SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 1) on Friday 28 November 2014 at 12.00noon

A buffet lunch will be available at the start of the meeting.

Contact: **Gillian Kelly, Principal Governance Services Officer Tel: 0191 561 1041**
Email: **gillian.kelly@sunderland.gov.uk**

Information contained within this agenda can be made available in other languages and formats.

9.	**NHS Five Year Forward View** Report of the Chief Officer, Sunderland Clinical Commissioning Group (copy attached).	101
10.	**Affordable Warmth and Excess Winter Deaths – Progress Update** Report of the Head of Housing Support and Community Living (copy attached).	109
11.	**Mental Health Trailblazer** Report of the Director of Public Health (copy attached).	113
12.	**Development Sessions and Forward Plan** Report of the Head of Strategy, Policy and Performance Management (copy attached).	121
13.	**Date and Time of the Next Meeting** The next meeting of the Board will be held on Friday 23 January 2015 at 12noon	

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

19 November 2014

Item No. 3

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 19 September 2014

MINUTES

Present: -

Councillor Mel Speding (in the Chair)	-	Sunderland City Council
Councillor Shirley Leadbitter	-	Sunderland City Council
Councillor Graeme Miller	-	Sunderland City Council
Councillor Pat Smith	-	Sunderland City Council
Neil Revely	-	Executive Director of People Services
Dave Gallagher	-	Chief Officer, Sunderland CCG
Dr Ian Pattison	-	Sunderland CCG
Kevin Morris	-	Healthwatch Sunderland

In Attendance:

Councillor Ronny Davison	-	Sunderland City Council
Claire Bradford	-	NHS Local Team
Jane Johnston	-	NHS Local Team
Sarah Reed	-	Assistant Chief Executive, Sunderland City Council
Kath Bailey	-	Locum Consultant in Public Health, Sunderland City Council
Sharon Lowes	-	Intelligence Lead, Sunderland City Council
Graeme Atkinson	-	Intelligence Lead, Sunderland City Council
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

HW14. Apologies

Apologies for absence were received from Councillors Kelly and Watson and Nonnie Crawford, Ken Bremner and Christine Keen.

HW15. Declarations of Interest

There were no declarations of interest.

HW16. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 25 July 2014 were agreed as a correct record.

HW17. Feedback from Advisory Boards

Adults Partnership Board

Councillor Speding informed the Board that the Adults Partnership Board had met on 9 September 2014 and the main issues considered had been: -

- Joint Workshop for Adults Partnership Board, Children's Trust and NHS Provider Forum
- Health and Wellbeing Board Agenda
- Sunderland Care and Support Company
- Winterbourne View Update
- Domestic Violence Needs Update
- Care Act: The Local Response
- Behaviour Change Workshop

Karen Graham advised that with regard to the domestic violence needs update, the Adults Partnership Board had agreed to establish a task and finish group which would include members of the Health and Wellbeing Board, providers and representatives from the Safer Sunderland Partnership.

The Board RESOLVED that the information be noted.

HW18. Update from the Integration and Transformation Board (including Accelerated Solutions Event update)

The Board were informed that the Integration and Transformation Board had met on the 21 August 2014 and the main issues discussed had been: -

- Governance
- Better Care Fund
- Follow up to ASE Event

The Better Care Fund plan had been through the fast track process and had received assurance with support. Officers had now been mandated to get on and implement the actions in the plan. Sunderland's Better Care Fund plan was one of five looked at early and all the other areas were in the same position. Plans were being submitted from other areas of the country on 19 September.

Neil Revely wished to record thanks to all the organisations who had been involved in the development of the plan and noted Sunderland's was the largest Better Care

Fund to be established in the country. A Government minister had visited Sunderland to congratulate the team on the day of the announcement but now the work would really start.

Dave Gallagher advised that the follow up to the Accelerated Solutions Event (ASE) would now take place in early December and referred the Board to appendix 1 to the minutes of the Integration Board which showed how the work streams were being brought forward.

Dave highlighted that as the Better Care Fund had been signed off and £168m would be shared between the two statutory bodies of the Council and the Clinical Commissioning Group (CCG), discussions had begun around enhancing governance arrangements. Proposals for governance were shown at appendix 2 and would include input from elected Members, the CCG, executive GPs and lay members. Neil added that 'Integration' was one of the key things which the Health and Wellbeing Board was overseeing and that the Better Care Fund was a subset of the whole integration agenda.

The Chair commented that the proposed governance arrangements were set out in a brief, succinct diagram and that the Health and Wellbeing Board had always been focused on getting people into the right place. Councillor Miller noted that this was a good starting point to an essential piece of work.

The Chair queried if there was a political dimension to this arrangement and how this would feed through to the Health and Wellbeing Board. Neil advised that the proposal was for an elected Member to represent the Council and a non-executive member to represent the CCG. Neil stated that he, Dave Gallagher and the relevant elected Member would provide a conduit from the Health and Social Care Integration Board to the Health and Wellbeing Board.

RESOLVED that the update be noted.

HW19. NHS England 0-5 Transfer Programme

Claire Bradford of the NHS England Area Team was in attendance to present to the Board on the NHS England 0-5 Transfer Programme.

The commissioning responsibilities for 0-5 year old children's public health services would transfer from NHS England to Local Authorities on 1 October 2015 and NHS England were responsible for ensuring the safe transfer of the responsibilities whilst aiming to improve outcomes for children and families.

The 0-5 Healthy Child Programme was delivered in partnership with the Department of Health, Public Health England and the Local Government Association and the services which would transfer to the Local Authority included the commissioning of health visiting services and family nurse partnership services.

The Healthy Child Programme was a multi-disciplinary programme involving a large number of services targeted at improving outcomes for children from before birth to

the age of 19 (and older for children with special educational needs). It was an evidence based programme with universal and targeted interventions.

Claire highlighted that the Health Visitor call to action was currently ongoing through organisations across the North East, and Sunderland was part of the early implementer scheme for modernisation. There was a lot of national interest in the expansion of numbers of health visitors and this was on track in the North East.

Following the transfer of Public Health commissioning to local authorities in April 2014, NHS England had been working with Sunderland on the informal co-commissioning of services for 0-5 year olds and also on joint priorities. This had been working very well and efforts were now being made to have the right structures in place for a mid-year transfer of responsibilities.

The Section 7A agreement, which would set out the elements of the 0-5 Healthy Child Programme which were to be commissioned by the local authority, would be updated for 2015 and would be shared with the Health and Wellbeing Board.

A financial process was also being undertaken to identify the value of the contract which was currently being provided by South Tyneside Hospitals across Gateshead, South Tyneside and Sunderland. A mandate had been agreed through the LGA for five key checks as part of the Healthy Child Programme but the number of health visitors was not agreed and the family health programme had not been mandated.

The Chair asked what the practical effects of the changes would be, as maternity was sitting within one area and health visiting in another. He queried how this would fit together and what would be the advantages for local people.

Claire Bradford stated that the Healthy Child Programme was designed to run from before birth and having one body commission these services made sense. This would also enable local authorities to look at the whole contribution services were making to the city and to ensure that these services did not chop and change.

Neil Revely highlighted that, because of the commitment which the Health and Wellbeing Board had to integrate, this was another opportunity and was part of the objective to achieve a ‘Better Start in Life’. He said that this was seen as a further opportunity to design whole new systems but shared concerns about the transition and wanted any disruption to be as minimal as possible.

Kath Bailey stated that it was the commissioning responsibilities rather than the health visiting staff who were transferring and the local authority would only receive the mandate for the universal elements of the programme. She asked if there had been any further guidance on the process and Claire Bradford advised that there was a regional LGA meeting taking place on Monday which may address some of the queries which were being raised.

Dr Pattison commented that GPs feel that there had been a disconnect between general practice and the health visiting service and colleagues saw this service as being second only to the district nursing service. He asked if the health visiting service specification had been shared with the CCG, as it would be interesting to try

and align this with the GP plans, and if there was a real increase in the number of health visitors.

Jane Johnston advised that the target was to have 180 WTE health visitors over the south of Tyne area and there were 176 currently in post, with student health visitors being counted in November and ten to begin training shortly. The initiative was also about reducing the caseloads of individual health visitors and understanding the work of health visiting across health and social care. She highlighted that GP practices should have a named health visitor and regular contact.

Dr Pattison noted that it was the informal contact which GPs found so valuable and they would appreciate more of that and not less. He was interested in the reference to locality working and if this would be aligned in the specification going forward. It was also important to highlight the role that health visitors played in safeguarding and also their work in early intervention and prevention. Claire added that Northumbria University was carrying out some work with health visitors to identify how they could work more effectively in localities.

Neil Revely commented that the discussion had confirmed that the Board was taking the right approach in focusing on integration and although the Better Care Fund had led the group to concentrate on adults initially, the next Transformation Board meeting would start to map work on children's integration.

The Chair asked how this would work practically on the ground and if local headteachers would be involved. He highlighted that the whole family approach was fundamental to the work of the Health and Wellbeing Board.

Jane Johnston advised that part of the call to action was to reduce the risk in transitions. Health visitors had good relationships with maternity services and there was a systematic process in place for handovers between them and to the school nursing service. There was to be a joint assessment of children at the age of two and half with the aim of achieving a better understanding of child development before they got to school. Health visitor involvement would start at 28 weeks of pregnancy.

Having thanked Claire for her presentation, it was: -

RESOLVED that the information be noted.

HW20. Peer Review – Implementation Plan Update

The Assistant Chief Executive and Head of Strategy and Performance submitted a joint report updating the Board on the progress which had been made in addressing the Health and Wellbeing Peer Challenge implementation plan.

The peer challenge had taken place in February 2014 and a proposed implementation plan had been presented to the Health and Wellbeing Board in May 2014, where the Board had agreed to receive six monthly updates. The 15 individual actions within the plan had been allocated to Board members and senior officers

within the Council and the CCG and the lead officers had put detailed responses together.

Sarah Reed, Assistant Chief Executive, advised that there were no major issues to draw to the attention of Board members but that this would be monitored moving forward. The evidence based approach would need to be reflected within the plan and it had been agreed that an annual assurance report would be produced. Outputs and outcomes would continue to be monitored and a report from Due North would come to the next meeting of the Board.

Neil Revely commented that, in filling in your own area of responsibility within the plan, you could see what others were doing and realised that there was a lot of commonality. Dave Gallagher added that it was good to see all of this information in one place but said that care needed to be taken to make sure that some areas did not contradict each other.

RESOLVED that the Implementation Plan update be noted.

HW21. Intelligence Hub Update

Sharon Lowes and Graeme Atkinson were in attendance to deliver a presentation on Sunderland's Intelligence approach.

The 'Intelligence Hub' was a new approach to using data and information which placed intelligence at the centre of everything the Council, and its partners, did and changed the way that business was done. The hub was not a stand alone being, but a dispersed model focusing on skills, techniques and tools.

The Intelligence Hub would promote an intelligence approach within the city; integrate, manage and share information; establish an information governance framework; and develop skills and capabilities.

A competitive dialogue process had taken place and this had resulted in 'Palantir' being appointed as the Strategic Partner for the project. Palantir were a global leader in data intelligence and would work with the Council to develop the approach and to deliver four user cases (rapid adopters), a single scalable framework, full skills and knowledge transfer through training and an Information Strategy.

The four 'rapid adopters' were Hospital Admissions, Strengthening Families, Flood Management and Community Clean Up. In the case of Hospital Admissions, the adoption of the Intelligence Hub was in the context of significant budget pressures and significant spend across the health and social care system. There was a requirement to understand the interventions in place and to identify the trends, patterns and themes across health and social care data.

For Strengthening Families there was a need to identify families and to understand what was working and that the right interventions were in place. The Intelligence Hub would also assist with data sharing and enable agencies to have different and appropriate levels of access to data about the same family.

The Intelligence Hub would establish Sunderland as an exemplar of an 'Intelligent City' and would create modern public services based on today's needs and anticipating future service requirements. The Hub would also help partners in the city to understand shared priorities and to direct collective resources to these.

The Chair stated that this was a new concept which had developed against the background of workforce transformation and budget cuts. The local authority had lost a significant amount of knowledge in recent years and the Intelligence Hub was a tool to redress some of that. However the Hub would fundamentally be driven by numbers rather than the ability of the local authority to carry out functions.

Sarah Reed highlighted that there were issues around knowledge and intelligence and when looking at the level of data analysis, the superior evidence base within Public Health had made the Council understand that there was not the right type of performance management within the authority. Work was taking place around community connectors and capacity was being looked at in a different way. There were risks and issues which needed to be monitored throughout the process.

Councillor Smith asked if this would put right where things had things had been wrong, for example with Children's Centres and the Youth Offending Service and Sharon advised that there would be a communications plan addressing these issues.

Dave Gallagher noted that the initiative was aimed at capturing numbers but also the soft intelligence. This would be placed as a community resource to be accessed safely and securely. Neil Revely stressed that soft intelligence, such as information from local councillors, should not be underestimated. The Intelligence Hub would not solve data issues overnight but would be an additional support.

Sharon advised that discussions had begun regarding the health rapid adopter and that Palantir as the strategic partner would bring a non-local government and non-NHS perspective. The Intelligence Hub was a new way of looking at information but would not replace the human element of the process.

Having thanked Sharon and Graeme for their presentation, the Board RESOLVED that the information be noted.

HW22. WHO Healthy Cities

The Executive Director of People Services submitted a report updating the Board on the World Health Organisation (WHO) Healthy Cities Programme.

Sunderland was first designated a WHO Healthy City in 2004 and cities applied for membership every five years based on renewed criteria. Each five year phase focused on core priority themes and would be launched with a political declaration and a set of strategic goals.

The core themes in WHO Healthy Cities Phase VI would be based on the local adaptation of the four priorities for policy action of Health 2020:

- investing in health through a life-course and empowering people;
- tackling the European Region's major health challenges of infectious and non-communicable diseases;
- strengthening people-centred systems and public health capacity and emergency preparedness and surveillance; and
- creating resilient communities and supportive environments.

As the aims of Phase VI were closely aligned to the Sunderland Health and Wellbeing Strategy, Sunderland had expressed an interest in being designated as a WHO Healthy City for Phase VI.

Sunderland was also a member of the Healthy Cities National Network which had held its inaugural meeting in August and was attended by Councillor Speding and Karen Graham. The next session would be held in Bristol in the Autumn and the Annual Conference for WHO Healthy Cities would take place in Athens in October.

RESOLVED that: -

(i) the proposal to apply fully for designation as a WHO Healthy City for Phase VI be endorsed; and

(ii) the upcoming annual conference be noted.

HW23. Health and Wellbeing Strategy – Communications Workshop

The Executive Director of People Services and the Head of Strategy and Performance submitted a joint report informing Board Members of a workshop which had been convened to help progress the Sunderland Health and Wellbeing Strategy.

The workshop would set the tone and direction for future social marketing and behaviour change strategies which would contribute to the improved health of local people. The workshop would take place on Monday 20 October 2014 between 1.00pm and 5.00pm at the Software Centre and all Members of the Health and Wellbeing Board were invited to attend.

The workshop was to be facilitated by Dr Henry Kippin and Ben Lucas and it was anticipated that this workshop would be the first in a series and that these would play a key role in taking forward the Health and Wellbeing strategy and improving the health and wellbeing of local people.

RESOLVED that the invitation to the communications workshop be noted.

HW24. Health and Wellbeing Board Development Session and Forward Plan

The Head of Strategy and Performance submitted a report informing the Board of the detail and scope of the next development session and the forward plan.

The next development session would be focused on safeguarding and would take place on Friday 10 October 2014. The topic for the session was “How does the City get confidence from and around Children and Adults Safeguarding” and would be independently facilitated by Anne Baxter.

Details of the timetable for the Board and its advisory groups and deadlines for submission of reports were also provided for information.

The Board RESOLVED that: -

(i) details of the next development session be noted;

(ii) the forward plan be noted and requests for any additional topics passed to Karen Graham; and

(iii) the timetable be noted.

HW25. Date and Time of Next Meeting

The next meeting of the Board will be held on Friday 28 November 2014 at 12noon

(Signed) M SPEDING
In the Chair

Item No. 4a

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

FEEDBACK FROM THE ADULTS PARTNERSHIP BOARD

Report of the Chair of the Adults Partnership Board

The Adults Partnership Board met on Tuesday 4th November, 2014.

3. Matters Arising
Joint Childrens Trust and Adults Partnership Board meeting
A joint meeting is to be held on the 24th November looking at areas for joint and individual work and reporting into the HWBB.

5. Strengthening Families
Helen Lancaster (HL) provided an update on the Strengthening Families approach, including the Troubled Families Programme. HL reported the aim is to establish clear, co-ordinated and integrated support pathways for families across all levels of need providing a common framework for the delivery of services.

DCLG have estimated Sunderland had 805 such families, however to date over 1000 families have been attached to the scheme and up to 31st October 68.5% have been 'turned around'.

Each of the five former regeneration areas of Sunderland have a Multi Agency Family Locality Team.

HL noted the local evaluation carried out by Ecorys has shown there is a good infrastructure in place with evidence of information sharing, increase in partnership working and the bringing together of children and adult services.

HL reported in May 2014 Phase 2 of the project was announced with Sunderland given early starter status from 1st January, 2015.

6. Tobacco Alliance Update
Gillian Gibson (GG) provided an update on the progress made, results of CLeaR peer assessment and the strategic aim on Making Smoking History in the North East Partnership who are taking forward the aim of reducing smoking in the north east to below 5% by 2025.

GG noted smoking still remains the biggest preventable cause of premature deaths and disease in Sunderland. GG noted overall the Sunderland Alliance was congratulated in reducing the smoking prevalence although smoking rates in pregnancy has seen an increase to 19.9%, compared to the national figure of 12%.

7. Age Friendly Cities
Estimates highlight that by 2037 the population aged over 60 in Sunderland will increase from 24% to 31.2%.
Stuart Cuthbertson (SC) provided an update on the progress of Sunderland's

application to become an Age Friendly City in partnership with Age UK.
Work is currently underway to refresh baseline data to submit an application to WHO for Sunderland to be given Age Friendly status.
SC noted a co-ordinated approach to tackling the WHO domains across all age groups (where appropriate) will support the City's economic growth and related skills and health issues.
It was noted how the People and Place & Economy Boards could help drive this forward with bench-marking, key plans and the involvement of key partners.

8. Mental Health Trailblazer Report
Gillian Gibson provided an update on the work undertaken by the North East Combined Authority to develop and submit a funding bid for a trailblazer project aiming to support people with common mental health issues back into work.
The Board supported the programme.
GG gave details of a new Workplace Health Alliance launch on the 26th November which is aimed at getting more smaller and medium sized businesses to sign up to promoting a healthy workforce.

9. Affordable Warmth Update
Alan Caddick (AC) reported that an affordable warmth Steering Group has been established and the Terms of Reference agreed. Members of the group include: Sunderland CCG, Age UK, SCC, City Hospitals, GP's, Warm Up North, Gentoo and South Tyneside Foundation Trust.
AC reported an early priority for the group was to consider what actions could be taken to help reduce excess winter deaths. Bids made to the CCG was successful in securing £6k towards the flu jab campaign and £100k for AgeUK to help keep people warm and safe over the winter.
AC noted in addition to developing the strategy the Steering Group will also monitor Warm Up North and Collective Switching. AC reported to date a further 199 people have signed up to the Collective Switching programme.
It noted the need to be clear on how affordable warmth will be measured against the reduction of hospital admissions, e.g during the month of October there were 250 more A&E Type 1 admissions than the previous year.

10. Date and Time of Next Meeting
The date for the next meeting is Tuesday 6th January 2015 at 2.30pm

Item No. 4b

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

FEEDBACK FROM THE SUNDERLAND NHS PROVIDER FORUM

Report of the Chair of the Sunderland NHS Provider Forum

The Sunderland NHS Provider Forum met on 5th November at South Tyneside Foundation Trust. 7 members were present representing 6 of the 7 members.

Issues discussed were:

ASE Event Follow up
The Forum expressed a desire to be involved in the follow up event as long as there is clarity on the purpose of the session and that it is action focussed.

Better Care Fund
Clarity was requested on the CCG underspend and reserve figures –assuming we will get some returned to the local health economy is a high risk strategy particularly when it is needed to pump prime the BCF.

It was also suggested that the BCF is not being well communicated with the social care system

As work on the BCF plan development has finished, the Provider Forum would like to request additional items the HWBB would like it to investigate on its behalf.

Role of the Provider Forum
The possibility of merging the provider forum into the transformation board was discussed and the TOR of both groups were looked at. This option was discounted as the provider forum:

- Wanted to retain the direct route to the HWBB
- Wanted to have a chair independent of the major commissioners
- Has a clear remit to advise the HWBB on any provider issues and to engage with providers on a regular basis

Membership of the Forum
The group welcomed Philip Foster to the group representing the largest care provider in Sunderland. The GP Alliance membership was discussed and agreed to review once issues regarding who they represent and their mandate were resolved.

Manpower
The LMC highlighted area teams stats showing that there has been a 16% reduction in GPs linking themselves to Sunderland compared to a 9% reduction across Tyne and Wear. The age of GPs was also highlighted with 26% over 55 and 39% over 50 – and with new retirement regulations, they could leave at any time.

Extra GPs are needed for the delivery of locality teams but there was no clearly articulated plan for recruitment and retention available. There was a consensus that

manpower issues were of significant concern in Sunderland and could seriously impact on the delivery of integration and the 5 year strategy.

Providers were requested to collate their key manpower issues to highlight the issue. The Forum agreed to request that the HWBB agree a methodology for developing solutions to manpower issues and to request involvement in this methodology.

Engagement Event
As part of the terms of reference of the forum, there is a commitment to hold an annual broader provider engagement session to provide information on the work of the forum and also to gain views from a wider range of providers on what the focus of the group should be over the next year.

Forum members were asked to provide comment on what would make the event a 'must attend' and whether there were alternative mechanisms for engagement to piggy back onto eg homecare providers networks.

HWB Assurance
It was agreed that providers are already regulated by a number of independent bodies and that the key question for assurance should be to focus on how providers are assisting the HWBB to deliver the HWB Strategy. This will be presented to the next HWBB for discussion.

It was felt that if the HWBB wanted greater involvement in statutory assurance processes, then there could be a strengthened role for the HWBB in existing statutory processes such as health scrutiny and in CQC feedback sessions.

RECOMMENDATIONS:
The Health and Wellbeing Board is recommended to:

- Note the content of the feedback report from the Provider Forum
- Suggest topics to task the provider forum with investigating on behalf of the HWBB
- Note the providers concerns over manpower issues
- Agree to receive a further report on assurance from providers

Sunderland City Council

NHS Sunderland Clinical Commissioning Group

INTEGRATION BOARD
Minutes of the meeting held
3.30pm on 5th November, 2014
Sunderland CCG

Present David Gallagher (DG)
Neil Revely (NR)
Gillian Gibson (GG)
Fiona Brown (FB)
Alison Greener (minutes)

ACTION

1. Apologies for Absence
Apologies received from Karen Graham, Nonnie Crawford, Sarah Reed and Debbie Burnicle.

2. Partnership Board Integrated Teams (including involvement from third sector organisations).
GG asked how Public Health can be involved in order to maximise opportunities within the third sector organisations.

GG to pick up with DB Age UK and Public Health involvement on how to get the best health outcomes for older people. GG does not understand the current structures and feels that there may be some gaps in the system. She is aware that the Public Health team is involved at a strategic level through this Board but considers that opportunities to improve health might be missed if there is not greater involvement as structures emerge.

ACTION: GG to speak to DB regarding Age UK and Public Health involvement regarding best health outcomes for older people **GG**

FB and DB have been discussing the integration of children's services and how this fits with current work. NR will be speaking to the Council Executive about this and it will also be on the agenda at the follow up event on the 9th December.

ACTION: NR to speak to the Council Executive regarding children's services and where it fits with current work. **NR**

DG suggested involving the Sunderland GP Alliance now that it is starting to form as well as taking it to the Transformation Board. GG asked if there should be consideration of no change within the first 6 months, minimal change within the first 18 months and with notice to be given after 6 months to prepare for change. NR was keen to engage in service redesign as soon as possible i.e. by the turn of the year with work being carried out on this over the next few weeks regarding the engagement of Health Visitor Managers and Health Visitors. He expressed concern that if we wait too long, it could infer that there will be no change. DG added the need for conversations taking place regarding the longer term strategy and to signal intent but that there may be opportunities to put some changes into place sooner.

FB has met with Ceri Bentham and Sarah Rushford from the Area Team to map out and agree on how to structure development sessions with the health visitor teams. When these development sessions are arranged, FB will inform the Board of the dates.

ACTION: FB to inform the Integration Board of development session dates **FB**

GG would like Public Health, as the lead for the commissioning of these services from October 2015, to be part of any transformation of health visitor services and to ensure more engagement with families to more fully understand their needs. FB confirmed that work on this in other areas of the country had proved successful. NR stated that the engagement with families and practitioners should start now. DG stated that the pace had to be right to ensure sufficiently quick change without stretching the capacity of teams or local people.

3. BCF

Formal feedback on the Sunderland BCF plan had been received and the status of “Assure with support” confirmed. DG has spoken to Alison Slater at NHS England Area Team and it was agreed that Ian Holliday and Graham King liaise with her to complete the small number of outstanding issues including formatting a risk log which can be easily resolved. Ian and Graham are continuing with this piece of work which will be taken to the next Health & Wellbeing Board.

NR commented that one LA stated that they were not submitting a BCF plan and DG confirmed that 3-4 LAs were not assured as plans

were not submitted. The good news is that Sunderland's plan can be sorted out locally with the Area Team and then to progress to delivery.

There was some debate about the pooled funds for the BCF and NR expressed some concern about the danger of unravelling what has been agreed. There has been particular attention regarding the distribution of money next year. FB & DB have had some positive discussions to progress this. The deficit was £9m and is now £3m and agreed sign off 13/14 with discussions regarding managing the £3m gap. Conversations need to continue at a senior level and a meeting is being held on Monday to discuss this, as well as 14/15 discussions.

DG stated that at this point in the year there isn't yet clarity on any ability the CCG might have to assist with this. NR stated that the BCF is relying on community services efficiencies which will result in an increase in the size of the BCF over time.

There was some discussion regarding due diligence and DG will pick this up. FB stated that this could be undertaken section 75 but that Sonia cannot set a budget if it does not balance.

ACTION: DG to pick up due diligence **DG**

4. Integrated Commissioning

DB has put a date in the diary to work through what an operating model will look like and is looking at NHS Accelerate or Oliver Wyman to assist in a masterclass, including the CCG and City Council. NR stated that a deadline of the next financial year should be when the revised position is in place. DG agreed that this was a starting point but that work needs further development. It was agreed that greater mutual understanding is needed regarding commissioning. FB and DB are progressing this.

5. Follow up ASE Event – 9th December

A planning conversation with Cap Gemini will be held next Monday, 10th November.

6. Governance Paper

This paper will go to the Health and Wellbeing Board and will include input from Lay members, GPs and Councillors. NR stated that he has not discussed this with Mel yet but that this should be in place by April 2015 at the latest. DG suggested having robust

admin in place to support to this revised group. DG will circulate the draft paper electronically and attaching it to the Health & Wellbeing Board paper.

ACTION: DG and NR to discuss admin support. **NR/DG**

7. Date and time of next meeting

Thursday 2nd December 2014 at 4pm in David Gallagher's office Pemberton House

Appendix

Health and Social Services Integration Board

DRAFT

Terms of Reference

Introduction

The Sunderland Health and Wellbeing Board agreed at its meeting of 14th January 2014 to establish a Health and Social Care Integration Programme Board to oversee on its behalf the delivery of health and social care integration.

Since then the Health and Well Being Board has signed off the Sunderland Better Care Fund Plan, which outlines the steps for development of health and social care integration using a pooled budget approach advocated nationally. For Sunderland, the scale of this pooled budget will be c£150 – 160m in 2015/16.

To ensure adequate corporate accountability of this fund by the two statutory accountable organisations – Sunderland City Council and NHS Sunderland CCG – a revised Health and Social Services Integration Board is proposed, building on the current Programme Board agreed in January 2014.

Purpose

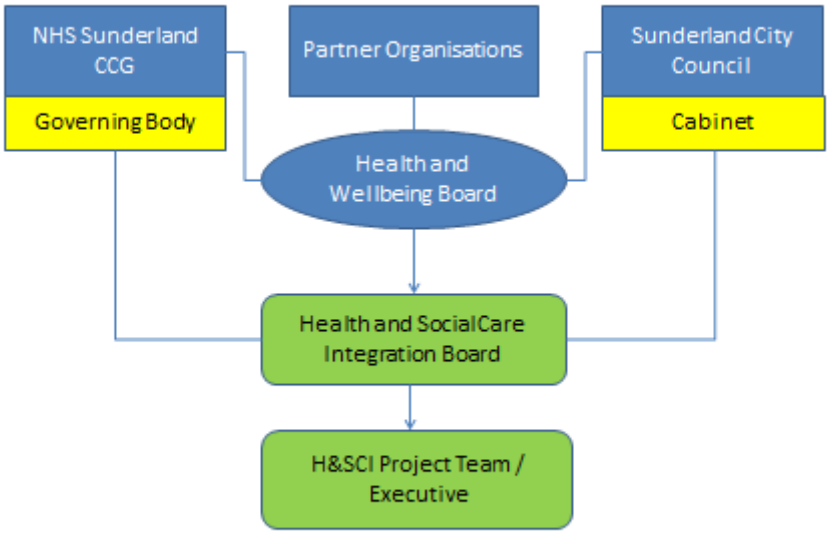
The Health and Social Care Integration Board will oversee the development and delivery of plans for the integration of health and social care in Sunderland.

This includes:

- Overseeing the development and delivery of specific health and social care pooled funding arrangements including the Better Care Fund.
- Overseeing the development and delivery of overall health and social care integration in Sunderland.
- Ensuring the robust discharge of statutory responsibilities and accountabilities for pooled funding

Governance

The board will report into the Health and Wellbeing Board via those members who are also members of that board. It will also report in to the two statutory bodies – Sunderland City Council and NHS Sunderland CCG via the respective members of the board.



Membership

Membership of the group will build upon the Health and Social Care Integration Programme Board and its initial membership with the addition of senior members of Sunderland City Council and NHS Sunderland CCG to facilitate joint working and accountability at cabinet and Governing Body level.

Membership is outlined below.

Role	**Sunderland City Council**	**NHS Sunderland CCG (Governing Body)**	**Health and Wellbeing Board**
GP Chair / executive GP		√	√
Vice chair of HWBB	√		√
Chief Officer		√	√
Assistant CEO	√		
Director of People's Services	√	√	√
Chief Finance Officer		√	
Treasurer	√		
Director of Commissioning, Planning and Reform		√	
Chief Operating Officer (People's Directorate)	√		
Lay Member		√	
Director of Public Health	√	√	√
Policy Lead for Health	√		

The board will also incorporate relevant and necessary subgroups, e.g. senior finance colleagues to deal with technical financial issues, or clinicians to provide a clinical viewpoint.

The group will elect a chair / have a rotating chair between council and CCG members.

Roles and Responsibilities

To fulfil its purpose the Programme Board will:

- Delegate and sponsor activities and work programmes within the HSCI Project Team / Executive
- Receive reports from that group
- Act as a conduit to the Sunderland Transformation Board, which is an advisory board to the CCG Executive Committee.
- Receive regular reports from sub groups
- Provide regular reports to the Sunderland Health and Wellbeing Board, Sunderland City Council and NHS Sunderland CCG.

Quorum

The board will be quorate if a minimum of five members are present, at least two of which must be from Sunderland City Council and NHS Sunderland CCG each.

Decision Making

The board will strive to ensure that any decisions are made by consensus. Should this not be possible a vote will be taken with the chairman having the casting vote.

Any major decisions will need to be taken to the Health and Wellbeing Board and the two statutory organisations.

Frequency of Meetings

The programme board will meet routinely on a monthly basis. Other ad-hoc meetings will be arranged as and when required.

Review

These terms of reference will be reviewed regularly and initially six months after agreement.

DG
November 2014

Item No. 6

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

HEALTH AND WELLBEING PERFORMANCE AND ASSURANCE

Report of the Executive Director of People Services

1. Purpose of the Report

This is the first report to the Health and Wellbeing Board (HWBB) that provides a number of elements of performance data including performance against outcomes and case study evidence of progression against the Health and Wellbeing Strategy (HWBS).

2. Background

As set out in the Health and Social Care Act, the HWBB has as its major responsibility the development and ongoing monitoring of a Health and Wellbeing Strategy. In Sunderland the HWBS was approved by the Board in March 2013. The implementation of the HWBS was delegated by the HWBB to a project group. This group is chaired by the Executive Director for People Services at the City Council and comprises of members from throughout the health and social care system in the City. This group includes a named Lead for each of the strategy's 6 Objectives and their role is to oversee actions that contribute to the delivery of the new ways of working that the HWBS design principles require.

The report is split into a number of distinct sections:
- Performance figures relating to outcomes
- A narrative description of areas of underperformance
- A description of key innovative actions taken under each of the 6 objectives.

It is also proposed that future reports also include:
- Assurance from key providers of delivery against the strategy
- An analysis of behaviour change as a result of the strategy.

The last two elements of the reporting are under development and progress against these will be reported to the Board in 2015.

3. Performance figures relating to outcomes

Included in the report are all the performance figures relating to the three major outcomes frameworks associated with health and wellbeing – the Public Health Outcomes Framework, the Adult Social Care Outcomes Framework and the NHS Outcomes Framework. For the purpose of this first performance report all of the associated indicators have been included, organised by strategic objective. This includes a red amber green rating for each outcome alongside an analysis of the trend or direction of travel.

4. A narrative description of areas of underperformance

A description of any areas of underperformance relating to the six HWBS objectives is included. As a number of the indicators relate to more than one of the strategic objectives, a section on cross cutting issues has also been included in the report.

5. A description of key innovative actions taken under each of the six objectives

There is an appreciation that the ethos of the strategy (its Design Principles and introducing a new way of doing things) is already impacting on the day to day work of many partner organisations across the city - this clearly highlights the confidence that partners have in the approach to service provision that the strategy advocates. The Leads from the six strategic objectives of the HWBS have provided evidence of how progress is being made against their objective. This is not to cover the 'business as usual' element of delivery, but to capture those actions that are new and/or innovative and are specifically targeted at the way that things are done as opposed to cataloguing what is done.

6. Future Steps

As highlighted above, there is an intention to strengthen the performance report by including assurance from partners and an assessment of behaviour change across organisations and local people. Both of these elements will be developed over the first quarter of 2015 and a further update will be brought to the HWBB.

It is recognised that partners are quality assured in a number of different ways – through Monitor, CQC, internal and external audit, peer review and scrutiny. It is not the intention to replace or reproduce any of these statutory mechanisms. Where possible existing mechanisms will be strengthened and the role of the HWBB clarified. What is currently missing from assurance processes is to ensure that delivery reflects the design principles and ways of working enshrined in the HWBS - it is proposed that this is the focus for the assurance reports.

In order to clearly articulate how implementation is being embedded, a 'plan on a page' will be prepared that will capture how organisational plans support the delivery of the strategy.

In terms of behaviour change, the first behaviour change workshop was held in October 2014. The workshop aimed to ensure that all partners had a common understanding of behaviour change and also developed a number of test cases to establish what will work in Sunderland. This is to be progressed throughout 2015 with a number of small test cases being developed alongside a number of more complex organisational and individual behaviours.

In parallel, discussions with Sunderland University are underway to deliver a joint programme that will establish a baseline and monitoring framework for the more innovative aspects of the implementation plan. The assets approach that the HWBS advocates is a new approach that demands new methods for improving health and in

turn this requires new and innovative ways of measuring success that will sit alongside the more traditional outcomes measures in this report.

Recommendations

The HWBB is recommended to:

- Receive the performance against outcome figures and provide any comments
- Receive the HWBS Objective actions and provide any comments
- Agree the next steps outlined in 6 above.

Appendix 1

Health and Wellbeing Performance Management

Vision	Design Principles	Objectives	Outcomes
Best possible Health and Wellbeing for Sunderland...by which we mean a City where everyone is as healthy as they can be, people live longer, enjoy a good standard of wellbeing and we see a reduction in health inequalities	Promoting independence and self care Equity Early Intervention Prevention Strengthening community Assets Life course Address the issues that have a wider impact on health Joint working	**Objective 1: Promoting understanding between communities and organisations**	1.1 There is increased awareness of the services and support available to people in their community and they are assisted to access these. 1.2 People are supported to make sustainable changes that will improve their health. This will be through services that are responsive to needs and also by utilising new technologies and methods of engagement with
		Objective 2: : Encouraging children and Young People have the best start in life	2.1 Parents and carers of children are encouraged to access early years opportunities. 2.2 Children and families are supported throughout the whole of a child's journey, including the transition into adulthood.
		Objective 3: Supporting and motivating everyone to take responsibility for their health and that of others	3.1 There is increased emotional health and resilience of everyone in Sunderland - individuals, families and communities. 3.2 Staff, volunteers and community leaders are aware of the main social determinants of health as well as the risks and opportunities, and where and how services can be accessed. 3.3 People (including young people) are aware of the importance of accessing long-acting health protecting interventions such as immunisation and screening and early presentation following the development of signs and symptoms of ill-health. 3.4 The healthy choice is the easier choice.
		Objective 4: Supporting everyone to contribute	4.1 The health barriers to employment and training are understood and people are supported to overcome them. 4.2 People are fit for work. 4.3 There is joint working with local businesses to ensure a healthy workforce 4.4 There is support for those who don't work to contribute in other ways
		Objective 5: Supporting people with long term conditions and their carers	5.1 The self management of Long Term Conditions is supported 5.2 Excellent integrated services are provided to support those with long term conditions and their carers 5.3 A good death for everyone is supported
		Objective 6: Supporting individuals and their families to recover from ill-health and crisis	6.1 Individuals and families have emotional resilience and control over their lives 6.2 There are excellent integrated services to support people to recover from episodes of ill health or crisis the choices that are available to facilitate the most effective support

Objective 1: Promoting understanding between communities and organisations Objective Lead - Jacqui Reeves Board Sponsor - Cllr Miller

Public Health Outcomes Framework				Service Lead	Latest Data	Actual To Date	2013/14 Target Comparison with North East Average if no target set		Trend - Direction of Travel	Risk to delivery & Comments
Improving the wider determinants of health	No	PHOF Code	Indicator			Sunderland Average	England Average	North East Average	Direction of Travel	
	1	1.16	Utilisation of green space for exercise/health reasons		Mar 2012 - Feb 2013	14.10	**15.3**	16.00	↑	Improved from 5.8 in 2011 -12 to 14.1 in 2012/13
	2	1.18i -	Social isolation: % of adult social care users who have as much social contact as they would like		2012/13	45.30	43.2	44.60	↔	It has remained stable over the last 3 years
	3	1.18ii	Social isolation: % of adult carers who have as much social contact as they would like		2012/13	40.60	41.3	49.60	-	No trend data available

Adult Social Care Outcomes Framework

Enhancing quality of life for people with care and support needs	No	ASOF	**Indicator**			Sunderland Average	England Average	North East Average or Target	Direction of Travel	Risk to delivery & Comments
	4	1A	Social care-related quality of life (NHSOF 2)		2013/14 (ASCS)	19.60	18.8	19.2 (Target)	↑	Improvement from 19.10 in 2012/13 to 19.60 in 2013/14
	5	1c- Part 1	Proportion of people using social care who receive self-directed support, and those receiving direct payments		2013/14	72.27	55.5%	72% (Target)	↑	Shows improvement from 73.08 in 2012/13 to 73.27 in 2013/14
	6	1c- Part 2	Proportion of people who receive self-directed support as a direct payments		2013/14	16.32%	16.5%	20% (Target)	↔	It has remained stable over the last 3 years
	7	1B	Porportion of people who use services who have control over their daily life		2013/14	76.25	76.1	77.22 (Target)	↑	Improved from 72.86 in 2012/13 to 76.25 in 2013/14
	8	1D	Carers can balance their caring roles and maintain their desired quality of life. Carer-reported quality of like (NHSOF 2.4)		.2012/13	8 (out of 12)				
	9	1L	Proportion of people who use services who reported that they had as much social contact as they would like		2013/14 (ASCS)	53.10	52.70	47.30	↑	Reveals improvement from 42.94 in 2012/13 to 53.10 in 2013/14

Delaying and reducing the need for care and support	3 10	2B - Part 1	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. (NHSOF 3.6i)			2013/14	85.53%	**81.4%**	86.4% (Target)	↑	Improvement from 76.32 in 2012/13 to 85.5 in 2013/14
	11	2B - Part 2	Proportion of older people (65 and over) offered reablement/rehabilitation services following discharge from hospital.			2013-2014	3.50%	**3.3%**		↑	Improved from 3.30 in 2012/13 to 3.5 in 2013/14
	12	2c Part 1	Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population - total			2013/14	8.71	**9.7**	10.5 (average of 24 people) Target	↑	It has improved from 12.59 in 2012/13 to 8.7 in 2013/14
	13	2c Part 2	Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population - social			2013/14	4.8	**3.1**	8.4 (average of 19 people)	↑	It has improved from 9.65 in 2012/13 to 4.8 in 2013/14
Ensuring that people have a positive experience of care and support	14	3A	Overall satisfaction of people who use services with their care and support.			2013/14	67.07%	**64.1%**	71.2%	↓	Deterioration from 70.21 in 2012/13 to 67.07 in 2013/14
	15	3B	Overall satisfaction of carers with social services.			2012/2013	45.59	42.70			Carers Survey biennial
	16	3C	The proportion of carers who report that they have been included or consulted in discussions about the person they care for.			2012/2013	77.78	72.90			Carers Survey biennial
	17	3D	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help: The proportion of people who use services and carers who find it easy to find information about support			2013/2014	76.90		74.4 (Target)	↑	Improved from 70.83 in 2012/13 to 76.90 in 2013/14
NHS Outcome Framework											
Preventing people from dying prematurely	18	1.6i	Reducing deaths in babies and young children: i Infant mortality (PHOF 4.1)		CCG	2010-2012	2.80	4.10	3.60	↑	Improved from 5.5 in 2001/03 to 2.8 in 2010/12 per 1000 0r from 48 in 2001/03 to 27 in 2010/12
	19	1.6ii	ii) Neonatal mortality and stillbirths		CCG	2012	*5.50*	*7.60*	*6.30*	↑	Improved from 9 in 2010 to 5.5 in 2012 per 1000 births 0r from 29 still births and neonatal deaths in 2010 to 17 in 2012
	20	1.6iii	iii) Five year survival from all cancers in children Reducing		CCG	2011		81.3			Data not available for Sunderland only national figures

	4										
Enhancing quality of life for people with long-term conditions	21	2	Health-related quality of life for people with long-term conditions (ASCOF 1A)	CCG	July 2013 to March 2014	0.70	0.743	0.72	↔	CCG have an asipration to improve this indicator significantly over the next 5 years
	22	2.1	Proportion of people feeling supported to manage their condition	CCG	2013/14	66.30	65.1	69.30	↓	Higher than england average but lower than NE average. Slight deterioration in 2013/14
	23	2.3i	Reducing time spent in hospital by people with long-term conditions: i) Unplanned hospitalisation for chronic ambulatory care sensitive conditions	CCG	2013/14	887.10	780.9	928.60	↑	CCG continues to show a reduction in ACS conditions due to implementation of pathways at CHS NHSFT
	24	2.3ii	ii) Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	CCG	2012/13	518.4	340.6	340.00	↑	CCG have an aspiration over next 5 years to reduce non electives by 15%, although focus is on frail elders rather than under19s.
	25	2.4	Enhancing quality of life for carers: Health-related quality of life for carers (ASCOF 1D)	CCG	July 2013 to March 2014	0.79	0.804	0.80	↑	
	26	2.6i	Enhancing quality of life for people with dementia: i) Estimated diagnosis rate for people with dementia (PHOF 4.16)	CCG	Jun-14	64.30%	64.00%		↑	CCG continues to show good progress towards a stretching 13/14 target of 67%.
Ensuring that people have a positive experience of	27	4.7	Improving experience of healthcare for people with mental illness: Patient experience of community mental health services	CCG	Jul-14	87.36	85.81	-	↓	Indicator is provider based and is based on NTW data

Objective 2: Encouraging children and Young People to have the best start in life
Objective lead - Sandra Mitchell Board Sponsor - Cllr Pat Smith

Public Health Outcomes Framework			Service Lead	Latest Data	Actual To Date	2013/14 Target Comparison with North East Average if no target set		Trend - Direction of Travel	Risk to delivery and Comments
	No	PHOF Code	Indicator		Sunderland Average	England Average	North East Average	Direction of Travel	
Improving the wider determinants of health	1	1.02i	School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/2013	53.1	51.7	45.2	-	No trend data available
	2	1.02i	School Readiness: The percentage of children with free school	2012/2013	33.8	36.0	28.7	-	No trend data available
	3	1.02ii	School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/2013	73.9	69.0	69.5	↑	It has improved from 69.2 in 2012/13 to 73.9 in 2013/14
	4	1.02ii	School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/2013	62.2	56.8	55	↑	It has improved from 57.6 in 2012/13 to 62.2 in 2013/14
	5	1.16	Utilisation of green space for exercise/health reasons	Mar 2012 - Feb 2013	14.1	15.3	16	↑	It has improved from 5.8 in 2011 -12 to 14.1 in 2012/13
	6	1.17	Fuel Poverty	2012	11.7	10.4	11.6	↑	It has improved from 11.9 in 2011 to 11.7 in 2012 or from 14, 482 to 13, 805
	7	1.18i -	Social isolation: % of adult social care users who have as much social contact as they would like	2012/13	45.3	43.2	44.6	↔	It has remained stable over the last 3 years
	8	1.18ii	Social isolation: % of adult carers who have as much social contact as they would like	2012/13	40.6	41.3	49.6	-	No trend data available
	9	2.01	Low birth weight of term babies	2011	2.7	2.8	2.7	↑	It has improved from 3.6 in 2010 to 2.7 in 2011
	10	2.02i	Breastfeeding - Breast feeding initiation	2012/13	60.3	73.9	59.3	↑	It has improved from 53.3 in 2010/11 to 60.3 in 2012/13
	11	2.02ii	Breastfeeding: Breastfeeding prevalence at 6 - 8 weeks after birth	2012/13	27.8	47.2	31.2	↑	It has improved from 24.7 in 2011/12 to 27.8 in 2012/13
	12	2.03	Smoking status at time of delivery	2012/13	18.5	12.7	19.7	↑	It has improved from 21.6 in 2010/11 to 18.5 in 2012/13

Health Improvement	6 13	2.04	Under 18 conceptions			2012	43.1	27.7	35.5	↑	It has reduced from 63.7 in 2003 to 43.1 in 2012
	14	2.04	Under 18 conceptions: conception in those aged under 16			2012	10.5	5.6	8.4	↔	It has remained stable over the last 2 years
	16	2.06i	Excess weight in 4 - 5 year olds			2012/13	24.0	22.2	24.2	↑	It has improved from 24.5 in 2011/12 to 24 in 2012/13
	17	2.06ii	Excess weight in 10 - 11 year olds			2012/13	35.5	33.3	35.6	↑	It has improved from 39.1 in 2011/12 to 35.5 in 2012/13
	19	2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 - 14 years)			2012/13	160.2	103.8	146.8	↑	It has improved from 211.4.1 in 2011/12 to 160.2 in 2012/13
	20	2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 - 4 years)			2012/13	211.2	134.7	189.5	↑	It has improved from 271.8 in 2011/12 to 211.2 in 2012/13
	21	2.08	Emotional well-being of looked after children			2012/13	13.6	14.0	14	↑	It has improved from 13.2 in 2011/12 to 13.6 in 2012/13
	24	2.17	Recorded diabetes			2012/13	6.3	6.0	6.37	↓	It has increased from 6.09 in 2011/12 to 6.3 in 2012/13
	25	2.23i	Self - reported well-being - people with a low satisfaction score			2012/13	7.6	6.8	7	↑	It has improved from 8.1 in 2011/12 to 7.6 in 2012/13
	26	2.23ii	Self - reported well-being - people with a low worthwhile score			2012/13	7.2	4.4	5.7	↓	It has increased from 5.9 in 2011/12 to 7.2 in 2012/13
	27	2.23iii	Self - reported well-being - people with a low happiness score			2012/13	12.1	10.4	12.6	↑	It has improved from 14.3 in 2011/12 to 12.1 in 2012/13
	28	2.23IV	Self - reported well-being - people with a high anxiety score			2012/13	23.1	21.0	22.5	↑	It has improved slightly from 23.4 in 2011/12 to 23.1 in 2012/13
	29	3.03i	Population vaccination coverage – Hepatitis B (1 year old)			2012/13	100.0				NE average not available
	30	3.03i	Population vaccination coverage – Hepatitis B (2 year old)			2012/13	83.3				NE average not available

Health Protection	31	3.03iii	Population vaccination coverage – Dtap/ IPV/ Hib (1 year old)			2012/13	98.2	94.7	96.5	↑	It has improved from 96.7 in 2011/12 to 98.2 in 2012/13
	32	3.03iii	Population vaccination coverage – Dtap/ IPV/ Hib (2 year old)			2012/13	98.2	96.3	97.8	↔	It has remained stable over the last 2 years
	33	3.03iv	Population vaccination coverage – MenC			2012/13	98.0	93.9	96	↑	It has improved from 96.5 in 2011/12 to 98 in 2012/13
	34	3.03v	Population vaccination coverage – PCV			2012/18	98.2	94.4	96.4	↑	It has improved from 96.6 in 2011/12 to 98.2 in 2012/13
	35	3.03vi	Population vaccination coverage – Hib/ Men C booster (2 years)			2012/13	96.3	92.7	95.5	↑	It has improved from 95.9 in 2011/12 to 96.3 in 2012/13
	36	3.03vi	Population vaccination coverage – Hib/ Men C booster (5 years)			2012/13	97.4	91.5	94.7	↑	It has improved from 95.2 in 2011/12 to 97.4 in 2012/13
	37	3.03vii	Population vaccination coverage – PCV booster			2012/13	95.9	92.5	95	↑	It has improved from 94 in 2011/12 to 95.9 in 2012/13
	38	3.03viii	Population vaccination coverage – MMR for one dose (2 years old)			2012/13	94.9	92.3	94.1	↑	It has improved from 93.6 in 2011/12 to 94.9 in 2012/13
	39	3.03ix	Population vaccination coverage – MMR for one dose (5 years old)			2012/13	96.0	93.9	96.2	↑	It has improved from 95.5 in 2011/12 to 96 in 2012/13
	40	3.03x	Population vaccination coverage – MMR for two dose (5 years old)			2012/13	92.7	87.7	91.7	↑	It has improved from 90.6 in 2011/12 to 92.7 in 2012/13
	41	3.03xii	Population vaccination coverage – HPV			2012/13	94.8	86.1	90	↑	It has improved from 90.2 in 2011/12 to 94.8 in 2012/13
	42	3.03xiii	Population vaccination coverage – PPV			2012/13	73.0	69.1	70.8	↔	It has remained stable over the last 2 years
Healthcare public health and preventing	43	4.01	Infant mortality			2010 - 2012	2.8	4.1	3.6	↑	It has improved from 5.5 in 2001-03 to 2.8 in 2010-12 rate per 1000
	44	4.02	Tooth decay in children aged 5			2011/2012	1.3	0.9	1.02		No trend data available

	8									
NHS Outcome Framework										
Preventing people from dying prematurely	45	1.6i	Reducing death in babies and young children: Infant mortality (PHOF 4.1)		2010-2012	2.8	4.1	3.6	↑	It has decreased from 3.3 in 2008-10 to 2.8 in 2010 - 12 per 1000
	46	1.6ii	Neonatal mortality and still births		2012 (calendar year)	5.5	7.6	6.3	↑	It has decreased from 9.0 in 2010 to 5.5 in 2012 and from 20 stillbirths and 9 neonatal deaths in 2010 to 12 still births and 5 neonatal deaths in 2012
	47	1.6iii	Five year survival from all cancers in children		2013/14		0.804			
Helping people to recover from episodes of ill health	48	3.2	Preventing lower respiratory tract infections (LRT) in children from becoming serious: Emergency admissions for children with LRTI		2013/14	468.9	368.6	452.7	↑	No target set for 2014/15, however direction of travel shows improvement compared to 2012/13 outturn of 591.4.
Ensuring that people	49	4.6	Friends and Family Test for Maternity Services - Ante Natal		Aug-14	71.0	66	76	↑	Rated as green due to being higher than England. Need to take into account the specific Trust's response rate
	50		Friends and Family Test for Maternity Services - Birth		Aug-14	81.0	77	84	↑	
	51		Friends and Family Test for Maternity Services - Post Natal		Aug-14	80.0	77	80	↑	

Objective 3: Supporting and motivating everyone to take responsibility for their health and that of others

Objective Lead - Gillian Gibson Board Sponsor - Cllr John Kelly

Public Health Outcome Framework				Service Lead	Latest Data	Actual To Date	2013/14 Target Comparison with North East Average if no target set		Trend - Direction of Travel	Risk to delivery & Comments
	No	PHOF Code	Indicator			Sunderland Average	England Average	North East Average	Direction of Travel	
Improving the wider determinants of health	1	1.16	Utilisation of green space for exercise/health reasons		Mar 2012 - Feb 2013	14.1	15.3	16	↑	It has improved from 5.8 in 2011 -12 to 14.1 in 2012/13
	2	1.17	Fuel poverty		2012	11.7	10.4	11.6		
	3	1.18i -	Social isolation: % of adult social care users who have as much social contact as they would like		2012/13	45.3	45.3	44.6	↔	It has remained stable over the last 3 years
	4	1.18ii	Social isolation: % of adult carers who have as much social contact as they would like		2012/13	40.6	41.3	49.6	-	No trend data available
Health Improvement	5	2.12	Excess weight in adults		2012	68.9	63.8	68	-	No trend data available
	6	2.13i	Percentage of physically active and inactive adults - active adults		2013	46.2%	55.6	52.8	↓	It has decresaed from 47.8 in 2012 to 46.2 in 2013
	7	2.13ii	Percentage of physically active and inactive adults - inactive adults		2013	36.4%	28.9	31.3	↑	It has improved from 37 in 2012 to 36.4 in 2013
	8	2.14	Smoking prevalence – adult (over 18s)		2012	23.4%	19.5	22.1	↑	It has improved from 24.6 in 2010 to 23.4 in 2012
	9	2.14	Smoking prevalence – routine and manual		2012	33.6%	29.7	31	↑	It has improved from 30.6 in 2011 to 33.6 in 2012
	10	2.17	Recorded diabetes		2012/2013	6.3%	6.01	6.37	↓	It has increased from 6.09 in 2011/12 to 6.32 in 2012/13
	11	2.18	Alcohol-related admissions to hospital		2012/2013	1071	637	856	↑	It has slightly decreased from 1088 in 2011/12 to 1071 in 2012/13
	12	2.20i	Cancer screening coverage - breast cancer		2013	77.3%	76.3	77.9	↓	It has deteriorated from 78.9 in 2012 to 77.3 in 2013
	13	2.20ii	Cancer screening coverage - cervical cancer		2013	77.0%	73.9	75.9	↓	It has deteriorated from 79.1 in 2012 to 77 in 2013
	14	2.21vii	Access to non-cancer screening programmes - diabetic retinopathy		2012/2013	92.5%	80.9	83.8	↑	It has improved from 82.7 in 2010/11 to 92.5 in 2011/12
	15	2.22v	Cumulative % of the eligible population aged 40 - 74 who received an NHS Health check		2013/2014	7.6%	9	10.4	-	No trend data available
	16	2.23i	Self-reported well-being - people with a low satisfaction score		2012/2013	7.6%	5.8	7	↑	It has improved from 8.1 in 2011/12 to 7.6 in 2012/13
	17	2.23ii	Self-reported well-being - people with a low worthwhile score		2012/2013	7.2%	4.4	5.7	↓	It has deteriorated from 5.9 in 2011/12 to 7.2 in 2012/13
	18	2.23iii	Self-reported well-being - people with a low happiness score		2012/2013	12.1%	10.4	12.6	↑	It has improved from 14.3 in 2011/12 to 12.1 in 2012/13
	19	2.23ii	Self-reported well-being - people with a high anxiety score		2012/2013	23.1%	21	22.5	↔	It has remained stable over the last 2 years
	20	2.24i	Falls and injuries in people aged 65 and over (persons)		2012/2013	2378 (rate per 100,000)	2011	2172	↓	It has increased from 2247 in 2011/12 to 2378 in 2012/13 rate per 100,000

	10 21	2.24ii	Falls and injuries in people aged 65 and over - aged 65 - 79		2012/2013	1,296	975	1156	↓	It has increased from 1134 in 2011/12 to 1296 in 2012/13 rate per 100,000
	22	2.24iii	Falls and injuries in people aged 65 and over - aged 80+		2012/2013	5,516	5015	5120	↓	It has increased from 5475 in 2011/12 to 5516 in 2012/13 rate per 100,000
Health Protection	23	3.02ii	Chlamydia screening detection rate (15-24 year olds)		2013	2,236	2,016	2,545		It has increased from 1935 in 2012 to 2236 in 2013 rate per 100,000
	24	3.03i	Population vaccination coverage - Hepatitis B (1 year old)		2012/2013	100%				
	25	3.03i	Population vaccination coverage - Hepatitis B (2 years old)		2012/2013	83.3				
	26	3.03ii	BCG vaccination coverage (1 and 2 year olds)		2012/2013					
	27	3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)		2012/2013	98.25	94.7	96.5	↑	It has improved from 96.7 in 2011/12 to 98.2 in 2012/13
	28	3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 year old)		2012/2013	98.2	96.3	97.8	↔	It has remained stable over the last 2 years
	29	3.03iv	Population vaccination coverage - MenC		2012/2013	98	93.9	96	↑	It has improved from 96.5 in 2011/12 to 98 in 2012/13
	30	3.03v	Population vaccination coverage - PCV		2012/2013	98.2	94.4	96.4	↑	It has improved from 96.6 in 2011/12 to 98.2 in 2012/13
	31	3.03vi	Population vaccination coverage - Hib / MenC booster (2 years old)		2012/2013	96.3	92.7	95.5	↑	It has improved from 95.9 in 2011/12 to 96.3 in 2012/13
	32	3.03vi	Population vaccination coverage - Hib / Men C booster (5 years)		2012/2013	97.4	91.5	94.7	↑	It has improved from 95.2 in 2011/12 to 97.4 in 2012/13
	33	3.03vii	Population vaccination coverage - PCV booster		2012/2013	95.9	92.5	95	↑	It has improved from 94 in 2011/12 to 95.9 in 2012/13
	34	3.03viii	Population vaccination coverage - MMR for one dose (2 years old)		2012/2013	94.9	92.3	94.1	↑	It has improved from 93.6 in 2011/12 to 94.9 in 2012/13
	35	3.03ix	Population vaccination coverage - MMR for one dose (5 years old)		2012/2013	96	93.9	96.2	↑	It has improved from 95.5 in 2011/12 to 96 in 2012/13
	36	3.03x	Population vaccination coverage - MMR for two doses (5 years old)		2012/2013	92.7	87.7	91.7	↑	It has improved from 90.6 in 2011/12 to 92.7 in 2012/13
	37	3.03xii	Population vaccination coverage - HPV		2012/2013	94.8	86.1	90	↑	It has improved from 90.2 in 2011/12 to 94.8 in 2012/13
	38	3.03xiii	Population vaccination coverage - PPV		2012/2013	73	69.1	70.8	↔	It has remained stable over the last 2 years
	39	3.04	People presenting with HIV at a late stage of infection		2010-29012	40	48.3	41.3	↑	It has improved from 51.4 in 2009-11 to 40 in 2010-12

Healthcare public health and preventing premature mortality	40	4.04i	Under 75 mortality rate from all cardiovascular diseases (persons)		2010 - 2012	99.9	81.1	92.4	↑	Tremendous progress has been made from 173 in 2001 -3 to 101.9 in 2009-11 to 99.9 in 2010 - 12 rate per 100,000
	41	4.04ii	Under 75 mortality rate from all cardiovascular diseases considered preventable (persons)		2010 - 2012	64	53.5	61.4	↑	Tremendous progress has been made from 123 in 2001 -3 to 67 in 2009-11 to 64 in 2010 - 12 rate per 100,000
	42	4.06i	Under 75 mortality rate from liver disease (persons)		2010 - 2012	23.9	18	22.3	↓	It has deteriorated from 18.3 in 2001 -3 to 23.6 in 2009-11 to 23.9 in 2010 - 12 rate per 100,000
	43	4.06ii	Under 75 mortality rate from liver disease considered preventable (persons)		2010 - 2012	22.5	15.8	19.7	↓	It has deteriorated from 16.4 in 2001 -3 to 22.3 in 2009-11 to 22.5 in 2010 - 12 rate per 100,000
	44	4.07i	Under 75 mortality rate from respiratory disease (persons)		2010 - 2012	47.6	33.5	42.2	↑	It has improved from 49.3 in 2009 -11 to 47.6 in 2010-12 rate per 100,000
	45	4.07ii	Under 75 mortality rate from respiratory disease considered preventable (persons)		2010 - 2012	28.4	17.6	23.8	↑	It has improved from 28.8 in 2009 -11 to 28.4 in 2010-12 rate per 100,000
	46	4.10	Suicide rate (persons)		2010 - 2012	11.7	8.5	9.8	↓	It has increased from 9.8 in 2009 - 2011 to 11.7 in 2010- 12 rate per 100,000
	47	4.12i	Preventable sight loss - age related macular degeneration (AMD		2012-2013	108.7	104.4	NE data NA	↑	It has improved from 165.7 in 2010/11 to 108.7 in 2012/13 per 100,000 or from 77 in 2010/11 to 53 in 2012/13
	48	4.12ii	Preventable sight loss - glaucoma		2012-2013	10.4	12.5	NE data NA	↑	It has improved from 15.4 in 2010/11 to 10.4 in 2012/13 per 100,000 or from 22 in 2010/11 to 15 in 2012/13
	49	4.12iii	Preventable sight loss - diabetic eye disease		2012-2013	3.8	3.5	NE data NA	↑	It has improved from 5. in 2010/11 to 3.8 in 2012/13 per 100,000 or from 12 in 2010/11 to 9 in 2012/13
	50	4.12iv	Preventable sight loss - sight loss certifications		2012-2013	55.5	42.3	NE data NA	↑	It has improved from 69.6 in 2010/11 to 55.5 in 2012/13 per 100,000 or from 192 in 2010/11 to 153 in 2012/13
	51	4.14i	Hip fractures in people aged 65 and over		2012-2013	668.7	568.1	627.8	↔	It has remained stable over the last 3 years
	52	4.14ii	Hip fractures in people aged 65 and over - aged 65-79		2012-2013	295.7	264.4	237.3	↓	It has increased from 277.2 in 2010/11 to 295.7 in 2012/13 or from 98 in 2010/11 to 108 in 2012/13
	53	4.14iii	Hip fractures in people aged 65 and over - aged 80+		2012-2013	1750	1528	1682	↑	It has improved from 1945 in 2010/11 to 1750 in 2012/13 rate per 100,000 or from 222 in 10/11 to 213 in 12/13
	54	4.16	Estimated diagnosis rate for people with dementia		2012-2013		48.7			No trend data available

	12									
NHS Outcome Framework										
Preventing people from dying prematurely	55	1ai	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults		2012 (calendar year)	3458.3	2801.4	3254.6		SCCG target for 2014/15 is 2,278 and Quality Premuim national indicator for 2014/15 - however includes both adult and child
	56	*1aii*	*Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare. ii Children and young people*		2012 (calendar year)	No data available	509.7			SCCG target for 2014/15 is 2,278 and Quality Premuim national indicator for 2014/15 - however
	57	1bi	Life expectancy at 75: i) Males		2010-2012	10.5	11.5	10.8	↓	Lower than National and North East average, however slight deterioration based on 2009-2011 at 10.4
	58	*1bii*	Life expectancy at 75: i) Females		2010-2012	11.9	13.3	12.5	↑	Lower than National and North East average, improvement based on 2009-2011 at
	59	*1.4*	Reducing premature mortality from the major causes of death: Under 75 mortality rate from cancer (PHOF 4.5i): i One-year survival from all cancers		2010-2012	174	146.5	171.4		
	61	*1.4ii*	Reducing premature mortality from the major causes of death: Under 75 mortality rate from cancer (PHOF 4.5): i One-year survival from all cancers		01/05/2014	66.73	68.7	68.01	↑	
	63	*1.5*	Reducing premature death in people with serious mental illness: Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9)		2011/12	330.6	337.4	434.2	↓	
	64	1.6i	Reducing deaths in babies and young children: i Infant mortality (PHOF 4.1		2010-2012	2.8	4.1	3.6	↑	It has decreased from 3.3 in 2008-10 to 2.8 in 2010 - 12 per 1000
	65	1.6ii	Reducing deaths in babies and young children: ii) Neonatal mortality and stillbirths		2012 (calendar year)	5.5	7.6	6.3	↑	It has decreased from 9.0 in 2010 to 5.5 in 2012 and from 20 stillbirths and 9 neonatal deaths in 2010 to 12 still births and 5 neonatal deaths in 2012
Enhancing quality of life for people with long-term conditions	68	2	Health-related quality of life for people with long-term conditions (ASCOF 1A)		2013/14 (ASCS)	19.60	18.8	19.2 (Target)		
	69	2.4	Enhancing quality of life for carers: Health-related quality of life for carers (ASCOF 1D)		July 2013 to March 2014	0.79	0.804	0.80	↑	

	13									
Helping people to recover from episodes of ill health or following injury	71	3a	Emergency admissions for acute conditions that should not usually require hospital admission		2012/13	1650.7	1181.9	1508.2	↑	High based on latest published data but significant reduction from 13/14 onwards
	72	3b	Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11)		2011-2012	13.1%	11.5	12.6	↑	Local data shows significant improvement in readmissions from 2013/14
	74	3.6i	Helping older people to recover their independence after illness or injury: i) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]*)		2013/14	85.53%	81.4%	86.4%		

Objective 4: Supporting everyone to contribute

Objective Lead - Berni Whitaker Board Sponsor - Nonnie Crawford

Public Health Outcome Framework				Service Lead	Latest Data	Actual To Date	2013/14 Target Comparison with North East Average if no target set		Trend - Direction of Travel	Risk to delivery & Comments
	No	PHOF Code	Indicator			Sunderland Average	England Average	North East Average	Direction of Travel	
Improving the wider determinants of health	1	1.01i	Children in poverty (all dependent children under 20)		2011	25.2	20.1	23.7	↑	There is a slight decrease from 24.4% in 2010 to 25.1% in 2011 or from 15,000 to 14,635. A significant number of children are living in poverty in Sunderland
	2	1.01ii	Children in poverty (under 16s)		2011	25.7	20.6	24.5	↑	It has improved from 26.7% in 2009 to 25.7% in 2011 or from 13,340 to 12,655. A significant number of children are living in poverty in Sunderland
	3	1.05	16 - 18 year olds not in education, employment or training		2013	8.0	5.3	7.6	↓	There is a slight increase from 7.6% in 2012 to 8% in 2013 or from 780 to 800.
	4	1.09i	Sickness absence - The percentage of employees who had at least one day off in the previous week		2009-2011	2.2	2.2	2.2	-	No trend data available
	5	1.09ii	Sickness absence - The percentage of working days lost due to sickness absence.		2009-2011	1.7	1.5	1.8	-	No trend data available
	6	1.16	Utilisation of green space for exercise/health reasons		Mar 2012 - Feb 2013	14.1	15.3	16	↑	It has improved from 5.8 in 2011 -12 to 14.1 in 2012/13
	7	1.18i -	Social isolation: % of adult social care users who have as much social contact as they would like		2012/13	45.3	43.2	44.6	↔	It has remained stable over the last 3 years
	8	1.18ii	Social isolation: % of adult carers who have as much social contact as they would like		2012/13	40.6	41.3	49.6	-	No trend data available
Health Improvement	9	2.12	Excess weight in adults		2012	68.9	63.8	68	-	No trend data available
	10	2.13i	Percentage of physically active and inactive adults - active adults		2013	46.2%	55.6	52.8	↑	It has improved from 47.8 in 2012 to 96.2 in 2013
	11	2.13ii	Percentage of physically active and inactive adults - inactive adults		2013	36.4%	28.9	31.3	↑	It has improved from 37 in 2012 to 36.4 in 2013
	12	2.14	Smoking prevalence – adult (over 18s)		2012	23.4%	19.5	22.1	↑	It has improved from 24.6 in 2010 to 23.4 in 2012
	13	2.14	Smoking prevalence – routine and manual		2012	33.6%	29.7	31	↑	It has improved from 30.6 in 2011 to 33.6 in 2012
	14	2.17	Recorded diabetes		2012/2013	6.3%	6.01	6.37	↓	It has increased from 6.09 in 2011/12 to 6.32 in 2012/13

	15	2.18	Alcohol-related admissions to hospital			2012/2013	1071	637	856	↑	It hasslightly deccreased from 1088 in 2011/12 to 1071 in 2012/13
	16	2.22iv	Cumulative % of the eligible population aged 40 - 74 who received an NHS Health check			2013/2014	7.6%	9	10.4	-	No trend data available
	17	2.23i	Self-reported well-being - people with a low satisfaction score			2012/2013	7.6%	5.8	7	↑	It has improved from 8.1 in 2011/12 to 7.6 in 2012/13
	18	2.23ii	Self-reported well-being - people with a low worthwhile score			2012/2013	7.2%	4.4	5.7	↓	It has deteriorated from 5.9 in 2011/12 to 7.2 in 2012/13
	19	2.23iii	Self-reported well-being - people with a low happiness score			2012/2013	12.1%	10.4	12.6	↑	It has improved from 14.3 in 2011/12 to 12.1 in 2012/13
	20	2.23ii	Self-reported well-being - people with a high anxiety score			2012/2013	23.1%	21	22.5	↔	It has remained stable over the last 2 years
Healthcare public health and preventing premature mortality	21	4.04i	Under 75 mortality rate from all cardiovascular diseases (persons)			2010 - 2012	99.9	81.1	92.4	↑	Tremendous progress has been made from 173 in 2001 -3 to 101.9 in 2009-11 to 99.9 in 2010 - 12 rate per 100,000
	22	4.04ii	Under 75 mortality rate from all cardiovascular diseases considered preventable (persons)			2010 - 2012	64.0	53.5	61.4	↑	Tremendous progress has been made from 123 in 2001 -3 to 67 in 2009-11 to 64 in 2010 - 12 rate per 100,000
	23	4.06i	Under 75 mortality rate from liver disease (persons)			2010 - 2012	23.9	18	22.3	↓	It has deteriorated from 18.3 in 2001 -3 to 23.6 in 2009-11 to 23.9 in 2010 - 12 rate per 100,000
	24	4.06ii	Under 75 mortality rate from liver disease considered preventable (persons)			2010 - 2012	22.5	15.8	19.7	↓	It has deteriorated from 16.4 in 2001 -3 to 22.3 in 2009-11 to 22.5 in 2010 - 12 rate per 100,000
	25	4.07i	Under 75 mortality rate from respiratory disease (persons)			2010 - 2012	47.6	33.5	42.2	↑	It has improved from 49.3 in 2009 -11 to 47.6 in 2010-12 rate per 100,000
	26	4.07ii	Under 75 mortality rate from respiratory disease considered preventable (persons)			2010 - 2012	28.4	17.6	23.8	↑	It has improved from 28.8 in 2009 -11 to 28.4 in 2010-12 rate per 100,000
	27	4.10	Suicide rate (persons)			2010 - 2012	11.7	8.5	9.8	↓	It has increased from 9.8 in 2009 - 2011 to 11.7 in 2010- 12 rate per 100,000
NHS Outcome Framework											
Preventing people from dying prematurely	28	*1.6*	Reducing premature death in people with serious mental illness: Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9)		*CCG*	*2011-2012*	330.6	337.4		↓	It has increased from 312.9 in 2010/11 to 330.6 in 2011- 12 SMR (Standardised Mortality Ratio)

Objective 5: Supporting people with long term conditions and their carers

Objective Lead - Debbie Burnicle Board Sponsor - Dave Gallagher

Public Health Outcome Framework				Service Lead	Latest Data	Actual To Date	2013/14 Target Comparison with North East Average if no target set		Trend - Direction of Travel	Risk to delivery & Comments
	No	PHOF Code	Indicator			Sunderland Average	England Average	North East Average	Direction of Travel	
Improving the wider determinants of health	1	1.16	Utilisation of green space for exercise/health reasons		Mar 2012 - Feb 2013	14.10	15.3	16	↑	It has improved from 5.8 in 2011 -12 to 14.1 in 2012/13
	2	1.17	Fuel poverty		2012	11.70	10.4	11.6	↑	It has improved from 11.9 in 2011 to 11.7 in 2012 or from 14,482
	3	1.18i -	Social isolation: % of adult social care users who have as much social contact as they would like		2012/13	45.30	43.2	43.2	↔	It has remained stable over the last 3 years
	4	1.18ii	Social isolation: % of adult carers who have as much social contact as they would like		2012/13	40.60	41.3	49.6	-	No trend data available
Healthcare public health and preventing premature mortality	5	4.04i	Under 75 mortality rate from all cardiovascular diseases (persons)		2010 - 2012	99.90	81.1	92.4	↑	Tremendous progress has been made from 173 in 2001 -3 to 101.9 in 2009-11 to 99.9 in 2010 - 12 rate per 100,000
	6	4.04ii	Under 75 mortality rate from all cardiovascular diseases considered preventable (persons)		2010 - 2012	64.00	53.5	61.4	↑	Tremendous progress has been made from 123 in 2001 -3 to 67 in 2009-11 to 64 in 2010 - 12 rate per 100,000
	7	4.06i	Under 75 mortality rate from liver disease (persons)		2010 - 2012	23.90	18	22.3	↓	It has deteriorated from 18.3 in 2001 -3 to 23.6 in 2009-11 to 23.9 in 2010 - 12 rate per 100,000
	8	4.06ii	Under 75 mortality rate from liver disease considered preventable (persons)		2010 - 2012	22.50	15.8	19.7	↓	It has deteriorated from 16.4 in 2001 -3 to 22.3 in 2009-11 to 22.5 in 2010 - 12 rate per 100,000
	9	4.07i	Under 75 mortality rate from respiratory disease (persons)		2010 - 2012	47.60	33.5	42.2	↑	It has improved from 49.3 in 2009 -11 to 47.6 in 2010-12 rate per 100,000
	10	4.07ii	Under 75 mortality rate from respiratory disease considered preventable (persons)		2010 - 2012	28.40	17.6	23.8	↑	It has improved from 28.8 in 2009 -11 to 28.4 in 2010-12 rate per 100,000
	11	4.09	Excess under 75 mortality in adults with serious mental illness		2011-2012	330.60	337.4			
	12	,4.10	Suicide rate		2010 - 2012	11.70	8.5	9.8	↓	It has increased from 9.8 in 2009 - 2011 to 11.7 in 2010- 12 rate per 100,000
	13	4.11	Emergency readmissions within 30 days of discharge from hospital (persons)		2011-2012	13.30	11.8	12.7	↓	It has increased from 12.9% in 2010/11 to 13.3 in 2011/12 or from 4787 in 2010/11 to 5021 in 2011/12

	14	4.12i	Preventable sight loss - age related macular degeneration (AMD			2012-2013	108.70	104.4	NE data NA	↑	It has improved from 165.7 in 2010/11 to 108.7 in 2012/13 per 100,000 or from 77 in 2010/11 to 53 in 2012/13
	15	4.12ii	Preventable sight loss - glaucoma			2012-2013	10.40	12.5	NE data NA	↑	It has improved from 15.4 in 2010/11 to 10.4 in 2012/13 per 100,000 or from 22 in 2010/11 to 15 in 2012/13
	16	4.12iii	Preventable sight loss - diabetic eye disease			2012-2013	3.80	3.5	NE data NA	↑	It has improved from 5. in 2010/11 to 3.8 in 2012/13 per 100,000 or from 12 in 2010/11 to 9 in 2012/13
	17	4.12iv	Preventable sight loss - sight loss certifications			2012-2013	55.50	42.3	NE data NA	↑	It has improved from 69.6 in 2010/11 to 55.5 in 2012/13 per 100,000 or from 192 in 2010/11 to 153 in 2012/13
	18	4.15i	Excess winter deaths index (single year all ages)			Aug 2011 - Jul 2012	14.90	16.1	11	↑	It has improved from 16.5 in 2006/07 to 14.9 in 2011/12 or from 149 in 2006/07 to 131 in 2011/12

Adult social care outcomes framework

	No	ASOF	Indicator				Sunderland Average	England Average	North East Average		
Enhancing quality of life for people with care and support needs	19	1A	Social care-related quality of life (NHSOF 2).			2013/14 (ASCS)	19.60	18.8	19.2 (Target)	↑	It has improved from 19.10 in 2012/13 to 19.60 in 2013/14
	20	1c-Part 1	Proportion of people using social care who receive self-directed support, and those receiving direct payments			2013/14	73.27%	55.5%	72%	↑	It has improved from 73.08 in 2012/13 to 73.27 in 2013/14
	21	1c-Part 2	Proportion of people who receive self-directed support as a direct payments			2013/14	16.32%	16.5%	20%	↔	It has remained stable over the last 3 years
	22	1B	Proportion of people who use services who have control over their daily life.			2013/14	76.25		77.22 (Target)	↑	It has improved from 72.86 in 2012/13 to 76.25 in 2013/14
	23	1ci	Proportion of people using social care who receive self-directed support, and those receiving direct payments			2013/14	73.27		72% (Target)		
	24	1D	caring roles and maintain their desired quality of life: Carer-reported quality of life. (NHSOF 2.4)			.2012/13	8 (out of 12)				
	25	1G	Proportion of adults with a learning disability who live in their own home or with their family. (PHOF 1.6)			2013/2014	78.98		84 (Target)		
	26	1H	Proportion of adults in contact with secondary mental health services living independently, with or without support. (PHOF 1.6)			2013/2014	82.30		78.5 (Target)		

	27	1L	Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. (PHOF 1.18)		2012/2013	53.10	52.7	47.3	↑	It has improved from 42.94 in 2012/13 to 53.10 in 2013/14
Delaying and reducing the need for care and support	28	2B - Part 1	Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. (NHSOF 3.6i)			85.53%	81.4%	86.4% (Target)	↑	It has improved from 76.32 in 2012/13 to 85.5 in 2013/14
	29	2B - Part 2	Proportion of older people (65 and over) offered reablement/rehabilitation services following discharge from hospital.		2013-2014	3.50%	**3.3%**			
	30	2C Part 1	When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence: Delayed transfers of care from hospital, and those which are attributable to adult social care			8.71	9.7	10.5 (average of 24 people) Target	↑	It has improved from 12.59 in 2012/13 to 8.7 in 2013/14
Ensuring that people have a positive experience of care and support	31	3A	People who use social care and their carers are satisfied with their experience of care and support services: Overall satisfaction of people who use services with their care and support.		2013/2014	67.07%	64.1%	71.2%	↓	It has deteriorated from 70.21 in 2012/13 to 67.07 in 2013/14
	32	3B	People who use social care and their carers are satisfied with their experience of care and support services: Overall satisfaction of carers with social services.		2012/2013	45.59	42.70			Carers Survey biennial
	33	3C	The proportion of carers who report that they have been included or consulted in discussions about the person they care for.		2012/2013	77.78	72.90			Carers Survey biennial
	34	3D	The proportion of people who use services and carers who find it easy to find information about support		2013/2014	76.90		74.4 (Target)	↑	It has improved from 70.83 in 2012/13 to 76.90 in 2013/14

NHS Outcome Framework

Preventing people from dying prematurely	35	1ai	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare: i Adults			2012 (calendar year)	3458.3	2801.4	3254.6		SCCG target for 2014/15 is 2,278 and Quality Premuim national indicator for 2014/15 - however includes both adult and child.
	36	1aii	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare: ii Children and young people			2012 (calendar year)	No data available	509.7			SCCG target for 2014/15 is 2,278 and Quality Premuim national indicator for 2014/15 - however includes both adult and child.
	37	1bi	Life expectancy at 75: i) Males			2010-2012	10.5	11.5	10.8	↓	Lower than National and North East average, however slight deterioration based on 2009-2011 at 10.4
	38	1bii	Life expectancy at 75: i) Females			2010-2012	11.9	13.3	12.5	↑	Lower than National and North East average,
	43	1.5	Reducing premature death in people with serious mental illness: Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9)			,2011/2012	*330.60*	337.4			
Enhancing quality of life for people with long-term conditions	45	2	Health-related quality of life for people with long-term conditions (ASCOF 1A)			2013/14 (ASCS)	19.60	18.8	19.2 (Target)		
	46	2.1	Proportion of people feeling supported to manage their condition			2013/14	66.30	65.1	68.7	↑	Performance above England Average, however below North East. Deterioration in comparison to 2012/13 at 69.9
	47	2.2	Improving functional ability in people with long-term conditions: Employment of people with long-term conditions (ASCOF 1E & PHOF 1.8)			2013/2014	6.80		8.0 (Target)		
	48	2.3i	i) Unplanned hospitalisation for chronic ambulatory care sensitive conditions			2013/14	887.10	780.9	928.60	↑	CCG continues to show a reduction in ACS conditions due to implementation of pathways at CHS NHSFT
	49	2.3ii	Reducing time spent in hospital by people with long-term conditions: ii) Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s			2012/13	518.4	340.6	340.00	↑	CCG have an aspiration over next 5 years to reduce non electives by 15%, although focus is on frail elders rather than under19s.
	50	2.4	Health-related quality of life for carers (ASCOF 1D)			July 2013 to March 2014	0.79	0.804	0.80	↑	
	51	2.5	Enhancing quality of life for people with mental illness: Employment of people with mental illness (ASCOF 1F & PHOF 1.8)			2013/2014	5.80		9.1 (Target)		

	52	2.6i	Enhancing quality of life for people with dementia: i) Estimated diagnosis rate for people with dementia (PHOF 4.16)		Jun-14	64.30%	64.00%		↑	CCG continues to show good progress towards a stretching 13/14 target of 67%.
Helping people to	53	3a	Emergency admissions for acute conditions that should not usually require hospital admission		2011/12	13.30	11.8	12.7	↑	It has increased from 12.9% in 2010/11 to 13.3 in 2011/12 or from 4787 in 2010/11 to 5021 in 2011/12
Ensuring that people have a positive experience of care	57	4.ai	Patient experience of primary care: i) GP services		2013/2014	89.00	85.7	88.2	↔	Target to be confirmed for 2014/15, however performance above England and North East average.
	58	4.aii	Patient experience of primary care: i i) GP Out of Hours services		2013/2014	63.10	66.2	66.2	↔	Target to be confirmed for 2014/15, performance is below England and North East average. CCG performance has shown a deterioration based on 2012/13 at 70.3
	59	4.aiii	Patient experience of primary care: iii NHS Dental services		2013/2014	90.80	84.2	89.2	↔	Performance is above England and North East average. CCG performance has shown a slight deterioration based on 2012/13 at 90.0
	60	4.4i	Improving access to primary care services: Access to i) GP services		2013/2014	79.10	74.6	77.1	↓	Performance is above England and North East average. CCG performance has shown a slight deterioration based on 2012/13 at 81.1
	61	4.4ii	Improving access to primary care services: Access to ii) NHS dental services		2013/2014	98.30	94.8	97.3	↑	Performance is above England and North East average. CCG performance has shown an improvement based on 2012/13 at 97.7
	62	4.7	Improving experience of healthcare for people with mental illness: Patient experience of community mental health services		Jul-14	87.36	85.81	-	↓	Indicator is provider based and is based on NTW data

Objective 6: Supporting individuals and their families to recover from ill-health and crisis Objective Lead - Neil Revely Board Sponsor - Cllr Mel Speding

Public Health Outcome Framework				Service Lead	Latest Data	Actual To Date	2013/14 Target Comparison with North East Average if no target set		Trend - Direction of Travel	Risk to delivery & Comments
	No	PHOF Code	Indicator			Sunderland Average	England Average	North East Average	Direction of Travel	
Improving the wider determinants of health	1	1.16	Utilisation of green space for exercise/health reasons		Mar 2012 - Feb 2013	14.1	15.3	16	↑	It has improved from 5.8 in 2011 -12 to 14.1 in 2012/13
	2	1.17	Fuel poverty		2012	11.7	10.4	11.6	↑	It has improved from 11.9 in 2011 to 11.7 in 2012
	3	1.18i -	Social isolation: % of adult social care users who have as much social contact as they would like		2012/13	45.3	43.2	44.6	↔	It has remained stable over the last 3 years
	4	1.18ii	Social isolation: % of adult carers who have as much social contact as they would like		2012/13	40.6	41.3	49.6	-	No trend data available
Health Improvement	5	2.24i	Falls and injuries in people aged 65 and over (persons)		2012/2013	2,378	2011	2172	↓	It has increased from 2247 to 2378 rate per 100,000
	6	2.24ii	Falls and injuries in people aged 65 and over - aged 65 - 79		2012/2013	1,296	975	1156	↓	It has increased from 1134 in 2011/12 to 1296 in 2012/13 rate per 100,000
	7	2.24iii	Falls and injuries in people aged 65 and over - aged 80+		2012/2013	5,516	5015	5120	↓	It has increased from 5475 in 2011/12 to 5516 in 2012/13 rate per 100,000
Health Protection	8	3.02ii	Chlamydia diagnoses (15-24 year olds)		2013	2,236	2,016	2545		It has increased from 1935 in 2012 to 2236 in 2013 rate per 100,000
Healthcare public health and preventing premature mortality	9	4.04i	Under 75 mortality rate from all cardiovascular diseases (persons)		2010 - 2012	99.9	81.1	92.4	↑	Tremendous progress has been made from 173 in 2001 -3 to 101.9 in 2009-11 to 99.9 in 2010 - 12 rate per 100,000
	10	4.04ii	Under 75 mortality rate from all cardiovascular diseases considered preventable (persons)		2010 - 2012	64	53.5	61.4	↑	Tremendous progress has been made from 123 in 2001 -3 to 67 in 2009-11 to 64 in 2010 - 12 rate per 100,000
	11	4.06i	Under 75 mortality rate from liver disease (persons)		2010 - 2012	23.9	18	22.3	↓	It has deteriorated from 18.3 in 2001 -3 to 23.6 in 2009-11 to 23.9 in 2010 - 12 rate per 100,000
	12	4.06ii	Under 75 mortality rate from liver disease considered preventable (persons)		2010 - 2012	22.5	15.8	19.7	↓	It has deteriorated from 16.4 in 2001 -3 to 22.3 in 2009-11 to 22.5 in 2010 - 12 rate per 100,000
	13	4.07i	Under 75 mortality rate from respiratory disease (persons)		2010 - 2012	47.6	33.5	42.2	↑	It has improved from 49.3 in 2009 -11 to 47.6 in 2010-12 rate per 100,000
	14	4.07ii	Under 75 mortality rate from respiratory disease considered preventable (persons)		2010 - 2012	28.4	17.6	23.8	↑	It has improved from 28.8 in 2009 -11 to 28.4 in 2010-12 rate per 100,000
	15	4.10	Suicide rate (persons)		2010 - 2012	11.7	8.5	9.8	↓	It has increased from 9.8 in 2009 - 2011 to 11.7 in 2010- 12 rate per 100,000

	16	4.11	Emergency readmissions within 30 days of discharge from hospital		2010 - 2012	13.3	11.8	12.7	↓	It has increased from 12.9% in 2010/11 to 13.3 in 2011/12 or from 4787 in 2010/11 to 5021 in 2011/12
	17	4.14i	Hip fractures in people aged 65 and over		2012-2013	668.7	568.1	627.8	↔	It has remained stable over the last 3 years
	18	4.14ii	Hip fractures in people aged 65 and over - aged 65-79		2012-2013	295.7	264.4	237.3	↓	It has increased from 277.2 in 2010/11 to 295.7 in 2012/13 Per 100,000 or from 98 in 2010/11 to 108 in 2012/13
	19	4.14iii	Hip fractures in people aged 65 and over - aged 80+		2012-2013	1750	1528	1682	↑	It has improved from 1945 in 2010/11 to 1750 in 2012/13 rate per 100,000 or from 222 in 10/11 to 213 in 12/13

Adult social care outcomes framework

	No	ASOF	Indicator							
Enhancing quality of life for people with care and support needs	20	1A	Social care-related quality of life (NHSOF 2).		2013/14	1960.00%	18.8	19.2 (Target)	↑	It has improved from 19.10 in 2012/13 to 19.60 in 2013/14
	21	1c-Part 1	Proportion of people using social care who receive self-directed support, and those receiving direct payments		2013/14	73.27%	55.5%	72%	↑	It has improved from 73.08 in 2012/13 to 73.27 in 2013/14
	22	1c-Part 2	Proportion of people who receive self-directed support as a direct payments		2013/14	16.32%	16.5%	20%	↔	It has remained stable over the last 3 years
	23	1B	Proportion of people who use services who have control over their daily life.		2013/14	76.25	76.1	77.22	↑	It has improved from 72.86 in 2012/13 to 76.25 in 2013/14
	24	1D	Carers can balance their caring roles and maintain their desired quality of life: Carer-reported quality of life. (NHSOF 2.4)		2012/2013	8 (out of 12)				
	25	IL	Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. (PHOF 1.18)		2013/2014	53.10	52.70	47.30	↑	It has improved from 42.94 in 2012/13 to 53.10 in 2013/14
Delaying and reducing the need for care and support	26	2B Part 1	Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. (NHSOF 3.6i)		2013/2014	85.53%	81.4%	86.4% (Target)	↑	It has improved from 76.32 in 2012/13 to 85.5 in 2013/14
	27	2c Part 2	When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence: Delayed transfers of care from hospital, and those which are attributable to adult social care.		2013/2014	4.8	3.1	8.4 (average of 19 people)	↑	It has improved from 9.65 in 2012/13 to 4.8 in 2013/14

Ensuring that people have a positive experience of care and support	28	3A	People who use social care and their carers are satisfied with their experience of care and support services: Overall satisfaction of people who use services with their care and support.		2013/2014	67.07%	64.1%	71.2%	↓	It has deteriorated from 70.21 in 2012/13 to 67.07 in 2013/14
	29	3B	People who use social care and their carers are satisfied with their experience of care and support services: Overall satisfaction of carers with social services.		2012/2013	45.59	42.70			Carers Survey biennial
	30	3C	Carers feel that they are respected as equal partners throughout the care process: The proportion of carers who report that they have been included or consulted in discussions about the person they care for.		2012/2013	77.78	72.90			Carers Survey biennial
	31	3D	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help: The proportion of people who use services and carers who find it easy to find information about support		2013/2014	76.90		74.4 (Target)	↑	It has improved from 70.83 in 2012/13 to 76.90 in 2013/14
NHS Outcome Framework										
Preventing people from dying prematurely	32	1ai	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare: i Adults		2012 (calendar year)	3458.3	2801.4	3254.6		SCCG target for 2014/15 is 2,278 and Quality Premuim national indicator for 2014/15 - however includes both adult and child.
	32	*1.aii*	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare: ii Children and young people		2012 (calendar year)	No data available	509.7			SCCG target for 2014/15 is 2,278 and Quality Premuim national indicator for 2014/15 - however includes both adult and child.
	33	1bi	Life expectancy at 75: i) Males		2010-2012	10.5	11.5	10.8	↓	Lower than National and North East average, however slight deterioration based on 2009-2011 at 10.4
	34	*1bii*	Life expectancy at 75: i) Females		2010-2012	11.9	13.3	12.5	↑	Lower than National and North East average, improvement based on 2009-2011 at 12.0
	35	*1.4i*	Reducing premature mortality from the major causes of death: Under 75 mortality rate from cancer (PHOF 4.5): i One-year survival from all cancers		2010 - 2012 PHOF 4.05i)	174.4	146.5	171.4	↑	It has improved from 204 in 2001/03 to 174.4 in 2010/12 rate per 100,000 or from 1384 in 2001/03 to 1235 in 2010/12
	36	*1.4ii*	Reducing premature mortality from the major causes of death: i) Five year survival from all cancers		01/05/2014	66.73	68.7	68.01	↑	
	39	*1.5*	Reducing premature death in people with serious mental illness: Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9)		2011/2012	*330.6*	337.4		↓	It has deteriorated from 312.9 in 2010/11 to 330.6 in 2011/12
	40	*1.7*	Reducing prematuredeath in people with a learning disability: Excess under 60 mortality rate in adults with a learning disability		2011/12	330.6	337.4	434.2	↓	

Ensuring quality of life for people with long term conditions	41	2.1	Proportion of people feeling supported to manage their condition		2013/14	66.30	65.1	68.7	↓	Performance above England Average, however below North East. Deterioration in comparison to 2012/13
	42	2.3i	Reducing time spent in hospital by people with long-term conditions: i) Unplanned hospitalisation for chronic ambulatory care sensitive conditions		2013/14	887.10	780.9	928.60	↑	CCG continues to show a reduction in ACS conditions due to implementation of pathways at CHS NHSFT
	43	2.3ii	Reducing time spent in hospital by people with long-term conditions: ii) Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s		2012/13	518.4	340.6	340.00	↑	CCG have an aspiration over next 5 years to reduce non electives by 15%, although focus is on frail elders rather than under19s.
Helping people to recover from episodes of ill health or following injury	44	3a	Emergency admissions for acute conditions that should not usually require hospital admission		2011/12	13.30	11.8	12.7	↑	It has increased from 12.9% in 2010/11 to 13.3 in 2011/12 or from 4787 in 2010/11 to 5021 in 2011/12
	50	3.8i	Helping older people to recover their independence after illness or injury: i) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]*)		2013/14	85.53%	81.4%	86.4% (Target)	↑	It has improved from 76.32 in 2012/13 to 85.5 in 2013/14
	51	3.8ii	Helping older people to recover their independence after illness or injury: Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]*)		2012-2013	3.50%	3.3%		↑	It has improved from 3.30 in 2012/13 to 3.5 in 2013/14
Ensuring that people have a positive experience of care	53	4b	Patient experience of hospital care		2013/14	75.8	76.9		↓	Data only available at National level or by Provider - Actual is based on provider City Hospitals Sunderland. Provider below national average and showing a slight deterioration based on 2012/13 performance of 77.0
	54	4.1	Improving people's experience of outpatient care: Patient experience of outpatient services		2011	81.70	79.5		↔	No current data available, City Hositals Sunderland's performance is above England average in 2011.
	55	4.3	Improving people's experience of accident and emergency services: Patient experience of A&E services		2012	81.70	79.1		↓	
	56	4.7	Improving experience of healthcare for people with mental illness: Patient experience of community mental health services		Jul-14	87.36	85.81	-	↓	Indicator is provider based and is based on NTW data

Appendix 2

Health and Wellbeing Strategy Performance Report

Performance Management Framework Structure

The performance management framework is based upon three national outcome frameworks that cover different areas of the health and care system:

- The Public Health Outcomes Framework (PHOF)
- NHS Outcomes Framework (NHSOF)
- Adult Social Care Outcomes Framework (ASCOF).

These frameworks help highlight common challenges at the local level across the health and care system, thereby informing local priorities and joint action. They are therefore an important tool in understanding progress made against the HWBS.

The outcome frameworks have common themes. The PHOF and NHSOF share goals on preventing premature death, whereas the NHSOF and ASCOF share goals on ensuring positive experience of care. The themes are supported by more detailed indicators that may be shared or complementary where there are shared goals.

The indicators from PHOF, NHSOF and ASCOF have been aligned to each of the HWBSs six Objectives and populated with the latest data available from across the health and social care system. The pages that follow provide information about the indicators currently showing red for each Objective as well as a more detailed understanding of how each of these indicators is performing.

Performance to Date

Objective 1

The indicators showing red for Objective 1 are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 1 contributes are:

- PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
- NHSOF: Indicator 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2012 -2013) and is mapped to objectives 1, and 6
- ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services. 2013/14 is mapped to objective 1, 5 and 6
- ASCOF: 2(C) – Part 2 - Delayed transfers of care attributable to social care 2013/14 and
  mapped to objective 1 and 6.

Objective 2

PHOF: Indicator 2.02 Breast feeding Initiation and prevalence at 6 – 8 weeks after birth (period 2012/13)

A key priority for providing the best start in life for a child is breastfeeding. Babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection than babies who are not, and breastfeeding is associated with lower levels of childhood obesity. There are also benefits to the mother including a faster return to pre-pregnancy weight and lower risk of breast and ovarian cancer. Increases in breastfeeding are expected to reduce illness in young children. This in turn will reduce hospital admissions for the 0-1 age group.

When compared with England (47.2%), and regional averages (31.2%), Sunderland (27.8%) performs worse in terms of the percentage of babies who continue to be breast fed at 6-8 weeks after birth. However this is an improvement from 24.7% in 2011/12 and almost one third of all babies who are breast fed at birth (60.3%) are no longer breastfeeding 6 to 8 weeks later (27.8%). Our ambition should be that all babies are breastfed so it is important that all should start to be breastfed at birth and continue to be breastfed during the first 6 months of life. Increasing breastfeeding rates must continue to be a priority.

PHOF: Indicator 2.03 Smoking at Time of Delivery (2012/13)

In the year 2012-13, 523 mothers were smoking at time of delivery in Sunderland. This represents 18.5% of all mothers in Sunderland, compared with 19.7% in the North East, and 12.7% in England. In Sunderland rates have fallen over recent years from 21.6 in 2010/11 to 18.5 in 2012/13. Smoking at time of delivery varies by age with younger mothers in their teens and twenties much more likely to smoke than mothers in their thirties and forties. Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

PHOF: Indicator 2.04 Under 18 Conception Rate (2012)

There were 207 conceptions in Sunderland during 2012 for females aged under 18, with around half leading to a birth. The latest annual conception rate is 43.1 per 1,000 females compared with 35.5 for the North East, and 27.7 for England. There is a very clear link between area deprivation and teenage conception, with rates in the most deprived areas around four times higher than the least deprived areas both locally and nationally. However Sunderland has seen a substantial and sustained reduction in the rate of conceptions in girls under the age of 18 years from 63.78 per 1000 girls in 2003 to 43.1 per 1000 in 2012. Nevertheless, although the gap is narrowing, Sunderland's rate is still significantly higher than the national average (27.7 per 1000).

PHOF: Indicator 2.07 Hospital Admissions for injuries, aged 0 to 14 (2012/13)

719 persons aged 0 to 14 were admitted to hospital due to accidental and deliberate injuries in 2012-13. The Sunderland rate was 160.2%, which is higher than the North East rate of 146.8% and England rate of 103.8. It has improved significantly from 211.4% in 2011/12 to 160.2% in 2012/13. Higher admission levels were also seen in very young children 0 to 4 years 211.2% compared 134.7 nationally.

PHOF: Indicator 4.02 Tooth decay in children aged 5 (2011-12)

Whilst children's oral health has improved over the past 20 years, five-year olds experiencing tooth decay in Sunderland was 1.32 slightly worse than England average of .9 and North East value of 1.02.

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Poor oral health can impact upon a child's ability to sleep, eat, speak, play and socialise with other children. Other consequences include pain, infections, poor diet, and impaired nutrition and growth. Oral health is thus a fundamental part of overall health and wellbeing. When children are not healthy, this affects their ability to learn, thrive and develop. In this way, good oral health can contribute to school readiness.

NHSOF: Indicator 3.2 - Preventing lower respiratory tract infections (LRT) in children from becoming serious: Emergency admissions for children with LRTI (2013/14)

Sunderland's performance at 468.9 is higher than National (368.6) and North East (452.7) average. No target set for 2014/2015; however direction of travel shows improvement compared to 2012/13 outturn of 591.4.

- There are other indicators showing red for Objective 2 that are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 2 contributes are:
  - PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5.

Objective 3

PHOF: Indicator: 2.20 Cancer screening coverage breast cancer (2013)

At March 2012 the breast screening coverage rate in Sunderland was 77.3%. This is lower than the North East average of 77.9% but better the national average of 76.3. Participation in the breast cancer screening programme can reduce deaths from breast cancer by about 35% among women who are regularly screened. Breast

cancer screening coverage in Sunderland has decreased from 78.9 in 2012 to 77.3 in 2013.

Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to increase coverage of cancer screening. Improvements in coverage would mean more breast cancers are detected at earlier, more treatable stages.

PHOF: Indicator 2.24 Injuries Due to Falls in people aged 65 and over (2012-13)

There were 1,163 admissions due to falls in 2012-13 in Sunderland for people aged 65 and over. The age standardised rate per 100,000 was 2378 in Sunderland, which is above the North East (2172), and England (2011.0) rates. The rate has increased from 2247 in 2011-12 to 2378 in 2012 -13

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people.

- There are other indicators showing red for Objective 3 that are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 3 contributes are:
  - PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5
  - PHOF: Indicator 2.13 Proportion of Physically Active Adults (2013) is mapped to objective 3 & 4
  - PHOF: Indicator: 2.18 Alcohol-Related Admissions (2012/13) is mapped to objective 3 & 4
  - PHOF: Indicator 2.22 Percentage Receiving an NHS Health Check (2013/14) is mapped to objective 3 and 4
  - PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
  - PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
  - PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12) and is mapped to objectives 3, 5 and 6
  - NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6

- NHSOF: Indicator 1b - Life expectancy at 75: Males (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6.

Objective 4

PHOF: Indicator 1.01 Children in Poverty (under 16s) (period 2011)

12,655 children (25.7%) in Sunderland live in households dependent on benefits or tax credits, compared with 24.5% in the North East and 20.6% nationally. Child poverty rates in Sunderland fell between 2009 and 2011 from 26.7% (13340) to 25.7% (12,655). The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

- There are other indicators showing red for Objective 4 that are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 4 contributes are:
  - PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 2.13 Proportion of Physically Active Adults (2013) is mapped to objective 3 & 4
  - PHOF: Indicator: 2.18 Alcohol-Related Admissions (2012/13) is mapped to objective 3 & 4
  - PHOF: Indicator 2.22 Percentage Receiving an NHS Health Check (2013/14) is mapped to objective 3 and 4
  - PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
  - PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6.

Objective 5

The indicators showing red for Objective 5 are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 1 contributes are:

- PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators

- PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5
- PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12 and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Males **(**2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6
- ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services. 2013/14 is mapped to objectives 1, 5 and 6.

Objective 6

The indicators showing red for Objective 6 are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 6 contributes are:

- PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12 and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Males **(**2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2012 -2013) and is mapped to objectives 1, and 6

- NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6
- ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services. 2013/14 is mapped to objective 1, 5 and 6
- ASCOF: 2(C) – Part 2 - Delayed transfers of care attributable to social care 2013/14 and
  mapped to objective 1 and 6.

Cross Cutting Indicators

PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons - all indicators

This has improved from 5.8% in 2011-2012 to 14.1% in 2012 – 2013. Inclusion of this indicator is recognition of the significance of accessible outdoor space as a wider determinant of public health. There is strong evidence to suggest that outdoor spaces have a beneficial impact on physical and mental well-being and cognitive function through both physical access and usage

PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like - all indicators

This has remained stable over the last 3 years at 45.3% but is better than the north east average of 44.6%

PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like - all indicators

At 40.6% this is much lower than the north east average of 49.6%.

There is a clear link between loneliness and poor mental and physical health. Social isolation has major health implications. It is linked in particular with factors such as growing older, loss of mobility, deprivation and sensory impairment. Strong social networks are often overlooked but are in fact critical to our health and wellbeing. A lack of social interaction can be as bad for health as smoking, obesity, lack of physical activity or misuse of alcohol

PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5

Just over 1 in 11 households in Sunderland are in fuel poverty (11.7%), which is above the North East (11.6%) and above the England (10.41%) rates. Levels of fuel poverty fell between 2011 and 2012 in Sunderland from 11.9% (14,482) to 11.7% (13,805). Fuel poverty in more prevalent in groups with low household incomes, including pensioners, persons on benefits, and working families with below average incomes and the low wage economy, particularly in North East and higher living costs contribute to levels of fuel poverty locally. Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes.

PHOF: Indicator 2.13 Proportion of Physically Active Adults (2013) is mapped to objective 3 & 4

46.2% of adults in Sunderland were physically active for at least 150 minutes per week in 2013. This is significantly lower than the North East region (52.8) and national (55.6%) rates. Levels of physical activity decreased from 47.8% in 2012 to 46.2% in 2013

PHOF: Indicator: 2.18 Alcohol-Related Admissions (2012/13) is mapped to objective 3 & 4

There were around 2,884 alcohol-related admissions to hospital for Devon residents in 2012-13. The Direct Age Standardised Rate of Admissions (1071 per 100,000) is much higher than the North East (856) and national (637) rates. The rate has decreased from 1088 in 2011/12 to 1071 in 2012/13.
Alcohol-Related Admission rates vary by age, with the highest rates in older age groups, reflecting the long-term effects of alcohol-use through life. Acute admissions (accidents and poisonings) are most common in young adults, mental health admissions in persons in their 40s and 50s, and admissions for chronic conditions in older age groups. Admission rates are higher for males than females.

PHOF: Indicator 2.22 Percentage Receiving an NHS Health Check (2013/14) is mapped to objective 3 and 4

6,444 people in Sunderland received a health check in 2013- 14. This represents 7.6% of the eligible population, which is below the North East (10.4%), and England (9%) rates.
The NHS Health Checks programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. A high take up of NHS Health Checks is important to identify early signs of poor health leading to opportunities for early interventions.

PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6

In Sunderland there were 706 cardiovascular deaths in under 75s, with an direct age standardised rate of 99.9 per 100,000 for 2010-12. The Sunderland rate in 2010-12 was above the North East (92.4) and England (81.1) rates. Significant reduction has been made from 173 in 2001 to 101.9 in 2009 – 11 to 99.9 in 2010 -12. Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment. Mortality from circulatory disease increases rapidly with age, with the highest mortality rates in under 75s in the 65 to 74 age group, and very few deaths in persons aged under 40.

PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6

The early death rate from respiratory disease in Sunderland in under 75s during 2010-2012 was 47.6 compared to North East rate of 42.2 and England rate of 35.5. There were 333 early deaths rates from respiratory disease in Sunderland between: 2010-2012. Smoking is considered the leading risk factor and a significant contributor to these deaths. Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease.

PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12) and is mapped to objectives 3, 5 and 6

Sunderland's rate of emergency readmissions within 30 days (13.3%) is higher than the North East value of 12.7% and England's value of 11.8%. It has increased from 12.9% in 2009–11 to 13.3% in 2011-12 or from 4787 readmissions to 5021 in 2011-12
This indicator will follow individuals discharged from hospital to monitor success in avoiding emergency admissions. Health interventions and social care will play significant roles in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short term.

NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6

Current performance at 3458.3 is higher than the North East (3254.6) and National (2801.4) figure. SCCG target for 2014/15 is 2,278 and Quality Premium national indicator for 2014/15 - however includes both adult and child.

NHSOF: Indicator 1b - Life expectancy at 75: Males **(**2010 -2012) and is mapped to objectives 3, 5 and 6

Sunderland figure of 10.5 is lower than National (11.5) and North East (10.8) average, and slight deterioration based on 2009-2011 at 10.4

NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6

Sunderland figure of 11.9 is lower than National (13.3) and North East (12.5) average, but improvement based on 2009-2011 at 12.0

NHSOF: Indicator 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2012 -2013) and is mapped to objectives 1, and 6

Sunderland's performance at 518 is higher than National (340) and North East (340) average. CCG have an aspiration over next 5 years to reduce non electives by 15%, although focus is on frail elders rather than under19s.

NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6

Sunderland's performance at 13.30 is higher than National (11.8) and North East (12.7) average. It has increased from 12.9% in 2010/11 to 13.3 in 2011/12 or from 4787 in 2010/11 to 5021 in 2011/12

ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services.
2013/14 is mapped to objective 1, 5 and 6

Sunderland's target for this was 86.4 % and achievement was 85.53% and National average was 81.4%. This measure reflects the effectiveness of reablement services**.**

ASCOF: 2(C) – Part 2 - Delayed transfers of care attributable to social care 2013/14 and mapped to objective 1 and 6

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. Sunderland year end result was 4.8% for 2013-2014 and National figure was 3.1. It has improved from 9.65 in 2012/13 to 4.8 in 2013/14.
This measures the impact of hospital services and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population, and is an indicator of the effectiveness of the interface within the NHS, and between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of both health and social care.

Appendix 3

KEY ACTIONS BY OBJECTIVE – NOVEMBER 2014

OBJECTIVE 1 – PROMOTING UNDERSTANDING BETWEEN COMMUNITIES AND ORGANISATIONS

- **Washington Area Committee** - A Community Health and Green Spaces Project links the local villages and provides a venue for events and activities; this will be a valuable resource to tackle Washington's health inequalities. Washington Mind is working with partners to encourage outdoor activities including dog walking, a walking group, bowling and cycling.
- **Sunderland Men's Health Network** is managed through a working group of 14 partners which leads campaigns across the city. The Sunderland Men's Health network have taken a three tiered approach in raising the profile of men's health:
  1. Seven different workshops that touched on men's health were offered to business management teams with the objective that they can then cascade this to their workforce including being aware of potential triggers
  2. Presence at Supermarkets engaging in conversation with members of the community
  3. Working with Jobcentre plus and their clients.

- **Wellbeinginfo.org**
  Statistics for April 2014 – June 2014 have shown that **150 unique visitors** accessed the dedicated crisis support page, which appears prominently across the website and signposts to appropriate support services. This averages out at over 3 unique visitors per day accessing crisis support information. Monthly statistics show that Primary Care service information appears in the top 5 most downloaded documents each month, alongside the Directory of Cancer Services and local Sexual Health Clinic information.

- **Wellbeing Roadshows**
  Twice a month Washington Mind staff go along to local **housing offices** to share wellbeing information with people popping in and out of the office to pay their rent. At each visit they actively engage with at least 50 people. Information bags are given out which include a range of leaflets and freebies. The information is changed and rotated for each roadshow and follows local and national campaigns. These roadshows have resulted in several individuals being signposted to appropriate services to meet their particular needs.

- **Training**
  Between April 1st 2013 and March 30th June 2014:
  'A Life Worth Living' training equips local people with the knowledge and skills to reduce the pain for those experiencing suicidal thoughts - 864 individuals received this training
  'Healthy Money, Healthy You' training helps people to identify the link between emotional distress and financial issues, as well as to increase knowledge of services that are available to provide appropriate and relevant support - 208 individuals received this training

'Promoting Emotional Resilience' training helps people to promote resilience both in themselves and others in order to cope better, take control and increase wellbeing - 245 individuals received this training

'Mental Health First Aid and Youth MHFA' provide a two day training programme that enables individuals to offer help to someone experiencing a mental health problem before professional help is obtained - 132 individuals received this training

'**Understanding Self-Harm'** training is for frontline staff and volunteers who wish to increase their knowledge and raise their awareness and understanding of the difficult issue of self-harm - 41 individuals has received this training

The North of England Mental Health Development Unit (NEMHDU) was commissioned to assess the physical health needs of people with Severe Mental Illness (SMI) and provide recommendations and training that will improve their physical health and address current health inequalities for this group. As a result WM and Aspire delivered **'Promoting Positive Practice in Physical and Mental Health**' which is a half day training course for frontline workers and volunteers to help them understand the multiple disadvantages that people with severe mental illness may face - 196 individuals received this training

OBJECTIVE 2 – ENSURING THAT CHILDREN AND YOUNG PEOPLE HAVE THE BEST START IN LIFE

- New data has recently been received which shows Sunderland **has improved performance** across all measures of the Early Years Foundation Stage profile
- Partnership working with **midwifery and health visitor services** has improved consent to data sharing and we are now engaging with a significantly higher number of parents during pregnancy. This involves inviting them to coffee mornings at Children's Centres whilst pregnant and a home visit following delivery. This has led to an increase in contact and participation and to the early identification of more vulnerable families in need of additional support
- A key activity within the Action Plan was to promote **cultural change** by developing a series of **key messages on Child Development** which would be widely shared. The messages have been agreed through a process of consultation with partners and shared with parent groups for a language and sense check. An exercise to engage a creative and media specialist in the communication of the message is currently underway.
- Further activity to promote cultural change and child development was via the introduction of a **Children's Centre champion model**. Currently the model has been developed and the first cohort of volunteers have enrolled and commenced their training.

OBJECTIVE 3 – SUPPORTING AND MOTIVATING EVERYONE TO TAKE RESPONSIBILITY FOR THEIR HEALTH AND THAT OF OTHERS

- The **re-shaping of services** to support people to live healthier lives in order to prevent ill-health is well advanced, based on engagement with local people who have multiple lifestyle risks. This engagement work has allowed people to identify factors that have helped them to make changes to improve their health as well as identifying barriers to future change that we may need to support them to address. It is anticipated that a new model of delivery, which will develop

Sunderland as a "Healthy Place" alongside service delivery and increased capacity in communities, will be in place by April 2015.

- In addition, a **review of sexual health services** has been undertaken. A key element of this has been a Health Equity Audit to identify where inequalities in need are not currently being addressed. A workshop involving a range of partners will be held in the North of the City where sexual health outcomes are particularly poor to identify actions to address this.

- The **Sunderland Health Champion programme** has continued to thrive. We now have more than 1,450 people signed up with over 650 having completed all five core modules. We have also developed two new modules which address needs relating to domestic abuse and physical wellness. We are piloting **a Young Health Champions** programme and currently have 79 Young Health Champions in four secondary schools in the City who now have the tools to support their fellow students. We are increasing the size of the pilot to six schools for the academic year 2014/15 and will recruit a new cohort of health champions in all of the schools involved. This “capacity building” approach has also been taken forward in other ways including **a “Community Connectors” pilot in the east of the City.**

- We have continued to increase awareness of the "**five a day for health and happiness**" or “five ways to wellbeing” through the Wellbeing Directory and wellbeinginfo.com, the Wellbeing network as well as through the emotional health and resilience module of the Health Champion training. The importance of providing additional support to some groups within the City has resulted in a number of initiatives, particularly for people with a range of mental health conditions. Initiatives include a new volunteer Mentoring and Befriending Service in the City which aims to improve mental wellness and a new Stop Smoking Service provided by the mental health trust to support people in mental health services to stop smoking. We are also piloting a “step down” programme for people leaving the Psychological Wellbeing Service which supports them to make positive lifestyle change, including taking up social opportunities, delivered through the Health Trainer Service.

- The **Sunderland Core Strategy** will be key in ensuring that Sunderland develops as a healthier place where the healthy choice is the easy choice. To this end, a Health Impact Assessment of the current version of the developing strategy has been undertaken which has identified a number of opportunities to improve health within the City.

- During 2014, there have been a number of stakeholder events that have considered a wide range of issues including **active travel, alcohol and achieving a 5% smoking prevalence.**

- Washington Area Committee has a priority to develop initiatives to **address social isolation and provide support for older people**. Partners including Washington Mind have delivered activities that reduce isolation and increase social interaction of older people and the most vulnerable. Activities delivered include crafts, TaiChi, Shiatsu, Reflexology, Reiki, Indian Head Massage,

Aromatherapy and Podiatry. WM also trained 452 people volunteer mentors on a 6 week course to work with older .

Case Study (George, 62). I have suffered from depression and anxiety for a number of years and receive medication for it. Since my day centre closed in 2002 I did not socially interact with people and even found going out with family stressful and a struggle. In 2013 I was at a vulnerable point in my life and had to seek medical help. After seeing various therapy councillors my GP recommended that I be referred to Washington Mind, where I have since met such friendly and caring staff and feel happy to be in a place where I can be with other people like myself who use the facility.

OBJECTIVE 4 – SUPPORTING EVERYONE TO CONTRIBUTE

- Work has been undertaken to identify **the external partners** who can have an impact on this Objective. Consideration has also been given to the sphere of influence the council has with local employers and how this can be galvanised to positively impact against objectives. Stakeholder mapping for all of the organisations who contribute towards the achievement of the outcomes under objective 4 will also take place to ensure that the right people are engaged and have joint ownership for progress towards and achievement of the objectives.

- The council is working very closely with AMACUS on the development and delivery of a **Workplace Health Alliance Scheme** and a steering group of partners from the private, public and voluntary sector has been formed to take forward the development. The scheme provides a mechanism to engage local employers with health and well-being and directly impact on the outcome 4.3 – 'there is joint working with local businesses to ensure a healthy workforce'. A launch event will be held on the 24th November 2014 at Washington Business Centre. This will raise awareness of the importance of health and well-being to economic prosperity and demonstrate the support services that are available to employers.

  We will also utilise the three Sunderland City Council Business Investment Team buildings: **Evolve, Sunderland Software Centre and Washington Business Centre**, as pilot workplaces to raise awareness of and test current and new approaches to health and well-being.

  Engagement work with agencies such as the DWP and training providers who can support the following outcomes, will take place once the workplace alliance health scheme moves into delivery:

- **Sunderland Wellbeing Network - Workplace Workshops**
  12 organisations and over 400 staff were involved in workshops on Stress and Anxiety; How to deal with a good work life balance and 'Mental Health Awareness' including tasters of Mental Health First Aid and A Life Worth Living.

OBJECTIVE 5 – SUPPORTING PEOPLE WITH LONG TERM CONDITIONS AND THEIR CARERS

- The CCG continues to work with partners towards delivery of its 10 transformational changes and 5 of these focus on people with long term conditions. **Integrated Community Locality Teams** are progressing well. They are being designed to focus on the most complex patients who account for 50% of the health and social care spend as their care is largely fragmented and reactive. All GP Practices are being incentivised to enhance the national incentive scheme which is about reducing unplanned admissions through more proactive care. The local enhancement will enable all practices to share information with each other in localities and with partners to enable proactive and coordinated care. This information will be used by the design teams to inform their proposed models for delivery of community integrated teams

  The Design team for the project are now in place with staff seconded from NTW, City Hospitals Sunderland and Sunderland City Council Social Care Team. These members of staff are working alongside the CCG staff in Pemberton House and are key members of the locality design teams. An induction afternoon was held for the South Tyneside FT design team members, consisting of community matrons and district nurses from each locality. These staff will be working within the design teams for 1 day a week each. A design team workshop was held at the Stadium of Light on the 25 September 2014. This was a key event that brought together the design team staff for each locality to develop their proposed model for integrated teams. Each Locality is actively working on how the team will operate in its locality whilst the central design teams is ensuring equity in terms of the standards of care.

- **Care in Care Homes**
  Implementation of the multi-agency team approach to care of people in care homes in the Coalfields continues and many of the lessons learned are informing the development of the Integrated Teams e.g. the skills needed for the medical leads such as GPs. It is likely that roll out of this model will be a fundamental part of the roll of out integrated teams as it's likely that many of the patients in the high risk/high cost group will be the initial focus of the integrated teams.

- The **Intermediate Care Hub** workshop was held in early September and partners on the Steering Group and Out of Hospital Board have agreed in principle to the proposed model which will enable 24/7 services; step up care to prevent admission as well as the current step down care out of hospital. The new model includes more standardised bed based care across the city and a review of the beds required as well as co location of the related health and social care teams in the Leechmere site by December/January. The colocation will enable the 24/7 cover supported by the telecare system; easier access to the equipment store and better relationships/connections across the health and social care teams to enable a more streamlined rapid response to individual need. The service has already been increased to evening and weekend working.

- The **End of Life Care Operational Group** held their first meeting on 23rd September 2014. The Terms of Reference was agreed with some amendments

and comments were made with regard to the action plan, both will be amended appropriately. The Deciding Right App has been legally approved and once this is available a communication will go out to GP's. This programme is about ensuring all GP Practices are proactively and consistently working to the Deciding Right standards of care for people at the end of their lives.

- The **Sunderland Psychological wellbeing service (IAPT)** is working from a number of community locations including Washington Mind. People with long term conditions are a priority area where the benefits of low level counselling and other support can make a difference to them managing their lives. IAPT have begun piloting the measurement of mental wellbeing using the WEMWBS tool. The aim of introducing WEMWBS was to identify a tool that was able to more effectively measure quality of life improvement, as clinical experience and qualitative service user feedback was suggesting other methods were not effectively measuring change.

  Case Study: Ruth - I first came to Washington Mind to access some counselling for my low mood and anxiety. At first I felt unsure as I have severe hearing loss and suffer constant pain from my physical condition. I took part in a Tai Chi for beginner's course which I really enjoyed. I went along with this group to other activities such as complementary therapies, which really helped me to relax and this in turn helped me to cope with my physical pains. I have been discharged from the pain clinic – accessing these services has been the best pain management.

- The work to roll out **Dementia Friendly Communities** is progressing with a pilot in the Coalfields area. This has seen a number of local businesses and organisations attend training and sign up to being Dementia Friends. Each GP locality is also working on a proposal to use their innovation funding to support practices to become more Dementia aware.

OBJECTIVE 6 – SUPPORTING INDIVIDUALS AND THEIR FAMILIES TO RECOVER FROM ILL HEALTH AND CRISIS

- **Intermediate Care / Reablement Hub**
  As noted above, current plans centre around bringing together the current Intermediate Care and Reablement functions, including bed based resources (e.g. Farnborough Court and Houghton ICAR) with Urgent Care and 24/7 nursing teams to establish a co-located and eventually an integrated service. The intention is to establish a co-located service at Leechmere Resource Centre by relocating the following teams:

  - Intermediate care team (ICT) – South Tyneside Foundation Trust (STFT), current base in Grindon Lane Primary Care Centre (GLPCC)
  - Urgent care team (UCT) – STFT, current base in GLPCC
  - Intermediate care hub staff - Sunderland care and Support (SC&S), current base Houghton Primary Care Centre (HPCC)
  - Reablement at home (RAH) team – SC&S, current base Leechmere.

The immediate benefits from such a move will enable nursing teams to have immediate access to the equipment store and closer working with the tele health service (e.g. community care alarms) to support their rapid/crisis response role 24/7. These benefits are in addition to the improved communication across teams enabling an enhanced response to patients.

It is also proposed that the service be known in future as a 'Recovery at Home' service, as the word 'intermediate' was not be well understood and /or had connotations not necessarily appropriate in the future e.g. 6 weeks free care.

- **Urgent Care Centres**
  Following consultation about the provision of Urgent Care Centres (UCC), the new GP led UCC model was implemented from the 1st September 2014. The new model provides greater consistency of service provision across the city and should lead to fewer referrals from the UCCs to A&E and local GPs. This model includes a UCC acting as a first point of contact for visitors to A&E, thereby relieving the pressure on A&E by allowing doctors to triage visitors to the most appropriate service (which may not be A&E). The new UCC model also includes greater promotion of the 111 service and self-care. Visitors are given advice about how they can deal with minor illness and injury without visiting a UCC e.g. by visiting a pharmacy instead. To date the move of the Grindon Lane UCC to the A/E site (Temporarily at Pallion Health Centre until the new A/E build in October 2015) has not led to an unexpected level of A/E attendances

- A new model for **GP Out of Hours services** has been designed following a 2 day Improvement event with partners. The model takes account of the 111 service and the new GP led urgent Care Centres and the development of the intermediate care service and integrated teams so that it complements the new developments. The service is likely to be based at the Leechmere site further supporting cross team working between health and social care. The service is about to go out to the market to be procured.

- **Gardening in Parks and Open Spaces**
  Discussions are taking place with partners to see whether people recovering from a period of ill health or health crisis can be given the opportunity rebuild their health and confidence by tending to parks and other open spaces. This activity will not only provide people with a known route to improving their physical and mental health and wellbeing through light physical activity, but also help to engender community spirit and pride in the local area by improving its physical appearance. It is hoped that medical practitioners will be able to prescribe and signpost patients, thereby enabling them to take part based on their capacity to help – this is likely to link into the exercise referral scheme and the integrated wellness model.

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

DUE NORTH: REPORT OF THE INDEPENDENT INQUIRY ON HEALTH EQUITY FOR THE NORTH

Report of the Director of Public Health

1. Purpose of the Report

This paper provides a briefing to the Sunderland Health and Wellbeing Board on *Due North: the Report of the Independent Inquiry on Health Equity for the North* issued on Monday 15th September.

This paper sets out: the background to the inquiry; the headlines for the current state of health inequalities; the inquiry recommendations; the results of a rapid mapping and sense check of action already underway in Sunderland to tackle health inequalities; and an outline of possible next steps.

2. Background

Due North is the report of an independent inquiry, commissioned by Public Health England. Its aim was to provide further evidence on the socio-economic determinants of health and additional insights into health inequalities for the North of England (covering the North East, North West and Yorkshire and the Humber regions). Whilst *Due North* is from and about the North of England, the issues presented and the recommendations made will be of interest to every part of the country and indeed to the country as a whole.

The report builds on the *Marmot Review* focusing on the following three themes:

- a fair start for children
- the economy and welfare
- democratic and community empowerment

The report provides additional evidence on what actions are needed to tackle the underlying determinants of health on the scale needed to make a difference. It also sets out challenges to local areas, communities, businesses, councils, the health sector and national political leaders about potential actions they could deliver which could disrupt these persistent health inequalities.

3. Current state

That health inequalities exist and persist across the North of England is not news; but that does not mean that health inequalities are inevitable. The local illustration of these health inequalities is that:

- a baby boy born in Sunderland can expect to live **12.1 fewer years in good health** than a baby boy born in Richmond on Thames

- a baby girl born in Sunderland can expect to live **12.5 fewer years in good health** than a baby girl born in Richmond on Thames

In general, the causes of health inequalities are the same across the country; it is the severity of these causes that is greater in the North of England, and which contributes to the observed regional pattern in health.

For information, the latest assessment of progress on the Marmot Indicators for Sunderland is included as Appendix 4.

4. Report Recommendations

Due North sets out four high level recommendations, as follows:

- tackle poverty and economic inequality within the North and between the North of England and the rest of England
- promote healthy development in early childhood
- share power over resources across the North and increase the influence that the public has on how resources are used to improve the determinants of health
- strengthen the role of the health sector in promoting health equity

Recommendations and underpinning supporting actions are aimed at two distinct groups:

- first, policy makers and practitioners working within agencies in the North of England, and
- secondly, central government.

A summary of the "grouped" recommendations is set out in Appendix 1.

Public Health England produced an interim response to the report in September 2014, but wishes to reflect more thoroughly on the evidence and recommendations. They will make a full response in spring 2015.

At regional level, the findings from the report were presented at the North East Health Summit on 30th October 2014. It is also likely that further discussion will be sought through the ANEC Leaders / Elected Mayors, Chief Executives' and Chairs of Health and Wellbeing Boards forums.

5. What are we already doing in Sunderland?

As previously noted, the recommendation themes within *Due North* are not new. It is therefore not surprising that there are already strategies and policies in place and actions being undertaken in Sunderland that are consistent with the recommendations being made.

Appendix 2 sets out the results so far of a rapid "mapping and sense check" exercise against the report recommendations. Additions or changes to these will be made in response to feedback from the Board.

It would also be useful to gain feedback from the Board about which of the recommendations from *Due North* we should prioritise for early action within the delivery plan for the Health and Wellbeing Strategy. We could choose priorities where:

1. We are making progress but do not feel this progress is good enough;
2. Despite the long history, we have not made progress;
3. Current opportunities mean we can tackle issues that might not have been considered before.

6. Next steps

Public Health England is also asking for feedback about the recommendations from the report; specifically they are asking the following questions (see Box 1):

Box 1: Comments on Due North

1. Are these recommendations pertinent?
    - do they have traction?
    - could they be usefully refined, and if so, how?
    - are there any of limited value?

2. What are the priorities to progress?

3. What would help to make this happen

4. What could you/your organisation do to support and drive progress?

Feedback from the Board in relation to these questions would be valued. The feedback template is provided at Appendix 3. The deadline for this exercise is **8th December 2014**.

The *Due North report* could also usefully be discussed within the local strategic partnership arrangements within Sunderland, for example, with the Economic and Education Leadership Boards, Adults and Children's Partnership Boards, and Safer Partnership. Discussion could include a range of partner organisations e.g., Sunderland CCG, University, CHS NHS FT. This could usefully be undertaken as a development workshop.

A full consideration would entail cross checking *Due North's* Recommendations against those of our recently developed Health and Wellbeing Strategy.

7. Recommendations

The Sunderland Health and Wellbeing Board is asked to:

- Note the high level recommendations made by the report *Due North;*
- Provide feedback about the findings from the rapid mapping and sense check set out in Appendix 2;

- Provide feedback about the top 3 issues that should be prioritised for early action within the delivery plan for the Health and Wellbeing Strategy;
- Provide any feedback about the usefulness and/or practicality of the recommendations, based on the questions on the template at Appendix 3;
- Confirm that they are content for further discussions to take place, within the local strategic partnership and key partner organisations.

Kath Bailey
Locum Consultant in Public Health

APPENDIX 1: Summary of recommendations and actions from *Due North*

For agencies in the North:	For central government:
1. Tackle poverty and economic inequality within the North and between the North of England and the rest of England	
• Develop health equity strategies that prevent and ameliorate poverty	• Provide investment for locally commissioned, integrated programmes for welfare reform, skills and employment to support people into work
• Focus public sector reform on preventing poverty and promoting prosperity	• Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas
	• Expand the role of Credit Unions and take measures to end the poverty premium
• Improve employment prospects of those out of work or entering the labour market	• Grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets
• Develop economic development strategies that reduce both economic and health inequalities	• Develop a national industrial strategy that reduces inequalities between the regions
• Implement and regulate the Living Wage	• End in-work poverty by implementing and regulating a Living Wage and ensure that welfare systems provide a Minimum Income for Healthy Living
• Invest in new housing and increase the availability of high quality affordable housing	• Develop policy to enable local authorities to tackle the issue of poor condition of the housing stock at the bottom end of the private rental market
• Assess the impact in the North of changes in national economic and welfare policies	• Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular
	• Extend the Measuring National Wellbeing programme to better monitor progress and influence policy on inequalities •

For agencies in the North:	For central government:
2. Promote healthy development in early childhood	
• Develop and sign up to a charter to protect the rights of children to the best possible health	• Embed a rights based approach to children's health across government
• Seek to incrementally increase the proportion of overall expenditure allocated to giving every child the best start and ensure expenditure reflects needs	• Increase the proportion of overall expenditure allocated to early years and ensure expenditure is focused according to needs
	• Reduce child poverty through the measures advocated by the Child Poverty Commission (e.g., paid parental leave, flexible working, affordable high quality childcare)
	• Reverse recent falls in the living standards of less advantaged families
• Ensure access to good quality universal early years education and childcare with a greater emphasis on those with greatest needs	• Make provision for universal, good quality early years education and childcare proportionately according to need across the country
	• Invest in raising the qualifications of staff working in early years childcare and education
• Protect universal integrated neighbourhood support for early child development (e.g., health visitors, children's centres)	• Increase investment in universal support to families through parenting programmes, children's centres and key workers, delivered to meet social needs
• Collect better data on children in the early years across organisations so that change can be tracked over time	• Commit to carrying out a cumulative impact assessment of any future welfare changes to ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated

For agencies in the North:	For central government:
3. Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health	
• Take the opportunity of greater devolved powers and resources to develop locally integrated programmes of economic growth and public services reform to support people into employment	• Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities
• Collaborate across combined authorities in the North to develop a Pan-Northern approach to economic development and health inequalities	• Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve
• Invest in and support the development of up publicly owned mutual organisations for providing public services where appropriate	
• Develop the capacity of communities to participate in local decision-making and developing solutions which inform policies and investments at local and national levels	• Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population
• Expand the involvement of citizens in shaping how local budgets are used	
• Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally	• Invest in and expand the role of Healthwatch as an independent community-led advocate that can hold government and public services to account for action and progress on health inequalities
• Develop community led systems for health equity monitoring and accountability	

CCGS and other NHS agencies in the North:	Public Health England:
4. Strengthen the role of the health sector in promoting health equity	
• Use the Social Value Act to ensure that procurement and commissioning maximises opportunities for high quality local employment, high quality care, and reductions in economic and health inequalities	• Support the involvement of Health and Wellbeing Boards and public health teams in the governance of Local Enterprise Partnerships and combined authorities
• Work with local authority Directors of Public Health and PHE to address the risk conditions (social and economic determinants of health) that drive health and social care system demand	• Support local authorities to produce a Health Inequalities Risk Mitigation Strategy
• Support Health and Well-being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities	• Support the development a network of Health and Well-being Boards across the North of England with a special focus on health equity
	• Work with Healthwatch and Health and Wellbeing Boards across the North of England to develop community-led systems for health equity monitoring and accountability
• Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained	• Contribute to a review of current systems for the central allocation of public resources to local areas
• Provide leadership to support health services and clinical teams to reduce children's exposure to poverty and its consequences	• Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services
• Work with local authorities, the Department for Work and Pensions (DWP) and other agencies to develop 'Health First' type employment support programmes for people with chronic health conditions	• Help to establish a cross-departmental system of health impact assessment
• Encourage the provision of services in primary care to reduce poverty among people with chronic illness, including, for example, debt and housing advice and support to access to disability-related benefits	• Collaborate on the development of a charter to protect the rights of children

APPENDIX 2

Due North Report – Next Steps for the North East

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
1: Tackle poverty and economic inequality within the North and between the North and the rest of England ***Agencies in the North should work together to:***				
1.1 Draw up health equity strategies that include measures to ameliorate and prevent poverty among the residents in each agency's patch.	The Children's Trust has the strategic lead for child and family poverty in the city and reducing child and family poverty is a strategic objective and a priority area for action in the Children and Young People's Plan 2014-17. The child poverty needs assessment is being refreshed to ensure that agencies are focusing on the right priorities, using an evidence-based approach.	Local Authority	Local Authority with partners	The Council is developing its approach to poverty proofing all strategic plans, using integrated impact assessment.
1.2 Establish integrated support across the public sector to improve the employment prospects of those out of work or entering the labour market.	The Sunderland Economic Leadership Board has an economic Masterplan that looks to improve employment opportunities for residents. In line with LEP Strategic Economic Plan, Sunderland is anticipating growth in: software development, advanced manufacturing, low carbon industry and innovation.	Local authority Combined Authority, with local support	Combined Authority, with local support	NELEP's Strategic Economic Plan highlights the need for "more and better jobs" to reduce the gap with the national average.

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
1.3 Adopt a common progressive procurement approach to promote health and to support people back into work.	Sunderland City Council is working to develop a commissioning for social value policy. Sunderland City Council is a partner within the bid for a mental health trailblazer which seeks to support people with common mental health conditions back into work. The public health team is in the process of procuring an Integrated Wellness Model for people in the city.	Local Authority and possibly health partners Combined Authority, with local support Local Authority	Local Authority	Sunderland's Psychological Wellbeing Service (commissioned by the CCG) includes a strong focus on employment support for people with mild-moderate mental health conditions and people with long term conditions.
1.4 Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery.	Sunderland City council has three key priorities, driven by three strategic partnerships for: economy, health and skills.	Local Authority and Combined Authority		It is recognised that each impacts on the other; for Sunderland to thrive, all three need to be addressed in a holistic and asset-focused way.
1.5 Implement and regulate the Living Wage at the local authority level.	In September 2014, Sunderland City Council agreed to implement the Living Wage. This means that Sunderland City Council has committed to pay all its workers at least £7.65 per hour.	Local Authority	Local Authority	Also consider inclusion within commissioning for social value policy.

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
1.6 Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.	Focus within Sunderland on the social stock and regeneration programme of Gentoo stock to decent home standards. Affordable housing is a priority for all new developments in partnership with a social landlord and to HCA standards. There is a voluntary registration scheme for private landlords.	Local Authority working with housing providers and social landlords		
1.7 Assess the impact in the North of changes in national economic and welfare policies.	Mitigating the impacts of welfare reform is a key priority for the city. VCS networks co-ordinating efforts on food banks. Within the Coalfields Area, a bid is being made to Comic Relief to establish an early action initiative for residents whose mental wellbeing is being affected by welfare reform and financial hardship.	Area Arrangements within the City (LA/CCG/VCS) Local Authority Combined Authority Regional and North levels	PHE KIT best placed to compile and assess impact	

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
2: Promote healthy development in early childhood ***Agencies in the North should work together to:***				
2.1 Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life and ensure that the level of expenditure on early years development reflects levels of need.	The "best start in life" is a key priority within the Health and Wellbeing Strategy; it is also a key priority for the People Directorate within the City Council. An increasingly targeted approach is being taken to resource allocation across the City Council, reflecting reducing budgets but supporting priority groups.	Local Authority Combined Authority Regional and North levels	Local Health Economy via Health and Wellbeing Board	Needs to be assessed across the whole health economy at local level
2.2 Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs, so that all children achieve an acceptable level of school readiness.	The "best start in life" and "school readiness" are key indicators for the Health and Wellbeing Strategy and key priorities for the People Directorate. Continued challenge and support for childcare settings means many are rated "good" or "outstanding" and the Early Years Foundation Stage Profile (EYFSP) is above regional and national performance.	Local Authority	Local Authority	

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
	The City has a network of Children's Centres that provide both universal early years services (which aim to prevent negative outcomes) and targeted evidence based early interventions for families in greatest need. The free early years' education entitlement is available to all 3 and 4 year olds in Sunderland and the free childcare entitlement is available for the most disadvantaged 2 year olds across the city. There is good take up of the 2 yr old offer and a priority is to increase this further.			
2.3 Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach.	A key priority in the People Directorate Plan is the further integration of services by locality. This will be delivered through a phased approach: phase 1 covering Council services to be integrated by April 2015; phase 2 will include wider partner services, specifically health visiting services and other health services. The local authority public health team is working closely with the NHS England CNTW Area Team to support the safe transition of commissioning for health visiting services to the Council with effect from October 2015.	Local Authority	Local Authority and health partners	

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
2.4 Collect better data on children in the early years across organisations so that we can track changes over time.	Consideration of a new ICT system is underway to support better tracking. Sharing of information with health partners remains an issue. Sunderland City Council is working on an Intelligence hub project which will better support requirements to transform the approach to intelligence. Strengthening Families is one of the early use cases for the project which should result in better and joined up approaches to data.	Local Authority	Local Authority and health partners	
2.5 Develop and sign up to a charter to protect the rights of children to the best possible health.	There is nothing at a local level, at present.	Development at Combined Authority Sign up at Local level		

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health ***Agencies in the North should work together to:***				
3.1 Establish deep collaboration between combined authorities in the North to develop a Pan-Northern approach to economic development and health inequalities.	There are examples of cross border working of the north east LEP area plus additional cross border working on economic development which includes working into Tees Valley such as a the hydrogen economic study. Sunderland is a signatory of the key cities' charter for devolution.	Combined Authority		
3.2 Take the opportunity offered by greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people into employment.	There is an in-work up-skilling pilot project running between Sunderland and South Tyneside to provide skills development for existing employees to encourage business growth and job creation. This is funded through the DWP local response fund and gives the local authorities the ability to define the project scope and response. The Mental health trailblazer is another example of DWP funding being given to authorities to define an appropriate local response to the issue of health and employment.	Combined Authority, with local support	Combined Authority, with local support	See recommendation 1.3

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
3.3 Revitalise Health and Wellbeing Boards to become stronger advocates for health both locally and nationally.	A recent LGA Peer Review commended Sunderland on its sound strategic partnership and leadership. The assets based approach of the Health and Wellbeing Strategy emphasises the Board's willingness to tackle the root causes of poor health and health inequalities. Partner organisations across Sunderland are using the Better Care Fund to integrate health and social care, including through the use of pooled resources - Sunderland is one of five health economies nationally given the go ahead.	Local Authority	Local Authority and all partners across the health economy	
3.4 Develop community led systems for health equity monitoring and accountability.				Possibly through the All Together Sunderland programme.
3.5 Expand the involvement of citizens in shaping how local budgets are used.	In line with the priorities within the Health and Wellbeing Strategy for promoting responsibility for health and supporting everyone to contribute, the All Together Sunderland programme seeks to empower communities to be more self-reliant and less reliant on public services.	Local Authority	Local Authority and all partners across the health economy	

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
	As a community leadership council, Sunderland is committed to enhancing the role local people play in shaping and delivering services. Local area people and place boards are developing capacity to shape local service provision at an area level.		Area Arrangements within the City (LA/CCG/VCS)	
3.6 Assess opportunities for setting up publicly owned mutual organisations for providing public services, where appropriate, and invest in and support their development.	Sunderland has been exploring and implementing alternative service delivery models and has created independent companies for care and support, city events and will be doing so for the wellness services in 2015. The council's transformation programme already includes exploration of joint ventures and mutual organisations as delivery models for public services.	Local Authority	Local Authority and all partners across the health economy	
3.7 Help develop the capacity of communities to participate in local decision-making and developing solutions which inform policies and investments at	In line with the priorities within the Health and Wellbeing Strategy for promoting responsibility for health and supporting everyone to contribute, the All Together Sunderland programme seeks to empower communities to be more self-reliant and less reliant on public services.	Local Authority	Local Authority and all partners across the health economy	

Recommendation	What actions are already underway in the local authority to support this specific recommendation?	At what level does this need to happen?	Who needs to take this work forward?	General comments
local and national levels.	Local area committees, people and place boards based around elected members and local community networks have been running for a number years and are being strengthened to ensure increasing influence over local services.		Area Arrangements within the City (LA/CCG/VCS)	

APPENDIX 3

Comments on Due North: report of the Inquiry on Health Equity for the North

Please return by: Monday 8 December 2014

Organisation	
Name	
Job title or role	
Address and post code	
Telephone number	
Email address	

It would be particularly valuable to have your views on the following:

1) Are these recommendations pertinent?
    - *do they have traction?*
    - *could they be usefully refined, and if so, how?*
    - *are there any of limited value*?
2) What are the priorities to progress?
3) What would help to make this happen
4) What could you/your organisation do to support and drive progress?

Please provide comments on the Due North report and recommendations, putting each new comment in a new row. When feeding back, please note the section you are commenting on (for example, policy context, evidence, recommendations). If your comment relates to the report as a whole then please put 'general'. Please complete by summarising issues/actions that you consider to be priorities

Please add or delete rows as necessary.

Section	General Comments
e.g. Current policy context	eg comment about current policy context.
eg Recommendation 1	eg general comment about tackling poverty and economic inequality within the north and between the north and the south
eg action 1.3.	eg comment about agencies in the north adopting common progressive procurement approach to promote health and to support people back into work
eg action 1.16	eg comment on central government should grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets

Section	General Comments

Are these recommendations pertinent? D*o they have traction? Could they be usefully refined, and if so, how? Are there any of limited value*?

What are the priorities to progress
What would help to make this happen
What could you/your organisation do to support and drive progress?

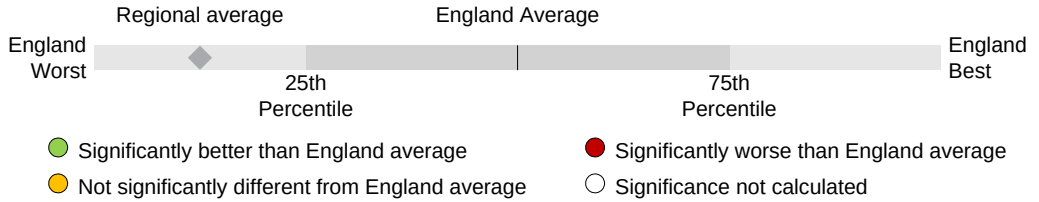
Please summarise actions that you believe are priorities for action
Closing date: Please forward this electronically by **Monday 8 December 2014** to northequity@phe.gov.uk

Public Health England

UCL Institute of Health Equity

Marmot Indicators for Local Authorities in England, 2014 - Sunderland

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that broadly correspond to the policy recommendations proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for Sunderland is shown as a circle, against the range of results for England, shown as a bar. For three indicators, local authority figures are not available and so only the regional value is reported.



Health outcome indicators

	Period	Local value	Regional value	England value	England worst	Range	England best
Healthy life expectancy at birth - Male (years)	2010 - 12	57.9	59.5	63.4	52.5		70.0
Healthy life expectancy at birth - Female (years)	2010 - 12	58.4	60.1	64.1	55.5		71.0
Life expectancy at birth - Male (years)	2010 - 12	77.0	77.8	79.2	74.0		82.1
Life expectancy at birth - Female (years)	2010 - 12	80.7	81.6	83.0	79.5		85.9
Inequality in life expectancy at birth - Male (years)	2010 - 12	10.7	-	-	16.0		3.9
Inequality in life expectancy at birth - Female (years)	2010 - 12	7.0	-	-	11.4		1.3
People reporting low life satisfaction (%)	2012/13	7.6	7.0	5.8	10.1		3.4

Giving every child the best start in life

	Period	Local value	Regional value	England value	England worst	Range	England best
Good level of development at age 5 (%)	2012/13	53.1	45.2	51.7	27.7		69.0
Good level of development at age 5 with free school meal status (%)	2012/13	33.8	28.7	36.2	17.8		60.0

Enabling all children, young people and adults to maximise their capabilities and have control over their lives

	Period	Local value	Regional value	England value	England worst	Range	England best
GCSE achieved 5A*-C including English & Maths (%)	2012/13	60.1	59.3	60.8	43.7		81.9
GCSE achieved 5A*-C including English & Maths with free school meal status (%)	2012/13	32.6	34.6	38.1	21.8		76.7
19-24 year olds not in education, employment or training (%)	2012/13		19.6	16.4			

Create fair employment and good work for all

	Period	Local value	Regional value	England value	England worst	Range	England best
Unemployment % (ONS model-based method)	2013	12.3	10.0	7.4	14.4		3.2
Long term claimants of Jobseeker's Allowance (rate per 1,000 population)	2013	17.1	17.4	9.9	32.6		2.3
Work-related illness (rate per 100,000 population)	2011/12		4630	3640			

Ensure a healthy standard of living for all

	Period	Local value	Regional value	England value	England worst	Range	England best
Households not reaching Minimum Income Standard (%)	2011/12		26.3	23.0			
Fuel poverty for high fuel cost households	2012	11.7	11.6	10.4	21.3		4.9

Create and develop healthy and sustainable places and communities

	Period	Local value	Regional value	England value	England worst	Range	England best
Utilisation of outdoor space for exercise/health reasons (%)	Mar 2012 - Feb 2013	14.1 z	16.0	15.3	0.5		41.2

Note: z - Value based on effective sample size <100

Indicator Descriptions

Healthy life expectancy at birth – males and females *Source: Office for National Statistics*

The average number of years a male or female would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. For a particular area and time period, it is an estimate of the average number of years a newborn would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period through their life.

Life expectancy at birth – males and females *Source: Office for National Statistics*

The average number of years a male or female would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn would survive if he or she experienced the age-specific mortality rates for that area and time period through their life.

Inequality in life expectancy at birth – males and females *Source: Public Health England*

This indicator measures inequalities in life expectancy within English local authorities. For each local authority, life expectancy at birth is calculated for each local deprivation decile based on Lower Super Output Areas (LSOAs). The slope index of inequality (SII) is then calculated based on these figures. The SII is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within each local authority and summarises this in a single number. This represents the range in years of life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across all deprivation deciles.

People reporting low life satisfaction *Source: Office for National Statistics*

The percentage of respondents in the ONS Annual Population Survey scoring 0-4 to the question "Overall, how satisfied are you with your life nowadays". Responses are given on a scale of 0-10, where 0 is "not at all satisfied" and 10 is "completely satisfied".

Good level of development at age 5 *Source: Department for Education*

Children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children. Children are defined as having reached a good level of development at the end of reception if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.

Good level of development at age 5 with free school meal status *Source: Department for Education*

Children known to be eligible for free school meals defined as having reached a good level of development (at the end of the EYFS as defined above) as a percentage of all children eligible for free school meals.

GCSE achieved (5A*-C including English & Maths) *Source: Department for Education*

The percentage of all pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent. Figures are the percentage of pupils at end of Key Stage 4 for schools maintained by the local authority and are based on the local authority in which the school is located.

GCSE achieved (5A*-C including English & Maths) with free school meal status *Source: Department for Education*
Pupils known to be eligible for free school meals achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent, as a percentage of all pupils eligible for free school meals.

19-24 year olds who are not in employment, education or training *Source: Department for Education*
The percentage of 19-24 year olds who are not in employment, education or training based on quarter four (October to December) data from the Labour Force Survey. Data are not available for this age group at local authority level and are therefore presented for English regions only.

Unemployment % (ONS model-based method) *Source: Office for National Statistics*
The percentage of the economically active population aged 16 and over without a job who were available to start work in the two weeks following their interview and who had either looked for work in the four weeks prior to interview or were waiting to start a job already obtained. Data for local authorities are based on an ONS model which uses Annual Population Survey estimates of unemployment along with the number of people claiming Jobseekers Allowance (JSA) averaged over 12 months, from Claimant Count data. Estimates for England and English regions are from the Annual Population Survey and are not model-based estimates.

Long-term claimants of Jobseeker's Allowance *Source: Office for National Statistics (NOMIS)*
The claimant count for Jobseeker's Allowance, reported as the crude rate of 16-64 year olds claiming for more than 12 months, per 1,000 resident population aged 16-64. This indicator can only be taken as a proxy measure of those in long term unemployment. As not all people who are unemployed are eligible for Jobseeker's Allowance, this indicator may underestimate the number of long term unemployed, but still provides an indicator of inequalities between local authorities.

Work-related illness *Source: Health and Safety Executive*
The prevalence rate of self-reported illness caused or made worse by work per 100,000 employed, for people working in the last 12 months. It includes the full range of illnesses from long standing to new cases.

Households not reaching Minimum Income Standard *Source: Joseph Rowntree Foundation*
The percentage of households not reaching the Minimum Income Standard (MIS), defined by the Joseph Rowntree Foundation as not having enough income to afford a 'minimum acceptable standard of living' (not including housing and childcare costs), based on what members of the public think is enough money to live on. The households covered are those comprising either a single adult or a couple, of working age or of pension age, plus up to four dependent children for couples or three for lone parents. The calculations cover about two-thirds of the UK population, around 41 million people.

Fuel poverty for high fuel cost households *Source: Department for Energy and Climate Change*
The percentage of households that experience fuel poverty based on the "low income, high cost" methodology, where households are considered to be fuel poor:
1 - If they have required fuel costs that are above average (the national median level)
2 - Were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

Percentage of people using outdoor places for exercise/health reasons *Source: Natural England*
The weighted estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes. Visits to the natural environment are defined as time spent "out of doors" (e.g. in parks, beaches or the countryside) but not time spent in own garden or routine shopping trips. A visit could be anything from a few minutes to all day and may include time spent close to home or workplace, further afield or while on holiday in England.

Item No. 8

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

AGE FRIENDLY CITIES

Report of the Executive Director of People Services, Sunderland City Council and the Director of Age UK, Sunderland

1.0. Purpose of Report

1.1 To advise the Board about partners plans to progress Sunderland's application to become an Age Friendly City.

2.0. Background

2.1 The World Health Organisation (WHO) co-ordinates an Age Friendly Cities programme which aims to engage cities to become more age-friendly in order to tap the potential that older people represent.

2.2 The WHO estimates that by 2030 around 3 out of every 5 people will live in an urban area. At the same time, as cities around the world are growing, their residents are growing older. The proportion of the global population aged 60 will double from 11% in 2006 to 22% by 2050. In Sunderland the population aged over 60 is projected to increase from 24% in 2012 to 31.2% in 2037.

2.3 As Sunderland's population becomes increasingly aged then age related health problems are likely to become of increasing concern, with likely increases in Dementia, limiting long-term illness and hospital admissions.

2.4 Given these anticipated changes to the city's demographics it is important for partners to take steps to meet the challenge these represent.

3.0 The WHO Global Network of Age-friendly Cities and Communities

3.1 The WHO Global Network of Age-friendly Cities and Communities was established to foster the exchange of experience and mutual learning between cities and communities worldwide. UK members of the network are Belfast, Brighton & Hove, Leeds, Manchester, Newcastle-upon-Tyne, Stoke-on-Trent and Liverpool. The Network provides partners with the opportunity to prepare an effective local policy approach for responding to population ageing.

3.2 The physical and social environments are key determinants of whether people can remain healthy, independent and autonomous long into their old age. The WHO Age-friendly Cities Guide highlights eight domains that cities and communities can address to better adapt their structures and services to the needs of older people – these are: the built environment, transport, housing,

social participation, respect and social inclusion, civic participation and employment, communication, and community support and health services.

3.3 In the past partners have combined their expertise, knowledge and experience to baseline the activity taking place in Sunderland that contributes to the eight Age-friendly City domains as well as the city's 50+ Strategy - this information was then used to baseline the city's position in relation to the domains. Work is currently on-going to refresh this baseline data in order that the Council can submit an application to the WHO on behalf of partners, for the Sunderland to be given Age Friendly status.

3.4 Applying to be part of the Network is straightforward and requires the Council to indicate its commitment to the Network cycle of continual improvement as well as commence the Network cycle of four steps outlined below:

1. Establish a mechanism to involve older people throughout the Age-friendly Cities and Communities cycle
2. Develop a baseline assessment of the age-friendliness of the city/community (covering the eight domains as a minimum)
3. Development of a 3-year city-wide action plan based on the findings of this assessment
4. Identification of indicators to monitor progress against this plan.

4.0 Sunderland as an All Age Friendly City

4.1 Though it is important for the partners to meet the challenges that an ageing population presents, it is equally important to ensure that everyone in Sunderland is considered when plans are made to address the eight domains. The built environment, transport and housing etc, are integral to everyone's lives and daily routine, consequently it is important that when these issues are addressed they consider the needs of everyone. This approach links neatly with the Council's Accessible Sunderland programme which aims to make the city as accessible as possible for local people, visitors and businesses.

4.2 A co-ordinated approach to tackling the WHO domains across all age groups (where it is appropriate), will support the city's economic growth and related skills and health issues and contribute to making Sunderland and enjoyable place to live, visit and do business.

5.0 Next Steps

5.1 Age UK Sunderland and the Council will continue to lead the work to become an All Age Friendly City and this will be monitored by the Adults Partnership Board. The Council, with the support of partners, will apply to the WHO for Age Friendly City status and commence the Network cycle of continual improvement.

5.2 Age UK Sunderland and the Council will be inviting partners to baseline their contribution to becoming an All Age Friendly City and will be encouraged to make action plan pledges and identify good practice case studies. To help

with this, partners will be asked to identify a key contact within their organisation that will be able to collate this information and act as their organisations contact in respect of other Age Friendly work that may arise.

6.0 Recommendation

6.1 That the Board supports the intention to pursue Age Friendly City status and agree the next steps as set out in section 5 of the report.

Contact Officer:
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Head of Strategy and Policy for People and Neighbourhoods
Office of the Chief Executive

Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

NHS ENGLAND 5 YEAR FORWARD VIEW

Lead Officer: David Gallagher, Chief Officer, Sunderland CCG

1. Purpose

The purpose of this report is to provide an overview of the key points outlined in the 5 Year Forward View published by NHS England in October 2014.

2. Background

The NHS Five Year Forward View was published by NHS England on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

3. Overview of NHS England 5 Year Forward View

General Overview

The forward view outlines that a radical upgrade in prevention and public health is needed and that NHS England will back hard hitting national action on obesity, smoking, alcohol and other major health risks.

The plan also outlines that strong public health related powers for local government and elected mayors will be given to enable local decisions.

Patients will also gain far greater control of their own care and there is a need to break down barriers in how care is provided across the health care economy.

There will be a focus on supporting people with multiple health conditions, rather than single diseases, however, there is recognition that one size will not fit all and so local health economies will be supported to choose from a small number of radical new care delivery options such as:

- Multispecialty Community Providers – Groups of GPs combining with nurses and other community health services, hospital specialist and perhaps mental health and social care to create integrated out-of-hospital care potentially employing hospital consultants, having admitting rights to hospital beds, running community hospitals or taking delegated control of the NHS budget.
- Primary and Acute Care Systems – The integrated hospital and primary care provider.
- Urgent & emergency care networks – Urgent and emergency care units re-designed to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services.
- Viable smaller hospitals - Smaller hospitals having new options to help them remain viable, including forming partnerships with other hospitals further afield and partnering with specialist hospitals to provide more local services.
- Specialised care – Specialised services to develop networks of services over a geography, integrating different organisation and services around patients using innovations such as prime contracting and / or delegated capitated budgets.
- Modern Maternity Services – NHS England will commission a review of future models for maternity services and midwives will have new options to take charge of the maternity services they offer.
- Enhanced care in care homes – new models of in-reach support, including medical reviews, medication reviews and rehab services.

In all cases one of the most important changes will be to expand and strengthen primary and out of hospital care.

There will also be a ‘New deal’ for GPs with more investment for Primary Care to upgrade the primary care infrastructure and scope of services, new funding through the Challenge scheme to support new ways of working and improved access to services and new options to encourage GP retention.

New funding will be committed to promote Dementia research and treatment and initiatives such as dementia friendly communities will be fully supported. The NHS ambition is to offer a consistent standard of support for patients newly diagnosed with dementia including named clinicians, proper care plans and the option of personal budgets

Genuine parity of esteem between physical and mental health is to be achieved by 2020. Providing new funding can be made available, the aim is to improve waiting times by 2020 to 95% of people referred for psychological therapies being seen within 6 weeks and those experiencing a first episode of psychosis to do so within a fortnight. Access standards will also be expanded to cover a comprehensive range

of mental health services, including children's services, eating disorders, and those with bipolar conditions.

Engaging Communities
Better support for carers – new ways will be found to support carers building on the new rights created by the Care Act including new volunteer programmes to help carers in crisis.

Encouraging community volunteering – the LGA have made proposals that volunteers should receive a 10% reduction in their council tax bill and are considering accrediting volunteers, ensuring they become part of the extended NHS family.

Stronger partnerships with charitable and voluntary sector organisations – Reduced time and complexity to secure local NHS funding by developing short national alternative to NHS contracts where grant funding is more appropriate.
NHS England will actively support national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing and product formulation.

NHS Structure & Leadership
There is no appetite for a wholesale structural reorganisation. The default assumption is that changes in local organisational configurations should arise only from local work to develop the new care models described above, or in response to clear local failure and the resulting implementation of special measures.

CCGS will also have the option of more control over the NHS Budget ranging from primary to specialised care and there should be consideration of local joint commissioning models between the NHS and Local Authority including integrated personalised commissioning as well as Better Care Fund style pooling budgets where appropriate.

A new risk based CCG assurance regime will be developed which will lighten the assurance reporting burden from highly performing CCGs whilst setting out a new 'special measures' support regime for those that are struggling.

Greater alignment between Monitor, TDA and NHS England which will complement the work of CQC and HEE including more joint working at a local level.

There will be local democracy on public health with local powers to LA's and elected mayors to allow local democratic decisions on public health policy and the NHS will play its part through Health & Wellbeing Boards. The NHS has a distinct role in secondary prevention, proactive primary care is central to this.

NHS as an Employer
The NHS is to set a national example including:

- Cutting access to unhealthy products on NHS premises
- Implementing food standards, including healthy options for night staff
- Support active travel schemes for staff

- Promote workplace wellbeing charter, the Global Corporate challenge and TUCS better health and work initiative, ensure NICE guidance on promoting healthy workplace is implemented particularly for mental health,
- Voluntary work based health and wellbeing programmes
- Strengthen occupational health

Supporting a modern workforce
NHS England, supported by Health Education England (HEE) will address immediate workforce gaps in key areas and put in place new measures to support employers to retain and develop their existing staff identifying education and training needs of current workforce.

Consideration will be taken of the most appropriate employment arrangements to enable current staff to work across organisational and sector boundaries.
Development of new health and care roles will be taken forward through the HEE's leadership of the implementation of the Shape of Training review for the medical profession and the 'Shape of Care' review for the nursing profession.

Exploiting the Information Revolution
National Information Board established which will publish 'road maps' laying out who will do what to transform digital care. Key elements include:

- Comprehensive transparency of performance data
- Expanded set of NHS accredited health apps for patients to use to manage their own care
- Fully interoperable electronic health records with patient access to write into them.
- Family doctor appointment and electronic and repeat prescribing available routinely online everywhere
- Bringing together audit data to support quality improvement
- Better use of technology such as smartphones

Accelerating health innovation
Steps taken by NHS England to speed innovation will include:

- Reducing costs of conducting randomised controlled trials (RCT)
- Expansion of the £15m a year 'Commissioning through evaluation' and early access to medicines programmes
- Consultation on a new approach for the Cancer Drugs Fund
- Development of a small number of test bed sites alongside Academic health science network and centres to serve as real world sites for combinatorial innovations that integrate new technologies, bioinformatics, new staffing models and payment for outcomes.
- Exploring the development of health and care 'new towns'.

Sustainability
To sustain a high quality NHS, action is needed in relation to the following three elements. Less impact on any one of them will require compensating action on the other two.

- Demand - A more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of

primary and out-of hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

- Efficiency - The ambition is for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. Requires investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two).

- Funding - Flat real terms NHS spending per person would take account of population growth. Flat NHS spending as a share of GDP would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

  Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.
  - In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.
  - In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.
  - In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to ‘flat real per person’ the £30 billion gap is closed by 2020/21.

Decisions on these options will need to be taken in the context of how the UK economy overall is performing, during the next Parliament.

4. Sunderland Position

An initial assessment of the degree of “fit” between the current plans within Sunderland to the requirements of the Five Year Forward View are summarised below:

NHS Forward View Requirement	Sunderland Position
Radical upgrade in prevention and public health	Enabling self-care and sustainability is one of the 3 strategic objectives for the CCG. Public Health continue to focus on prevention including the development of a wellness model.
Radical new delivery options including: • Multispecialty community providers • Primary and acute care systems • Urgent and emergency care networks • Viable smaller hospitals • Specialised care • Modern maternity services • Enhanced care in care homes	The CCG have a focus on developing multispecialty community providers through the work on integrated community locality teams as opposed to the integrated hospital and primary care provider model. A service specification has now been developed for maternity services at CHSFT. This was in draft form in 2014/15 with a view to being formally implemented in 2015/16. The pilot for enhanced care in care homes has been in operation in the coalfields locality for some time with a view that this will be rolled out city wide.
Requirement to expand and strengthen primary and out of hospital care is fundamental.	In addition to the work outlined above, the CCG have initially agreed that wider primary care should be a specific workstream moving forward into 2015/16.
New deal for GPs including investment to upgrade primary care infrastructure.	Significant programme of work underway to strengthen the IT infrastructure of primary care led by the CCG. Funding provided to support the development of the GP Alliance across Sunderland. Awaiting further information on specific investments nationally.
Dementia friendly communities will be fully supported nationally.	The development of dementia friendly communities has been a key transformational change for the CCG with a pilot in Houghton Town centre underway.
Consistent standard of support for patients diagnosed with dementia including named clinicians, proper care plans and the option of personal budgets.	This will be delivered through the Integration in the Localities.

Genuine parity of esteem between physical and mental health to be achieved by 2020	The CCG have strong evidence of parity of esteem being integral to health and care planning and have demonstrated evidence against all 12 requirements (outlined within the Strategic Plan).
95% of people referred for psychological therapies to be seen within 6 weeks and those requiring a first episode of psychosis to be seen within a fortnight.	The CCG feel this will be achieved within the next 12 months.
Better Support for carers building on the rights outlined in the Care Act.	We continue to support carers including the implementation of a carers innovation scheme to improve the identification, registration and support offered to carers within the GP practice and encourage onward referral to the Sunderland Carers centre if appropriate.
Stronger partnerships with charitable and voluntary sector organisations by developing short national alternative to NHS contracts where grant funding is more appropriate.	The CCG have a number of services which are funded via grants as opposed to NHS contracts. Awaiting further national guidance on this.
CCGs to co-commission primary care	Further guidance has now been issued with a requirement for CCGs to further develop delegated commissioning proposals for submission 9th January 2015 with arrangements implemented from 1st April onwards. To begin this work in Sunderland the CCG Governing Body is discussing this in two development sessions in November and December.
NHS as an employer to set national example including: • Cutting access to unhealthy products on NHS premises; • Implementing food standards, including healthy options for night staff; • Support active travel schemes for staff; • Promote workplace wellbeing charter etc; • Voluntary based health and wellbeing programmes; • Strengthen occupational health.	Consideration of a piece of work to review all NHS employers against these criteria.
Efficiency – NHS to achieve 2% net	Based on history 1.5% net efficiency

efficiency gains each year for the rest of the decade – possibly increasing to 3% over time.	should be achievable. 2% represents an ambitious target. Fundamental to achievement will be delivery of new care models which in turn would require "non recurred" pump priming monies in order to facilitate change. The CCG's plans already acknowledge and incorporate new models of care focussing on reducing demand in the acute sector. Non recurrent funding has also been set aside to finance this substantial "modernisation/change" agenda.

5. Conclusion

From reviewing the key points outlined in the 5 year forward view, it is clear that the CCG priorities are generally aligned with those directed nationally as outlined above.

Although the redesign of maternity services has not been identified as a transformational change for the CCG moving forward, a service specification was developed and implemented as part of the contract with City Hospitals Sunderland in draft form in 2014/15. The specification has been refined taking into consideration feedback from the recent CQC visit to the Trust and will be implemented formally as part of the 2015/16 contract. An additional note will be included in the service specification referring to the need to review following the publication of national recommendations for maternity services in summer 2015.

It is recommended that a specific piece of work focused on the CCG and partners as NHS Employers is considered to ensure all local health and care organisations meet the requirements nationally.

6. Recommendations

The Board is asked to:

- Note the key points of the NHS England 5 year forward view
- Note how current and planned work fits within the Five Year Forward View
- Support additional work necessary, including ensuring all local NHS organisations meet the recommendations outlined in this report.

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Director Debbie Burnicle
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Date **18 November 2014**

Item No. 10

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

AFFORDABLE WARMTH AND EXCESS WINTER DEATHS – PROGRESS UPDATE

Report of the Head of Housing Support and Community Living

1 Introduction

1.1 A presentation was given to the Adults' Partnership Board in May 2014, setting out the current position with the city's approach to Affordable Warmth, the levels of fuel poverty that exist and the current position with excess winter deaths.

1.2 On the back of the presentation and the subsequent discussion at the Board it was agreed that a multi-agency Affordable Warmth Steering Group would be set up. The purpose of the Steering Group would be to ensure the development of an Affordable Warmth Strategy and Plan and to ensure that agreed objectives and outcomes are delivered against.

Furthermore it was agreed that the Steering Group would report to the Adults Partnership Board, on a bi-annual basis and also to the Health and Well-being Board.

2 Progress to date

2.1 An Affordable Warmth Steering Group has been established with membership from key agencies e.g.

- Sunderland CCG
- Age UK
- City Council – People Services, Public Health, Policy
- City Hospitals
- GPs
- Warm Up North (British Gas)
- Gentoo
- South Tyneside Foundation Trust

2.2 The Group has agreed a Terms of Reference (see attached), which sets out the outputs and outcomes for the Group.

2.3 A 'Task and Finish Group' has been set up to develop the Affordable Warmth Strategy and Plan and this is well advanced and should be available in draft form by the end of December.

Notwithstanding the need to develop the Strategy an early priority for the Steering Group was to consider what actions could be taken to help reduce excess winter deaths, particularly focusing on those people with long-term conditions. It is pleasing to say that the work of the group has resulted in bids being made to the CCG which have been successful. One bid for £6K to do work with GP surgeries in the North Area linked to the flu jab campaign; and another bid from Age UK for £100k to help keep people warm and safe over the winter and prevent hospital admissions will both help those with long-term conditions. The latter bid also includes an amount for energy solutions for those most in need that may need a boiler repair or a new boiler installing. It is proposed that we combine this with the Council's Hardship Fund thus providing a useful sum of money that can be used to make a real difference to affordable warmth and fuel poverty for those most in need in the city.

3.0 In addition to developing the Strategy and ensuring outputs and outcomes are actioned, the Steering Group will also monitor the progress of initiatives such as Warm Up North and Collective Switching and the impact that they are having on affordable warmth and fuel poverty. Updates on both of the initiatives will be provided at the meeting.

4.0 In conclusion, it is hoped that having a multi-agency approach to affordable warmth will enable a 'whole system' approach to be developed which will result in positive outcomes for the city's residents and reductions in health and social care spend, as well as the environmental benefits that will accrue.

5.0 The Board is asked to note the progress made to date.

Sunderland Affordable Warmth Steering Group

Terms of Reference

- **Introduction**

Everyone should have access to a warm home that they can afford to heat, but for many households in the city this is difficult to achieve. The reasons for this can include poor insulation, inefficient heating, low incomes and the cost of fuel. Cold and energy inefficient homes are detrimental to health and many households are in fuel poverty.

The role of the Affordable Warmth Steering Group will be to ensure that a strategic, multi-agency approach will be taken to help reduce fuel poverty, improve affordable warmth, improve health and well-being and reduce excess winter deaths, particularly for the most vulnerable groups in the city. In addition, improvements in energy efficiency and promoting carbon savings will also be a key focus for the group.

- **Vision**

The Group will work to a vision, that being;

“To work in partnership to ensure that everyone in the city can afford to live in a warm, safe home. Homes will be energy efficient; have reduced carbon emissions achieved through greater awareness and understanding which leads to improved health and quality of life”

- **Membership of the Group**

Membership is open to all agencies and individuals who can make a positive contribution to improving affordable warmth and reducing fuel poverty in the city.

- **Frequency of meetings**

The Group will meet on a monthly basis up to the end of December 2014 and then bi-monthly from February 2015.

- **Chairing of the Meeting**

The meeting will be chaired by the Council's Head of Housing Support and Community Living up to the end of December 2014, after which the position will be reviewed.

- **Reporting Arrangements**

The Group will report to the Adult Partnership Board on a bi-annual basis

- **Outputs for the Group**
    - The development of an Affordable Warmth Strategy and Action Plan;

- **Outcomes for the Group from the Strategy and Action Plan**
    - Improved housing stock
    - Improved health and well-being for households at risk of fuel poverty
    - Reductions in fuel poverty
    - Increased energy efficiency and reduced energy use
    - Reductions in excess winter deaths
    - Reduced costs for the health service, particularly in reducing hospital admissions, and less cost for health and social care services per se
    - Improved quality of life
    - Reduced social exclusion
    - Improved air quality in the home
    - Enhanced capability and resilience of individuals
    - Behavioural and cultural change
    - Environmental benefits in the reduction of CO2 emissions

Item No. 11

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

MENTAL HEALTH TRAILBLAZER

Report of the Director of Public Health

1 Purpose

1.1 The purpose of the report is to provide information to the Sunderland Health and Wellbeing Board about the work that has been undertaken across the seven local authority areas in the North East Combined Authority (those in Tyne and Wear, Northumberland and Durham) to develop and submit a funding bid for a trailblazer project aiming to support people with common mental health issues back into work and seek support for Sunderland's ongoing participation in this work.

1.2 The Leader and Chief Executive of the council agreed to Sunderland's involvement and staff from public health and strategy and performance have been involved in the work. Sunderland CCG had agreed that public health would provide the interface with this work on their behalf. A paper was taken to the Adults Partnership Board on 24th October.

1.3 At combined authority level, the work is being led by Northumberland County Council, as the Portfolio Holder for Employability, Inclusion and Skills within the North East Combined Authority.

2. Background

2.1 Mental ill-health is prevalent in the working age population and is associated with high economic and social costs to individuals and society at large. Mental health problems are more common among people who are on benefits and out of work than those in employment.

2.2 The Royal College of Psychiatrists and the British Psychological Society define common mental health conditions as including the following: depression, generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder. These conditions cause marked emotional distress and interfere with daily function; but they do not usually affect insight or cognition.

2.3 The most recent psychiatric morbidity survey (2007) reported that 19.7% of women and 12.5% of men have a common mental disorder at a given point in time. Of these, the majority have depressive disorders or anxiety disorders; more than half suffer from a mixed anxiety and depressive disorder. In Sunderland it is estimated that around 27,500 people aged 18-64 will have a common mental health disorder[1].

[1] Estimate for 2014 from www.pansi.org.uk

2.4 Between 2010 and 2014, the government made changes to illness and disability related welfare benefits. Incapacity Benefit (IB), Severe Disablement Allowance (SDA) and Income Support (IS) paid on the grounds of illness or disability were phased out and replaced with Employment and Support Allowance (ESA). Recipients of ESA are obliged to undergo a "work capability assessment". The possible outcomes of this assessment are as follows:

- ***found fit for work*** – the individual is now ineligible for ESA, but may be able to claim Job Seekers' Allowance (JSA) or Income Support (IS)
- ***found to be too unwell to work at present, but work is possible in the future*** – the individual is allocated to the "work related activities group" and must undertake activities such as training and work focussed interviews
- ***found that illness or disability has a severe effect on their ability to work now and in the future*** – the individual is allocated to the "support group"

2.5 The 7 Council areas in the north east combined authority have persistently high claimant rates for out-of-work benefits. Latest data shows that the rate of ESA claimants is particularly high (see Box 1).

Box 1: Benefit claimant data as at February 2014

% of working age population claiming key DWP benefits:
- Sunderland – 15.6% (approximately 27,890 persons)
- North East Combined Authority – 13.7% (approximately 170,940 persons)
- Great Britain – 10.6% (approximately 4,215,690 persons)

% working age population claiming ESA or incapacity benefits
- Sunderland - 9.2% (approximately 16,370 persons)
- North East Combined Authority – 7.9% (approximately 98,300 persons)
- Great Britain – 6.2% (approximately 2,451,480)

Numbers of ESA claimants with mental or behavioural disorders:
- Sunderland – approximately 6,450 persons
- North East Combined Authority – approximately 38,520 persons
- Great Britain – approximately 969,450 persons

Of these, the following numbers are in the work related activities group:
- Sunderland – approximately 2,020 persons
- North East Combined Authority – approximately 10,630 persons
- Great Britain – approximately 277,280 persons

2.6 In general, employment support programmes and health interventions are currently not performing successfully in terms of positive outcomes, particularly sustained job outcomes, for this group.

3. Introduction

3.1 During July 2014, the North East Local Enterprise Partnership (LEP) was approached by the Cabinet Office and invited to bid for £1.7m via the Transformation Challenge Award (TCA). Similar approaches were made to Greater Manchester, Blackpool, and West London.

3.2 The bid will require matched funding. The North East Combined Authority is currently exploring whether the European Social Fund (ESF) could be used to provide this.

3.3 These areas were asked to develop and submit bids which aim to:

- Design and develop a mental health and employment integration trailblazer to inform future national and local support for people with common mental health conditions; and
- Test integrated and better sequenced delivery models to complement public services at the local level at scale.

3.4 The expected outcomes for the trailblazer are as follows:

- Improved employment outcomes for ESA claimants with common mental health conditions;
- Better integration of mental health and employment interventions;
- Shared outputs and outcomes e.g., benefit off-flows, sustained employment and clinical recovery;
- Improved value for money through integration;
- Reduced costs for other support services;
- Improved evidence base through robust evaluation.

3.5 Officers from the seven local authorities met during August and had some preliminary discussions with partner organisation. This was followed by a design workshop in September, which included partners such as Job Centre Plus, Northumberland Tyne & Wear NHS Foundation Trust, and the NHS North of England Commissioning Support Unit.

3.6 The workshop included sharing of good practice; this included a presentation by the Sunderland Psychological Wellbeing Service which provides employment support alongside psychological therapies for people with mild to moderate mental health problems and people with long term conditions.

3.7 The output of the design workshop was a proposed design model for the trailblazer, which was shared with participants for comment. Based on these comments, a bid was developed and submitted to the Cabinet Office on 1st October 2014. A formal decision announcement is anticipated on 21st November 2014.

4. The mental health trailblazer design model

4.1 The trailblazer will co-ordinate, integrate and add to a wide range of services already provided for people with common mental health problems. A central resource will be created which can broker employment support into existing psychological wellbeing/ IAPT services commissioned by CCGs. The service model will be based on the NICE approved Individual Placement Service (IPS) model, where each individual receives tailored support to support them into employment alongside their clinical recovery. Caseloads will be jointly managed by clinical and employment staff.

4.2 The primary goal is to achieve competitive employment which is consistent with each individuals stated preferences. Job search and placement should be rapid. Long term training or 'work preparation' interventions would not be considered to be successful outcomes.

4.3 Benefits counselling will be provided to support the transition from welfare to work. Continued in-work support will be provided past the end of the clinical intervention to promote sustaining work and prevent high rates of falling out of work.

4.4 Should the bid be successful, the new elements to be funded by the TCA are as follows:

- A central resource of employment coaches that will be brokered into psychological wellbeing/IAPT services;
- Sustained in-work support which includes both employment and clinical elements;
- Training with front line employment and mental health practitioners to ensure early identification of issues and employment is key factor in recovery plans for clinical intervention; and
- Telephone based advice for practitioners on the best course of action or support for individuals they may be working with.

4.5 The trailblazer would aim to support approximately 1,500 participants of working age from across the North East Combined Authority area over a two year period. The following would be eligible:

- ESA claimants where a common mental health problem is the primary reason for the claim;
- ESA work related activities group before referral to the Work Programme;
- ESA work related activities group on completing the Work Programme.
- JSA ex-Incapacity Benefits where Work Capability Assessment identified a common mental health condition.

4.6 A diagram of the model is included in the Appendix.

5. Next Steps

5.1 The timetable for the next steps is as follows:

- October 2014 - Wider consultation on the model will begin immediately when approval is received from Cabinet Office.
- October 2014 – Project development group established and convened, with work plan and key milestone dates agreed.
- November 2014 - Reports to Health and Well Being Boards across the Combined Authority area.
- November 2014 - formal decision announcement is anticipated on 21st November 2014.
- November 2014 – Confirmation of governance arrangements through North East Combined Authority.
- December 2014 - Procurement process for of in-work support telephone service to be appraised.
- January 2015 - Employment of project manager.
- January 2015 – Data sharing protocols negotiations.
- February – March 2015 - Employment of staffing and training needs audits – training plans implemented.
- February – March 2015 – Full briefings of Jobcentres and other referral sources to confirm referral processes.
- April 2015 – Go live.

6. Recommendations

6.1 The Sunderland Health and Wellbeing Board is asked to:

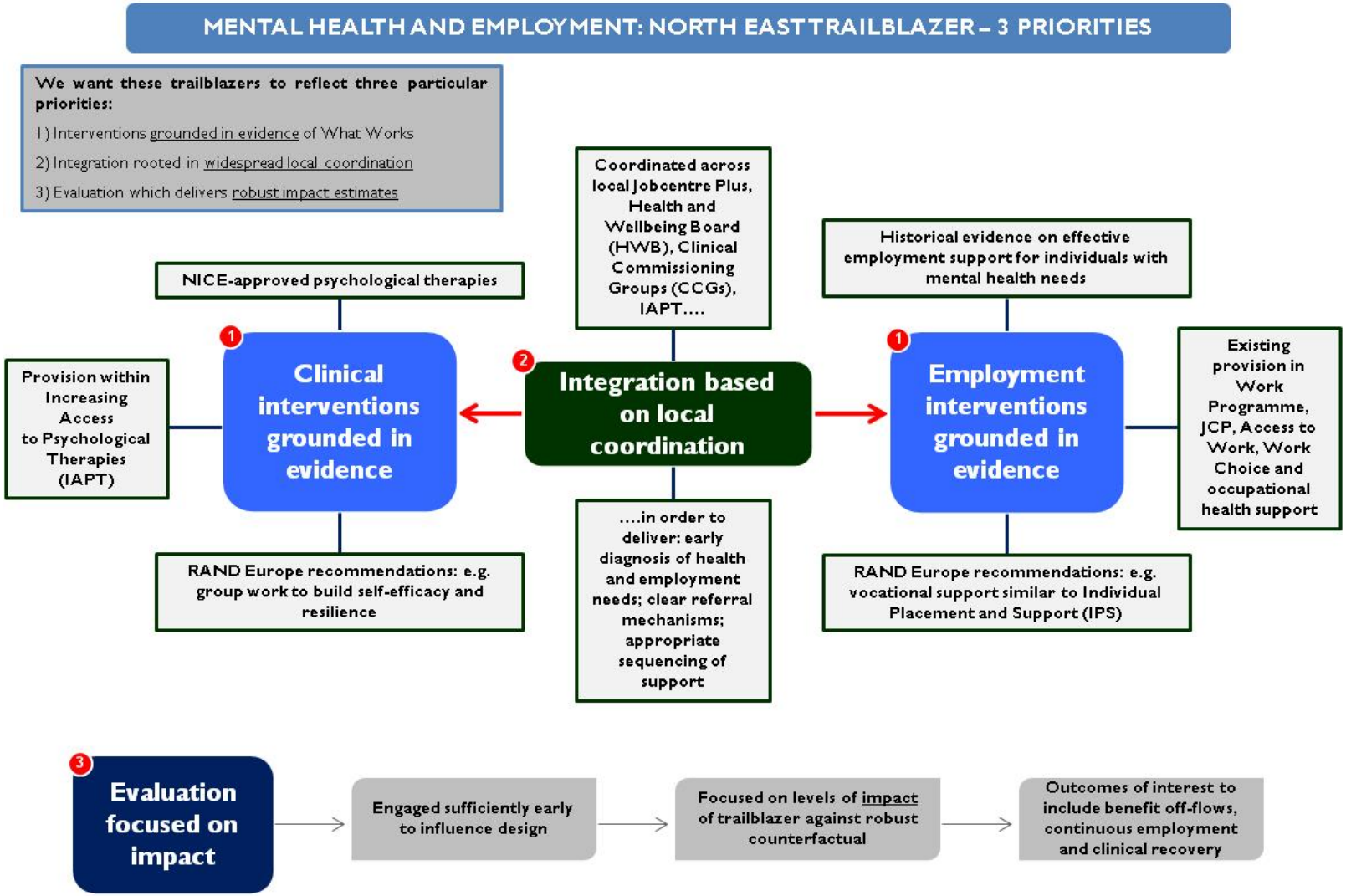
- Note the work undertaken so far on the mental health trailblazer application.
- Support Sunderland's continued participation in this work as a means of working towards the following strategic goals for the city:

  - Supporting and motivating everyone to take responsibility for their health and that of others;
  - Supporting everyone to contribute;
  - Supporting individuals and their families to recover from ill-health and crisis.

- Support development of the model for local implementation through the Mental Health Partnership Board.
- Provide feedback on the proposed delivery model for the mental health trailblazer.

Kath Bailey
Locum Consultant in Public Health

APPENDIX


MENTAL HEALTH AND EMPLOYMENT: NORTH EAST TRAILBLAZER – 3 PRIORITIES
We want these trailblazers to reflect three particular priorities:
1) Interventions grounded in evidence of What Works
2) Integration rooted in widespread local coordination
3) Evaluation which delivers robust impact estimates
Coordinated across local Jobcentre Plus, Health and Wellbeing Board (HWB), Clinical Commissioning Groups (CCGs), IAPT....
NICE-approved psychological therapies
Historical evidence on effective employment support for individuals with mental health needs
1
Clinical interventions grounded in evidence
2
Integration based on local coordination
1
Employment interventions grounded in evidence
Provision within Increasing Access to Psychological Therapies (IAPT)
Existing provision in Work Programme, JCP, Access to Work, Work Choice and occupational health support
RAND Europe recommendations: e.g. group work to build self-efficacy and resilience
....in order to deliver: early diagnosis of health and employment needs; clear referral mechanisms; appropriate sequencing of support
RAND Europe recommendations: e.g. vocational support similar to Individual Placement and Support (IPS)
3
Evaluation focused on impact
Engaged sufficiently early to influence design
Focused on levels of impact of trailblazer against robust counterfactual
Outcomes of interest to include benefit off-flows, continuous employment and clinical recovery

Item No. 12

SUNDERLAND HEALTH AND WELLBEING BOARD 28 November 2014

BOARD DEVELOPMENT SESSION AND FORWARD PLAN

Report of the Head of Strategy, Policy and Performance Management

1. PURPOSE OF THE REPORT

To inform the Board of the date and scope of the next development session and the forward plan.

2. DEVELOPMENT SESSION

There are no development sessions planned before the next HWBB. It is proposed that the future scheduled dates in 2015 be used for in depth review topics – giving the Board an opportunity to look at key issues in greater depth, either as a closed session or bringing in partners from other strategic boards in the city and delivery partners as appropriate.

The Board is requested to give consideration to topics that would be of interest for future sessions, but initial suggestions include:

- Collective risk management and assurance
- Joint working between Economic Leadership Board and HWBB
- Integrating needs assessments

3. FORWARD PLAN

Health and Wellbeing Board Agenda - Forward Plan 2014 – 15		
	28th November	23rd January
Standing Items	• Update from Advisory Groups • Development Sessions Briefing • Integration and Transformation Board	• Update from Advisory Groups • Development Sessions Briefing • Integration and Transformation Board
Joint Working	• Age friendly City update (SC/AP) • Due North	• NHS Monies for Social Care 2014/15 (GK) • Integrated Impact Assessment – HIA of the Core Strategy (NC/VT) • Pharmaceutical Needs Assessment

External Links	• Update on APB review topic – housing and fuel poverty • Mental Health Trailblazer	• NHS England plans to publish a 'five year forward view' of the NHS • Intelligence hub update • North East PHE Centre – Summary business plan and prospectus

4. BOARD TIMETABLE

Attached as Appendix 1 is the Board timetable showing the deadlines for agenda items, papers and the provisional times for the advisory groups.

5. RECOMMENDATIONS

The Board is recommended to

- Suggest topics for in depth closed/partnership sessions for 2015
- note the forward plan and suggest any additional topics
- note the timetable

SUNDERLAND HEALTH AND WELLBEING BOARD

MEETINGS 2014/15

Call for Agenda Items	Notification of Agenda items	Adults Partnership Board	Children's Trust	Provider Forum (tbc)	Integration Board	Deadline For Board Papers (to KG)	Chairs Briefing	Publication Deadline	Members briefing	HWBB Meeting Date
26 March (Weds)	9 April (Weds)	13 May (Tuesday)	8 May (Thurs)	7 May (Weds)	24 April (Thurs)	5 May (Mon)	6 May 9-10.00	8 May (Thursday)	9 May (Friday)	16 May (Friday)
21 may (Weds)	4 June (Weds)	8 July (Tuesday)	9 July (Weds)	10 July (Thursday)	2 July (weds)	14 July (Mon)	15 July 9.00-9.30	17 July (Thursday)	18 July (Friday)	25 July (Friday)
23 July (Weds)	6 August (Weds)	9 September (Tuesday)	11 September (Thurs)	4 September (Thursday)	21 August (Thurs)	8 September (Mon)	10 Sept 9.00-10.00	11 September (Thursday)	12 September (Friday)	19 September (Friday)
24 Sept (Weds)	8 October (Weds)	4 November (Tuesday)	13 November (Thurs)	6 November (Thursday)	5 November (weds)	17 November (Mon)	19 Nov 2.00-3.00	20 November (Thursday)	21 November (Friday)	28 November (Friday)
3rd Dec (Weds)	17 Dec (Weds)	6 January (Tuesday)	13 January (Tues)	8 January (Thursday)	6 Jan (Tues)	12 January (Mon)	13 Jan – 2.00-3.00	15 January (Thursday)	16 January (Friday)	23 January 2015 (Friday)
28 Jan (Weds)	11 February (Weds)	3 March (Tuesday)	5 March (Thursday)	5 March (Thursday)	26 Feb (Thurs)	9 March (Mon)	10 March – 2.00-3.00	12 March (Thursday)	13 March (Friday)	20 March 2015 (Friday)