims to strengthen patient and public voice at both local and national levels and to do this, Healthwatch England would be established and LINks would become local HealthWatch organisations. Healthwatch England would also be a sub-committee of the Care Quality Commission.

At least one representative of local HealthWatch would be a statutory member of the Health and Wellbeing Board and it would be important for the local group to develop strong relationships with key partners in order to develop a shared understanding of the needs of the local population.

The Department of Health had set out what an effective local HealthWatch would be like and while it would take forward LINks responsibility for gathering people's views and making those views known to service commissioners and providers, they would also take on the responsibility for supporting individuals directly. Local authorities were asked to build on what was best and Sunderland would add to and amend the local HealthWatch model as the development progressed. This would be linked to action learning sets which would assist peer learning and sharing and facilitate continuous improvement for all LINks.

Sunderland had not elected to bid to be a HealthWatch pathfinder but would remain close to the process and gather information through the evaluation of the pathfinders and learning events.

Over the transition year, consultation would be carried out in Sunderland in order to engage diverse individuals and groups in the design and development of local HealthWatch. Sue Winfield, Chair of the Sunderland PCT, would lead the HealthWatch transition workstream process and Jean Carter would be the officer lead.

Councillor Speding commented that there was an understandable need to have a HealthWatch representative with a full and equal position on the Health and Wellbeing Board but asked where the challenge to the Board would come from. Neil Revely advised that this would be from the Health and Wellbeing Scrutiny Committee as it was best placed to provide the necessary overview and challenge.

The Chair noted that the HealthWatch representative would require support in attending the Health and Wellbeing Board to ensure that they remained engaged with the work of the Board.

Following discussion it was: -

RESOLVED that: -

(i) the next steps for the HealthWatch transition be approved: and

(ii) the Early Implementer Health and Wellbeing Board receive further updates as the transition progresses.

HW7. GP COMMISSIONING PATHFINDER BID

Dr Pattison presented the application document for Sunderland's GP Commissioning Consortia Pathfinder Programme bid and outlined the process which had developed the consortium.

The way GPs had come together had been very important and there had been good engagement and a formal election process carried out to select six GPs to sit on the Board and Dr Pattison to act as Chair. Dr Pattison would remain as Chair until statutory responsibilities came into effect.

The governance structure for the Sunderland Commissioning Consortium Board was outlined together with its relationship to PCT Boards and Committees. The emphasis was on locality working where the Consortium could take on delegated responsibility in the future.

The North East was seen to be taking the lead in the process and the Department of Health is monitoring the local consortia closely. The Consortium had identified eight high impact interventions to address the gap in life expectancy in Sunderland and would lead on the following four issues: -

- 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

These were identified as priority health requirements for the people of Sunderland and were achievable within the pathfinder timeframe.

Dr Pattison informed the Board that there would be a Consortium lead for clinical effectiveness who would work on ironing out clinical variation between practices. Nonnie Crawford highlighted that a good example of this was the impact a previous commissioning group had made on treatment of COPD in one surgery which was so effective it was going to be rolled out across all practices in the city.

Attention was drawn to the list of GP practices and the lack of uniformity in sizes of practice lists in relation to the number of GPs. Dr Pattison explained that some of this information was skewed in that not all practices had treated the number of GPs as Full Time Equivalents and the statistics did not take into account different models of provision, such as the use of nurse practitioners. Dr Pattison commented that he would like to see a lower average of patients allocated to each GP as there was a risk that change could not take place if there were not enough GPs in the area or if they were overworked.

The issue of recruitment and retention of GPs was also raised and it was noted that there was a difficulty in that doctors did not want to live in the Sunderland area and a plan for addressing this was required.

Following discussion, it was: -

RESOLVED that the GP Commissioning Consortia pathfinder bid be noted.

HW8. FUTURE MEETINGS

The Board discussed the dates and times of future meetings. It was noted that lunchtime meetings were more convenient for GPs and the most appropriate days to meet were Wednesday and Friday. It was agreed that a schedule of meetings would be devised on this basis and circulated to Board members.

(Signed) P WATSON
Chair

Item No. 3

16 SEPTEMBER 2011

REPORT TO THE SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD

REPORT BY EXECUTIVE DIRECTOR HEALTH, HOUSING AND ADULT SERVICES

THE STRATEGIC PLANNING PROCESS

1.0 PURPOSE OF THE REPORT

1.1 To provide board members with an overview of the Strategic Planning Process

1.2 To provide board members with background to the development of the Health Housing Adult Services, Childrens Services and City Services Directorate three year plans

2.0 THE STRATEGIC PLANNING PROCESS

2.1 The council operates an annual Strategic Planning Process which translates its priorities into targets and outcomes for the forthcoming financial year and subsequent two years that will lead to continued improvement in service delivery and the use of resources

2.1 The purpose of the Strategic Planning Process is to ensure the council's service delivery and the use of resources contribute to the achievement of the Sunderland Partnership's Vision for the city *"Creating a better future for everyone in Sunderland - Sunderland will be a welcoming, internationally recognised city where people have the opportunity to fulfil their aspirations for a healthy, safe and prosperous future."*

2.2 The strategic planning process helps drive toward continuous improvement in everything the council does, and to ensure that every member of staff can identify and understand the role they play in the achievement of the council's priorities.

2.3 The council will in future use this strategic planning activity to align the organisations commissioning intentions

3.0 RECOMMENDATIONS

3.1 The Early Implementer Health and Wellbeing Board is recommended to receive this report for information

3.2 The Early Implementer Health and Wellbeing Board should consider inviting partners to present their organisations strategic plans to the next meeting of the Early Implementer Health and Wellbeing Board

Item No. 4

SUNDERLAND EARLY IMPLEMENTER HEALTH AND WELLBEING BOARD **16 SEPTEMBER 2011**

NHS REFORM

Report of the Executive Director, Health, Housing And Adult Services

1.0 PURPOSE OF THE REPORT

1.1 To provide information to members of the board on Government changes to the NHS

1.2 To highlight any implications for Sunderland

2.0 BACKGROUND

2.1 The Government set out a number of changes to the way the NHS operates in its Health and Social Care Bill. The Bill was paused to allow a 'listening exercise' with recommendations from the NHS futures forum submitted to the Health Secretary. In June 2011 the Health Secretary announced changes to the Bill based on these recommendations. The Health and Social Care Bill is due to have its report stage and third reading on 6th and 7th September 2011.

2.2 The main changes for the NHS include a changing role for the Secretary of State, the development of a National NHS Commissioning Board, the creation of Clinical Commissioning Groups and changing roles for Monitor and the Care Quality Commission

2.3 Strategic Health Authorities (SHA's) have recently been clustered in four separate areas: London, North, Midlands and South. On 11 August 2011 Ian Dalton CBE was announced to the post of Chief Executive of NHS North of England. Strategic Health Authorities cluster Chief Executives will assume their roles on Monday 3 October 2011 to continue until the abolition of SHA's in 2013.

2.4 The Department of Health has indicated that despite issuing *Cluster Implementation Guidance* in January there is still significant inconsistency in how the 50 PCT clusters operate. This consistency is vital for the Quality, Innovation, Productivity and Prevention (QUIPP) to deliver the £20bn in efficiency savings and to support the NHS reforms. PCT's will cease to exist during 2013.

2.5 The Government has asked the NHS Futures Forum to continue a new phase of conversations with patients, service users and professionals. The forum led by GP Professor Steve Field, will provide independent advice on four themes:

- Information – how to make information improve health, care and wellbeing
- Education and training – how to develop the healthcare workforce to deliver world-class healthcare
- Integrated care – how to ensure the Governments' modernisation programme leads to better integration of services around people's needs
- The public's health – how to ensure the public's health remains at the heart of the NHS

3.0 THE ROLE AND FUNCTION OF THE SECRETARY OF STATE

3.1 The Secretary of State will continue to be responsible for promoting a comprehensive health service; the Bill does not change this. The Bill does however, include new duties to oversee the health service and report on the health service annually

3.2 In the past the duty to provide has been delegated by the Secretary of State to the health authorities, this is no longer the case as the Department of Health is not a provider of NHS services and has neither the staff nor facilities to make NHS services available to the public

3.3 The removal of the duty to provide is part of the Government's long standing intention to separate commissioner from provider. This does not in any way undermine Secretary of State's accountability or responsibility for the health service

3.4 The Bill sets out that under new proposals the duty to provide will be given directly to the NHS Commissioning Board and Clinical Commissioning Groups

3.5 The Secretary of State will provide national leadership across all three domains of public health:-

i) Health improvement
ii) Health protection
iii) Health services

In addition the Secretary of State will publish a public health outcomes framework.

4.0 THE NHS COMMISSIONING BOARD

4.1 The Board will be a single national organisation with a single operating model however; many of its functions will be delivered sub-nationally such as commissioning of primary care services

4.2 The board will be responsible for deploying around £20bn of the national budget for specialist services and primary care, this will include holding 35,000 contracts for primary care services

4.3 The Board will agree and deliver improved outcomes and account to Ministers and Parliament for progress.

4.4 Support quality improvements by promoting consistent national Quality Standards, a culture which promotes research and innovation. Providing world class support for clinically led service improvement and leadership.

4.5 Promote innovative ways of demonstrating how care can be made more integrated for patients.

4.6 The Board will also have a role delivering preventative and public health services, commissioning on behalf of Public Health England

4.7 The Board will host clinical networks advising on areas of care such as cancer, and the new senates (probably around 15) which will embed clinical expertise in commissioning decisions

4.8 The Board will start to operate in a shadow form as a special health authority in October 2011. By October 2012 the Board will be established as an independent statutory body with powers for the authorisation of Clinical Commissioning Groups

4.9 Approximately 3500 staff will perform functions of the board, operating on a local basis and will be involved in functions such as;

- Operational relationships with CCGs such as support in monitoring finance, performance and commissioning
- Stakeholder relationships including with the local government and HealthWatch

Although it is too early to say how these locality teams will be organised, they will initially reflect the current PCT cluster arrangements

5.0 CLINICAL COMMISSIONING GROUP

5.1 Clinical Commissioning Groups (CCGs) will manage around £80bn from the national budget but will be held accountable by the NHS Commissioning Board.

5.2 The report into developing the NHS Commissioning Board sets out proposals for the Board's role in overseeing the work of CCGs, which includes the following elements;

- A framework with outcomes for which the CCGs are accountable and the resources available to them, the Commissioning Outcomes Framework will be based on NICE national standards and will involve financial performance rewards
- A range of tools to support the effective commissioning which CCGs can adapt to reflect local needs. This should include guidance, modal pathways and standard contracts
- A continuing programme of organisational development

- A system of authorisation so that CCGs take on commissioning and budget responsibilities when they are ready
- A transparent rules-based approach to intervene to support CCGs in difficulty

6.0 MONITOR

6.1 Monitor will be the sector regulator for health. The core duty will be to promote and protect patient's interest

6.2 To carry out their duty Monitor will need to support the delivery of integrated services for patients where this would improve the quality of care for patients or improve efficiency

6.3 Monitors functions include; price setting and supporting the continuity of vital services in the event of financial failure, the licensing of providers and that competition is fair and operating in the best interests of the patients. Monitor will continue to authorise trusts as they seek to become foundation trusts by 2014 and will continue to obtain assurances from the Care Quality Commission as part of the authorisation process

7.0 PUBLIC HEALTH ENGLAND

7.1 Local authorities will take new responsibilities for public health led by jointly appointed Directors of Public Health.

7.2 Local authorities will be supported by a new integrated public health service Public Health England (PHE)

7.3 PHE will bring together the diverse range of public health expertise currently distributed across the health system.

7.4 It will ensure access to expert advice, intelligence and evidence,

7.5 PHE will be established as an Executive Agency, providing greater operational independence within a structure clearly accountable to the Secretary of State for Health

7.6 PHE will strengthen the national response on emergency preparedness, health protection and support public health delivery across the three domains of public health through information, evidence, surveillance and professional leadership.

7.7 PHE will have a particular key role in health protection, protecting people from hazards such as infectious diseases, radiation, chemicals and any emergencies caused by these.

7.8 A series of Public Health Reform Updates will be published during Autumn 2011:

- The Outcomes Framework
- The Public Health England Operating Model
- Public Health in local government and the Director of Public Health
- Public Health Funding Regime
- Workforce

7.9 Subject to Parliament, upper tier and unitary local authorities will take on their new public health responsibilities in April 2013.

8.0 IMPLICATIONS FOR SUNDERLAND

8.1 Key implications include the establishment of new or revised relationships with organisations and individuals within the new NHS landscape at national and local level/

8.2 Revised governance arrangements will be required to support an integrated approach to health and social care for the population of Sunderland.

8.3 Ensuring development of the Health and Wellbeing Board to maximise opportunities from the reforms to integrate NHS, public health and social care plans and provision.

8.4 Through Health and Wellbeing Board ensuring NHS commissioning plans are integrated with and reflect local joint health and wellbeing strategies. These must be informed by a joint – owned city wide strategic needs assessment.

8.5 Development of the Public Health transition plan to include finance, workforce and relationship to PHE.

8.6 Opportunity to implement integrated working at locality level with Clinical Commissioning Group (CCG).

8.7 Provision of local authority support during the CCG authorization process.

8.8 Ensure that functions transferred to the local authority are funded appropriately to minimise impact on the Council's financial efficiency plan.

Overall, combined with the strengthening of democratic legitimacy within health, the NHS Reforms offer significant opportunities to accelerate joint commissioning and provision of services for the benefit of Sunderland residents.

The Board is asked to receive this report for information and note the contents.