At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on WEDNESDAY, 7th July, 2010 at 5.30 p.m.

Present:-

Councillor P. Walker in the Chair

Councillors Fletcher, A Hall, Maddison, , Padgett, Shattock, D. Smith, Snowdon and N. Wright.

Also in Attendance:-

Karen Brown	-	Sunderland City Council
Sharman Cummings	-	NTW NHS Trust
Carol Harries	-	City Hospitals Sunderland NHS Foundation Trust
Emma Hindmarsh	-	Sunderland City Council
Claire Harrison	-	Sunderland City Council
Ian Holliday	-	NTW NHS Trust
Judith Hunter	-	City Hospitals Sunderland NHS Foundation Trust
Suresh Joseph	-	NTW NHS Trust
Russell Patton	-	NTW NHS Trust
John Smith	-	Sunderland City Council
Steve Wilkinson	-	Local Involvement Network

Apologies for Absence

Apologies for absence were received on behalf of Councillor S Old, K Chamberlin

Minutes of the last Meeting of the Committee held on 9th June, 2010

1. RESOLVED that the minutes of the meeting of the Committee held on 9th June, 2010 be confirmed and signed as correct record

Declarations of Interest

Update Report on Sunderland Telecare Service

Councillor Shattock declared a personal interest in the item as a family member experienced learning disabilities.

Reference from Cabinet - Care Quality Commission (CQC) – Results of a CQC Service Inspection of Safeguarding Adults and Choice and Control for Older People

The Chief Executive submitted a report (copy circulated) to provide members with a summary of the Care Quality Commission (CQC's) judgement in relation to a Service Inspection of adult social care in Sunderland. The inspection focussed on two specific areas – Safeguarding vulnerable adults and Choice & Control for older people.

(For copy report – see original minutes)

The Chairman welcomed Mr Neil Revely, Executive Director of Health, Housing and Adult Services, John Fisher, Head of Service (Adult Services) and Graham King, Head of Performance, Commissioning & Change to the Committee and invited them to present the report.

Mr Revely explained that the changing context of the national adult safeguarding agenda was moving to alignment with the existing safeguarding children framework.

Mr Revely drew attention to the overall findings of the inspection, that the grades for Safeguarding and Choice and Control for older people were both adequate and the Council's capacity to improve was judged promising.

Mr Revely highlighted a number of issues which had already been tackled including:-

- Improved performance management reporting and scrutiny of issues to the Board;
- Dedicated Project Manager to take forward safeguarding actions;
- Strengthening arrangements to lead on the transformation agenda within adult social care;
- Recruiting an independent chair of Safeguarding Adults Board;
- Expanded safeguarding training;
- Commissioning revised advocacy arrangements to better support people in safeguarding process.
- Revised consultation processes in line with Council's Consultation Strategy to ensure older people and carers had a greater say in shaping commissioned services;
- Significant shift in emphasis towards not just maintaining people at home with their personal care needs, but in enabling them to perform tasks for themselves;
- Improved support for carers focusing on the needs of the carer separately to support them in their ongoing caring role.

Mr Revely advised that an Improvement Action Plan had already been developed following the inspection and the Scrutiny Committee would have the opportunity to consider the improvements being made at their next meeting.

Councillor D. Smith advised that he looked forward to having sight of the draft action plan. He advised that he was concerned that on occasions people had not been included in discussion and were hindered from attending meetings in relation to their care.

Mr Graham King advised that a report would be taken to July Cabinet regarding access to Adult Advocacy services.

Councillor Shattock commented that the inspection report highlighted issues of concern in relation to the need to strengthen middle management for front line staff. Mr Revely advised that the Directorate would take on board readily the comments made in the report and management systems would be improved. He advised that the Council worked in conjunction with its partners in providing adult social care in Sunderland and the management issue could relate to other organisations. The quality of training for managers was excellent; however it was acknowledged that there were not sufficient middle managers in training to support others.

Councillor N. Wright stated that she had been the Portfolio Holder for Healthy City at the time of the inspection and was disappointed with some of the comments contained within it. However, there were a number of positive comments from the inspection with promising prospects for improvement. Many suggested improvements were already in place and Councillor Wright had full confidence in the team to make further progress.

Consideration having been given to the report, it was:-

2. RESOLVED that the Care Quality Commission's judgement about the Council's delivery of adult social care in the inspection areas, and their comments about the Council's and City's areas of strength and for improvement be noted.

Review of the Management of Malnutrition and Dehydration in Hospitals

The Chief Executive submitted a report (copy circulated) to make proposals to the Scrutiny Committee for their forthcoming review of malnutrition and dehydration in hospitals.

(For copy report – see original minutes)

Ms. Karen Brown, Scrutiny Officer presented the report and outlined the Terms of Reference for the review. She also asked the Committee to consider co-opting a member of a representative group, sector or organisation relevant to the scope of the review for the municipal year to assist with evidence gathering and deliberations.

3. RESOLVED that:-

i) the Committee endorse the scope of the review for 2010/11, and

ii) the Scrutiny Officer be requested to seek nominations from representative groups, sectors or organisations relevant to the scope of the review for the municipal year to assist with evidence gathering and deliberations.

Total Place Pilot – Final Report

The Chief Executive submitted a report (copy circulated) to present the Scrutiny Committee with the Gateshead, South Tyneside and Sunderland Total Place Final Report into Alcohol and Drug Misuse.

(For copy report – see original minutes)

Mr. Lee Cranston, Assistant Head of Corporate Policy presented the report. Mr Cranston reminded Members of the background to the government initiative.

Total Place was a government initiative that looks at how a 'whole area' approach to public services could lead to better services at less cost. It sought to identify and avoid overlap and duplication between organisations – delivering a step change in both service improvement and efficiency at a local and national level.

13 pilot areas participated in the scheme, each area ensuring a diverse mix of economic, geographical and demographic profiles.

The theme for the Gateshead, South Tyneside and Sunderland pilot was alcohol and drug misuse and was determined through consultation and workshops with partners. It was clear that alcohol and drug misuse was an area where there are common issues and challenges with crosscutting links across partnerships and priorities.

Mr. Cranston advised that the Total Place name had been abandoned by the new government, however it was hoped that the premise of total place would survive; providing better services at less cost and without duplication.

In response to a question from Councillor Shattock, Mr. Cranston advised that the reason the report had taken so long to come to Committee was partly due to the Purdah period in the run up to the General Election and partly due to awaiting the information in the submission being collated around what the pilots were seeking to do differently, the potential benefits of the work, what the barriers to it were, and what the evidence used to back this up was.

Councillor Shattock enquired that as the future for total place was unclear, whether it was anticipated that there would still be good outcomes for the region as a result of the work achieved so far.

Mr Cranston advised that there was strong commitment to fulfil the key strands of the pilot. Its success to date has emerged through local organisations driving a localised agenda, aimed at clearly benefiting customers and citizens. This drive will continue and the greater collaboration and cohesion between the public and voluntary sectors will be a lasting requirement with the benefits already being realised.

4. RESOLVED that the contents of the report be received and noted.

Update Report on Sunderland Telecare Service

The Executive Director of Health, Housing and Adult Services and Director of Learning Disability Services submitted a report (copy circulated) to update the Committee on the Sunderland Telecare Service.

(For copy report – see original minutes)

Mr Philip Foster General Manager, Provider Services, was in attendance to present the report.

Mr Foster advised that Sunderland Telecare supported people to maximise individual choice and independence in their own home, enabling vulnerable people to stay safe at home; promoting well being and preventing unnecessary admission to hospital or long term institutional care.

The Telecare service currently supported 20,000 people to live at home and is backed up by the monitoring centre with a team available 24 hours a day to provide a rapid response across the city within an average of 15 minutes. The service dealt with approximately 300,000 calls last year.

Mr Foster advised that the social and health care teams were all trained to a minimum of NVQ Level 3.

Members congratulated Mr Foster on the fantastic service provided by Telecare in Sunderland.

In response to an enquiry from Councillor Smith regarding the example given by Mr Foster of how Telecare could raise an alarm if for instance an individual had not opened their fridge door within an expected time frame, Mr Foster advised that that the specific Telecare service was based on sensors that provide an early and identified warning of a potential emergency in the homes of vulnerable people particularly those with learning difficulties. More advanced systems based on lifestyle monitoring were being developed that will both be reactive and responsive in nature (another example being temperature monitoring). Carers would be significantly involved and all details would be included in an individual's care plan. Such facilities were not meant to be intrusive in nature and any issues would be dealt with in a respectful and ethical manner.

In response to a question from Councillor Shattock, Mr Foster advised that Sunderland Telecare uses Telecare equipment connected to the City Council's 24 hour control room based at Moorside.

The technical team consists of 12 members of staff who work on a shift pattern and are available to fit equipment, make battery changes etc.

Alert calls are answered by an expert control room operator who will determine the nature of the call and initiate an appropriate response, including contacting relatives or carers, or in the event of an emergency, the appropriate emergency services. If appropriate, the response service consisting of 40 highly trained Mobile Social and Health Care Assistants can be dispatched by the control room to a person's home to provide advice, support and a variety of assistance. The service operates 5 vans per shift that are positioned across the city and endeavours to have 2 members of staff in the vans at all times if possible with a gender balance of 1 male and 1 female.

Sunderland Telecare also provides vulnerable Sunderland residents with access to an Overnight Care Service, supporting people with complex needs to live at home through the provision of planned and emergency support, with the aim of preventing unnecessary admission into care.

Customers may only have to pay a small weekly charge to cover the monitoring of the alarm and the mobile response provided by staff. People who are assessed as needing the service or who require additional Telecare equipment to enable them to remain living safe and independent and safely at home will have an individual financial assessment to determine how much, if anything, they may need to pay.

The service also offers carbon monoxide sensors at a charge of £3.30 per week. Revenue from this is reinvested back in to the Telecare service.

Mr Revely commented that the enthusiasm for the service is demonstrated in all members of staff. He advised that the payback from the service was clearly demonstrated and the clear prevention objective meant this was a service well worth investing in.

The Chairman having thanked Mr Foster for his report on the tremendous service that was being delivered by Telecare across the city, it was:

5. RESOLVED that the contents of the report be received and noted.

Provision of Social Care for Adults with a Learning Disability

The Executive Director of Health, Housing and Adult Services and Director of Learning Disability Services submitted a report (copy circulated) to inform the Committee of the Council's plans to commission the provision of social care for adults with a learning disability living in nine residential homes in the City.

(For copy report – see original minutes)

The Chairman welcomed John Fisher, Head of Adult Services and Kate Simpson, Northumberland Tyne and Wear NHS Trust and invited them to present the report.

Councillor Shattock commented that the new arrangements would mean a huge change for the people within the residential homes affected and she questioned what type of consultation had taken place.

Mr Fisher advised that full consultation had taken place with individuals and their families and advocates had been made available where necessary.

With regard to TUPE (Transfer of Undertakings (Protection of Employment) Regulations) arrangements, Ms Simpson clarified that these regulations provide employment rights to employees when their employer changes as a result of a transfer of undertaking. She advised that all staff had been consulted in the undertaking. This means that the employees employed by the NTW NHS Trust when the transfer takes effect automatically become employees of the new employer on the same terms and conditions. Ms Simpson advised that occupational pension rights were not guaranteed under TUPE but there was agreement to establish a comparable pension provision.

Ms Simpson advised the Committee that employees who transferred under TUPE would provide continuity for the client group; however some members of staff had expressed a desire to remain with the Trust.

In response to a question from Councillor Shattock, Mr Fisher explained the benefits of supported tenancy. He advised that most clients within the existing residential homes within the city would remain in the same home with a change in the type of tenancy. Supported tenancy enables clients to live independently and to successfully maintain their accommodation. The assured tenancy will empower people to take control of their own lives and to learn the skills necessary to be able to successfully maintain their home and allows individuals to draw on housing benefits.

6. RESOLVED that the contents of the report be received and noted.

Annual Work Programme 2010 – 11

The Chief Executive submitted a report (copy circulated) for the Committee to receive an updated work programme for the 2010-11 Council year.

(For copy report – see original minutes)

7. RESOLVED that the contents of the report be received and noted.

Forward Plan – Key Decisions for the Period 1 July 2010 – 31 October 2010

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider the Executive's Forward Plan for the period 1 July – 31 October 2010.

(For copy report – see original minutes)

Ms Claire Harrison, Acting Scrutiny Officer presented the report and advised that it should be noted that in the current edition of the Forward Plan there were three issues which were relevant to the Committee's remit.

8. RESOLVED that the contents of the report be received and noted.

Date of Next Meeting: Wednesday 15th September, 2010 at 5.30 pm in the Civic Centre, Committee Room No.1

The Chairman then closed the meeting having thanked Members and Officers for their support.

(Signed) P. WALKER,
Chairman.

HEALTH & WELLBEING SCRUTINY COMMITTEE 15 September 2010

RESPONSE FROM CABINET – 24 JUNE 2010

POLICY REVIEW – TACKLING HEALTH INEQUALITIES IN SUNDERLAND

JOINT REPORT OF THE EXECUTIVE DIRECTOR OF HEALTH, HOUSING AND ADULT SERVICES AND THE PORTFOLIO HOLDER FOR HEALTHY CITY
STRATEGIC PRIORITIES: SP2: Healthy City.

CORPORATE PRIORITIES: CIO1: Delivering Customer Focused Services, CIO4: Improving Partnership Working to Deliver 'One City'.

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide feedback from the Cabinet meeting held on 24 June 2010, which considered the Health and Wellbeing Scrutiny Committee's Policy report into tackling health inequalities in Sunderland.

2. BACKGROUND INFORMATION

2.1 The investigation into Tackling Health Inequalities in Sunderland conducted by the Health and Wellbeing Scrutiny Committee falls under the remit of the Health, Housing and Adult Services Directorate and is, within the service area covered by the Healthy City Portfolio Holder.

2.2 On 24 June 2010, Cabinet considered the Final Report of the Health and Wellbeing Scrutiny Committee into tackling health inequalities in Sunderland. This report provides feedback from the Portfolio Holder following the Cabinet's consideration of, and decisions in relation to this Committee's recommendations.

2.3 Following on from this report, progress towards completion of the actions will be monitored through the Action Plan, with standardised six monthly monitoring reports to be presented to the Committee.

3. RESPONSE FROM CABINET TO THE POLICY REVIEW

3.1 Following consideration of the Final Report, Cabinet approved the recommendations in their entirety. Details of each recommendation and proposed actions to be taken following approval by Cabinet are provided in the Action Plan attached at **Appendix A**.

3.2 Cabinet commended and congratulated the Committee and its officers for their hard work in undertaking the policy review and additional work.

4. RECOMMENDATIONS

4.1 That Members note the proposed actions detailed within the Action Plan, appended to this report **(Appendix A)** and seek clarification on its content where felt appropriate.

5. BACKGROUND PAPERS

5.1 The following background papers were used in the preparation of this report:-

(i) Cabinet Agenda, 24 June 2010

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karen.brown@sunderland.gov.uk

Appendix A

Health and Wellbeing Scrutiny Committee
Tackling Health Inequalities Policy Review Recommendations 09/10

Ref	Recommendation	Action	Owner	Progress Commentary
	Establish an Elected Member champion and an Executive Management Team lead for health inequalities, who will direct a work programme including widespread officer engagement in inequalities needs assessment, equity audit and health impact assessment overseen by the Office of the Chief Executive	> Neil Revely (Executive Director of Health, Housing and Adult Services) to become EMT lead for Health Inequalities > Portfolio Holder for Health and Wellbeing to become lead member for inequalities >Undertake a 'baseline analysis' of what is currently being done to address the Social Determinants of Health (SDH) and Health Equity > On the basis of the outcomes of the baseline analysis consider how sustainable work on the SDH and health equity can be incorporated > Formulate an action plan that incorporates the findings. The action plan should included short term activities, as well as long term measure for structural change.	HHAS	Neil Revely and Cllr M Speding to take role as executive management team and elected member champion for health inequalities. Research is currently underway to assess / analyse the current performance of the Council against the critical success factors in tackling inequality in health: 1. Understand health equity concept 2. Aware of SDH 3. City Leadership 4. Partnership 5. Policy intervention 6. Mainstream Service 7. Special Programmes 8. Measuring, monitoring and evaluation

	Elected Members to be provided with appropriate specific levels of briefings around health inequalities in Sunderland and the strategic and operational actions required to reduce them in a sustainable way	> Assess the quantity and quality of information available on the SDH and health equality that has been developed for awareness raising and advocacy purposes > Complement existing information on the SDH and health equity with specific facts and figures that are relevant to engage elected members (at Area Committee level and city wide) in regular briefing > Develop communication materials (brochures, information and web-based resources etc) incorporating the information	HHAS / Corporate Comms	Design for elected member handbook, currently with communications / city print for input. Meeting to be arranged with democratic services / community leadership to arrange appropriate briefing times/methods.
	Appropriate briefings be undertaken with all Heads of Service and relevant officers across all directorates in relation to health inequalities, and using health needs assessment, health equity audit and health impact assessment appropriately in strategic planning and operational delivery	> Assess the quantity and quality of information available on the SDH and health equality that has been developed for awareness raising and advocacy purposes > Complement existing information on the SDH and health equity with specific facts and figures that are relevant to engage decision makers (at ward level and city wide) in regular briefing > Develop communication materials (brochures, information and web-based resources etc) incorporating the information > Organise a training session on SDH and Health equity for relevant staff, practitioners, and/or policy makers. > HIA training – send key staff to Health Impact Assessment training (including health equity impact assessment course) > Exchange with others on effective methodologies that communicate health promotion messages to targeted groups via social marketing approach > Develop action plan / workshop event	HHAS	Currently working with Heads of Service on behalf of the Health Inequalities Service Assessment (Sunderland Way of Working). Developing Self assessment tolls for HoS to complete to gauge the level of understanding of Health inequalities across the Council.

	Adopt a health inequalities toolkit for Sunderland, which caters for the various stakeholders across the city (including Elected Members, Council Officers, partner organisations and members of the public) to ensure that new policies and service designs consider the potential health impacts of implementation	> Adopt Influencing Health toolkit (Best practice in Yorkshire and Humber) > Identify and enhance opportunities to ensure recognition of the SDH and health equity in policy formation. > Identify how consideration for the SDH and Health equity and evaluation of policy measures can be mainstreamed into policy making processes. > Identify central guidelines, common targets and mechanisms for action to address the SDH and health equity, assess where they can be established or improved. > Assess whether there is coherence between the National, Local and Regional levels in efforts to address health equity and SDH.	Community Leadership	Toolkit currently with Communications / City print for feedback (initially for Elected members – this will be developed for officers / partner organisations as appropriate)
	The existing joint strategic needs assessment at a City wide, ward and 'natural neighbourhood' level to be enhanced through the development of Area Committees' role in highlighting and identifying local needs and in particular their commissioning role in supporting the delivery of local area plans in delivering services and support that meets the needs of an area	> Assess what information systems are available in to analyse and monitor social determinants and health equity > Analyse whether the information systems in place are sufficient and/or how they can be improved > Organise a training session on SDH and Health equity for relevant staff, practitioners, and/or policy makers.	HHAS	Work to be planned .

	Develop mechanisms to ensure that the impact on reducing health inequalities are considered by all scrutiny committees and area committees as part of the work planning process	> Organise a training session on SDH and Health equity for relevant staff, practitioners, and/or policy makers. > Complement existing information on the SDH and health equity with specific facts and figures that are relevant to engage elected members (at Area Committee level and city wide) in regular briefing > Adopt Influencing Health toolkit for use with all Scrutiny committees > Identify how consideration for the SDH and Health equity and evaluation of policy measures can be mainstreamed into scrutiny processes.	HHAS / Scrutiny	Toolkit currently being developed – once developed a number of training sessions will be booked with Scrutiny Officers / elected members to introduce / explain functions.
	Ensure that Sunderland City Council and Area Committees continue to provide support to develop a co-ordinated approach for Voluntary and Community Sector organisations across Sunderland in delivering their services within local communities and neighbourhood settings, using the Compact as the agreed framework for partnership working with the Voluntary and Community Sector be continued	> Scope partners, policy, programme or project initiatives that are being planned or implemented in other sectors that affect health equity, and identify common objectives. > Ensure that all grants given to support the VCS work towards delivering services around common goals > Share information around SDH to all partners > Approach organisations involved in policy and programme initiatives that have an impact upon health equity to highlight synergies and offer support.	City Services	Corporate Grants group formed to gather 'picture' of current grant funded/ contracted voluntary groups.
	City Council to become an exemplar in ensuring employees benefit through 'Health at Work' Schemes and should engage with the regional workplace health programme	> Building on good practice identify more examples of successful policies and interventions that address the social determinants of health inequalities. > Exchange with other partners to consider why these policies and interventions were successful and what elements may or may not be transferable	Corporate Personnel	Sunderland are engaged within the regional workplace programme. Mapping of current workplace programmes affecting health being carried out.

	Through the Sunderland Partnership the Council should engage with large and medium employers of routine and manual workers across the city and assist them in implementing workplace health programmes for local workforces	> Explore links with the private sector for collaboration on initiatives that address the SDH and health equity > Develop a Stakeholder map > Approach organisations involved in policy and programme initiatives that have an impact upon health equity to highlight synergies and share information and good practice. > Share information around SDH to all partners	LSP / corporate personnel	Partnership engaging with Marmot review team. Mike Grady from Review team to present at September Delivery and Improvement Board.
	Further explore innovative practice from across the country in relation to addressing health inequalities, in particular the example of the London Borough of Newham, to ensure that advice and guidance on benefits and re-entering employment targets the main issues facing the long-term unemployed	> Building on good practices identify more examples of successful policies and interventions that address the social determinants of health inequalities. > Exchange with other partners to consider why these policies and interventions were successful and what elements may or may not be transferable > Identify online information sources with e.g. best practice > Contribute to or set up user friendly mechanisms to communicate applicable data and evidence to policy makers and practitioners within and outside of the health sector	Economic Development	Research / Case study finding being completed by International Team

	Sunderland Partnership and its delivery partnership submit a formal response to the Marmot Review to the Health and Wellbeing Scrutiny Committee, demonstrating how partners are supporting delivery for the local population around active travel plans, availability of good quality green spaces, healthy local food environments, energy efficiency in housing, reduction of fuel poverty, integration of planning and removal of barriers to community participation	> Scope partners, policy, programme or project initiatives that are being planned or implemented in other sectors that affect health equity, and identify common objectives. > Approach organisations involved in policy and programme initiatives that have an impact upon health equity to highlight synergies and offer support. > Explore links with the private sector for collaboration on initiatives that address the SDH and health equity > Hold 'training' and 'awareness raising' sessions with each of the Delivery groups around the agenda > Work with the Delivery and Improvement board to submit formal response > Identify how consideration for the SDH and Health equity and evaluation of policy measures can be mainstreamed into partnership processes.	LSP	Working with representatives from HHAS to inform partners about the Marmot Review / implications of the review for the Partnership. Mike Grady from marmot Review team to attend September Delivery and Improvement Board.

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 15th SEPTEMBER 2010

CARE QUALITY COMMISSION (CQC) –CQC SERVICE IMPROVEMENT PLAN (SAFEGUARDING ADULTS AND CHOICE AND CONTROL FOR OLDER PEOPLE)

REPORT OF THE EXECUTIVE DIRECTOR OF HEALTH, HOUSING and ADULT SERVICES

STRATEGIC PRIORITIES: SP2: Healthy City.
CORPORATE PRIORITIES: CIO1: Delivering Customer Focused Services, CIO4: Improving Partnership Working to Deliver 'One City'.

1. Purpose of the Report

1.1 The purpose of the report is to present to Members, the CQC Improvement Plan for Health, Housing and Adult Services following the Service Inspection that took place in January 2010.

2. Background

2.1 At July's Scrutiny Committee, the results of the service inspection were shared with Members. CQC identified Choice & Control (for older people only) as the main area for inspection, together with a mandatory inspection of safeguarding arrangements for vulnerable adults, as well as reviewing the Directorate Capacity to Improve.

2.2 As previously reported, CQC considered Sunderland is performing adequately in relation to Choice and Control for older people and Safeguarding. It is also considered Sunderland has promising prospects for improvement.

2.3 The 20 recommendations for improvement have been presented to Cabinet, and as part of the process for responding to the inspection, the CQC Improvement Plan has been developed.

3. Current Position

3.1 The CQC Improvement Plan (Appendix 1) sets out the 20 improvement areas, detailing the specific actions and timeframes that have been identified as central to meeting the overall improvement areas.

3.2 During the inspection, the Inspection Team visited the Council to gather evidence and explore issues during their 2 week fieldwork visit. The Inspectors shared key messages throughout their visit, which allowed

for some of the actions outlined in the Improvement Plan to start being implemented.

3.3 There are some actions within the Improvement Plan that were already being taken forward as the directorate had recognised that these areas needed improving prior to the Inspection.

3.4 Work has now commenced on all specific actions, as evident through the CQC Improvement Plan; with some actions now completed.

4. Conclusion

4.1 It is recognised that the directorate needs to continue implementing the CQC Improvement Plan, in order that we continue to improve and strengthen our role in safeguarding and providing choice and control for older people.

5. Recommendation

5.1 It is recommended that Members:

- Receive the report and CQC Improvement Plan for information
- Are reassured that actions have been and will continue to be progressed
- Will receive further updates at future meetings.

6. Background Papers

Cabinet Report 24 June 2010 Care Quality Commission (CQC) – Results of a CQC service inspection of safeguarding adults and choice and control for older people

Sunderland City Council

CQC IMPROVEMENT PLAN MONITORING FORM

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Improvement Area 1 – Address the risks and challenges of the widely devolved safeguarding arrangements. **Improvement Area 4 – Engage health partners in agreed multi-agency safeguarding arrangements & secure alignment of internal arrangements.**						
Safeguarding	1. Hold emergency meeting of SAB with mandatory commitment for partners to agree actions relating to safeguarding in Improvement Plan	Meeting of SAB held (minutes)	Jun-10	JF	Complete	Signed commitment of SAB partners to this Improvement Plan Memo of understanding
		Develop memorandum of understanding between partners This was agreed verbally and all SAB members signed the minutes to agree the process. An agreement plan is in place following the meeting on 12/4/10, but no memo yet signed. Due to go to next Board for sign off.		SK		
Safeguarding	2. Ensure SAB roles & responsibilities reviewed to act as leadership team for safeguarding in the city	Signed commitment of SAB partners to revised roles and responsibilities of Board as a leadership group. Independent Chair now appointed. Initial meeting held with Chair to take forward.	Jun-10	JF		Individual 'job descriptions' agreed for SAB Members
Safeguarding	3. Agree number of sub-groups to meet, answerable to Board linked to Adult Social Care Board to: a) tackle improvements identified in this Plan & CQC inspection; b) Provide longer-term functional support to SAB with regular report of progress & findings	Establish time-limited groups authorised to take forward defined actions within improvement plan	Jun-10	SK	Complete	SAB become more effective in discharging its duties through development of sub-groups with clearly defined & published roles & responsibilities. Sub-groups with membership are: Reflective Practise; Policy & Procedures; Training & Development; Serious Case Review; Marketing and Communication;
		Actions in Improvement Plan identified in Risk, Choice & Safeguarding Project with clear actions for sub-groups identified with a September timescale for delivery		SK	Complete	
		Publish list of SA Sub-Groups with roles & responsibilities, including reporting agreements to SAB	Sep-10	SK	Complete	

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Safeguarding	4. Appoint Independent chair of safeguarding board with clear roles, responsibilities and authority	Independent chair out to advert – short listing took place at the end of June. Chair appointed in July.	Jul-10	JF		Independent Chair appointed
		Re-draft of roles and responsibilities of SAB members. All permanent sub groups have been established and will be signed off at SAB in September		JF		Redrafted roles & responsibilities signed off by SA Board
Safeguarding	5. Work with SAB sub-group to establish clearer protocols for reporting "concerns" rather than "safeguarding"	Develop & publish protocols about reporting of "safeguarding" & "concerns", with practical case studies available authorised via SA Board	Sep-10	SK		Publish protocols & training documentation Performance report Expect to see increase in number of 'concerns' the safeguarding issues Performance measures identifying % of safeguarding notifications deemed appropriate via performance reporting
		Embed revised protocols in training & training materials – due August 10		SK		
		Integrate monitoring of use & effectiveness of revised protocols amongst partners in performance reporting to SAB, including qualitative assessment of decision-making	Sep-10	PA		
Safeguarding	6. Work with SAB sub-group to establish mechanisms for formally exploring repeat or multiple abuse in individual agencies which can be raised to Board to sanction action, to address thematic issues more clearly, particularly in group living, including management of people with challenging behaviour	Integrate monitoring of multiple notifications & investigations into performance reporting – included first draft in March 2010 report	Jun-10	PA		Publish protocols & training documentation Performance report Expect reduction in number of multiple notification & investigation, including qualification analysis via SAB performance reporting
		Develop exception reporting to Board to discuss analysis of underlying reasons from multiple mechanisms – first SAB draft for end of Jun-10 report for NTW, partner agency with multiple notifications		PA		

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		Develop feedback mechanisms from provider identified in exception reporting to SAB about progress in addressing key issues – agreed approach with SAB		PA		
Safeguarding	7. Restructure SA Team in light of expectations for improvement to make them more "fit for purpose" to environment & customer expectations	Produce revised structure for SA Team informed by CQC Inspection findings, authorised by SA Board Benchmarking carried out and a plan produced showing the gaps in service when compared. Structure on agenda for Personnel Committee in September	Jul-10 Aug-10	SK		Revised SA Team structure
Safeguarding	8. As part of restructure & business processes re-engineering, ensure communications between partners involved in safeguarding alerts made more systematic, including feedback about results to those about whom alerts made or representatives & those responsible for alerts	Establish revised business processes for managing safeguarding activity focussed on management of information in SA Team – on target	Sep-10	DB		Production of revised business processes Production of supporting training documentation Performance report Expect improvement in % of cases in which outcomes were reported to be fed back to subject of alerts & those responsible in appropriate timescales
		Embed analysis of outcomes of communication (& training take-up) in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making progressing		PA		

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Safeguarding	9. Sub-group of SAB to review current, and develop more strategically targeted, marketing campaign aimed at raising safeguarding awareness in the city amongst public and providers, including success criteria	Produce marketing campaign to promote public & professional awareness & knowledge of safeguarding, integrating national "Dignity in Care" campaign In progress, a marketing sub group established and a draft a communication plan to go to SAB in September	Sep-10	SK/DKE		Marketing plan specifying communication mix
		Develop SMART expectations of campaign's impact & embed expectations in performance reporting to SAB		PA		Performance report Improvements in SMART expectations of marketing campaign awareness
Safeguarding	10. Review Annual Report to ensure it captures CQC improvements and is more rigorous in its analysis of safeguarding activity and issues, and delivered to Board more promptly	Produce Annual Report with SMART action plan for 2010/11, grounded in Improvement Plan	Jun-10	SK		Publish Annual Report with SMART action plan
		Present Annual Report to Adult Board within Local Strategic Partnership to galvanise partner support – SAB agreed Annual Plan and SAB are a sub group of the LSP				Presentation to LSP
Safeguarding	11. Work with health partners as a priority area to reinforce safeguarding (see training) and to review alerter/referral routes about safeguarding, including review of interfaces and improving dignity in care, discussed in CQC Report	Establish time-limited Health sub-group to address issues - health time limited group set up - SK to schedule meetings, roles time limited group to set up as 'virtual group'	Jul-10	JF		Health Sub-Group established
		Revise protocols & procedures for safeguarding to reflect improvements across health/social care	Jul-10	SK		Published protocols & training documentation signed off with health partners

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		Improve safeguarding training with health staff partners, with clear expectations and support. Tyne & Wear Care Alliance undertaking training needs analysis of all partner agencies.	Sep-10	SK		Improved take up of safeguarding training from health staff partners
		Embed analysis outcomes of training for health partners in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making	Sep-10	PA		Performance report Expect to see increase in appropriate safeguarding notifications from specific health sources during 2010/11
Improvement Area 20 – Work with the safeguarding adult's partnership board to undertake a training needs analysis across agencies and develop a comprehensive training plan based in the information, **Improvement Area 2 – Ensure that practitioners and managers in all agencies are competent for their roles in safeguarding.**						
Safeguarding	1. Develop skills audit to identify skills gap for staff in all agencies, particularly care agencies, involved in safeguarding activity	Produce comprehensive skills audit summary of staff in all agencies with safeguarding responsibilities as "snapshot" position through SAB - sub group held on 25/5 to discuss work the group will take forward – pulled together audit which has been agreed by existing chair of SAB	Jul-10	MP		Produce skills audit across partner agencies
		Develop mechanisms for updating this skills audit across partners on a regular basis – this will be taken forward by the same sub group	Jul-10	SK		SAB agreement about regular update of skills audit baseline amongst staff
Safeguarding	2. As result of skills audit, analyse workforce & training requirements for individual agency and commissioning training about	Develop prioritised training programme over next 3 years aimed at addressing "skills gap", including targeting specific partner agencies	Aug-10	MP		SAB-commissioned multi-agency prioritised training programme produced

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	safeguarding from Tyne & Wear Care Alliance (to be signed off by SAB), including reviewing current training content to ensure more holistic approach taken than training on "policies & procedures"	Produce training modules aimed at addressing holistic training content – Sub group have begun to review training	Aug-10	MP		Revised training & training material to reflect this action
		Embed analysis outcomes of training for all partners in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making	Aug-10	PA		Performance report Improved take up of safeguarding training from partners Expect to see increase in appropriate safeguarding notifications during 2010/11
Safeguarding	3. Ensure there is effective quality assurance system – & monitoring - about preventing harm, abuse, neglect & dignity in care (& appropriate safeguarding reporting & actions) in all commissioned services, i.e. those provided in-house, contracts or grant-maintained service, which includes staff training, supervision & oversight about dignity, safeguarding & issues, e.g. pre-admission assessments	All service specifications in commissioned & in-house services to have specific SMART arrangements relating to safeguarding & dignity – continued to be embedded. 3 more commissioning management arrangements agreed post Mar-10	In all commissioning arrange-ments as renewed/ develop-ed until Mar-12	PA		Service specifications all contain customer safeguarding & respect & dignity expectation
		Safeguarding issues fully and routinely monitored as part of **all** commissioning monitoring/ review arrangements with providers, with agreed actions for improvement identified, agreed and monitored for progress; embedded in contract management arrangements	Aug-10	PA		Assure safeguarding issues fully and routinely monitored as part of **all** commissioning monitoring/ review arrangements with providers, with agreed actions for improvement identified, agreed and monitored for progress; In turn, this will result in more appropriate and better managed safeguarding notifications and investigations, with improved victim outcomes and empowerment,
		Establish unscheduled contract review system between commissioners & providers if sufficient concerns about	Aug-10	PA/SL		

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		safeguarding with potential to terminate commissioning arrangement				particularly in targeted agencies (detailed outcomes to be agreed).
		Improved assurance and quality of pre-admission assessments as part of support for reassessment exercise for Commissioning for Quality in OP Care Homes - completed for OP governance framework, governance metrics identified to be embedded in wider eg LD and NTW homes as a commissioner to incorporate it into the quality standards/spec etc and monitoring. Will be part of service specs from march 2012.	May-10	NT	Partial complete	Improve outcomes against this area of Sunderland's Commissioning for Quality for Care Homes from original baseline position. Outcome in reassessment remains an outstanding issue to be reviewed at next round of commissioning for quality reassessment.
Safeguarding	4. Ensure framework established and results reported to ensure city partners have adequate and appropriate levels of staff and training beyond awareness-raising, specifically targeting investigation and use of advocacy training on regular audit basis	Implement information management system for training of partners to support monitoring of safeguarding – As part of the swift enhancement AIS has a safeguarding element; this is currently being tweaked by Northgate providers to meet Sunderland requirements. Need to agree business processes to ensure the flow is correct. System in place now, will be ready for training in August	Sep-10 August 10	DB		
		Publish revised training materials relating to different levels of training, including workshops specifically on appropriate use of advocacy, authorised via SAB	Sep-10	SK		Revised training & training material to reflect this action

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		Embed analysis outcomes of training associated with advocacy for all partners in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making	Sep-10	PA		Performance report Improved take up of safeguarding training from partners Increase in appropriate take-up of advocacy in safeguarding in 2010/11 Increased level of empowerment of safeguarding victims & better outcomes
Safeguarding	5. Work with SAB partners to ensure that there's a framework to assure long-term impact of safeguarding training, including assurance & governance mechanisms for operational delivery	Develop Quality Assurance Framework to assure partners' quality systems support safeguarding in organisation - progressing	Sep-10	SK		Publish Quality Assurance Framework principles covering safeguarding to be signed off by SAB
		Embed training outcomes for all partners in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making	Sep-10	PA		Performance report Improved take up of safeguarding training from partners SMART targets for better safeguarding outcomes across partners (to be agreed)
Safeguarding	6. Ensure there's leadership training for SAB members, Adult Social Care Partnership Board members & elected members about roles in SAB & safeguarding	SAB-commissioned leadership training programme delivered based on revised roles and responsibilities of SAB – awaiting appointment of chair, training currently being scheduled for Autumn 2010	Jun-10	JF		SAB members able to discharge revised responsibilities (specific measures in this Outcomes Record)
Improvement Area 3 – Ensure that people who are the subject of alerts and their representatives have an effective voice and role in safeguarding investigations and in oversight of safeguarding arrangements.						
Safeguarding	1. Review reasons for not appointing advocates in seemingly suitable cases & present report to SAB, including improvement plan	Produce report to SAB on this issue, highlighting underlying causes & providing recommendations for improvement with a view to increasing	Jul-10	SK		Report on advocacy with recommendations

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	to increase take-up of advocacy & IMCA	the use of advocacy support. – A plan has been produced to inform commissioning				
Safeguarding	2. Develop focussed training about role of advocates across SAB partners and reinforce IMCA training	See Action 4) in Improvement Areas 20 & 2 for advocacy training.	Sep-10	SK		
		Review & reinforce IMCA training in safeguarding, with clear expectations & support	Sep-10	SK		Revised training & training material to reflect this action
		Embed analysis outcomes of training associated with IMCA for all partners in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making	Sep-10	PA		Performance report Improved take up of IMCA training from partners Expect to see increase in appropriate take-up of IMCA in safeguarding during 2010/11 Increased level of empowerment of safeguarding victims & better outcomes
Safeguarding	3. Consider impact of commissioning intentions for revised/new advocacy/IMCA service relating to safeguarding	With SAB, review existing, and develop improved commissioning of revised, advocacy arrangements to better support safeguarding over next 3 years – in development as part of re-commissioning of advocacy arrangements for all vulnerable adults	Sep-10	SL		Develop city commissioning intentions & service specifications for advocacy in safeguarding, as appropriate which will result in: Improvement in take up of advocacy & IMCA as part of safeguarding activity. Targeted monitoring of outcomes of safeguarding in specifications

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Safeguarding	4. Ensure operational difficulties identified in use of advocacy & IMCA, e.g. timeliness of involvement, invites to meetings	Within Action 1), provide analysis of operational difficulties experienced in use of advocacy – Analysis completed with recommendations incorporated into commissioning management	Jul-10	SK		As Action 1
		Develop & implement performance measures to improve operational difficulties and embed in safeguarding performance reporting – in progress – agreed with SAB to report in June 2010 performance report	Jun-10	PA		Performance report Operational improvements associated with advocacy process (e.g. timeliness etc.) Increased level of empowerment of safeguarding victims & better outcomes
Safeguarding	5. Assure recommendations for improvement have appropriate governance arrangements to SAB capturing outcomes for people experiencing safeguarding processes to ensure more person-centred approach	Ensure that Quality Assurance Framework discussed in Action 5) in Improvement Areas 2 & 20 includes monitoring of outcomes of safeguarding issues against which partners expected to demonstrate compliance	Sep-10	SK		Publish Quality Assurance Framework principles covering safeguarding to be signed off by SAB
		Embed outcomes for all partners in performance reporting to SAB, including qualitative assessment of appropriateness of decision-making	Sept-10	PA		Performance report Embedded safeguarding reporting into partner agencies' performance reports SMART targets for better safeguarding outcomes across partners (to be agreed)
Safeguarding	6. Assure communication to people subject to alert or their representatives are fully & appropriately informed routinely of	Embed outcomes of safeguarding outcomes feedback in performance reporting to SAB	Jul-10	PA		Developed mechanism to assure people felt informed about safeguarding throughout process Performance Report

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	progress of their case in revised communications mechanisms in safeguarding process and this is built into training					Improve proportion of people involved in safeguarding who felt involved in process and its outcomes (targets to be agreed)
Safeguarding	7. Assure that issues highlighted in CQC report associated with need to make appropriate information governance more systematic operationally are addressed via SAB and through staff training, including issues associated with consent	Identify areas of practical operational improvements in information governance and security – Information governance to be written once the protocols/processes agreed	Jul-10	DB		Improved compliance with rigorous IG requirements amongst partners in safeguarding process
		SAB-commissioned routine reporting of extent of compliance with – and also extent of "breaches" against – information governance arrangements in place and thematic actions taken to assure compliance Information governance to be written once the protocols/processes agreed	Jul-10	CB		
Improvement Area 5 – Increase their focus on harassment and anti-social behaviour towards all vulnerable groups and ensure that people who are harassed benefit from multi agency action to address the problem.						
Safeguarding	1. Assure Council's Anti-Social Behaviour Teams' safeguarding training started to identify safeguarding issues	Embed outcomes of ASB Teams safeguarding outcomes feedback in performance reporting to SAB	Jun-10	PA	Complete	Performance Report Increase in appropriate notifications & outcomes through ASB Teams
Safeguarding	2. Explore issues highlighted about police involvement in reporting and tackling discrimination of vulnerable people, and put in place appropriate action	Improve police reporting of discrimination & harassment against people with disabilities & older people due to disabilities or circumstances	Mar-11	NR/SK		Monitorable changes in perceptions of SAB partners about police-related issues highlighted in CQC Report. More detailed outcomes to be defined.

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Service Inspection	3. Improve operational pathways of care and support for people at risk of harm, abuse and/or neglect via domestic violence or other community safety issues	Develop & streamline integrated pathways to support people at risk of these multiple issues including "navigating" support	Dec-10			Development of integrated support pathways, including "navigated" support mechanisms;
		Embed reporting of management and outcome of cases in which underlying safeguarding, domestic violence and/or community safety issues were evidenced as being addressed	Dec-10			Reporting mechanisms to SAB & Safer Sunderland Partnership about outcomes of pathways
Safeguarding	4. Accelerate integration of reporting of harassment & discrimination of people with disabilities and other marginalised groups through ARCH Help-line, and monitoring of this intelligence	Implement reporting of people with disabilities and other marginalised groups through ARCH Help-line	Oct-10			ARCH Help-line functionality
		Embed analysis of ARCH Help-line utilisation in performance reporting to SAB & Sunderland Safer Partnership	Oct-10			Performance Report Increase in reporting of harassment & discrimination via ARCH
Safeguarding	5. Improve multi-agency working to better support care and support and promote safeguarding for people at risk in B&B and hostel accommodation	Integrate safeguarding & adult social care considerations into "gateway" proposals to help people reduce risk of homelessness in existing Business Improvement Project & embed outcomes in performance reporting – now part of BIP Project for Risk of Homelessness	Jan-11	PJS		Performance Report Increase level of appropriate notifications & outcomes from housing partners and via "gateways
		Work with housing partners to improve accreditation & enforcement of private rented sector accommodation & improve against Decent Homes Standards – integrate work into accreditation/enforcement ongoing	Jan-11	AC/DW		Improve proportion of vulnerable households in suitable accommodation & properties meeting decent homes standards Targeted improvement of private rented sector accommodation

Action	Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Improvement Area 6 – Work with partners to ensure older people have equitable access to holistic support in their homes through consistent pathways and a greater choice of services.					
CMA	1. Ensure implementation of revised Care Management & Assessment model and Care Brokerage provides enhanced support for people to access signposted services, including domestic care, routinely monitored via Social Care Governance mechanisms	Deliver on products described in Care Management & Assessment and other Choice & Control Projects, e.g. care management model; incorporating brokerage; care navigation and signposting; access to reablement; self-directed support solutions. Structures and operating model agreed for CMA and Care Brokerage. Internal business processes currently being developed, together with implementation of upgraded IT systems and Resource Allocation System. Training to commence Sept-10.	May-10	JU		Deliver on key outputs & outcomes, including LAA targets to improve following indicators in 2010/11, as well as local measures: Number of people supported to live independently (NI 136); Proportion of carers' who were provided with services (NI 135); People 65+ years say they receive information, assistance and support needed to exercise choice & control to live independently (NI 139); Proportion of people "on the books" provided with self-directed support (NI 130); Timescales for assessment and service provision (NI 132, 133) Greater customer satisfaction; Greater level of customer outcomes being identified and met; Greater degree of customer choice and control, including about issues wider than "personal care" issues Generation of agreed efficiencies.
Communications	2. Develop targeted marketing campaign based on customer/ carer intelligence aimed at improving awareness of social	Targeted marketing campaign aimed at improving awareness of social care and re-designed web-site, with a self-assessment tool being developed,	Sep-10	DKE		Marketing plan specifying communication mix SMART measures for campaign: as Action 1) outcomes

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	care, including re-design & simplifying of Council's web-site, with development of self-assessment tool	including SMART measures about its success in 2010/11, informed by OP population profiling to promote active targeting - Draft marketing campaign developed with corporate communications				
		Establishment of community "in-reach" teams, with pilot approach established linked to Customer Services solution – Four pilots developed, three associated with GP surgeries to better identify older people and those with LD who might need 'a little bit of help' (ongoing), fourth in Southwick/Fulwell wards based on population profiling about to start in Sept-10. Also discussing implications for closer work with wellness service.	Sep-10	JU		Development of principles of community in-reach teams with partners Programme for development of these teams As Action 1) for outcomes
Low Level	3. Development of localised community "in-reach" teams, with pilot approach in GP surgery and established linked to Council's Customer Services solution, including "Prevention Checklist" to identify or for people to self-identify their needs	Develop "Prevention Checklist" Checklist produced and the Customer Service Network is fully engaged with community in reach	Jun-10	NT	Complete	Checklist developed with metrics about implementation
		Complete & evaluate pilot with GP surgeries making recommendations about further roll out for 2010/11 (GP sites are: Washington & Church View progressing	Jul-10	NT JU PF		Production of report evaluating pilots

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Communications	4. Development of marketing campaign aimed specifically at other (particularly health) professionals, including GP surgeries	Develop targeted marketing campaign aimed at professionals and GPs, including SMART measures about its success in 2010/11 – DMT agreed marketing strategy	Sep-10	DKE		Performance outcomes as in Action 1)
IT	5. Fully re-develop Starting Point or equivalent to make better use of IT-enabled opportunities to access information about services	Re-develop Starting Point or equivalent to make better use of IT-enabled opportunities to access information about services – Developing options re starting point	Sep-10	CB		Effective resource directory meeting customer & resident needs Ensure SMART targets in terms of take-up & customer & professional feedback about effectiveness Improvements in NI 136 & 139
Communications	6. Review public/professional communication mechanisms & media plan in light of marketing analysis.	Produce media and communications plan to support marketing campaigns Review of all publicity material used – currently being developed by Council's Communication Team as part of wider promotion of HHAS	Jun-10	DKE		Marketing plan specifying communication mix
CMA	7. Ensure design of documentation associated with Care Management & Assessment Model is designed to be customer-friendly to address issues highlighted in CQC report	Produce customer-friendly assessment, personal planning & carers' assessment documentation to support CMA Model, agreed with user support groups – progressing - draft revision of personal plan will be used as 'Support Plan' in LD which has case group validation. Will involve user groups in Aug-10 more comprehensively prior to launch	Jul-10	JU		Produce key CMA documents Improve customer satisfaction with information, advice & support provided (already baselined) across all client groups Improvements in NI 130
CMA	8. Reduce OT waitlist for specialist assessment via establishment of revised Care Management & Assessment model, incorporating	Implement CMA Model & reablement solutions, managing existing OTW waitlist. A scoping paper was prepared	Sep-10	JU		Reablement pathways Increased number of people re-enabled/rehabilitated Improvements in NI 125, proportion

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	reablement/rehabilitation processes and address related issues, e.g. access to advice & assistance	outlining how and what will be implemented in relation to reablement. Including looking at existing services currently using the reablement approach and explaining what services could be re-designed to deliver this approach.				of people aged 65+ living at home 3 months after hospital discharge Improvements in NI 136 & 139
CMA	9. Ensure greater promotion of Direct Payments and other self-directed support solutions as part of revised Care Management & Assessment Model, including staff training, and monitoring of effectiveness via Social Care Governance Mechanism embedded in performance arrangements	Develop training programme for social care practitioners in self-directed support; training scheduled for Sept-10 for all social care practitioners on the new ways of working within CMA incorporating self directed support	Jun-10	LC	Completed	Development of training programme
		Embed monitoring of take-up of value & different forms of self-directed support into performance reporting – will now form part of performance reporting from Jun-10 performance reports	Jun-10	PA		Improvement in take-up of self-directed support solutions (NI 130); Improvement in individual elements of self-directed support e.g. Direct Payments relating to self-directed solutions for older people, take up of Personal Assistants etc.
Communications & SDS	10. Ensure development of self-directed solutions adequately reflect requirements of city's diverse population and these solutions are appropriately marketed	Ensure marketing campaign discussed in Action 2) of this Improvement Area reflect city's diverse population; - strategy integrated into marketing campaign and explicitly includes consideration of diverse population	Sep-10	DKE		Improvement in take-up of self-directed support solutions that reflects Sunderland's diverse population

Action	Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Improvement Area 7 – Ensure that partnerships effectively support safe and timely hospital discharges.					
Service Inspection	1. Undertake Rapid Improvement Workshop with health partners about delayed transfers of care and scope resulting actions, including more systematic joint monitoring of reasons for poor hospital discharge between hospital and Council governance teams.	Establish citywide Rapid Improvement Plan to address issues, including scoping issues agreed by all partners. Formally agree with partners that no patients living in community will be discharged directly to residential/ nursing care, and that this includes adequate pre-admission assessment for care homes	Apr-10	NT	Complete	Reduction in delayed transfers of care (NI 140); Improvement in number of people aged 65+ who were discharged from hospital to care homes (new NI); Improvement in emergency readmission rates within 28 days of discharge (new NI).
Reablement	2. Identify appropriate PCT/Council reablement and other subsequent pathways after hospital discharge	Develop reablement & other subsequent pathways post-hospital discharge as part of the Rapid Improvement Plan & discussions with PCT – Directorates approach to reablement is being progressed, with a view to becoming operational in Oct-10. Discussions with PCT continue, with a view to securing additional therapy time to support overall pathway.	Jun-10	SL		As performance outcomes in action 1) and in Action 3)
Reablement	3. Develop, commission and promote reablement/ rehabilitation pathways amongst staff.	Commission & market reablement/ rehabilitative pathways amongst staff within DH best practise guidance. Progressing	Sep-10	SL		Performance outcomes include: Number of people supported to live independently (NI 136); Proportion of carers' who were provided with services (NI 135); People 65+ years say they receive information, assistance and support needed to exercise choice & control to live independently (NI 139);

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
						Proportion of people "on the books" provided with self-directed support (NI 130); Timescales for assessment and service provision (NI 132, 133) Improvements in NI 125 & take up of non-residential Intermediate Care
Complex Needs	4. Lease hard-to-let sheltered housing from housing partners as short- and medium-term "halfway house" facilities	Improve availability of sheltered housing for rehabilitation and intermediate care – progressing	Mar-11	NT		As Action 3) but also including: Reduction in number of older people admitted to residential /nursing care (ex-PAF C72)
Improvement Area 8 – Ensure older people with mental health needs & carers have effective access to specialist staff, services & opportunities.						
Service Inspection	1. Ensure OP population profiling related to social care incorporates place mapping of people with dementia to facilitate early health/social care intervention	Work with PCT to profile older population to inform active targeting of those with dementia as part of Needs Assessment (Action 2))	Jun-10	PA/SL	Partial Complete	Number of people supported to live independently (NI 136, ex-PAF C32), including number with cognitive impairment; Proportion of carers' who were provided with services (NI 135); Reduction in number of older people admitted to residential /nursing care (ex-PAF C72)
		Work with PCT to develop early intervention & subsequent pathways as part of Dementia Strategy (as part of Action 4) - progressing	Sep-10	SL		
Service Inspection	2. Progress dementia needs assessment & resulting commissioning intentions associated with dementia with PCT	Produce Needs Assessment report presented to Strategic Commissioning Group to inform joint commissioning intentions – first report prepared for Sept-10	Sep-10	PA		As Action 1) performance outcomes Needs Assessment Report to Strategic Commissioning Group
Complex Needs	3. Implement commissioning intentions associated with dementia, particularly those with more complex care needs	Commission individual elements: Safer Walking – devices currently being tested; Extended Overnight Service – will	Dec-10 – Mar-11 for spec-ifications	SL		Production of specific specifications for individual Service Level Agreements, grant-maintained & contracted services

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		be incorporated into Commissioning for Quality for Home Care (Mar-11); Extended short-break at home – scheduled to provided by Personal Budgets by Aug-10; Specialist dementia care reablement/intermediate care Support development of "Memory Clinics" for individuals Other commissioning intentions identified in Needs Assessment				As Action 1) performance outcomes, but including specific equivalent outcomes for people with dementia only, e.g. number of people with dementia supported to live independently (NI 136)
Service Inspection	4. Use Needs Assessment to lead community "in-reach" to work with GPs to provide early intelligence about people with dementia and more complex needs	Establishment of community "in-reach" teams, with pilot approach established linked to Customer Services solution to include identification of people with dementia - progressing	Oct-10	NT		Development of principles of community in-reach teams with partners Programme for development of these teams As Action 1) performance outcomes, but including specific equivalent outcomes for people with dementia only, e.g. number of people with dementia supported to live independently (NI 136)
Service Inspection	5. Develop specialist expertise amongst staff about identifying health symptoms & supporting people with dementia, making best use available expertise in Directorate and city	Develop PCT-based training for social care practitioners about dementia and other health symptoms – staff training scheduled for Nov-2010 in relation to dementia type symptoms.	Aug-10	LC/JC		As Action 4) performance outcomes
		Develop PCT exception feedback mechanisms about those individuals that are known and were recently	Aug-10	JC		Reporting protocols between adult social care & PCT services about identifying these issues

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		visited by social care staff whose condition was not identified				Improvement in emergency readmission rates within 28 days of discharge (new NI).
Complex Needs	6. Improve social care access to housing in sheltered accommodation with view to better, longer-term management of individuals' cases	Integrated social care and housing-related support for older people in sheltered accommodation – progressing	Mar-11	AC/NT		As Action 4) performance outcomes: Improvements in number of people in residential/nursing care (ex-PAF C72); Improvements in number of people supported to live independently in sheltered accommodation
Service Inspection	7. Consider specific governance and commissioning intentions for people living alone and with no supporters, particularly those with complex needs	Integrate this requirement into Needs Assessment reports to identify people likely to be living alone - progressing	Dec-10	PA		Needs Assessment Report include analysis of people living alone OP population profiling to include this analysis
		Use of this intelligence to inform "community in-reach" solutions	Dec-10	NT		As performance outcomes in Action 3) for Improvement Area 7
Improvement Area 9 – Give more attention to carers' needs and the outcomes that carers seek to achieve for themselves.						
Service Inspection	1. Improve carers' assessment by offering separate DH Carers' Assessment & option for separate worker to be involved as standard practise	Reassess carers' assessment and carers' support plan process to improve choice for carers Implement revised processes	May-10	NT	Complete	Improved take-up of DH Carers' Assessment Improved take-up of carers' support plans and card Improved access to advice, information & services for carers about Carers' Centre Proportion of carers' who were provided with advice, information services (NI 135); Improved customer satisfaction about revised arrangements Proportion of carers felt involved or
Service Inspection	2. Ensure carers' assessment includes discussion and analysis of new carers' support plan, card and emergency plans		May-10	NT	Complete	

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
						consulted as much as they wanted to be in discussions about support & services provided to the person they care for
Service Inspection	3. Review approach in framework of Carers' Strategy to improve carers' rights, particularly in relation to maintaining work opportunities, as highlighted in CQC Inspection Report, including setting SMART targets	Development of performance management arrangements to monitor SMART outcomes of Strategy – progressing via quarterly reporting (end Jun-10 report being prepared)	Jun-10	PA		Performance report about Carers' Strategy, including SMART monitoring of outcomes
		Reviewed and re-commissioned, if appropriate, take-up of employment opportunities for carers	Sep-10	SL/PF		Improved number of carers "on the books" known to be in paid work
Service Inspection	4. Improve staff training aimed at carers' awareness and monitor effectiveness of approach via Social Care Governance mechanisms	Training programme for staff about carers' rights, awareness-raising and practical solutions, including issues identified in Actions 1) & 2)	Jul-10	NT/LC		As actions 1) & 2)
Performance & Governance	5. Ensure there's detailed performance & governance arrangements to support work with carers	Produce revised set of carers' measures incorporating: Service carers' measures – measures/targets agreed to be part of monitoring from Jun-10 report (Action 4), and internal targets agreed. Population carers' measures to support Carers' Strategy in Adult Social Care Partnership Board – progress information as part of Carer's Strategy.	May-10	PA		Set of carers' measures integrated into performance reporting across Directorate, Council & city
Service Inspection	6. Review and improve commissioning arrangements for both respite (for people cared for)	Produce commissioning intentions relating to respite & short-breaks, including for people with dementia &	Sep-10	SL	Complete	Publish service specification for in-house, grant-maintained & contractual arrangements for respite & short-

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	and short-breaks (for carers), including those with dementia, including addressing equity of access to short-break solutions	their carers – decommissioned existing short break contracts, following review, with a view to providing more choice via use of personal budgets.				break
		Developed performance measures to assure equity of access to short-break solutions, including effectiveness of signposting to Carers' Centre - progressing	Sep-10	PA		Set of performance measures to assure equity of access to short-break solutions, including effectiveness of signposting to Carers' Centre
Personalisation in the Community	7. Develop pilot, and roll out if successful, joint work with GP surgeries and primary care to support carers' needs operationally and integrate into Carers' & 50+ Strategy	Revise Carers' & 50+ Strategy actions to incorporate roll out of pilot work with GP surgeries – progressing	Oct-10	SL		Revised Carers' & 50+ Strategy to reflect improvements Improvements in terms of: Performance outcomes identified in Actions 1) & 2) Increase number of people supported to live independently (NI 136); Increase in residents' perceptions of degree of choice & control to live independently (NI 139); Improvements in the number of people provided with self-directed support (NI 130);
		Ensure that establishment of community "in-reach" teams in GP practises includes targeted support for carers linked to Customer Services solution	Oct-10	NT		
Improvement Area 10 – Ensure that advocacy is available to those who need it especially where processes are complex and where people are thinking of taking up personal budgets.						
Service Inspection (Safeguarding)	1. Ensure advocacy is available (including considering commissioning) about management of personal budgets	Develop commissioning intentions to support advocacy via self-directed support – progressing via re-commissioning of all advocacy	Oct-10	SL		Publish service specification for advocacy & ensure it includes requirements to support self-directed support

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		Integrated performance commissioning arrangements for take-up and effectiveness (see Improvement Area 16) – commissioning performance measures agreed	Oct-10	PA		Set of commissioning performance measures including take-up of advocacy to support self-directed solutions, e.g. number of Personal Budgets generated via advocacy
Service Inspection	2. Improve staff training aimed at identifying need for advocacy and IMCA and monitor effectiveness via Social Care Governance mechanisms	Training programme for staff about advocacy and IMCA; Targeted monitoring of take-up and outcomes to team level	Jul-10	LC		Revised training & training material to reflect this action Improved take up of advocacy & IMCA training amongst staff Expect to see increase in appropriate take-up of IMCA & advocacy in 2010/11 Increased level of empowerment of customers & better outcomes
Service Inspection	3. Council to review advocacy arrangements and complete process of commissioning Independent Advocacy Service for Older People & Dementia Advisory Service for people with more complex needs	Review & potentially re-commission advocacy arrangements for people with more complex needs – progressing, about to go to tender	Oct-10	SL/PA		Publish service specification for advocacy, with appropriate performance measures to reflect service take-up

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Improvement Area 11 – Urgently ensure that safeguarding benefits from robust quality and performance management arrangements. **Improvement Area 13 – Ensure that safeguarding is supported by effective information management systems.**						
Safeguarding	1. Urgently review information governance and management with view to implementing plan to meet Audit Commission best practise standards for information management (i.e. to make information authorised, comprehensive, relevant, timely, accurate and up-to-date) – agreement about external impact of information management to be signed off by SAB members	Produce report and improvement plan of information management & governance based on review. Issues identified and improvement plan built on Prince 2 methodology produced as part of wider Risk, Choice & Safeguarding Project.	Apr-10	DB	Complete	Report & action plan to improve performance & information governance mechanisms associated with safeguarding
		Production of Data Improvement Programme for safeguarding data based on principles in Directorate – progressing using Council's DIP framework. Currently in development	Jun-10	PA		Evidential improvement in existing data quality of safeguarding records using Data Quality measures formally agreed with SAB members
		Embed monitoring of data quality in performance reporting to Board – scheduled to be reported in Sept-10 report	Jun-10	PA		Performance Report containing data quality measures
Safeguarding	2. Implement revised business processes to ensure better information management & communication about safeguarding issues	Produce revised business processes, incorporating information exchange mechanisms to support revised information management processes, including Action 3 – low level business processes currently being developed for Sept-10 implementation of AIS	Jul-10	DB		Production of revised business processes reflecting improved information management & communications
Safeguarding	3. Complete migration of Safeguarding Adults database to upgraded Swift system using revised business processes	Quality assured historical and new SA activity data transferred into upgraded Swift system module to support revised information management and	Aug-10	DiB		Migration completed in upgraded system

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
		governance mechanisms will result in improved data management and governance capabilities – Information from the current database will no longer be migrated across to AIS. Safeguarding element of AIS will run from new information with a reference made to any historical data. Data improvement exercise in current database currently in development				
Safeguarding	4. Led by sub-group of SAB, develop performance reporting for Board to ensure reporting relevant.	Produce performance report to SAB based around Balanced Scorecard incorporating recommendations in CQC Report and performance reporting discussed in these reports will result in better understanding of data and qualitative intelligence	Phase I: May-10 Phase II: Oct-10	PA	Phase I completed	Performance Report containing performance monitoring highlighted in targeted areas of this Improvement Plan between Apr – Oct-10
Improvement Area 12 – Urgently ensure staff have the capacity and competence to deliver the current transformation and safeguarding agenda.						
CMA	1. Ensure launch of revised Care Management & Assessment Model coincides with extensive change management training focussing on promotion of independence, personalisation and balancing risk, choice & control	Delivery of change management training programme for social care practitioners and Directorate staff – CMA will go live in October and training is booked for all social care staff throughout September. The training content is currently being developed.	May-10	LC		Success of training programme monitored through performance outcomes relating to Care Management & Assessment discussed in Action 1) of Improvement Area 6
Service Inspection	2. Review programme approach and change management issues as result of CQC Inspection	Complete Directorate re-structure which incorporates review of programme approach – progressing	May-10	PB		Directorate re-structure

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	recommendations in Directorate & revise expectations of delivery & capacity in organisation	new posts out for advertisement internally				
Service Inspection	3. Implement case file audit process internally with appropriate governance arrangements to share issues thematically more robustly in line with Social Care Governance Toolkit	Full implementation of revised case file audit process across Directorate	Mar-10	NT	Complete	Case file audit process & toolkit implemented
		Revised case file audit thematic findings integrated into performance reporting & Customer Experience Model	May-10	PA	Complete	Publish & implement Customer Experience Model
Improvement Area 14 – Ensure that the voices of third sector partners, people who use services and citizens are all heard in the development of the vision for social care services. **Improvement Area 17 – Put in place structures & arrangements giving strong collective voice to older people, carers & other vulnerable groups.**						
Personalisation in the Community	1. Assure development of Reference Groups of customers/ carers and residents and mechanisms exist to share views about strategic direction and experiences of social care	Establish specific Reference Groups of customers, carers & residents with clear roles, responsibilities, governance & communication/ feedback mechanisms	Apr-10	PA	Complete	Publish report & establish Reference Groups, including terms of reference
		Produce report establishing how framework for views of customers and residents to feed directly into strategies & commissioning	Apr-10	PA	Complete	Produce Customer Experience Report to achieve these actions & implement framework
Personalisation in the Community	2. Council to review its Citizens' Panel with view to consider how it could develop a network of older people as a sub-set of Panel members (alongside Reference Group) to provide greater voice to older people & identify governance arrangements	Develop older people's panel based on Citizens' Panel – working with Age UK Sunderland regarding strengthening voice of older people using 50+ forums as a basis	Dec-10	SR/PA		Performance measures based on extent to which older people able to influence way Council shapes services in the City

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Service Inspection	3. Review & improve Social Care Governance Model to ensure that strengthened across Directorate including views & transparent communication to/from: Reference Groups/ User Forums; Safeguarding messages; Customer/Carer Representative Groups; Members; "Expert customers" Staff via quality circles Learning from complaints and integrated into performance management system more transparently, with outcomes fed back	Produce revised SCG framework explaining how results will influence commissioning and performance management	Mar-10	PA	Complete	Produce Customer Experience Report – successor for SCG Model
		Fully implement revised Customer Experience Model - progressing	Dec-10	PA		Improved arrangements for quality assurance and understanding customer experience and outcomes. Improvements in targeted areas highlighted via SCG framework
Service Inspection	4. Review complaints process from customers perspective and ensure that there's greater clarity between Council and providers' complaints mechanisms, as well as distinguishing between safeguarding, dissatisfaction and complaints	Produce report reviewing complaints process with recommendations for improvement	Sep-10	SK		Report produced
		Implement recommendations of report	Sep-10	SK		Implement recommendations
		Embed reporting of complaints in contract performance management arrangements, including thematic issues	Sep-10	PA	Complete	Ensure contract performance management arrangements includes thematic monitoring of complaints
Service Inspection	5. Review existing "service user groups" across all client groups with aim of developing more thematic sub-groups to Reference Groups (e.g. for personalisation) to address issues identified in CQC	Reconvene Service User Groups with clear roles, responsibilities, governance and communication/ feedback mechanisms – progressing, mapping exercise underway	Nov-10	PA		Map customer groups across HHAS Review satisfaction of group members with their ability to help shape and improve services

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
	inspection about developing more engaged forums with governance arrangements identified in Action 1					
Improvement Area 15 – Work with stakeholders to ensure strategies and plans are supported by clear, measurable and resourced delivery plans including community safety targets for improving safeguarding and addressing discrimination and harassment.						
Service Inspection	1. Review and revise all relevant strategies' resulting action plans, including Carers' and 50+ Strategies and SAB Plan, to ensure they contain SMART objectives and implement performance management arrangements to their respective governance bodies.	Produce SAB Plan's action plan to better reflect Improvement Plan actions including SMART targets as part of Annual Report, for 2010/11 – action captured in Action (10) of Improvement Area 1) & 4) – about to be published	Jun-10	SK		Publish Annual Report with SMART action plan
		Develop performance management and governance arrangements to monitor SMART outcomes of 50+ & Carers' Strategies – progressing, anticipated completion in Sept-10	Jun-10	PA		Improved SMART performance measures for: 50+ Strategy Delivery Plan Carer's Strategy Delivery Plan
		Implement performance reports to monitor progress and impact of Carers' and 50+ Strategies – progressing, anticipated completion in Sep-10	Jun-10	PA		Develop performance reports for: 50+ Strategy Delivery Plan Carer's Strategy Delivery Plan
Service Inspection	2. Ensure there are much stronger and more appropriate links between Council and city planning arrangements relating to community safety, safeguarding and protection including Community Safety Strategy	Produce report reviewing effectiveness of current planning arrangements shared between SAB and Sunderland Safer Partnership, with agreed recommendations for improvement, with improvements informing SA Plan and next iteration of Community Safety Strategy	Mar-11	SK		Report produced with SMART recommendations for improvement, including performance outcomes to be developed based on expected improvements in appropriateness and outcomes of safeguarding monitoring and wider Community Safety statistics

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Service Inspection	3. Ensure Directorate & partnership performance management arrangements adequately reflect action planning for improvement against performance measures & PM Strategy more rigorously escalates perceived performance issues to Heads of Service.	Produce report reviewing PM Strategy, incorporating recommendations for improvement identified in CQC reporting	Apr-10	PA	Complete	Performance Management Strategy published aligned to new changes in performance management reporting in wider Council, including escalation issues via Balanced Scorecard approach
		Implement agreed improvements including "escalation arrangements"	Apr-10	PA	Complete	
Improvement Area 16 – Strengthen interagency planning and commissioning to jointly agree and fund strategies for older people and carers.						
Service Inspection	1. Consider carers' commissioning & joint commissioning implications to support promotion of new carer support arrangements and their consequences with carers, their reference group and carers representative groups	Produce report setting out agreed carers' commissioning intentions with appropriate consultation about shaping these services	Oct-10	SL		Publish service specification for in-house, grant-maintained & contractual arrangements for carers' support & services, with specific outcome measures
		Implementation plan for commissioning support for carers	Oct-10	SL		Improvements in: Specific outcome measures in service specifications Commissioned services aimed at carers, measured via proportion of carers' services (ex-PAF C62) Proportion of Department of Health Carers' Assessments undertaken; Proportion of carers' who were provided with advice, information services (NI 135); Proportion of carers that felt involved or consulted as much as they wanted to be in discussions about support and services provided to the person they care for

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Service Inspection	2. Ensure routine commissioning management arrangements reflect issues associated with customer outcomes both in current contract management arrangements with home care & revised outcomes within Commissioning for Quality Project	Finalise current commissioning monitoring arrangements relating to customer outcomes and care quality	Mar-10	PA	Complete	Publish contract management arrangements report Implement customer outcomes in commissioning management framework in line with Customer Experience Model
		Deliver revised arrangements in routine commissioning management arrangements – now implemented	Sep-10	PA	Complete	Implement revised arrangements in routine commissioning management arrangements
		Produce & implement revised Commissioning Framework Toolkit to better reflect customer outcomes in these commissioning arrangements	Sep-10	GK/SL/PA	Complete	Produce Commissioning Framework Toolkit
Managing the Market	3. Progress Managing the Market Project to develop framework in which to manage market in different sectors using '3 Tier Model' of consulting/ communicating about strategic priorities & commissioning intentions	Produce detailed Market Management framework integrated into Commissioning Framework Toolkit A framework and report for engaging the market and changing the market perceptions was produced. This framework is now being implemented.	Jun-10	GK	Complete	Managing the Market Framework integrated into Commissioning Framework Toolkit Improved provider/partner satisfaction with degree of consultation and communication about commissioning intentions Increased internal stakeholder awareness of the project, including the identification of specific issues impacting market conditions and provider performance. Provider awareness, acceptance and support for project intentions, including feedback on provider requirements - initial focus on engaging providers via existing forums, including MH, LD & Home

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
						Care Providers Forums & TWCA Employers' Network to consult about communication framework. Improvements in: Improvements in range of services available to customers & residents; Improved Value for Money due to improved commissioning; Provider/partner satisfaction with degree of consultation and communication about commissioning intentions, including impact of self-directed support Improvements in take-up of Self-Directed Support (NI 130)
Service Inspection	4. Agree mechanism for embedding intelligence gathering into Needs Assessment Framework	Revise Commissioning Framework Toolkit to reflect gathering market intelligence as part of Needs Assessment Framework – complete	Mar-10	PA		Revised Commissioning Framework Toolkit
Managing the Market	5. Develop and implement Communications Framework and governance toolkit associated with Managing the Market	Produce detailed Communications Plan associated with Market Management framework – progressing	Sep-10	DKE		Communications Plan for Managing the Market As performance outcomes in Action 3)
Service Inspection	6. Address operational issues providers' have in contacting/ communicating with Council by integrating issues in commissioning management arrangements	Finalise current commissioning monitoring arrangements relating to operational issues as part of monitoring of customer outcomes and care quality – '3 tier model' launched with providers	Mar-10	GK/SL/PA		Address operational issues associated with providers contacting Council within 3 tiers model, i.e.: Operational contact Business Relationship contact Strategic Commissioning contact

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Service Inspection	7. Review (joint) commissioning capacity and identify recommendations for improvement in terms of support for carers, older people with dementia, older people with learning disabilities and those from black and minority ethnic communities	Produce report & plan identifying commissioning issues and capacity to deliver to HHAS and Strategic Commissioning Group	Sep-10	SL		Produce report & plan Improvements in: Commissioned services aimed at these groups highlighted in CQC Report Improvements in representation of these groups within commissioned services and support
		Implement agreed recommendations of report	Sep-10	SL		
Service Inspection	8. Complete phased roll out of monitoring/ review arrangements against governance toolkit over next 2 years, with all new or revised specifications (whether in-house, contractual or grant-maintained) using outcome-based framework.	Ensure all service specifications in commissioned services have specific SMART outcome-based arrangements – progressing	End date: Mar-12	PA		Publish service specification for in-house, grant-maintained & contractual arrangements, with specific outcome measures in agreed commissioning management arrangements
		Fully implement routine monitoring/ review, including scheduled/ unscheduled reviews, as part of **all** commissioning arrangements, with agreed actions for improvement identified & monitored for progress				All routine monitoring/review arrangements to use this outcome-based framework
Improvement Area 18 – Work with providers to align self-directed care to their business models. **Improvement Area 19 – Work with the voluntary sector to improve the range of services and address issues of longer-term viability.**						
Managing the Market	1. Develop framework which includes consideration of consequences for providers of personalisation on their business models.	Produce detailed Managing the Market Framework discussed in Improvement Area 16 Action 3) that includes implications of self-directed support for providers – progressing – incorporated into managing the market framework published Jun-10	Oct-10	GS		Performance outcomes as in Improvement Area 16 Action 3). Also: Increase in levels of self-directed support across providers (NI 130 sub-sets)

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Managing the Market	2. Actions 3 - 5 in Improvement Area 16 relate to consequences of self-directed care, as well as "traditionally commissioned" care	Embed self-directed support requirements into detailed Managing the Market Framework	Sep-10	DKE/PA		Managing the Market Framework provides due consideration of self-directed support consequences integrated into Commissioning Framework Toolkit Approach to self-directed support integrated into Communications Plans Performance outcomes as in Improvement Area 16 Action 4) – 5)
Managing the Market	3. Actions 3 – 5 in Improvement Area 16 relate to consequences for Third Sector, including issues of long-term sustainability	Embed Third Sector support requirements & their longer-term sustainability into Managing the Market Framework	Sep-10	GK/DKE/ PA/SL		Managing the Market Framework provides consideration of Third Sector support & sustainability integrated into Commissioning Framework Toolkit Approach to self-directed support integrated into Communications Plans Performance outcomes as in Improvement Area 16 Action 4) – 5) Improvements in: Effectiveness of Third Sector to identify diverse funding via support mechanisms; Increased number of "adult social care" Third Sector organisations accessing other alternatives than "adult social care" granted-maintained funding in GFS1 Return Customer take-up & outcomes in Third Sector services, including NI 136, number of people supported to live independently & NI 139.

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
						City's performance against NI 7 (environment for Third Sector)
Service Inspection	4. Provide support to number of Third Sector organisations to access alternative funding streams	Enhance Third Sector support arrangements in HHAS – progressing via focus on building capacity	Sep-10	SL	Complete	Improved effectiveness of Third Sector to identify more diverse funding via support mechanisms
Service Inspection	5. Link Third Sector to Area Committee arrangements and the monies available via Strategic Initiatives Budget.	Third Sector support arrangements includes support via revised Area Committees linked to area-based priorities	Sep-10	SL	Complete	Improved take-up of Area Committee funding Increased number of "adult social care" Third Sector organisations accessing other alternatives than "adult social care" granted-maintained funding in GFS1 Return Customer take-up & outcomes in Third Sector services, including NI 136, number of people supported to live independently & NI 139. City's performance against NI 7 (environment for Third Sector)
Service Inspection	6. Work with PCT commissioning processes to raise awareness of provider support requirements, particularly smaller organisations	Improve Third Sector support arrangements of PCT & ensure it's aligned with, and learns from, support arrangements in Council – PCT Third Sector Commissioning – Group has reviewed it's processes learning lessons for Council and PCT have commissioned a number of Third Sector organisations over past financial year	Sep-10	SL		Increased number of Third Sector organisations accessing PCT funding

Action		Sub-Actions & Progress	Target Date	Owner	Project Status	Outputs & Outcomes Achieved
Service Inspection	7. Support development of Regional Workforce Development for care sector – centred on recommendations covering aspects of WFD to be implemented regionally.	Work on 6 subgroups set up to scope and progress recommendations on: Workforce Development Workforce Remodelling Recruitment & Retention Leadership, Management & Commissioning Joint & Integrated Working Regulation, Quality & Improvement	Mar-12	LC/MP		Improved compliance against National Minimum Standards and Commissioning for Quality and other local commissioning expectations, particularly those that relate to staff training and development.
		Fully implemented recommendations for Workforce Development	Mar-12	LC		
Service Inspection	8. Review, commission and improve training associated with self directed support options, supporting people with complex needs, carers' rights and develop understanding of advocacy with Third & other care sectors	Devise & implement training programme for social care staff and providers addressing these issues;	Dec-10	LC		Improvement in effective take-up amongst customers & their outcomes of these issues (e.g. of self-directed solutions, advocacy etc.), monitored via performance outcomes in Improvement Area 6) Action 1) and advocacy outcomes

HEALTH & WELL-BEING SCRUTINY COMMITTEE

15 September 2010

RE PROVISION OF COMMUNITY CHILD AND ADOLESCENT MENTAL HEALTH SERVICES ACROSS SOUTH OF TYNE AND WEAR

Report of the Children's Lead for Commissioning, Sunderland Teaching Primary Care Trust

1. Purpose of the Report

1.1 The purpose of this report is to provide members with an update on progress to date in relation to the re provision of Child and Adolescent Mental Health (CAMH) and Learning Disability Services across South of Tyne and Wear.

2. Definition of Terms

2.1 A four tiered model is used to describe levels of mental health need and services to meet these needs:

Tier 1:	Universal services to meet the mental health needs of all children and young people and address the needs of children and young people with mild and early stage problems (15%)
Tier 2:	Services to meet the needs of children and young people with moderately severe problems
Tier 3:	Services to meet the needs of children and young people with complex, severe or persistent mental health needs
Tier 4:	Services to meet the needs of children and young people with highly complex and severe mental health needs (including in-patient services)

3. Background

3.1 There have been a number of long-standing issues in relation to the provision of CAMH and Learning Disability Services across South of Tyne and Wear.

3.2 At Tier 4 the issues identified include:

- Suitability of estates
- Access to services in particular difficulties over admission and case mix
- Lack of intensive treatment services resulting in children and young people receiving out of area treatment
- Centrally provided day and out-patient services covering large geographic area

- No specifically commissioned services for young people with eating disorders
- Lack of integration of services

3.3 The North East Commissioning Team, in partnership with local commissioners, led on work to address these issues that has resulted in:

- A new regional model of integrated children and young people's services being delivered from purpose built accommodation from July 2011 to include:
  - Services for children and young people with severe learning disabilities (6 beds)
  - Services for children and young people with mild to moderate learning disabilities (12 beds)
  - Young people's low secure learning disability service (8 beds)
  - Children and young people's services – 14 beds including 4 flex beds where intensive support is needed and 2 flex beds for admission of children under 12 years
- Establishment of neuro-developmental disorder service
- Sub-regional intensive support service for children and young people with complex mental health, behavioural and social care needs
- Establishment of a regional young people's eating disorder service (!0 beds)

3.4 At tier 3 the issues identified include:

- Fragmented service provision based on historic commissioning Arrangements, with services lacking the critical mass, skills (particularly in relation to psychiatry) and capacity to most effectively meet the needs of the population served
- Access to services including: referral criteria; location of services; response to dna (did not attend); flexibility of service delivery models; and provision of urgent and emergency (24/7) services
- Fragmented provision of services for children in special circumstances including children and young people with learning disabilities; looked after children; and children with complex behavioural, mental health and social care needs
- Capacity to respond to modernisation agenda including delivery of outcome focused, evidence based standards of care within Children's Trust Arrangements
- Recording and reporting of service effectiveness and outcome monitoring

3.5 NHS SOTW has led on work to address these issues through the establishment of a project board comprising of representatives from both the PCT and Local Authority (Children's Services). This board has worked with a broad range of partners including provider organisations to develop a single service specification outlining the scope and

function of service; service standards and performance monitoring arrangements.

3.6 The option of existing service providers working together to re-provide services to meet the requirements of the service specification was fully explored with them by the board however this was not considered to be a viable option. In view of this, and the need to develop community based intensive support services, the project board recommended that a single contract for the provision CAMHS and Learning Disability Services across South of Tyne should be sought. This recommendation was approved by the PCT commissioning board in August 2009.

3.7 The main issues identified in relation to the provision of Tier 2 services is the variation in size, scope, levels of resource and models of service provision in Sunderland, South Tyneside and Gateshead.

4. Current Position

4.1 A project board comprising of representatives from the PCT and Children's Services in Sunderland, South Tyneside and Gateshead. The purpose of this board is to:

- Review the balance of CAMHS and Learning Disability provision across the Tiers in SOTW including the development of a total resource map

- Agree a commissioning plan for the provision of Community Services (Tiers 2 and 3)

- Commission through the mechanism of a formal competitive tender, the provision of Community CAMH Services across South of Tyne and Wear to deliver:

    - A comprehensive range of integrated CAMH Services to all children and young people from birth to their eighteenth birthday with complex, severe or persistent mental health needs (re provision)
    - Services for children and young people with learning disabilities (re provision)
    - Services for children in special circumstances (re provision)
    - Intensive support services for children and young people with acute mental health needs to prevent unnecessary in-patient admission (new provision)
    - Multi-systemic treatment services for children and young people with complex mental health, behavioural and social care needs

- Review and re provide Community CAMH Service provision at Tier 2 for children and young people with moderate mental health needs

4.2 Procurement of Community CAMH and Learning Disability Services at Tier 3 will commence from August 2010, with award of contract planned for April 2011 and service commencement planned from October 2011.

4.3 In order to ensure that the new service most effectively meets the needs of the local population a process of formal consultation on the service delivery model commenced on 2nd August 2010 and will continue to 1st August 2010.

4.4 Key areas for consultation will be based around the themes identified in the National Review of CAMHS including:

- Promoting awareness of mental health and mental health services
- Trust including developing trusting relationship with staff and clarity over confidentiality
- Access to services including information, location, ongoing support
- Communication
- Involvement including opportunities to discuss what services and interventions are available
- Holistic approach including links to other services

4.5 The outcomes from this consultation will be used to inform the final service specification and ongoing engagement process will inform further development of the service.

5. Recommendations

5.1 Members are asked to:

- Note and comment on progress to date
- Agree to receive further progress updates including the outcomes of formal consultation exercise

6. Background Papers

CMHS Consultation Documents

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 15 September 2010

EQUITY AND EXCELLENCE: LIBERATING THE NHS SUMMARY AND CONSULTATION QUESTIONS ON THE LOCAL DEMOCRATIC LEGITIMACY IN HEALTH PROPOSALS

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 The purpose of this report is to provide members with a summary of the 'Equity and excellence in health, liberating the NHS white paper' a summary of the consultation paper, 'Increasing democratic legitimacy in health', and to suggest a response to the consultation paper.

1.2 At an informal meeting of the Scrutiny Committee held on 1 September members discussed the consultation paper and the comments from that meeting are included in this report. From those comments a suggested response to the consultation has been proposed.

2. Background

2.1 On 12th July, the Secretary of State for Health, launched the equity and excellence in health, liberating the NHS white paper. The white paper represents a major restructuring of health services and councils' responsibilities in relation to health improvement, and coordination of health and social care. It aims to remove unnecessary bureaucracy and devolve power to the local level. It proposes the transfer of public health responsibilities to local authorities, with the role of joining up health improvement, health services and social care locally to achieve better outcomes and greater efficiency.

2.2 The government is currently consulting on the detail of four elements of the white paper; these are:

- Commissioning for patients,
- Regulating healthcare providers
- Transparency in outcomes
- A framework for the NHS and local democratic legitimacy in health.

2.3 This report provides a summary of the white paper. Given the importance and relevance local democratic legitimacy in health consultation, this report also provides a summary of this consultation paper.

2. Summary of the white paper proposals

2.1 One of the central features of the proposals in the white paper is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act for patients and support them in their healthcare

choices. It is proposed that most commissioning decisions will be made by consortia of GP practices, which will push decision making much closer to patients and local communities, and ensure commissioners are accountable to them. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners, to design joined-up services that make sense to patients and the public.

3. Roles and resources for local councils

3.1 Within this new system, local authorities will have an enhanced role in health. Specifically Councils will have greater responsibility in four areas:

- leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity.

3.2 With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services together with wider services including disability, housing and talking crime and disorder. The local authority will lead the process of undertaking joint strategic needs assessments across health and local authority services and promote joint commissioning between GP consortia and local authorities.

3.3 Primary Care Trusts' public health improvement functions and budgets will be transferred to councils after the abolition of PCTs in 2013. Local Directors of Public Health will be jointly appointed by local authorities and the new national Public Health Service, which will take a national lead on improving public health.

3.4 A ring-fenced public health budget will be allocated to local authorities to support their public health and health improvement functions, with a guarantee to maintain NHS spending in real terms, though there will be efficiencies in the region of 45 per cent of total NHS management costs to offset rising demographic demands. There will be no bail-outs for organisations which overspend public budgets.

3.5 Councils will be required to establish health and wellbeing boards to join up the commissioning of local NHS services, social care and health improvement, underpinned by an extension and simplification of powers to enable joint working between the NHS and local authorities.

3.6 The proposals indicate the requirement to strengthen local democracy, by building on the existing mechanisms whereby people are given a strong voice. The collective voice of patients and the public will be strengthened through arrangements led by local authorities and at National level, through a consumer champion, HealthWatch, located in Care Quality Commission (CQC).

4. Joint licensing role for Monitor and the Care Quality Commission

4.1 Monitor[1] will become the economic regulator for all health and social care providers, with the independent regulator for health and adult social care in England, the Care Quality Commission[2] (CQC) focusing on quality assurance for all health and social care, both public and private. All service providers will have a joint licence overseen by both Monitor and the CQC.

5. GP commissioning consortia

5.1 The government intends to give responsibility to GPs for managing the bulk of NHS resources and for commissioning care on behalf of patients through groups of GPs or GP commissioning consortia, in order to ensure that decisions are underpinned by clinical insight and local health knowledge. They will be supported and held to account by the NHS commissioning board. These commissioning consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty to ensure patient and public involvement.

6. NHS Commissioning Board

6.1 An independent national NHS Commissioning Board will allocate NHS resources to the GP consortia and support them in their commissioning decisions. It will also:

- Provide national leadership on commissioning for quality improvement
- Promote patient involvement and choice
- Support the development of GP commissioning consortia
- Commission national and regional specialist services and community services such as GP, dentistry, pharmacy and maternity services
- Allocate and account for NHS resources.

7. Public Health Service

7.1 A national Public Health Service will be established to integrate and streamline existing health improvement and protection bodies and functions, including an increased emphasis on research, analysis and evaluation. It will be responsible for vaccination and screening programmes and, in order to manage public health emergencies, it will have powers in relation to the NHS matched by corresponding duties for NHS resilience.

8. Patient and public voice

8.1 Health Watch England will be created as an independent consumer champion within the Care Quality Commission (CQC). At national level, HealthWatch England will provide leadership to local branches and will provide advice to national bodies, including the NHS Commissioning Board, Monitor and the

[1] Monitor - Assesses, licences and monitors NHS Foundation Trusts
[2] CQC - Regulates health and adult social care provision

Secretary of State. It will also have the power to propose CQC investigations of poor services, based on local intelligence.

8.2 Local involvement networks (LINks) will be rebranded as Local HealthWatch and will ensure that the voices of patients and carers are at the heart of the commissioning process. Local HealthWatch will be commissioned, funded by and accountable to local authorities, which will have a legal duty to ensure that HealthWatch is operating effectively.

9. Consultation paper on local democratic legitimacy in health

9.1 This consultation paper aims to build on the proposals in the White Paper to increase local democratic legitimacy in health. The government wants to achieve this through local authorities:

i. being given a stronger role in supporting patient choice and ensuring effective local voice
ii. taking on local public health improvement functions, and
iii. promoting more effective NHS, social care and public health commissioning arrangements. The government wishes to bring about major structural change to give effect to these changes.

10. Proposals for delivering this

10.1 The government is proposing to change Local Involvement Networks (LINKS) into local HealthWatch, commissioned by councils, with an extended remit to provide complaints advocacy and supporting customers in accessing / choosing services.

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

Q2 Should local HealthWatch take on the wider role outlined in paragraph 8.2, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Comments from the informal Scrutiny Committee:

Concerns were expressed that the proposals to allow HealthWatch to offer advocacy to those people who find it difficult to voice their problems should not turn HealthWatch into a complaints handling organisation, but one that would actively seek views or receive feedback from activities, of which complaints would be one.

If these proposals are implemented, there will be a need to ensure local HealthWatch have support from service commissioners.

Concerns were expressed about the holding to account of local HealthWatch with Health Watch England expected to have this local knowledge. It seems logical that the national HealthWatch should form part of CQC but it is unclear how local information will inform regulators opinion of services.

Suggested response:

Holding local Health Watch to account for its performance against its contract could be part of the role of Overview and Scrutiny Committees, helping them to hold commissioners and those responsible for health improvement and adult social care to account. Overview and Scrutiny already work collaboratively with LINk on health and social care improvements, which would continue. This measure would ensure local HealthWatch are truly independent of their commissioners, i.e. the Executives of local authorities, while accountable for their performance.

10.2 As part of the consultation, the government would like to know what more could be done to join services in a way that people understand. It states that joint working is vital to developing a personalised health care system that reflects people's health and care needs and that this white paper presents an opportunity to join services up. The consultation paper sets out improvements to integrated working, developed around people and not institutions. This means the whole care pathway needs to be improved – from prevention, treatment and care, to recovery, rehabilitation and re-ablement.

10.3 The paper proposes:

- Building on the existing personal budgets in social care and extending into NHS.
- Developing quality standards across patient pathways.
- An effective inspectorate of essential quality standards that span health and social care delivered through CQC.
- A payment system to support joint working e.g. for hospital readmission, which should encourage full engagement of the health and care economy before discharge from hospital.
- Freeing up providers to focus on the needs of people, with proposals to free up constraints and allow foundation trusts to augment their NHS role, by, for example expanding into social care.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Suggested response:

We are in favour of underpinning joint working with statutory powers to support the integration agenda. There needs to be a formal arrangement underpinning joint working rather than relying on good relationships and good will. Within this statutory framework the Council should be free to commission joint services that are appropriate to the needs to the community.

10.4 The government proposes that Councils should establish health and well-being boards, to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The local authority would bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs. In time it is likely that health and well-being boards will determine the strategy for allocation of the health elements of place based budgeting.

10.5 The four main functions of the health and well-being board would be:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment.
- To promote integration and partnership across areas, including promoting joined up commissioning plans across the NHS, social care and public health.
- To support joint commissioning and pooled budget arrangements where all parties agree this makes sense.
- To undertake a scrutiny role in relation to major service redesign.

10.6 The Council and commissioners partners would be under a duty to cooperate with the health and well-being Board. Responsibility and accountability for commissioning decisions, will be with the NHS Commissioning Board and GP consortia. However, the proposal is that through the Board, the Council and commissioners would have influence over each other.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 10.5?

Comments from the informal Scrutiny Committee

It is appropriate that the new Board will have a scrutiny role in its decision making process however with regard to the proposal to remove health oversight and scrutiny powers from Councils, the loss of the independence of scrutiny of decisions is a concern.

Suggested response:

It is appropriate that the board should have the first three functions however the fourth function requires independence and should be with the existing model of Overview and Scrutiny.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Suggested response:

We support use of best practice to support the health and wellbeing boards in the knowledge that many councils and local partnerships already have very similar structures to improve co-ordination and collaboration on health improvement and addressing health inequalities.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Suggested response:

We note the proposal to join-up the work of the new arrangements with Children's Trusts. The government will need to provide further clarity on this, as we are aware that the government is currently proposing significant changes to the role and responsibilities of Children's Trusts, including changing the requirement to have one. If this proposal proceeds we would wish to see a formal arrangement between the board and trust and overview and scrutiny to ensure transparency of decision making and public accountability.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

10.7 It is proposed that the membership of health and well-being boards will consist of councillors, social care, NHS commissioners and local government and patient champions, with councillors determining who should chair the board. The Councils' Director of Pubic Health, will have a major role in advising the board. It is also expected that GP consortia and Health Watch representatives will be given seats on the boards.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 10.7?

Suggested response:

We agree that where Boards are established, membership should consist of a range of people, including those with clinical and health improvement expertise. However, we feel that the membership of Boards should not be prescribed in law, rather that the local authority, should have the flexibility to determine what is the most appropriate Board membership for their local area.

We also feel that councillors should have the majority seats on the Board, given that they alone, have a democratic mandate to ensure services meet the needs of their constituents and local users of health services.

There would be a need to avoid inordinately large Health and Wellbeing Boards. It is difficult to envisage how decisions would be made in a Board with a large number of members of differing powers, some democratically elected and some not. Membership could be better if restricted to a core group of members, with equal and full voting powers. Others mentioned in the consultation document could be regular attendees and/ or called as witnesses as and when required.

Given the role that Health Watch members will have in championing the voice of patients and advocating on behalf of complaints, we feel that the proposed role for them, would mean that they are better suited to becoming more involved with the work of Overview and Scrutiny committees, helping to ensure that they maintain a degree of independence from those taking commissioning decisions and developing strategy.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

Suggested response:

Commissioners should engage with the Council's health overview and scrutiny function on a frequent and regular basis, to ensure significant changes to services are largely in the interest of health and social care services for the area. This should limit disputes in the first place, but if there is any dispute, this should be left for local authorities to determine with its partners how to resolve them.

10.8 If a health and wellbeing board was created within a local authority, it would have a new role in promoting joint working, with the aim of making commissioning plans across the NHS, public health and social care coherent, responsive and integrated. It would be able to exercise strategic oversight of health and care services. To avoid duplication, the government proposes that the statutory functions of the Overview and Scrutiny Committee to refer matters to the Secretary of State or to be consulted on major changes to services, would transfer to the health and wellbeing board.

10.9 The consultation paper further states that public scrutiny is an essential part of ensuring that Government and public services remain effective and accountable. It helps to achieve a genuine accountability for the use of public resources. A formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Suggested response:

We do not support this arrangement. Health Overview and Scrutiny Committees have made a real difference in championing the public interest and challenging health commissioners and providers to deliver better health services. The scrutiny of health services must be transparent and have a strong element of democratically accountable oversight, independent of the health service, in order to ensure that it is responsive to the local public's needs. Health Overview and Scrutiny should work alongside the new board and retain the powers to be effective, such as a formalised call-in of decisions arrangements.

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Suggested response:

Overview and Scrutiny committees should retain their statutory health scrutiny powers. The need for local democratic accountability through, locally elected non executive members, independent of those commissioning or developing services, is even more important in the context of health and well being boards leading local health improvement work and in the context of commissioning decisions being taken by executive members, council officers and GPs. Removing these powers from Overview and Scrutiny committees would lead to confusion as what the role of Overview and Scrutiny is in scrutinising health issues and would could potentially mean that the health functions of the Council would be the only area of Council activity that non-executive members on Overview and Scrutiny Committees cannot comprehensively scrutinise.

If it is decided to proceed with these proposals, then we would welcome full clarity from the government about the continued role of Overview and Scrutiny Committees in scrutinising health issues. We would also welcome the flexibility, to be able to ensure that non-executive members can have a role in the work of health and well-being boards.

10.10 Questions 17 and 18 are general question on the proposals.

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

Q18 Do you have any other comments on this document?

Suggested response:

The proposals must include clear and transparent accountability arrangements to local communities, which build on existing accountability rather than creating new structures. It remains to be seen how effective the new Board will be at holding the new GP consortia to account; although there will be more local authority involvement, the current role of Overview and Scrutiny Committees will go and this leaves a void in public accountability.

We are pleased to see the recognition that Councils are the best placed body to lead health improvements in their local area and that Council's will need additional resources to deliver this work.

Local authorities and their partners should be left to lead and manage health services, in accordance with local need. Indeed Councils should be free to commission joint adult social care and health services teams, providing holistic services around patients' needs.

If the government decides to proceed with a national outcome framework, then it should not be too prescriptive and should not cover too many issues, as health and well-being board's need to be free to address local issues.

5. Conclusion

5.1 The Committee is asked to endorse the suggested response for submission as part of the formal consultation.

6. Background Papers

Equity and Excellence in Health, liberating the NHS white paper
Commissioning for patients – consultation paper
Regulating healthcare providers – consultation paper
Transparency in outcomes – consultation paper
A framework for the NHS and local democratic legitimacy in health – consultation paper

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HEALTH & WELL-BEING SCRUTINY COMMITTEE

15 September 2010

CENTRE FOR PUBLIC SCRUTINY 8TH ANNUAL CONFERENCE - FEEDBACK

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide the Committee with feedback from the Centre for Public Scrutiny (CfPS) 8th Annual Conference that was held on 30 June and 1 July 2010.

2. Background

2.1 The Council's Overview and Scrutiny Handbook contains a protocol for use of the Scrutiny Committees budget by Members to attend training and conferences (Protocol 5 refers). This allows Members to gain specialist knowledge and expertise within a particular area of scrutiny and is in addition to the list of standing conferences and corporate development programme.

2.2 At the start of the municipal year it was agreed to send delegates from the 7 scrutiny committees to the CfPS Annual Scrutiny Conference held on Wednesday 30 June and Thursday 1 July 2010 at The Brewery, London. The Conference was attended by a number of members from the various committees including Councillor Peter Walker, Chair of Health & Well-Being Scrutiny Committee.

3. Conference Summary

3.1 The title of the conference was 'Accountability works - Sustaining Outcomes in Changing Times'. The theme was future accountability and transparency in public services. The theme covered issues such as regaining public trust, tackling inequalities and addressing how to sustain outcomes from accountability in hard financial times. Delegates debated how accountability can create opportunities for the public to shape the delivery of local services, for example, through the Total Place initiative.

Speakers

3.2 Keynote opening session - Accountability Works
Matthew Taylor, Chief Executive, RSA
A combination of more demanding public attitudes and the expectations of greater availability of public data mean that the demands of public accountability will grow, whether public agencies like it or not. The question is how to develop new, more creative forms of accountability.

3,3 Accountability for people and places – what does it mean in practice?
Darren Johnson, Former Chair, London Assembly, Chair, London Assembly Environment Committee

Real examples of impact at a local level and a sharing of views on how accountability through scrutiny can reconnect people to those with power.

3.4 Getting to the heart of the matter: tackling social inequality
Lord Victor Adebowale CBE, Chief Executive, Turning Point
This session considered how services can be restructured so they are effective and easily accessible for those most in need of them.

Discussions and Workshops

3.5 'Total Place Total Accountability' Panel
Chair: Nick Raynsford MP
Maurice Frankel, Director, Campaign for Freedom of Information
Professor George Jones, Emeritus Professor of Government, LSE
Lord Michael Bichard, Executive Director, Institute for Government

The programme formerly known as Total Place was the former government's initiative to seek to "deliver better services at less cost, through effective collaboration between local organisations and leadership". How will decision-makers be held to account for the shared decisions they make, particularly around service change and efficiencies? What role do elected councillors have in setting the strategic direction and scrutinising the outcomes of Total Place programmes?

Workshops

3.6 Winning back public trust: contributing to local democratic renewal
Jonathan Birdwell, Researcher, Demos
Lessons learned from a two year investigation into the factors affecting trust in local councils.

3.7 National pledges, local outcomes: making the NHS Constitution a reality
James Doughty, Policy Manager, Appointments Commission
Gareth Hadley, East of England and East Midlands Appointments Commissioner
Exploring what the NHS Constitution really means for organisations and how NHS non-executives and other 'scrutineers' can support the implementation of the principles, values, rights and pledges contained in the Constitution and obtain assurance that they are being translated into real outcomes on the front line.

3.8 Scrutiny in a cold climate: influencing tough choices about efficiency savings and shared services
Catherine Staite, Director, Organisational Development, Office for Public Management
We are entering a period of significant change, driven partly by the new political environment and partly a major cut in resources for local government. These changes will see a radical shift from the current reality, in which councils are mainly providers delivering a wide range of services to one in which they are have two key roles; as community leaders and as

commissioners of services. This workshop will explore how scrutiny can respond to these changes.

3.9 Citizen Power: what enhanced public transparency means for formal accountability
Simon Burall - Director, Involve
The citizen - government relationship has changed profoundly in the last 20 years as citizens have come to expect a greater say in what is done in their name. This change has accelerated over the last 3-5 years as technological changes put increasing amounts of government data directly into citizen's hands. At the same time, citizens have ever increasing ways to meet and talk together.

3.10 Scrutiny – where professional evidence and public opinion collide?
Emma Maier, Editor, Local Government Chronicle Richard Jeavons, Chief Executive, Independent Reconfiguration Panel
Exploring the role that scrutiny committees play as a public forum for gathering evidence, which can take the form of expert, professional advice or views, opinions and experiences from the public and service users.

3.11 Member Development Day
Coming challenges for scrutiny: the next year
Jessica Crowe, Executive Director, Centre for Public Scrutiny
Highlighting the challenges that scrutiny will face in the next year, and suggesting some opportunities for scrutineers to influence the agenda locally.

3.12 Scrutiny Café
Knowledge and Skills Sessions
Joint scrutiny: your powers
Crime and disorder: what are CDRPs and how do they operate?
The local accountability picture - who else does scrutiny at a local level?
Health scrutiny: working more closely with your LINk
Performance management and improvement
Working with officers to get the outcomes you're looking for
Negotiating, questioning and leadership skills for scrutineers
Taking control of your scrutiny reviews: understanding planning

4. Recommendation

4.1 The Committee is asked to receive the feedback from the conference .

5. Background Papers

Seminar Programme

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HEALTH & WELL-BEING SCRUTINY COMMITTEE

15th September 2010

ANNUAL WORK PROGRAMME 2010-11

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 For the Committee to receive an updated work programme for the 2010-11 Council year.

2. Background

2.1 The Scrutiny Committee is responsible for setting its own work programme within the following remit:

> *Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Food Law Enforcement; Citizenship (Adults); and External inspections (Adult Services)*

2.2 The work programme can be amended during the year and any Member of the Committee can add an item of business.

3. Current Position

3.1 In addition to the items taken at the scheduled meetings the following activities have taken place since the last meeting:

3.2 The regional review of the Health Needs of the Ex-Service Community has been progressing over the summer. Following the Overview Day on 28 June the review moved into three workstreams: Physical Health, Mental Health and Social & Economic Well-Being.

3.3 An informal meeting of the committee was held on 1 September to comment on the consultation currently underway on the Health White Paper.

4. Conclusion & Recommendation

4.1 That Members note the updated work programme.

5. Background Papers
None

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE WORK PROGRAMME 2010-11

	JUNE 09.06.10	**JULY 07.07.10**	**SEPTEMBER 15.09.10**	**OCTOBER 13.10.10**	**NOVEMBER 10.11.10**	**DECEMBER 08.12.10**	**JANUARY 12.01.11**	**FEBRUARY 09.02.11**	**MARCH 09.03.11**	**APRIL 06.04.11**
Cabinet Referrals & Responses	Article 4: Food Law Enforcement Service Plan. (NJ)	CQC Service Inspection of Safeguarding Adults & Choice & Control for Older People	CQC Service Inspection – Action Plan Response to 'Tackling Health Inequalities in Sunderland' Review					LSP Delivery Report		
Policy Review	Proposals for policy reviews (KJB) Ex-Service Personnel Review (KJB) Regional Health Protocol (KJB)	Scope of review – Malnutrition in Hospitals (KJB)	Appointment of Coopted Member Ex-Service Personnel Review Progress (KJB)		Evidence Gathering – City Hospitals Sunderland				Final Draft Report	Final Report
Performance			Performance & VfM Annual Report (GK)				Performance Q2 April – Sept 09 (GK)			Performance Framework Q3 (GK)
Scrutiny	Mid-Staffordshire NHS hospitals Foundation Trust – Francis Report (CH) Internal Service Development (CW) CfPS Conference attendance (KJB)	TeleCare Services (PF) Total Place (LC) Social Care for Adults with LD (JF)	CAMHS Review (PCT) Health White Paper Consultation CfPS Conference Feedback	Out of Hours Service (PF) Review of District Nursing Update Transforming Community Services		Children's Acute Pathway Reform (NHS)				Annual Report (KB)
CCfA/Members items/Petitions										

At every meeting: Forward Plan items within the remit of this committee / Work Programme update

HEALTH & WELL-BEING SCRUTINY COMMITTEE

15th September 2010

FORWARD PLAN – KEY DECISIONS FOR THE 1 SEPTEMBER – 31 DECEMBER PERIOD

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of the Report

1.1 To provide Members with an opportunity to consider the Executive's Forward Plan for the period 1 September – 31 December 2010.

2. Background Information

2.1 The Council's Forward Plan contains matters which are likely to be the subject of a key decision to be taken by the Executive. The Plan covers a four month period and is prepared and updated on a monthly basis.

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

2.3 In considering the Forward Plan, members are asked to consider only those issues which are under the remit of the Scrutiny Committee. These are as follows:-

General Scope: To consider issues relating to health and adult social care services

Remit: Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Food Law Enforcement; Citizenship (Adults); and External inspections (Adult Services)

3. Current Position

3.1 The relevant extract from the Forward Plan is attached.

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

4. Recommendations

4.1 To consider the Executive's Forward Plan for the current period.

5. Background Papers

Forward Plan 1 September – 31 December 2010

Contact Officer : Karen Brown, Scrutiny Officer
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Forward Plan –

Key Decisions for the period 01/Sep/2010 to 31/Dec/2010

R.C. Rayner,
Chief Solicitor,
Sunderland City Council.

13 August 2010

Forward Plan: Key Decisions for the next four months – 01/Sep/2010 to 31/Dec/2010

No.	Description of Decision	Decision Taker	Anticipated Date of Decision	Principal Consultees	Means of Consultation	When and how to make representations and appropriate Scrutiny Committee	Documents to be considered	Contact Officer	Tel No
01426	To agree Moving from Contracting to Personalised Budgets (Day Care Services - OP)	Cabinet	06/Oct/2010	Cabinet Service Users and Carer Groups, Portfolio Holder, Adult Services Staff, Health Partners	Briefings and/or meetings with interested parties	Via the Contact Officer by 20 September 2010 - Health & Wellbeing Scrutiny Committee	Full Report	John Fisher	5661876
01438	To agree the Contributions Policy	Cabinet	03/Nov/2010	Cabinet, Service Users and Ward Members, Portfolio Holders	Briefings and/or meetings with interested parties	Via the Contact Officer by 20 October 2010 - Health and Wellbeing Scrutiny Committee	Report	Neil Revely	5661880
01436	To agree for the Council to assist with and facilitate the transfer of NTW's learning disability homes to a Registered Social Landlord.	Cabinet	03/Nov/2010	Cabinet, Service Users and Carer Groups, Portfolio Holder, Adult Services Staff, Health Partners	Briefings and/or meetings with interested parties.	Via the Contact Officer by 20 October 2010 - Health and Wellbeing Scrutiny Committee	Full Report	John Fisher	5661876

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 15 September 2010

POLICY REVIEW – APPOINTMENT OF A CO-OPTED MEMBER

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 For the Committee to endorse the nomination of one representative on the Health & Well-Being Scrutiny Committee for a time-limited project in relation to Malnutrition and Dehydration in Hospitals.

2. Introduction

2.1 The Council's constitution says that:

"*Each overview and scrutiny committee or sub-committee shall be entitled to recommend to Council the appointment of a number of people as non-voting co-optees*."

2.2 Co-opted members can make a considerable and valuable contribution to the work of a Scrutiny Committee through broadening the range of experience, skills and knowledge available to support elected members in their deliberations.

2.3 At its meeting on 7th July 2010 the Scrutiny Committee agreed to pursue a review of malnutrition and dehydration in hospitals and agreed to co-opt one representative to support the review.

2.4 The Scrutiny Committee has agreed that the nominated representative on the Health & Well-Being Scrutiny Committee will serve up to April 2011 when the review will be completed.

3. Background

3.1 The Committee has determined that membership of the Committee should include one nominated representative to support delivery of this project as a non-voting member.

4. Protocol

4.1 The Overview and Scrutiny Handbook contains a Protocol for the Appointment of Co-opted Members to Scrutiny Committees.

4.2 The Protocol includes guidance on the issues to consider when making a nomination to Council. This includes considering the range of skills and knowledge the Committee will need to effectively deliver its work-programme.

4.3 The co-opted nominee should be a member of a representative group, sector or organisation relevant to the scope of the Policy Review being undertaken.

5. Nominations

5.1 Following the meeting in July, an invitation was issued to relevant organisations to put forward suitable nominations.

5.2 Two organisations have made nominations and details of the individuals are set out below:

1. Age UK Nomination

Alan Patchett, Director of Age UK

Knowledge of the issue
Through our national 'Hungry to be Heard' campaign I took up the issue of malnutrition in hospitals with City Hospitals Sunderland and we have worked together to raise awareness and address the issue. This has had mixed success. I can also bring national research findings to the Committee and as an organisation we are doing some research with patients recently discharged from hospital. I also have a very good understanding of health and social care issues in the City and of the way health and social care organisations work.

Experience
My role gives me a unique insight into many issues that affect older people who make up the majority of people affected by this issue. I am also Chair of the Older People's Partnership Action Group in Sunderland, member of the Adult Social Care Partnership Board and Board Member of Years Ahead – the Regional Forum on Ageing. I am very experienced at committee work and have other roles as Chair of the Sunderland Community Network, Chair of the Volunteer Centre – Sunderland, and Board Member of Sunderland Centre for Voluntary Service.

This issue is of major importance for the city because it has a real effect on the ability of a person to fight off and recover from illness more quickly. I would welcome the opportunity to make a contribution to the work of the committee in examining this important issue.

2. Links Nomination

Ralph S Price, Board Member

Knowledge of the issue
I am willing to be available on an ad hoc basis on this issue. My impression is that actual malnutrition / dehydration is not really a problem in hospitals. (They claim after all to have the services of a dietician and others). However, questions regarding appropriateness

might be raised. It certainly is an issue for some care / nursing homes though.

Experience
I have experience, by the way of work in a number of homes and hospitals and also as user. These things it should be remembered are linked to things like general health and pressure management. I don't expect revolution, but I am only interested in improving outcomes.

5.3 As the Committee has received more than the required number of nominations the Scrutiny Committee will be required to select a co-opted member based on their view of the contribution each individual can make to the review.

5.4 When selecting co-opted members the Committee should:

- Evaluate these against the requirements identified.
- Give preference to individuals able to make the broadest contribution to the required skills and knowledge base.

5.5 Members are reminded that the Policy Review title is Management of Malnutrition and Dehydration in Hospitals. The aim of the review is

To review strategies to support the decision-making of health professionals involved in the provision of food and fluids, nutritional support and public health advice/interventions for Sunderland hospital inpatients in order to manage avoidable malnutrition and dehydration.

5.7 The review will be within the following terms of reference:

a) To consider the whole process for providing hospital meals: menu/nutritional planning; preparation; meal time; monitoring [who is eating their meal]; and clear-up;
b) To explore issues around the identification of patients who are admitted to hospital malnourished and whether that status has changed on discharge;
c) To explore reasons why patients are not eating their meals;
d) To establish how patients who find it difficult to feed themselves are supported to do so;
e) To evaluate the effectiveness of management, treatment and education/training programmes relevant to malnutrition and dehydration;
f) To explore what happens to monitoring information and how it is used to ensure all people receive the nutrition they require.

6 Recommendation

6.1 The Committee is asked to endorse one nominee and refer the nominations to Council for appointment to the Committee.

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HEALTH & WELL-BEING SCRUTINY COMMITTEE 15 September 2010

HEALTH OF THE EX-SERVICE COMMUNITY

Report of the Chief Executive

1. Purpose of Report

1.1 For the Committee to receive a briefing about progress on the regional health scrutiny review of ex-service personnel.

2. Background

2.1 In December 2009 a bid was made to the Centre for Public Scrutiny (CfPS) on behalf of the 12 local authorities' overview and scrutiny committees in the North East. In summary the bid made was for a project that would "*examine the physical, mental and broader health needs of ex-servicemen and women, their families and communities, how they are being assessed and met across the range of agencies at regional and local level, and how far ex-service personnel and their families are aware of the support available to them*".

2.2 The Health & Well-Being Scrutiny Committee is the lead Scrutiny Committee for this project which will be managed by a newly formed Regional Joint Health Scrutiny Group. The Scrutiny Committee is being kept informed of the project and will continue to receive regular reports and updates until the Project is concluded at the end of 2010.

2.3 An event to launch the review took place on 28 June 2010. A summary of the overview day is attached.

3. Project Work Streams

3.1 Three work streams focus on a specific issue relating to health inequalities. Progress from the work streams is as follows:

a) Physical Health

Physical Health Work Stream has made significant progress in the evidence gathering and has met with the SHA and PCT – one of the main topics of discussion was around the Military and NHS interface. A number of concerns were raised which will be investigated as the work progresses e.g. GP's understanding of the particular issues with ex-services personnel.

A visit to Catterick Garrison has been planned.

b) Mental Health

The Mental Health Work Stream has also made significant progress with the production and distribution of a questionnaire to identify policies and strategies for housing at local levels. This Work Stream will be talking to ex-service personnel in future meetings

c) Socio-economic wellbeing (including housing, employment, support for families, transport and benefits)

The Socio-Economic Wellbeing Work Stream has held an evidence gathering session with veterans. This workstream has also carried out a consultation with housing providers about policies in place to support service leavers. Future workstreams will explore housing and employment issues in detail.

4. Conclusion

4.1 The Scrutiny Committee is asked to note the progress report.

5. Background Papers

Bid to the Centre for Public Scrutiny
Draft Programme for the Baseline Evidence Day
MOD (2008) The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans http://www.mod.uk/NR/rdonlyres/415BB952-6850-45D0-B82D-C221CD0F6252/0/Cm7424.pdf
MOD (2009) The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans, external reference Group annual report http://www.mod.uk/NR/rdonlyres/BBAC5D78-7183-403F-B45E-8259C27B5932/0/TheNationsCommitmentAnnualReport_2009.pdf

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The health needs of the ex-Service community

Summary of the Scrutiny Overview Day – 28 June 2010

Background - The scrutiny review

The scrutiny review is a joint exercise of the health overview and scrutiny committees of all twelve local authorities in North East England, namely:

> Darlington, Durham, Gateshead, Hartlepool, Middlesbrough, Newcastle, North Tyneside, Northumberland, Redcar and Cleveland, Stockton-on-Tees, South Tyneside and Sunderland

Health overview and scrutiny committees are groups of local councillors with powers to inquire into, and make recommendations about, matters of local priority.

The health of ex-service personnel and their families is a national priority, as set out in the Command paper **The Nation's Commitment**. It is a matter of particular interest to the North East, where a larger-than-average share of the ex-service community live.

The review aims to address the possible inequalities in health experienced by the ex-service community by:

- improving understanding of the health needs and experiences of the ex-service community, compared with the general population

- looking into how a wide range of statutory and voluntary organisations help to meet those needs, and how that can be improved.

The Overview Day

The programme for the Overview Day is set out in Appendix 1.

The event was Chaired by Councillor Robin Todd from Durham County Council and hosted by Shaun Gordon from the Centre for Public Scrutiny.

Speakers included:

Shaun Gordon	Expert Adviser, Centre for Public Scrutiny
Steve Flanagan	Scrutiny Officer, Newcastle upon Tyne City Council
Caroline Fox	Surgeon General's Department Cross-Government Lead (Health), Ministry of Defence
Sir Andrew Cash	Co-Chair, Ministry of Defence / UK Department of Health Partnership Board and Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
Major Johnny Lighten	5th Battalion Royal Regiment of Fusiliers, Territorial Army
Major Andrew Philpott	Chief of Staff, 15 (North East) Brigade at HM Forces
Warrant Officer Ian Tervit	Royal Air Force
Flight Sergeant Danny Downs	Royal Air Force
Heather Nicolson	The Career Transition Partnership
Andrew Drake MBE	Royal British Legion
Stephen Groves	Strategic Head of Emergency Preparedness, NHS North East
Rachael Shimmin	Corporate Director, Adults, Wellbeing and Health, Durham County Council

Detailed presentations made by these speakers, where available, may be found in Appendix 2.

Fifty-six people attended the Overview Day, including twenty-two scrutiny members, fourteen scrutiny support staff, and twenty guests from a range of health, social care and third sector organisations. Of these twenty guests, eleven contributed presentations during the day. All twelve councils across the North East of England region were represented. Attendees are listed in Appendix 3.

Tyne Tees television broadcast a news story on Monday 28 June covering the event, watch on ITV player at: http://www.itv.com/tynetees/veteran-care61082/. The Northern Echo also published a news article, which may be read at: http://www.thenorthernecho.co.uk/news/8244003.Call_for_helpline_to_suppo.

Summary of presentations, including Qs+As

Morning session

Councillor Robin Todd, Shaun Gordon, Steve Flanagan, Caroline Fox and Sir Andrew Cash

Councillor Todd welcomed members and representatives from health, social care and third sector organisations to Durham, for what would be the start of an important regionwide scrutiny review, involving all 12 local councils across the region.

Shaun Gordon's presentation summarised the aims and objectives of the ex-Service community health scrutiny and set out the project's methodology for carrying out the review. Shaun also shared some information about the role of the Centre for Public Scrutiny and its' role in the review.

Steve Flanagan shared some quantitative data relating to the ex-Service community population gathered through research, including information on population numbers, nationally and in the North-East region, and the health experiences and needs of the ex-Service community by age, and made comparisons with a general population. Steve also identified key aspects of physical health and mental health, and set out some of the social and economic wellbeing issues facing members of the ex-Service community. Steve also reflected on the nation's responsibilities for the welfare of the Service and ex-Service communities referred to in the Military Covenant and identified the recent revision to the NHS Operating Framework in England for 2010/11 relating to military veterans.

Caroline Fox's presentation focused on *Improving Joined Up Care for Veterans and Injured Service Personnel Across the UK*. Caroline explained the context of the Defence Medical Services, and how they are set up to support UK Armed Forces worldwide operations. Caroline used a series of maps to illustrate the location of medical services across the UK, and identified five MoD Hospital Units, including a centre at Northallerton in North Yorkshire, the closest Unit to the North East region. The MoD also has contracts with Hospital Trusts in Newcastle and Darlington, as well as thirty other NHS Hospital Trusts. Caroline also stressed the importance of the Government Service Personnel Command Paper. (http://www.mod.uk/DefenceInternet/AboutDefence/WhatWeDo/Personnel/Welfare/SPCP/). The Command Paper is underpinned by two important principles. First, it is designed to end any disadvantage that armed service imposes on servicemen and servicewomen, their families and veterans. It specifically seeks to counter the difficulties that follow from being required to move around the country or the world, and identifies those areas where special treatment is needed to achieve this. Second, the Paper sets out how the Government can better support and recognise those who have been wounded in the service of their country. Caroline identified some specific examples of support such as the continuation of the Military Ward in Birmingham, prosthetic limb provision, improving information on veterans' health needs and the roll out of community mental health programmes following pilot schemes. For example, in relation to prosthetic limb provision, Caroline commented that people need the same level of support for when they are 'in Service' and when they move to being 'ex-Service' – indeed, the transition should be seamless. Caroline also

explained the Army Recovery Capability plan, which seeks to achieve a balance between those who would benefit from remaining with their 'parent unit' and those who would be better supported elsewhere. Servicemen and servicewomen will have 'individual recovery plans', focusing on what they can do, rather than what they cannot do. For those who leave the Service, there will be some emphasis to achieve a smooth transition from military support towards re-entering civilian life, and in relation to health, for example, having services provides by the NHS, local authorities and third sector organisations. There are challenges within this process, which includes a 2-year post discharge follow-up period, including developing an understanding of the differing cultures, that of military life against civilian life. It may be that ex-Service personnel do not know their 'rights', or receive the services they are entitled to, and do public services try to find out if this is so or not? Plans are in place to have one of four Personnel Recovery Centres located at Catt Erick Barracks by April 2012. Finally, Caroline put forward a challenge to regional public services, "*Are you services sufficiently responsive to the needs of veterans and their dependents?"*

Sir Andrew Cash's presentation, like Caroline's, focused on a national perspective, with some local knowledge. He emphasised that his role as Co-Chair of the MoD / UK DH Partnership Board is about moving the focus on from policy and strategy to delivery on the ground. Sir Andrew confirmed that approximately 10% of recruits come from the North East of England region, and that many join the Army. Sir Andrew also noted that 18,000 personnel leave the Services each year, the majority "fit and well". Sir Andrew also reaffirmed the Government's priority to veterans' health issues in the 2010/11 NHS Operating Framework, and explained some of the activities taking place which underpin that commitment. Sir Andrew confirmed that formal guidance (the NHS Armed Forces Handbook) will be given to NHS organisations during summer 2010, and that regional Armed Forces Forums are being established with formal links through strategic health authorities to the Department of Health and Ministry of Defence. NHS North East will identify a lead executive director to participate in the North East forum, supported by a Chief Executive from a North East located primary care trust or hospital trust. Sir Andrew also added that the Department of Health and Ministry of Defence are working with the Royal College of General Practitioners to produce an eLearning package for GPs in relation to managing veterans' health needs. The Department of Health's Military Health Programme also recognises the important of the transition from military life to civilian life, and work is underway involving a range of organisations and representative groups, including the Association of the Directors of Adults Social Services. Initiatives include the direct transfer of medical records to GPs and the identification of veterans in primary care settings, with guidance being provided to GPs for clinical coding, and a proposal for wider identification to support research and commissioning. A key issue is *"What are the complications that may present a barrier to the transfer of care between military health services, when a person in in-service, to primary care health services, when a person is ex-Service?"* Sir Andrew also drew attention to initiatives to improve health outcomes, relating to mental health and prosthetics and priority treatment. The Tees, Esk and Wear Valleys NHS Foundation Trust has been involved in a national community mental health pilot scheme, and achieved a Care of Veterans Award at the 2009 Military and Civilian Partnership Awards event. Sir Andrew stressed the need to co-ordinate mental health services, for those in-Service, for reservists and for veterans, through coherent care

pathways. In relation to prosthetic limbs, Sir Andrew commented on that the success of the Headley Court rehabilitation regime means that the majority of personnel who have lost limbs are highly mobile and require specialist limbs. Veterans can expect priority treatment for Service-related injuries, subject to the clinical needs of others. Finally, Sir Andrew suggested that there is much that local public services can do, including nominating an Armed Forces lead for their organisation, supporting the NHS North East Armed Forces Network and taking part in the NE Armed Forces Forum. It will also be important for local authorities to support the transition process between health and social care, particularly so since military culture is about people having things done for them, rather than having the skills to go out and find out what is available. Sir Andrew also suggested that veterans be identified as a target population in local authority strategic planning processes, such as social exclusion, homelessness and offending.

Morning session – Qs+As and comments from the floor

Q. Councillor Veronica Dunn, from Newcastle upon Tyne City Council, asked about segmentation between in-Service and ex-Service personnel and reservists.

> A. Sir Andrew confirmed that the 18,000 personnel who leave the Services each year do not include reservists. Sir Andrew also agreed that approaches to support the needs of the –ex-Service community need to be cognisant of the importance of transition between military and civilian life, that that reservists too need to be included in this pathway.

Q. Ann Cains, from Stockton-on-Tees Council, asked if there is a differentiation between meeting the health needs of the officer corps against those in the ranks.

> A. Sir Andrew confirmed that treatment was provided on the basis of clinical need alone.

Q. Councillor Brenda Osborne, from Gateshead Council, asked if there is any data correlating social profiles of new recruits which may be used when they leave the Services, where ex-Services personnel go for mental health support, and if GPs have any data relating to ex-Services personnel.

> A. Sir Andrew replied that currently no specific data is gathered relating to the social profile of new recruits which may be used on discharge. In relation to mental health checks, a full assessment is carried out by military health services before someone leaves the Service, followed by a further check one year on. Finally, GPs do not collate data specifically on the ex-Service personnel, though there are plans to provide further support to GPs as shared in the presentation slides.

Comment. Councillor Graham Hall, from Sunderland City Council, commented that he felt that public services had a responsibility to support ex-Service personnel and their families and dependents. He feels that this should be legislated for, and encouraged all local authorities to nominate an Armed Forces champion.

Response. Sir Andrew agreed with the prospect of local authorities having Armed Forces champions.

Comment. Unknown speaker. Too much emphasis was given in Steve Flanagan's presentation on the mental health support needed to address the increased prevalence of suicide amongst young men on discharge, and not enough recognition of those with much longer Service experience.

Response. Steve commented that whilst he recognised the health needs of all ex-Service personnel, the information relating to young people was drawn from recent research reports, and presents a real challenge for health professionals.

Q. Councillor Ian Haszeldine, from Darlington Borough Council commented that when in-Service, healthcare services and costs are provided by the military and when ex-Service, there is a transfer of responsibility from the military to the NHS. Are there any costs to ex-Service personnel arising from the transfer of care to the NHS, and perhaps local councils?

A. Sir Andrew commented that it may be so depending on the circumstances, but it was a Government policy matter. Shaun added that it may be an area for one of the Scrutiny Review work stream working groups to follow up, perhaps in relation to social care costs.

Afternoon session

Major Johnny Lighten and Major Andrew Philpott (the Army's perspective), Warrant Officer Ian Tervit and Flight Sergeant Danny Downs (the RAF's perspective), Health Nicolson, Andrew Drake MBE, Stephen Groves and Rachael Shimmin

Majors Light and Philpott identified that there are over 40,000 serving personnel across the North East region (which includes Yorkshire and the Humber region), though this figure does not include veterans. Each year, about 1500 service leavers are managed through the Catterick Infantry Training Centre and through the Army Foundation College in Harrogate. Some of these are not suited to Army life, and may not have active experience but are still considered Service leavers. Some are vulnerable and may be in need of further health support services when in civilian life. Major Lighten emphasised that different pathways are needed for different people.

Flight Sergeant Danny Downs and Warrant Officer Ian Tervit explained the discharge process relating to health and social care issues, and the transition to civilian life for ex-RAF personnel in the North East of England. Warrant Officer Tervit, who is the Practice Manager at RAF Leeming, explained that the Military's Department of Community Mental Health located in Tidworth, in Wiltshire, is responsible for the transfer of patient information to NHS organisations.

Heather Nicolson is the Regional Manager at the Resettlement Centre at Catterick which is part of the Career Transition Partnership (CTP). Heather's presentation explained that the Partnership is the outcome of a partnering agreement between the Ministry of Defence and Right Management, in union with the Regular Forces Employment Association and the Officers Association. The Partnership provides transition services to all eligible ranks of the Armed Forces. Indeed, the Catterick centre has achieved Centre of Excellence status for Health and Safety courses. Heather shares some data relating to users of the CTP's services, which are segmented as those with less than 4 years Service, those with 4 to 6 years Service and those with more than 6 years Service. Each of these different groups will have different needs, and so access difference services. Heather also set out how the Partnership provides resettlement training and job finding assistance. She emphasised that there is no charge for this service to potential employers. Heather produced some figures and graphs illustrating that over 5600 Service leavers have expressed an interest in resettling in the North East region over the last two years and how most people who are eligible for CTP support take it up. Heather also commented that a National Audit Office report, *Leaving the Services*, published in July 2007, identified that the UK is at the forefront of providing tailored, professional help to military personnel as they leave. The report may be accessed at:
http://www.nao.org.uk/publications/0607/leaving_the_services.aspx

Andrew Drake MBE is the County Manager for the North East Royal British Legion. Andrew shared some national and local information in his presentation, and also set out some data relating to contacts the Royal British Legion has in the North East of England, by age, by residence (i.e. type of accommodation), by need for benefit assistance, by need for grants support and by employment training needs. For example, nearly 50% of all contacts live in local authority housing, one-quarter are 'owner-occupiers', and 9% and 8% are in private rental accommodation or homeless

respectively. 15 ex-Service personnel (1%) are in prison. Note that nationally about 25% of the ex-Service community live in local authority accommodation. Andrew is also aware that the Legion does not reach all people in need across the region. Furthermore, Andrew shared useful information relation to how the Legion allocates grants by area of need, for example, during 2008/09, 20% of grants in the North East were allocated towards the purchase of household goods. 20% was also allocated to meeting priority debts. Andrew identified some challenges for the North East community, such as the need to identify all veterans and communicate with them effectively about how they may access support services. Andrew feels that support services may be better co-ordinated. Andrew recognises the need for local community champions, and reflects that while the Legion can provide generalist support, there is also a need for ex-Service personnel to access specialist support.

Stephen Groves of NHS North East took forward some of the relevant change to the NHS Operating Framework and set out a timeline for how local NHS organisations are responding to the increasing importance of the NHS in shaping better health outcomes for the ex-Service community. Stephen invited scrutiny members to join NHS North East at a regionwide event on 29 September which will bring together key personnel involved in commissioning and providing health and social care services. (Note; The Scrutiny Review Project Board will seek out further information about the event and identify the best way for the scrutiny review to engage with it).

Rachael Shimmin of Durham County Council shared some statistics relating to the prevalence of members of the ex-Service community, with a national and regional perspective. Rachael noted that 31% of the ex-Service community live alone compared to 19% of adults in a UK population. This means that the needs of the ex-Service community may be different than a general population. Rachael commented that adult social care services are available to ex-Service personnel, such as for people with physical difficulties, for people with sensory difficulties and for people with substance misuse issues, though acknowledges that some may not know of the existence of such support services. In fact, further to an enquiry from a Councillor during the morning session, it may be that some in the ex-Service community will be eligible for the provision of adult social care? Rachael also identified a connection the existence of Post Traumatic Stress Disorder and a pathway into the criminal justice system, and that the most common crime relates to domestic abuse. Rachael also noted the prevalence of drug and alcohol misuse across the region. Rachael's presentation also recognised the issues facing veterans, and the new Coalition Government's approach towards developing adult social care services, including recognising the provision of extra support for veterans' mental health needs. Rachael also set out national and local (in Durham) support that is currently available, including mental health services, general adult care services, such as *Fair Access to Care*, equipment and adaptations and community transport, and other support services, such as welfare rights, access to employment services, adult learning services and housing services. Rachael provided a summary of the ADASS, ADCS and LGA response to the 2009 MoD consultation relating to the Nation's *Commitment to the Armed Forces Community.* The response does not support any additional duties on public bodies to deliver support to the Armed Forces Community but does recognise the benefits of creating a network of local advocates to act as champions for the Armed Forces Community. Finally, Rachael identified a number of areas for consideration, including the provision and accessibility of information, removing the

stigma from seeking help and support and improving local networks between local authorities, Armed Forces and local armed forces support groups. Rachael also recognises the financial pressures mean that the focus will be on those with greatest assessed needs.

Note: The Royal Navy were unable to provide a representative due to a diary conflict with another meeting, but will be engaged with the scrutiny review as it progresses.

Afternoon session – Qs+As and comments from the floor

Q. Councillor Graham Hall, from Sunderland City Council, asked if GPs will be asked to enquire if a new patient is a member of the ex-Service community.

> A. Rachael Shimmin replied that though this does not currently happen in terms of the provision of basic level information to a GP, it may be something that scrutiny members may wish to consider and take a view on in terms of its' recommendations.

Q. Councillor Hall also asked about established networks across public services to support the sharing of information with the ex-Service community.

> A. Andrew Drake welcomed the suggestion.

Q. Councillor Haszeldine asked about eligibility criteria for access to the services available from the Career Transition Partnership?

> A. Heather Nicolson confirmed that the service is available to ex-Service community members regardless of rank, and that there are different levels of provision reflecting different needs.

Work stream discussion groups

Members and guests were invited to join one of three work stream discussion groups, exploring links between the health needs of the ex-Service community and physical health, mental health and social and economic wellbeing. These groups were facilitated by Jon Ord (Middlesbrough Council), Jeremy Brock (Durham County Council) and Angela Frisby (Gateshead Council) respectively. When the scrutiny work stream working groups are established, they will be led by Middlesbrough (Physical Health), Durham (Mental Health) and Gateshead (Social and Economic Wellbeing). Officers from Newcastle upon Tyne City Council will provide overall project leadership. It is expected that the Chair of the Health Scrutiny Project Board will be agreed at the next regional scrutiny network meeting in September 2010.

Detailed information on work stream discussions may be found in Appendix 4.

However, key issues arising from the work stream discussion groups are set out below:

Physical Health work stream

- Access to GP services is important, as will be any services arising from an examination of needs, which may be met through primary care, community care, social care, acute care or mental health care.

- It is important that local clinicians providing care and support to members of the ex-Service community have the necessary skills and knowledge relating to the nature of the physical injury so they can continue the treatment plan.

- Early leavers also need access to health and social care services. Not all veterans are single men, or women, so it is important that families and dependents are also connected into local healthcare services, such as GP access, in civilian life.

- Note: there is a real need for public services to understand the Armed Forces culture, where long service leavers, perhaps someone leaving the Army aged 40 after more than 20 years service, will not have the skills or knowledge to go out and find about services by themselves. Such individuals are used to having the Army sort out access to such services whilst in-Service.

Mental Health work stream

- The need for public services to commission and deliver integrated health and social care services.

- The ex-Service community needs to understand what problems face them in terms of accessing health and social care public services, and identify the barriers they face when trying to access services.

- Research illustrates that early leavers are most vulnerable; can this group be ‘flagged up’ by the Armed Forces with GPs and local health care providers?

Social and Economic Wellbeing workstream

- It would be helpful if members of the ex-Service community could access co-ordinated pathways to various public services, depending on their particular needs.

- They may be a significant time gap between discharge and the need to access public services in support of social and economic wellbeing, and it is important for public services to recognise that the availability of information on such services needs to reflect this.

- The design of information about services to enhance social and economic wellbeing should involve members of the ex-Service community. It needs to be available in formats that are appropriate to ex-Service personnel and their families and dependents.

Conclusion

Councillor Robin Todd of Durham County Council concluded the event reflecting on the breadth and depth of information provided during a very interesting day. Councillor Todd also thanked members and guests for their valuable presentations and contributions, and looked forward to the scrutiny review progressing and making a positive contribution to the health of the ex-Service community.

ENDS

APPENDIX 1

REGIONAL SCRUTINY OF HEALTH OF EX-SERVICE COMMUNITY
OVERVIEW DAY
THE GALA THEATRE, DURHAM,
MONDAY 28 JUNE 2010

10	30	Registration Councillors asked to indicate which of the workstream tables they will join (if not indicated in advance)
11	00	**Welcomes and introductions** Councillor Robin Todd, Chair, Adults Health and Wellbeing Scrutiny Committee, Durham County Council
	05	**Summary of the scrutiny project** Shaun Gordon, Expert Advisor, Centre for Public Scrutiny
	15	**Summary of information already gathered for the scrutiny project** Steve Flanagan, scrutiny officer, Newcastle City Council
	30	**What is being done nationally** Sir Andrew Cash , Co-chair, MoD / UK Departments of Health Partnership Board and Chief Executive, Sheffield Teaching Hospitals NHS Trust
	45	Caroline Fox, Surgeon General's Department Cross-Government Lead (Health), Ministry of Defence
12	00	Sir Andrew Cash & Caroline Fox Q&A
	30	Lunch
01	00	**The position in the North East**
	00	**The Army** Major Johnny Lighten, 5th Battalion Royal Regiment of Fusiliers, Territorial Army
	05	**The Royal Air Force** Warrant Officer Tervit and Flight Sgt Danny Downs, RAF
	10	**The Royal Navy** To be confirmed – post note: apologies were received

	15	**Career Transition Partnership** Heather Nicholson, Regional Manager
	25	**Royal British Legion** Andrew Drake MBE, County Manager
	40	**Health & care service commissioners and providers** Stephen Groves, NHS North East and Rachael Shimmin, Corporate Director Adults Well-Being & Health, Durham County Council
	55	General Q&A
02	10	comfort break
	15	**Group discussions** Councillors join workstream tables. Discussion facilitated by workstream lead officers. First session – Regional guests arranged thus: Armed forces on mental health table Ex-service reps on physical health table Service providers on sociological wellbeing table
	30	Regional guests rotate
	35	Second session
	50	Regional guests rotate
	55	Third session
03	10	Open session for final comments and questions
	25	Wind up and conclusions
	30	Tea, coffee and networking

APPENDIX 2

PRESENTATIONS

Shaun Gordon, Centre for Public Scrutiny

Steven Flanagan, Scrutiny Officer, Newcastle upon Tyne City Council

Caroline Fox, Surgeon General's Department Cross-Government Lead (Health), Ministry of Defence

Sir Andrew Cash, Co-chair, MoD / UK Departments of Health Partnership Board and Chief Executive, Sheffield Teaching Hospitals NHS Trust

Major Johnny Lighten, 5th Battalion Royal Regiment of Fusiliers, Territorial Army

Heather Nicholson, Regional Manager, Career Transition Partnership

Andrew Drake CBE, Royal British Legion

Stephen Groves, NHS North East

APPENDIX 3

OVERVIEW DAY, 28 JUNE 2010 - LIST OF ATTENDEES

In attendance

Cllr Ian Haszeldine	Darlington
Cllr Wendy Newall	Darlington
Abbie Metcalfe	Darlington
Cllr Robin Todd	Durham
Cllr Jean Chaplow	Durham
Cllr David Farry	Durham
Jeremy Brock	Durham
Feisal Jassat	Durham
Cllr Stuart Green	Gateshead
Angela Frisby	Gateshead
Cllr Mary Fleet	Hartlepool
Cllr Sheila Griffin	Hartlepool
James Walsh	Hartlepool
Jon Ord	Middlesbrough
Cllr Veronica Dunn	Newcastle
Cllr Lawrence Hunter	Newcastle
Cllr Doreen Huddart	Newcastle
June Hunter	Newcastle
Steve Flanagan	Newcastle
Cllr Barbara Stevens	North Tyneside
Cllr Margaret Finley	North Tyneside
Dave Parkin	North Tyneside
Cllr Margaret Richards	Northumberland
Cllr Terry Robson	Northumberland
Jackie Roll	Northumberland
Cllr Wendy Wall	Redcar & Cleveland
Cllr Steve Kay	Redcar & Cleveland
Cllr John McCabe	South Tyneside
Paul Baldasera	South Tyneside
Cllr Ann Cains	Stockton
Cllr Julia Cherrett	Stockton
Cllr Aidan Cockerill	Stockton
Peter Mennear	Stockton
Anthony Duffy	Stockton

Cllr Graham Hall	Sunderland
Karen Brown	Sunderland
Catherine Parker	NHS County Durham and Darlington Public Health Specialist
Dave Britton	Regional MH Commissioning Team
Lynn Wilson	Regional MH Commissioning Team
Symon day	TEWV NHS Trust Veterans Mental Health Project lead clinician
Les Pickering	Northumberland Care Trust
Michelle Turnbull	NHS South of Tyne and Wear
Philip Whitfield	Assistant Director Strategic Intelligence Stockton PCT
Ken Ross	NHS County Durham and Darlington Public Health Specialists
Tony Walsh	Public Health Specialist

Sir Andrew Cash	Co-chair MoD/UK Departments of Health Partnership Board
Caroline Fox	Surgeon General's Department Cross-Government Lead (Health) Ministry of Defence
Major Johnny Lighten	5th Battalion Royal Regiment of Fusiliers, Territorial Army
W/O Ian Tervit	RAF
Flight Sgt Danny Downs	RAF
Andrew Drake MBE	Royal British Legion
Stephen Groves	NHS North East
Rachael Shimmin	Corporate Director Adults Well-Being & Health Durham County Council
Shaun Gordon	Expert Advisor, Centre for Public Scrutiny
Dave Rutter	Department of Health Military Health
Rob Moorhead	Department of Health Military Health
Heather Nicholson	Regional Manger, Career Transition Partnership

APPENDIX 4

Social and Economic Wellbeing work stream post presentations discussions

Objectives

The workstream would seek to look at the following issues:

- Effective communication and awareness
- Relationship between the veteran community and housing, employment and skills
- Wider health needs of veteran community
- What progress regionally/nationally? Including against the Command Paper commitments.
- Potential for supporting delivery
- Unified approach between local authorities and third sector
- Barriers

Work could include looking at good practice and site visits as appropriate.

Discussion

- Need co-ordinated pathways with effective links and communications

- Distinct lack of knowledge of the services available, as there are many resources available but many of the ex-service are unaware, concluding therefore that there is a definite need for awareness raising as the services are actually available.

- There is no joined up approach in terms of the information provided to ex-servicemen. This makes it difficult to identify problems and solutions.

- Should be some responsibility placed on the Armed Forces for 'tapping' into services that are already established.

- A number of smaller VCS organisations are starting to provide niche services for veterans but there is no overall co-ordination.

- More responsibility should be placed on the statutory sector, specifically Local Authorities (LA). A focal point should be publicised, with LAs establishing a system of finding out who the veterans are as we know very little about ex-servicemen needs and consequently do not know the location of the ex-service community. For eg, to include and measure sections on applications to the council ie. housing benefit appns, homeless appns, and any other appns. Pack to be given/sent out to each applicant with information on services available contained? This information should then be collated. Common areas could then potentially be identified.

- As service leavers sometimes develop problems later, it is important that a focal point is established so that ex-servicemen can access services at any time after leaving the services as contacts/contact numbers/agencies change names,

addresses and contact numbers over time. These contacts should be localised and certainly not national with ideas being focussed on having a member as an Armed Forces champion to progress the services or an LA officer to be an Armed Forces champion to provide up to date info/advice.

- There was some discussion as to how a helpline or other central contact point could be managed, and whether it should be on a national basis.

- The Service Personnel and Veterans Agency (SPVA) is good in many respects but there needs to be greater local focus. Many people prefer to go to local services, and many people prefer to access these in person, so a helpline approach may not be appropriate for all.

- There is a need to ensure that there is equality of access to services, across the lifestages of veterans, and their status when in the armed forces (ie,. whether officers or other ranks).

Health and Wellbeing Scrutiny Committee

Performance Report 2009/2010 – Health, Social Care and Sport and Leisure Services

Report of the Chief Executive, Executive Director Health, Housing and Adults Services and Executive Director City Services

1.0 Purpose of the report

The purpose of this report is to provide Health and Wellbeing Scrutiny Committee with a performance update relating to the period April 2009 to March 2010. This report includes key achievements during 2009/10, residents satisfaction with services and progress in relation to the LAA targets and other national indicators.

2.0 Background

2.1 Members will recall that a new performance framework was implemented during 2008/2009. This includes 198 new National Indicators which replaces previous national performance frameworks. As part of this new framework 49 national indicators have been identified as key priorities to be included in the Local Area Agreement (LAA). Performance against the priorities identified in the LAA and associated improvement targets have been reported to Scrutiny Committee throughout 2009 as part of the quarterly performance monitoring arrangements. The LAA priorities have been a key consideration in CAA in terms of the extent to which the partnership is improving outcomes for local people. CAA was introduced in April 2009 to provide an independent assessment of how local public services are working in partnership to deliver outcomes for an area. However, the coalition government have abolished CAA with immediate effect. Progress in the LAA will continue to be monitored through 2010/11 (which is the last year of the agreement) through the Council and the Sunderland Partnership's performance management and reporting arrangements. The performance will be reviewed when further national direction is available to ensure that it is fit for purpose.

As part of the development of Scrutiny particularly in terms of strengthening performance management arrangements, Policy Review recommendations have been incorporated in to the quarterly performance report on a pilot basis. The aim is to identify achievements and outcomes that have been delivered in the context of overall performance management arrangements to enhance and develop Scrutiny's focus on delivering better outcomes and future partnership working. The next progress report will be provided in December 2010.

2.2 ***Appendix 1*** provides an overview of the position for relevant national indicators and also any local performance indicators that have been retained to supplement areas in the performance framework that are not well covered by the national indicator set.

3.0 Findings

3.1 Key Achievements

The council opened three new 'Extra Care' schemes in Silksworth (Beckwith Mews), Washington (Woodridge Gardens) and Hetton (Bramble Hollow). The Extra care schemes enable people to live in their own homes independently providing access to tailored care and support to meet individuals needs, it also gives access to other social health and wellbeing opportunities. The new extra care housing schemes have come about thanks to an inventive partnership between the council, Housing 21 and Frank Haslam Milan North East (FHM). A further scheme is being developed with Gentoo Group at the Racecourse Estate in Houghton le Spring, this will provide 47 two bedroom units of accommodation. It is due to be completed and opened by summer 2011.

Our Moorside Contact Centre has been accredited by the Telecare Services Association (TSA) for meeting new stricter call handling standards and answering 98.5% of Telecare Alarm calls within 60 seconds and 99% of calls within 3 minutes. The Contact Centre handles more than 23,000 alarm calls per month and provides a critical service to vulnerable residents. The accreditation is nine months ahead of the new standards deadline.

Grindon Mews a centre for people with learning difficulties officially opened in November 2009. The £2.6million community social care facility offers specialist social care support to adults aged 18-65 who have profound and multiple learning disabilities. The centre is designed to maximise independence, promote individual choice and help aid social inclusion. It includes specialist day opportunities for up to 28 adults per day and opportunities and re-enablement for up to 15 adults per day who have physical disabilities.

Two new 25m Community Pools opened in Silkworth and Hetton. The new sites mean that even more people have access to excellent sporting facilities close to where they live, encouraging people of all ages and abilities to enjoy the pools, be physically active, and have fun. There were a total of 2,265,877 visits to leisure centres during 2009/2010. The number of swims has increased from 608,807 in 2008/2009 to 657,016 during 2009/2010. The opening of the two new 25m community pools in Hetton and Silksworth will increase this figure further during 2010/2011.

3.2 Customer Focus

More residents feel that older people in their local area were able to get the services and support they need to continue to live at home for as long as they want to, 40% said they did feel such support was available compared to 36% in 2008/09. This is higher than the national average of 30% and also the regional average of 35.5%.

Residents consider themselves to be healthier, 69% describe their health as either good or very good compared to 66% in 2008.

The Community Spirit Summer survey 2009 asked about how easy people find it to be healthy in their local area. The findings highlighted that respondents generally find it easy to be healthy in their local area but slightly less so when it comes to being physically active and having good emotional well being. A range of activity has been introduced to address the findings in the survey which includes:

- Working with schools to educate children on healthy eating, how to cook healthily and how to improve school meals, referral programmes to support individuals and families who have weight issues with their diets, and introduction of the Heartbeat Award which recognises restaurants and other food retailers who offer healthy alternatives.
- Increased opportunities to do physical activity by developing a city wide network of Wellness Centres and more localised Community Wellness Venues to improve accessibility
- A Happiness and Well Being Network has been established where representatives from a number of organisations and members of the public meet to help improve their mental health, happiness and well being through interactive workshops. A review of services people with mental health problems access initially is currently taking place.
- Intervention services are being introduced in terms of referring people into alcohol treatment services if they go to hospital because of alcohol related injuries/illnesses or are arrested while drunk. Campaigns are being run to raise the awareness of the number of units in alcoholic drinks, safe drinking levels and where to go for advice
- There are a number of services available to help people stop smoking, including, the NHS Stop Smoking Service, staff in Wellness Centres and advisors in various locations across the city e.g. community pharmacies and GP practices. Extra support is also available for pregnant women who smoke.

3.3 Performance

In relation to health and wellbeing six national indicators are priorities identified in the LAA. An overview of available performance can be found in the following table

Performance Indicator	Performance 2008/09	Performance 2009/10	Trend	Target 2009/10	Target achieved
NI119 % of residents who consider themselves to be in good health	66.2%	68.9%	▲	69.2%	×
NI120 All – age mortality rates expressed per 100,000 population	579 (F) 878(M)	578.70(F) 851 (M)	▲	546 (F) 748 (M)	× ×
NI39 Alcohol-harm related hospital admission rates expressed per 100,000	2378	2659	▼	2204	×

NI123 16+ current smoking rate prevalence	1100	1289	▲	1437	✗
NI136 People supported to live independently through social services (all ages)	3124.19	3008.31	▼	3415	✗
NI130 Social care clients receiving Self Directed support (per 100,000 population)	5.83%	7.42%	▲	8.50%	✗
NI139 People over 65 who say they receive the information, assistance & support needed to exercise choice & control to live independently	36.2%	39.8%	▲	39.2%	✓

A full overview of performance can be found in appendix 1 the following section contains those performance indicators that are declining and / or haven't achieved the target set for 2009/10.

3.3.1 Social Care

NI 136 People supported to live independently through social services

The number of adults of all ages supported to live independently per 100,000 population declined from 3124.19 per 100,000 in 2008/09 to 2008.31 per 100,000 in 2009/10. Work began in 2009/10 to develop community in reach programmes (e.g. working with GP Practices) to identify potential new customers who may require social services. This work will continue and expand in 2010/11. For example, the Directorate completed an older people's population profiling for the city, and used this as the basis for a more targeted and pro-active approach to supporting individuals. The Council is working on a Department of Health pilot with Church View Medical Practice to better identify people who might need some help, e.g. who feel isolated, need financial advice or improve their health and wellness, and has already identified a small number of people that both the GP practice and the Council need to provide a greater level of support. The principles of the pilot are about to be rolled out with another GP practise to better support people with learning disabilities, whilst a similar exercise is being undertaken to identify older people living alone on low benefits in the Fulwell and Southwick wards who might need a "little bit of help" in daily living, as part of community in-reach solutions. These solutions will mean that the Council will start to improve its performance against this indicator as a result of this locality-based working, including the use of in-reach teams to penetrate into communities, improved marketing and working with the Third Sector to build capacity and more focussed outcomes.

NI 130 Social care clients receiving self-directed support

The percentage of social care clients receiving self-directed support has improved from 5.83% during 2008/09 to 7.42% during 2009/10; however the target of 8.50% has not been achieved. The Council is currently revising its Community Care Assessment and Care Management processes to better ensure that customers are more able to identify solutions to meet their needs

and preferences, including through Personal Budgets and Direct Payments. This may include, for example, support via Personal Assistants, that enable people to carry out not just daily living tasks such as personal care, but also access to leisure and social activities.

There's expected to be a significant increase in the number of new and existing clients will be offered self directed support from 1st November 2010 to help achieve the 30% target set for 2010/11. Personal Budgets and Direct Payments are a form of financial payments to enable assessed individuals to make direct choices about their social care. There were 819 social care clients receiving self directed support in 2009/2010 compared to 693 in 2008/2009. Aside from offering greater choice and control for individuals, Direct Payments are also a more cost-effective way of providing support to individuals. During 2009/10 6,689 older people have been supported to live independently in their own home.

3.3.2 Health Inequalities

NI120 All age all cause mortality rate

Latest performance relates to 2006 – 2008 pooled rates and mortality rates have slightly improved since the previous reporting period and have not achieved the 2009/10 target of 546 for females and 748 for males per 100,000 population.

A number of projects that aim to improve performance are currently underway examples can be found below.

The Community Delivery Team (CDT), which is a nurse led service, has started to deliver NHS Health Checks in community venues across Sunderland. A telephone service where people can ring to book a NHS Health Check is also due to be launched. The number of pharmacies offering NHS Health Checks is 7. From 1st November 2009 to 30th June 2010 over 500 eligible Health Checks have been carried out. 60% of men who have had a NHS Health Check in a pharmacy have been identified as high risk.

The delivery of Wellness Services across Sunderland continues with increased opportunities for individuals to access a range of physical activity opportunities to prevent individuals developing health risks. Activities include walking and cycling.

Work continues to evolve both the children's and adults weight management intervention programmes to develop into a seamless life course approach to a support programme. Work continues with the STPCT to ensure targeted and specialist interventions and services are targeting areas and individuals with the most need through the exercise referral and the weight management programme.

NI123 16+ current smoking rate prevalence

Latest performance shows 1289 smoking quitters per 100,000 population. Performance has improved compared to 2008/09 however, the target of 1437 quitters per 100,000 population for 2009/10 has not been achieved. Key actions to improve this position include:

- Expanding and improving intermediate services (tier 2) for existing and new providers to support the doubling of throughput of stop smoking services, with an additional 38 providers and 117 advisers in 2009/10. This included recruiting mentors to support existing providers and advisors and working more closely with GPs to better identify smokers who may want to quit to signpost individuals, particularly those with chronic conditions, to Stop Smoking Services;
- Expanding and improving specialist services (tier 3) to support the doubling of throughput of stop smoking services in line with AOP and contractual targets, with an additional 4 advisors in 2009/10. Activities included development of workplace initiatives in ASDA, "More Than" insurance and City Hospitals Sunderland. This also included follow-up of people using the service who then did not fulfil the programme;
- Commissioning the voluntary sector to deliver brief intervention for stop smoking. 14 community groups have now been trained delivering a service, with 31 people in total. All groups are in deprived communities.
- Improved commissioned service models, and training, to improve rates of access to smoking cessation services, including in the community and with "hard-to-reach" groups. This includes marketing the services through the Community Development Officer, who recruited and trained Third Sector organisations to undertake interventions, with significantly improved "community in-reach" which will drive improvements towards NI 123, as well as marketing events such as publicity material and No Smoking Day;
- Re-establishment of local tobacco alliances for the purpose of delivering against national and local tobacco control priorities and supporting the achievement of smoking 4 week quit targets;
- The Sunderland Smokefree Tobacco Alliance has held facilitated sessions and developed an action plan covering:
- Reducing exposure to second-hand smoke
  FRESH have undertaken a media campaign around Smoke Free Families and recently been involved with a campaign around 'why it's a good idea to take 7 steps out…'. 6 people have been trained to deliver Reducing Second Hand Smoking in homes.

NI39 Alcohol Related admissions

The rate of hospital admissions per 100,000 for alcohol related harm will continue to increase as a consequence of NHS investment in alcohol treatment services. Latest performance is 2659 admissions per 100,000 population which is considerably more than the 2009/10 target of 2204. Improvement interventions include:

- Develop Hospital Liaison Project in line with national good practice to help reduce alcohol related hospital admissions.

- Commission Gastro nurse specialist within the FT to work with dependant drinkers and develop pathways into Tiers 3 and 4 from the hospital.
- Enhance the Hospital Liaison Project to a 7 day per week service.
- Develop a care co-ordination process with key partners to help reduce the number of frequent flyers attending hospital.
- Develop an out-patient clinic with the Gastro Nurse specialist to reduce the number of admissions.
- Enhance pathways within the hospital and community.

4.0 Recommendation

That the committee considers the continued good progress made by the council and the Sunderland Partnership and those areas requiring further development to ensure that performance is actively managed.

Report Key

This is the level of performance at 31st March 2009. A question mark means that information is not available

This is the level of performance at 31st March 2010. A question mark means that information is not available

The target is what we want to achieve

	2008/09 Outturn	2009/10 Outturn	Are we improving?	Target	Have we achieved the target?	Commentary
The % of older people discharged from hospital and bebefiting from intermediate care / rehabilitation still living at home 3 months after discharge (NI125).	70.50 %	72.90 %	✓	78.30 %	▲	
The % of adults, older people and carers who are social care clients receiving self-directed support. (NI130)	5.83 %	7.42 %	✓	8.50 %	▲	• New and existing clients will be offered self directed support from 1st August 2010 to help achieve the 30% target set for 2010/11
The % of carers whose needs were assessed or reviewed by the council. (NI135)	54.10 %	56.50 %	✓	56.40 %	★	• A new initiative in late 2009/10 was implemented to ensure all carers engaging with HHAS are offered a separate carer assessments.

This is a comparison of the 2008/09 outturn against the 2009/10 outturn. The symbols mean

performance has improved	✓
performance is stable	→
performance has declined	✗
Information is not available	?

This traffic light is a comparison of performance at 31st March 2010 against the target

The target has been achieved	★
Performance is within 10% of the target	●
The target has not been achieved	▲
Not applicable due to no target being set	?!

Adult Social Care

	2008/09 Outturn	2009/10 Outturn	Are we improving?	Target	Have we achieved the target?	Commentary
The % of older people discharged from hospital and benefiting from intermediate care / rehabilitation still living at home 3 months after discharge (NI125).	70.50 %	72.90 %	✓	78.30 %	▲	
The % of adults, older people and carers who are social care clients receiving self-directed support. (NI130)	5.83 %	7.42 %	✓	8.50 %	▲	• New and existing clients will be offered self directed support from 1st August 2010 to help achieve the 30% target set for 2010/11
The % of carers whose needs were assessed or reviewed by the council. (NI135)	54.10 %	56.50 %	✓	56.40 %	★	• A new initiative in late 2009/10 was implemented to ensure all carers engaging with HHAS are offered a separate carer assessments.
The rate of adults per 100,000 population that are assisted directly through social services funded support to live independently. (NI136)	3,124....	3,008....	✗	3,415....	▲	• Work began in 2009/10 to develop community in-reach programmes (eg working with GP practices) to identify potential new customers who may require social care services. This work will continue and expand in 2010/11.
The percentage of residents who believe that older people locally receive the support they need to live independently at home as long as possible. (NI139)	36.20 %	39.80 %	✓	39.20 %	★	
The % of vulnerable people (i.e. people who are receiving a Supporting People Service) who have moved on from supported accommodation in a planned way. (NI141)	82.21 %	77.60 %	✗	85.00 %	▲	• This is an area for improvement. Performance deteriorated due to a higher number of SP contracts aimed at supporting young people with sometimes variable and difficult to change behaviour.
The % of vulnerable people (i.e. people who are receiving a Supporting People Service) who have established or are maintaining independent living. (NI142)	98.45 %	98.87 %	✓	99.00 %	●	• This is an area for improvement. Performance deteriorated due to a higher number of SP contracts aimed at supporting young people with sometimes variable and difficult to change behaviour.
The percentage of adults with learning disabilities in settled accommodation at the time of their assessment or latest review. (NI145)	104.1...	76.10 %	✗	80.00 %	●	• In 2008/09 the numerator was for a 6 month period collection and then doubled as per guidance, for 2009/10 the indicator was for a 12 month collection period.
The percentage of adults with learning disabilities in paid employment at the time of their assessment or latest review. (NI146)	3.10 %	4.10 %	✓	4.20 %	●	• Further improvement may be achieved in 2009/10 through the WNF employment scheme for people with disabilities to get people employment ready.
The % of new clients where the time from first contact to completion of assessment is less than or equal to four weeks. (NI132)	89.40 %	76.80 %	✗	92.80 %	▲	• This is being addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and assess individuals who need some help through an initial advice & assessment team.
The % of new clients for whom the time from completion of assessment to provision of services in the care package is less than or equal to 4 weeks. (NI133)	90.00 %	91.20 %	✓	91.20 %	★	• The Improvement to date may be an indirect consequence of freeing up practitioner resources via greater use of Independent Living Team to provide individuals with low-levels of equipment.
The % of respondents who consider themselves to have received fair treatment by various local services. (NI140)	74.60 %	72.20 %	✓	74.60 %	●	
The number of admissions of supported residents aged 65 or over to residential/nursing care per 10,000 population (LPI035)	84.90	80.99	✓	84.40	★	• Reduction due to greater provision of intermediate care service and extra care.
Percentage of items of equipment delivered within 7 working days (BV056).	90.00 %	91.56 %	✓	93.00 %	●	• Improvements made in 2009/10 through revised processes around the assessement and delivery of equipment.

Health Inequalities (please refer to main body of the report for commentary)

	2008/09 Outturn	2009/10 Outturn	Are we improving	Target	Have we achieved the target?	Commentary
The rate of alcohol related hospital admissions per 100,000 population (NI039).	2,378....	2,659....		2,204....		
The % of residents who report that they are in good health (NI119)	66.20	68.90		69.20		
The mortality rate per 100,000 population, from all causes at all ages - females (NI120f).	579.82	578.70		546.00		
The mortality rate per 100,000 population, from all causes at all ages - males (NI120m).	878.22	851.00		748.00		
Mortality rates from all circulatory diseases per 100,000 population aged under 75 (NI121).	98.00	88.90		80.50		
Mortality rates from all cancers per 100,000 population aged under 75 (NI122)	137.00	141.14		120.70		
The rate of self-reported 4-week smoking quitters per 100,000 population aged 16 or over (NI123).	1,100....	1,289....		1,437....		

Sport and Leisure

	2008/09 Outturn	2009/10 Outturn	Are we improving?	Target	Have we achieved the target?	Commentary
The % of the population (aged 16 plus) who participate in sport for at least 30 minutes on 3 or more times a week (NI008)	18.70 %	19.60 %	✓	23.03 %	▲	• The figure of 19.6% is based on a two year pooled data from the active people survey (Oct 07 to Oct 09) to boost the annual sample size from 500 to 1000. The baseline is 20.1%. The confidence level is +/- 3.5% so the interim figure represents no change from the 2008 baseline.
% of population volunteering in sport and active recreation for at least one hour per week (LPI018).	4.30 %	4.94 %	✓	4.56 %	★	
Total number of visits to leisure centres (LPI021)	2,236,294.00	2,265,877.00	✓	2,258,657.00	★	
Total number of swims within leisure centres (LPI022)	608,807.00	657,016.00	✓	614,355.00	★	
Total number of other visits to leisure centres (LPI023)	1,627,487.00	1,608,861.00	✗	1,644,302.00	●	• Other visits have been affected by the closure of the Northumbria Centre and Silksworth artificial turf pitch.

Environmental Health

	2008/09 Outturn	2009/10 Outturn	Are we improving?	Target	Have we achieved the target?	Commentary
The percentage of satisfied customers with regulatory services. (trading standards, environmental health and licensing) (NI182)	77.00 %	77.70 %		78.00 %		
The number of significant issues that the Trading Standards Service is called upon to deal with less the number that it is actually able to deal with (NI183).	4.25	3.21		3.75		
The percentage of food establishments within the local authority area which are broadly compliant with food law (NI184).	87.20	82.92		88.00		Statistics for premises being 'broadly compliant' have altered following new guidance produced by the Food Standards Agency. This guidance aims to improve consistency in the rating of food premises prior to the introduction of a 'National Food Hygiene Ratings Scheme' later this year. In Sunderland the management of food safety in local businesses was identified as an area of where assistance was required prior to the introduction of our own 'Scores on the Doors' rating scheme. This was addressed by the organising of three seminars across the city and the subsequent implementation of training courses to help food businesses. This will ensure that the number of premises becoming 'broadly compliant' will increase and conditions in all establishments are expected to improve.