Sunderland City Council

# HEALTH AND WELL-BEING SCRUTINY COMMITTEE

# AGENDA

## Meeting to be held at the Civic Centre, Committee Room 1 on Wednesday 21st April, 2010 at 5.30 pm


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| 1. | **Apologies for Absence** | |
| 2. | **Minutes of the Extraordinary Meeting of the Committee held on 22nd February, 2010 and of the last Meeting of the Committee held on 10th March, 2010**<br><br>(Copy attached). | 1 |
| 3. | **Declarations of Interest (Including Whipping Declarations)** | - |
| 4. | **Response from the Secretary of State Regarding Church View Medical Practice**<br><br>Scrutiny Item<br><br>Report of the Chief Executive (copy attached). | 20 |
| 5. | **Sunderland Local Involvement Network**<br><br>Scrutiny Item<br><br>Report of the Sunderland Local Involvement Network (copy attached). | 33 |


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Item for Information

Report of the Chief Executive (copy attached).

R.C. RAYNER,
Chief Solicitor.

Civic Centre,
SUNDERLAND.

13 April, 2010

**At an Extraordinary meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on MONDAY, 22ND FEBRUARY, 2010 at 9.15 a.m.**

**Present:-**

Councillor P. Walker in the Chair

Councillors Paul Maddison, Old, Shattock and M. Smith

**Also Present:-**

| | | |
|---|---|---|
| Yvonne Crawford | - | Director of Public Health |
| Margaret Elliot | - | Sunderland Home Care Associates |
| Brent Kilmurray | - | Director of Service and Strategy Development, Sunderland TPCT |
| Alan Patchett | - | Director of Age Concern Sunderland |
| Helen Paterson | - | Executive Director of Children's Services |
| Neil Revely | - | Executive Director of Health, Housing and Adult Services |
| Canon Stephen Taylor | - | Chair of Sunderland Partnership |
| Vince Taylor | - | Head of Strategic Economic Development |
| Ann Dingwall | - | Care Manager, Health, Housing and Adult Services |
| Nicola Morrow | - | Healthy Cities Officer, Health, Housing and Adult Services |

**Declarations of Interest**

There were no declarations of interest.

**Policy Development and Review: Tackling Health Inequalities in Sunderland – Expert Jury Day**

The Chief Executive submitted a report (copy circulated) to support evidence gathering for the 2009/10: Tackling Health Inequalities in Sunderland – Expert Jury Day.

(For copy report – see original minutes).

The Chairman welcomed everyone to the Committee and introduced Ann Dingwall, Care Manager, Health, Housing and Adult Services and Nicola Morrow, Healthy Cities Officer, Health, Housing and Adult Services and advised that they would facilitate the flow of information and discussion by Members.

Mr. Nigel Cummings, Scrutiny Officer, outlined the Schedule for the day.
Mr. Cummings referred to the meeting that Members of the Committee had recently held with Professor Peter Goldblatt who was a member of the Marmot Review Team that had undertaken a Strategic Review of Health Inequalities in England post 2010.

The Review recommended 6 policy objectives as follows:-

1. Giving every child the best start in life (highest priority recommendation) – increasing the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

2. Enabling all children, young people and adults to maximise their capabilities and have control over their lives – reducing social inequalities in pupils' educational outcomes; prioritise reducing social inequalities in life skills.

3. Creating fair employment and good work for all.

4. Ensuring a healthy standard of living for all minimum income for healthy living.

5. Creating and developing sustainable places and communities.

6. Strengthening the role and impact of ill-health prevention – core efforts of public health departments focused on interventions related to the social determinants of health proportionately across the gradient.

Mr. Cummings advised that the Expert Jury Day was the second part of the Committee's major Policy Review and was designed to allow Members to question internal staff, service users, carers and external providers in addition to the opportunities presented at Committees and the Community Day.

At this juncture the Chairman welcomed Brent Kilmurray, Director of Strategy and Service Development, Sunderland City Hospitals NHS Foundation Trust to the Committee and invited them to respond to the four questions posed from an NHS perspective.

*Question 1 – What does the term Health Inequalities mean to you?*

Mr. Kilmurray outlined the broad Sunderland context. Average health status in Sunderland was poorer than across England as a whole with life expectancy lower than for England. However, there was a ten year variation in life expectancy between those wards with the best and poorest health in Sunderland. Between 2% and 70% of households in the City were receiving worklessness benefits and 50% of the City's smokers lived in the most deprived areas; the largest proportion coming from the lowest social economic groupings.

Health status was strongly linked to social and economic disadvantage, as measured by factors such as income, housing, culture and education. Mr. Kilmurray stated that the health of the City was also determined by the City's industrial heritage.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Kilmurray advised that Sunderland Teaching Primary Care Trust had a vision contained within its Strategic Plan which consisted of 3 strands:-

1) better health;
2) better patient experience;
3) better use of your money.

By 2015 it was hoped that people would live longer and have better access to prevention services; there would be a reduction in negative lifestyle choices and a reduction in the number of long term conditions. It was important to close the inequality gap between Sunderland and England, 5% was seen as a realistic target. There needed to be better alignment with partners, with greater joined up working. A key aspect of the Trust's policy was to ensure that patients received care and advice in the most appropriate setting.

Some of the expected outcomes would be to improve life expectancy, reduce childhood obesity and reduce alcohol related admissions.

A number of initiatives were taking place. These include tiered obesity services (tier 1 consisting of population wide basic intervention and prevention, tier 2 - specialist obesity services and tier 3 – special services for chronic obesity). Improvement of alcohol services, the reintroduction of school health checks and cancer awareness were also initiatives to improve outcomes.

All strategic plans had a financial strategy. A lot of money was tied up in treatment services and there would be a move to invest as much as £80 million in prevention.

Maximizing the effectiveness of Equality Impact Assessments as a tool to manage performance was extremely important and a more systematic approach to them needed to be taken.

*Questions 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Kilmurray advised that NHS services were universal rather than area based, however, certain services such as community matrons had differing numbers of patients in a given area depending on need. The use of social marketing would ensure a more targeted approach to get underneath groups of patients. GPs had a critical role to play in personalisation.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr. Kilmurray advised that if the 5 year vision was delivered then the outcome of closing the health inequalities gap would be successful but challenging. There would be a reduction in the variations between wards and between the City and England.

Key to realising this success would be far greater engagement with people who make poor lifestyle choices with more screening interventions. Mr. Kilmurray advised that he would like to see more outreach and accessible services to catch vulnerable groups. This could be delivered by decommissioning specific hospital services (a transfer of resources) to prevention, for example, emergency admissions for long term conditions could be reduced by enabling the individual to better manage their condition at home with the help of the community matron service and urgent care teams.

As part of the Digital Challenge a new high technology initiative pilot, Telehealth, would help patients with long term health conditions to monitor their own vital health signs without repeated visits to their GP or hospital. The Telehealth equipment enables users to undertake agreed tests such as blood pressure, blood oxygen saturation levels which are then relayed electronically to health professionals through the telephone line. Any results falling outside of agreed parameters trigger an automatic alert for the appropriate response to be made.

Referring to Local Enhanced Services, the Chairman questioned how they were reviewed and how it was decided which services would be provided within an area.

Mr. Kilmurray advised that enhanced services plug a gap in essential services or deliver higher than specified standards, with the aim of helping the PCT to reduce demand on secondary care. There was a mechanism in place for contracting out to GPs and they were subject to a performance system.

In order to decide what is needed in an area, a whole raft of information was collected upon which to base a decision. Some services might be locally developed to meet local health needs or a piece of work may be commissioned.

Councillor Smith queried whether there were any planned changes to single practice GPs.

Mr. Kilmurray advised that as all GPs were involved in clinical governance there would be a desire to partner.

Following Mr. Kilmurray's attendance, the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Vince Taylor, Head of Strategic Economic Development, Sunderland Council to the meeting and invited him to respond to the questions from an economic development perspective.

*Question 1 – What does the term Health Inequalities mean to you?*

Mr. Taylor advised that there was a distinct difference between morbidity and mortality, the causes of such being very complicated. Lifestyle choices such as smoking, lack of physical activity and poor diet were contributory factors, however, these behaviours, although modifiable by the individual, were heavily influenced by socio economic position and the social environment.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Taylor explained that he worked within the Office of the Chief Executive Directorate and was responsible for the International Team which co-ordinates implementation of the City's International Strategy, the Area Co-ordination Team which develop Local Area Plans for the 5 Regeneration Areas in the City, as local interpretations of the Sunderland Strategy and Local Area Agreement and co-ordinate partnership responses to issues and opportunities contained within them.

The Sunderland Partnership Health Priority had a vision to ensure everyone in Sunderland will have the opportunity to live long, healthy, happy and independent lives. The Economic Masterplan for Sunderland included health considerations particularly with regard to healthy urban planning. Mr. Taylor stated that the Masterplan had identified key industries for growth in which there was a hope of encouraging new businesses to come to Sunderland and a high number of jobs created. Improvement in economic conditions in Sunderland would have a direct impact on the City's health.

Mr. Taylor referred to the importance of technological innovation and improvement in social care. The Council owned Telecare network was installed in 20,000 homes throughout the City.

*Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Taylor advised that the Council's Area Committees had moved into a new process of Local Area Plans based on a partnership model. Each Area Committee had a Local Area Plan and an investment budget. The primary aim of the service was to co-ordinate and enable Sunderland's corporate and partnership response to the social regeneration issues facing the City to endeavour to narrow the gap between the most deprived areas of the City and the rest of the City and Country as a whole.

Community Chest funding was social capital that encouraged social interaction.

The working neighbourhood fund was paid to Local Authorities and communities to help tackle worklessness and increasing skills and enterprise levels. Evidence showed that work could improve individuals' health. People on incapacity benefit and income support were helped to gain employment.

Local Multi Agency Problem Solving Groups (LMAPS) were in place as multi agency response groups to address local crime and disorder problems.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr. Taylor advised that success would be a reduction in mortality and morbidity which would take a long time.

In terms of Mr. Taylor's role, he advised that his aim was to increase prosperity within the City. However, given the current economic climate there would not be the luxury of new initiatives coming through.

The number of people in lower paid jobs was not out of line with the rest of Tyne and Wear, however, there were a lot of people in Sunderland that were not engaging in any type of employment. As a City centre, there were relatively few people who worked in it.

Following Mr. Taylor's attendance the facilitators and Members drew out key issues from the responses to the questions. A full list of the key issues identified by the Committee can be found at the end of these minutes.

The Chairman welcomed Neil Revely, Executive Director of Health, Housing and Adult Services, and invited him to respond to the four questions posed.

*Question 1 – What does the term Health Inequalities mean to you?*

Mr. Revely advised that the term meant unfairness, disadvantage and differences in opportunities. The Marmot Review concluded that wealth and health were inextricably linked.

Mr. Revely stated that on some occasions health inequalities would be a symptom not a cause. It was important to consider what could be done to minimise the impact in the short term and eradicate it in the long term.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Revely advised that in his statutory role as Director of Adult Social Services, a Joint Strategic Needs Assessment (including a Housing Needs Assessment) was carried out with the Director of Public Health. Mr. Revely felt that there was not enough impact assessment work being carried out; although some joint commissioning occurred with the PCT to this regard it tended to be more disease specific.

Mr. Revely recognised the need to do more in relation to impact assessments and advised that he would like to see more assessment at neighbourhood level.

*Questions 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Revely felt that there was not enough neighbourhood specific work, particularly in those areas perceived as 'disadvantaged'.

More in depth investigation was happening which could measure greatest need and where there was most input of services. Mr Revely stated that equality of access may not result in equality of outcomes. In order to achieve this, services would not be uniform across the City.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr Revely stated that he would want the highest ambitions for the City and to expect the best health outcomes in the world in the long term. In the short term very specific targets would be set in shorter time periods.

Targeting key groups of people could make a huge impact. For example the knock on effect of reducing trips and falls could be highly significant given the long term physical, psychological and social consequences of such preventable occurrences.

Councillors Shattock and M. Smith both cited examples of ward based experience with constituents who had problems with obtaining suitable housing. Housing was a key to the broader aspects of health, for example the correlation between warm homes and winter deaths. Mr Revely advised that the Directorate would be investing in thermal imaging technology to determine badly insulated homes. Consequently individual streets could be targeted.

The Chairman questioned what was being done to encourage people off benefits and into work.

Mr Revely advised that Working Families Tax Credit had gone a long way to helping people in the benefit trap.

Following Mr. Revely's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Canon Stephen Taylor, Chair of the Sunderland Partnership, to the Committee and invited him to respond to the questions.

*Question 1 – What does the term Health Inequalities mean to you?*

Referring to the Marmot report, Canon Taylor advised that in England the many people who were currently dying prematurely each year as a result of health inequalities, would otherwise have enjoyed in total between 1.3 and 2.5 million extra years of life. When surveyed, 66.2% of people in Sunderland reported that they felt they were healthy.

Approximately 5 years ago an analysis was undertaken of developing countries, those countries that targeted health inequalities as opposed to economic growth saw the greatest impact.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Canon Taylor advised that as a delivery partnership, the Healthy City partnership currently they only measured what the TPCT did as opposed to measuring impact, this was not as good as it could be. The capacity existed to achieve a fairer distribution of health but there needed to be better collaborative working to make change happen. The delivery plans were in place, however, joined up action to obtain activity had some way to go.

*Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Canon Taylor felt that neighbourhoods were not tackled effectively. Area Committees could act as an intelligence hub to identify hot spots in wards and consider the appropriate action.

He also felt that some schools were now like 'fortresses' as a result of the safeguarding agenda. Consequently groups and organisations that had an important message to deliver to young people around risk taking behaviour or health were barred from talking to them in the school setting.

Canon Taylor was extremely worried about the increase in alcohol consumption and associated anti social behaviour. He felt that instances of liver disease will be a huge problem in the future. Alcohol pricing was a contributory factor and Canon Taylor would favour local pricing policies to control this.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

The Local Area Agreement (LAA) set out the health targets which were among the worst in North East. He felt that as part of Community Leadership it was Councillors' duty to lead by example.

Following Canon Taylor's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Alan Patchett, Age Concern, to the Committee and invited him to respond to the four questions posed.

*Question 1 – What does the term health inequalities mean to you?*

Mr. Patchett stated that health inequalities were the differences in health between different sections of the population. Life expectancy was a big indicator but inequalities manifest themselves in many ways throughout Sunderland.

Mr. Patchett reminded the Committee that he represented the over 50 age group within the City. He stated that it appeared inequality grew as people got older, for example, there were instances where older people were denigrated by their GP when they presented with an illness by being told 'What do you expect at your age?'

Mr. Patchett advised that a postcode lottery is applicable in the provision of many healthcare services. The current NHS health checks that were being actively promoted were aimed at 40-74 year olds. While there may be a very good medical reason for the age bracket it looked like institutional inequality.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Patchett advised that Age Concern's mission statement was 'to promote the well being of all older people throughout the City of Sunderland, improve their quality of life and help them maintain independence'.

Health Impact Assessments were not used as the resources were not available.

Age Concern had an Involving Older People policy, which meant they involved and listened to older people and asked them what they wanted and needed to tailor services appropriately.

By working with the Older People's Partnership Board (OPPAG), 50+ forums and the World Health Organisation, Age Concern ensured that the interests of those aged 50 and over were empowered to address health issues.

*Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Patchett advised that his organisation was Citywide and delivered to a community of interest – older people – rather than a geographical location. They provided a number of services, including:-

- Information and advice, specifically in relation to helping people maximise their income – there was a recognised link to low income, poor health and low life expectancy.

- Social focus groups for people with mental health problems.

- Tea with Dorothy Group which provided support for gay, lesbian and transgender groups.

- Men's groups – older men were particularly hard to reach.

- Day and lunch clubs.

- Good neighbour promotion.

Mr. Patchett commented that nutrition was a major factor affecting the health of older people. He stated that a neighbourhood focus was good but care must be taken not to target only 'deprived areas' and ignore the rest which may lead to health inequality.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr. Patchett advised that a lot of god work had been carried out in Sunderland with regard to the 50+ population. These included the Healthy Ageing City Profile for WHO Healthy Ageing Network, the introduction of age friendly City self assessment, the 50+ Strategy and OPPAG.

Success would mean every individual having the opportunity to live a long, healthy, happy and fulfilling life with access to appropriate health interventions when they needed them.

This would be achieved by:-

- Involving and empowering people as well as informing and educating.

- Enable people to make choices by providing accessible and appropriate support services.

- Prevention was the key. There was a need to adopt a preventative approach – Age Concern aimed to work with 50-65 year olds to help them plan for the future by improving their health, building up social networks and activities and planning for their financial future so that when they retire they are in control of their own lives.

- Evidence exists to show there is a direct link to low income and poor health and this can be addressed by helping older people to maximise their income. From January 2009 to January 2010 Age Concern had helped 3,649 people aged 60+ to claim approximately £2.3 million of benefits and this has a major impact on their lifestyle and health.

- There was a need to stop being driven by central government targets but use those targets as a mechanism to engage people and communities to take charge of their own lives.

- Poor life expectancy and poor health starts in childhood and goes right through into adulthood and old age and therefore adopting a Life Course Approach, as recommended by the WHO could achieve the above.

- There are many determinants of health and the Life Course Approach would help to address all issues that affect a person's health and help prevent poor health.

- The VCS can play a major role in helping statutory partners to get to those 'hard to reach' communities and also deliver low level prevention services in the community.

Following Mr. Patchett's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Dr. Helen Paterson, Executive Director of Children's Services, to the Committee and invited her to respond to the four questions posed from a Children's Services perspective.

*Question 1 – What does the team Health Inequalities mean to you?*

Dr. Paterson advised that social class and social scale led to poorer outcomes in lower socio economic groups. She informed the Committee that children in lower social classes were twice as likely to die under the age of 15.

The Every Child Matters approach aims that every child, whatever their background or circumstance, to have the support they need to:-

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution;
- achieve economic well being;

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Dr. Paterson stated that the Local Authority's vision was to ensure young people receive the help and support they need to achieve their potential and get the best out of life.

Comparisons needed to be made with children in other parts of the Country.
A recently published national report indicated that for children living in a deprived area, 8% were likely to be obese, 9% would have a low birth rate and were 12% more likely to have an accident.

Child health inequality in Sunderland was being tackled in a number of ways: health improvement was well established as part of the Children and Young People's Plan

and the Child Poverty Strategy aimed to show a demonstrable reduction in child poverty via activities that stem from a number of work streams including worklessness.

The Children's Trust regularly challenged performance delivery.

*Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Dr. Paterson advised that there were newly commissioned obesity services which will target hot spots in wards, low income families and BME communities. Children's Centres were universal in offer, but targeted individual activities at a local level. A different range of partners worked at the children's centres.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Dr. Paterson stated that she would like to see young people to be more informed and educated in relation to risky behaviour. She would like to see better lifestyle opportunities for young people and access to medical and sport facilities that would improve mental well being.

She would hope that all youngsters would live the same length of time as the longest living in the rest of the world.

Councillor Smith questioned how children's centres monitored the people using the service to ensure they were targeting vulnerable and hard to reach groups.

Dr. Paterson advised that the TPCT tracked the live birth list. She stated that children's centres were excellent but parents needed to be willing to attend, accordingly much more outreach work was being carried out.

In response to Members' queries regarding health checks in school, Dr. Paterson advised that health and weight checks were carried out for reception and year 5 children along with the inoculation programme, however, there was not the same level of screening that used to take place within the actual school setting.

Following the questioning of Dr. Paterson, the facilitator and Members of the Committee drew out the key issues from the responses.

The Chairman welcomed Nonnie Crawford, Director of Public Health, to the Committee.

*Question 1 – What does the term Health Inequalities mean to you?*

Dr. Crawford advised that health inequalities meant the unfair and unnecessary differences among groups in Sunderland and between wards and neighbourhoods.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Dr. Crawford advised that a key focus would be to extend life expectancy and obtain fair access to services. Public Health has carried out a Health Impact Assessment that helped inform the prioritisation of health needs.

*Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and how do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Dr. Crawford stated that neighbourhoods were not specifically targeted as well as they could be. She advised that there were 65 natural neighbourhoods in the City and 9 were lower than the national average. It was important to engage with the people in the 9 neighbourhoods to determine what needed to be done differently.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Dr. Crawford showed Members a map of the region which indicated in green areas where the health inequalities gap had been reduced. Sunderland was red.

Dr. Crawford would like to see the two year life expectancy gap between men and women in the City close alongside the overall gap between Sunderland and England as a whole. A reduction in teenage pregnancy rates and fantastic breast feeding figures would also be extremely desirable.

In response to a question from Councillor Shattock, Dr. Crawford advised that she believed Gateshead had been more successful in closing the gap because over the last 5 years they had created a community driven vision for health and well being and a focus on neighbourhoods. Changes to practice based commissioning had been implemented in Gateshead which ensured all GPs worked together effectively. Gateshead Council's portfolio holder chaired the strategic committees on health.

Dr. Crawford stated that she would like to see a minimum price for alcohol and felt that Elected Members were in an ideal position to drive the proposal forward.

With regard to Area Committees, Dr. Crawford felt that resources should be utilised and delivered in the pockets where it was most needed as opposed to trying to distribute funding equally. It should be borne in mind that the defined area frameworks for the Council might not fit geographically with those of PCT.

There needed to be a corporate approach to tackling the problems; although there was a lot of good work taking place by organisations, they were often not working together.

Health Equity Audits were a key tool to embed evidence on equalities in planning commissioning and service delivery.

Following Dr. Crawford's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Margaret Elliot, Executive Director of Sunderland, Homecare Associates to the Committee and invited her to respond to the four questions posed from a provider perspective.

Ms. Elliot advised the Sunderland Homecare Associates was an employee owned social enterprise employing over 300 people.

*Question 1 – What does the term Health Inequalities mean to you?*

Ms. Elliot defined health inequalities in terms of specific morbidity conditions that would contribute to differences in the health of people such as obesity, alcohol and liver damage and smoking and lung cancer.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Ms. Elliot advised that the organisation had approximately 500 service users and impact assessments were carried on, for example, fall management. All review and assessments take into account any improvements.

*Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Ms. Elliot advised that the organisation worked in partnership with health and social care partners and Gentoo.

Ms. Elliot described some of the organisations Sunderland Homecare Associates worked with, including Sit n b Fit – which provided seated exercise for people with mobility problems. Such organisations needed to be encouraged.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Ms. Elliot advised that there must be definite measurable improvements. Forums for listening to people were extremely important.

Following Ms. Elliot's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman thanked Members and Officers for their attendance and their contribution and closed the meeting.

(Signed) P. WALKER,
Chairman.

**At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on WEDNESDAY, 10TH MARCH, 2010 at 5.30 p.m.**

**Present:-**

Councillor P. Walker in the Chair

Councillors A. Hall, Paul Maddison, Morrissey, Shattock and M. Smith and Snowdon.

**Also in Attendance:-**

| | | |
|---|---|---|
| Nonnie Crawford | - | Director of Public Health |
| Carol Harries | - | City Hospitals Sunderland NHS Foundation Trust |
| Claire Harrison | - | Sunderland City Council |
| Nigel Cummings | - | Sunderland City Council |
| Graham King | - | Sunderland City Council |
| Sharon Lowes | | Sunderland City Council |
| Councillor Tate | | |

**Apologies for Absence**

Apologies for absence were received on behalf of Councillors Fletcher, Leadbitter and Old.

**Minutes of the Last Meeting of the Committee held on 10th February, 2010**

1. RESOLVED that the minutes of the last meeting of the Committee held on 10th January, 2010 be confirmed and signed as a correct record.

**Declarations of Interest (including Whipping Declarations)**

There were no declarations of interest.

**Update on Policy Review Recommendations: 'Quality Commissioning for Vulnerable Adults'**

The Director of Health, Housing and Adult Services submitted a report (copy circulated) to update the Committee on progress against the policy review

recommendations, from the Quality Commissioning for Vulnerable Adults Policy Review 2007/08.

(For copy report – see original minutes)

Ms. Sharon Lowes, Strategic Commissioning Manager presented the report and provided progress against the remaining policy review recommendations in turn.

Councillor Paul Maddison enquired how many people worked in the call handling team and was advised by Ms. Lowes that there were eight full time equivalent members of staff.

2. RESOLVED that:-

i) In future the update report is received by the Committee on a bi annual basis, and

ii) Recommendation 13 - to consider ways of capturing the knowledge of the voluntary sector to inform judgements and decision-making, with appropriate systems is closed as Provider Forums had been reviewed and will be used as a mechanism for capturing knowledge from the voluntary and independent sectors, in order to improve future commissioning.

**Changes to the Annual Health Check**

The Chief Executive submitted a report (copy circulated) to consider changes to the Care Quality Commission's (CQC) new assessment processes.

(For copy report – see original minutes)

Mr. Cummings advised the Committee that the CQC can now receive information from committees throughout the year, and use it both in key assessments (such as decisions to register a service) and in ongoing monitoring of services throughout the year. The old system of a once-a-year commentary from scrutiny committees was being replaced by a system that will give a more continuous influence in assessments. It will also give a more regular feedback on what is being done with the information received.

The CQC were looking to invite committees to get involved in discussions about how to work together in the new assessment systems, (including systems for registering health and social care providers, and assessments of PCTs and councils as commissioners).

Councillor Paul Maddison requested a list of Members of the CQC and Mr. Cummings agreed to circulate the information.

3. RESOLVED that members note the report and look to invite the local representative of the Care Quality Commission to a future meeting of the committee.

**Policy Development and Review 2009/10 : Draft Report**

The Chief Executive submitted a report (copy circulated) to provide Members of the committee with the first draft report from the evidence gathered in relation to this year's policy review on health inequalities.

(For copy report – see original minutes)

Mr. Nigel Cummings, Scrutiny Officer presented the report and advised that the review document presented in detail the evidence, research and conclusions drawn throughout the review process and members were asked to comment on this for relevance, clarity and accuracy.

Mr Cummings advised that he had received a number of comments from the TPCT and Adult Services and would feed them into the final report.

The Chairman advised that a further meeting would be arranged with the Committee to firm up and agree the final recommendations.

The Chairman also stated that he would like to see more statistics at a neighbourhood level in the report in order to target areas within wards where inequality was most acute.

Councillor Paul Maddison referred to Newham Council's pilot project to help residents who would be financially worse off if their benefits ceased to get off benefits and into work by assisting them with their rent if necessary. He also noted that Newham were chosen to pilot universal free school meals for primary age children and he queried why they had taken such a groundbreaking approach.

Dr. Nonnie Crawford advised that Newham was taking a corporate approach to its bad health outcomes to accelerate improvement.

In response to a question from Councillor Shattock regarding what was meant by 'corporate approach', Dr. Crawford advised that this meant a clear recognition of the need for joint action by local authorities, their directorates and their partners.

Members congratulated Mr. Cummings on the excellent report.

4. RESOLVED that:-

i) that the Health and Wellbeing Scrutiny Committee provide comments on the draft report and that any agreed amendments are made, and

ii) that consideration is given to themes and issues for recommendations to be included in the policy review report by the Health and Wellbeing Scrutiny Committee, and

iii) that a final review report is presented to the Health and Wellbeing Scrutiny Committee at its April 2009 meeting.

**Work Programme 2009/10**

The Chief Executive submitted a report (copy circulated) to consider the current Work Programme for 2009/10 Council Year.

(For copy report – see original minutes).

Ms. Claire Harrison, Assistant Scrutiny Officer, presented the report.

The Committee were advised that future items to be included on the work programme were a report relating to the proposed changes to the laws governing powered mobility scooters and powered wheelchairs and a Clinical Governance report from City Hospitals.

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

**Forward Plan – Key Decisions for the Period 1st March – 30th June 2010**

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider those items on the Executive's Forward Plan for the period 1st March – 30th June which relate to the Health and Well-Being Scrutiny Committee.

(For copy report – see original minutes).

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

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

The Chairman thanked everyone for their attendance and closed the meeting.

(Signed) P. WALKER,
Chairman.

# HEALTH & WELLBEING SCRUTINY COMMITTEE

# 21st April 2010

## RESPONSE FROM THE SECRETARY OF STATE – RE: CHURCH VIEW MEDICAL PRACTICE

### REPORT OF THE CHIEF EXECUTIVE

**Strategic Priority : Healthy City**

### 1. Why has this report come to the Committee?

1.1 The report provides Members with the response from the Secretary of State for Health and the Independent Reconfiguration Panel on the Church View Medical Practice Integrated Care Pilot.

### 2. Background

2.1 The Health and Wellbeing Scrutiny Committee wrote to the Secretary of State on 17th November 2009 on the matter of the Church View Medical Practice care pilot and the rules surrounding exemptions for such pilot schemes.

### 3. Current position

3.1 The initial letter to the Secretary of State and the responses are attached for Members information. The Health and Wellbeing Scrutiny Committee's solicitor will provide a brief explanation of the implications of the responses for members information.

### 5 Recommendation

5.1 That Members note the responses and comment on issues arising from the content.

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**Contact Officer:** Nigel Cummings, Scrutiny Officer: 0191 561 1006: nigel.cummings@sunderland.gov.uk

Secretary of State
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Date: 17th November 2009

Rt Hon Andy Burnham MP,

On behalf of the Health and Well-Being Scrutiny Committee of Sunderland City Council, I write to exercise the power of the Committee to refer an issue to the Secretary of State as outlined in regulation 4.5 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

The issue surrounds the Integrated Care Pilot Programme introduced by the Department of Health in 2008. The aim of the pilot schemes under this programme was to test and evaluate new ways in which PCT's could commission more integrated services. The programme invited innovative applications from prospective integrated care pilot sites and there were over 100 applications.

The proposed pilot scheme was responded to within Sunderland City Council's area by City Hospitals Sunderland NHS Foundation Trust (City Hospitals) and Church View Medical Practice (Church View). Church View is a GP Practice in Sunderland and, pursuant to the pilot scheme has been examined by the Cooperation and Competition Panel under the principles and rules of Cooperation and Competition. The proposal is one of Sixteen Integrated Care Organisations (ICO) pilot projects commissioned by the Department of Health. The Cooperation and Competition Panel has found that the proposed merger is consistent with the principles and rules and recommends that it be allowed to proceed.

In summary the council has the following concerns:

i. In respect of the requirement to consult when an exemption is claimed by an NHS body for a pilot scheme under regulation 4(2)(b) there is currently no obligation to notify the local authority of the exercising of this exemption and this appears to be a gap in the regulations.

ii. The OSC are concerned that there needs to be greater clarity around what constitutes a pilot scheme and the opportunity to provide comment on what a pilot scheme is about. In this instance the pilot scheme is to run for 3 years and involves the permanent features such as the transfer of staff, which effectively negates the opportunity to extend the pilot and so it becomes a fait accompli.

iii. The OSC consider that the proposal is in effect a substantial development or variation of health services in the OSC's area which links to the issue of what is or is not defined as a substantial development or variation in health services.

iv. There are also a number of features surrounding the pilot that the OSC has concerns over. These concerns are more fully set out below for your information.

The Cooperation and Competition Panels' findings and recommendations are based on the conclusion that the proposed merger will not impose any significant costs on patients or taxpayers by reducing the scope for patient choice or competition or undermining the primacy of GP gatekeeper function, and will allow the benefits that might be realised from an integrated care organisation to be explored. Church View and City Hospitals informed the Cooperation and Competition Panel that the merger would benefit patients by removing organisational and contractual barriers and would lead to an improvement in patient care. The clinical integration and improved communication between primary and secondary care would help to prevent avoidable admissions, facilitate discharge and help prevent the admission in their target population. City Hospitals and Church View both consider that the merger will allow them to explore new models of working together to deliver improved outcomes through active management of patients with long term conditions.

The application for the pilot scheme has come to the attention of Sunderland City Council's Health and Well-being Scrutiny Committee (the OSC) following representations from Dr Roger Ford who is the Secretary of Sunderland's Local Medical Committee.

Dr Ford outlined a number of concerns regarding, in particular, the consultation upon and the commissioning of this service and raised his concerns with the OSC. Dr Ford states that there had been no consultation with GP's, their elected representatives in the city, the public, patients of the practice or members of the local health community, and as a consequence there is no clarity around the purpose of the pilot. A copy of Dr Ford's letter dated 22 June 2009 copied to the OSC is attached.

The proposal was brought before the OSC on the 14th October 2009 via a presentation from Dr Helen Groom on behalf of both the City Hospital and Church View.

At that meeting, members of the OSC questioned the legality of the lack of consultation in respect of the pilot scheme. The initial concerns were that the OSC's knowledge of the proposals under the pilot scheme only came before the OSC once the pilot scheme had been successfully considered by the Cooperation and Competition Panel, some twelve months after the initial application.

Given the proposal is a vertical integration of a GP Practice from the community into a hospital setting, concerns were raised due to the fact that this was potentially a substantial development or variation in the provision of health services in the area of this local authority, upon which the OSC had not been consulted.

The OSC have looked at the legal basis for the decision by City Hospitals and Church View not to consult. The legal basis appears to be pursuant to the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations Act 2002 (the Regulations) together with the definition of a pilot scheme, for primary care purposes, under the National Health Service (Primary Care) Act 1997 (the Act). The Regulations at Regulation 4(2)(b) allow for any proposal for a pilot scheme, within the meaning of Section 4 of the 1997 Act to be exempt from the requirement to consult with an Overview and Scrutiny Committee pursuant to Regulation 4(1).

On 15th October 2009 the OSC wrote directly to the Head of the Primary Care Commissioning Team for Sunderland Teaching Primary Care Trust and requested that they confirm upon what statutory basis and provisions they had relied in respect of not consulting with the OSC, (copy attached).

By letter dated 22nd October 2009, the Head of Primary Care Commissioning for Sunderland Teaching Primary Care Trust responded and confirmed that indeed, they had relied upon the pilot scheme exemption under the Regulation 4 including submitting the proposals for the pilot scheme to the integrated care pilot lead from the Department of Health who subsequently confirmed that there was no formal requirement to consult with the OSC, (copy attached).

However, the OSC have significant concerns for the following reasons.

On the 8th April 2009, a paper, substantial development and variations in NHS service, was placed before the OSC by Liz Allen, Head of Public Involvement - Patient, User, Carer and Public Involvement Team for NHS South of Tyne and Wear, the report was a joint report of the Chief Executives of Sunderland Teaching Primary Care Trust, City Hospitals Foundation Trust, the Northumberland Tyne and Wear Trust and North East Ambulance Services, (copy attached).

That Report confirmed an agreement as to what was or was not to be considered as a substantial developments or substantial variations in local NHS services in terms of consulting with the OSC.

That list included the following:

- Method of delivery – altering the way a service is delivered may be a substantial change, for example, moving a particular service into the community rather than being entirely hospital based

- Issues to be considered as controversial to local people, e.g. where historically services have been provided in a particular way or at a particular location.

The pilot scheme currently being proposed, in the view of the OSC, falls into either of those two categories. Despite the fact that it is a pilot scheme, the OSC are informed that the pilot scheme will last for over three years and includes

permanent features such as the transfer of staff. In addition, according to the local medical committee, not only have the OSC not been consulted upon the proposal, neither has any consultation taken place with the public, the patients of the practice or indeed, any members of the local health community.

The OSC accept that the current legislative provisions under the Regulations provide that, per se, that pilot schemes as defined by section 4 of the Act are exempt from the requirement for consultation.

This letter is being sent to the Secretary of State to raise the OSC's concerns regarding the lack of consultation in this matter notwithstanding that the proposal is a pilot scheme. The OSC interpret the Regulations to state that if it considers any proposal to be a proposal for the substantial development or variation of the health services in the area of the OSC, then it may report those concerns to the Secretary of State.

The Regulations do not state whether that proposal is required to be a pilot scheme proposal or any other form of proposal. It simply states that it is a proposal and therefore, the OSC ask that the Secretary of State consider the substance of proposed variation in health services through this pilot scheme and the implications under this proposal, rather than the label of a pilot scheme and revert back to the OSC.

For information the committee report and the comments of Dr Ford are enclosed. If the Secretary of State requires further information we are happy to provide supporting documentation as required, please contact Nigel Cummings Scrutiny Officer Tel; 0191 561 1006 or via email Nigel.cummings@sunderland.gov.uk

Yours sincerely,

Cllr Peter Walker
Chair of the Health and Wellbeing Scrutiny Committee

*From the Rt Hon Andy Burnham MP*
*Secretary of State for Health*

Department of Health

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

*Tel: 020 7210 3000*

POC1_489603

Councillor Peter Walker
Chair
Health and Wellbeing Scrutiny Committee
Sunderland City Council
PO Box 100
Civic Centre
Sunderland
SR2 7DN

15 MAR 2010

Dear Peter,

**REFERRAL BY SUNDERLAND CITY COUNCIL HEALTH AND WELLBEING SCRUTINY COMMITTEE – CHURCH VIEW MEDICAL PRACTICE INTEGRATED CARE PILOT**

Thank you for your letter of 17 November 2009 formally referring proposals about the Church View Medical Practice integrated care pilot in Sunderland.

As you know, I asked the Independent Reconfiguration Panel (IRP) to undertake an initial assessment of the referral.

The Panel has now completed its initial assessment and shared its advice with me.

A copy of the Panel's advice is appended to this letter and will be published on their website on 15 March 2010 (www.irpanel.org.uk)

In order to make a decision on this matter, I have considered the concerns raised by your Committee and have taken into account the IRP's initial advice on the matter.

**Grounds for referral by your Committee**

In your letter of 17 November 2009, you essentially raised four concerns:

- in respect of the requirement to consult when an exemption is claimed by an NHS body fir a pilot scheme under regulation 4(2)(b) there is currently no obligation to notify the local authority of the exercising of this exemption and this appears to be a gap in the regulations;

- the OSC are concerned that there needs to be a greater clarity around what constitutes a pilot scheme and the opportunity to provide comment on what a pilot scheme is about. In this instance, the pilot scheme is to run for three years and

involves the permanent features such as the transfer of staff, which effectively negates the opportunity to extend the pilot and so it becomes a fait accompli;

- the OSC consider that the proposal is in effect a substantial development or variation of health services in the OSC's area which links to the issue of what is or is not defined as a substantial development or variation in health services; and

- concerns surrounding the pilot.

**Local reassurance**

As the IRP points out in its advice, the Integrated Care Pilot Programme prospectus and accompanying evidence base document emphasise that integrated care *"can be an effective way of delivering health care, providing opportunities to break down barriers between primary and secondary care as well as health and social care"*.

The IRP agrees with this view and supports the pilot programme as an opportunity to test innovative models for service delivery aimed at improving the quality of patient care. The CVMP/CHS pilot has undergone a rigorous and detailed selection process within the Department of Health and has also been investigated and approved by the NHS Co-operation and Competition Panel. I concur with this.

**Integration**

Better integration has the potential to deliver some of the key objectives for improving health and care services, including better quality of care, greater personalisation, a shift towards health promotion and reduced inequalities.

The programme of Integrated Care Pilots provides an opportunity for pilots, their partners and the community more widely to use their 'on the ground' knowledge of local populations to design services that are flexible, personalised and seamless.

The current 16 pilots are all being evaluated against a set of criteria including impact on health outcomes, improved quality of care, service user satisfaction, and effective relationships and systems.

Better integration has grown in profile in recent times and the evaluation process will contribute to a robust, evidence base on the impact of evaluation.

I hope that your Committee can continue to support the pilot in its objectives of improving services for patients. The pilot has been making good progress on agreeing terms and the contract is scheduled to novate (finalising the new arrangements) on 1 April 2010.

**Conclusion**

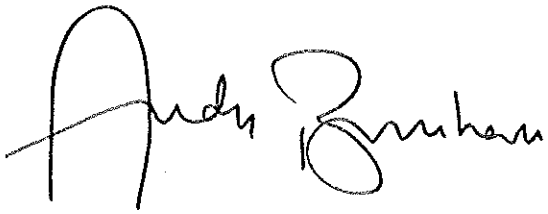
I am satisfied the IRP's advice is in the interests of the local health service and I hope that your Committee will continue to work with local NHS partners in the best interests of patients.

Department of Health

I am copying this letter to:

David Stout, Acting Chief Executive, NHS North East
Dr Peter Barrett, Chair, IRP
Chris Mullin MP

Yours sincerely,



**ANDY BURNHAM**

AG 09.03

*Kierran Cross*
*First Floor*
*11 Strand*
*London*
*WC2N 5HR*

The Rt Hon Andrew Burnham MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

15 February 2010

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Referral by Sunderland City Council Health and Wellbeing Scrutiny Committee**
**Church View Integrated Care Pilot**

Thank you for forwarding copies of the referral letters and supporting documentation from Cllr Peter Walker, Chair of the Health and Wellbeing Scrutiny Committee (the OSC), Sunderland City Council. NHS North East provided initial assessment information. We requested and received supplementary information from the Department of Health. A list of all the documents considered in the initial assessment is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. The IRP considers each referral on its merits and its advice in this case is set out below. **It concludes that this referral is not suitable for full review.**

**Background**
The Integrated Care Pilot Programme was instigated by the Department of Health in October 2008 to test and evaluate new ways in which PCTs could commission more integrated services. The programme invited applications from prospective pilot sites and received more than 100 applications.

The Church View Medical Practice (CVMP) and City Hospitals Sunderland NHS Foundation Trust (CHS) applied to take part in the programme. Under the pilot, CVMP and CHS will work together as an integrated organisation, collaborating in partnership with the PCT provider arm, social services and the Patient Participation Group. The pilot involves a variation to the Primary Medical Services (PMS) contract held by CVMP. CVMP and CHS will merge and CVMP's staff and the PMS contract will be transferred to CHS.
The pilot aims to prevent avoidable hospital admissions through early intervention management for individuals with emerging risk and intensive case management for very high-risk individuals. It will focus initially on around 50-150 patients from the practice population with long-term conditions known to be at high risk of hospital admission.

CVMP and CHS were notified in March 2009 that their application had been chosen as one of sixteen national pilots but were advised that they would need to make a formal submission to the NHS Co-operation and Competition Panel (CCP) for "formal advice". The CCP formally announced its investigation on 12 June 2009. Sunderland Local Medical Committee wrote to the CCP on 22 June 2009 to express its concerns with the pilot, copying its letter to the chair of the OSC. Sunderland Teaching PCT wrote to the CCP on 25 June 2009 to outline its views on the pilot. The PCT commented that it *"has given support to the submission by CHS and CVMP for a pilot application but has not consulted regarding the pilot proposal. A change in contract holder ie novation is not a matter on which the PCT would routinely consult as these are implemented through a routine internal process and would not lead to any major service change for patients"*. The CCP examined the proposal and, in its report of August 2009, found the merger to be consistent with its Principles and Rules and recommended that it be allowed to proceed.

Following a meeting of the OSC, the committee scrutiny officer wrote to Sunderland Teaching PCT on 15 October 2009 raising concerns about the process for consultation on substantial developments and variations and seeking clarification as to why no consultation had been undertaken with the OSC concerning the pilot scheme. The PCT responded in a letter of 17 November 2009 that it had determined *"that as this is a 'pilot', and not a substantial development or variation of health services (the pilot is proposing to affect approximately 50 people which is less than 1% of the Practice population, list size 6300), it is exempt from the statutory duty to consult…."*. Further, the letter quoted paragraph 4(2)(b) of the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002 which the PCT considered provided an exemption from the requirement to consult with overview and scrutiny committees in respect of any proposal for a pilot scheme within the meaning of section 4 of the NHS (Primary Care) Act 1997.

**Basis for referral**

The OSC's referral letter of 17 November 2009 states that referral is made in exercise of the power outlined in Regulation 4.5 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

The OSC summarises *"the following concerns:*

*i* *In respect of the requirement to consult when an exemption is claimed by an NHS body for a pilot scheme under regulation 4(2)(b) there is currently no obligation to notify the local authority of the exercising of this exemption and this appears to be a gap in the regulations.*

*ii* *The OSC are concerned that there needs to be greater clarity around what constitutes a pilot scheme and the opportunity to provide comment on what a pilot scheme is about. In this instance the pilot scheme is to run for 3 years and involves the permanent features such as the transfer of staff, which effectively negates the opportunity to extend the pilot and so it becomes a fait accompli.*

*iii* *The OSC consider that the proposal is in effect a substantial development or variation of health services on the OSC's area which links to the issue of what is or is not defined as a substantial development or variation in health services.*

*iv* *There are also a number of features surrounding the pilot that the OSC has concerns over."*

The concerns at iv above include:

- the role of the GP as "gatekeeper" to NHS secondary care
- the potential effect of changes to employment contracts for staff at CVMP
- the lack of consultation with the OSC on the basis that proposals for pilot schemes are exempted from the requirement to consult with overview and scrutiny committees
- that irrespective of any exemption to consult on pilots, the proposed scheme represents a substantial development or variation and as such, the OSC should have been consulted
- lack of consultation with the public, patients of the practice, and other members of the local health community

**IRP View**

With regard to the concerns raised by the OSC, the Panel notes that:

- legal advice from the Department of Health's solicitors confirms that:
    - paragraph 4(2)(b) of the 2002 Regulations was revoked in 2006
    - the NHS (Primary Care) Act 1997 has also been revoked
- the Department of Health has also confirmed that:
    - applications to take part in the Integrated Care Pilot Programme, including the CVMP pilot, come within the statutory framework of the NHS Act 2006
    - information to potential applicants to the programme was contained in *Integrated Care Pilot Programme: Prospectus for potential pilots,* issued by the Department in October 2008
- a protocol for determining what constitutes a substantial variation or development is in place between the OSC and the local NHS
- the CCP's report on the proposed merger of CVMP and CHS explicitly considered the GP gatekeeper role and concluded that the function would be protected subsequent to the merger by a number of factors, including the professional obligations of GPs to act in the best interests of patients and other measures to protect patient choice that would be put in place
- the need to ensure that all practice staff receive adequate HR support to explain the changes and the effect it would have on their employment rights is recognised in the pilot application: the Department of Health's response of 31 March 2009 highlights potential workforce implications and stresses that applicants must be aware of and understand compliance with current DH workforce policy, particularly in relation to the transfer of staff
- since paragraph 4(2)(b) of the 2002 Regulations was revoked in 2006, at the time the pilot scheme was being developed no exemption to consult with OSCs on pilot schemes existed
- as no exemption to consultation existed, whether or not the scheme was deemed to be substantial should have been a matter for consideration against the agreed protocol along with consideration of any further action required
- the pilot application states that CVMP has an active patient participation group that has always been involved with new developments with the practice and that the group supports the proposed pilot

**Conclusion**

The Integrated Care Pilot Programme prospectus and accompanying evidence base document emphasise that integrated care *"can be an effective way of delivering health care, providing opportunities to break down barriers between primary and secondary care as well as health and social care"*. The IRP agrees with this view and supports the pilot programme as an opportunity to test innovative models for service delivery aimed at improving the quality of patient care. The CVMP/CHS pilot has undergone a rigorous and detailed selection process within the Department of Health and has also been investigated and approved by the NHS Co-operation and Competition Panel.

It is clear from the documentary evidence supplied to the IRP that widespread confusion existed about paragraph 4(2)(b) of the 2002 Regulations which previously provided an exemption from the duty to consult OSCs on proposals for pilot schemes but which was revoked in 2006. At the time the application was made to take part in the Integrated Care Pilot Programme no exemption from the duty to consult OSCs on substantial developments or variations existed for pilot schemes. Neither the OSC nor the local NHS appear to have been aware of this change in the regulations.

The IRP appreciates that a proposal of this nature, including the transfer or novation of a PMS contract from a GP practice to a foundation trust, may be a matter of some local interest and that a scrutiny committee may wish to consider whether such a proposal represents a substantial development or variation in accordance with its agreed protocol. It is encouraging that a protocol for determining what constitutes a substantial development or variation is in place. The effective operation of the protocol is, however, dependent on a commitment to early involvement and the appropriate exchange of relevant information.

Misunderstanding about the duty to consult on pilot schemes notwithstanding, information about the pilot has been made available to the IRP that directly addresses the OSC's concerns and could usefully have been made available to the OSC. The IRP considers that, had the OSC been more involved at earlier stage and an explanation of the purpose of the pilot provided, the referral of this matter could have been avoided.

**Further action**

The IRP advises that:

1 The pilot should proceed in accordance with the requirements and systems for evaluation set out by the DH Integrated Care Pilot Programme.

2 The local NHS should clarify any outstanding queries that the OSC may have regarding the operation of the pilot – including, if required, arrangements for the transfer of staff employment and arrangements following the conclusion of the pilot period.

3 The OSC, having received any further information it requests, should consider how it wishes to proceed in line with the options for further action outlined in the protocol.

4 For the benefit of the NHS, OSCs and other interested bodies, the Department of Health should take steps to communicate the current legal position regarding consultation with OSCs and the status of pilot schemes.

5 DH guidance on the scrutiny of health services is out-of-date and under revision. The revised guidance is an opportunity to clarify some of the issues raised by this referral and to promulgate useful messages – including the benefits of the early involvement of local people in developing proposals for change and the value of a local protocol to determine what constitutes a substantial development or variation.

The IRP considers that this matter can be resolved locally and is not suitable for full review.

Yours sincerely

Dr Peter Barrett
Chair, IRP

# HEALTH & WELLBEING SCRUTINY COMMITTEE

# 21st April 2010

## SUNDERLAND LOCAL INVOLVEMENT NETWORK

### REPORT OF SUNDERLAND LINk

### Strategic Priority : Healthy City

### 1. Why has this report come to the Committee?

1.1 The presentation will provide Members with an overview of the work of the Sunderland Local Involvement Network (LINk) and provides the committee with the opportunity to look at how the Sunderland LINk compliments the work of the council and the scrutiny function.

1.2 The work of the Committee in delivering its work programme will support the Council in achieving its Strategic Priority of a Healthy City, support delivery of the Healthy City theme of the Local Area Agreement, and help the Council achieve Corporate Improvement Objectives CIO1 (delivering customer focussed services) and C104 (improving partnership working to deliver 'One City').

### 2. Background

2.1 The Health and Wellbeing Scrutiny Committee has invited Sunderland Local Involvement Network to attend the April 2010 Scrutiny Committee meeting to provide a brief presentation as to the work undertaken by the LINk during the year.

### 3. Current position

3.1 LINks were created by a law passed by Parliament - the Local Government and Public Involvement in Health Act 2007 - which sets out their legal duties and powers. In addition, Government has issued Regulations and Directions describing the detail of LINk activities which have the force of law and must be complied with. This provides LINks with a considerable authority to work directly with the NHS and Local Authority on behalf of the local community. The legislation creating LINks also abolished Patients Forums across England on 31st March 2008.

3.2 The presentation outlines the work that Sunderland LINk has been involved with during the previous year as well as identifying some of the more specific issues dealt with.

## 4. Conclusion

4.1 The presentation will provide members with an overview of the role and work of the Sunderland LINk.

## 5 Recommendation

5.1 That Members consider and comment on the presentation made by the Sunderland LINk.

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**Contact Officer:** Nigel Cummings, Scrutiny Officer: 0191 561 1006: nigel.cummings@sunderland.gov.uk

# Sunderland Local Involvement Network (LINk)


LINk Sunderland

Sunderland Local Involvement Network is hosted by Age Concern Sunderland

# The Vision for LINk is:-

- *"To help create a local system where every section of the community, has the opportunity to say what they want from local care services, with the certainty that the people who plan and run them will listen and respond."* (Local Government and Public Involvement Act - October 2007)

# Intention of LINks

- Create a stronger more independent voice
- Broaden representation
- Long term provide a  single approach to public involvement in Health and Social Care service improvement and development
- Future – may involve more services

# Aims & Expectations

- Health & Social Care Services have an opportunity to improve when local people are more involved in planning those services

- Sunderland LINk will recruit and empower members of the public and groups to evaluate, view and report on local services – feed into Quality Accounts

# Who

Anyone, Individuals, members of groups or organisations

## How you can be involved

On an ad-hoc basis – issue specific participants

or

Members – people who give regular commitment to help
Enter and View roles – talking to service users.
Core group – Management responsibilities

# LINk Model

Specialist Task / Sub Groups

Publicity Sub group

Registered LINk Membership

Wider population

LINk CORE GROUP

Wider population

H o s t

COMMISSIONERS and SERVICE PROVIDERS

Finance Sub group

LINk Sunderland

Sunderland Local Involvement Network is hosted by Age Concern Sunderland

**ENGAGEMENT**
LINk engages with community & receives feedback about health & social care

**FEEDBACK**
outcomes to community

**LINk OUTCOMES**

**ANALYSIS**
LINk analyses feedback & identifies trends & priorities which form basis of work programme.
LINk may make visit to validate feedback

**SERVICE CHANGE OR IMPROVEMENT**


**ACTION**
LINk writes reports & recommendations based on analysis & sends to Commissioners

**SYSTEM RESPONSE**
Commissioners respond to LINk within 20 working days detailing action to be taken & discuss with Provider changes to be made

# What we have been doing so far

- Carrying out surveys for LINk
- For Health and Well Being Review Committee
- Formulating work plans
- Publicity strategy

Your Health

Your Say

Your Sunderland LINk

All publicity will have this “brand”

- Talking to groups and organisations about issues
- Gathering people's views on highlighted issues
- Asked providers and Commissioners about some issues raised.

# Specific Issues identified

- Vulnerable patients not attending appts
- Patients not attending appts.
- Information on GP's Websites
- Monitoring of home care services
- Smokers at city hospitals
- New Commissioning arrangements for district nursing services.
- Discharge process from hospital

- Annual conference in February
- Confirmed issues already raised
- Raised further issues for Mental Health services
- Services for people with disabilities
- Enter and view training has raised additional issues

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**Health and Wellbeing Scrutiny Committee**

**21st April 2010**

**Performance Report Quarter 3 (April – December 2009)**

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

## 1.0 Purpose of the report

1.1 The purpose of this report is to provide Health and Wellbeing Scrutiny Committee with a performance update relating to the period April to December 2010. This quarter the report includes:

- Progress in relation to the LAA targets and other national indicators.
- Progress in relation to the Home Care Provision and Dementia Care Policy Review Recommendations.
- Results of the annual budget consultation which took place during October/November 2009

## 2.0 Background

2.1 Members will recall that a new national 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 are a key consideration in CAA in terms of the extent to which the partnership is improving outcomes for local people.

2.2 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. The first results were reported on the Oneplace website (www.oneplace.direct.gov.uk) on 9 December 2009. Health and Wellbeing Scrutiny Committee considered the findings of the draft Area assessment report in January 2010.

2.3 Members will recall from previous performance reports that the CAA lead plans to adopt a Risk Assessment Matrix which will be the primary tool against which the Sunderland Partnership will be assessed. The Matrix will incorporate those issues that were identified in the first year of the CAA area assessment as having the most potential to become red flags and green flags. These are;

2.4 Once the Risk Assessment Matrix has been agreed, the CAA Lead will use it to monitor progress against the agreed performance trajectory (up until the end of September 2010) for each issue to arrive at his final area assessment judgement for 2010. Progress will be monitored through the Council and the Sunderland Partnership's performance management and reporting arrangements. As part of ongoing improvement planning the Sunderland Partnership's Delivery Plans have

been refreshed to ensure that the work programme is targeting the right issues, and outcomes can be demonstrated, minimising the risk of areas for improvement becoming red flags in 2010. These Delivery Plans were presented to Scrutiny committees in February 2010.

2.5 The annual budget consultation took place during October/November 2009. The consultation took the form of a survey followed by participatory workshops which were held across Sunderland with Community Spirit panel members and representatives from the voluntary and community sector. The purpose of the workshops was to prioritise approaches to addressing the budget priorities that had been drawn from the survey results and also provide attendees with:

- A better understanding of the issues that have to be addressed in the budget setting process and information about the budget priorities
- An opportunity to hear the viewpoints of others when making judgements about budget priorities

2.6 The findings helped to inform the Council Revenue Budget for 2010/2011 which was approved on 3 March at a meeting of the full Council. A summary of how resources will be directed to the top priorities identified in relation to health and wellbeing can be found in section 3

2.7 As part of the development of Scrutiny particularly in terms of strengthening performance managements 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 both as part of CAA requirements and future partnership working. Progress in relation to the Home Care Provision and Dementia Care Policy Reviews are attached as ***Appendix 1.***

***Appendix 2*** provides an update of the position for relevant national indicators and also the local performance measures, which are used by CQC to judge the delivery of adult social care. This includes the results of the former CSCI Performance Assessment Framework (PAF) indicators within Adult Services.

## 3.0 Findings

## 3.1 Performance

3.1.1 In relation to Health and Wellbeing nine national indicators are priorities identified in the LAA. An update is available in relation to 3 Nis in relation to the period April to December 2009. An overview of performance can be found in the following table.

| Ref | Description | 2008/09 Outturn | Latest Update | Trend | Target 2009/10 | On Target |
|---|---|---|---|---|---|---|
| NI 130 | Social care clients receiving Self Directed Support | 0.06% | 6.73% | ▲ | 8.5% | ✓ |
| NI 136 | People supported to live independently through social services (all adults) | 3124.19 | 2865.2 | ▼ | 3415 | ✘ |
| NI 139 | People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently | 35.5% | n/a | n/a | Next target 2010/11 | n/a |
| NI 120f | All-age all cause mortality rate - female | 562 | 578.7 | ▼ | 546 | ✘ |
| NI 120m | All-age all cause mortality rate - Male | 777 | 851 | ▼ | 748 | ✘ |
| NI 119 | Self-reported measure of people's overall health and wellbeing | 66.2 | n/a | n/a | n/a | n/a |
| NI 123 | 16+ current smoking rate prevalence | 1100 | 749.8 | ▼ | 1437 | ✘ |
| NI 39 | Rate of Hospital Admissions per 100,000 for Alcohol Related Harm | 2378 | 2636 | ▼ | 2207 | ✘ |
| NI 119 | Self-reported measure of people's overall health and wellbeing | 66.2 | n/a | n/a | Next target 2010/11 | n/a |

3.1.2 Part of the local performance measures, which are used by the Care Quality Commission to judge the delivery of adult social care, includes the results of the former Performance Assessment Framework (PAF) indicators within Adult Services. An update against all relevant PAF (now local performance) indicators for the 12 months ending March and December 2009 (or the latest available position) can be found in Appendix 1.

3.1.3 Performance against the National and local indicators remained mixed during 2009/2010 and a more detailed analysis is presented below. Key risks and related improvement activity are described in the following sections.

**3.1.4 How healthy is the city and are citizen's health & emotional well being improving?**

**NI120 All age all cause mortality rate**

Latest performance relates to 2006 – 2008 pooled rates and mortality rates have increased since the previous reporting period and are not on schedule to achieve the 2009/10 target of 546 for females and 748 for males per 100,000 population

A number of Masterclasses are being held as part of the Bakers Dozen work by the Health Inequalities National Support team. The outcomes of these masterclasses will be incorporated into the partnership's Delivery Plans as part of ongoing action planning at the end of March / early April along with relevant outputs when the work of the national team is completed.

In addition a programme of Health Checks is being implemented - 8348 checks are programmed for 2009/10. Cardiovascular risk programme process model has also been developed to form the basis for commissioning requirements during 2010/11 Target outputs from this programme will be available when commissioning has been undertaken.

The city's Wellness Service works to improve individual's health and well-being through the provision of physical activity opportunities, lifestyle advice and education. Working with the Teaching Primary Care Trust (TPCT) and the Third Sector, the Wellness Service actively targets and engages with people who do not yet have physically active lifestyles to provide health information, advice and active support to change their lifestyles to help reduce their risk or maintenance of chronic or lifestyle diseases. The outcome will clearly affect a range of health improvements (including those that are National Indicators) including increasing life expectancy; preventing heart disease and stroke; reducing blood pressure and obesity; and improving mental health and well-being. In 2008, the Council and PCT were awarded Beacon status for their work in reducing health inequalities in the city's neighbourhoods and its willingness to innovate. This provided the city to deliver a number of learning exchanges between Councils and PCTs to help them and the city identify best practise.

In order to do this, the Wellness Service has developed a range of preventative services, targeted interventions and specialist support services at a local level, including within its 7 Wellness Centres in the city:

- *Prevention - Community Wellness Programme* via 8 Community Wellness venues across the city designed to attract residents who do not want to participate in main Wellness Centres. There were over 10,000 attendances to these venues with specialist sessions with CWP Wellness Coaches. This includes specialist support for a small number of people that have significant learning disabilities at one of these wellness venues, which has proved to be popular and successful;
- *Prevention - Community Classes for those over 50:* Specific classes for this age group started in Sep-08, and are specifically designed to improve mobility, balance and coordination to decrease likelihood of falls and increase individuals' ability to continue to live independently. There are currently 192 engaged on the Programme, which includes "Sit N B Fit" classes;
- *Prevention – Wellness…it's a Walk in the Park:* Wellness Service has recently marketed a citywide marketing programme, including marked routes across each of the 5 areas of the city. Routes in the city's parks will typically be 1 – 3 miles in distance, and be suitable for people with life-limiting conditions;
- *Targeted Intervention - Sunderland Exercise Referral & Weight Management Programme* operates from Wellness Centres and community venues, providing greater choice of activities for patients. The Programme is a physical activity referral system enabling health professionals to recommend a course of exercise for patients with a variety of medical conditions. It ensures people at risk are identified sooner and referred to the appropriate health, diet and physical activity advice that will make a difference to their long term well-being. Since April 2009, throughput exceeded its targets in terms of number of people starting 15 week programme (1,987), including GP surgery referrals (over 125), with referrals received from all city's GP practices;
- *Targeted Intervention – Workforce Health & Wellbeing Project* is a research pilot designed to test the effectiveness of the workplace by targeting employees working within Sunderland and Gateshead Council who fall into the category of being lower paid employees who also live in areas of higher deprivation. To date 1584 employees have been contacted to take part in the programme, 333 have received a NHS health check with referral mechanisms where relevant for

exercise, alcohol services, smoking and weight management. The project ends in October and a business case is currently being drafted to potentially continue the project and involve more employers in Sunderland. A further project includes Wellness on 2 Wheels Summer Cycling Programme, with over 50 Council employees accessing one or more of these organized bike rides.

- *Targeted Intervention – Supporting People Wellness Project* works with a small number of particularly vulnerable individuals residing with the Salvation Army to improve their health and well-being, including membership of the Wellness Centre to encourage people to increase their activity levels which will not only help their health and well-being, but their self-esteem, confidence and social skills and promote community cohesion as well;
- *Specialist Service – Specialist Weight Management Service:* This Programme, for individuals identified by GPs as clinically obese, delivered in partnership between the Wellness Service, TPCT and City Hospitals. A multi-disciplinary team based at the Aquatic Centre consisted of a psychologist, dietician and exercise practitioner. The Service provides a traditional clinical programme with access to a leisure facility.

**NI123 16+ current smoking rate prevalence**

Latest performance (April to December 2009) is 749.8 smoking quitters per 100,000 population. Performance has declined compared to 2008/09 and currently not on schedule to meet the 2009/10 target of 1437 quitters per 100,000 head of population. 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;
- Development of the pregnancy and training roles and a focus on key priority groups e.g. routine and manual, including Smoking in Pregnancy pathways, with specialist advisors in ante-natal settings;
- 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
- Supporting smokers to stop
- Media, communications, social marketing and effective education
- Reducing the availability and supply of tobacco products- licit and illicit-and addressing the supply of tobacco to children
- Tobacco regulation
- Reducing tobacco promotion
- Research, monitoring and evaluation

**NI39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm**
The rate of hospital admissions per 100,000 for alcohol related harm is increasing as a consequence of NHS investment in alcohol treatment services. Latest performance is 2636 admissions per 100,000 population (April to September 2009) which is considerably more than the 2009/10 target of 2207.

The significant investment to tackle alcohol issues in Sunderland, is being made through a new Alcohol Strategy. This includes Alcohol Treatment programmes targeted towards violent offenders with alcohol misuse issues

New alcohol services are being commissioned which include:

- Enhancement of Tier 1 and 2 provision. Widen the scope of delivery of screening and brief interventions to ensure that interventions can be offered to 20% of the estimated Hazardous drinking population annually (approx. 4930)
- Enhancement of Tier 3 and 4 provision. Expand tier 3 services to provide treatment for 20% of the estimated Harmful drinking population annually (approx. 1242)
- Expansion of tier 3 and 4 services to provide treatment for 205 of the estimated Moderate and Severe Dependent Drinking populations annually (approx. 150)
Reducing alcohol use in young people

*3.4.2 How is the city improving citizen's quality of life?*

*NI 136 People supported to live independently through social services (all ages)*: One of the main sub-objectives in this area is to promote independence for individuals in order for them to live in their own homes for as long as possible. This is particularly true for older people, but also includes support for younger adults with life-limiting conditions. The latest performance update for the measure that relates to this objective is currently lower than the target of 3284 per 100,000 for 2009/10, and it is unlikely that performance target will be met.

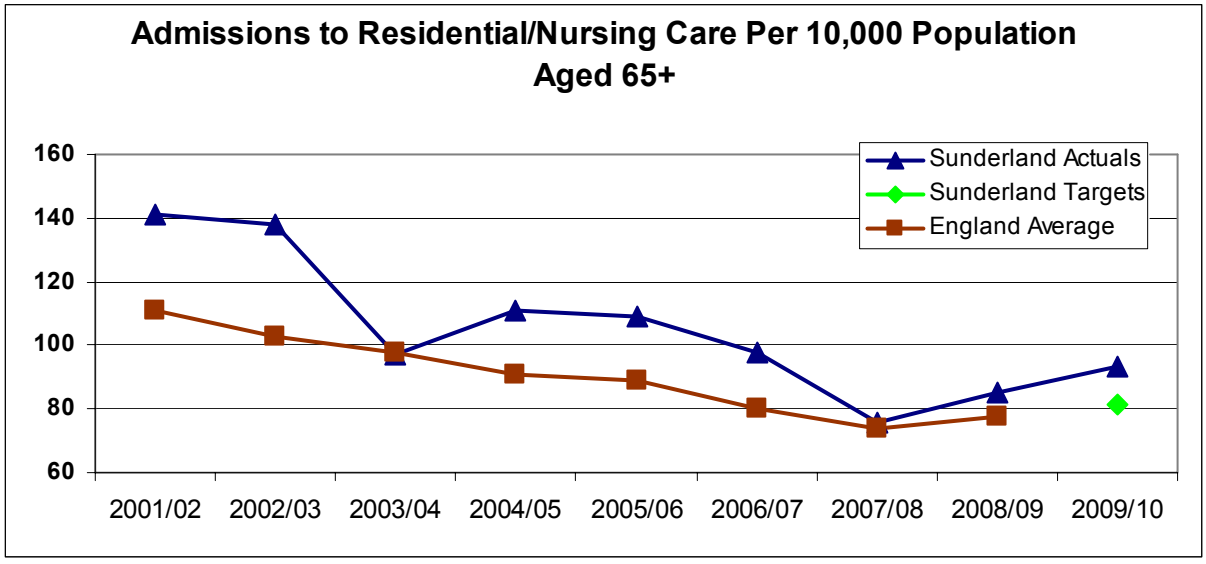
The Directorate of Health, Housing and Adult Services is currently addressing this issue, via developing community "in-reach" solutions as part of the Council's overall Customer Service strategy. For example, the Directorate recently completed an older people's population profiling for the city, and used this as the basis for a more targeted and pro-active approach to supporting individuals. For example, the Council is working on a Department of Health pilot with Church View Medical Practice to better identify people who might 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 will be rolled out to the North, as well as West, Sunderland Area, working with another GP, and is expected to identify a far wider range of individuals more pro-actively in 2010/11. 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.

3.4.3 *What choice and control do vulnerable adults have in relation to their Council services?*

*NI 130: Adult social care customers receiving Self-Directed Support (Direct Payments, Individual & Personalised Budgets):* The Department of Health's definition for this indicator relates to the proportion of people supported by an ongoing adult social care package ("customer base") that were supported by either Direct Payments or Individual Budgets or alternatively had an individual Personal Budget. Some 6.7% of the Council's customer base was supported through these Self-Directed solutions for the 12 months ending December 2009, on course to meet the target of 8.4% for 2009/10. The Directorate is widening the availability of self-directed support, including through Personalised and Individualised Budgets, to provide people with more flexibility to choose and purchase support which reflects their needs and preferences. 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.

One further measure in this objective is the number of admissions to authority-supported permanent residential or nursing care. The national strategy is to reduce this level and promote more support, particularly intensive support at home. Although there have been efforts to reduce emergency admission rates through the implementation of more preventative measures over the last 3 years e.g. increased use of Urgent Care Team and Primary Care Centres, there continue to be significant pressures on admissions and re-admissions of older people to care.



Strategies developed over the last two years have improved individuals' ability to remain in their own home for as long as possible – which is what most people want. This was supported through the development of Extra Care, the first two schemes for which, at Silksworth and in Washington are now open, with a range of on-site facilities accessible by the local community, including restaurants/cafes (run by a Community Interest Company that employs 29 people with learning disabilities) and a community library. Around 80 of these units at both sites are now occupied, with 22 of these households containing one or more people with dementia. Two further Extra Care Schemes will open over the next 2 years (in Hetton and Houghton), which will provide 175 mixed-tenure apartments in the city.

### 3.2 Budget Consultation

3.2.1 As part of the budget consultation a series of workshops were held where participants were asked to prioritise a range of approaches to addressing the budget priorities that emerged from the survey results. The top two priorities identified during the consultation in relation to social care were:

- Continuing to extend the availability and range of services that can be provided through the evening and overnight such as the Sunderland Telecare service
- Extending the range of support services (for example, advice and advocacy services) to enable more people to direct their own social care budgets.

3.2.2 During 2010/2011 the council will allocate additional resources to these priorities to support delivery of Sunderland's 15 Year Plan for Adult Social Care. One of the main aims is for every person to have the support to live independently in their own home or community, if that is what they want. An additional £2.636 million will be invested in:

- Staff and equipment for the Telecare service which enables people to live in their own home for longer, with increased safety, confidence and independence. For example, household / personal alarms and sensors that indicate when a person might be at risk and provides a rapid response service
- Contingency for additional costs that may arise through the recent government announcement to provide free personal care to those with assessed high care needs
- Meeting the costs of residential and nursing accommodation provided through independent care providers.

3.2.3 An additional £1.58 million will be allocated as part of the Social Care Reform Grant to support the modernisation of Adult Social Care services. Part of this modernisation will be to continue to improve the process by which people are assessed for Adult Social Care. For example, some of the changes that have already been made are the introduction of a team of Independent Living Officers who are able to assess individuals for smaller items of equipment (such as bath boards and grab rails) and fit and install the item within the same day from the stock

of items they carry. The grant will also be used to pilot the latest developments in Telecare equipment to help people with more complex needs live independently in their own homes for longer.

3.2.4 Modernisation will also include extending the range of support services available to assist more people to self-direct their own social care budget (see above discussion). This means that they can have more choice and control over how the services they need are delivered, if that is what the wish. For example, the Social Care Resource Agency helps people who direct their own social care budget to identify opportunities and services within the community to meet their assessed needs.

### 3.3 Policy Review Recommendations

3.3.1 The recommendations agreed to improve Dementia Care and Home Care Provision in Sunderland as part of the committees Policy Reviews will deliver a range of improvement activity. A full overview of progress is attached as appendix 2, the table below provides a summary of the number and percentage of each policy reviews recommendations that have been achieved, are on schedule to be achieved or are not on schedule to be achieved.

| **Policy Review** | **Rag Key** | | |
|---|---|---|---|
| | **Green** (Recommendation achieved) | **Amber** (On schedule) | **Red** (Not on schedule) |
| Dementia Care | 12 (54%) | 5 (23%) | 5 (23%) |
| Home Care Provision | 0 | 11(100%) | 0 |

Improvements made to date include; better use of information to clarify the prevalence and incidence of dementia in Sunderland, co-ordinating requirements in relation to campaigns to reduce stigma and raising awareness, progressing work with GPs and their practices to raise the profile and referrals routes of the Community Health Team and recognising the importance of the third sector in delivering good quality support to people with dementia.

## 3 Recommendation

3.1 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.

## 4 Background papers

Budget Consultation 2010/11

**Dementia Care in Sunderland Policy Review Recommendations - Progress April to December 2009**

| RAG Key | | Current Performance |
|---|---|---|
| ★ | Green - Recommendation achieved | 12 Recommendations (54%) |
| ● | Amber - On schedule to achieve recommendation | 5 Recommendations (23%) |
| ▲ | Red - Not on schedule to achieve recommendation | 5 Recommendations (23%) |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR01 | To clarify the prevalence and incidence of dementia in Sunderland by initially utilising information that has already been collated by the PCT and Local Authority. This will also provide a means of examining the levels of under diagnosis of dementia, which currently exist in Sunderland. | PRR01.1 Initiate work with the needs analysis group to clarify incidence of dementia | Lowes, Sharon | 31/12/2009 | ★ | Work was initiated with the Health, Housing and Adult Services Needs Analysis Group to clarify prevalence and incidence of dementia and the initial findings were presented to the OPMH Strategy Group in December 2009. This work confirmed the information in existence, regarding prevalence levels within Sunderland. At the request of the OMPH Strategy Group, a more detailed needs assessment has been commissioned, in order to understand the diagnosing patterns within Sunderland; and in particular what this means for Sunderland over the next 3-5 years and beyond. A project initiation document has been presented to leads for the OPMH Group and work has commenced with initial analysis results expected in June 2010 with further timescales to be agreed. |
| PRR02 | To undertake the development of a Reducing Stigma Campaign that includes a focus on the positive experiences of people with dementia | PRR02.1 Work with equivalent groups in relation to information requirements | Lowes, Sharon | 31/12/2009 | ★ | The OPMH Strategy Group is working with the equivalent groups across Gateshead and South Tyneside in relation to information requirements for delivering the National Dementia Strategy. This includes the two campaigns recommended by the Committee. Now that the National awareness raising campaign has been launched work is being done to map requirements for local follow through. |
| | | PRR02.2 Identify monies to fund campaigns | Lowes, Sharon | 31/12/2009 | ★ | Monies are being identified within PCT/LA which will be used to fund these campaigns. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR03 | To develop and promote a Raising Awareness Campaign that provides a coordinated approach involving all the major stakeholders. | PRR03.1 Work with equivalent groups in relation to information requirements | Lowes, Sharon | 31/12/2009 | | The OPMH Strategy Group is working with the equivalent groups across Gateshead and South Tyneside in relation to information requirements for delivering the National Dementia Strategy. This includes the two campaigns recommended by the Committee. Now that the National awareness raising campaign has been launched work is being done to map requirements for local follow through. |
| | | PRR03.2 Identify monies to fund campaigns | Lowes, Sharon | 31/12/2009 |  | Monies are being identified within PCT/LA which will be used to fund these campaigns. |
| PRR04 | That Sunderland City Council, if the opportunity arises, should apply to be a demonstrator site for the Dementia Advisor role as outlined in the National Dementia Strategy. | PRR04.1 Apply for Dementia Advisor Role demonstrator site | Lowes, Sharon | 30/04/2010 |  | Due an unsuccessful application, the PCT and LA are commissioning an Advocacy Service for older people, which includes the specific function of a dementia advisor service within the specification. This service is in the process of being commissioned via a formal tender process with the service expected to be operational in May 2010. |
| PRR05 | To review the current Public Health Strategy in order that messages within the strategy focusing on healthy lifestyles include links to the prevention of vascular dementia. | PRR05.1 Engage with the PCT | Lowes, Sharon | 30/09/2009 |  | A meeting took place with Public Health Colleagues and the OPMH Strategy Group to look at how prevention of vascular dementia could be promoted. Now that the National awareness raising campaign has been launched this recommendation will be taken forward mapped to that in conjunction with health colleagues. |
| PRR06 | To develop a coordinated stakeholder service directory that is available to the general public that provides advice and information on dementia services through information that is already held on the Starting Point Database which, is currently in use in the city. . This process would allow for the review of the existing information that is available, taking into consideration the quality and accessibility of support throughout an individual's journey. | PRR06.1 Undertake a review of information that is in use across the city | Lowes, Sharon | 30/04/2010 |  | The Task and Finish Group (set up to undertake a review of information) continues to meet and is in the process of undertaking the first stage of the action.<br>• Review existing information types and sources of information.<br>• Develop an Information Pathway, including standards and the notion of personal information plans for people and their carers.<br><br>This approach would allow for the service directory to be developed and is anticipated it will be linked to objectives within the NDS also being developed such as Dementia Advisor and Memory Clinics. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR07 | To review the current pathway of care identifying where changes need to be made in order that an early diagnosis and intervention can become a reality, including the referral into the pathway. | PRR07.1 Audit against NDS Objectives | Lowes, Sharon | 31/12/2009 |  | As reported in the last update, the Joint Commissioning Framework has been developed which identified commissioning of a memory assessment service as a priority. Work has commenced with SunWest Practice Based Commissioning Cluster, to pilot a memory assessment service. This pilot will help shape the future pathway of care and will commence in April 2010. |
| | | PRR07.2 Develop a joint commissioning plan | Lowes, Sharon | 31/12/2009 |  | The Joint Commissioning Framework has been developed which identified commissioning of a memory assessment service as a priority. Work has commenced with SunWest Practice Based Commissioning Cluster, to pilot a memory assessment service. This pilot will help shape the future pathway of care and will commence in April 2010. |
| PRR08 | To review the role of the liaison service within City Hospitals to identify and address any capacity issues in service provision. | PRR08.1 Undertake the review as recommended | Lowes, Sharon | 30/10/2009 |  | The review of the Liaison Service is ongoing via a task and finish group approach and it is expected that gaps identified will be addressed via the re-allocation mental health resources effectively. |
| PRR09 | To ensure inclusiveness when implementing the local response to the National Dementia Strategy that consideration is given to young people and people with learning disabilities who have dementia. | PRR09.1 Include commissioners in the baseline audit and plan development | Lowes, Sharon | 31/12/2009 |  | The Joint Commissioning Framework for National Dementia Strategy within Sunderland ensures that inclusiveness is achieved by focussing on needs of people with dementia, rather than age. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR10 | To progress the workforce development strategy that exists in each sector (Local Authority, Public Health, and PCT) so that all dementia service providers offer good quality services to people with dementia. | PRR10.1 Engage the Tyne & Wear Care Alliance | Lowes, Sharon | 30/10/2009 |  | This recommendation is being progressed via objective 13 of the NDS as services are being re-aligned against it. Along with HHAS workforce, the independent sector workforce are being supported and incentivised to meet requirements via Sunderland Quality Standards for care homes for older people and is being followed by similar Quality Standards for Homecare. The standards relating to dementia include basic dementia training for staff linked to Life Story Work support planning as well as identification of a senior staff member to take the lead in quality of care for people with dementia. Work is ongoing to ensure the above is supported by TWCA and NTW in reach. |
| PRR11 | To raise awareness of the Community Mental Health Team in Sunderland, including increasing the profile of the team and how potential service users can access the service | PRR11.1 Develop a communication plan | Lowes, Sharon | 31/12/2009 |  | The CMHT have activated their communications plan, which increasing their profile and as reported previously, referrals to the service are more appropriate and timely. |
| | | PRR11.2 Raise team profile and referral routes | Lowes, Sharon | not set |  | Work continues to be progressed with GPs and their practices to raise the profile and referral routes. Improvements have been made in the referrals received by GPs. |
| PRR12 | To undertake a financial exercise on current spending levels for services that provide support for people with dementia and compare this to other Local Authorities and PCTs, with a view to informing best practice in both the current and future provision of services. . | PRR12.1 Establish a Task Group to progress the recommendation | Lowes, Sharon | 30/10/2009 |  | This recommendation is being taken forward by the PCT/Health, Housing and Adult Services, Finance Managers, as it is a complex exercise due to the many different levels and range of services people with dementia access. Further complications arise when dementia is not recorded as the main presenting need. It is important to assess current cost as accurately as possible before attempting to predict future requirements, especially anticipating the potential increase in early detection and diagnosis NDS objectives will produce, therefore the PCT has commissioned specialist Dementia Modelling expertise to facilitate this in each LA area and an initial wokshop has been held. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR13 | To review existing support services to ensure they are fit for purpose against the vision set by the National Dementia Strategy identifying good practice and clear areas for improvement | PRR13.1 Commission a Task Group | Lowes, Sharon | 30/04/2010 |  | Objective 6 has been identified as a regional priority and funding has been provided by DH and RIEP to support implementation across LA's over a period of 2-3years via a project plan (dependent on continued funding). The first stage in the process will be development of a comprehensive evidence base followed by processes to ensure that personalisation changes are fully inclusive of people with dementia and their carers with the final stage supporting reviewed service provision by identifying good practice and development of innovative pilots. The commissioning lead from Sunderland will work alongside the project in the City's best interests as applicable and report on progress. |
| PRR14 | To recognise the importance of third sector in delivering good quality support to people with dementia through better engagement across the statutory and third sector. | PRR14.1 Review Third Sector engagement | Lowes, Sharon | 31/12/2009 |  | The Joint Commissioning Framework recognises the contribution that the third sector plays and will continue to play in supporting people with dementia to live well. Organisations have received grant assistance funding from both PCT and LA for 2010 to support work with people with dementia and their carers. Close links remain with these organisations and they are included in all new development plans. |
| | | PRR14.2 Role of the Third Sector acknowledged and built into the joint commissioning plan | Lowes, Sharon | 31/12/2009 |  | Throughout the baseline audit, the contribution provided by third sector organisations was acknowledged and will be built upon as the joint commissioning plan is developed. |
| PRR15 | To review and strengthen existing peer support mechanisms, which could be strengthened by the statutory sector working closer with the third sector. | PRR15.1 Commission a task group to undertake the review and report findings | Lowes, Sharon | 26/02/2010 |  | A review of peer support networks is currently being undertaken. Findings will be mapped against NDS objectives with full involvement of current third sector providers. Strengthening of these services will be undertaken as part of the whole system as services develop against the NDS objectives. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR16 | That consideration is given to the possibility of a Dementia Champion within Sunderland City Council as outlined in the National Dementia Strategy. | PRR16.1 Present a report to the Adult Social Care partnership Board | Lowes, Sharon | 29/01/2010 |  | Discussions have taken place within HHAS regarding the Dementia Champion, as it is recognised that many people working across the council 'champion' the needs of people with dementia. An anticipated presentation of a paper at the February Adult Social Care Partnership Board to discuss this recommendation further will now take place in April. |
| PRR17 | That the Health and Wellbeing Review Committee receives regular reports on the local implementation plan. | PRR17.1 Report to committee on a quarterly basis | Lowes, Sharon | 30/10/2009 |  | Through this monitoring, regular updates are provided on the key areas for consideration as the local implementation plan includes the review recommendations. |
| PRR18 | That the Health and Wellbeing Review Committee provides a written response to the Department of Health on the National Dementia Strategy | PRR18.1 Written repose to Department of Health on National Dementia Strategy | Cummings, Nigel | 04/11/2009 |  | Letter sent on behalf of the committee to Department of Health with a response to the newly published National Dementia Strategy. |

## Home Care Provision Policy Review Recommendations - Progress Report April to December

| | RAG Key | Current Performance |
|---|---|---|
| ★ | Green - Recommendation achieved | 0 Recommendation (0%) |
| ● | Amber - On schedule to achieve recommendation | 11 Recommendation (100%) |
| ▲ | Red - Not on schedule to achieve recommendation | 0 Recommendation (0%) |

| Ref | Recommendation Description | Owner | Due Date | RAG | Commentary |
|---|---|---|---|---|---|
| PRR.HC01 | To ensure through the commissioning process that home care providers have the organisational structures in place to deliver the agreed care to service users on an operational level. | Lowes, Sharon | 31/08/2010 | ● | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC02 | To ensure that through the commissioning process home care providers have the organisational capacity and resources in place to meet the service requirements of additional home care packages. | Lowes, Sharon | 31/08/2010 | ● | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC03 | To ensure that all home care organisations provide zonal working arrangements for employees through coordinated and realistic work rotas. | Lowes, Sharon | 31/08/2010 | ● | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC04 | To continue to investigate and develop more robust monitoring systems for home care providers across the city, including the use of new technologies and spot checks. | Lowes, Sharon | 31/08/2010 | ● | Work is being progressed to introduce an electronic monitoring system across home care providers, which will be able to monitor the length of time care workers are in an individual's home (including arrival times and departure). This new system will be piloted with a number of providers in the first instance |

| Ref | Recommendation Description | Owner | Due Date | RAG | Commentary |
|---|---|---|---|---|---|
| PRR.HC05 | To look at the development of an annual survey for home care staff, service users and managers to provide a more comprehensive picture of service provision from a variety of stakeholder views. | Lowes, Sharon | 31/08/2010 |  | The need for an annual survey has been built into the programme of surveys that are undertaken by the Directorate. It is included in the work programme of the Researcher. |
| PRR.HC06 | To investigate the potential of a standardised minimum training programme for all home care staff across all local agencies with the intention that all home care workers are encouraged to enrol on NVQ level 2. | Lowes, Sharon | 31/08/2010 |  | Discussions are taking place with Tyne and Wear Care Alliance in relation to reviewing the existing training available for home care workers. This will be linked closely with the work undertaken to develop Sunderland Home Care Quality Standards. |
| PRR.HC07 | To improve the health and safety of care workers and ultimately service provision to service users by home care providers investing in the use of mobile phones and other technology. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC08 | To investigate home care organisations reimbursing any fees incurred by newly recruited employees from CRB checks once they have completed an agreed term of employment. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |

| Ref | Recommendation Description | Owner | Due Date | RAG | Commentary |
|---|---|---|---|---|---|
| PRR.HC09 | To ensure that the induction procedures of home care organisations provide new employees with the training, initial and ongoing supervision required to perform the duties of their role. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC10 | To evaluate the quality of Home Care Plans and look to ensure that the plans have detailed outcomes for services users and carers and also ensure, where practicable, that the plans are easily accessible or in a pre-determined location for the home care worker. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC11 | To ensure that supervisors and contact staff of home care organisations are also fully trained to deal with emergency situations that may occur. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |

## Health and Wellbeing Scrutiny Committee Appendix 1
## Strategic Priority - Healthy City

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| **Outcome - By 2025 100% of people with long term conditions in Sunderland will be supported to live at home for as long as they wish and feel able** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 130 | Social care clients receiving Self Directed Support | 5.83 | 6.73 | Jan to Dec | ▲ | 8.50 | ✘ | Performance against this indicator increased from 5.8% to 6.7% between the 12 months ending March and December 2009, and is on course to meet the target of 8.5% for 2009/10 if performance is sustained. There were increases in most divisions with the exception of people with physical disabilities, an area for improvement. |
| NI 136 | People supported to live independently through social services (all adults) | 3124.19 | 2865.2 | April to Dec | ▼ | 3415 | ✘ | As a result of the decrease in the numbers helped to live at home, there was a corresponding decline in terms of the number of adults aged 18+ years helped to live independently for December-09. However, the year end outturn may be partially offset by increased numbers of people supported through grant-maintained services. |
| **National Indicators** | | | | | | | | |
| NI 124 | People with a long-term condition supported to be independent & in control of their condition | 73% (200708) | Annual | | | Not Set | | |
| NI 125 | Achieving independence for older people through rehabilitation/intermediate care | 70.5% | 64.70% | April to Dec | ▼ | 78.30% | ✘ | Performance deteriorated to 67.5% older people currently achieving independence through rehabilitation and intermediate care. This needs to improve to 78.3% by 2009/10. |
| NI 131 | Delayed transfers of care | 14.20 | 5.06 | April to Dec | ▲ | not set | | Only includes delayed discharges within Sunderland hospitals |
| NI 132 | Timeliness of social care assessment (all adults) | 89.4% | 80.53% | April to Dec | ▼ | 92.80% | ✘ | Performance has deteriorated to 82%, with the target for 2009/10 is set at 92.8%. Performance across all divisions, except for MH, showed the same trend and needs to improve (true also for MH), but is most highlighted for LD Services. |
| NI 133 | Timeliness of social care packages following assessment (all Adults 18+) | 90% | 91.58% | April to Dec | ▲ | 91.20% | ✓ | Waiting times for care packages have improved significantly, with 91.1% completed in agreed timescales (as has performance for those with PD aged <65). The current level is just short of the 09/10 target of 91.2% and improvements should be maintained. |
| NI 134 | The number of emergency bed days per head of weighted population | 218717.00 | Annual | | | 199096 | n/a | |
| NI 141 | Percentage of vulnerable people achieving independent living | 82.21% | 83.58% | Oct to Dec | ▲ | 85% | ✘ | Significant improvements demonstrated between 2007/08 and 2008/09. Increase was unexpected and reasons are unknown and although performance has deteriorated since Mar-09, this measure has improved considerably when compared to March 2008. |
| NI 142 | Number of vulnerable people who are supported to maintain independent living | 98.45% | 99.34% | Oct to Dec | ▲ | 99% | ✓ | The target of 98% for 2008/09 was achieved well before the end of the year and this was possibly attributed to very low levels of provider unavailability and high levels of utilisation amongst contracted service, and it appears this is set to continue. |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| NI 145 | Adults with learning disabilities in settled accommodation | 100% | 88.12% | Jan to Dec | ▼ | 80% | ✓ | Progress was made in relation to the percentage of LD clients in settled accommodation to 88.1% (601 clients). Performance is currently above target for 2009/10 (80%) and the current figure needs to be maintained. |
| NI 149 | Adults in contact with secondary mental health services in settled accommodation | n/a | 64.70% | Jan to Dec | | 65.60% | ✘ | There was an increase in the number of adults with MH (545 clients) in settled accommodation |
| **Local Indicators** | | | | | | | | |
| BV 54 | Older people helped live at home | 100.24 | 94.4 | Jan to Dec | ▼ | 113 | ✘ | There has been a marked decrease in the number of clients helped to live at home for OP clients, and improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |
| BV 58 | % People with statement of needs | 100% | 99.16% | Jan to Dec | ▼ | 100% | ✘ | The majority of clients received a statement of need for the period ending December 2009. Although, performance is still rated as 'good' (based on the old PAF bandings), services should aim to provide all clients with a statement of needs. |
| BV 195 | Acceptable waiting times for asst | 91.4% | 84.7% | April to Dec | ▼ | 93.20% | ✘ | Performance against the timescales for assessment for older people deteriorated, and remains below the target of 93.2%. |
| BV 196 | Acceptable wait for care packages | 90% | 92.5% | April to Dec | ▲ | 91% | ✓ | Waiting times for care packages for older people have improved significantly, with 92.2% completed in agreed timescales. The current level is above the 09/10 target of 92% and improvements should be maintained. |
| BV 201 | Adults receiving direct payments | 251 | 280.8 | Jan to Dec | ▲ | 297 | ✘ | The number of clients with Direct Payments at the end of the latest period (December-09) has increased and is on course to meet its target |
| LPI 31 | Adults with physical disabilities helped to live at home | 6.2 | 5.72 | Jan to Dec | ▼ | 6.8 | ✘ | There has been a marked decrease in the number of clients with physical disabilities helped to live at home, and improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |
| LPI 32 | Adults with learning disabilities helped to live at home | 3.2 | 3.16 | Jan to Dec | ◀▶ | 4 | ✘ | The number of clients with learning disabilities helped to live at home has largely been maintained since March-09, but improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |
| LPI 33 | Adults with mental health problems helped to live at home | 3.47 | 3.31 | Jan to Dec | ▼ | 3.58 | ✘ | There has been a marked decrease in the number of clients with mental health issues helped to live at home, and improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| LPI 34 | % carers receiving a specific carers service | 19.3% | 17.35% | Jan to Dec | ▼ | 20.60% | ✘ | Performance in relation to services for carers has decreased when compared to 2008/09, with 17.4% of customers in which carers were receiving services. There's evidence from a range of sources (e.g. case file audit, carer & representative groups feedback) that the Directorate's approach to supporting carers is not as consistent as it should be. This will need to be addressed during the remainder of 2009/10, as this is also an area for improvement identified by CQC. |
| LPI 38 | % clients receiving a review | 77.6% | 71.03% | Jan to Dec | ▲ | 78.40% | ✓ | At 71% for end December, performance deteriorated across most divisions in 2009/10, and performance is now categorised as 'acceptable' (based on the old PAF bandings). However, it's noted that Directorate intend to address this issue via increasing review caseloads for practitioners in remainder of 2009/10. |
| LPI 39 | Ethnicity of people receiving an assessment | 0.98% | 1.79% | April to Dec | ▲ | 1.25% | ✓ | The current level exceeds the 2009/10 target and a direct result of the short- and longer-term case-finding resources for people from BME groups that the Directorate expanded in 2008/09. |
| LPI 40 | Ethnicity of older people receiving services following assessment | 0.7% | 1.14% | April to Dec | ▲ | 1% | ✓ | Performance has improved in terms of the proportion of older clients from BME populations subsequently receiving services, and is representative of population. |
| **Outcome - By 2025 through the Homes for Life Older Peoples programme extra care style accommodation will be fully developed across all areas of the city with a significant reduction in the number of admissions to residential and nursing care** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 139 | People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently | 35.5% | Annual | | | Not Set | | |
| **National Indicators** | | | | | | | | |
| NI 127 | Self reported experience of social care users | n/a | Annual | | | Not Set | | |
| NI 128 | User reported measure of respect and dignity in their treatment | n/a | | | | | | |
| NI 135 | Carers receiving needs assessment or review and a specific carer's service, or advice & inf. | 54.1% | 54.84% | Jan to Dec | ▲ | 56.40% | ✘ | This measure has fluctuated since March – for the latest period, 54.8% of carers received information, advice or services, compared to the 2008/09 outturn of 54.1%. This means the performance is just under the target for 2009/10 although the improvement since March will need to be maintained until year end. |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| **Local Indicators** | | | | | | | | |
| LPI 35 | Admissions of supported residents aged 65+ | 84.90 | 68.14 | April to Dec | ▼ | 84.4 | ✘ | Rates of supported admissions to permanent residential/nursing care for clients aged 65+ years increased quite significantly. There were 388, and this increased to 430, admissions to care for the 12 months ending March and December 2009, respectively. The level needs to reduce to no more than 386 in 2009/10 through, for example, full implementation of Intermediate Care at Home. |
| LPI 36 | Admissions of supported residents aged 18-64 | 1.20 | 0.74 | April to Dec | ▼ | 1.02 | ✘ | The number of individuals aged 18-64 years admitted to permanent residential/nursing care in 2008/09 was 24 clients. 18 clients have been admitted during the latest period, which equals the target set for 2009/10. |
| LPI 37 | % allocated a single room in nursing or residential care | 100% | 100% | April to Dec | ◄► | 100% | ✓ | |
| **Outcome - 'By 2025 life expectancy for men will equal that of women** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 120f | All-age all cause mortality rate - female | 562.00 | 578.7 | 2006-2008 pooled rate | ▼ | 546 | ✘ | |
| NI 120m | All-age all cause mortality rate - male | 777.00 | 851 | | ▼ | 748 | ✘ | |
| **National Indicators** | | | | | | | | |
| NI 121 | Mortality rate from all circulatory diseases at ages under 75 | | 88.9 | Annual out turn | n/a | | | |
| NI 121f | Mortality rate from all circulatory diseases at ages under 75 (females) | 63.9 | To Follow | | | not set | | |
| NI 121m | Mortality rate from all circulatory diseases at ages under 75 (males) | 134.79 | | | | not set | | |
| NI 122 | Mortality from all cancers at ages under 75 | | 141.1 | Annual out turn | n/a | | n/a | |
| NI 122f | Mortality from all cancers at ages under 75 (females) | 121.94 | To Follow | | | not set | | |
| NI 122m | Mortality from all cancers at ages under 75 (males) | 153.81 | | | | not set | | |
| NI 129 | End of life access to appropriate care enabling people to be able to choose to die at home | new 2009/10 | Annual | | | not set | | |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| **Outcome - 'By 2025 smoking prevalence will be reduced to 15% and there will be no differences between wards in Sunderland. The level of smoking in pregnancy will have reduced to less than 5%** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 119 | Self-reported measure of people's overall health and wellbeing | 66.2 | Annual | | | Not Set | | |
| NI 123 | Stopping smoking | 1100 | 774.36 | April to Dec | ▼ | 1437 | ✘ | |
| **Outcome - By 2025 the number of hospital admissions due to alcohol will be reduced to that of the 20% best performing local authorities across the country and there will be clear treatment pathways and a shift away from a binge drinking culture** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 39 | Rate of Hospital Admissions per 100,000 for Alcohol Related Harm | 2378 | 2549.3 | April to Sept | ▼ | 2207 | ✘ | |
| **Outcome - By 2025 we will have significantly increased the numbers of adults and children participating in sport** | | | | | | | | |
| **National Indicators** | | | | | | | | |
| NI 8 | Adult participation in sport | 18.7% | 19.60% | April to Dec | ▲ | 23.03% | ✘ | The figure of 19.6% is based on a two year active people survey (Oct 07 to Oct 09). Sport England advised us to add the two years together in order to boost the annual sample size from 500 to 1000. The baseline is 20.1%. Sport England do not see this as a significant decline as it does not exceed 3.5% +/-. |
| **Local Indicators** | | | | | | | | |
| LPI 19 | % of pop within 20 minutes of quality assured sports facility | 49.86% | Annual | | | 49.86% | n/a | |
| LPI 18 | % of population volunteering in sport and active recreation | 4.3 | | | | 4.56 | | |
| LPI 21 | Total visits to leisure centres | 2236294 | | | | 2258657 | | |
| LPI 22 | Total number of swims within leisure centres | 608807 | | | | 614355 | | |
| LPI 23 | Total number of other visits to leisure centres | 1627487 | | | | 1644302 | | |
| **Outcome - We will ensure that people feel that local services have the best interests of the community at heart so that by 2025 more than two thirds of the population agree that this is the case** | | | | | | | | |
| **Local Indicators** | | | | | | | | |
| BV 56 | Percentage of items of equipment delivered within 7 working days | 90% | 91.68% | April to Dec | ▲ | 93% | ✘ | Progress has been made in relation to this indicator, with 91.9% of equipment delivered in 7 working days for the 12 months ending December, compared to the 2008/09 outturn of 90.1%. |

# HEALTH AND WELLBEING SCRUTINY COMMITTEE

**21st April 2010**

## CONSULTATION ON PROPOSED CHANGES TO THE LAWS GOVERNING POWERED MOBILITY SCOOTERS & POWERED WHEELCHAIRS

**Report of the Chief Executive**

**STRATEGIC PRIORITIES: SP2: Healthy City.**

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

### 1. Why has this report come to the Committee?

1.1 To provide the opportunity for members to contribute to the current consultation taking place on proposed changes to the laws governing powered mobility scooters and powered wheelchairs.

### 2. Background

2.1 At its meeting on 11th November 2009, the Health and Wellbeing Scrutiny Committee received a report on the Shop Mobility Scheme operating in Sunderland. This followed a request from the committee to look into issues of safety and legislation surrounding such vehicles.

2.2 Following discussions the committee agreed to communicate their concerns around the legislation of mobility scooters to the appropriate body, in this case the Department of Transport. As a result of this the Health and Wellbeing Scrutiny Committee have been invited to contribute to the current consultation taking place around mobility scooters.

### 3. Current Position

3.1 The Department for Transport (DfT) is currently undertaking consultation on proposed changes to the legislation covering powered mobility scooters and powered wheelchairs (referred to as "invalid carriages" in legislation).

3.2 The aim of any reforms taken forward following the consultation would be to deliver cost-effective improvements to the safety of mobility vehicle users, pedestrians and other road users, while supporting continued mobility for disabled people.

3.3 The consultation document, appendix 1, is divided into 5 sections as follows:

- Legal Classification of Mobility Scooters

- Design Standards for Mobility Scooters
- Users of Mobility Vehicles
- Vehicles in Use
- Other Issues.

The consultation began on Wednesday 3 March 2010 and responses need to be with the DfT by no later than Friday 28 May 2010.

## 4. Conclusion

4.1 The Health and Wellbeing Scrutiny Committee has the opportunity to provide feedback into the wider consultation around the legislation governing mobility scooters.

## 5. Recommendation

5.1 That Members provide comments on the consultation document and that these comments are submitted to the DfT as the Health and Wellbeing Scrutiny Committee's formal response.

## 6. Background Papers

Health and Wellbeing Scrutiny Committee Agenda 2009
Consultation on proposed changes to the laws governing powered mobility scooters & powered wheelchairs (DfT-2010-10)

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**Contact Officer:** Nigel Cummings, Scrutiny Officer, 561 1006
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**APPENDIX 1: ANNUAL REPORT**

**Annual Report: Health and Wellbeing Scrutiny Committee 2009/10**

Chair: Cllr Peter Walker  Vice-Chair: Cllr Christine Shattock

Committee Members: Cllr Jill Fletcher, Cllr Anne Hall, Cllr Sylvia Old, Cllr Mary Smith, Cllr Dianne Snowden, Cllr Shirley Leadbitter, Cllr Paul Maddison, Cllr Anthony Morrisey and Cllr Peter Maddison.

It has been another busy year for the Health and Wellbeing Scrutiny Committee, during which time we have delivered an ambitious work programme providing discussion and challenge on a range of topics and issues.

Our major policy work this year saw the committee undertake a review that looked into health inequalities across Sunderland, and this has been an extremely challenging and rewarding piece of work. In gathering evidence for the review we held a very successful Community Event Day at the Stadium of Light, where speakers from the Department of Health, Durham University, Sunderland Teaching Primary Care Trust and the local authority provided valuable information and stimulated much debate. The event attracted stakeholders, voluntary groups and the general public and gave us some useful evidence.

The committee also had the opportunity to hold discussions with a senior researcher working for the recently published Marmot Review, an independent study into reducing health inequalities in England. We also held an expert jury event where a number of witnesses were invited to give evidence to the committee which added to the evidence base of the review.

The review, although ambitious, has highlighted a number of key themes and produced recommendations that we trust can help to develop and ensure that future strategies and policies consider the implications on health outcomes within Sunderland.

Alongside our policy review we have looked at a number of other issues including the legislation surrounding mobility scooters and powered wheelchairs. What we found was very little legislation governing such vehicles and agreed to write to the Department of Transport on this issue. As a result we have been invited to contribute to a wider consultation around this issue

and have provided a detailed response. The committee hopes that ultimately greater legislation will lead to improved safety for scooter users, pedestrians and other road users.

The committee has continued to be involved in a piece of work that began in 2008/09 around the quality and provision of home care services. I am pleased to report that work is continuing to introduce an electronic monitoring system for home care providers along with an annual survey for home care staff, service users and managers. These measures, recommended by the committee, will help to drive up the quality of home care provision in Sunderland.

One of the strengths of the scrutiny process is that we can look into issues or concerns around service provision that are raised by elected members. This year we were asked to consider the out of hours service provision in Sunderland, a broad range of statutory services provided to meet the emergency needs of individuals. Following the highlighting of these concerns and subsequent reports from the HHAS Directorate a working group has been established with key stakeholders, including a representative of the committee, to review current arrangements and look at service improvements. The Health and Wellbeing Scrutiny Committee will be kept fully informed of the progress of the working group.

This provides a snapshot of some of the work undertaken by the committee during the year, and I feel that along with the hard work of my colleagues on the committee we have had another successful year. I look forward to 2010/11 being another rewarding year for the Health and Wellbeing Scrutiny Committee.

Cllr Peter Walker
Chair of the Health and Wellbeing Scrutiny Committee

# Consultation response form

**CONSULTATION ON PROPOSED CHANGES TO REGULATIONS COVERING POWERED MOBILITY SCOOTERS & POWERED WHEELCHAIRS**

**PART 1 – information about you**

| | |
|---|---|
| Name: | |
| Address: | |
| Postcode: | |
| E-mail address: | |
| Company Name or Organisation if applicable) | |

Please tick one box from the list below that best describes you/your company or organisation

| | |
|---|---|
| ☐ | Member of the public |
| ☐ | Small or medium Enterprise (up to 50 employees) |
| ☐ | Large Company |
| ☐ | Representative Organisation |
| ☐ | Interest Group |
| ☐ | Local Government |
| ☐ | Central Government |
| ☐ | Police |
| ☐ | Other (please specify) |
| If you are responding on behalf of an organisation/interest group how many members do you have and how did you obtain the views of your members: | |
| If you would like your response or personal details to be treated confidentially please explain why (and please see the Freedom of Information advice on page 10 of the consultation package): | |

## PART 2: YOUR VIEWS

This consultation seeks your views on proposed changes to the legislation covering “invalid carriages”.

### Section A: Legal classification of vehicles

| |
|---|
| Q1. Do you think that the term “invalid carriage” should be replaced with a different term? |
| Yes ☐ No ☐ |
| Q2. What term would you suggest? |
| |
| Q3.Do you think that the terms “Class 2” and “Class 3” should be replaced by more descriptive terms such as “slower speed mobility vehicle” and “faster speed mobility vehicle”? |
| Yes ☐ No ☐ |
| If yes, what terms would you suggest? |
| |
| Q4. Do you think the legislation should make a distinction between mobility scooters and powered wheelchairs? |
| Yes ☐ No ☐ |

### Section B: Design standards for mobility vehicles

***Maximum speed capability***

| |
|---|
| Q5. Do you think that Class 3 vehicles should be designed to be capable of travelling at speeds higher than 8mph on the carriageway? |
| Yes ☐ No ☐ |
| Q6. If you think there should be a higher speed capability, what maximum speeds do you suggest, and why? |
| |

***Vehicle Weight limits***

| |
|---|
| Q7. Do you think the current unladen weight limit is still appropriate? (The weight limit for Class 2 vehicles is 113.4kg, and for Class 3 vehicles is 150kg? |
| Yes ☐ No ☐ (class 2 vehicles)<br>Yes ☐ No ☐ (class 3 vehicles) |
| Q8. If you think the permitted unladen weight should increase, what should it increase to, and why? |
| |
| Q9. Should some mobility vehicles permit the carriage of a baby or a small child as a passenger? |
| Yes ☐ No ☐ |
| Q10. If you suggested changes in reply to questions 8 and 9 above, do you have evidence to support your suggestions? If you have evidence what is it? Or do you believe that further research and trialling is needed before a decision is taken? |
| |

***Safer vehicle design***

| |
|---|
| Q11. Do you think that technology is available that could reduce the likelihood and severity of injury caused by a collision with a mobility scooter? |
| Yes ☐ No ☐ |
| If yes, what technology do you have in mind? |
| |
| Q12. Should any increase in weight only be permitted if such technology is used? |
| Yes ☐ No ☐ |

***Conspicuousness***

| |
|---|
| Q13. Do you think that additional requirements should be imposed to make mobility vehicles more conspicuous to help to improve the safety of the mobility vehicle user and the safety of other road users? |
| Yes ☐ No ☐ |
| Q14. If you do think that additional requirements should be imposed, what do you suggest? |
| |

## Section C: Users of mobility vehicles

### *Minimum age*

| Q15. Do you think that the minimum age of 14 when a person may use a Class 3 vehicle should be kept the same, removed or lowered? | |
|---|---|
| Kept the same<br>Lowered<br>Removed | ☐<br>☐<br>☐ |
| Q16. If you think the minimum age should be lowered, what do you suggest it be lowered to? | |
| | |

### *Information, training and fitness to drive*

| Q17. What do you think should be done to improve the information and advice that is available to people who want to use a mobility vehicle? |
|---|
| |
| Q18. Should all mobility vehicle users be required to undergo compulsory training? |
| Yes ☐ No ☐ |
| Q19. How do you suggest such training might be organised and delivered? How could it be funded (for example through user fees)? |
| |
| Q20. Should all users be required to undergo an assessment of their suitability to drive a mobility vehicle? |
| Yes ☐ No ☐ |
| Q21. How do you suggest such an assessment might be organised and delivered? How could it be funded (for example through user fees)? |

| |
|---|
| |

**Section D: Vehicles in Use**

***Registration***

| |
|---|
| Q22. Do you think a mobility vehicle registration scheme is needed? |
| Yes ☐ No ☐ |
| If so, why? |
| Q23. Do you think the current registration scheme with DVLA should be improved, for example, through better enforcement? |
| Yes ☐ No ☐ |
| If yes, how? |
| Q24. Do you think the current registration scheme should be replaced by a locally run registration scheme? (We would be interested in exploring whether this could be linked to existing schemes, for example the Blue Badge disabled parking scheme.) |
| |

| |
|---|
| |
| Q25. Do you think it would be better to register users rather than registering vehicles? |
| Yes ☐ No ☐ |
| If so, how might it work? |
| |
| Q26. Do you have any other suggestions for how a registration scheme would work? |
| |
| Q27. Do you think the registration should be required for Class 2 vehicles as well as Class 3 vehicles? |
| Yes ☐ No ☐ |
| If so, why? |
| |

***Insurance***

| Q28. Do you think that a minimum of third party insurance should be compulsory for users of mobility vehicles? |
|---|
| Yes ☐ No ☐ |

***Criminal offences***

| Q29. Do you think that the section 35 offence (drivers of carriages injuring persons by furious driving) is adequate? |
|---|
| Yes ☐ No ☐ |
| Which driver behaviours do you think are not at present adequately covered by the legislation and should be the subject of further detailed proposals? |
| |

***Maximum permitted speed***

| Q30. Do you think that a Class 3 vehicle should be permitted to travel faster than the current limit of 8mph on the road? |
|---|
| Yes ☐ No ☐ |
| Q31. What do you see as the potential benefits and risks of an increased speed limit? |
| Q32. What do you think the new maximum permitted speed should be? |
| |

| Q33. When the speed limiter is switched off, users of Class 3 vehicles may drive above 4mph provided they are on the carriageway and not on the footway. To aid concordance with this regulation, should mobility vehicles then automatically display a sign on the rear that indicates that they must not be used on the footway? |
| --- |
| Yes ☐ No ☐ |

Data collection

| Q34. What type of data do you think it would be helpful to record and why? |
| --- |
| |

Please send consultation responses to:

Mobility Vehicles Consultation
Department for Transport
Zone 2/15
Great Minster House
76 Marsham Street
London
SW1P 4DR

Email: mobilityvehiclesconsultation@dft.gsi.gov.uk

# HEALTH AND WELLBEING SCRUTINY COMMITTEE

**21st April 2010**

## ANNUAL REPORT

**Report of the Health and Wellbeing Scrutiny Committee**

**STRATEGIC PRIORITIES: SP2: Healthy City.**

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

### 1. Why has this report come to the Committee?

1.1 To approve the Health and Wellbeing Scrutiny Committee report as part of the overall scrutiny annual report 2009/10 that is to be presented to Council.

### 2. Background

2.1 In previous years each scrutiny committee has published an individual account of the work conducted by the committee in an annual report, and was presented to Council. The annual report reflected the committees work programme and included achievements, highlights and policy review work.

2.2 This year for the first time the annual report will be a single combined report of all seven scrutiny committees. The annual report will outline the development in the scrutiny function and provide snapshots of the outcomes achieved during the last 12 months.

### 3. Health and Wellbeing Scrutiny Committee 2009/10

3.1 The proposed Health and Wellbeing Scrutiny Committee report is attached at appendix 1 for member's consideration. The report provides a very brief snapshot of the some of the main work undertaken by the committee during 2009/10. It should be noted that the report is written from the perspective of the Chair of the Committee reflecting over the year.

3.2 Some of the main themes covered in the annual report revolve around the following issues:

- Out of Hours Care
- Mobility Scooters
- Home Care Services
- Policy Review: Tackling Health Inequalities in Sunderland.

## 4. Conclusion

4.1 The Committee has delivered another ambitious work programme in 2009/10, which is reflected in the annual report. The Scrutiny Committee has worked well with Council Directorates, stakeholders and partner organisations to deliver the work programme and the Scrutiny Committee has tackled a number of key issues throughout the year and looked to work with officers and stakeholders to provide solutions and improvements to services delivered across the city.

## 5. Recommendation

5.1 That Members approve the Health and Wellbeing report 2009/10 for inclusion in the Overview and Scrutiny Annual Report 2009/10.

## 6. Background Papers

6.1 2009/10 Agendas

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**Contact Officer:** Nigel Cummings, Scrutiny Officer, 561 1006
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**APPENDIX 1: ANNUAL REPORT**

## Annual Report: Health and Wellbeing Scrutiny Committee 2009/10

Chair: Cllr Peter Walker  Vice-Chair: Cllr Christine Shattock

Committee Members: Cllr Jill Fletcher, Cllr Anne Hall, Cllr Sylvia Old, Cllr Mary Smith, Cllr Dianne Snowden, Cllr Shirley Leadbitter, Cllr Paul Maddison, Cllr Anthony Morrisey and Cllr Peter Maddison.

It has been another busy year for the Health and Wellbeing Scrutiny Committee, during which time we have delivered an ambitious work programme providing discussion and challenge on a range of topics and issues.

Our major policy work this year saw the committee undertake a review that looked into health inequalities across Sunderland, and this has been an extremely challenging and rewarding piece of work. In gathering evidence for the review we held a very successful Community Event Day at the Stadium of Light, where speakers from the Department of Health, Durham University, Sunderland Teaching Primary Care Trust and the local authority provided valuable information and stimulated much debate. The event attracted stakeholders, voluntary groups and the general public and gave us some useful evidence.

The committee also had the opportunity to hold discussions with a senior researcher working for the recently published Marmot Review, an independent study into reducing health inequalities in England. We also held an expert jury event where a number of witnesses were invited to give evidence to the committee which added to the evidence base of the review.

The review, although ambitious, has highlighted a number of key themes and produced recommendations that we trust can help to develop and ensure that future strategies and policies consider the implications on health outcomes within Sunderland.

Alongside our policy review we have looked at a number of other issues including the legislation surrounding mobility scooters and powered wheelchairs. What we found was very little legislation governing such vehicles and agreed to write to the Department of Transport on this issue. As a result we have been invited to contribute to a wider consultation around this issue and have provided a detailed response. The committee hopes that ultimately greater legislation will lead to improved safety for scooter users, pedestrians and other road users.

The committee has continued to be involved in a piece of work that began in 2008/09 around the quality and provision of home care services. I am pleased to report that work is continuing to introduce an electronic monitoring system for home care providers along with an annual survey for home care staff,

service users and managers. These measures, recommended by the committee, will help to drive up the quality of home care provision in Sunderland.

One of the strengths of the scrutiny process is that we can look into issues or concerns around service provision that are raised by elected members. This year we were asked to consider the out of hours service provision in Sunderland, a broad range of statutory services provided to meet the emergency needs of individuals. Following the highlighting of these concerns and subsequent reports from the HHAS Directorate a working group has been established with key stakeholders, including a representative of the committee, to review current arrangements and look at service improvements. The Health and Wellbeing Scrutiny Committee will be kept fully informed of the progress of the working group.

This provides a snapshot of some of the work undertaken by the committee during the year, and I feel that along with the hard work of my colleagues on the committee we have had another successful year. I look forward to 2010/11 being another rewarding year for the Health and Wellbeing Scrutiny Committee.

Cllr Peter Walker
Chair of the Health and Wellbeing Scrutiny Committee

**HEALTH & WELL-BEING SCRUTINY COMMITTEE 21st APRIL, 2009**

**POLICY DEVELOPMENT & REVIEW 2009/10: DRAFT FINAL REPORT**

**LINK TO WORK PROGRAMME: POLICY DEVELOPMENT & REVIEW**

**Report of the Chief Executive**

**STRATEGIC PRIORITIES: SP2: Healthy City**
**CORPORATE PRIORITIES: CIO1, CIO4**

## 1. Why has this report come to committee?

1.1 The report provides Members of the committee with the final draft report from the evidence gathered in relation to this year's policy review on health inequalities.

1.2 The review report presents in detail the evidence, research and conclusions drawn throughout the review process and recommendations arising from this evidence gathering. Members are asked to give consideration to the final report and the recommendations of the policy review.

1.3 The review into health inequalities has clear links to all the Councils Strategic Priorities in particular 'Healthy City.' The review also has links to Corporate Priorities on delivering customer focused services and improving partnership working.

## 2. Background

2.1 At its meeting on 17th June, 2009 following discussions regarding the work programme the Committee consider the possibility of a study into the issue of health inequalities in Sunderland.

2.2 The review came at an important time in light of the work being undertaken at both regional and national levels. The Committee used its skills and expertise to stimulate community engagement and develop themes presented during their evidence gathering procedures. Health and social care feature heavily in the Sunderland Strategy with an aim that 'everyone in Sunderland is able to enjoy a healthy life with access to excellent health and social care facilities when needed'.

## 3. The Draft Final Report

3.1 The draft final report on Tackling Health Inequalities in Sunderland is attached as an appendix to this report and presents members with the facts and evidence that have been gathered throughout the review process. As part of the review process evidence was obtained from a variety of national, regional and local key witnesses and stakeholders.

3.2 The report is divided into a number of sections which provide the background information to the review, how the review was carried out and the findings and conclusions from the review process. The findings from the review reflect the themes set out in the Marmot Review: Fair Society, Healthy Lives as follows:

- Health Inequalities – The National and Local Picture
- The Early Years of Life
- Employment and Income
- Places and Communities
- The Prevention Agenda.

3.3 Members are asked to read the report and comment on the content with particular reference to the recommendations arising from the evidence gathered and presented in the report. Members may wish to amend the report for purposes of accuracy, clarity or relevance to ensure the report is a true reflection of the work undertaken.

## 4. Conclusion

4.1 The Health and Wellbeing Scrutiny Committee are presented with a final draft copy of the policy review document for comment and amendment with the aim of producing a final report for presentation and approval by Cabinet.

## 5. Recommendation

5.1 That the Health and Wellbeing Scrutiny Committee provide comments on the final draft report and that any agreed amendments are made.

5.2 That consideration is given to the recommendations contained in the final draft report.

5.3 That the agreed final report is presented to the Cabinet for approval at its June 2010 meeting.

---

**Contact Officer:** **Nigel Cummings (0191 553 1006)**
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# Health and Well-Being Scrutiny Committee
# Policy Review 2009 – 2010

# Tackling Health Inequalities in Sunderland
# Draft Final Report

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# 1 Foreword from the Chairman of the Committee

On behalf of the Health and Well-Being Scrutiny Committee I am delighted to publish this report. I would like to thank all those who participated in the process, for their time and effort and continued commitment in helping Sunderland to continuously improve.

The Community Day was a hugely successful event and I was very interested to hear the views of all those who attended. We were able to gather a great deal of useful information from the day. I would also particularly like to thank our expert witnesses for the detailed evidence they gave to the Committee.

The importance of tackling health inequalities cannot be underestimated and it is unbelievable to think that in today's world, where a person lives can have a major impact on their health and length of life, but it does. Why do people in Sunderland die two years earlier than the average for England? Even more significantly men and women from the least deprived areas of Sunderland can expect to live longer than men and women from the most deprived areas. The factors that contribute to this are numerous and do not lie entirely in the traditional health domain and issues including stress, the environment, transport and housing all play just as significant a role in determining life expectancy.

The recently published Marmot Review 'Fair Society, Healthy Lives' identifies many of the key challenges facing the country in relation to health inequalities and it was extremely beneficial to have Professor Peter Goldblatt, Senior Researcher for the Marmot Review, visit Sunderland and provide evidence to the committee. It was extremely useful and timely to hear firsthand about the findings of the review and the implications nationally, regionally and locally.

Finally I would like to thank my colleagues on the Health and Wellbeing Scrutiny Committee for their valuable input and contribution throughout the course of this ambitious piece of work. I hope that the work and recommendations from this policy review can help to address some of the issues that have been highlighted and can contribute in some way to narrowing the gap in life expectancy across Sunderland.

Councillor Peter Walker, Chair of the Health and Well-Being Scrutiny Committee

## 2 Introduction

2.1 The Annual Scrutiny Conference was held at the Stadium of Light on 11th June 2009 and at the Health and Wellbeing breakout session a number of viable policy review proposals were formulated for discussion by Members of the committee. At its meeting on 17th June 2009 following discussions regarding the work programme the Committee considered the possibility of a study into issues around tackling health inequalities.

## 3 Aim of the Review

3.1 To look at an overview of the strategic and operational approaches within Sunderland for tackling the main determinants of health inequalities.

## 4 Terms of Reference

4.1 The title of the review was agreed as 'Tackling Health Inequalities in Sunderland' and its terms of reference were agreed as:

(a) To identify and gain an understanding of the main determinants of health inequalities across Sunderland;

(b) To examine and assess the interventions currently in use across the city for reducing the main determinants of health inequalities;

(c) To investigate the inequities in health across wards in Sunderland;

(d) To look at examples of best practice and innovative service provision from local authorities, PCT's and other stakeholder groups across the country in relation to identified determinants; and

(e) To review the council's and partners policies and strategic priorities to ensure linkages across the council are achieved and relevant.

4.2 Members agreed that as the review progressed, they may feel that the review should narrow its focus further in order to ensure that robust findings and recommendations are produced.

4.3 Members agreed to look particularly at the strategic implications of health inequalities and how the priorities of various stakeholders look to address the issues around the main determinants of health inequalities.

## 5 Methods of Investigation

5.1 The approach to this work included a range of research methods namely:

(a) Desktop research – review of relevant documentation including government documents such as The Marmot Review 'Fair Society, Healthy Lives.'
(b) Interviews – with key individuals both internally and externally
(c) Focus groups – with key individuals both internally and externally
(d) Questionnaire
(e) Presentations at committee
(f) A Community Day - large public event (see **Appendix 1**)
(g) Expert Jury Event

5.2 All participants were assured that their individual comments would not be identified in the final report, ensuring that the fullest possible answers were given.

5.3 Interviews with the following personnel were carried out:

(a) Nicola Morrow – Healthy City Coordinator – Sunderland City Council
(b) Lee Cranston – Assistant Head of Corporate Policy – Sunderland City Council
(c) Professor Peter Goldblatt – Lead Researcher - The Marmot Review
(d) Nonnie Crawford – Director of Public Health – Sunderland TPCT
(e) Ben Seale – Joint Commissioning Manager – NHS SOTW

5.4 Visits were undertaken to look at the work of the Warm Front referral team, the NHS Health Check initiative and the NHS Stop Smoking team at Monkwearmouth Hospital.

5.5 A health inequalities questionnaire was conducted for the Health and Wellbeing Scrutiny Committee by the Sunderland LINk.

5.6 A Community Day held on 21st January 2010, invited views from the public, service users, carers and provider organisations. Approximately 120 delegates took part in the event. Key Speakers for the event included:

(a) Professor Tim Blackman – Durham University
(b) Neil Revely – Director of Health, Housing and Adult Services
(c) Martin Gibbs – Department of Health
(d) Nonnie Crawford – Director of Public Health

5.7 An expert Jury Event on 22nd February 2010, where final evidence was presented to members of the committee by:

(a) Nicola Morrow – Healthy City Coordinator, HHAS (who gave an introduction to the event and facilitated along with Ann Dingwall)
(b) Brent Kilmurray – Sunderland Teaching Primary Care Trust
(c) Neil Revely – Executive Director HHAS
(d) Canon Stephen Taylor – Chair of the Local Strategic Partnership
(e) Nonnie Crawford – Director of Public Health
(f) Alan Patchett – Age Concern and Community Network
(g) Dr Helen Patterson – Executive Director Children's Services
(h) Vince Taylor – Head of Strategic Economic Development
(i) Margaret Elliott - Social Enterprise

5.8 The Sunderland LINk conducted a survey on behalf of the Health and Wellbeing Scrutiny Committee with a small sample of the population of Sunderland. The aim of the survey was to gather opinions and comments on a number of issues related to health and inequality. The results of this survey have helped to inform the final report and **Appendix 2** of this report provides full details of the survey.

5.9 It should also be noted that many of the statements made are based on qualitative research i.e. interviews and focus groups. As many people as possible were interviewed in an attempt to gain a cross section of views, however it is inevitable from this type of research that some of the statements made may not be representative of everyone's views. All statements in this report are made based on information received from more than one source, unless it is clarified in the text that it is an individual view. Opinions held by a small number of people may or may not be representative of others' views but are worthy of consideration nevertheless.

# 6 Findings of the Review

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to look at the most effective evidence-based strategies for reducing health inequalities in England from 2010. The Health and Wellbeing Scrutiny Committee's findings, for reasons of clarity and order, relate to the main policy objectives identified in The Marmot Review: Fair Society, Healthy Lives.

## 6.1 Health Inequalities – The National and Local Picture

### What is Health Inequality?

6.1.1 The term health inequality in the most basic sense is the gap between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds. The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, the unfair and avoidable differences in health status seen within and between wards.

6.1.2 The social determinants of health are best displayed as in Figure 1 an image designed by Dahlgren and Whitehead in 1992.

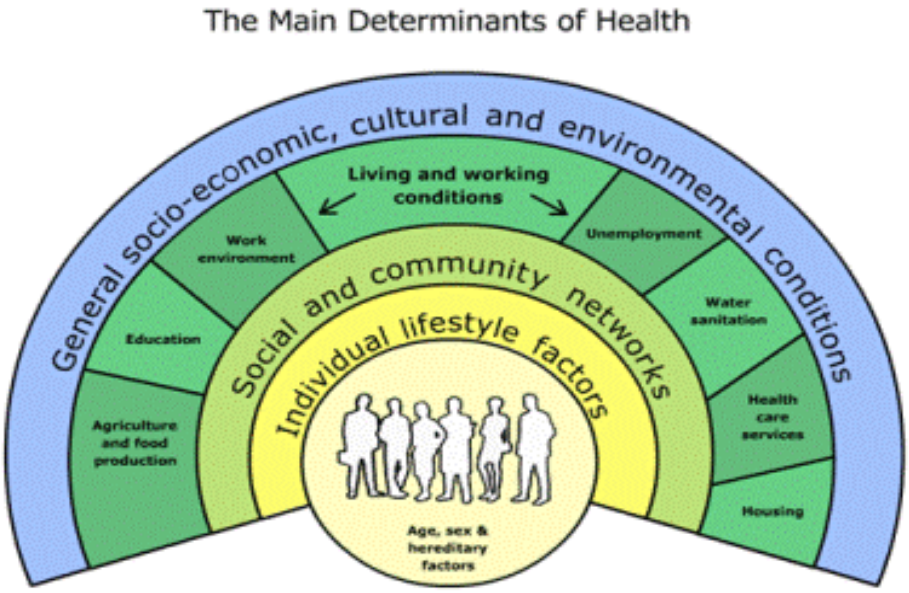



Figure 1: Main Determinants of Health: Dahlgren and Whitehead

6.1.3 The World Health Organisation in its publication "Social Determinants of Health: The Solid Facts" stated that "Health policy was once thought to be about little more than the provision and funding of medical care: the social determinants of health were discussed only among academics. This is now changing. While medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place."

6.1.4 At the committees Expert Jury Event many of the witnesses expressed the view that health inequality principally was around social class and social scale and that health issues were often an outcome of a situation. In fact, as an example, it was highlighted that those from the lowest social classes were twice as likely to die before the age of 15 as those from the highest social classes. Factors including age, gender, vulnerability, social, accidental, genetic, economic position and lifestyle choice were all regarded as attributable to health inequalities nationally and locally by many of the witnesses interviewed.

6.1.5 Members at the Community Event Day highlighted that personal and community wealth caused inequalities in health. During discussions with attendees it was reported that the feeling is that people living in difficult circumstances with little money were less likely to care about their health and were more likely to resort to coping with this through mediums such as alcohol and tobacco. Conversely to this more advantaged people were far more likely to live longer as they could afford and have access to better health care as well as experiencing a higher standard of living with less of the stresses encountered by those more disadvantaged.

6.1.6 This is supported by the Marmot Review which highlights that many of the determinants of health inequalities lie outside the health service and in the social aspects of life. Similarly to views expressed at the Expert Jury Day and the Community Event Day, those most disadvantaged in society have the least positive experiences and vice versa. This relationship between social circumstances and health is referred to as the social gradient of health and plays an important part in life expectancy.

**Health Inequalities: Facts and Figures – The National Perspective**

6.1.7 8.2 million adults age 16-64 are drinking above the recommended maximum daily levels and alcohol misuse is calculated at costing the health service £1.7bn per annum.

6.1.8 The level of obesity in 2-10 years olds in England has risen from 9.9% to 14.3% in 2004.

6.1.9 Eating at least 5 portions of fruit and vegetables a day can lead to a reduction in overall deaths from chronic diseases such as heart disease of up to 20%. While processed foods contribute around 75% of salt to the UK diet.

6.1.10 There are great differences in life expectancy dependent on location, for example males in Blackpool have a life expectancy eight years less than males in Kensington & Chelsea.

6.1.11 Obesity is one of the major public health issues in the developing world. In 2003, 22% of men and 23% of women were obese. By 2010, without intervention, this figure would increase to 33% of men and 28% of women.

**Health Inequalities: Facts and Figures – The Local Perspective**

6.1.12 Binge drinking is a concern nationally as well as locally with levels of binge drinking very similar across NHS South of Tyne and Wear with Sunderland rated the fourth

worst local authority for binge drinking in England with South Tyneside sixth and Gateshead ninth respectively.

6.1.13 The percentage of children who are obese rises from 12.6% in 4/5 year olds to 21.4% for 10/11 year olds.

6.1.14 On average people in Sunderland die two years earlier than the average for England. Men and Women from the least deprived areas of Sunderland can expect to live longer than men and women from the most deprived areas: about seven and a half years longer for men and about seven years longer for women.

6.1.15 Of the adult population from the 25 wards in Sunderland, 12 wards were below the prescribed PCT average of between 23% and 29% of adults consuming five portions of fruit or vegetables per day with one ward significantly lower at less than 20%.

6.1.16 An average 600 people per year in Sunderland die due to smoking related diseases and smoking among adults remains above the average for the North East and for England at 33.8% with some wards indicating levels up to 45%.

6.1.17 Falls are a major cause of ill health among older people and the rate of falls in Sunderland is higher than that for Gateshead and South Tyneside.

6.1.18 Local data combined with geographical indicators allows for comparisons of disadvantage across the country. Figure 2 illustrates the proportion of the population experiencing significant disadvantage on a daily basis.

| Domain | Sunderland | England |
|---|---|---|
| Overal Index of Multiple Deprivation | 43% | 20% |
| Income domain | 37% | 20% |
| Employment domain | 56% | 20% |
| Health deprivation and disability domain | 62% | 20% |
| Education, skills and training domain | 41% | 20% |
| Barriers to housing and services domain | 8% | 20% |
| Crime and disorder domain | 22% | 20% |
| Living environment domain | 2% | 20% |
| Income deprivation affecting children domain | 28% | 20% |
| Income deprivation affecting older people domain | 47% | 20% |

*Source of data: Department for Communities and Local Government*

Figure 2: Proportion of the population living within the 20% most disadvantaged areas across England

## 6.2 The Early Years of Life

### Early child development

6.2.1 The Primary Care Trust has a clear vision for better health, better patient experience and better use of resources by 2015, and part of this is for people to live longer and receive fair access to services. The importance of improving life experiences cannot be underestimated and these begin even before the very start of life. During the expert jury event witnesses from the primary care trust highlighted the importance of their continuing work with high risk women who are pregnant including reducing smoking during pregnancy and improving breast feeding figures. The PCT are also set to re-launch school health checks and undertake a review of the school nursing service. All of this work evidences the importance placed on those early child years by NHS South of Tyne and Wear and Sunderland Teaching Primary Care Trust, as well as how this can help to reduce health issues in later life.

6.2.2 At the Community Event Day held in January 2010 it was highlighted that breast feeding had seen an increase in the Shiney Row area due to the Sure Start programme. However, it was recognised that it is not easy to breast feed in the city as it is still seen as not publicly acceptable. It was also acknowledged that hospitals make it too easy for mothers to bottle feed by providing ready prepared bottles.

6.2.3 The local authorities Children's Services Directorate will operate from 1 April 2010 to a 15-year strategic plan, the Children and Young People Plan, which links in with the Every Child Matters outcomes framework. The plan looks to promote healthier lives in young people through a variety of initiatives including healthy diet to reduce the rate of childhood obesity in the city. It also looks to improve life chances for young people from -9 months onwards through schemes to increase breast feeding rates and reduce smoking during pregnancy. There is also the Children's Plan**,** the Department for Children, Schools and Families' (DCSF) 10-year strategy to make England the best place in the world for children and young people to grow up in. The Children's Plan is aligned with the Every Child Matters Outcomes Framework and a range of policies and strategies have been developed by DCSF to support Children's Services and Children's Trusts to achieve improved outcomes.

6.2.4 It is worth noting that 51% of children are living in low income families compared to 44% in the North East and 42% nationally. In recognising this Children's Services are in the consultation phase of the development of action plans to deliver the Child Poverty Strategy which will look to address a number of issues around poverty and providing better life chances for young people. This will require a universal and integrated approach with the local authority and key stakeholders working together.

6.2.5 It should also be noted that the local Children's Trust regularly challenges the performance and delivery of services provided by the local authority and other key stakeholders. The Children's Trust has a vital role in: agreeing, reviewing and signing off the Children and Young People's Plan; contributing to the Local Area Agreement (LAA); and in driving the operational plans which underpin them both. LAAs are now the primary vehicle for central government to agree targets for local government and its partners. The Children's Trust is also one of the main thematic partnerships of the Local Strategic Partnership which agrees the priorities for improvement in the LAA.

6.2.6 There was an emphasis on providing more locality or neighbourhood level based provision and in particular a more family based approach for those most in need. Children's Centres also have an important role to play, and this goes beyond those very early years, in providing a whole range of provision from a variety of partners targeted to meet the needs of those who attend. The major issue is that those who attend are usually self motivated, want to be there and are the most informed members of the area. More outreach work is being undertaken to reach those most in need, distanced from society or hard to reach, but this can prove difficult as many of these families often don't wish to be on the radar.

6.2.7 In looking to provide the best possible start for young people Durham and Newham are providing universal Free School Meals (FSMs) to all primary school children. The pilots will run for two years from September 2009 and each pilot will be tested against a control group where the current rules for eligibility for FSMs apply to inform the full evaluation. The pilots are joint funded to a total of £20 million from Department for Children, Schools and Families and the Department of Health and match funded by the successful local authorities, taking the total to £40 million.

Local Authorities in deprived areas were invited to bid to take part in a two year pilot which looks at the health benefits of free school meals. It will investigate whether free school meals can reduce obesity, change eating habits at home, impact on behaviour and academic performance at school, improve school standards and improve general health and well being.

**Education and Maximising Life Chances**

6.2.8 In the findings of the Marmot Review there is a clear identification of the inequalities in educational outcomes affecting physical and mental health, as well as income, employment and quality of life. Young people need to be more informed and educated so they can make informed choices about their health and acknowledged that young people can do risky things, but that this was part of their development and growing up. At the expert jury day it was noted that lifestyle opportunities needed to be well informed and that the whole wellbeing of the child was important. The Joint Strategic Needs Assessment for Sunderland states that there needs to be focus on building the resilience of children and young people in recognising that risk taking behaviours do not happen in isolation, for example there are explicit links between alcohol misuse, educational attainment, teenage pregnancy etc.

6.2.9 There needs to be more targeted interventions within the school setting to allow for young people to make those lifestyle choices in an informed manner. There needs to be greater intelligence gathering on a neighbourhood level. A number of witnesses identified this need to gather local intelligence in order to better understand many of the issues associated with inequalities. This is perhaps most important in achieving educational parity through understanding families, schools and the local community setting. The issue was raised about the increasing difficulty in accessing schools for organisations with information for young people through the increased measures of the Safeguarding Agenda.

6.2.10 Throughout the evidence gathering process the importance of community was evident and the central role that school has to play in this. Members of the public identified the importance of using schools as good community bases to offer courses, activities and develop that link between young people, the family and the wider local community. The extended school model is an important one which can breakdown those traditional boundaries and help young people to develop the life and social skills required. Extended schools services provide a core offer of activities, advice and opportunities including healthy school meals and healthy vending strategies as well as travel-to-school schemes (encouraging safe walking and cycling) and active play projects. The new Extended Services Disadvantage Subsidy from central government has been established to support those children and families who are most disadvantaged, particularly those living in poverty or in the looked after system. The ‘Healthy Schools’ initiative is a key part of addressing health issues, with healthy schools teams providing consultancy to schools on key areas such as substance misuse, healthy lifestyles, and relationships.

6.2.11 Education and maximising life chance does not stop at school it continues beyond 16 and the Marmot Review acknowledges this continuation of education in its findings. It is important to prevent young people from falling into the NEET (Not in Education, Employment or Training) trap and the local authority is working well to develop appropriate early interventions including work related experiences and a pre-16 curriculum offer. Again the issue of quality information was highlighted by witnesses to ensure that the advice given was timely and of a high quality. It was

felt important that the transition from compulsory education to post-16 education and training was a smooth transition to reduce the chances of a young person becoming NEET. Recent research from one northern city indicated that one in seven young people identified as NEET over a long term died within 10 years of falling out of the system. This shocking statistic emphasises the importance of the contribution children's services will make to the new responsibilities which are due to be transferred to local authorities in 2010 for commissioning, funding and in some cases providing educational opportunities for 16 to 19 year olds.

6.2.12 There is also a need for young people to be able to access a range of services within the community which can develop their own skills which will help them to improve their life chances and maximise their capabilities including continuing education, debt management, substance misuse, housing issues, pregnancy and parenting skills. All of which will have an impact on a persons life chances and health outcomes in the future. Figure 3 overleaf is from a random sample of the Sunderland population and indicates the level of knowledge relating to support services available for people locally.

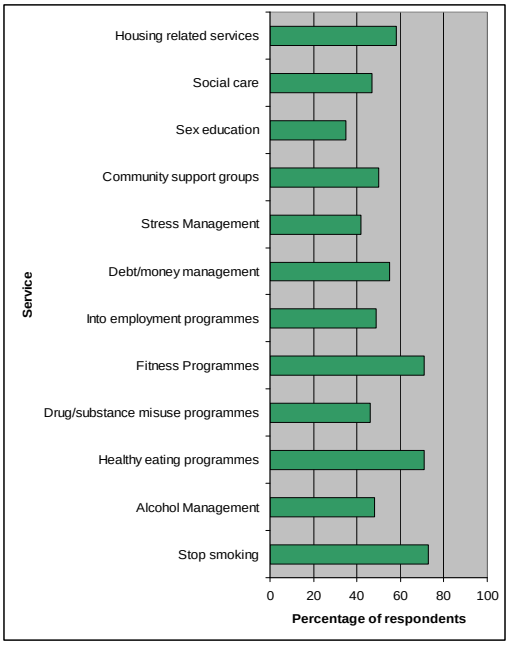



Figure 3: To show if respondents are aware of or know how to access a variety of services

6.2.13 A common theme throughout the entire evidence gathering was one of the misuses of alcohol, cigarettes and drugs by young people. It was argued that drunkenness was a lifestyle choice made by many young people and that going out equated to getting drunk. Many of the attendees at the community event day echoed these sentiments particularly around the availability and access of cheap alcohol and suggested a minimum pricing structure for alcohol or possibly alcohol free zones in certain parts of the city. Around 20% of 13 year old boys and girls describe consuming alcohol but by the age of 15 these figures have doubled. It was also noted that the smoke free legislation and the work of the Tobacco Alliance had made a positive impact on the city but there were still concerns around the sale of illicit cigarettes regionally and nationally. The Joint Strategic Needs Assessment for Sunderland also identifies a very high level of children and young people who still live with adults who smoke and are at risk due to second hand smoke.

6.2.14 Members also visited Monkwearmouth Hospital to learn more about classes, programmes and initiatives to getting people to stop smoking. The NHS funded

stop smoking programme has been in existence for 10 years. It was highlighted that the profile of the smoker was changing, and in particular young girls who smoke was on the increase. Figures from the PCT support this with Sunderland having a higher proportion of year 8 (5% v 3%) and year 10 (20% v 13%) girls who smoke compared to their male equivalents. However the team were constantly looking to accommodate and adjust to cultural changes in the smoker's profile. Members enquired why smoking in younger girls was increasing, and they were informed that the main drivers for younger girls taking up smoking were perceptions of looking more mature, the image of being an adult and it kept them thin. The NHS Stop Smoking Team also explained that bespoke programmes produced good results and that the messages of stopping smoking needed to be consistent and constantly driven as part of the stop smoking programme. The team also acknowledged the importance of local knowledge in tackling the issue.

## 6.3 Employment and Income

### Employment and Work

6.3.1 In terms of health inequalities the contribution that good employment makes for good health cannot be underestimated and similarly the way unemployment contributes to poor health. This was discussed at the community event day by a number of attendees and there was an acknowledgement of the correlation between unemployment and ill health. It was further identified that while unemployment and economic inactivity were associated with higher rates of poor health and mental illness, it was also argued that poor health can in itself lead to difficulties in both securing and retaining employment. Attendees believed that aspirations needed to be raised through increased voluntary opportunities within various organisations across the city. As well as ensuring people who were not in work still felt valued and were offered help from an independent advocate on issues of debt, health and emotional well being.

6.3.2 Local authorities' work in supporting and boosting their local economies is one of a council's less well known activities among the general public. However, for a considerable time now, they have been playing an active part in regenerating communities, promoting their areas to attract inward investment, developing training opportunities to help people improve their employment opportunities and supporting those who are out of work, for example with welfare benefits advice. Sunderland is no different having secured funding from the Working Neighbourhood Fund (WNF) which replaces the Neighbourhood Renewal Funding (NRF). Working with Partners, the City Council has developed a detailed programme for WNF; including elements focussed on client engagement, pathways to employment, skills and training, health support and enterprise initiatives. The WNF represents an additional opportunity to significantly reduce the inequalities within the City caused by unemployment, low skill levels and low levels of enterprise. The WNF will allow for an improved Job Linkage Service to help those people who find themselves unemployed by providing more guidance and support on training opportunities and getting back into work, while also working within communities to encourage enterprise activities where appropriate.

6.3.3 At the expert jury day it was explained that the WNF was focused on people who received out of work benefits including incapacity and income support. The claimant rate for working age people on out of work benefits was 18.8% (May 2009) and in the worst performing neighbourhoods stands at 30.6% (May 2009). The majority of cases concern mental health (stress) and back pain, yet through moving from

incapacity back into work can often see improvements in these conditions. Work continues to develop programmes of specialist activities to strengthen the employment opportunities for the long term unemployed and disadvantaged groups including a Skills and Employability Strategy with the Learning Partnership.

6.3.4 The jobs people move into also need to be good jobs that allow a degree of control and flexibility, insecure or poor quality employment is also very much associated with poor physical and mental health. There also needs to be an equal opportunity within the labour market for those with disabilities, single mothers etc. Again through the WNF, Sunderland City Council is developing a number of schemes which reflect this including Employment Support for People with Disabilities, Mental Health Employment Specialists and with People into Employment – Support for Carers.

6.3.5 The Community Event Day also highlighted the merits of employers within the city looking proactively at the opportunities available to their respective workforces. Offering at work health checks, screenings or information on services available within the public domain was seen as a positive step in promoting health outcomes at work and giving people greater control, information and choice in the work environment.

**Income and Wellbeing**

6.3.6 The complexity of the benefit system as well as its disincentive nature to returning to employment are highlighted within the Marmot Review and are recognised as a barrier to improved income, social standing and wellbeing. It is argued by Professor Goldblatt, a senior researcher for the Marmot Review, that the benefit system in this country is so complex that no-one truly understands it fully, and that it needs to be made clearer with much of the complexity removed.

6.3.7 The link was made at the community event day between the real need for people to work and how this helps to prevent addiction and improve health generally. The number of people on Job Seekers Allowance or Incapacity Benefit was also recognised as of concern. It was also argued though, that people would not return to work if this would reduce their benefits and ultimately leave them in a worse financial position. Witnesses from the expert jury day agreed that many people wanted to work but when often the move into employment had a negative effect on income, thus many people suffered from being caught in a benefit trap.

6.3.8 Obviously this is a challenging issue that requires innovative ways of changing the culture of many people. Professor Goldblatt cited the example of the London Borough of Newham (LBN) that recognised the impact of unemployment on health and developed the Mayor's Employment Project. The service was locally developed to offer support to the long-term unemployed with the objective of getting these people back to work. The project is delivered by advisors who offer expert benefit advice and financial support and provides the guarantee that people will not be worse off when returning to work and will top up housing benefit for a year if needed. The advisors offer help in setting up in-work benefits and establishing childcare arrangements. The scheme has placed 220 residents of LBN back into work and no-one has needed to claim the additional subsidies from the local authority. The scheme has allayed the traditional fears and allowed people to escape the benefit trap through sound advice and information.

## 6.4 Places and Communities

### Local Communities

6.4.1 Neighbourhoods and communities are an extremely important aspect of the health inequalities equation as acknowledged by the Marmot Review and as a recurring theme throughout the committees own research. There is a real issue around mapping the work that is undertaken in communities and neighbourhoods. Are the areas of greatest need where we have the concentration of services? At the expert jury day this was expressed as not always being the case. It was also highlighted that when everyone is treated equally it simply means the healthier get healthier and there is no narrowing of the gap in equalities. Within and across wards the level of variation can be great and both the PCT and local authority are looking to identify neighbourhoods where engagement needs to be targeted. Many of the traditional ways of engaging with communities need to be looked at and new ways of working developed to improve outcomes. There was recognition of the equality of outcomes and the need to be brave when looking at targeting services and providing the right levels of intervention in each area.

6.4.2 The community event day identified a number of issues that people believed contributed to health outcomes, a number of which revolved around neighbourhoods and where a person lives. The new wellness centres were identified as an excellent resource as well as the numerous community leisure facilities in place or under construction across the city. The built environment and development of green spaces across the city was also highlighted as important in providing an attractive environment in which to live.

6.4.3 Attendees also regarded the accessibility of services, shops and activities as important. This highlighted the issue of effective transport links across the city and the issue of ensuring new services or facilities have considered the accessibility arrangements for various groups and backgrounds that exist within Sunderland. Transports primary function is to enable access to people, goods and services. Transport has major health impacts from road accidents, levels of physical activity and associated health effects from weight gain, air pollution and access to a range of services. It is recognised that the adverse health effects fall disproportionately on the most vulnerable groups in society, those living in poorer communities who suffer from environments which discourage active travel, active play and where more accidents are experienced.

6.4.4 ‘Walkable’ neighbourhoods or environments are recognised as places where people are more likely to know their neighbours, participate politically, trust others, and be socially engaged. ‘Walkability’ is something that cannot be planned for without a co-ordinated approach to the built environment as a whole, bringing together housing, transport and the planning system. This illustrates the need for an integrated and coordinated approach to embed health considerations.

6.4.5 The plans and policies of urban planners are instrumental in affecting the conditions in which people live and work, how people access services and facilities, their lifestyles and ability to develop strong social networks. These are key determinants of the health, wellbeing and quality of life of people in cities. Healthy urban planning is about planning for people. It means putting the needs of people and communities at the heart of the planning process, and considering the implications of decisions on health and wellbeing. It also needs to find a balance between social,

environmental and economic pressures similar to planning for sustainable development.

6.4.6 NHS services are universal in nature and this is something that needs to be considered and this was recognised at the expert jury day. G.P's play a crucial role within communities and this can help the NHS to provide local enhanced services through the collection of information on key groups of people within communities. This could allow for better monitoring and better reaction within local areas. The NHS recognised the emerging theme of personalisation. The NHS has a good base and strong foundations around service delivery and working with the local authority and other agencies is looking to better coordination and delivery of services to ensure resources are deployed to those areas or groups most in need. Again attendees at the community day event also expressed their satisfaction with the service from G.P's generally. Many also emphasised how G.P's were able to provide information or access to health programmes.

6.4.7 The easy access and sheer volume of fast food outlets across the city and in communities was discussed by many attendees at the community event day. This follows on from the accessibility issue in communities and it is important that not only do people have access to good quality services but also to good local environments and that includes food. The importance of a healthy diet cannot be stressed enough and people need to be able to access fresh fruit and vegetables. This is not always the case and issues around affordability do play a major part. There is an issue for local authorities and planners to consider the health outcomes of planning decisions on local communities. There needs to a good range of choices on the high street to allow local families to make an informed choice. Links can be made here with local voluntary groups in providing classes to give families the confidence to buy and use fruit and vegetables rather than the easier fast food option.

6.4.8 The voluntary and community sector also play an important part in local communities and provide facilities and opportunities within neighbourhoods. Members discovered examples of internet cafes and luncheon clubs offering nutritious meals and Sit n B Fit schemes which saw joint agency working on a local level. Good neighbourhood projects which look to get communities more involved with each other creating a positive impact on the way people feel about where they live. It was identified that there needs to be more work undertaken to encourage similar joined up working in communities that can move the health agenda forward.

**The Role of Area and Scrutiny Committees**

6.4.9 The importance of neighbourhood data has been touched upon already during this review but it cannot be underestimated in terms of inequality and the targeting of resources. A number of expert witnesses highlighted the role of area committees in addressing this agenda. Area committees are undertaking a new role and defining their own local area plans which involve partner organisations and the third sector. Each local area plan has an investment budget to enhance or supply services locally. Local area committees also have community chest funding which provides social capital and enables communities to improve socially and this too can impact on health outcomes.

6.4.10 Area committees can provide a real focus for developing community outcomes and also providing intelligence on neighbourhood and community level. This intelligence can then provide for targeting of resources to those areas and neighbourhoods

most in need. Area committees provide an interface between local councillors, officers, interest groups and the community to work together and move forward on various agenda fronts which can only serve to improve the health agenda. The use of area committees can also provide for a joined up approach to service delivery and also allow for community input into how services or projects can best work in a neighbourhood.

6.4.11 The scrutiny function also has a part to play in tackling health inequalities. The very nature of health inequalities means there is an impact on all strands of the scrutiny function, and it is important that scrutiny committees look to challenge the key determinants of health inequalities where applicable. There are a number of key documents that can assist the process including the Joint Strategic Needs Assessment (JSNA) which outlines current and future needs of a local population. The JSNA can help to assess how effectively current services are meeting the needs of communities, identify unmet needs and assist with service planning and innovation.

## 6.5 The Prevention Agenda

### The Changing Landscape

6.5.1 The focus over the next five years for the NHS is around developing the prevention agenda and this is clearly outline in the NHS strategy 2010-2015: from good to great . Preventative, People Centred, Productive. There is a growing focus on developing services that are more accessible within communities and enhance the probabilities of reaching vulnerable groups. The real challenge for the health service will be the decommissioning from treatment to prevention, particularly in a perceived period of limited growth. At the expert jury day the importance of investing in community and G.P settings was highlighted, as well as looking at how we manage people with long term conditions. Being able to put people in greater control of their condition can lead to fewer emergency admissions and this is exemplified by the TeleHealth pilot, that is part of the Digital Challenge programme, which has seen reducing numbers of hospital admission.

6.5.2 There are numerous schemes working within communities that have an impact on the prevention agenda. Currently Sunderland City Council and housing partners are continuing efforts in working towards every possible home in Sunderland being insulated. From 2010, this will include trials of solid wall insulation for private homes. The City Council through its Health, Housing and Adult Services Directorate are also developing an Affordable Warmth Strategy to look at tackling issues around fuel poverty. It is schemes like this that can provide real benefits and ensure that resources are directed to where they are needed most.

6.5.3 There needs to be a corporate council approach to driving and tackling the inequalities agenda. There is no doubt that a lot of good work is being undertaken but the links need to be established between the key stakeholders. Also throughout the evidence gathering it became clear that there is a need for every service to consider the health impact of all policies and strategies that are to be implemented. A number of expert witnesses acknowledged that there was a lack of use of health impact assessments across departments. Every service considers the risks of a new project, service or strategy but this must include the health benefits. The importance of health outcomes for Sunderland cannot be underestimated in policy planning or implementation.

6.5.4 There is also a very important role for local elected members to play in driving health inequalities forward. At the expert jury day it was reported that no-one ever raises the issues of a healthy lifestyle or the inequalities in health as an issue with an Elected Member. This raised an interesting point around the role of members as champions of their communities and the need for them to understand the implications of policy decisions on the health of their communities and neighbourhoods.

6.5.5 During the survey conducted by Sunderland LINk on behalf of the committee the question was posed as to what was important in maintaining a healthy lifestyle, the question was open and no options or tick boxes were provided. Figure 4 below shows the results. The results indicate that diet and exercise score well which is positive and illustrates that the message around these themes is being understood and acknowledged. However more importantly it shows how other messages around a healthy lifestyle including health checks, screenings and perhaps more alarmingly smoking and drinking are not hitting the mark. The local lifestyle survey identified that 42.3% of adult males and 21.8% of adult females within Sunderland drink heavily on a single occasion at least once a week, the averages for England are 24.7% and 15.4% respectively.

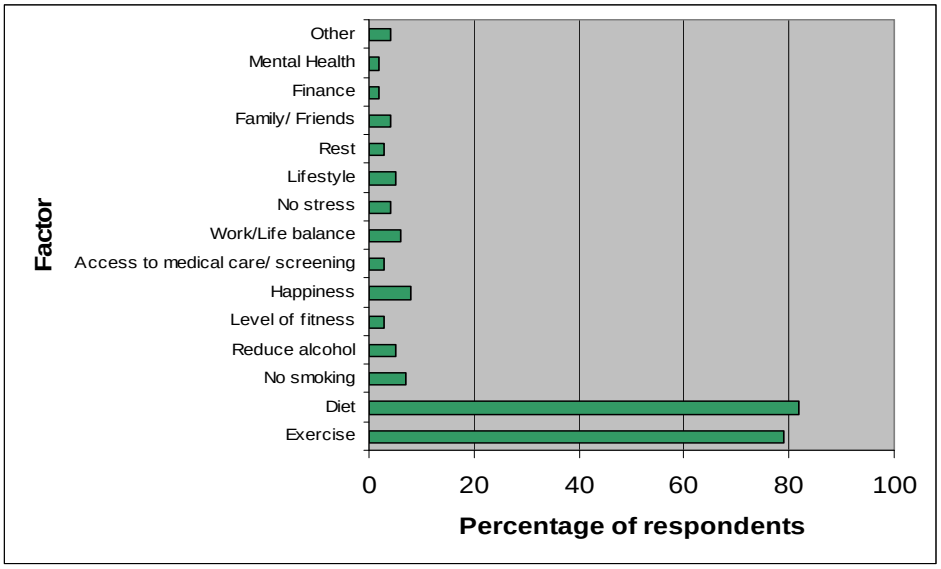



Figure 4: To show factors all respondents consider important in maintaining a healthy life

6.5.6 As indicated drinking and the effects of alcohol are not confined to young people and the proportion of the adult population that drink at harmful levels across the week is highest in the wards of Houghton (35%), Washington East & St. Peters (34%) and St. Michaels (33%), but none of these figures are significantly higher than the average proportion across Sunderland as a whole (29%). According to Sunderland's Director of Public Health what is interesting is the difference compared with other lifestyle indicators e.g. smoking which increases as the socioeconomic gradient declines, whilst with alcohol there isn't a similar correlation, harmful and hazardous drinking occurs across the gradient although there is a suggestion of a decline with age.

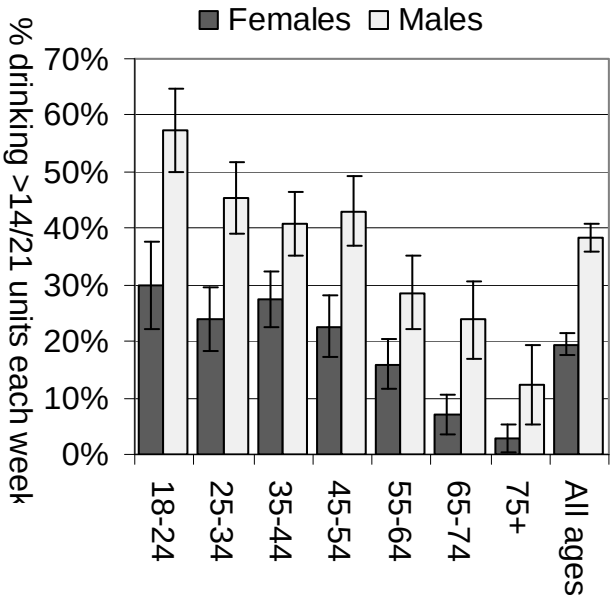



Figure 5: Proportion of adults drinking at unsafe levels each week

6.5.7 Again smoking rates among the adult population in Sunderland are also higher than the national averages. The prevalence of smoking in Sunderland based on Health Survey for England data indicates that 32% of adults smoke. When the population is broken down into groups with similar social and demographic characteristics, the proportion who smoke among 'low income families in estate based social housing' was significantly higher that the overall proportion who smoke across Sunderland.

| Ward | Persons % who smoke | Persons Total Responding | Signficance* |
|---|---|---|---|
| Barnes | 22.8% | 189 | - |
| Castle | 25.4% | 181 | - |
| Copt Hill | 27.3% | 183 | - |
| Doxford | 18.7% | 171 | - |
| Fulwell | 17.3% | 168 | L |
| Hendon | 28.4% | 134 | - |
| Hetton | 27.1% | 129 | - |
| Houghton | 23.0% | 248 | - |
| Millfield | 27.7% | 141 | - |
| Pallion | 33.6% | 152 | - |
| Redhill | 31.3% | 163 | - |
| Ryhope | 28.8% | 191 | - |
| St Anne's | 27.8% | 151 | - |
| St Chad's | 29.3% | 157 | - |
| St Michael's | 22.5% | 151 | - |
| St Peter's | 25.0% | 132 | - |
| Sandhill | 30.1% | 173 | - |
| Shiney Row | 21.9% | 192 | - |
| Silksworth | 22.8% | 228 | - |
| Southwick | 27.7% | 159 | - |
| Washington Central | 22.1% | 172 | - |
| Washington East | 22.8% | 167 | - |
| Washington North | 26.2% | 183 | - |
| Washington South | 20.2% | 173 | - |
| Washington West | 23.6% | 191 | - |
| Unknown ward | 25.0% | 28 | |
| Sunderland | 25.1% | 4307 | |

Source: 2008 South of Tyne and Wear Lifestyle Survey, NHS South of Tyne and Wear

* H = significantly higher than Sunderland average at 95% level of confidence, L = significantly lower, - = not significantly different

Figure 6: Proportion of Adults that smokes by Sunderland ward

6.5.8 The third sector also has a huge part to play in moving forward the prevention agenda and already does a lot of good work within communities. It is crucial that services engage with communities on the right level and a good in-road in to communities is through the already established voluntary networks within communities. A number of social enterprise schemes are also operating with good results and these organisations need to be considered in developing a joined up approach. It is also important that the voluntary and community sectors are supported in the delivery of programmes which can impact on the prevention agenda.

**Total Place Pilots**

6.5.9 'Total Place', is an ambitious and challenging programme that, in bringing together elements of central government and local agencies within a place, aims to achieve three things, create service transformations that can improve the experience of local residents and deliver better value, deliver early efficiencies to validate the work and develop a body of knowledge about how more effective cross agency working delivers the above. This work weaves together two complimentary strands. A 'counting' process that maps money flowing through the place (from central and local bodies) and makes links between services, to identify where public money can be spent more effectively.

6.5.10 Sunderland working in partnership with South Tyneside and Gateshead are looking at the theme of alcohol and drug misuse as a Total Place pilot. This was determined through consultation and workshops with various partners. It is clear that alcohol and drug misuse is a concern that all three local areas have a common affinity with and presents challenges in developing approaches and solutions as well as identifying cross-cutting links with partnerships and priorities.

## 7 Conclusions

The Committee made the following overall conclusions:-

7.1 How you start life, where you live, develop through childhood, the experiences you encounter, your education and employment all have a major part to play in your personal health outcomes and life expectancy. Health inequalities are inextricably linked to the place on the social scale that a person sits, and the more advantaged a person is the more positive the outcomes become. Is this fair and is it necessary, particularly as many of these inequalities could be avoided. The Marmot Review argues that creating and investing in a fairer society is essential to the improvement of health in the whole population, and this is something that all stakeholders need to consider when considering tackling the inequalities of health in Sunderland and nationally.

7.2 The early years of life have the biggest impression on the life course and the choices, lifestyle and health outcomes of any individual and the role that school and family life play in this cannot be underestimated. The social and educational skills developed at an early age through school and family provide individuals with the knowledge to make choices that will influence their life course. The universal free school meals pilot could also provide new evidence to the debate around the best opportunities at the earliest stages of life. Following positive results from the initial pilot authorities it is proposed to extend the pilot to a further six local authorities by September 2010.

7.3 Projects like Sure Start and the Children Centres provide support to young mothers by bringing together a number of support services to provide a positive start for children. It is important that it reaches those who need it most and not simply those who know how to access the service. With this in mind further outreach work is being undertaken across localities to ensure the hardest to reach families get the same support. Children's centres support the most vulnerable and youngest parents not only in bringing up their children but also to develop themselves through providing access to training and employment advice and opportunities and thereby improving their quality of life and standard of living overall.

7.4 Whole school pilots need to look at how the school and the community as a whole work together in partnership. The role of the school as a place to offer courses and activities that develop links between groups within communities is not one that should be dismissed lightly. This dual role as a school and community base can also then provide for access to services including stop smoking classes, healthy eating courses and sex education that are traditionally held in G.P. practices, clinics or other locations that are often remote from neighbourhoods or communities.

7.5 The very real issue of under-age drinking and smoking and the damage this can do to young people is evident throughout the research. The very real concerns that people have about the seemingly spiralling nature of these issues was also highlighted numerous times. The ready availability of cheap alcohol in supermarkets and local shops together with the illicit sales in cigarettes has a direct effect on the health outcomes of individuals in later life. Young people will take risks but these risks need to be informed around the consequence of actions.

7.6 Without the correct knowledge and information the opportunities for making informed decisions becomes limited and positive health outcomes are reduced. This knowledge and information comes from a wide variety of sources including the home, school, friends and communities. All these factors contribute to the choices that are made and the resultant health outcomes. There are clear links between educational attainment and health outcomes and through various settings both within school, the community and the workplace there needs to be as much opportunity as possible to allow for the access to information that can inform the choices people make.

7.7 Unemployment and economic inactivity are directly linked to ill health and this in turn can lead to difficulties in finding or maintaining employment. The status and control people have in their working lives is a contributable factor to their health and wellbeing, being able to have a degree of control or flexibility can reduce stress. In a time of economic instability and a global recession it is difficult to see the aspiration of every job being of this nature. However, there is a lot of important work being undertaken to develop new skills and provide training opportunities to get back to work. The social enterprise schemes are one such example and give employees real control and flexibility as they own the company through the shares they receive. The Working Neighbourhood Fund has also provided the local authority with funding to develop programmes and initiatives which can look to target those most in need of support in returning to work and taking people out of poverty, so they are not trapped in unemployment or earning poverty wages which can impact on their future health.

7.8 The issue of the benefit trap and the complexities of the benefit system are highlighted in the Marmot Review and these issues are not easy to address. However, as can be seen from the London Borough of Newham example, innovative solutions are there to be found. Sunderland offered mortgage rescue plans during the recent financial crisis to help families in the area keep their homes and prevent unnecessary homelessness.

7.9 It is not that people do not want to work rather that they want to be better off for working. Employment can mean many things to a person including development of new skills, better financial standing, increased opportunities and ultimately better health. How we address this over the coming years will take a whole city approach with many of the key stakeholders, enterprises and businesses working together to improve the employment opportunities where they are available.

7.10 The health inequalities agenda is heavily influenced by community and neighbourhood, where a person lives, works and socialises will have a major impact on their lifestyle and health outcomes. So it is important that services have the information to target resources effectively in the right localities. There is already a lot of good work being undertaken at a neighbourhood level through the wellness service, PCT and voluntary sector and this should continue with clear links and a joined up approach. That services are available at low cost in local community venues also helps to remove some of the barriers to participation that may previously have existed.

7.11 Lack of transport links or accessibility to services can only act as a barrier to certain communities or groups within the city. Careful consideration must be given to where services are delivered from to ensure the maximum benefit and that this does not deter those most in need of receiving this support. A similar statement can be applied to the built environment and the importance of access to open and green spaces as well as to a varied choice on the high street.

7.12 Area committees also have an important role to play in bringing together key stakeholders and developing useful data around neighbourhoods for the delivery of strategies and projects. The area committees also have the opportunity to play a major role in the delivery of projects to improve health outcomes on a ward and neighbourhood level. The local knowledge of elected members, the input of local organisations and the opinions of local people can prove vital in the successful implementation of projects on the ground, and this can only be a strength of the area committee role.

7.13 Health impact assessments are an important aspect of assessing the health impacts of policies, strategies and initiatives while health equity audits ensure that access to services is equitable. As well as this the Joint Strategic Needs Assessments (JSNA) can play a crucial role in identifying current and future health needs of local communities, as well as inform the priorities and targets set by Local Area Agreements. JSNA's can also provide focus for scrutiny and area committees to ensure policy direction addresses need within communities. Health needs should be assessed in the delivery of all policies and strategies as inequalities exist in all facets of the life course. It is important to ensure that actions as a result of policy or strategy do not widen the gap in health inequalities but instead strive to create positive health outcomes.

7.14 When we talk of health inequalities and look at the stark figures and statistics for Sunderland these revolve around preventable illnesses. The move from treatment to prevention will be a key challenge for everyone but it is one of the ways identified in the majority of research which can help to reduce health inequalities. Smoking, drinking, teenage pregnancy and obesity all follow the social gradient and if people can make more informed choices through education and early years development there is a greater chance of prevention of such issues in adult life.

7.15 The importance of identifying the health impacts and implications of decisions made by key stakeholders cannot be underestimated. There needs to be a clear understanding of the issues around health for policy and decision makers to ensure informed choices are made that benefit the communities and neighbourhoods of Sunderland. Almost every aspect of life, as can be seen, has an impact on a person's health and the choices they make, therefore it is paramount that Sunderland has the ability to assess strategies and decisions for health outcomes and health equity.

7.16 The total place pilot allows for a new way of working and developing greater links between key stakeholders and communities. It also provides for looking at new ways of engaging and involving all stakeholders in the development of services and initiatives and looks to remove duplications and concentrate efforts on those most in need. Total Place is a new way of thinking and provides for looking at age old problems in a new way, it is this sort of project that could highlight effective measures for tackling health inequalities and narrowing the gap.

## 8 Recommendations

8.1 The Health and Well Being Scrutiny Committee has taken evidence from a variety of sources to assist in the formulation of a balanced range of recommendations. The Committees key recommendations to the Cabinet and partner organisations (where applicable) are as outlined below:-

(a) That 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 be established;

(b) That all Elected Members are 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;

(c) That 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;

(d) That 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) be adopted to ensure that new policies and service designs consider the potential health impacts of implementation;

(e) That the existing joint strategic needs assessment at a City wide, ward and 'natural neighbourhood' level 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;

(f) That mechanisms for ensuring that impact on reducing health inequalities are considered by all scrutiny committees and area committees as part of the work planning process be developed;

(g) 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;

(h) That the City Council become an examplar in ensuring employees benefit through 'Health at Work' Schemes and should engage with the regional workplace health programme.

(i) 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;

(j) That 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, be further explored; and

(k) That in conjunction with our partner organisations; the Council ensures a whole city approach to reducing inequalities through engagement, support and working in partnership to understand the roles and responsibilities including current action plans in relation to the health inequalities agenda;

(l) That the 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.

## 9. Acknowledgements

9.1 The Committee is grateful to all those who have presented evidence during the course of our review. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

(a) Nicola Morrow – Healthy City Coordinator – Sunderland City Council
(b) Lee Cranston – Assistant Head of Corporate Policy – Sunderland City Council
(c) Professor Peter Goldblatt – Lead Researcher - The Marmot Review
(d) Nonnie Crawford – Director of Public Health – Sunderland Teaching Primary Care Trust
(e) Ben Seale – Joint Commissioning Manager – NHS South of Tyne and Wear
(f) Professor Tim Blackman – Dean of Queen's Campus - Durham University
(g) Neil Revely – Director of Health, Housing and Adult Services – Sunderland City Council
(h) Martin Gibbs – Head of the Health Inequalities Unit - Department of Health
(i) Brent Kilmurray – Commercial Director PCT Provider Services - Sunderland Teaching Primary Care Trust
(j) Canon Stephen Taylor – Chair of the Local Strategic Partnership
(k) Alan Patchett – Age Concern and Community Network
(l) Dr Helen Patterson – Executive Director Children's Services – Sunderland City Council
(m) Vince Taylor – Head of Strategic Economic Development – Sunderland City Council
(n) Margaret Elliott - Social Enterprise Scheme
(o) Stephen Wilkinson – Co-ordinator – Sunderland LINk

## 10. Background Papers

10.1 The following background papers were consulted or referred to in the preparation of this report:


(a) The Marmot Review, 2010. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010.

(b) Department of Health 2010. A Smoke Free Future: A Comprehensive Tobacco Control Strategy for England.

(c) Healthy Urban Planning in Practice, 2003. Report of the WHO City Action Group on Healthy Urban Planning.

(d) Director of Public Health Annual Report for Sunderland 2009/10. Sunderland Teaching Primary Care Trust.

(e) Director of Public Health Annual Report for Sunderland 2008/09. Sunderland Teaching Primary Care Trust.

(f) The Local Government Association, 2010. The Social Determinants of Health and the Local Authority.

(g) APHO and Department of Health, 2009. Health Profile Sunderland.

(h) Department of Health, 2009. Tackling Health Inequalities: 10 Years on.

(i)_ Sunderland City Council, 2009. Community Spirit Summer Survey.

(j) Sunderland City Council and NHS South of Tyne and Wear, 2009. Sunderland Joint Strategic Needs Assessment 2009 Refresh.

**Appendix 1 – Community Day**

The Community Day was held at the Stadium of Light on 21st January 2009. Below was the itinerary for the day.

| | | | |
|---|---|---|---|
| | **Buffet lunch** | 12:00-12:45 | (45 mins) |
| **1** | **Cllr Peter Walker, Chair of HWB Scrutiny Committee**<br>Welcome | 12:45-12:50 | (5 mins) |
| **2** | **Martin Gibbs, Health Inequalities Unit – Department of Health**<br>The national policy environment around Health Inequalities | 12:55-13:20 | (25 mins) |
| **3** | **Professor Tim Blackman, Dean of Durham University's Queens Campus**<br>The regional perspective of Health Inequalities | 13:20-13:40 | (20 mins) |
| **4** | **Nonnie Crawford, Director of Public Health**<br>The NHS perspective of Health Inequalities in Sunderland | 13:40– 14:00 | (20 mins) |
| **5** | **Neil Revely, Director of Health, Housing and Adult Services, Sunderland City Council**<br>The Local Authority perspective & the Healthy City | 14:00 – 14:25 | (25 mins) |
| | **Coffee break** | 14:25-14:45 | (20 mins) |
| **6** | **Group discussion** | 14:45-16:00 | (1¼ hrs) |
| **7** | **Cllr Peter Walker, Chair of HWB Scrutiny Committee**<br>Questions and close | 16:00-16:15 | (15 mins) |

The day generated much discussion about the issue of health inequality.

# Appendix 2 – Tackling Health Inequalities Questionnaire Results

182 questionnaires were completed by residents across the city to inform the Tackling Health Inequalities Policy Review. The main findings are shown below.

**Figure 1: To show sex of all respondents**

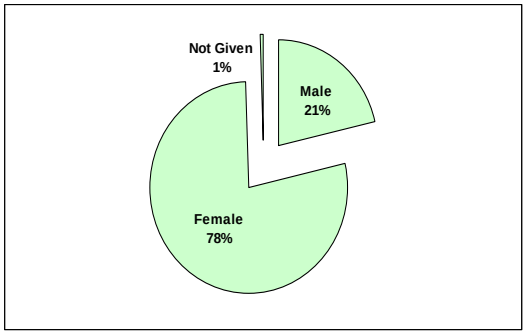



**Figure 2: To show age of all respondents**

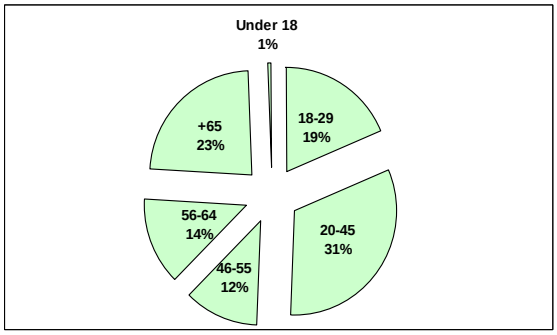



**Figure 3 to show percentage of respondents from each postcode area**

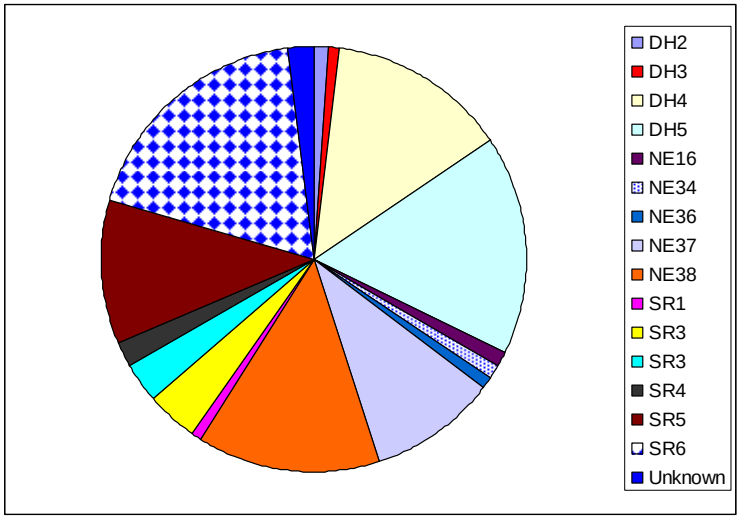



**Figure 4 Percentage of all respondents who consider themselves healthy by age and sex**

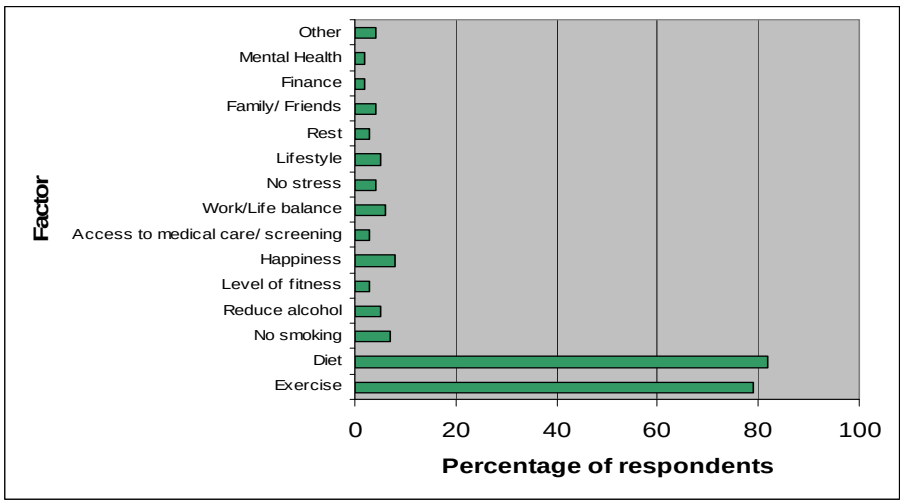
| Age | Total | Male | Female |
|---|---|---|---|
| Under 18 | 100 | - | 100 |
| 18-29 | 96.5 | 100 | 93.3 |
| 30-45 | 82.8 | 77.8 | 83.7 |
| 46-55 | 66.7 | 55.6 | 75 |
| 56-64 | 88 | 83.3 | 89.5 |
| 65+ | 81.4 | 90.9 | 77.4 |
| **Total** | **83.5** | **79.5** | **84.5** |

**Figure 5 Percentage of all respondents who consider themselves healthy by postcode area.**

| Postcode | Total |
|---|---|
| DH4 (Houghton-le-Spring Area) | 96 |
| DH5 (Houghton-le-Spring Area) | 84 |
| NE37 (Washington Area) | 79 |
| NE38 (Washington Area) | 88 |
| SR5 (Sunderland Area) | 60 |
| SR6 (Sunderland Area) | 94 |
| **Percentage of all respondents** | **83.5** |

The 6 postcode areas with the greatest percentage of respondents were selected for comparison in the above figure.

**Figure 6: To show factors all respondents consider important in maintaining a healthy life**




**A selection of comments provided by respondents when they were asked: "Do you think where you live affects your health in a good way or a bad way. What are these?"**

"Both: Bad way- Traffic and mess on the streets. Good way- Open spaces and access to facilities" DH4

"I don't think where I live affects my health either positively or negatively." DH4

"There is access to cheaper fruit and veg and activities for children" DH4

"It is good to have a leisure centre nearby and the school is within walking distance. It would be good to have more facilities near that enabled families to do more physical activities" DH4

"There is nothing to do. There are no parks or places to exercise" SR2

"Living near to GP surgery and shops really helps" NE38

"In a good way, excellent neighbours, neighbourhood watch scheme, it is a semi-rural area with good walking opportunities close to home" SR3

"I think it is up to the individual as to whether they choose to live a healthy lifestyle. i.e. choosing whether to visit the fish and chip shop or the fruit and veg shop" DH4

"Money and the culture in certain areas can affect lifestyle." NE37

"Living in a miserable neglected area can affect your mood and health dramatically." NE38

**Figure 5: To show if respondents are aware of or know how to access variety of services**

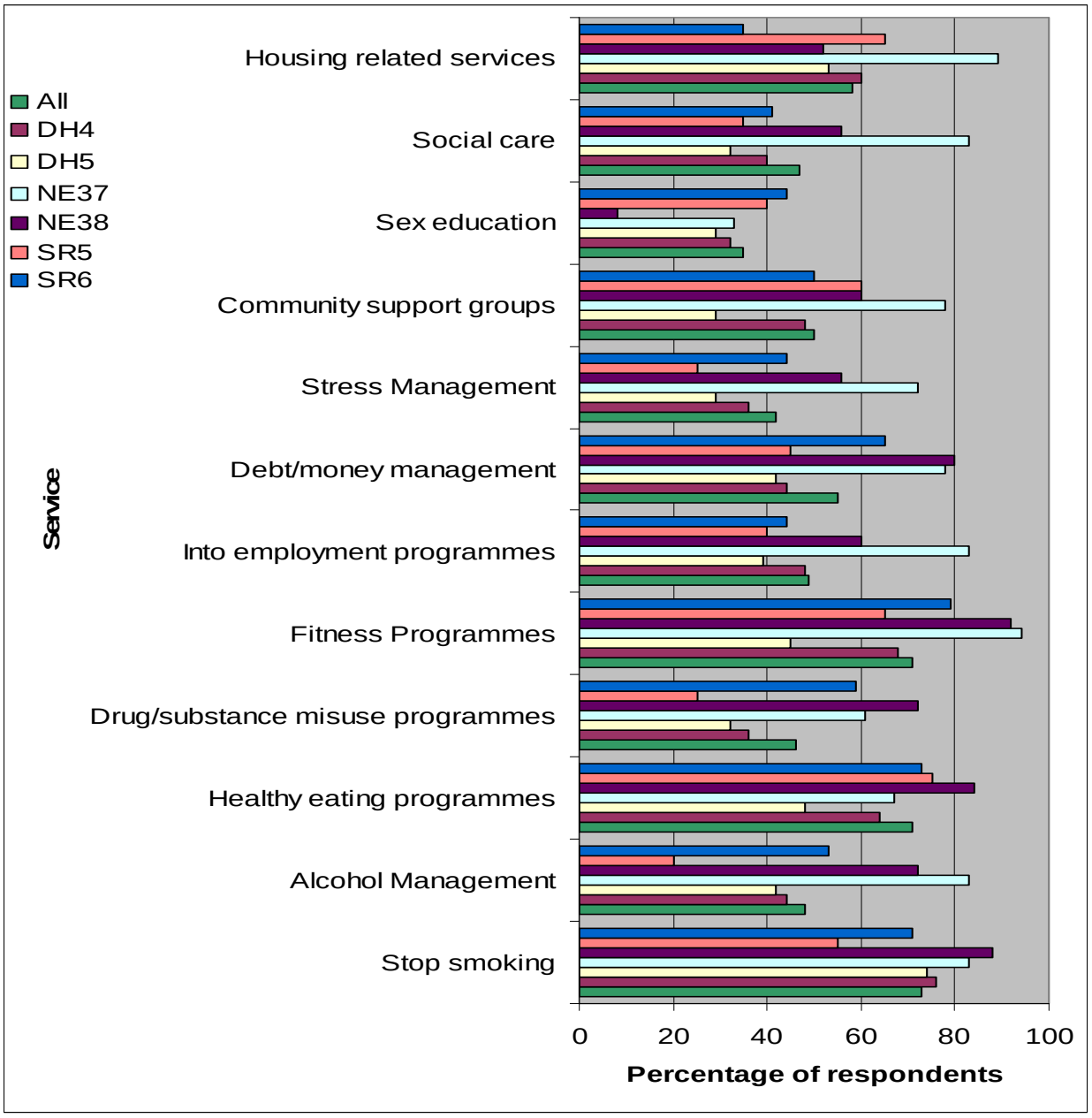



**Figure 6: To show the method respondents considered the best way to be informed about services**

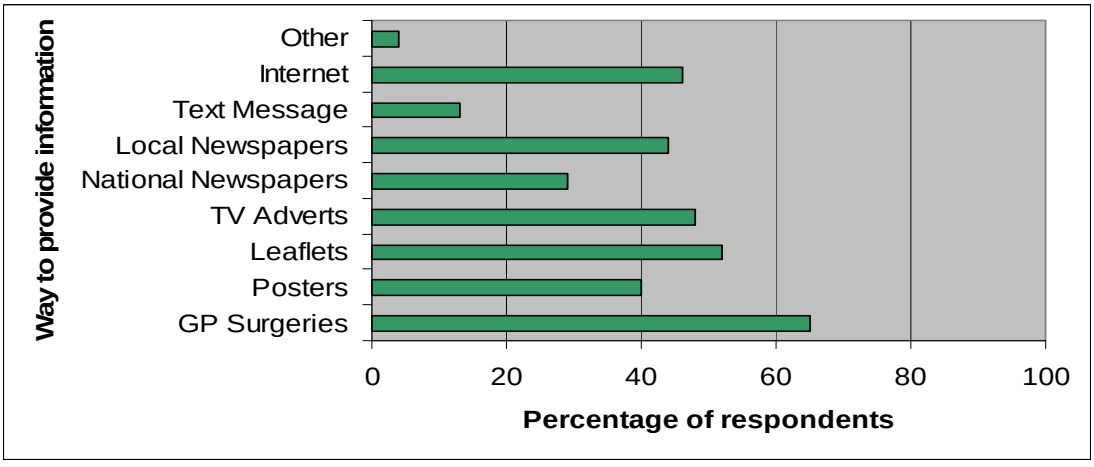



**Figure 7: To show factors which would affect respondents accessing services**

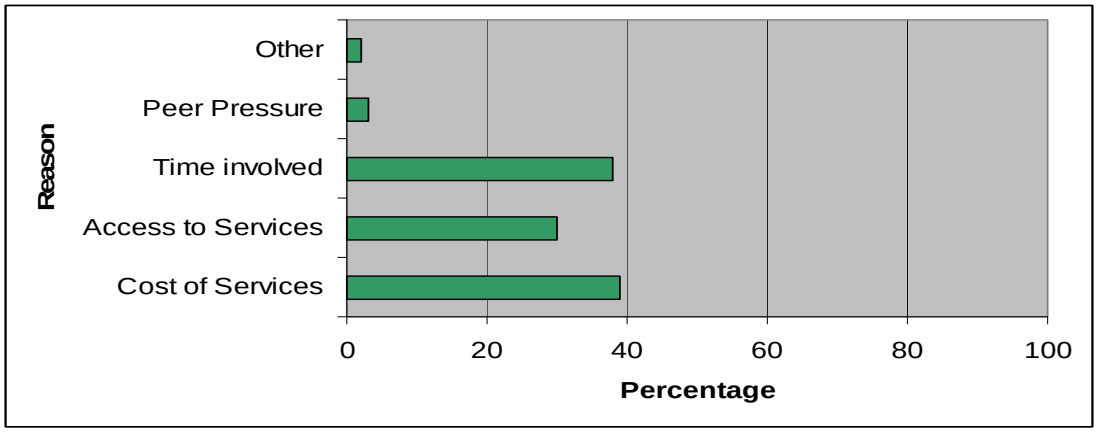
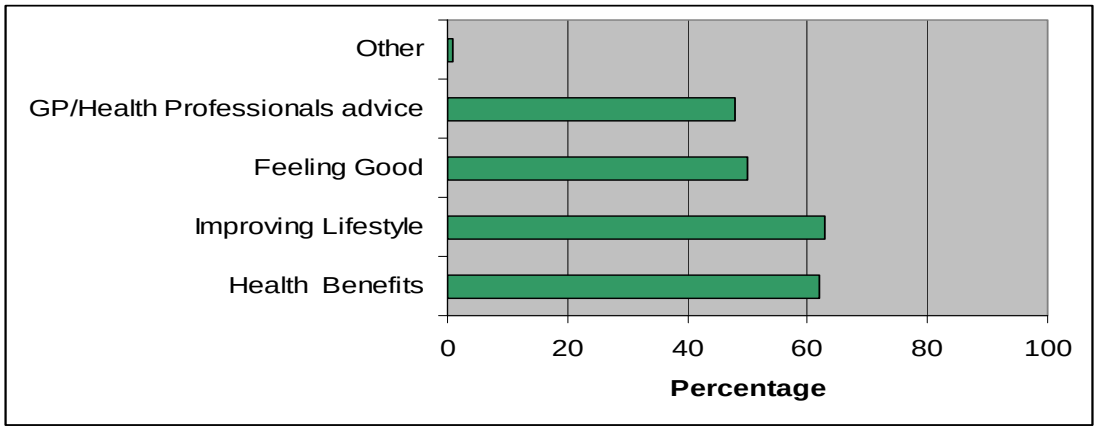



**Figure 8: To show what factors would encourage respondents to access services**



# HEALTH & WELLBEING SCRUTINY COMMITTEE 21 APRIL 2010

## WORK PROGRAMME 2009-10

### REPORT OF THE CHIEF EXECUTIVE

**STRATEGIC PRIORITIES: SP2: Healthy City.**

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

### 1. Why has this report come to the Committee?

1.1 The report attaches, for Members' information, the current work programme for the Committee's work during the 2009-10 Council year.

1.2 The work of the Committee in delivering its work programme will support the Council in achieving its Strategic Priority of a Healthy City, support delivery of the Healthy City theme of the Local Area Agreement, and help the Council achieve Corporate Improvement Objectives CIO1 (delivering customer focussed services) and C104 (improving partnership working to deliver 'One City').

### 2. Background

2.1 The work programme is a working document which Committee can develop throughout the year. As a living document the work programme allows Members and Officers to maintain an overview of work planned and undertaken during the Council year.

### 3. Current position

3.1 The work programme reflects discussions that have taken place at the 10 March 2010 Scrutiny Committee meeting. The current work programme is attached as appendix to this report.

### 4. Conclusion

4.1 The work programme developed from the meeting will form a flexible mechanism for managing the work of the Committee in 2009-10.

### 5 Recommendation

5.1 That Members note the information contained in the work programme.

## 6. Glossary

n/a

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**Contact Officer:** Nigel Cummings, Scrutiny Officer: 0191 561 1006 : nigel.cummings@sunderland.gov.uk

| | JUNE 17.06.09 | JULY 08.07.09 | SEPTEMBER 16.09.09 | OCTOBER 14.10.09 | NOVEMBER 11.11.09 | DECEMBER 9.12.09 | JANUARY 13.01.10 | FEBRUARY 10.02.10 | MARCH 10.03.10 | APRIL 21.04.10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Policy Review | Proposals for policy review (Review Coord) | Scope of review (Review Coord) | Approach to Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Draft report (Review Coord) | Final Report |
| Scrutiny | Proposed Restructuring of Community Nurse Teams in Sunderland (TQ)<br><br>Workforce Development in the Independent Care Sector (TWCA)<br><br>Health and Wellbeing Inequalities (NCx)<br><br>Food Law Enforcement Safety Plan. (NJ) | Position Statement on Autism (SL)<br><br>Pandemic Influenza & Measles – Update (NCx) | Beacon Award – Reducing Health Inequalities | NTW Crisis Resolution Team (RP)<br><br>Intensive Rehabilitation & Recovery Services for Men & Women (CW/MW)<br><br>Washington MPC (GK)<br><br>Integrated Care Pilot Scheme (SL) | Annual Home Care Report including Home Care Services Progress Report (SL)<br><br>Shop Mobility Scheme (PB)<br><br>Barmston Medical Practice (LA)<br><br>Ocular Oncology | Quality Standards for Residential and Nursing Homes for Older People (GK)<br><br>Total Place (LC)<br><br>Redesign of Drug and Alcohol Programmes (BS)<br><br>District Nursing Review (CB) | Electronic Prescriptions (LA)<br><br>NHS Constitution (LA) | Provision of Public Services to People with Learning Disabilities (GK/JF)<br><br>Response to Out of Hours Care Query (GK)<br><br>WHO Healthy City (NM) | | Annual Report (Review Coord)<br><br>Sunderland LINk Report (SW)<br><br>Mobility Scooter Consultation (NC) |
| Scrutiny (Performance) | | Acute MH care – bed numbers | Performance & VfM Assessment (Paul Allen)<br><br>Dementia Care in Sunderland Policy Review 08/09 – Progress (SL)<br><br>Quality Commissioning Progress Monitor 07/08 Policy review SL | Acute MH care – bed numbers | Day Opportunities Update | | Dementia Care in Sunderland Policy Review 08/09 – Progress (SL)<br><br>Performance Framework Q2 (GR)<br><br>Strategic Planning Process 2010/11 (JB)<br><br>Acute MH care – bed numbers | Annual Delivery Plan | Quality Commissioning Progress Monitor 07/08 Policy review SL<br><br>Annual Health Check | Performance Framework Q3 (Paul Allen)<br><br>Home Care Services Progress Report (SL) |
| Ref Cabinet | Cabinet Response to the Policy Review-Dementia Care in Sunderland | | | | | | | | | |

| Committee business | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord)<br><br>Cooption Report | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) |
|---|---|---|---|---|---|---|---|---|---|---|
| CCFA/ Members items/Petitions | | | | | | | Review of CCfA | | | |
| Information | | Forward Plan | Conference Attendance<br><br>CfPS Bid<br><br>Forward Plan | Forward Plan | Forward Plan | Forward Plan<br><br>Joint Scrutiny Proposals | Forward Plan | Forward Plan | Forward Plan | Forward Plan |

Scrutiny Items – Carried Forward

Crisis Resolution Team Update – A further update to come back to committee (Sept 10)
Intensive Rehabilitation & Recovery Services for Men & Women (Sept 10)
Futures Team & Supported Living Model – Report in next Municipal Year (GK)
Presentation on interventions and services available to those with alcohol dependency issues (PCT)
City Hospitals – Clinical Governance Report (CH)
MH Reprovision (TR)

# HEALTH AND WELLBEING SCRUTINY COMMITTEE

## FORWARD PLAN – KEY DECISIONS FOR THE PERIOD 1 MAY 2010 – 31 AUGUST 2010

**REPORT OF THE OFFICE OF THE CHIEF EXECUTIVE 21 APRIL 2010**

### 1. Purpose of the Report

1.1 To provide Members with an opportunity to consider those items on the Executive's Forward Plan for the period 1 May 2010 – 31 August 2010 which relate to the Health and Wellbeing Scrutiny Committee.

### 2. Background Information

2.1 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 To this end, it has been agreed that, on a pilot basis, the most recent version of the Executive's Forward Plan should be included on the agenda of each of the Council's Scrutiny Committees.

### 3. Current Position

3.1 Following member's comments on the suitability of the Forward Plan being presented in its entirety to each committee it should be noted that only issues relating to the specific remit of the Health and Wellbeing Scrutiny Committee are presented for information and comment.

3.2 For members information the remit of the Health and Wellbeing Scrutiny Committee is as follows:-

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).

3.3 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 period 1 May 2010 – 31 August 2010

## 4. Background Papers

None

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Contact Officer : Nigel Cummings 0191 561 1006
Nigel.cummings@sunderland.gov.uk

# Forward Plan: Key Decisions from - 01/May/2010 to 31/Aug/2010
# Items which fall within the remit of the Health and Wellbeing Scrutiny Committee

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| 01367 | To recommend Council to adopt the Food Law Enforcement Service Plan for 2010/11 in respect of Environmental Health and Trading Standards. | Cabinet | 09/Jun/2010 | Member with Portfolio for Safer City | Briefing Session | Via Contact Officer by 21 May 2010 – Health and Wellbeing Scrutiny Committee | Report and Plan | Norma Johnston | 5611973 |
| 01394 | To agree the Re-Procurement of Day Care Services | Cabinet | 09/Jun/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 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |
| 01395 | To agree the Re-Procurement of Day Care Services for people with Dementia | Cabinet | 09/Jun/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 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |
| 01396 | To agree the Re-procurement of Home Care Services | Cabinet | 09/Jun/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 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| 01388 | To consider the recommendations of the Health and Well-Being Scrutiny Committee following a review of tackling health inequalities in Sunderland | Cabinet | 09/Jun/2010 | Health, Housing and Adult Services staff, external providers, service users, carers, public | Evidence at Scrutiny Committee, interviews, community event, expert jury event | Via Contact Officer by 21 May 2010 - Health and Well-Being Scrutiny Committee | Policy Review final report | Nigel Cummings | 5611006 |
| 01399 | To agree the Procurement of a Care Provider for Extra Care (for people with Dementia) | Cabinet | 09/Jun/2010 | Cabinet, Service Users and Carer Groups, Portfolio Holder, Adult Services Staff and Health Partners | Briefings and/or meetings with interested parties | Via the Contact Officer by 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |
| 01397 | To agree the Re-procurement of Short Break Services | Cabinet | 21/Jul/2010 | Cabinet, Service Users and Carer Groups, Portfolio Holder, Adult Services Staff and Health Partners | Briefings and/or meetings with interested parties | Via the Contact Officer by 21 June 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |

**At an Extraordinary meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on MONDAY, 22ND FEBRUARY, 2010 at 9.15 a.m.**

**Present:-**

Councillor P. Walker in the Chair

Councillors Paul Maddison, Old, Shattock and M. Smith

**Also Present:-**

| | | |
|---|---|---|
| Yvonne Crawford | - | Director of Public Health |
| Margaret Elliot | - | Sunderland Home Care Associates |
| Brent Kilmurray | - | Director of Service and Strategy Development, Sunderland TPCT |
| Alan Patchett | - | Director of Age Concern Sunderland |
| Helen Paterson | - | Executive Director of Children's Services |
| Neil Revely | - | Executive Director of Health, Housing and Adult Services |
| Canon Stephen Taylor | - | Chair of Sunderland Partnership |
| Vince Taylor | - | Head of Strategic Economic Development |
| Ann Dingwall | - | Care Manager, Health, Housing and Adult Services |
| Nicola Morrow | - | Healthy Cities Officer, Health, Housing and Adult Services |

**Declarations of Interest**

There were no declarations of interest.

**Policy Development and Review: Tackling Health Inequalities in Sunderland – Expert Jury Day**

The Chief Executive submitted a report (copy circulated) to support evidence gathering for the 2009/10: Tackling Health Inequalities in Sunderland – Expert Jury Day.

(For copy report – see original minutes).

The Chairman welcomed everyone to the Committee and introduced Ann Dingwall, Care Manager, Health, Housing and Adult Services and Nicola Morrow, Healthy Cities Officer, Health, Housing and Adult Services and advised that they would facilitate the flow of information and discussion by Members.

Mr. Nigel Cummings, Scrutiny Officer, outlined the Schedule for the day.
Mr. Cummings referred to the meeting that Members of the Committee had recently held with Professor Peter Goldblatt who was a member of the Marmot Review Team that had undertaken a Strategic Review of Health Inequalities in England post 2010.

The Review recommended 6 policy objectives as follows:-

1. Giving every child the best start in life (highest priority recommendation) – increasing the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

2. Enabling all children, young people and adults to maximise their capabilities and have control over their lives – reducing social inequalities in pupils' educational outcomes; prioritise reducing social inequalities in life skills.

3. Creating fair employment and good work for all.

4. Ensuring a healthy standard of living for all minimum income for healthy living.

5. Creating and developing sustainable places and communities.

6. Strengthening the role and impact of ill-health prevention – core efforts of public health departments focused on interventions related to the social determinants of health proportionately across the gradient.

Mr. Cummings advised that the Expert Jury Day was the second part of the Committee's major Policy Review and was designed to allow Members to question internal staff, service users, carers and external providers in addition to the opportunities presented at Committees and the Community Day.

At this juncture the Chairman welcomed Brent Kilmurray, Director of Strategy and Service Development, Sunderland City Hospitals NHS Foundation Trust to the Committee and invited them to respond to the four questions posed from an NHS perspective.

*Question 1 – What does the term Health Inequalities mean to you?*

Mr. Kilmurray outlined the broad Sunderland context. Average health status in Sunderland was poorer than across England as a whole with life expectancy lower than for England. However, there was a ten year variation in life expectancy between those wards with the best and poorest health in Sunderland. Between 2% and 70% of households in the City were receiving worklessness benefits and 50% of the City's smokers lived in the most deprived areas; the largest proportion coming from the lowest social economic groupings.

Health status was strongly linked to social and economic disadvantage, as measured by factors such as income, housing, culture and education. Mr. Kilmurray stated that the health of the City was also determined by the City's industrial heritage.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Kilmurray advised that Sunderland Teaching Primary Care Trust had a vision contained within its Strategic Plan which consisted of 3 strands:-

1) better health;
2) better patient experience;
3) better use of your money.

By 2015 it was hoped that people would live longer and have better access to prevention services; there would be a reduction in negative lifestyle choices and a reduction in the number of long term conditions. It was important to close the inequality gap between Sunderland and England, 5% was seen as a realistic target. There needed to be better alignment with partners, with greater joined up working. A key aspect of the Trust's policy was to ensure that patients received care and advice in the most appropriate setting.

Some of the expected outcomes would be to improve life expectancy, reduce childhood obesity and reduce alcohol related admissions.

A number of initiatives were taking place. These include tiered obesity services (tier 1 consisting of population wide basic intervention and prevention, tier 2 - specialist obesity services and tier 3 – special services for chronic obesity). Improvement of alcohol services, the reintroduction of school health checks and cancer awareness were also initiatives to improve outcomes.

All strategic plans had a financial strategy. A lot of money was tied up in treatment services and there would be a move to invest as much as £80 million in prevention.

Maximizing the effectiveness of Equality Impact Assessments as a tool to manage performance was extremely important and a more systematic approach to them needed to be taken.

*Questions 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Kilmurray advised that NHS services were universal rather than area based, however, certain services such as community matrons had differing numbers of patients in a given area depending on need. The use of social marketing would ensure a more targeted approach to get underneath groups of patients. GPs had a critical role to play in personalisation.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr. Kilmurray advised that if the 5 year vision was delivered then the outcome of closing the health inequalities gap would be successful but challenging. There would be a reduction in the variations between wards and between the City and England.

Key to realising this success would be far greater engagement with people who make poor lifestyle choices with more screening interventions. Mr. Kilmurray advised that he would like to see more outreach and accessible services to catch vulnerable groups. This could be delivered by decommissioning specific hospital services (a transfer of resources) to prevention, for example, emergency admissions for long term conditions could be reduced by enabling the individual to better manage their condition at home with the help of the community matron service and urgent care teams.

As part of the Digital Challenge a new high technology initiative pilot, Telehealth, would help patients with long term health conditions to monitor their own vital health signs without repeated visits to their GP or hospital. The Telehealth equipment enables users to undertake agreed tests such as blood pressure, blood oxygen saturation levels which are then relayed electronically to health professionals through the telephone line. Any results falling outside of agreed parameters trigger an automatic alert for the appropriate response to be made.

Referring to Local Enhanced Services, the Chairman questioned how they were reviewed and how it was decided which services would be provided within an area.

Mr. Kilmurray advised that enhanced services plug a gap in essential services or deliver higher than specified standards, with the aim of helping the PCT to reduce demand on secondary care. There was a mechanism in place for contracting out to GPs and they were subject to a performance system.

In order to decide what is needed in an area, a whole raft of information was collected upon which to base a decision. Some services might be locally developed to meet local health needs or a piece of work may be commissioned.

Councillor Smith queried whether there were any planned changes to single practice GPs.

Mr. Kilmurray advised that as all GPs were involved in clinical governance there would be a desire to partner.

Following Mr. Kilmurray's attendance, the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Vince Taylor, Head of Strategic Economic Development, Sunderland Council to the meeting and invited him to respond to the questions from an economic development perspective.

*Question 1 – What does the term Health Inequalities mean to you?*

Mr. Taylor advised that there was a distinct difference between morbidity and mortality, the causes of such being very complicated. Lifestyle choices such as smoking, lack of physical activity and poor diet were contributory factors, however, these behaviours, although modifiable by the individual, were heavily influenced by socio economic position and the social environment.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Taylor explained that he worked within the Office of the Chief Executive Directorate and was responsible for the International Team which co-ordinates implementation of the City's International Strategy, the Area Co-ordination Team which develop Local Area Plans for the 5 Regeneration Areas in the City, as local interpretations of the Sunderland Strategy and Local Area Agreement and co-ordinate partnership responses to issues and opportunities contained within them.

The Sunderland Partnership Health Priority had a vision to ensure everyone in Sunderland will have the opportunity to live long, healthy, happy and independent lives. The Economic Masterplan for Sunderland included health considerations particularly with regard to healthy urban planning. Mr. Taylor stated that the Masterplan had identified key industries for growth in which there was a hope of encouraging new businesses to come to Sunderland and a high number of jobs created. Improvement in economic conditions in Sunderland would have a direct impact on the City's health.

Mr. Taylor referred to the importance of technological innovation and improvement in social care. The Council owned Telecare network was installed in 20,000 homes throughout the City.

*Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Taylor advised that the Council's Area Committees had moved into a new process of Local Area Plans based on a partnership model. Each Area Committee had a Local Area Plan and an investment budget. The primary aim of the service was to co-ordinate and enable Sunderland's corporate and partnership response to the social regeneration issues facing the City to endeavour to narrow the gap between the most deprived areas of the City and the rest of the City and Country as a whole.

Community Chest funding was social capital that encouraged social interaction.

The working neighbourhood fund was paid to Local Authorities and communities to help tackle worklessness and increasing skills and enterprise levels. Evidence showed that work could improve individuals' health. People on incapacity benefit and income support were helped to gain employment.

Local Multi Agency Problem Solving Groups (LMAPS) were in place as multi agency response groups to address local crime and disorder problems.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr. Taylor advised that success would be a reduction in mortality and morbidity which would take a long time.

In terms of Mr. Taylor's role, he advised that his aim was to increase prosperity within the City. However, given the current economic climate there would not be the luxury of new initiatives coming through.

The number of people in lower paid jobs was not out of line with the rest of Tyne and Wear, however, there were a lot of people in Sunderland that were not engaging in any type of employment. As a City centre, there were relatively few people who worked in it.

Following Mr. Taylor's attendance the facilitators and Members drew out key issues from the responses to the questions. A full list of the key issues identified by the Committee can be found at the end of these minutes.

The Chairman welcomed Neil Revely, Executive Director of Health, Housing and Adult Services, and invited him to respond to the four questions posed.

*Question 1 – What does the term Health Inequalities mean to you?*

Mr. Revely advised that the term meant unfairness, disadvantage and differences in opportunities. The Marmot Review concluded that wealth and health were inextricably linked.

Mr. Revely stated that on some occasions health inequalities would be a symptom not a cause. It was important to consider what could be done to minimise the impact in the short term and eradicate it in the long term.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Revely advised that in his statutory role as Director of Adult Social Services, a Joint Strategic Needs Assessment (including a Housing Needs Assessment) was carried out with the Director of Public Health. Mr. Revely felt that there was not enough impact assessment work being carried out; although some joint commissioning occurred with the PCT to this regard it tended to be more disease specific.

Mr. Revely recognised the need to do more in relation to impact assessments and advised that he would like to see more assessment at neighbourhood level.

*Questions 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Revely felt that there was not enough neighbourhood specific work, particularly in those areas perceived as 'disadvantaged'.

More in depth investigation was happening which could measure greatest need and where there was most input of services. Mr Revely stated that equality of access may not result in equality of outcomes. In order to achieve this, services would not be uniform across the City.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr Revely stated that he would want the highest ambitions for the City and to expect the best health outcomes in the world in the long term. In the short term very specific targets would be set in shorter time periods.

Targeting key groups of people could make a huge impact. For example the knock on effect of reducing trips and falls could be highly significant given the long term physical, psychological and social consequences of such preventable occurrences.

Councillors Shattock and M. Smith both cited examples of ward based experience with constituents who had problems with obtaining suitable housing. Housing was a key to the broader aspects of health, for example the correlation between warm homes and winter deaths. Mr Revely advised that the Directorate would be investing in thermal imaging technology to determine badly insulated homes. Consequently individual streets could be targeted.

The Chairman questioned what was being done to encourage people off benefits and into work.

Mr Revely advised that Working Families Tax Credit had gone a long way to helping people in the benefit trap.

Following Mr. Revely's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Canon Stephen Taylor, Chair of the Sunderland Partnership, to the Committee and invited him to respond to the questions.

*Question 1 – What does the term Health Inequalities mean to you?*

Referring to the Marmot report, Canon Taylor advised that in England the many people who were currently dying prematurely each year as a result of health inequalities, would otherwise have enjoyed in total between 1.3 and 2.5 million extra years of life. When surveyed, 66.2% of people in Sunderland reported that they felt they were healthy.

Approximately 5 years ago an analysis was undertaken of developing countries, those countries that targeted health inequalities as opposed to economic growth saw the greatest impact.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Canon Taylor advised that as a delivery partnership, the Healthy City partnership currently they only measured what the TPCT did as opposed to measuring impact, this was not as good as it could be. The capacity existed to achieve a fairer distribution of health but there needed to be better collaborative working to make change happen. The delivery plans were in place, however, joined up action to obtain activity had some way to go.

Q*uestion 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Canon Taylor felt that neighbourhoods were not tackled effectively. Area Committees could act as an intelligence hub to identify hot spots in wards and consider the appropriate action.

He also felt that some schools were now like 'fortresses' as a result of the safeguarding agenda. Consequently groups and organisations that had an important message to deliver to young people around risk taking behaviour or health were barred from talking to them in the school setting.

Canon Taylor was extremely worried about the increase in alcohol consumption and associated anti social behaviour. He felt that instances of liver disease will be a huge problem in the future. Alcohol pricing was a contributory factor and Canon Taylor would favour local pricing policies to control this.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

The Local Area Agreement (LAA) set out the health targets which were among the worst in North East. He felt that as part of Community Leadership it was Councillors' duty to lead by example.

Following Canon Taylor's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Alan Patchett, Age Concern, to the Committee and invited him to respond to the four questions posed.

*Question 1 – What does the term health inequalities mean to you?*

Mr. Patchett stated that health inequalities were the differences in health between different sections of the population. Life expectancy was a big indicator but inequalities manifest themselves in many ways throughout Sunderland.

Mr. Patchett reminded the Committee that he represented the over 50 age group within the City. He stated that it appeared inequality grew as people got older, for example, there were instances where older people were denigrated by their GP when they presented with an illness by being told 'What do you expect at your age?'

Mr. Patchett advised that a postcode lottery is applicable in the provision of many healthcare services. The current NHS health checks that were being actively promoted were aimed at 40-74 year olds. While there may be a very good medical reason for the age bracket it looked like institutional inequality.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Mr. Patchett advised that Age Concern's mission statement was 'to promote the well being of all older people throughout the City of Sunderland, improve their quality of life and help them maintain independence'.

Health Impact Assessments were not used as the resources were not available.

Age Concern had an Involving Older People policy, which meant they involved and listened to older people and asked them what they wanted and needed to tailor services appropriately.

By working with the Older People's Partnership Board (OPPAG), 50+ forums and the World Health Organisation, Age Concern ensured that the interests of those aged 50 and over were empowered to address health issues.

*Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Mr. Patchett advised that his organisation was Citywide and delivered to a community of interest – older people – rather than a geographical location. They provided a number of services, including:-

- Information and advice, specifically in relation to helping people maximise their income – there was a recognised link to low income, poor health and low life expectancy.

- Social focus groups for people with mental health problems.

- Tea with Dorothy Group which provided support for gay, lesbian and transgender groups.

- Men's groups – older men were particularly hard to reach.

- Day and lunch clubs.

- Good neighbour promotion.

Mr. Patchett commented that nutrition was a major factor affecting the health of older people. He stated that a neighbourhood focus was good but care must be taken not to target only 'deprived areas' and ignore the rest which may lead to health inequality.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Mr. Patchett advised that a lot of god work had been carried out in Sunderland with regard to the 50+ population. These included the Healthy Ageing City Profile for WHO Healthy Ageing Network, the introduction of age friendly City self assessment, the 50+ Strategy and OPPAG.

Success would mean every individual having the opportunity to live a long, healthy, happy and fulfilling life with access to appropriate health interventions when they needed them.

This would be achieved by:-

- Involving and empowering people as well as informing and educating.

- Enable people to make choices by providing accessible and appropriate support services.

- Prevention was the key. There was a need to adopt a preventative approach – Age Concern aimed to work with 50-65 year olds to help them plan for the future by improving their health, building up social networks and activities and planning for their financial future so that when they retire they are in control of their own lives.

- Evidence exists to show there is a direct link to low income and poor health and this can be addressed by helping older people to maximise their income. From January 2009 to January 2010 Age Concern had helped 3,649 people aged 60+ to claim approximately £2.3 million of benefits and this has a major impact on their lifestyle and health.

- There was a need to stop being driven by central government targets but use those targets as a mechanism to engage people and communities to take charge of their own lives.

- Poor life expectancy and poor health starts in childhood and goes right through into adulthood and old age and therefore adopting a Life Course Approach, as recommended by the WHO could achieve the above.

- There are many determinants of health and the Life Course Approach would help to address all issues that affect a person's health and help prevent poor health.

- The VCS can play a major role in helping statutory partners to get to those 'hard to reach' communities and also deliver low level prevention services in the community.

Following Mr. Patchett's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Dr. Helen Paterson, Executive Director of Children's Services, to the Committee and invited her to respond to the four questions posed from a Children's Services perspective.

*Question 1 – What does the team Health Inequalities mean to you?*

Dr. Paterson advised that social class and social scale led to poorer outcomes in lower socio economic groups. She informed the Committee that children in lower social classes were twice as likely to die under the age of 15.

The Every Child Matters approach aims that every child, whatever their background or circumstance, to have the support they need to:-

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution;
- achieve economic well being;

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Dr. Paterson stated that the Local Authority's vision was to ensure young people receive the help and support they need to achieve their potential and get the best out of life.

Comparisons needed to be made with children in other parts of the Country.
A recently published national report indicated that for children living in a deprived area, 8% were likely to be obese, 9% would have a low birth rate and were 12% more likely to have an accident.

Child health inequality in Sunderland was being tackled in a number of ways: health improvement was well established as part of the Children and Young People's Plan

and the Child Poverty Strategy aimed to show a demonstrable reduction in child poverty via activities that stem from a number of work streams including worklessness.

The Children's Trust regularly challenged performance delivery.

*Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Dr. Paterson advised that there were newly commissioned obesity services which will target hot spots in wards, low income families and BME communities. Children's Centres were universal in offer, but targeted individual activities at a local level. A different range of partners worked at the children's centres.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Dr. Paterson stated that she would like to see young people to be more informed and educated in relation to risky behaviour. She would like to see better lifestyle opportunities for young people and access to medical and sport facilities that would improve mental well being.

She would hope that all youngsters would live the same length of time as the longest living in the rest of the world.

Councillor Smith questioned how children's centres monitored the people using the service to ensure they were targeting vulnerable and hard to reach groups.

Dr. Paterson advised that the TPCT tracked the live birth list. She stated that children's centres were excellent but parents needed to be willing to attend, accordingly much more outreach work was being carried out.

In response to Members' queries regarding health checks in school, Dr. Paterson advised that health and weight checks were carried out for reception and year 5 children along with the inoculation programme, however, there was not the same level of screening that used to take place within the actual school setting.

Following the questioning of Dr. Paterson, the facilitator and Members of the Committee drew out the key issues from the responses.

The Chairman welcomed Nonnie Crawford, Director of Public Health, to the Committee.

*Question 1 – What does the term Health Inequalities mean to you?*

Dr. Crawford advised that health inequalities meant the unfair and unnecessary differences among groups in Sunderland and between wards and neighbourhoods.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Dr. Crawford advised that a key focus would be to extend life expectancy and obtain fair access to services. Public Health has carried out a Health Impact Assessment that helped inform the prioritisation of health needs.

*Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and how do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Dr. Crawford stated that neighbourhoods were not specifically targeted as well as they could be. She advised that there were 65 natural neighbourhoods in the City and 9 were lower than the national average. It was important to engage with the people in the 9 neighbourhoods to determine what needed to be done differently.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Dr. Crawford showed Members a map of the region which indicated in green areas where the health inequalities gap had been reduced. Sunderland was red.

Dr. Crawford would like to see the two year life expectancy gap between men and women in the City close alongside the overall gap between Sunderland and England as a whole. A reduction in teenage pregnancy rates and fantastic breast feeding figures would also be extremely desirable.

In response to a question from Councillor Shattock, Dr. Crawford advised that she believed Gateshead had been more successful in closing the gap because over the last 5 years they had created a community driven vision for health and well being and a focus on neighbourhoods. Changes to practice based commissioning had been implemented in Gateshead which ensured all GPs worked together effectively. Gateshead Council's portfolio holder chaired the strategic committees on health.

Dr. Crawford stated that she would like to see a minimum price for alcohol and felt that Elected Members were in an ideal position to drive the proposal forward.

With regard to Area Committees, Dr. Crawford felt that resources should be utilised and delivered in the pockets where it was most needed as opposed to trying to distribute funding equally. It should be borne in mind that the defined area frameworks for the Council might not fit geographically with those of PCT.

There needed to be a corporate approach to tackling the problems; although there was a lot of good work taking place by organisations, they were often not working together.

Health Equity Audits were a key tool to embed evidence on equalities in planning commissioning and service delivery.

Following Dr. Crawford's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Margaret Elliot, Executive Director of Sunderland, Homecare Associates to the Committee and invited her to respond to the four questions posed from a provider perspective.

Ms. Elliot advised the Sunderland Homecare Associates was an employee owned social enterprise employing over 300 people.

*Question 1 – What does the term Health Inequalities mean to you?*

Ms. Elliot defined health inequalities in terms of specific morbidity conditions that would contribute to differences in the health of people such as obesity, alcohol and liver damage and smoking and lung cancer.

*Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?*

Ms. Elliot advised that the organisation had approximately 500 service users and impact assessments were carried on, for example, fall management. All review and assessments take into account any improvements.

*Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?*

Ms. Elliot advised that the organisation worked in partnership with health and social care partners and Gentoo.

Ms. Elliot described some of the organisations Sunderland Homecare Associates worked with, including Sit n b Fit – which provided seated exercise for people with mobility problems. Such organisations needed to be encouraged.

*Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?*

Ms. Elliot advised that there must be definite measurable improvements. Forums for listening to people were extremely important.

Following Ms. Elliot's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman thanked Members and Officers for their attendance and their contribution and closed the meeting.

(Signed) P. WALKER,
Chairman.

**At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on WEDNESDAY, 10TH MARCH, 2010 at 5.30 p.m.**

**Present:-**

Councillor P. Walker in the Chair

Councillors A. Hall, Paul Maddison, Morrissey, Shattock and M. Smith and Snowdon.

**Also in Attendance:-**

| | | |
|---|---|---|
| Nonnie Crawford | - | Director of Public Health |
| Carol Harries | - | City Hospitals Sunderland NHS Foundation Trust |
| Claire Harrison | - | Sunderland City Council |
| Nigel Cummings | - | Sunderland City Council |
| Graham King | - | Sunderland City Council |
| Sharon Lowes | | Sunderland City Council |
| Councillor Tate | | |

**Apologies for Absence**

Apologies for absence were received on behalf of Councillors Fletcher, Leadbitter and Old.

**Minutes of the Last Meeting of the Committee held on 10th February, 2010**

1. RESOLVED that the minutes of the last meeting of the Committee held on 10th January, 2010 be confirmed and signed as a correct record.

**Declarations of Interest (including Whipping Declarations)**

There were no declarations of interest.

**Update on Policy Review Recommendations: 'Quality Commissioning for Vulnerable Adults'**

The Director of Health, Housing and Adult Services submitted a report (copy circulated) to update the Committee on progress against the policy review

recommendations, from the Quality Commissioning for Vulnerable Adults Policy Review 2007/08.

(For copy report – see original minutes)

Ms. Sharon Lowes, Strategic Commissioning Manager presented the report and provided progress against the remaining policy review recommendations in turn.

Councillor Paul Maddison enquired how many people worked in the call handling team and was advised by Ms. Lowes that there were eight full time equivalent members of staff.

2. RESOLVED that:-

i) In future the update report is received by the Committee on a bi annual basis, and

ii) Recommendation 13 - to consider ways of capturing the knowledge of the voluntary sector to inform judgements and decision-making, with appropriate systems is closed as Provider Forums had been reviewed and will be used as a mechanism for capturing knowledge from the voluntary and independent sectors, in order to improve future commissioning.

**Changes to the Annual Health Check**

The Chief Executive submitted a report (copy circulated) to consider changes to the Care Quality Commission's (CQC) new assessment processes.

(For copy report – see original minutes)

Mr. Cummings advised the Committee that the CQC can now receive information from committees throughout the year, and use it both in key assessments (such as decisions to register a service) and in ongoing monitoring of services throughout the year. The old system of a once-a-year commentary from scrutiny committees was being replaced by a system that will give a more continuous influence in assessments. It will also give a more regular feedback on what is being done with the information received.

The CQC were looking to invite committees to get involved in discussions about how to work together in the new assessment systems, (including systems for registering health and social care providers, and assessments of PCTs and councils as commissioners).

Councillor Paul Maddison requested a list of Members of the CQC and Mr. Cummings agreed to circulate the information.

3. RESOLVED that members note the report and look to invite the local representative of the Care Quality Commission to a future meeting of the committee.

**Policy Development and Review 2009/10 : Draft Report**

The Chief Executive submitted a report (copy circulated) to provide Members of the committee with the first draft report from the evidence gathered in relation to this year's policy review on health inequalities.

(For copy report – see original minutes)

Mr. Nigel Cummings, Scrutiny Officer presented the report and advised that the review document presented in detail the evidence, research and conclusions drawn throughout the review process and members were asked to comment on this for relevance, clarity and accuracy.

Mr Cummings advised that he had received a number of comments from the TPCT and Adult Services and would feed them into the final report.

The Chairman advised that a further meeting would be arranged with the Committee to firm up and agree the final recommendations.

The Chairman also stated that he would like to see more statistics at a neighbourhood level in the report in order to target areas within wards where inequality was most acute.

Councillor Paul Maddison referred to Newham Council's pilot project to help residents who would be financially worse off if their benefits ceased to get off benefits and into work by assisting them with their rent if necessary. He also noted that Newham were chosen to pilot universal free school meals for primary age children and he queried why they had taken such a groundbreaking approach.

Dr. Nonnie Crawford advised that Newham was taking a corporate approach to its bad health outcomes to accelerate improvement.

In response to a question from Councillor Shattock regarding what was meant by 'corporate approach', Dr. Crawford advised that this meant a clear recognition of the need for joint action by local authorities, their directorates and their partners.

Members congratulated Mr. Cummings on the excellent report.

4. RESOLVED that:-

i) that the Health and Wellbeing Scrutiny Committee provide comments on the draft report and that any agreed amendments are made, and

ii) that consideration is given to themes and issues for recommendations to be included in the policy review report by the Health and Wellbeing Scrutiny Committee, and

iii) that a final review report is presented to the Health and Wellbeing Scrutiny Committee at its April 2009 meeting.

**Work Programme 2009/10**

The Chief Executive submitted a report (copy circulated) to consider the current Work Programme for 2009/10 Council Year.

(For copy report – see original minutes).

Ms. Claire Harrison, Assistant Scrutiny Officer, presented the report.

The Committee were advised that future items to be included on the work programme were a report relating to the proposed changes to the laws governing powered mobility scooters and powered wheelchairs and a Clinical Governance report from City Hospitals.

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

**Forward Plan – Key Decisions for the Period 1st March – 30th June 2010**

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider those items on the Executive's Forward Plan for the period 1st March – 30th June which relate to the Health and Well-Being Scrutiny Committee.

(For copy report – see original minutes).

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

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

The Chairman thanked everyone for their attendance and closed the meeting.

(Signed) P. WALKER,
Chairman.

# HEALTH & WELLBEING SCRUTINY COMMITTEE

# 21st April 2010

## RESPONSE FROM THE SECRETARY OF STATE – RE: CHURCH VIEW MEDICAL PRACTICE

### REPORT OF THE CHIEF EXECUTIVE

**Strategic Priority : Healthy City**

### 1. Why has this report come to the Committee?

1.1 The report provides Members with the response from the Secretary of State for Health and the Independent Reconfiguration Panel on the Church View Medical Practice Integrated Care Pilot.

### 2. Background

2.1 The Health and Wellbeing Scrutiny Committee wrote to the Secretary of State on 17th November 2009 on the matter of the Church View Medical Practice care pilot and the rules surrounding exemptions for such pilot schemes.

### 3. Current position

3.1 The initial letter to the Secretary of State and the responses are attached for Members information. The Health and Wellbeing Scrutiny Committee's solicitor will provide a brief explanation of the implications of the responses for members information.

### 5 Recommendation

5.1 That Members note the responses and comment on issues arising from the content.

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**Contact Officer:** Nigel Cummings, Scrutiny Officer: 0191 561 1006: nigel.cummings@sunderland.gov.uk

Secretary of State
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Date: 17th November 2009

Rt Hon Andy Burnham MP,

On behalf of the Health and Well-Being Scrutiny Committee of Sunderland City Council, I write to exercise the power of the Committee to refer an issue to the Secretary of State as outlined in regulation 4.5 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

The issue surrounds the Integrated Care Pilot Programme introduced by the Department of Health in 2008. The aim of the pilot schemes under this programme was to test and evaluate new ways in which PCT's could commission more integrated services. The programme invited innovative applications from prospective integrated care pilot sites and there were over 100 applications.

The proposed pilot scheme was responded to within Sunderland City Council's area by City Hospitals Sunderland NHS Foundation Trust (City Hospitals) and Church View Medical Practice (Church View). Church View is a GP Practice in Sunderland and, pursuant to the pilot scheme has been examined by the Cooperation and Competition Panel under the principles and rules of Cooperation and Competition. The proposal is one of Sixteen Integrated Care Organisations (ICO) pilot projects commissioned by the Department of Health. The Cooperation and Competition Panel has found that the proposed merger is consistent with the principles and rules and recommends that it be allowed to proceed.

In summary the council has the following concerns:

i. In respect of the requirement to consult when an exemption is claimed by an NHS body for a pilot scheme under regulation 4(2)(b) there is currently no obligation to notify the local authority of the exercising of this exemption and this appears to be a gap in the regulations.

ii. The OSC are concerned that there needs to be greater clarity around what constitutes a pilot scheme and the opportunity to provide comment on what a pilot scheme is about. In this instance the pilot scheme is to run for 3 years and involves the permanent features such as the transfer of staff, which effectively negates the opportunity to extend the pilot and so it becomes a fait accompli.

iii. The OSC consider that the proposal is in effect a substantial development or variation of health services in the OSC's area which links to the issue of what is or is not defined as a substantial development or variation in health services.

iv. There are also a number of features surrounding the pilot that the OSC has concerns over. These concerns are more fully set out below for your information.

The Cooperation and Competition Panels' findings and recommendations are based on the conclusion that the proposed merger will not impose any significant costs on patients or taxpayers by reducing the scope for patient choice or competition or undermining the primacy of GP gatekeeper function, and will allow the benefits that might be realised from an integrated care organisation to be explored. Church View and City Hospitals informed the Cooperation and Competition Panel that the merger would benefit patients by removing organisational and contractual barriers and would lead to an improvement in patient care. The clinical integration and improved communication between primary and secondary care would help to prevent avoidable admissions, facilitate discharge and help prevent the admission in their target population. City Hospitals and Church View both consider that the merger will allow them to explore new models of working together to deliver improved outcomes through active management of patients with long term conditions.

The application for the pilot scheme has come to the attention of Sunderland City Council's Health and Well-being Scrutiny Committee (the OSC) following representations from Dr Roger Ford who is the Secretary of Sunderland's Local Medical Committee.

Dr Ford outlined a number of concerns regarding, in particular, the consultation upon and the commissioning of this service and raised his concerns with the OSC. Dr Ford states that there had been no consultation with GP's, their elected representatives in the city, the public, patients of the practice or members of the local health community, and as a consequence there is no clarity around the purpose of the pilot. A copy of Dr Ford's letter dated 22 June 2009 copied to the OSC is attached.

The proposal was brought before the OSC on the 14th October 2009 via a presentation from Dr Helen Groom on behalf of both the City Hospital and Church View.

At that meeting, members of the OSC questioned the legality of the lack of consultation in respect of the pilot scheme. The initial concerns were that the OSC's knowledge of the proposals under the pilot scheme only came before the OSC once the pilot scheme had been successfully considered by the Cooperation and Competition Panel, some twelve months after the initial application.

Given the proposal is a vertical integration of a GP Practice from the community into a hospital setting, concerns were raised due to the fact that this was potentially a substantial development or variation in the provision of health services in the area of this local authority, upon which the OSC had not been consulted.

The OSC have looked at the legal basis for the decision by City Hospitals and Church View not to consult. The legal basis appears to be pursuant to the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations Act 2002 (the Regulations) together with the definition of a pilot scheme, for primary care purposes, under the National Health Service (Primary Care) Act 1997 (the Act). The Regulations at Regulation 4(2)(b) allow for any proposal for a pilot scheme, within the meaning of Section 4 of the 1997 Act to be exempt from the requirement to consult with an Overview and Scrutiny Committee pursuant to Regulation 4(1).

On 15th October 2009 the OSC wrote directly to the Head of the Primary Care Commissioning Team for Sunderland Teaching Primary Care Trust and requested that they confirm upon what statutory basis and provisions they had relied in respect of not consulting with the OSC, (copy attached).

By letter dated 22nd October 2009, the Head of Primary Care Commissioning for Sunderland Teaching Primary Care Trust responded and confirmed that indeed, they had relied upon the pilot scheme exemption under the Regulation 4 including submitting the proposals for the pilot scheme to the integrated care pilot lead from the Department of Health who subsequently confirmed that there was no formal requirement to consult with the OSC, (copy attached).

However, the OSC have significant concerns for the following reasons.

On the 8th April 2009, a paper, substantial development and variations in NHS service, was placed before the OSC by Liz Allen, Head of Public Involvement - Patient, User, Carer and Public Involvement Team for NHS South of Tyne and Wear, the report was a joint report of the Chief Executives of Sunderland Teaching Primary Care Trust, City Hospitals Foundation Trust, the Northumberland Tyne and Wear Trust and North East Ambulance Services, (copy attached).

That Report confirmed an agreement as to what was or was not to be considered as a substantial developments or substantial variations in local NHS services in terms of consulting with the OSC.

That list included the following:

- Method of delivery – altering the way a service is delivered may be a substantial change, for example, moving a particular service into the community rather than being entirely hospital based

- Issues to be considered as controversial to local people, e.g. where historically services have been provided in a particular way or at a particular location.

The pilot scheme currently being proposed, in the view of the OSC, falls into either of those two categories. Despite the fact that it is a pilot scheme, the OSC are informed that the pilot scheme will last for over three years and includes

permanent features such as the transfer of staff. In addition, according to the local medical committee, not only have the OSC not been consulted upon the proposal, neither has any consultation taken place with the public, the patients of the practice or indeed, any members of the local health community.

The OSC accept that the current legislative provisions under the Regulations provide that, per se, that pilot schemes as defined by section 4 of the Act are exempt from the requirement for consultation.

This letter is being sent to the Secretary of State to raise the OSC's concerns regarding the lack of consultation in this matter notwithstanding that the proposal is a pilot scheme. The OSC interpret the Regulations to state that if it considers any proposal to be a proposal for the substantial development or variation of the health services in the area of the OSC, then it may report those concerns to the Secretary of State.

The Regulations do not state whether that proposal is required to be a pilot scheme proposal or any other form of proposal. It simply states that it is a proposal and therefore, the OSC ask that the Secretary of State consider the substance of proposed variation in health services through this pilot scheme and the implications under this proposal, rather than the label of a pilot scheme and revert back to the OSC.

For information the committee report and the comments of Dr Ford are enclosed. If the Secretary of State requires further information we are happy to provide supporting documentation as required, please contact Nigel Cummings Scrutiny Officer Tel; 0191 561 1006 or via email Nigel.cummings@sunderland.gov.uk

Yours sincerely,

Cllr Peter Walker
Chair of the Health and Wellbeing Scrutiny Committee

*From the Rt Hon Andy Burnham MP*
*Secretary of State for Health*

Department of Health

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

*Tel: 020 7210 3000*

POC1_489603

Councillor Peter Walker
Chair
Health and Wellbeing Scrutiny Committee
Sunderland City Council
PO Box 100
Civic Centre
Sunderland
SR2 7DN

15 MAR 2010

Dear Peter,

**REFERRAL BY SUNDERLAND CITY COUNCIL HEALTH AND WELLBEING SCRUTINY COMMITTEE – CHURCH VIEW MEDICAL PRACTICE INTEGRATED CARE PILOT**

Thank you for your letter of 17 November 2009 formally referring proposals about the Church View Medical Practice integrated care pilot in Sunderland.

As you know, I asked the Independent Reconfiguration Panel (IRP) to undertake an initial assessment of the referral.

The Panel has now completed its initial assessment and shared its advice with me.

A copy of the Panel's advice is appended to this letter and will be published on their website on 15 March 2010 (www.irpanel.org.uk)

In order to make a decision on this matter, I have considered the concerns raised by your Committee and have taken into account the IRP's initial advice on the matter.

**Grounds for referral by your Committee**

In your letter of 17 November 2009, you essentially raised four concerns:

- in respect of the requirement to consult when an exemption is claimed by an NHS body fir a pilot scheme under regulation 4(2)(b) there is currently no obligation to notify the local authority of the exercising of this exemption and this appears to be a gap in the regulations;

- the OSC are concerned that there needs to be a greater clarity around what constitutes a pilot scheme and the opportunity to provide comment on what a pilot scheme is about. In this instance, the pilot scheme is to run for three years and

involves the permanent features such as the transfer of staff, which effectively negates the opportunity to extend the pilot and so it becomes a fait accompli;

- the OSC consider that the proposal is in effect a substantial development or variation of health services in the OSC's area which links to the issue of what is or is not defined as a substantial development or variation in health services; and

- concerns surrounding the pilot.

**Local reassurance**

As the IRP points out in its advice, the Integrated Care Pilot Programme prospectus and accompanying evidence base document emphasise that integrated care *"can be an effective way of delivering health care, providing opportunities to break down barriers between primary and secondary care as well as health and social care"*.

The IRP agrees with this view and supports the pilot programme as an opportunity to test innovative models for service delivery aimed at improving the quality of patient care. The CVMP/CHS pilot has undergone a rigorous and detailed selection process within the Department of Health and has also been investigated and approved by the NHS Co-operation and Competition Panel. I concur with this.

**Integration**

Better integration has the potential to deliver some of the key objectives for improving health and care services, including better quality of care, greater personalisation, a shift towards health promotion and reduced inequalities.

The programme of Integrated Care Pilots provides an opportunity for pilots, their partners and the community more widely to use their 'on the ground' knowledge of local populations to design services that are flexible, personalised and seamless.

The current 16 pilots are all being evaluated against a set of criteria including impact on health outcomes, improved quality of care, service user satisfaction, and effective relationships and systems.

Better integration has grown in profile in recent times and the evaluation process will contribute to a robust, evidence base on the impact of evaluation.

I hope that your Committee can continue to support the pilot in its objectives of improving services for patients. The pilot has been making good progress on agreeing terms and the contract is scheduled to novate (finalising the new arrangements) on 1 April 2010.

**Conclusion**

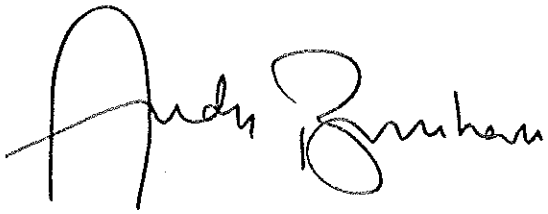
I am satisfied the IRP's advice is in the interests of the local health service and I hope that your Committee will continue to work with local NHS partners in the best interests of patients.

Department of Health

I am copying this letter to:

David Stout, Acting Chief Executive, NHS North East
Dr Peter Barrett, Chair, IRP
Chris Mullin MP

Yours sincerely,



**ANDY BURNHAM**

AG 09.03

*Kierran Cross*
*First Floor*
*11 Strand*
*London*
*WC2N 5HR*

The Rt Hon Andrew Burnham MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

15 February 2010

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Referral by Sunderland City Council Health and Wellbeing Scrutiny Committee**
**Church View Integrated Care Pilot**

Thank you for forwarding copies of the referral letters and supporting documentation from Cllr Peter Walker, Chair of the Health and Wellbeing Scrutiny Committee (the OSC), Sunderland City Council. NHS North East provided initial assessment information. We requested and received supplementary information from the Department of Health. A list of all the documents considered in the initial assessment is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. The IRP considers each referral on its merits and its advice in this case is set out below. **It concludes that this referral is not suitable for full review.**

**Background**
The Integrated Care Pilot Programme was instigated by the Department of Health in October 2008 to test and evaluate new ways in which PCTs could commission more integrated services. The programme invited applications from prospective pilot sites and received more than 100 applications.

The Church View Medical Practice (CVMP) and City Hospitals Sunderland NHS Foundation Trust (CHS) applied to take part in the programme. Under the pilot, CVMP and CHS will work together as an integrated organisation, collaborating in partnership with the PCT provider arm, social services and the Patient Participation Group. The pilot involves a variation to the Primary Medical Services (PMS) contract held by CVMP. CVMP and CHS will merge and CVMP's staff and the PMS contract will be transferred to CHS.
The pilot aims to prevent avoidable hospital admissions through early intervention management for individuals with emerging risk and intensive case management for very high-risk individuals. It will focus initially on around 50-150 patients from the practice population with long-term conditions known to be at high risk of hospital admission.

CVMP and CHS were notified in March 2009 that their application had been chosen as one of sixteen national pilots but were advised that they would need to make a formal submission to the NHS Co-operation and Competition Panel (CCP) for "formal advice". The CCP formally announced its investigation on 12 June 2009. Sunderland Local Medical Committee wrote to the CCP on 22 June 2009 to express its concerns with the pilot, copying its letter to the chair of the OSC. Sunderland Teaching PCT wrote to the CCP on 25 June 2009 to outline its views on the pilot. The PCT commented that it *"has given support to the submission by CHS and CVMP for a pilot application but has not consulted regarding the pilot proposal. A change in contract holder ie novation is not a matter on which the PCT would routinely consult as these are implemented through a routine internal process and would not lead to any major service change for patients"*. The CCP examined the proposal and, in its report of August 2009, found the merger to be consistent with its Principles and Rules and recommended that it be allowed to proceed.

Following a meeting of the OSC, the committee scrutiny officer wrote to Sunderland Teaching PCT on 15 October 2009 raising concerns about the process for consultation on substantial developments and variations and seeking clarification as to why no consultation had been undertaken with the OSC concerning the pilot scheme. The PCT responded in a letter of 17 November 2009 that it had determined *"that as this is a 'pilot', and not a substantial development or variation of health services (the pilot is proposing to affect approximately 50 people which is less than 1% of the Practice population, list size 6300), it is exempt from the statutory duty to consult…."*. Further, the letter quoted paragraph 4(2)(b) of the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002 which the PCT considered provided an exemption from the requirement to consult with overview and scrutiny committees in respect of any proposal for a pilot scheme within the meaning of section 4 of the NHS (Primary Care) Act 1997.

**Basis for referral**

The OSC's referral letter of 17 November 2009 states that referral is made in exercise of the power outlined in Regulation 4.5 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

The OSC summarises *"the following concerns:*

*i* *In respect of the requirement to consult when an exemption is claimed by an NHS body for a pilot scheme under regulation 4(2)(b) there is currently no obligation to notify the local authority of the exercising of this exemption and this appears to be a gap in the regulations.*

*ii* *The OSC are concerned that there needs to be greater clarity around what constitutes a pilot scheme and the opportunity to provide comment on what a pilot scheme is about. In this instance the pilot scheme is to run for 3 years and involves the permanent features such as the transfer of staff, which effectively negates the opportunity to extend the pilot and so it becomes a fait accompli.*

*iii* *The OSC consider that the proposal is in effect a substantial development or variation of health services on the OSC's area which links to the issue of what is or is not defined as a substantial development or variation in health services.*

*iv* *There are also a number of features surrounding the pilot that the OSC has concerns over."*

The concerns at iv above include:

- the role of the GP as "gatekeeper" to NHS secondary care
- the potential effect of changes to employment contracts for staff at CVMP
- the lack of consultation with the OSC on the basis that proposals for pilot schemes are exempted from the requirement to consult with overview and scrutiny committees
- that irrespective of any exemption to consult on pilots, the proposed scheme represents a substantial development or variation and as such, the OSC should have been consulted
- lack of consultation with the public, patients of the practice, and other members of the local health community

**IRP View**

With regard to the concerns raised by the OSC, the Panel notes that:

- legal advice from the Department of Health's solicitors confirms that:
    - paragraph 4(2)(b) of the 2002 Regulations was revoked in 2006
    - the NHS (Primary Care) Act 1997 has also been revoked
- the Department of Health has also confirmed that:
    - applications to take part in the Integrated Care Pilot Programme, including the CVMP pilot, come within the statutory framework of the NHS Act 2006
    - information to potential applicants to the programme was contained in *Integrated Care Pilot Programme: Prospectus for potential pilots,* issued by the Department in October 2008
- a protocol for determining what constitutes a substantial variation or development is in place between the OSC and the local NHS
- the CCP's report on the proposed merger of CVMP and CHS explicitly considered the GP gatekeeper role and concluded that the function would be protected subsequent to the merger by a number of factors, including the professional obligations of GPs to act in the best interests of patients and other measures to protect patient choice that would be put in place
- the need to ensure that all practice staff receive adequate HR support to explain the changes and the effect it would have on their employment rights is recognised in the pilot application: the Department of Health's response of 31 March 2009 highlights potential workforce implications and stresses that applicants must be aware of and understand compliance with current DH workforce policy, particularly in relation to the transfer of staff
- since paragraph 4(2)(b) of the 2002 Regulations was revoked in 2006, at the time the pilot scheme was being developed no exemption to consult with OSCs on pilot schemes existed
- as no exemption to consultation existed, whether or not the scheme was deemed to be substantial should have been a matter for consideration against the agreed protocol along with consideration of any further action required
- the pilot application states that CVMP has an active patient participation group that has always been involved with new developments with the practice and that the group supports the proposed pilot

**Conclusion**

The Integrated Care Pilot Programme prospectus and accompanying evidence base document emphasise that integrated care *"can be an effective way of delivering health care, providing opportunities to break down barriers between primary and secondary care as well as health and social care"*. The IRP agrees with this view and supports the pilot programme as an opportunity to test innovative models for service delivery aimed at improving the quality of patient care. The CVMP/CHS pilot has undergone a rigorous and detailed selection process within the Department of Health and has also been investigated and approved by the NHS Co-operation and Competition Panel.

It is clear from the documentary evidence supplied to the IRP that widespread confusion existed about paragraph 4(2)(b) of the 2002 Regulations which previously provided an exemption from the duty to consult OSCs on proposals for pilot schemes but which was revoked in 2006. At the time the application was made to take part in the Integrated Care Pilot Programme no exemption from the duty to consult OSCs on substantial developments or variations existed for pilot schemes. Neither the OSC nor the local NHS appear to have been aware of this change in the regulations.

The IRP appreciates that a proposal of this nature, including the transfer or novation of a PMS contract from a GP practice to a foundation trust, may be a matter of some local interest and that a scrutiny committee may wish to consider whether such a proposal represents a substantial development or variation in accordance with its agreed protocol. It is encouraging that a protocol for determining what constitutes a substantial development or variation is in place. The effective operation of the protocol is, however, dependent on a commitment to early involvement and the appropriate exchange of relevant information.

Misunderstanding about the duty to consult on pilot schemes notwithstanding, information about the pilot has been made available to the IRP that directly addresses the OSC's concerns and could usefully have been made available to the OSC. The IRP considers that, had the OSC been more involved at earlier stage and an explanation of the purpose of the pilot provided, the referral of this matter could have been avoided.

**Further action**

The IRP advises that:

1 The pilot should proceed in accordance with the requirements and systems for evaluation set out by the DH Integrated Care Pilot Programme.

2 The local NHS should clarify any outstanding queries that the OSC may have regarding the operation of the pilot – including, if required, arrangements for the transfer of staff employment and arrangements following the conclusion of the pilot period.

3 The OSC, having received any further information it requests, should consider how it wishes to proceed in line with the options for further action outlined in the protocol.

4 For the benefit of the NHS, OSCs and other interested bodies, the Department of Health should take steps to communicate the current legal position regarding consultation with OSCs and the status of pilot schemes.

5 DH guidance on the scrutiny of health services is out-of-date and under revision. The revised guidance is an opportunity to clarify some of the issues raised by this referral and to promulgate useful messages – including the benefits of the early involvement of local people in developing proposals for change and the value of a local protocol to determine what constitutes a substantial development or variation.

The IRP considers that this matter can be resolved locally and is not suitable for full review.

Yours sincerely

Dr Peter Barrett
Chair, IRP

# HEALTH & WELLBEING SCRUTINY COMMITTEE

# 21st April 2010

## SUNDERLAND LOCAL INVOLVEMENT NETWORK

### REPORT OF SUNDERLAND LINk

### Strategic Priority : Healthy City

### 1. Why has this report come to the Committee?

1.1 The presentation will provide Members with an overview of the work of the Sunderland Local Involvement Network (LINk) and provides the committee with the opportunity to look at how the Sunderland LINk compliments the work of the council and the scrutiny function.

1.2 The work of the Committee in delivering its work programme will support the Council in achieving its Strategic Priority of a Healthy City, support delivery of the Healthy City theme of the Local Area Agreement, and help the Council achieve Corporate Improvement Objectives CIO1 (delivering customer focussed services) and C104 (improving partnership working to deliver 'One City').

### 2. Background

2.1 The Health and Wellbeing Scrutiny Committee has invited Sunderland Local Involvement Network to attend the April 2010 Scrutiny Committee meeting to provide a brief presentation as to the work undertaken by the LINk during the year.

### 3. Current position

3.1 LINks were created by a law passed by Parliament - the Local Government and Public Involvement in Health Act 2007 - which sets out their legal duties and powers. In addition, Government has issued Regulations and Directions describing the detail of LINk activities which have the force of law and must be complied with. This provides LINks with a considerable authority to work directly with the NHS and Local Authority on behalf of the local community. The legislation creating LINks also abolished Patients Forums across England on 31st March 2008.

3.2 The presentation outlines the work that Sunderland LINk has been involved with during the previous year as well as identifying some of the more specific issues dealt with.

## 4. Conclusion

4.1 The presentation will provide members with an overview of the role and work of the Sunderland LINk.

## 5 Recommendation

5.1 That Members consider and comment on the presentation made by the Sunderland LINk.

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**Contact Officer:** Nigel Cummings, Scrutiny Officer: 0191 561 1006: nigel.cummings@sunderland.gov.uk

# Sunderland Local Involvement Network (LINk)


LINk Sunderland

Sunderland Local Involvement Network is hosted by Age Concern Sunderland

# The Vision for LINk is:-

- *"To help create a local system where every section of the community, has the opportunity to say what they want from local care services, with the certainty that the people who plan and run them will listen and respond."* (Local Government and Public Involvement Act - October 2007)

# Intention of LINks

- Create a stronger more independent voice
- Broaden representation
- Long term provide a  single approach to public involvement in Health and Social Care service improvement and development
- Future – may involve more services

# Aims & Expectations

- Health & Social Care Services have an opportunity to improve when local people are more involved in planning those services

- Sunderland LINk will recruit and empower members of the public and groups to evaluate, view and report on local services – feed into Quality Accounts

# Who

Anyone, Individuals, members of groups or organisations

## How you can be involved

On an ad-hoc basis – issue specific participants

or

Members – people who give regular commitment to help
Enter and View roles – talking to service users.
Core group – Management responsibilities

# LINk Model

Specialist Task / Sub Groups

Publicity Sub group

Registered LINk Membership

Wider population

LINk CORE GROUP

Wider population

H o s t

COMMISSIONERS and SERVICE PROVIDERS

Finance Sub group

LINk Sunderland

Sunderland Local Involvement Network is hosted by Age Concern Sunderland

**ENGAGEMENT**
LINk engages with community & receives feedback about health & social care

**FEEDBACK**
outcomes to community

**LINk OUTCOMES**

**ANALYSIS**
LINk analyses feedback & identifies trends & priorities which form basis of work programme.
LINk may make visit to validate feedback

**SERVICE CHANGE OR IMPROVEMENT**


**ACTION**
LINk writes reports & recommendations based on analysis & sends to Commissioners

**SYSTEM RESPONSE**
Commissioners respond to LINk within 20 working days detailing action to be taken & discuss with Provider changes to be made

# What we have been doing so far

- Carrying out surveys for LINk
- For Health and Well Being Review Committee
- Formulating work plans
- Publicity strategy

Your Health

Your Say

Your Sunderland LINk

All publicity will have this “brand”

- Talking to groups and organisations about issues
- Gathering people's views on highlighted issues
- Asked providers and Commissioners about some issues raised.

# Specific Issues identified

- Vulnerable patients not attending appts
- Patients not attending appts.
- Information on GP's Websites
- Monitoring of home care services
- Smokers at city hospitals
- New Commissioning arrangements for district nursing services.
- Discharge process from hospital

- Annual conference in February
- Confirmed issues already raised
- Raised further issues for Mental Health services
- Services for people with disabilities
- Enter and view training has raised additional issues

# How to contact local LINks office

24 Stockton Road
Sunderland
SR2 7AQ

T 0191 565 9045
E enquiries@sunderlandLINk.org.uk
W www.sunderlandlink.org.uk

**Health and Wellbeing Scrutiny Committee**

**21st April 2010**

**Performance Report Quarter 3 (April – December 2009)**

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

## 1.0 Purpose of the report

1.1 The purpose of this report is to provide Health and Wellbeing Scrutiny Committee with a performance update relating to the period April to December 2010. This quarter the report includes:

- Progress in relation to the LAA targets and other national indicators.
- Progress in relation to the Home Care Provision and Dementia Care Policy Review Recommendations.
- Results of the annual budget consultation which took place during October/November 2009

## 2.0 Background

2.1 Members will recall that a new national 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 are a key consideration in CAA in terms of the extent to which the partnership is improving outcomes for local people.

2.2 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. The first results were reported on the Oneplace website (www.oneplace.direct.gov.uk) on 9 December 2009. Health and Wellbeing Scrutiny Committee considered the findings of the draft Area assessment report in January 2010.

2.3 Members will recall from previous performance reports that the CAA lead plans to adopt a Risk Assessment Matrix which will be the primary tool against which the Sunderland Partnership will be assessed. The Matrix will incorporate those issues that were identified in the first year of the CAA area assessment as having the most potential to become red flags and green flags. These are;

2.4 Once the Risk Assessment Matrix has been agreed, the CAA Lead will use it to monitor progress against the agreed performance trajectory (up until the end of September 2010) for each issue to arrive at his final area assessment judgement for 2010. Progress will be monitored through the Council and the Sunderland Partnership's performance management and reporting arrangements. As part of ongoing improvement planning the Sunderland Partnership's Delivery Plans have

been refreshed to ensure that the work programme is targeting the right issues, and outcomes can be demonstrated, minimising the risk of areas for improvement becoming red flags in 2010. These Delivery Plans were presented to Scrutiny committees in February 2010.

2.5 The annual budget consultation took place during October/November 2009. The consultation took the form of a survey followed by participatory workshops which were held across Sunderland with Community Spirit panel members and representatives from the voluntary and community sector. The purpose of the workshops was to prioritise approaches to addressing the budget priorities that had been drawn from the survey results and also provide attendees with:

- A better understanding of the issues that have to be addressed in the budget setting process and information about the budget priorities
- An opportunity to hear the viewpoints of others when making judgements about budget priorities

2.6 The findings helped to inform the Council Revenue Budget for 2010/2011 which was approved on 3 March at a meeting of the full Council. A summary of how resources will be directed to the top priorities identified in relation to health and wellbeing can be found in section 3

2.7 As part of the development of Scrutiny particularly in terms of strengthening performance managements 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 both as part of CAA requirements and future partnership working. Progress in relation to the Home Care Provision and Dementia Care Policy Reviews are attached as ***Appendix 1.***

***Appendix 2*** provides an update of the position for relevant national indicators and also the local performance measures, which are used by CQC to judge the delivery of adult social care. This includes the results of the former CSCI Performance Assessment Framework (PAF) indicators within Adult Services.

## 3.0 Findings

### 3.1 Performance

3.1.1 In relation to Health and Wellbeing nine national indicators are priorities identified in the LAA. An update is available in relation to 3 Nis in relation to the period April to December 2009. An overview of performance can be found in the following table.

| Ref | Description | 2008/09 Outturn | Latest Update | Trend | Target 2009/10 | On Target |
|---|---|---|---|---|---|---|
| NI 130 | Social care clients receiving Self Directed Support | 0.06% | 6.73% | ▲ | 8.5% | ✓ |
| NI 136 | People supported to live independently through social services (all adults) | 3124.19 | 2865.2 | ▼ | 3415 | ✘ |
| NI 139 | People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently | 35.5% | n/a | n/a | Next target 2010/11 | n/a |
| NI 120f | All-age all cause mortality rate - female | 562 | 578.7 | ▼ | 546 | ✘ |
| NI 120m | All-age all cause mortality rate - Male | 777 | 851 | ▼ | 748 | ✘ |
| NI 119 | Self-reported measure of people's overall health and wellbeing | 66.2 | n/a | n/a | n/a | n/a |
| NI 123 | 16+ current smoking rate prevalence | 1100 | 749.8 | ▼ | 1437 | ✘ |
| NI 39 | Rate of Hospital Admissions per 100,000 for Alcohol Related Harm | 2378 | 2636 | ▼ | 2207 | ✘ |
| NI 119 | Self-reported measure of people's overall health and wellbeing | 66.2 | n/a | n/a | Next target 2010/11 | n/a |

3.1.2 Part of the local performance measures, which are used by the Care Quality Commission to judge the delivery of adult social care, includes the results of the former Performance Assessment Framework (PAF) indicators within Adult Services. An update against all relevant PAF (now local performance) indicators for the 12 months ending March and December 2009 (or the latest available position) can be found in Appendix 1.

3.1.3 Performance against the National and local indicators remained mixed during 2009/2010 and a more detailed analysis is presented below. Key risks and related improvement activity are described in the following sections.

**3.1.4 How healthy is the city and are citizen's health & emotional well being improving?**

**NI120 All age all cause mortality rate**

Latest performance relates to 2006 – 2008 pooled rates and mortality rates have increased since the previous reporting period and are not on schedule to achieve the 2009/10 target of 546 for females and 748 for males per 100,000 population

A number of Masterclasses are being held as part of the Bakers Dozen work by the Health Inequalities National Support team. The outcomes of these masterclasses will be incorporated into the partnership's Delivery Plans as part of ongoing action planning at the end of March / early April along with relevant outputs when the work of the national team is completed.

In addition a programme of Health Checks is being implemented - 8348 checks are programmed for 2009/10. Cardiovascular risk programme process model has also been developed to form the basis for commissioning requirements during 2010/11 Target outputs from this programme will be available when commissioning has been undertaken.

The city's Wellness Service works to improve individual's health and well-being through the provision of physical activity opportunities, lifestyle advice and education. Working with the Teaching Primary Care Trust (TPCT) and the Third Sector, the Wellness Service actively targets and engages with people who do not yet have physically active lifestyles to provide health information, advice and active support to change their lifestyles to help reduce their risk or maintenance of chronic or lifestyle diseases. The outcome will clearly affect a range of health improvements (including those that are National Indicators) including increasing life expectancy; preventing heart disease and stroke; reducing blood pressure and obesity; and improving mental health and well-being. In 2008, the Council and PCT were awarded Beacon status for their work in reducing health inequalities in the city's neighbourhoods and its willingness to innovate. This provided the city to deliver a number of learning exchanges between Councils and PCTs to help them and the city identify best practise.

In order to do this, the Wellness Service has developed a range of preventative services, targeted interventions and specialist support services at a local level, including within its 7 Wellness Centres in the city:

- *Prevention - Community Wellness Programme* via 8 Community Wellness venues across the city designed to attract residents who do not want to participate in main Wellness Centres. There were over 10,000 attendances to these venues with specialist sessions with CWP Wellness Coaches. This includes specialist support for a small number of people that have significant learning disabilities at one of these wellness venues, which has proved to be popular and successful;
- *Prevention - Community Classes for those over 50:* Specific classes for this age group started in Sep-08, and are specifically designed to improve mobility, balance and coordination to decrease likelihood of falls and increase individuals' ability to continue to live independently. There are currently 192 engaged on the Programme, which includes "Sit N B Fit" classes;
- *Prevention – Wellness…it's a Walk in the Park:* Wellness Service has recently marketed a citywide marketing programme, including marked routes across each of the 5 areas of the city. Routes in the city's parks will typically be 1 – 3 miles in distance, and be suitable for people with life-limiting conditions;
- *Targeted Intervention - Sunderland Exercise Referral & Weight Management Programme* operates from Wellness Centres and community venues, providing greater choice of activities for patients. The Programme is a physical activity referral system enabling health professionals to recommend a course of exercise for patients with a variety of medical conditions. It ensures people at risk are identified sooner and referred to the appropriate health, diet and physical activity advice that will make a difference to their long term well-being. Since April 2009, throughput exceeded its targets in terms of number of people starting 15 week programme (1,987), including GP surgery referrals (over 125), with referrals received from all city's GP practices;
- *Targeted Intervention – Workforce Health & Wellbeing Project* is a research pilot designed to test the effectiveness of the workplace by targeting employees working within Sunderland and Gateshead Council who fall into the category of being lower paid employees who also live in areas of higher deprivation. To date 1584 employees have been contacted to take part in the programme, 333 have received a NHS health check with referral mechanisms where relevant for

exercise, alcohol services, smoking and weight management. The project ends in October and a business case is currently being drafted to potentially continue the project and involve more employers in Sunderland. A further project includes Wellness on 2 Wheels Summer Cycling Programme, with over 50 Council employees accessing one or more of these organized bike rides.

- *Targeted Intervention – Supporting People Wellness Project* works with a small number of particularly vulnerable individuals residing with the Salvation Army to improve their health and well-being, including membership of the Wellness Centre to encourage people to increase their activity levels which will not only help their health and well-being, but their self-esteem, confidence and social skills and promote community cohesion as well;
- *Specialist Service – Specialist Weight Management Service:* This Programme, for individuals identified by GPs as clinically obese, delivered in partnership between the Wellness Service, TPCT and City Hospitals. A multi-disciplinary team based at the Aquatic Centre consisted of a psychologist, dietician and exercise practitioner. The Service provides a traditional clinical programme with access to a leisure facility.

**NI123 16+ current smoking rate prevalence**

Latest performance (April to December 2009) is 749.8 smoking quitters per 100,000 population. Performance has declined compared to 2008/09 and currently not on schedule to meet the 2009/10 target of 1437 quitters per 100,000 head of population. 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;
- Development of the pregnancy and training roles and a focus on key priority groups e.g. routine and manual, including Smoking in Pregnancy pathways, with specialist advisors in ante-natal settings;
- 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
- Supporting smokers to stop
- Media, communications, social marketing and effective education
- Reducing the availability and supply of tobacco products- licit and illicit-and addressing the supply of tobacco to children
- Tobacco regulation
- Reducing tobacco promotion
- Research, monitoring and evaluation

**NI39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm**
The rate of hospital admissions per 100,000 for alcohol related harm is increasing as a consequence of NHS investment in alcohol treatment services. Latest performance is 2636 admissions per 100,000 population (April to September 2009) which is considerably more than the 2009/10 target of 2207.

The significant investment to tackle alcohol issues in Sunderland, is being made through a new Alcohol Strategy. This includes Alcohol Treatment programmes targeted towards violent offenders with alcohol misuse issues

New alcohol services are being commissioned which include:

- Enhancement of Tier 1 and 2 provision. Widen the scope of delivery of screening and brief interventions to ensure that interventions can be offered to 20% of the estimated Hazardous drinking population annually (approx. 4930)
- Enhancement of Tier 3 and 4 provision. Expand tier 3 services to provide treatment for 20% of the estimated Harmful drinking population annually (approx. 1242)
- Expansion of tier 3 and 4 services to provide treatment for 205 of the estimated Moderate and Severe Dependent Drinking populations annually (approx. 150)
Reducing alcohol use in young people

*3.4.2 How is the city improving citizen's quality of life?*

*NI 136 People supported to live independently through social services (all ages)*: One of the main sub-objectives in this area is to promote independence for individuals in order for them to live in their own homes for as long as possible. This is particularly true for older people, but also includes support for younger adults with life-limiting conditions. The latest performance update for the measure that relates to this objective is currently lower than the target of 3284 per 100,000 for 2009/10, and it is unlikely that performance target will be met.

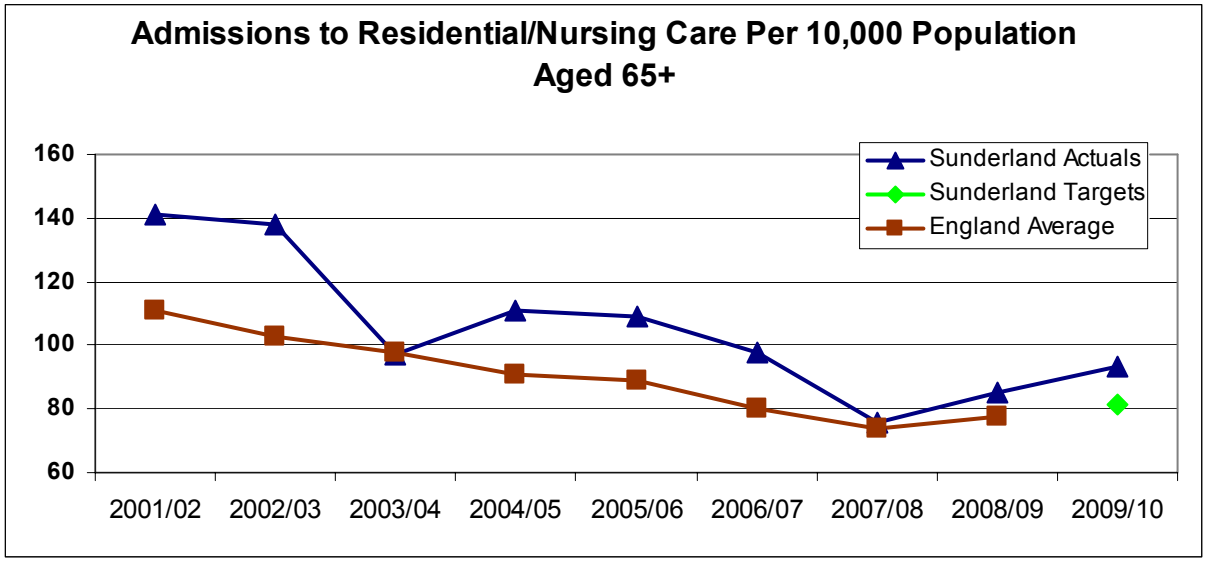
The Directorate of Health, Housing and Adult Services is currently addressing this issue, via developing community "in-reach" solutions as part of the Council's overall Customer Service strategy. For example, the Directorate recently completed an older people's population profiling for the city, and used this as the basis for a more targeted and pro-active approach to supporting individuals. For example, the Council is working on a Department of Health pilot with Church View Medical Practice to better identify people who might 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 will be rolled out to the North, as well as West, Sunderland Area, working with another GP, and is expected to identify a far wider range of individuals more pro-actively in 2010/11. 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.

*3.4.3 What choice and control do vulnerable adults have in relation to their Council services?*

*NI 130: Adult social care customers receiving Self-Directed Support (Direct Payments, Individual & Personalised Budgets):* The Department of Health's definition for this indicator relates to the proportion of people supported by an ongoing adult social care package ("customer base") that were supported by either Direct Payments or Individual Budgets or alternatively had an individual Personal Budget. Some 6.7% of the Council's customer base was supported through these Self-Directed solutions for the 12 months ending December 2009, on course to meet the target of 8.4% for 2009/10. The Directorate is widening the availability of self-directed support, including through Personalised and Individualised Budgets, to provide people with more flexibility to choose and purchase support which reflects their needs and preferences. 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.

One further measure in this objective is the number of admissions to authority-supported permanent residential or nursing care. The national strategy is to reduce this level and promote more support, particularly intensive support at home. Although there have been efforts to reduce emergency admission rates through the implementation of more preventative measures over the last 3 years e.g. increased use of Urgent Care Team and Primary Care Centres, there continue to be significant pressures on admissions and re-admissions of older people to care.



Strategies developed over the last two years have improved individuals' ability to remain in their own home for as long as possible – which is what most people want. This was supported through the development of Extra Care, the first two schemes for which, at Silksworth and in Washington are now open, with a range of on-site facilities accessible by the local community, including restaurants/cafes (run by a Community Interest Company that employs 29 people with learning disabilities) and a community library. Around 80 of these units at both sites are now occupied, with 22 of these households containing one or more people with dementia. Two further Extra Care Schemes will open over the next 2 years (in Hetton and Houghton), which will provide 175 mixed-tenure apartments in the city.

### 3.2 Budget Consultation

3.2.1 As part of the budget consultation a series of workshops were held where participants were asked to prioritise a range of approaches to addressing the budget priorities that emerged from the survey results. The top two priorities identified during the consultation in relation to social care were:

- Continuing to extend the availability and range of services that can be provided through the evening and overnight such as the Sunderland Telecare service
- Extending the range of support services (for example, advice and advocacy services) to enable more people to direct their own social care budgets.

3.2.2 During 2010/2011 the council will allocate additional resources to these priorities to support delivery of Sunderland's 15 Year Plan for Adult Social Care. One of the main aims is for every person to have the support to live independently in their own home or community, if that is what they want. An additional £2.636 million will be invested in:

- Staff and equipment for the Telecare service which enables people to live in their own home for longer, with increased safety, confidence and independence. For example, household / personal alarms and sensors that indicate when a person might be at risk and provides a rapid response service
- Contingency for additional costs that may arise through the recent government announcement to provide free personal care to those with assessed high care needs
- Meeting the costs of residential and nursing accommodation provided through independent care providers.

3.2.3 An additional £1.58 million will be allocated as part of the Social Care Reform Grant to support the modernisation of Adult Social Care services. Part of this modernisation will be to continue to improve the process by which people are assessed for Adult Social Care. For example, some of the changes that have already been made are the introduction of a team of Independent Living Officers who are able to assess individuals for smaller items of equipment (such as bath boards and grab rails) and fit and install the item within the same day from the stock

of items they carry. The grant will also be used to pilot the latest developments in Telecare equipment to help people with more complex needs live independently in their own homes for longer.

3.2.4 Modernisation will also include extending the range of support services available to assist more people to self-direct their own social care budget (see above discussion). This means that they can have more choice and control over how the services they need are delivered, if that is what the wish. For example, the Social Care Resource Agency helps people who direct their own social care budget to identify opportunities and services within the community to meet their assessed needs.

### 3.3 Policy Review Recommendations

3.3.1 The recommendations agreed to improve Dementia Care and Home Care Provision in Sunderland as part of the committees Policy Reviews will deliver a range of improvement activity. A full overview of progress is attached as appendix 2, the table below provides a summary of the number and percentage of each policy reviews recommendations that have been achieved, are on schedule to be achieved or are not on schedule to be achieved.

| **Policy Review** | **Rag Key** | | |
|---|---|---|---|
| | **Green** (Recommendation achieved) | **Amber** (On schedule) | **Red** (Not on schedule) |
| Dementia Care | 12 (54%) | 5 (23%) | 5 (23%) |
| Home Care Provision | 0 | 11(100%) | 0 |

Improvements made to date include; better use of information to clarify the prevalence and incidence of dementia in Sunderland, co-ordinating requirements in relation to campaigns to reduce stigma and raising awareness, progressing work with GPs and their practices to raise the profile and referrals routes of the Community Health Team and recognising the importance of the third sector in delivering good quality support to people with dementia.

## 3 Recommendation

3.1 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.

## 4 Background papers

Budget Consultation 2010/11

**Dementia Care in Sunderland Policy Review Recommendations - Progress April to December 2009**

| RAG Key | | Current Performance |
|---|---|---|
| ★ | Green - Recommendation achieved | 12 Recommendations (54%) |
| ● | Amber - On schedule to achieve recommendation | 5 Recommendations (23%) |
| ▲ | Red - Not on schedule to achieve recommendation | 5 Recommendations (23%) |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR01 | To clarify the prevalence and incidence of dementia in Sunderland by initially utilising information that has already been collated by the PCT and Local Authority. This will also provide a means of examining the levels of under diagnosis of dementia, which currently exist in Sunderland. | PRR01.1 Initiate work with the needs analysis group to clarify incidence of dementia | Lowes, Sharon | 31/12/2009 | ★ | Work was initiated with the Health, Housing and Adult Services Needs Analysis Group to clarify prevalence and incidence of dementia and the initial findings were presented to the OPMH Strategy Group in December 2009. This work confirmed the information in existence, regarding prevalence levels within Sunderland. At the request of the OMPH Strategy Group, a more detailed needs assessment has been commissioned, in order to understand the diagnosing patterns within Sunderland; and in particular what this means for Sunderland over the next 3-5 years and beyond. A project initiation document has been presented to leads for the OPMH Group and work has commenced with initial analysis results expected in June 2010 with further timescales to be agreed. |
| PRR02 | To undertake the development of a Reducing Stigma Campaign that includes a focus on the positive experiences of people with dementia | PRR02.1 Work with equivalent groups in relation to information requirements | Lowes, Sharon | 31/12/2009 | ★ | The OPMH Strategy Group is working with the equivalent groups across Gateshead and South Tyneside in relation to information requirements for delivering the National Dementia Strategy. This includes the two campaigns recommended by the Committee. Now that the National awareness raising campaign has been launched work is being done to map requirements for local follow through. |
| | | PRR02.2 Identify monies to fund campaigns | Lowes, Sharon | 31/12/2009 | ★ | Monies are being identified within PCT/LA which will be used to fund these campaigns. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR03 | To develop and promote a Raising Awareness Campaign that provides a coordinated approach involving all the major stakeholders. | PRR03.1 Work with equivalent groups in relation to information requirements | Lowes, Sharon | 31/12/2009 | | The OPMH Strategy Group is working with the equivalent groups across Gateshead and South Tyneside in relation to information requirements for delivering the National Dementia Strategy. This includes the two campaigns recommended by the Committee. Now that the National awareness raising campaign has been launched work is being done to map requirements for local follow through. |
| | | PRR03.2 Identify monies to fund campaigns | Lowes, Sharon | 31/12/2009 |  | Monies are being identified within PCT/LA which will be used to fund these campaigns. |
| PRR04 | That Sunderland City Council, if the opportunity arises, should apply to be a demonstrator site for the Dementia Advisor role as outlined in the National Dementia Strategy. | PRR04.1 Apply for Dementia Advisor Role demonstrator site | Lowes, Sharon | 30/04/2010 |  | Due an unsuccessful application, the PCT and LA are commissioning an Advocacy Service for older people, which includes the specific function of a dementia advisor service within the specification. This service is in the process of being commissioned via a formal tender process with the service expected to be operational in May 2010. |
| PRR05 | To review the current Public Health Strategy in order that messages within the strategy focusing on healthy lifestyles include links to the prevention of vascular dementia. | PRR05.1 Engage with the PCT | Lowes, Sharon | 30/09/2009 |  | A meeting took place with Public Health Colleagues and the OPMH Strategy Group to look at how prevention of vascular dementia could be promoted. Now that the National awareness raising campaign has been launched this recommendation will be taken forward mapped to that in conjunction with health colleagues. |
| PRR06 | To develop a coordinated stakeholder service directory that is available to the general public that provides advice and information on dementia services through information that is already held on the Starting Point Database which, is currently in use in the city. . This process would allow for the review of the existing information that is available, taking into consideration the quality and accessibility of support throughout an individual's journey. | PRR06.1 Undertake a review of information that is in use across the city | Lowes, Sharon | 30/04/2010 |  | The Task and Finish Group (set up to undertake a review of information) continues to meet and is in the process of undertaking the first stage of the action.<br>• Review existing information types and sources of information.<br>• Develop an Information Pathway, including standards and the notion of personal information plans for people and their carers.<br><br>This approach would allow for the service directory to be developed and is anticipated it will be linked to objectives within the NDS also being developed such as Dementia Advisor and Memory Clinics. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR07 | To review the current pathway of care identifying where changes need to be made in order that an early diagnosis and intervention can become a reality, including the referral into the pathway. | PRR07.1 Audit against NDS Objectives | Lowes, Sharon | 31/12/2009 |  | As reported in the last update, the Joint Commissioning Framework has been developed which identified commissioning of a memory assessment service as a priority. Work has commenced with SunWest Practice Based Commissioning Cluster, to pilot a memory assessment service. This pilot will help shape the future pathway of care and will commence in April 2010. |
| | | PRR07.2 Develop a joint commissioning plan | Lowes, Sharon | 31/12/2009 |  | The Joint Commissioning Framework has been developed which identified commissioning of a memory assessment service as a priority. Work has commenced with SunWest Practice Based Commissioning Cluster, to pilot a memory assessment service. This pilot will help shape the future pathway of care and will commence in April 2010. |
| PRR08 | To review the role of the liaison service within City Hospitals to identify and address any capacity issues in service provision. | PRR08.1 Undertake the review as recommended | Lowes, Sharon | 30/10/2009 |  | The review of the Liaison Service is ongoing via a task and finish group approach and it is expected that gaps identified will be addressed via the re-allocation mental health resources effectively. |
| PRR09 | To ensure inclusiveness when implementing the local response to the National Dementia Strategy that consideration is given to young people and people with learning disabilities who have dementia. | PRR09.1 Include commissioners in the baseline audit and plan development | Lowes, Sharon | 31/12/2009 |  | The Joint Commissioning Framework for National Dementia Strategy within Sunderland ensures that inclusiveness is achieved by focussing on needs of people with dementia, rather than age. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR10 | To progress the workforce development strategy that exists in each sector (Local Authority, Public Health, and PCT) so that all dementia service providers offer good quality services to people with dementia. | PRR10.1 Engage the Tyne & Wear Care Alliance | Lowes, Sharon | 30/10/2009 |  | This recommendation is being progressed via objective 13 of the NDS as services are being re-aligned against it. Along with HHAS workforce, the independent sector workforce are being supported and incentivised to meet requirements via Sunderland Quality Standards for care homes for older people and is being followed by similar Quality Standards for Homecare. The standards relating to dementia include basic dementia training for staff linked to Life Story Work support planning as well as identification of a senior staff member to take the lead in quality of care for people with dementia. Work is ongoing to ensure the above is supported by TWCA and NTW in reach. |
| PRR11 | To raise awareness of the Community Mental Health Team in Sunderland, including increasing the profile of the team and how potential service users can access the service | PRR11.1 Develop a communication plan | Lowes, Sharon | 31/12/2009 |  | The CMHT have activated their communications plan, which increasing their profile and as reported previously, referrals to the service are more appropriate and timely. |
| | | PRR11.2 Raise team profile and referral routes | Lowes, Sharon | not set |  | Work continues to be progressed with GPs and their practices to raise the profile and referral routes. Improvements have been made in the referrals received by GPs. |
| PRR12 | To undertake a financial exercise on current spending levels for services that provide support for people with dementia and compare this to other Local Authorities and PCTs, with a view to informing best practice in both the current and future provision of services. . | PRR12.1 Establish a Task Group to progress the recommendation | Lowes, Sharon | 30/10/2009 |  | This recommendation is being taken forward by the PCT/Health, Housing and Adult Services, Finance Managers, as it is a complex exercise due to the many different levels and range of services people with dementia access. Further complications arise when dementia is not recorded as the main presenting need. It is important to assess current cost as accurately as possible before attempting to predict future requirements, especially anticipating the potential increase in early detection and diagnosis NDS objectives will produce, therefore the PCT has commissioned specialist Dementia Modelling expertise to facilitate this in each LA area and an initial wokshop has been held. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR13 | To review existing support services to ensure they are fit for purpose against the vision set by the National Dementia Strategy identifying good practice and clear areas for improvement | PRR13.1 Commission a Task Group | Lowes, Sharon | 30/04/2010 |  | Objective 6 has been identified as a regional priority and funding has been provided by DH and RIEP to support implementation across LA's over a period of 2-3years via a project plan (dependent on continued funding). The first stage in the process will be development of a comprehensive evidence base followed by processes to ensure that personalisation changes are fully inclusive of people with dementia and their carers with the final stage supporting reviewed service provision by identifying good practice and development of innovative pilots. The commissioning lead from Sunderland will work alongside the project in the City's best interests as applicable and report on progress. |
| PRR14 | To recognise the importance of third sector in delivering good quality support to people with dementia through better engagement across the statutory and third sector. | PRR14.1 Review Third Sector engagement | Lowes, Sharon | 31/12/2009 |  | The Joint Commissioning Framework recognises the contribution that the third sector plays and will continue to play in supporting people with dementia to live well. Organisations have received grant assistance funding from both PCT and LA for 2010 to support work with people with dementia and their carers. Close links remain with these organisations and they are included in all new development plans. |
| | | PRR14.2 Role of the Third Sector acknowledged and built into the joint commissioning plan | Lowes, Sharon | 31/12/2009 |  | Throughout the baseline audit, the contribution provided by third sector organisations was acknowledged and will be built upon as the joint commissioning plan is developed. |
| PRR15 | To review and strengthen existing peer support mechanisms, which could be strengthened by the statutory sector working closer with the third sector. | PRR15.1 Commission a task group to undertake the review and report findings | Lowes, Sharon | 26/02/2010 |  | A review of peer support networks is currently being undertaken. Findings will be mapped against NDS objectives with full involvement of current third sector providers. Strengthening of these services will be undertaken as part of the whole system as services develop against the NDS objectives. |

| Ref | Recommendation Description | Action | Responsible Officer | Deadline | RAG | Progress |
|---|---|---|---|---|---|---|
| PRR16 | That consideration is given to the possibility of a Dementia Champion within Sunderland City Council as outlined in the National Dementia Strategy. | PRR16.1 Present a report to the Adult Social Care partnership Board | Lowes, Sharon | 29/01/2010 |  | Discussions have taken place within HHAS regarding the Dementia Champion, as it is recognised that many people working across the council 'champion' the needs of people with dementia. An anticipated presentation of a paper at the February Adult Social Care Partnership Board to discuss this recommendation further will now take place in April. |
| PRR17 | That the Health and Wellbeing Review Committee receives regular reports on the local implementation plan. | PRR17.1 Report to committee on a quarterly basis | Lowes, Sharon | 30/10/2009 |  | Through this monitoring, regular updates are provided on the key areas for consideration as the local implementation plan includes the review recommendations. |
| PRR18 | That the Health and Wellbeing Review Committee provides a written response to the Department of Health on the National Dementia Strategy | PRR18.1 Written repose to Department of Health on National Dementia Strategy | Cummings, Nigel | 04/11/2009 |  | Letter sent on behalf of the committee to Department of Health with a response to the newly published National Dementia Strategy. |

| Home Care Provision Policy Review Recommendations - Progress Report April to December | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | RAG Key | | | Current Performance | |
| ★ | Green - Recommendation achieved | | | 0 Recommendation (0%) | |
| ● | Amber - On schedule to achieve recommendation | | | 11 Recommendation (100%) | |
| ▲ | Red - Not on schedule to achieve recommendation | | | 0 Recommendation (0%) | |
| | | | | | |
| **Ref** | **Recommendation Description** | **Owner** | **Due Date** | **RAG** | **Commentary** |
| PRR.HC01 | To ensure through the commissioning process that home care providers have the organisational structures in place to deliver the agreed care to service users on an operational level. | Lowes, Sharon | 31/08/2010 | ● | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC02 | To ensure that through the commissioning process home care providers have the organisational capacity and resources in place to meet the service requirements of additional home care packages. | Lowes, Sharon | 31/08/2010 | ● | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC03 | To ensure that all home care organisations provide zonal working arrangements for employees through coordinated and realistic work rotas. | Lowes, Sharon | 31/08/2010 | ● | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC04 | To continue to investigate and develop more robust monitoring systems for home care providers across the city, including the use of new technologies and spot checks. | Lowes, Sharon | 31/08/2010 | ● | Work is being progressed to introduce an electronic monitoring system across home care providers, which will be able to monitor the length of time care workers are in an individual's home (including arrival times and departure). This new system will be piloted with a number of providers in the first instance |

| Ref | Recommendation Description | Owner | Due Date | RAG | Commentary |
|---|---|---|---|---|---|
| PRR.HC05 | To look at the development of an annual survey for home care staff, service users and managers to provide a more comprehensive picture of service provision from a variety of stakeholder views. | Lowes, Sharon | 31/08/2010 |  | The need for an annual survey has been built into the programme of surveys that are undertaken by the Directorate. It is included in the work programme of the Researcher. |
| PRR.HC06 | To investigate the potential of a standardised minimum training programme for all home care staff across all local agencies with the intention that all home care workers are encouraged to enrol on NVQ level 2. | Lowes, Sharon | 31/08/2010 |  | Discussions are taking place with Tyne and Wear Care Alliance in relation to reviewing the existing training available for home care workers. This will be linked closely with the work undertaken to develop Sunderland Home Care Quality Standards. |
| PRR.HC07 | To improve the health and safety of care workers and ultimately service provision to service users by home care providers investing in the use of mobile phones and other technology. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC08 | To investigate home care organisations reimbursing any fees incurred by newly recruited employees from CRB checks once they have completed an agreed term of employment. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |

| Ref | Recommendation Description | Owner | Due Date | RAG | Commentary |
|---|---|---|---|---|---|
| PRR.HC09 | To ensure that the induction procedures of home care organisations provide new employees with the training, initial and ongoing supervision required to perform the duties of their role. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC10 | To evaluate the quality of Home Care Plans and look to ensure that the plans have detailed outcomes for services users and carers and also ensure, where practicable, that the plans are easily accessible or in a pre-determined location for the home care worker. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |
| PRR.HC11 | To ensure that supervisors and contact staff of home care organisations are also fully trained to deal with emergency situations that may occur. | Lowes, Sharon | 31/08/2010 |  | The contractual arrangements for the Home Care Services across the city will be renegotiated in August 2010; this activity will ensure that the recommendation is undertaken |

## Health and Wellbeing Scrutiny Committee Appendix 1
## Strategic Priority - Healthy City

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| **Outcome - By 2025 100% of people with long term conditions in Sunderland will be supported to live at home for as long as they wish and feel able** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 130 | Social care clients receiving Self Directed Support | 5.83 | 6.73 | Jan to Dec | ▲ | 8.50 | ✘ | Performance against this indicator increased from 5.8% to 6.7% between the 12 months ending March and December 2009, and is on course to meet the target of 8.5% for 2009/10 if performance is sustained. There were increases in most divisions with the exception of people with physical disabilities, an area for improvement. |
| NI 136 | People supported to live independently through social services (all adults) | 3124.19 | 2865.2 | April to Dec | ▼ | 3415 | ✘ | As a result of the decrease in the numbers helped to live at home, there was a corresponding decline in terms of the number of adults aged 18+ years helped to live independently for December-09. However, the year end outturn may be partially offset by increased numbers of people supported through grant-maintained services. |
| **National Indicators** | | | | | | | | |
| NI 124 | People with a long-term condition supported to be independent & in control of their condition | 73% (200708) | Annual | | | Not Set | | |
| NI 125 | Achieving independence for older people through rehabilitation/intermediate care | 70.5% | 64.70% | April to Dec | ▼ | 78.30% | ✘ | Performance deteriorated to 67.5% older people currently achieving independence through rehabilitation and intermediate care. This needs to improve to 78.3% by 2009/10. |
| NI 131 | Delayed transfers of care | 14.20 | 5.06 | April to Dec | ▲ | not set | | Only includes delayed discharges within Sunderland hospitals |
| NI 132 | Timeliness of social care assessment (all adults) | 89.4% | 80.53% | April to Dec | ▼ | 92.80% | ✘ | Performance has deteriorated to 82%, with the target for 2009/10 is set at 92.8%. Performance across all divisions, except for MH, showed the same trend and needs to improve (true also for MH), but is most highlighted for LD Services. |
| NI 133 | Timeliness of social care packages following assessment (all Adults 18+) | 90% | 91.58% | April to Dec | ▲ | 91.20% | ✓ | Waiting times for care packages have improved significantly, with 91.1% completed in agreed timescales (as has performance for those with PD aged <65). The current level is just short of the 09/10 target of 91.2% and improvements should be maintained. |
| NI 134 | The number of emergency bed days per head of weighted population | 218717.00 | Annual | | | 199096 | n/a | |
| NI 141 | Percentage of vulnerable people achieving independent living | 82.21% | 83.58% | Oct to Dec | ▲ | 85% | ✘ | Significant improvements demonstrated between 2007/08 and 2008/09. Increase was unexpected and reasons are unknown and although performance has deteriorated since Mar-09, this measure has improved considerably when compared to March 2008. |
| NI 142 | Number of vulnerable people who are supported to maintain independent living | 98.45% | 99.34% | Oct to Dec | ▲ | 99% | ✓ | The target of 98% for 2008/09 was achieved well before the end of the year and this was possibly attributed to very low levels of provider unavailability and high levels of utilisation amongst contracted service, and it appears this is set to continue. |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| NI 145 | Adults with learning disabilities in settled accommodation | 100% | 88.12% | Jan to Dec | ▼ | 80% | ✓ | Progress was made in relation to the percentage of LD clients in settled accommodation to 88.1% (601 clients). Performance is currently above target for 2009/10 (80%) and the current figure needs to be maintained. |
| NI 149 | Adults in contact with secondary mental health services in settled accommodation | n/a | 64.70% | Jan to Dec | | 65.60% | ✘ | There was an increase in the number of adults with MH (545 clients) in settled accommodation |
| **Local Indicators** | | | | | | | | |
| BV 54 | Older people helped live at home | 100.24 | 94.4 | Jan to Dec | ▼ | 113 | ✘ | There has been a marked decrease in the number of clients helped to live at home for OP clients, and improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |
| BV 58 | % People with statement of needs | 100% | 99.16% | Jan to Dec | ▼ | 100% | ✘ | The majority of clients received a statement of need for the period ending December 2009. Although, performance is still rated as 'good' (based on the old PAF bandings), services should aim to provide all clients with a statement of needs. |
| BV 195 | Acceptable waiting times for asst | 91.4% | 84.7% | April to Dec | ▼ | 93.20% | ✘ | Performance against the timescales for assessment for older people deteriorated, and remains below the target of 93.2%. |
| BV 196 | Acceptable wait for care packages | 90% | 92.5% | April to Dec | ▲ | 91% | ✓ | Waiting times for care packages for older people have improved significantly, with 92.2% completed in agreed timescales. The current level is above the 09/10 target of 92% and improvements should be maintained. |
| BV 201 | Adults receiving direct payments | 251 | 280.8 | Jan to Dec | ▲ | 297 | ✘ | The number of clients with Direct Payments at the end of the latest period (December-09) has increased and is on course to meet its target |
| LPI 31 | Adults with physical disabilities helped to live at home | 6.2 | 5.72 | Jan to Dec | ▼ | 6.8 | ✘ | There has been a marked decrease in the number of clients with physical disabilities helped to live at home, and improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |
| LPI 32 | Adults with learning disabilities helped to live at home | 3.2 | 3.16 | Jan to Dec | ◀▶ | 4 | ✘ | The number of clients with learning disabilities helped to live at home has largely been maintained since March-09, but improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |
| LPI 33 | Adults with mental health problems helped to live at home | 3.47 | 3.31 | Jan to Dec | ▼ | 3.58 | ✘ | There has been a marked decrease in the number of clients with mental health issues helped to live at home, and improving this level remains an outstanding area for improvement. This needs to be addressed in the revised Care Management & Assessment Model to provide a more pro-active approach to identify and support individuals with functional dependencies who need some help. |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| LPI 34 | % carers receiving a specific carers service | 19.3% | 17.35% | Jan to Dec | ▼ | 20.60% | ✘ | Performance in relation to services for carers has decreased when compared to 2008/09, with 17.4% of customers in which carers were receiving services. There's evidence from a range of sources (e.g. case file audit, carer & representative groups feedback) that the Directorate's approach to supporting carers is not as consistent as it should be. This will need to be addressed during the remainder of 2009/10, as this is also an area for improvement identified by CQC. |
| LPI 38 | % clients receiving a review | 77.6% | 71.03% | Jan to Dec | ▲ | 78.40% | ✓ | At 71% for end December, performance deteriorated across most divisions in 2009/10, and performance is now categorised as 'acceptable' (based on the old PAF bandings). However, it's noted that Directorate intend to address this issue via increasing review caseloads for practitioners in remainder of 2009/10. |
| LPI 39 | Ethnicity of people receiving an assessment | 0.98% | 1.79% | April to Dec | ▲ | 1.25% | ✓ | The current level exceeds the 2009/10 target and a direct result of the short- and longer-term case-finding resources for people from BME groups that the Directorate expanded in 2008/09. |
| LPI 40 | Ethnicity of older people receiving services following assessment | 0.7% | 1.14% | April to Dec | ▲ | 1% | ✓ | Performance has improved in terms of the proportion of older clients from BME populations subsequently receiving services, and is representative of population. |
| **Outcome - By 2025 through the Homes for Life Older Peoples programme extra care style accommodation will be fully developed across all areas of the city with a significant reduction in the number of admissions to residential and nursing care** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 139 | People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently | 35.5% | Annual | | | Not Set | | |
| **National Indicators** | | | | | | | | |
| NI 127 | Self reported experience of social care users | n/a | Annual | | | Not Set | | |
| NI 128 | User reported measure of respect and dignity in their treatment | n/a | | | | | | |
| NI 135 | Carers receiving needs assessment or review and a specific carer's service, or advice & inf. | 54.1% | 54.84% | Jan to Dec | ▲ | 56.40% | ✘ | This measure has fluctuated since March – for the latest period, 54.8% of carers received information, advice or services, compared to the 2008/09 outturn of 54.1%. This means the performance is just under the target for 2009/10 although the improvement since March will need to be maintained until year end. |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| **Local Indicators** | | | | | | | | |
| LPI 35 | Admissions of supported residents aged 65+ | 84.90 | 68.14 | April to Dec | ▼ | 84.4 | ✘ | Rates of supported admissions to permanent residential/nursing care for clients aged 65+ years increased quite significantly. There were 388, and this increased to 430, admissions to care for the 12 months ending March and December 2009, respectively. The level needs to reduce to no more than 386 in 2009/10 through, for example, full implementation of Intermediate Care at Home. |
| LPI 36 | Admissions of supported residents aged 18-64 | 1.20 | 0.74 | April to Dec | ▼ | 1.02 | ✘ | The number of individuals aged 18-64 years admitted to permanent residential/nursing care in 2008/09 was 24 clients. 18 clients have been admitted during the latest period, which equals the target set for 2009/10. |
| LPI 37 | % allocated a single room in nursing or residential care | 100% | 100% | April to Dec | ◄► | 100% | ✓ | |
| **Outcome - 'By 2025 life expectancy for men will equal that of women** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 120f | All-age all cause mortality rate - female | 562.00 | 578.7 | 2006-2008 pooled rate | ▼ | 546 | ✘ | |
| NI 120m | All-age all cause mortality rate - male | 777.00 | 851 | | ▼ | 748 | ✘ | |
| **National Indicators** | | | | | | | | |
| NI 121 | Mortality rate from all circulatory diseases at ages under 75 | | 88.9 | Annual out turn | n/a | | | |
| NI 121f | Mortality rate from all circulatory diseases at ages under 75 (females) | 63.9 | To Follow | | | not set | | |
| NI 121m | Mortality rate from all circulatory diseases at ages under 75 (males) | 134.79 | | | | not set | | |
| NI 122 | Mortality from all cancers at ages under 75 | | 141.1 | Annual out turn | n/a | | n/a | |
| NI 122f | Mortality from all cancers at ages under 75 (females) | 121.94 | To Follow | | | not set | | |
| NI 122m | Mortality from all cancers at ages under 75 (males) | 153.81 | | | | not set | | |
| NI 129 | End of life access to appropriate care enabling people to be able to choose to die at home | new 2009/10 | Annual | | | not set | | |

| Ref | Description | 2008/2009 Outturn | Latest Update | Time period | Trend | 2009/2010 Target | On Target | Comments |
|---|---|---|---|---|---|---|---|---|
| **Outcome - 'By 2025 smoking prevalence will be reduced to 15% and there will be no differences between wards in Sunderland. The level of smoking in pregnancy will have reduced to less than 5%** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 119 | Self-reported measure of people's overall health and wellbeing | 66.2 | Annual | | | Not Set | | |
| NI 123 | Stopping smoking | 1100 | 774.36 | April to Dec | ▼ | 1437 | ✘ | |
| **Outcome - By 2025 the number of hospital admissions due to alcohol will be reduced to that of the 20% best performing local authorities across the country and there will be clear treatment pathways and a shift away from a binge drinking culture** | | | | | | | | |
| **Local Area Agreement Indicators** | | | | | | | | |
| NI 39 | Rate of Hospital Admissions per 100,000 for Alcohol Related Harm | 2378 | 2549.3 | April to Sept | ▼ | 2207 | ✘ | |
| **Outcome - By 2025 we will have significantly increased the numbers of adults and children participating in sport** | | | | | | | | |
| **National Indicators** | | | | | | | | |
| NI 8 | Adult participation in sport | 18.7% | 19.60% | April to Dec | ▲ | 23.03% | ✘ | The figure of 19.6% is based on a two year active people survey (Oct 07 to Oct 09). Sport England advised us to add the two years together in order to boost the annual sample size from 500 to 1000. The baseline is 20.1%. Sport England do not see this as a significant decline as it does not exceed 3.5% +/-. |
| **Local Indicators** | | | | | | | | |
| LPI 19 | % of pop within 20 minutes of quality assured sports facility | 49.86% | Annual | | | 49.86% | n/a | |
| LPI 18 | % of population volunteering in sport and active recreation | 4.3 | | | | 4.56 | | |
| LPI 21 | Total visits to leisure centres | 2236294 | | | | 2258657 | | |
| LPI 22 | Total number of swims within leisure centres | 608807 | | | | 614355 | | |
| LPI 23 | Total number of other visits to leisure centres | 1627487 | | | | 1644302 | | |
| **Outcome - We will ensure that people feel that local services have the best interests of the community at heart so that by 2025 more than two thirds of the population agree that this is the case** | | | | | | | | |
| **Local Indicators** | | | | | | | | |
| BV 56 | Percentage of items of equipment delivered within 7 working days | 90% | 91.68% | April to Dec | ▲ | 93% | ✘ | Progress has been made in relation to this indicator, with 91.9% of equipment delivered in 7 working days for the 12 months ending December, compared to the 2008/09 outturn of 90.1%. |

# HEALTH AND WELLBEING SCRUTINY COMMITTEE

**21st April 2010**

## CONSULTATION ON PROPOSED CHANGES TO THE LAWS GOVERNING POWERED MOBILITY SCOOTERS & POWERED WHEELCHAIRS

**Report of the Chief Executive**

**STRATEGIC PRIORITIES: SP2: Healthy City.**

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

### 1. Why has this report come to the Committee?

1.1 To provide the opportunity for members to contribute to the current consultation taking place on proposed changes to the laws governing powered mobility scooters and powered wheelchairs.

### 2. Background

2.1 At its meeting on 11th November 2009, the Health and Wellbeing Scrutiny Committee received a report on the Shop Mobility Scheme operating in Sunderland. This followed a request from the committee to look into issues of safety and legislation surrounding such vehicles.

2.2 Following discussions the committee agreed to communicate their concerns around the legislation of mobility scooters to the appropriate body, in this case the Department of Transport. As a result of this the Health and Wellbeing Scrutiny Committee have been invited to contribute to the current consultation taking place around mobility scooters.

### 3. Current Position

3.1 The Department for Transport (DfT) is currently undertaking consultation on proposed changes to the legislation covering powered mobility scooters and powered wheelchairs (referred to as "invalid carriages" in legislation).

3.2 The aim of any reforms taken forward following the consultation would be to deliver cost-effective improvements to the safety of mobility vehicle users, pedestrians and other road users, while supporting continued mobility for disabled people.

3.3 The consultation document, appendix 1, is divided into 5 sections as follows:

- Legal Classification of Mobility Scooters

- Design Standards for Mobility Scooters
- Users of Mobility Vehicles
- Vehicles in Use
- Other Issues.

The consultation began on Wednesday 3 March 2010 and responses need to be with the DfT by no later than Friday 28 May 2010.

## 4. Conclusion

4.1 The Health and Wellbeing Scrutiny Committee has the opportunity to provide feedback into the wider consultation around the legislation governing mobility scooters.

## 5. Recommendation

5.1 That Members provide comments on the consultation document and that these comments are submitted to the DfT as the Health and Wellbeing Scrutiny Committee's formal response.

## 6. Background Papers

Health and Wellbeing Scrutiny Committee Agenda 2009
Consultation on proposed changes to the laws governing powered mobility scooters & powered wheelchairs (DfT-2010-10)

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**Contact Officer:** Nigel Cummings, Scrutiny Officer, 561 1006
Nigel.Cummings@sunderland.gov.uk

**APPENDIX 1: ANNUAL REPORT**

## Annual Report: Health and Wellbeing Scrutiny Committee 2009/10

Chair: Cllr Peter Walker  Vice-Chair: Cllr Christine Shattock

Committee Members: Cllr Jill Fletcher, Cllr Anne Hall, Cllr Sylvia Old, Cllr Mary Smith, Cllr Dianne Snowden, Cllr Shirley Leadbitter, Cllr Paul Maddison, Cllr Anthony Morrisey and Cllr Peter Maddison.

It has been another busy year for the Health and Wellbeing Scrutiny Committee, during which time we have delivered an ambitious work programme providing discussion and challenge on a range of topics and issues.

Our major policy work this year saw the committee undertake a review that looked into health inequalities across Sunderland, and this has been an extremely challenging and rewarding piece of work. In gathering evidence for the review we held a very successful Community Event Day at the Stadium of Light, where speakers from the Department of Health, Durham University, Sunderland Teaching Primary Care Trust and the local authority provided valuable information and stimulated much debate. The event attracted stakeholders, voluntary groups and the general public and gave us some useful evidence.

The committee also had the opportunity to hold discussions with a senior researcher working for the recently published Marmot Review, an independent study into reducing health inequalities in England. We also held an expert jury event where a number of witnesses were invited to give evidence to the committee which added to the evidence base of the review.

The review, although ambitious, has highlighted a number of key themes and produced recommendations that we trust can help to develop and ensure that future strategies and policies consider the implications on health outcomes within Sunderland.

Alongside our policy review we have looked at a number of other issues including the legislation surrounding mobility scooters and powered wheelchairs. What we found was very little legislation governing such vehicles and agreed to write to the Department of Transport on this issue. As a result we have been invited to contribute to a wider consultation around this issue

and have provided a detailed response. The committee hopes that ultimately greater legislation will lead to improved safety for scooter users, pedestrians and other road users.

The committee has continued to be involved in a piece of work that began in 2008/09 around the quality and provision of home care services. I am pleased to report that work is continuing to introduce an electronic monitoring system for home care providers along with an annual survey for home care staff, service users and managers. These measures, recommended by the committee, will help to drive up the quality of home care provision in Sunderland.

One of the strengths of the scrutiny process is that we can look into issues or concerns around service provision that are raised by elected members. This year we were asked to consider the out of hours service provision in Sunderland, a broad range of statutory services provided to meet the emergency needs of individuals. Following the highlighting of these concerns and subsequent reports from the HHAS Directorate a working group has been established with key stakeholders, including a representative of the committee, to review current arrangements and look at service improvements. The Health and Wellbeing Scrutiny Committee will be kept fully informed of the progress of the working group.

This provides a snapshot of some of the work undertaken by the committee during the year, and I feel that along with the hard work of my colleagues on the committee we have had another successful year. I look forward to 2010/11 being another rewarding year for the Health and Wellbeing Scrutiny Committee.

Cllr Peter Walker
Chair of the Health and Wellbeing Scrutiny Committee

# Consultation response form

**CONSULTATION ON PROPOSED CHANGES TO REGULATIONS COVERING POWERED MOBILITY SCOOTERS & POWERED WHEELCHAIRS**

**PART 1 – information about you**

| | |
|---|---|
| Name: | |
| Address: | |
| Postcode: | |
| E-mail address: | |
| Company Name or Organisation if applicable) | |

Please tick one box from the list below that best describes you/your company or organisation

| | |
|---|---|
| ☐ | Member of the public |
| ☐ | Small or medium Enterprise (up to 50 employees) |
| ☐ | Large Company |
| ☐ | Representative Organisation |
| ☐ | Interest Group |
| ☐ | Local Government |
| ☐ | Central Government |
| ☐ | Police |
| ☐ | Other (please specify) |
| If you are responding on behalf of an organisation/interest group how many members do you have and how did you obtain the views of your members: | |
| If you would like your response or personal details to be treated confidentially please explain why (and please see the Freedom of Information advice on page 10 of the consultation package): | |

## PART 2: YOUR VIEWS

This consultation seeks your views on proposed changes to the legislation covering “invalid carriages”.

### Section A: Legal classification of vehicles

| |
|---|
| Q1. Do you think that the term “invalid carriage” should be replaced with a different term? |
| Yes ☐ No ☐ |
| Q2. What term would you suggest? |
| |
| Q3.Do you think that the terms “Class 2” and “Class 3” should be replaced by more descriptive terms such as “slower speed mobility vehicle” and “faster speed mobility vehicle”? |
| Yes ☐ No ☐ |
| If yes, what terms would you suggest? |
| |
| Q4. Do you think the legislation should make a distinction between mobility scooters and powered wheelchairs? |
| Yes ☐ No ☐ |

### Section B: Design standards for mobility vehicles

***Maximum speed capability***

| |
|---|
| Q5. Do you think that Class 3 vehicles should be designed to be capable of travelling at speeds higher than 8mph on the carriageway? |
| Yes ☐ No ☐ |
| Q6. If you think there should be a higher speed capability, what maximum speeds do you suggest, and why? |
| |

***Vehicle Weight limits***

| |
|---|
| Q7. Do you think the current unladen weight limit is still appropriate? (The weight limit for Class 2 vehicles is 113.4kg, and for Class 3 vehicles is 150kg? |
| Yes ☐ No ☐ (class 2 vehicles)<br>Yes ☐ No ☐ (class 3 vehicles) |
| Q8. If you think the permitted unladen weight should increase, what should it increase to, and why? |
| |
| Q9. Should some mobility vehicles permit the carriage of a baby or a small child as a passenger? |
| Yes ☐ No ☐ |
| Q10. If you suggested changes in reply to questions 8 and 9 above, do you have evidence to support your suggestions? If you have evidence what is it? Or do you believe that further research and trialling is needed before a decision is taken? |
| |

***Safer vehicle design***

| Q11. Do you think that technology is available that could reduce the likelihood and severity of injury caused by a collision with a mobility scooter? |
|---|
| Yes ☐ No ☐ |
| If yes, what technology do you have in mind? |
| |
| Q12. Should any increase in weight only be permitted if such technology is used? |
| Yes ☐ No ☐ |

***Conspicuousness***

| Q13. Do you think that additional requirements should be imposed to make mobility vehicles more conspicuous to help to improve the safety of the mobility vehicle user and the safety of other road users? |
|---|
| Yes ☐ No ☐ |
| Q14. If you do think that additional requirements should be imposed, what do you suggest? |
| |

## Section C: Users of mobility vehicles

### *Minimum age*

| Q15. Do you think that the minimum age of 14 when a person may use a Class 3 vehicle should be kept the same, removed or lowered? | |
|---|---|
| Kept the same<br>Lowered<br>Removed | ☐<br>☐<br>☐ |
| Q16. If you think the minimum age should be lowered, what do you suggest it be lowered to? | |
| | |

### *Information, training and fitness to drive*

| Q17. What do you think should be done to improve the information and advice that is available to people who want to use a mobility vehicle? |
|---|
| |
| Q18. Should all mobility vehicle users be required to undergo compulsory training? |
| Yes ☐ No ☐ |
| Q19. How do you suggest such training might be organised and delivered? How could it be funded (for example through user fees)? |
| |
| Q20. Should all users be required to undergo an assessment of their suitability to drive a mobility vehicle? |
| Yes ☐ No ☐ |
| Q21. How do you suggest such an assessment might be organised and delivered? How could it be funded (for example through user fees)? |

| |
|---|
| |

**Section D: Vehicles in Use**

***Registration***

| Q22. Do you think a mobility vehicle registration scheme is needed? |
|---|
| Yes ☐ No ☐ |
| If so, why? |
| Q23. Do you think the current registration scheme with DVLA should be improved, for example, through better enforcement? |
| Yes ☐ No ☐ |
| If yes, how? |
| Q24. Do you think the current registration scheme should be replaced by a locally run registration scheme? (We would be interested in exploring whether this could be linked to existing schemes, for example the Blue Badge disabled parking scheme.) |
| |

| |
|---|
| |
| Q25. Do you think it would be better to register users rather than registering vehicles? |
| Yes ☐ No ☐ |
| If so, how might it work? |
| |
| Q26. Do you have any other suggestions for how a registration scheme would work? |
| |
| Q27. Do you think the registration should be required for Class 2 vehicles as well as Class 3 vehicles? |
| Yes ☐ No ☐ |
| If so, why? |
| |

***Insurance***

| Q28. Do you think that a minimum of third party insurance should be compulsory for users of mobility vehicles? |
|---|
| Yes ☐ No ☐ |

***Criminal offences***

| Q29. Do you think that the section 35 offence (drivers of carriages injuring persons by furious driving) is adequate? |
|---|
| Yes ☐ No ☐ |
| Which driver behaviours do you think are not at present adequately covered by the legislation and should be the subject of further detailed proposals? |
| |

***Maximum permitted speed***

| Q30. Do you think that a Class 3 vehicle should be permitted to travel faster than the current limit of 8mph on the road? |
|---|
| Yes ☐ No ☐ |
| Q31. What do you see as the potential benefits and risks of an increased speed limit? |
| Q32. What do you think the new maximum permitted speed should be? |
| |

| Q33. When the speed limiter is switched off, users of Class 3 vehicles may drive above 4mph provided they are on the carriageway and not on the footway. To aid concordance with this regulation, should mobility vehicles then automatically display a sign on the rear that indicates that they must not be used on the footway? |
| --- |
| Yes ☐ No ☐ |

Data collection

| Q34. What type of data do you think it would be helpful to record and why? |
| --- |
| |

Please send consultation responses to:

Mobility Vehicles Consultation
Department for Transport
Zone 2/15
Great Minster House
76 Marsham Street
London
SW1P 4DR

Email: mobilityvehiclesconsultation@dft.gsi.gov.uk

# HEALTH AND WELLBEING SCRUTINY COMMITTEE

**21st April 2010**

## ANNUAL REPORT

**Report of the Health and Wellbeing Scrutiny Committee**

**STRATEGIC PRIORITIES: SP2: Healthy City.**

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

### 1. Why has this report come to the Committee?

1.1 To approve the Health and Wellbeing Scrutiny Committee report as part of the overall scrutiny annual report 2009/10 that is to be presented to Council.

### 2. Background

2.1 In previous years each scrutiny committee has published an individual account of the work conducted by the committee in an annual report, and was presented to Council. The annual report reflected the committees work programme and included achievements, highlights and policy review work.

2.2 This year for the first time the annual report will be a single combined report of all seven scrutiny committees. The annual report will outline the development in the scrutiny function and provide snapshots of the outcomes achieved during the last 12 months.

### 3. Health and Wellbeing Scrutiny Committee 2009/10

3.1 The proposed Health and Wellbeing Scrutiny Committee report is attached at appendix 1 for member's consideration. The report provides a very brief snapshot of the some of the main work undertaken by the committee during 2009/10. It should be noted that the report is written from the perspective of the Chair of the Committee reflecting over the year.

3.2 Some of the main themes covered in the annual report revolve around the following issues:

- Out of Hours Care
- Mobility Scooters
- Home Care Services
- Policy Review: Tackling Health Inequalities in Sunderland.

## 4. Conclusion

4.1 The Committee has delivered another ambitious work programme in 2009/10, which is reflected in the annual report. The Scrutiny Committee has worked well with Council Directorates, stakeholders and partner organisations to deliver the work programme and the Scrutiny Committee has tackled a number of key issues throughout the year and looked to work with officers and stakeholders to provide solutions and improvements to services delivered across the city.

## 5. Recommendation

5.1 That Members approve the Health and Wellbeing report 2009/10 for inclusion in the Overview and Scrutiny Annual Report 2009/10.

## 6. Background Papers

6.1 2009/10 Agendas

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**APPENDIX 1: ANNUAL REPORT**

## Annual Report: Health and Wellbeing Scrutiny Committee 2009/10

Chair: Cllr Peter Walker  Vice-Chair: Cllr Christine Shattock

Committee Members: Cllr Jill Fletcher, Cllr Anne Hall, Cllr Sylvia Old, Cllr Mary Smith, Cllr Dianne Snowden, Cllr Shirley Leadbitter, Cllr Paul Maddison, Cllr Anthony Morrisey and Cllr Peter Maddison.

It has been another busy year for the Health and Wellbeing Scrutiny Committee, during which time we have delivered an ambitious work programme providing discussion and challenge on a range of topics and issues.

Our major policy work this year saw the committee undertake a review that looked into health inequalities across Sunderland, and this has been an extremely challenging and rewarding piece of work. In gathering evidence for the review we held a very successful Community Event Day at the Stadium of Light, where speakers from the Department of Health, Durham University, Sunderland Teaching Primary Care Trust and the local authority provided valuable information and stimulated much debate. The event attracted stakeholders, voluntary groups and the general public and gave us some useful evidence.

The committee also had the opportunity to hold discussions with a senior researcher working for the recently published Marmot Review, an independent study into reducing health inequalities in England. We also held an expert jury event where a number of witnesses were invited to give evidence to the committee which added to the evidence base of the review.

The review, although ambitious, has highlighted a number of key themes and produced recommendations that we trust can help to develop and ensure that future strategies and policies consider the implications on health outcomes within Sunderland.

Alongside our policy review we have looked at a number of other issues including the legislation surrounding mobility scooters and powered wheelchairs. What we found was very little legislation governing such vehicles and agreed to write to the Department of Transport on this issue. As a result we have been invited to contribute to a wider consultation around this issue and have provided a detailed response. The committee hopes that ultimately greater legislation will lead to improved safety for scooter users, pedestrians and other road users.

The committee has continued to be involved in a piece of work that began in 2008/09 around the quality and provision of home care services. I am pleased to report that work is continuing to introduce an electronic monitoring system for home care providers along with an annual survey for home care staff,

service users and managers. These measures, recommended by the committee, will help to drive up the quality of home care provision in Sunderland.

One of the strengths of the scrutiny process is that we can look into issues or concerns around service provision that are raised by elected members. This year we were asked to consider the out of hours service provision in Sunderland, a broad range of statutory services provided to meet the emergency needs of individuals. Following the highlighting of these concerns and subsequent reports from the HHAS Directorate a working group has been established with key stakeholders, including a representative of the committee, to review current arrangements and look at service improvements. The Health and Wellbeing Scrutiny Committee will be kept fully informed of the progress of the working group.

This provides a snapshot of some of the work undertaken by the committee during the year, and I feel that along with the hard work of my colleagues on the committee we have had another successful year. I look forward to 2010/11 being another rewarding year for the Health and Wellbeing Scrutiny Committee.

Cllr Peter Walker
Chair of the Health and Wellbeing Scrutiny Committee

**HEALTH & WELL-BEING SCRUTINY COMMITTEE 21st APRIL, 2009**

**POLICY DEVELOPMENT & REVIEW 2009/10: DRAFT FINAL REPORT**

**LINK TO WORK PROGRAMME: POLICY DEVELOPMENT & REVIEW**

**Report of the Chief Executive**

**STRATEGIC PRIORITIES: SP2: Healthy City**
**CORPORATE PRIORITIES: CIO1, CIO4**

## 1. Why has this report come to committee?

1.1 The report provides Members of the committee with the final draft report from the evidence gathered in relation to this year's policy review on health inequalities.

1.2 The review report presents in detail the evidence, research and conclusions drawn throughout the review process and recommendations arising from this evidence gathering. Members are asked to give consideration to the final report and the recommendations of the policy review.

1.3 The review into health inequalities has clear links to all the Councils Strategic Priorities in particular 'Healthy City.' The review also has links to Corporate Priorities on delivering customer focused services and improving partnership working.

## 2. Background

2.1 At its meeting on 17th June, 2009 following discussions regarding the work programme the Committee consider the possibility of a study into the issue of health inequalities in Sunderland.

2.2 The review came at an important time in light of the work being undertaken at both regional and national levels. The Committee used its skills and expertise to stimulate community engagement and develop themes presented during their evidence gathering procedures. Health and social care feature heavily in the Sunderland Strategy with an aim that 'everyone in Sunderland is able to enjoy a healthy life with access to excellent health and social care facilities when needed'.

## 3. The Draft Final Report

3.1 The draft final report on Tackling Health Inequalities in Sunderland is attached as an appendix to this report and presents members with the facts and evidence that have been gathered throughout the review process. As part of the review process evidence was obtained from a variety of national, regional and local key witnesses and stakeholders.

3.2 The report is divided into a number of sections which provide the background information to the review, how the review was carried out and the findings and conclusions from the review process. The findings from the review reflect the themes set out in the Marmot Review: Fair Society, Healthy Lives as follows:

- Health Inequalities – The National and Local Picture
- The Early Years of Life
- Employment and Income
- Places and Communities
- The Prevention Agenda.

3.3 Members are asked to read the report and comment on the content with particular reference to the recommendations arising from the evidence gathered and presented in the report. Members may wish to amend the report for purposes of accuracy, clarity or relevance to ensure the report is a true reflection of the work undertaken.

## 4. Conclusion

4.1 The Health and Wellbeing Scrutiny Committee are presented with a final draft copy of the policy review document for comment and amendment with the aim of producing a final report for presentation and approval by Cabinet.

## 5. Recommendation

5.1 That the Health and Wellbeing Scrutiny Committee provide comments on the final draft report and that any agreed amendments are made.

5.2 That consideration is given to the recommendations contained in the final draft report.

5.3 That the agreed final report is presented to the Cabinet for approval at its June 2010 meeting.

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**Contact Officer:** **Nigel Cummings (0191 553 1006)**
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# Health and Well-Being Scrutiny Committee
# Policy Review 2009 – 2010

# Tackling Health Inequalities in Sunderland
# Draft Final Report

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# 1 Foreword from the Chairman of the Committee

On behalf of the Health and Well-Being Scrutiny Committee I am delighted to publish this report. I would like to thank all those who participated in the process, for their time and effort and continued commitment in helping Sunderland to continuously improve.

The Community Day was a hugely successful event and I was very interested to hear the views of all those who attended. We were able to gather a great deal of useful information from the day. I would also particularly like to thank our expert witnesses for the detailed evidence they gave to the Committee.

The importance of tackling health inequalities cannot be underestimated and it is unbelievable to think that in today's world, where a person lives can have a major impact on their health and length of life, but it does. Why do people in Sunderland die two years earlier than the average for England? Even more significantly men and women from the least deprived areas of Sunderland can expect to live longer than men and women from the most deprived areas. The factors that contribute to this are numerous and do not lie entirely in the traditional health domain and issues including stress, the environment, transport and housing all play just as significant a role in determining life expectancy.

The recently published Marmot Review 'Fair Society, Healthy Lives' identifies many of the key challenges facing the country in relation to health inequalities and it was extremely beneficial to have Professor Peter Goldblatt, Senior Researcher for the Marmot Review, visit Sunderland and provide evidence to the committee. It was extremely useful and timely to hear firsthand about the findings of the review and the implications nationally, regionally and locally.

Finally I would like to thank my colleagues on the Health and Wellbeing Scrutiny Committee for their valuable input and contribution throughout the course of this ambitious piece of work. I hope that the work and recommendations from this policy review can help to address some of the issues that have been highlighted and can contribute in some way to narrowing the gap in life expectancy across Sunderland.

Councillor Peter Walker, Chair of the Health and Well-Being Scrutiny Committee

## 2 Introduction

2.1 The Annual Scrutiny Conference was held at the Stadium of Light on 11th June 2009 and at the Health and Wellbeing breakout session a number of viable policy review proposals were formulated for discussion by Members of the committee. At its meeting on 17th June 2009 following discussions regarding the work programme the Committee considered the possibility of a study into issues around tackling health inequalities.

## 3 Aim of the Review

3.1 To look at an overview of the strategic and operational approaches within Sunderland for tackling the main determinants of health inequalities.

## 4 Terms of Reference

4.1 The title of the review was agreed as 'Tackling Health Inequalities in Sunderland' and its terms of reference were agreed as:

(a) To identify and gain an understanding of the main determinants of health inequalities across Sunderland;

(b) To examine and assess the interventions currently in use across the city for reducing the main determinants of health inequalities;

(c) To investigate the inequities in health across wards in Sunderland;

(d) To look at examples of best practice and innovative service provision from local authorities, PCT's and other stakeholder groups across the country in relation to identified determinants; and

(e) To review the council's and partners policies and strategic priorities to ensure linkages across the council are achieved and relevant.

4.2 Members agreed that as the review progressed, they may feel that the review should narrow its focus further in order to ensure that robust findings and recommendations are produced.

4.3 Members agreed to look particularly at the strategic implications of health inequalities and how the priorities of various stakeholders look to address the issues around the main determinants of health inequalities.

## 5 Methods of Investigation

5.1 The approach to this work included a range of research methods namely:

(a) Desktop research – review of relevant documentation including government documents such as The Marmot Review 'Fair Society, Healthy Lives.'
(b) Interviews – with key individuals both internally and externally
(c) Focus groups – with key individuals both internally and externally
(d) Questionnaire
(e) Presentations at committee
(f) A Community Day - large public event (see **Appendix 1**)
(g) Expert Jury Event

5.2 All participants were assured that their individual comments would not be identified in the final report, ensuring that the fullest possible answers were given.

5.3 Interviews with the following personnel were carried out:

(a) Nicola Morrow – Healthy City Coordinator – Sunderland City Council
(b) Lee Cranston – Assistant Head of Corporate Policy – Sunderland City Council
(c) Professor Peter Goldblatt – Lead Researcher - The Marmot Review
(d) Nonnie Crawford – Director of Public Health – Sunderland TPCT
(e) Ben Seale – Joint Commissioning Manager – NHS SOTW

5.4 Visits were undertaken to look at the work of the Warm Front referral team, the NHS Health Check initiative and the NHS Stop Smoking team at Monkwearmouth Hospital.

5.5 A health inequalities questionnaire was conducted for the Health and Wellbeing Scrutiny Committee by the Sunderland LINk.

5.6 A Community Day held on 21st January 2010, invited views from the public, service users, carers and provider organisations. Approximately 120 delegates took part in the event. Key Speakers for the event included:

(a) Professor Tim Blackman – Durham University
(b) Neil Revely – Director of Health, Housing and Adult Services
(c) Martin Gibbs – Department of Health
(d) Nonnie Crawford – Director of Public Health

5.7 An expert Jury Event on 22nd February 2010, where final evidence was presented to members of the committee by:

(a) Nicola Morrow – Healthy City Coordinator, HHAS (who gave an introduction to the event and facilitated along with Ann Dingwall)
(b) Brent Kilmurray – Sunderland Teaching Primary Care Trust
(c) Neil Revely – Executive Director HHAS
(d) Canon Stephen Taylor – Chair of the Local Strategic Partnership
(e) Nonnie Crawford – Director of Public Health
(f) Alan Patchett – Age Concern and Community Network
(g) Dr Helen Patterson – Executive Director Children's Services
(h) Vince Taylor – Head of Strategic Economic Development
(i) Margaret Elliott - Social Enterprise

5.8 The Sunderland LINk conducted a survey on behalf of the Health and Wellbeing Scrutiny Committee with a small sample of the population of Sunderland. The aim of the survey was to gather opinions and comments on a number of issues related to health and inequality. The results of this survey have helped to inform the final report and **Appendix 2** of this report provides full details of the survey.

5.9 It should also be noted that many of the statements made are based on qualitative research i.e. interviews and focus groups. As many people as possible were interviewed in an attempt to gain a cross section of views, however it is inevitable from this type of research that some of the statements made may not be representative of everyone's views. All statements in this report are made based on information received from more than one source, unless it is clarified in the text that it is an individual view. Opinions held by a small number of people may or may not be representative of others' views but are worthy of consideration nevertheless.

# 6 Findings of the Review

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to look at the most effective evidence-based strategies for reducing health inequalities in England from 2010. The Health and Wellbeing Scrutiny Committee's findings, for reasons of clarity and order, relate to the main policy objectives identified in The Marmot Review: Fair Society, Healthy Lives.

## 6.1 Health Inequalities – The National and Local Picture

### What is Health Inequality?

6.1.1 The term health inequality in the most basic sense is the gap between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds. The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, the unfair and avoidable differences in health status seen within and between wards.

6.1.2 The social determinants of health are best displayed as in Figure 1 an image designed by Dahlgren and Whitehead in 1992.

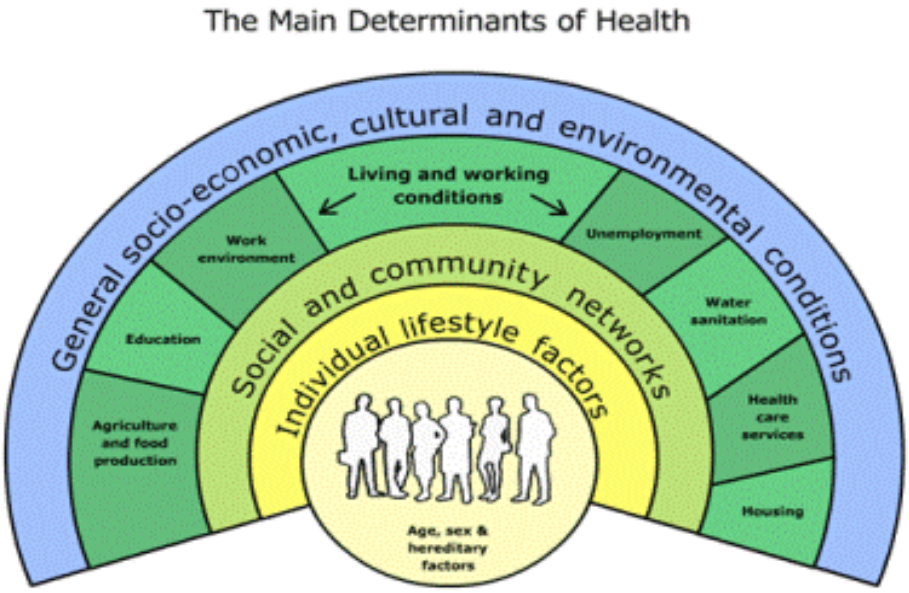



Figure 1: Main Determinants of Health: Dahlgren and Whitehead

6.1.3 The World Health Organisation in its publication "Social Determinants of Health: The Solid Facts" stated that "Health policy was once thought to be about little more than the provision and funding of medical care: the social determinants of health were discussed only among academics. This is now changing. While medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place."

6.1.4 At the committees Expert Jury Event many of the witnesses expressed the view that health inequality principally was around social class and social scale and that health issues were often an outcome of a situation. In fact, as an example, it was highlighted that those from the lowest social classes were twice as likely to die before the age of 15 as those from the highest social classes. Factors including age, gender, vulnerability, social, accidental, genetic, economic position and lifestyle choice were all regarded as attributable to health inequalities nationally and locally by many of the witnesses interviewed.

6.1.5 Members at the Community Event Day highlighted that personal and community wealth caused inequalities in health. During discussions with attendees it was reported that the feeling is that people living in difficult circumstances with little money were less likely to care about their health and were more likely to resort to coping with this through mediums such as alcohol and tobacco. Conversely to this more advantaged people were far more likely to live longer as they could afford and have access to better health care as well as experiencing a higher standard of living with less of the stresses encountered by those more disadvantaged.

6.1.6 This is supported by the Marmot Review which highlights that many of the determinants of health inequalities lie outside the health service and in the social aspects of life. Similarly to views expressed at the Expert Jury Day and the Community Event Day, those most disadvantaged in society have the least positive experiences and vice versa. This relationship between social circumstances and health is referred to as the social gradient of health and plays an important part in life expectancy.

**Health Inequalities: Facts and Figures – The National Perspective**

6.1.7 8.2 million adults age 16-64 are drinking above the recommended maximum daily levels and alcohol misuse is calculated at costing the health service £1.7bn per annum.

6.1.8 The level of obesity in 2-10 years olds in England has risen from 9.9% to 14.3% in 2004.

6.1.9 Eating at least 5 portions of fruit and vegetables a day can lead to a reduction in overall deaths from chronic diseases such as heart disease of up to 20%. While processed foods contribute around 75% of salt to the UK diet.

6.1.10 There are great differences in life expectancy dependent on location, for example males in Blackpool have a life expectancy eight years less than males in Kensington & Chelsea.

6.1.11 Obesity is one of the major public health issues in the developing world. In 2003, 22% of men and 23% of women were obese. By 2010, without intervention, this figure would increase to 33% of men and 28% of women.

**Health Inequalities: Facts and Figures – The Local Perspective**

6.1.12 Binge drinking is a concern nationally as well as locally with levels of binge drinking very similar across NHS South of Tyne and Wear with Sunderland rated the fourth

worst local authority for binge drinking in England with South Tyneside sixth and Gateshead ninth respectively.

6.1.13 The percentage of children who are obese rises from 12.6% in 4/5 year olds to 21.4% for 10/11 year olds.

6.1.14 On average people in Sunderland die two years earlier than the average for England. Men and Women from the least deprived areas of Sunderland can expect to live longer than men and women from the most deprived areas: about seven and a half years longer for men and about seven years longer for women.

6.1.15 Of the adult population from the 25 wards in Sunderland, 12 wards were below the prescribed PCT average of between 23% and 29% of adults consuming five portions of fruit or vegetables per day with one ward significantly lower at less than 20%.

6.1.16 An average 600 people per year in Sunderland die due to smoking related diseases and smoking among adults remains above the average for the North East and for England at 33.8% with some wards indicating levels up to 45%.

6.1.17 Falls are a major cause of ill health among older people and the rate of falls in Sunderland is higher than that for Gateshead and South Tyneside.

6.1.18 Local data combined with geographical indicators allows for comparisons of disadvantage across the country. Figure 2 illustrates the proportion of the population experiencing significant disadvantage on a daily basis.

| Domain | Sunderland | England |
|---|---|---|
| Overal Index of Multiple Deprivation | 43% | 20% |
| Income domain | 37% | 20% |
| Employment domain | 56% | 20% |
| Health deprivation and disability domain | 62% | 20% |
| Education, skills and training domain | 41% | 20% |
| Barriers to housing and services domain | 8% | 20% |
| Crime and disorder domain | 22% | 20% |
| Living environment domain | 2% | 20% |
| Income deprivation affecting children domain | 28% | 20% |
| Income deprivation affecting older people domain | 47% | 20% |

*Source of data: Department for Communities and Local Government*

Figure 2: Proportion of the population living within the 20% most disadvantaged areas across England

## 6.2 The Early Years of Life

### Early child development

6.2.1 The Primary Care Trust has a clear vision for better health, better patient experience and better use of resources by 2015, and part of this is for people to live longer and receive fair access to services. The importance of improving life experiences cannot be underestimated and these begin even before the very start of life. During the expert jury event witnesses from the primary care trust highlighted the importance of their continuing work with high risk women who are pregnant including reducing smoking during pregnancy and improving breast feeding figures. The PCT are also set to re-launch school health checks and undertake a review of the school nursing service. All of this work evidences the importance placed on those early child years by NHS South of Tyne and Wear and Sunderland Teaching Primary Care Trust, as well as how this can help to reduce health issues in later life.

6.2.2 At the Community Event Day held in January 2010 it was highlighted that breast feeding had seen an increase in the Shiney Row area due to the Sure Start programme. However, it was recognised that it is not easy to breast feed in the city as it is still seen as not publicly acceptable. It was also acknowledged that hospitals make it too easy for mothers to bottle feed by providing ready prepared bottles.

6.2.3 The local authorities Children's Services Directorate will operate from 1 April 2010 to a 15-year strategic plan, the Children and Young People Plan, which links in with the Every Child Matters outcomes framework. The plan looks to promote healthier lives in young people through a variety of initiatives including healthy diet to reduce the rate of childhood obesity in the city. It also looks to improve life chances for young people from -9 months onwards through schemes to increase breast feeding rates and reduce smoking during pregnancy. There is also the Children's Plan**,** the Department for Children, Schools and Families' (DCSF) 10-year strategy to make England the best place in the world for children and young people to grow up in. The Children's Plan is aligned with the Every Child Matters Outcomes Framework and a range of policies and strategies have been developed by DCSF to support Children's Services and Children's Trusts to achieve improved outcomes.

6.2.4 It is worth noting that 51% of children are living in low income families compared to 44% in the North East and 42% nationally. In recognising this Children's Services are in the consultation phase of the development of action plans to deliver the Child Poverty Strategy which will look to address a number of issues around poverty and providing better life chances for young people. This will require a universal and integrated approach with the local authority and key stakeholders working together.

6.2.5 It should also be noted that the local Children's Trust regularly challenges the performance and delivery of services provided by the local authority and other key stakeholders. The Children's Trust has a vital role in: agreeing, reviewing and signing off the Children and Young People's Plan; contributing to the Local Area Agreement (LAA); and in driving the operational plans which underpin them both. LAAs are now the primary vehicle for central government to agree targets for local government and its partners. The Children's Trust is also one of the main thematic partnerships of the Local Strategic Partnership which agrees the priorities for improvement in the LAA.

6.2.6 There was an emphasis on providing more locality or neighbourhood level based provision and in particular a more family based approach for those most in need. Children's Centres also have an important role to play, and this goes beyond those very early years, in providing a whole range of provision from a variety of partners targeted to meet the needs of those who attend. The major issue is that those who attend are usually self motivated, want to be there and are the most informed members of the area. More outreach work is being undertaken to reach those most in need, distanced from society or hard to reach, but this can prove difficult as many of these families often don't wish to be on the radar.

6.2.7 In looking to provide the best possible start for young people Durham and Newham are providing universal Free School Meals (FSMs) to all primary school children. The pilots will run for two years from September 2009 and each pilot will be tested against a control group where the current rules for eligibility for FSMs apply to inform the full evaluation. The pilots are joint funded to a total of £20 million from Department for Children, Schools and Families and the Department of Health and match funded by the successful local authorities, taking the total to £40 million.

Local Authorities in deprived areas were invited to bid to take part in a two year pilot which looks at the health benefits of free school meals. It will investigate whether free school meals can reduce obesity, change eating habits at home, impact on behaviour and academic performance at school, improve school standards and improve general health and well being.

**Education and Maximising Life Chances**

6.2.8 In the findings of the Marmot Review there is a clear identification of the inequalities in educational outcomes affecting physical and mental health, as well as income, employment and quality of life. Young people need to be more informed and educated so they can make informed choices about their health and acknowledged that young people can do risky things, but that this was part of their development and growing up. At the expert jury day it was noted that lifestyle opportunities needed to be well informed and that the whole wellbeing of the child was important. The Joint Strategic Needs Assessment for Sunderland states that there needs to be focus on building the resilience of children and young people in recognising that risk taking behaviours do not happen in isolation, for example there are explicit links between alcohol misuse, educational attainment, teenage pregnancy etc.

6.2.9 There needs to be more targeted interventions within the school setting to allow for young people to make those lifestyle choices in an informed manner. There needs to be greater intelligence gathering on a neighbourhood level. A number of witnesses identified this need to gather local intelligence in order to better understand many of the issues associated with inequalities. This is perhaps most important in achieving educational parity through understanding families, schools and the local community setting. The issue was raised about the increasing difficulty in accessing schools for organisations with information for young people through the increased measures of the Safeguarding Agenda.

6.2.10 Throughout the evidence gathering process the importance of community was evident and the central role that school has to play in this. Members of the public identified the importance of using schools as good community bases to offer courses, activities and develop that link between young people, the family and the wider local community. The extended school model is an important one which can breakdown those traditional boundaries and help young people to develop the life and social skills required. Extended schools services provide a core offer of activities, advice and opportunities including healthy school meals and healthy vending strategies as well as travel-to-school schemes (encouraging safe walking and cycling) and active play projects. The new Extended Services Disadvantage Subsidy from central government has been established to support those children and families who are most disadvantaged, particularly those living in poverty or in the looked after system. The ‘Healthy Schools’ initiative is a key part of addressing health issues, with healthy schools teams providing consultancy to schools on key areas such as substance misuse, healthy lifestyles, and relationships.

6.2.11 Education and maximising life chance does not stop at school it continues beyond 16 and the Marmot Review acknowledges this continuation of education in its findings. It is important to prevent young people from falling into the NEET (Not in Education, Employment or Training) trap and the local authority is working well to develop appropriate early interventions including work related experiences and a pre-16 curriculum offer. Again the issue of quality information was highlighted by witnesses to ensure that the advice given was timely and of a high quality. It was

felt important that the transition from compulsory education to post-16 education and training was a smooth transition to reduce the chances of a young person becoming NEET. Recent research from one northern city indicated that one in seven young people identified as NEET over a long term died within 10 years of falling out of the system. This shocking statistic emphasises the importance of the contribution children's services will make to the new responsibilities which are due to be transferred to local authorities in 2010 for commissioning, funding and in some cases providing educational opportunities for 16 to 19 year olds.

6.2.12 There is also a need for young people to be able to access a range of services within the community which can develop their own skills which will help them to improve their life chances and maximise their capabilities including continuing education, debt management, substance misuse, housing issues, pregnancy and parenting skills. All of which will have an impact on a persons life chances and health outcomes in the future. Figure 3 overleaf is from a random sample of the Sunderland population and indicates the level of knowledge relating to support services available for people locally.

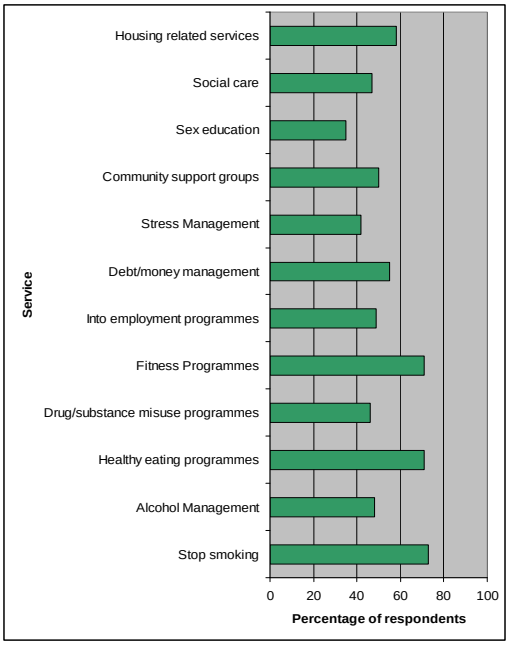



Figure 3: To show if respondents are aware of or know how to access a variety of services

6.2.13 A common theme throughout the entire evidence gathering was one of the misuses of alcohol, cigarettes and drugs by young people. It was argued that drunkenness was a lifestyle choice made by many young people and that going out equated to getting drunk. Many of the attendees at the community event day echoed these sentiments particularly around the availability and access of cheap alcohol and suggested a minimum pricing structure for alcohol or possibly alcohol free zones in certain parts of the city. Around 20% of 13 year old boys and girls describe consuming alcohol but by the age of 15 these figures have doubled. It was also noted that the smoke free legislation and the work of the Tobacco Alliance had made a positive impact on the city but there were still concerns around the sale of illicit cigarettes regionally and nationally. The Joint Strategic Needs Assessment for Sunderland also identifies a very high level of children and young people who still live with adults who smoke and are at risk due to second hand smoke.

6.2.14 Members also visited Monkwearmouth Hospital to learn more about classes, programmes and initiatives to getting people to stop smoking. The NHS funded

stop smoking programme has been in existence for 10 years. It was highlighted that the profile of the smoker was changing, and in particular young girls who smoke was on the increase. Figures from the PCT support this with Sunderland having a higher proportion of year 8 (5% v 3%) and year 10 (20% v 13%) girls who smoke compared to their male equivalents. However the team were constantly looking to accommodate and adjust to cultural changes in the smoker's profile. Members enquired why smoking in younger girls was increasing, and they were informed that the main drivers for younger girls taking up smoking were perceptions of looking more mature, the image of being an adult and it kept them thin. The NHS Stop Smoking Team also explained that bespoke programmes produced good results and that the messages of stopping smoking needed to be consistent and constantly driven as part of the stop smoking programme. The team also acknowledged the importance of local knowledge in tackling the issue.

## 6.3 Employment and Income

### Employment and Work

6.3.1 In terms of health inequalities the contribution that good employment makes for good health cannot be underestimated and similarly the way unemployment contributes to poor health. This was discussed at the community event day by a number of attendees and there was an acknowledgement of the correlation between unemployment and ill health. It was further identified that while unemployment and economic inactivity were associated with higher rates of poor health and mental illness, it was also argued that poor health can in itself lead to difficulties in both securing and retaining employment. Attendees believed that aspirations needed to be raised through increased voluntary opportunities within various organisations across the city. As well as ensuring people who were not in work still felt valued and were offered help from an independent advocate on issues of debt, health and emotional well being.

6.3.2 Local authorities' work in supporting and boosting their local economies is one of a council's less well known activities among the general public. However, for a considerable time now, they have been playing an active part in regenerating communities, promoting their areas to attract inward investment, developing training opportunities to help people improve their employment opportunities and supporting those who are out of work, for example with welfare benefits advice. Sunderland is no different having secured funding from the Working Neighbourhood Fund (WNF) which replaces the Neighbourhood Renewal Funding (NRF). Working with Partners, the City Council has developed a detailed programme for WNF; including elements focussed on client engagement, pathways to employment, skills and training, health support and enterprise initiatives. The WNF represents an additional opportunity to significantly reduce the inequalities within the City caused by unemployment, low skill levels and low levels of enterprise. The WNF will allow for an improved Job Linkage Service to help those people who find themselves unemployed by providing more guidance and support on training opportunities and getting back into work, while also working within communities to encourage enterprise activities where appropriate.

6.3.3 At the expert jury day it was explained that the WNF was focused on people who received out of work benefits including incapacity and income support. The claimant rate for working age people on out of work benefits was 18.8% (May 2009) and in the worst performing neighbourhoods stands at 30.6% (May 2009). The majority of cases concern mental health (stress) and back pain, yet through moving from

incapacity back into work can often see improvements in these conditions. Work continues to develop programmes of specialist activities to strengthen the employment opportunities for the long term unemployed and disadvantaged groups including a Skills and Employability Strategy with the Learning Partnership.

6.3.4 The jobs people move into also need to be good jobs that allow a degree of control and flexibility, insecure or poor quality employment is also very much associated with poor physical and mental health. There also needs to be an equal opportunity within the labour market for those with disabilities, single mothers etc. Again through the WNF, Sunderland City Council is developing a number of schemes which reflect this including Employment Support for People with Disabilities, Mental Health Employment Specialists and with People into Employment – Support for Carers.

6.3.5 The Community Event Day also highlighted the merits of employers within the city looking proactively at the opportunities available to their respective workforces. Offering at work health checks, screenings or information on services available within the public domain was seen as a positive step in promoting health outcomes at work and giving people greater control, information and choice in the work environment.

**Income and Wellbeing**

6.3.6 The complexity of the benefit system as well as its disincentive nature to returning to employment are highlighted within the Marmot Review and are recognised as a barrier to improved income, social standing and wellbeing. It is argued by Professor Goldblatt, a senior researcher for the Marmot Review, that the benefit system in this country is so complex that no-one truly understands it fully, and that it needs to be made clearer with much of the complexity removed.

6.3.7 The link was made at the community event day between the real need for people to work and how this helps to prevent addiction and improve health generally. The number of people on Job Seekers Allowance or Incapacity Benefit was also recognised as of concern. It was also argued though, that people would not return to work if this would reduce their benefits and ultimately leave them in a worse financial position. Witnesses from the expert jury day agreed that many people wanted to work but when often the move into employment had a negative effect on income, thus many people suffered from being caught in a benefit trap.

6.3.8 Obviously this is a challenging issue that requires innovative ways of changing the culture of many people. Professor Goldblatt cited the example of the London Borough of Newham (LBN) that recognised the impact of unemployment on health and developed the Mayor's Employment Project. The service was locally developed to offer support to the long-term unemployed with the objective of getting these people back to work. The project is delivered by advisors who offer expert benefit advice and financial support and provides the guarantee that people will not be worse off when returning to work and will top up housing benefit for a year if needed. The advisors offer help in setting up in-work benefits and establishing childcare arrangements. The scheme has placed 220 residents of LBN back into work and no-one has needed to claim the additional subsidies from the local authority. The scheme has allayed the traditional fears and allowed people to escape the benefit trap through sound advice and information.

## 6.4 Places and Communities

### Local Communities

6.4.1 Neighbourhoods and communities are an extremely important aspect of the health inequalities equation as acknowledged by the Marmot Review and as a recurring theme throughout the committees own research. There is a real issue around mapping the work that is undertaken in communities and neighbourhoods. Are the areas of greatest need where we have the concentration of services? At the expert jury day this was expressed as not always being the case. It was also highlighted that when everyone is treated equally it simply means the healthier get healthier and there is no narrowing of the gap in equalities. Within and across wards the level of variation can be great and both the PCT and local authority are looking to identify neighbourhoods where engagement needs to be targeted. Many of the traditional ways of engaging with communities need to be looked at and new ways of working developed to improve outcomes. There was recognition of the equality of outcomes and the need to be brave when looking at targeting services and providing the right levels of intervention in each area.

6.4.2 The community event day identified a number of issues that people believed contributed to health outcomes, a number of which revolved around neighbourhoods and where a person lives. The new wellness centres were identified as an excellent resource as well as the numerous community leisure facilities in place or under construction across the city. The built environment and development of green spaces across the city was also highlighted as important in providing an attractive environment in which to live.

6.4.3 Attendees also regarded the accessibility of services, shops and activities as important. This highlighted the issue of effective transport links across the city and the issue of ensuring new services or facilities have considered the accessibility arrangements for various groups and backgrounds that exist within Sunderland. Transports primary function is to enable access to people, goods and services. Transport has major health impacts from road accidents, levels of physical activity and associated health effects from weight gain, air pollution and access to a range of services. It is recognised that the adverse health effects fall disproportionately on the most vulnerable groups in society, those living in poorer communities who suffer from environments which discourage active travel, active play and where more accidents are experienced.

6.4.4 ‘Walkable’ neighbourhoods or environments are recognised as places where people are more likely to know their neighbours, participate politically, trust others, and be socially engaged. ‘Walkability’ is something that cannot be planned for without a co-ordinated approach to the built environment as a whole, bringing together housing, transport and the planning system. This illustrates the need for an integrated and coordinated approach to embed health considerations.

6.4.5 The plans and policies of urban planners are instrumental in affecting the conditions in which people live and work, how people access services and facilities, their lifestyles and ability to develop strong social networks. These are key determinants of the health, wellbeing and quality of life of people in cities. Healthy urban planning is about planning for people. It means putting the needs of people and communities at the heart of the planning process, and considering the implications of decisions on health and wellbeing. It also needs to find a balance between social,

environmental and economic pressures similar to planning for sustainable development.

6.4.6 NHS services are universal in nature and this is something that needs to be considered and this was recognised at the expert jury day. G.P's play a crucial role within communities and this can help the NHS to provide local enhanced services through the collection of information on key groups of people within communities. This could allow for better monitoring and better reaction within local areas. The NHS recognised the emerging theme of personalisation. The NHS has a good base and strong foundations around service delivery and working with the local authority and other agencies is looking to better coordination and delivery of services to ensure resources are deployed to those areas or groups most in need. Again attendees at the community day event also expressed their satisfaction with the service from G.P's generally. Many also emphasised how G.P's were able to provide information or access to health programmes.

6.4.7 The easy access and sheer volume of fast food outlets across the city and in communities was discussed by many attendees at the community event day. This follows on from the accessibility issue in communities and it is important that not only do people have access to good quality services but also to good local environments and that includes food. The importance of a healthy diet cannot be stressed enough and people need to be able to access fresh fruit and vegetables. This is not always the case and issues around affordability do play a major part. There is an issue for local authorities and planners to consider the health outcomes of planning decisions on local communities. There needs to a good range of choices on the high street to allow local families to make an informed choice. Links can be made here with local voluntary groups in providing classes to give families the confidence to buy and use fruit and vegetables rather than the easier fast food option.

6.4.8 The voluntary and community sector also play an important part in local communities and provide facilities and opportunities within neighbourhoods. Members discovered examples of internet cafes and luncheon clubs offering nutritious meals and Sit n B Fit schemes which saw joint agency working on a local level. Good neighbourhood projects which look to get communities more involved with each other creating a positive impact on the way people feel about where they live. It was identified that there needs to be more work undertaken to encourage similar joined up working in communities that can move the health agenda forward.

**The Role of Area and Scrutiny Committees**

6.4.9 The importance of neighbourhood data has been touched upon already during this review but it cannot be underestimated in terms of inequality and the targeting of resources. A number of expert witnesses highlighted the role of area committees in addressing this agenda. Area committees are undertaking a new role and defining their own local area plans which involve partner organisations and the third sector. Each local area plan has an investment budget to enhance or supply services locally. Local area committees also have community chest funding which provides social capital and enables communities to improve socially and this too can impact on health outcomes.

6.4.10 Area committees can provide a real focus for developing community outcomes and also providing intelligence on neighbourhood and community level. This intelligence can then provide for targeting of resources to those areas and neighbourhoods

most in need. Area committees provide an interface between local councillors, officers, interest groups and the community to work together and move forward on various agenda fronts which can only serve to improve the health agenda. The use of area committees can also provide for a joined up approach to service delivery and also allow for community input into how services or projects can best work in a neighbourhood.

6.4.11 The scrutiny function also has a part to play in tackling health inequalities. The very nature of health inequalities means there is an impact on all strands of the scrutiny function, and it is important that scrutiny committees look to challenge the key determinants of health inequalities where applicable. There are a number of key documents that can assist the process including the Joint Strategic Needs Assessment (JSNA) which outlines current and future needs of a local population. The JSNA can help to assess how effectively current services are meeting the needs of communities, identify unmet needs and assist with service planning and innovation.

## 6.5 The Prevention Agenda

### The Changing Landscape

6.5.1 The focus over the next five years for the NHS is around developing the prevention agenda and this is clearly outline in the NHS strategy 2010-2015: from good to great . Preventative, People Centred, Productive. There is a growing focus on developing services that are more accessible within communities and enhance the probabilities of reaching vulnerable groups. The real challenge for the health service will be the decommissioning from treatment to prevention, particularly in a perceived period of limited growth. At the expert jury day the importance of investing in community and G.P settings was highlighted, as well as looking at how we manage people with long term conditions. Being able to put people in greater control of their condition can lead to fewer emergency admissions and this is exemplified by the TeleHealth pilot, that is part of the Digital Challenge programme, which has seen reducing numbers of hospital admission.

6.5.2 There are numerous schemes working within communities that have an impact on the prevention agenda. Currently Sunderland City Council and housing partners are continuing efforts in working towards every possible home in Sunderland being insulated. From 2010, this will include trials of solid wall insulation for private homes. The City Council through its Health, Housing and Adult Services Directorate are also developing an Affordable Warmth Strategy to look at tackling issues around fuel poverty. It is schemes like this that can provide real benefits and ensure that resources are directed to where they are needed most.

6.5.3 There needs to be a corporate council approach to driving and tackling the inequalities agenda. There is no doubt that a lot of good work is being undertaken but the links need to be established between the key stakeholders. Also throughout the evidence gathering it became clear that there is a need for every service to consider the health impact of all policies and strategies that are to be implemented. A number of expert witnesses acknowledged that there was a lack of use of health impact assessments across departments. Every service considers the risks of a new project, service or strategy but this must include the health benefits. The importance of health outcomes for Sunderland cannot be underestimated in policy planning or implementation.

6.5.4 There is also a very important role for local elected members to play in driving health inequalities forward. At the expert jury day it was reported that no-one ever raises the issues of a healthy lifestyle or the inequalities in health as an issue with an Elected Member. This raised an interesting point around the role of members as champions of their communities and the need for them to understand the implications of policy decisions on the health of their communities and neighbourhoods.

6.5.5 During the survey conducted by Sunderland LINk on behalf of the committee the question was posed as to what was important in maintaining a healthy lifestyle, the question was open and no options or tick boxes were provided. Figure 4 below shows the results. The results indicate that diet and exercise score well which is positive and illustrates that the message around these themes is being understood and acknowledged. However more importantly it shows how other messages around a healthy lifestyle including health checks, screenings and perhaps more alarmingly smoking and drinking are not hitting the mark. The local lifestyle survey identified that 42.3% of adult males and 21.8% of adult females within Sunderland drink heavily on a single occasion at least once a week, the averages for England are 24.7% and 15.4% respectively.

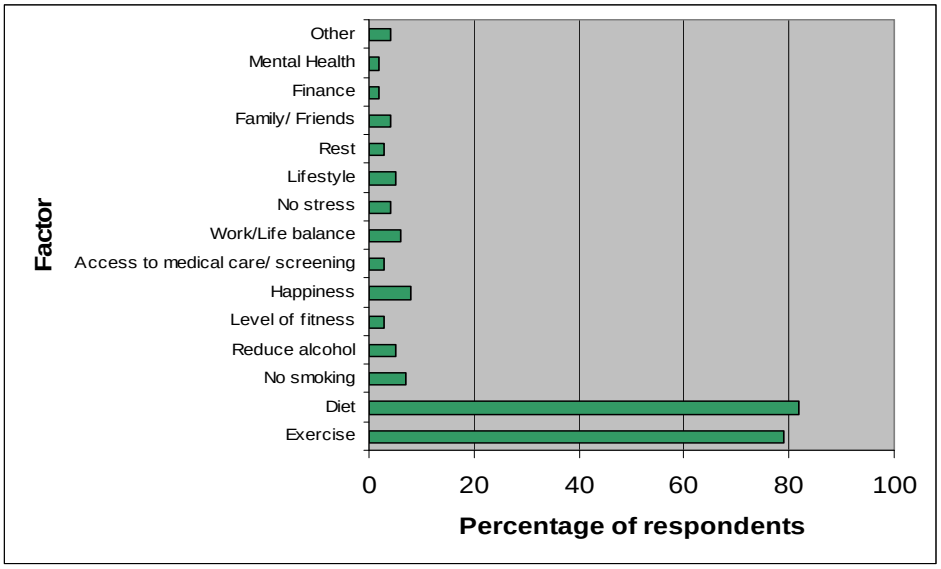



Figure 4: To show factors all respondents consider important in maintaining a healthy life

6.5.6 As indicated drinking and the effects of alcohol are not confined to young people and the proportion of the adult population that drink at harmful levels across the week is highest in the wards of Houghton (35%), Washington East & St. Peters (34%) and St. Michaels (33%), but none of these figures are significantly higher than the average proportion across Sunderland as a whole (29%). According to Sunderland's Director of Public Health what is interesting is the difference compared with other lifestyle indicators e.g. smoking which increases as the socioeconomic gradient declines, whilst with alcohol there isn't a similar correlation, harmful and hazardous drinking occurs across the gradient although there is a suggestion of a decline with age.

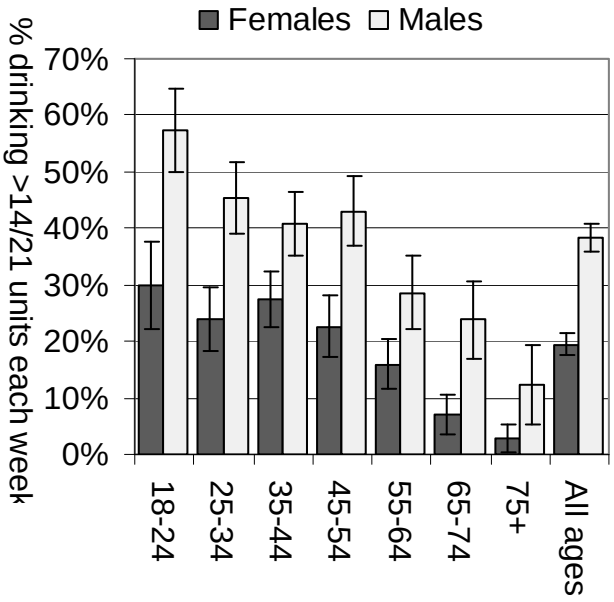



Figure 5: Proportion of adults drinking at unsafe levels each week

6.5.7 Again smoking rates among the adult population in Sunderland are also higher than the national averages. The prevalence of smoking in Sunderland based on Health Survey for England data indicates that 32% of adults smoke. When the population is broken down into groups with similar social and demographic characteristics, the proportion who smoke among 'low income families in estate based social housing' was significantly higher that the overall proportion who smoke across Sunderland.

| Ward | Persons % who smoke | Persons Total Responding | Signficance* |
|---|---|---|---|
| Barnes | 22.8% | 189 | - |
| Castle | 25.4% | 181 | - |
| Copt Hill | 27.3% | 183 | - |
| Doxford | 18.7% | 171 | - |
| Fulwell | 17.3% | 168 | L |
| Hendon | 28.4% | 134 | - |
| Hetton | 27.1% | 129 | - |
| Houghton | 23.0% | 248 | - |
| Millfield | 27.7% | 141 | - |
| Pallion | 33.6% | 152 | - |
| Redhill | 31.3% | 163 | - |
| Ryhope | 28.8% | 191 | - |
| St Anne's | 27.8% | 151 | - |
| St Chad's | 29.3% | 157 | - |
| St Michael's | 22.5% | 151 | - |
| St Peter's | 25.0% | 132 | - |
| Sandhill | 30.1% | 173 | - |
| Shiney Row | 21.9% | 192 | - |
| Silksworth | 22.8% | 228 | - |
| Southwick | 27.7% | 159 | - |
| Washington Central | 22.1% | 172 | - |
| Washington East | 22.8% | 167 | - |
| Washington North | 26.2% | 183 | - |
| Washington South | 20.2% | 173 | - |
| Washington West | 23.6% | 191 | - |
| Unknown ward | 25.0% | 28 | |
| Sunderland | 25.1% | 4307 | |

Source: 2008 South of Tyne and Wear Lifestyle Survey, NHS South of Tyne and Wear

* H = significantly higher than Sunderland average at 95% level of confidence, L = significantly lower, - = not significantly different

Figure 6: Proportion of Adults that smokes by Sunderland ward

6.5.8 The third sector also has a huge part to play in moving forward the prevention agenda and already does a lot of good work within communities. It is crucial that services engage with communities on the right level and a good in-road in to communities is through the already established voluntary networks within communities. A number of social enterprise schemes are also operating with good results and these organisations need to be considered in developing a joined up approach. It is also important that the voluntary and community sectors are supported in the delivery of programmes which can impact on the prevention agenda.

**Total Place Pilots**

6.5.9 'Total Place', is an ambitious and challenging programme that, in bringing together elements of central government and local agencies within a place, aims to achieve three things, create service transformations that can improve the experience of local residents and deliver better value, deliver early efficiencies to validate the work and develop a body of knowledge about how more effective cross agency working delivers the above. This work weaves together two complimentary strands. A 'counting' process that maps money flowing through the place (from central and local bodies) and makes links between services, to identify where public money can be spent more effectively.

6.5.10 Sunderland working in partnership with South Tyneside and Gateshead are looking at the theme of alcohol and drug misuse as a Total Place pilot. This was determined through consultation and workshops with various partners. It is clear that alcohol and drug misuse is a concern that all three local areas have a common affinity with and presents challenges in developing approaches and solutions as well as identifying cross-cutting links with partnerships and priorities.

## 7 Conclusions

The Committee made the following overall conclusions:-

7.1 How you start life, where you live, develop through childhood, the experiences you encounter, your education and employment all have a major part to play in your personal health outcomes and life expectancy. Health inequalities are inextricably linked to the place on the social scale that a person sits, and the more advantaged a person is the more positive the outcomes become. Is this fair and is it necessary, particularly as many of these inequalities could be avoided. The Marmot Review argues that creating and investing in a fairer society is essential to the improvement of health in the whole population, and this is something that all stakeholders need to consider when considering tackling the inequalities of health in Sunderland and nationally.

7.2 The early years of life have the biggest impression on the life course and the choices, lifestyle and health outcomes of any individual and the role that school and family life play in this cannot be underestimated. The social and educational skills developed at an early age through school and family provide individuals with the knowledge to make choices that will influence their life course. The universal free school meals pilot could also provide new evidence to the debate around the best opportunities at the earliest stages of life. Following positive results from the initial pilot authorities it is proposed to extend the pilot to a further six local authorities by September 2010.

7.3 Projects like Sure Start and the Children Centres provide support to young mothers by bringing together a number of support services to provide a positive start for children. It is important that it reaches those who need it most and not simply those who know how to access the service. With this in mind further outreach work is being undertaken across localities to ensure the hardest to reach families get the same support. Children's centres support the most vulnerable and youngest parents not only in bringing up their children but also to develop themselves through providing access to training and employment advice and opportunities and thereby improving their quality of life and standard of living overall.

7.4 Whole school pilots need to look at how the school and the community as a whole work together in partnership. The role of the school as a place to offer courses and activities that develop links between groups within communities is not one that should be dismissed lightly. This dual role as a school and community base can also then provide for access to services including stop smoking classes, healthy eating courses and sex education that are traditionally held in G.P. practices, clinics or other locations that are often remote from neighbourhoods or communities.

7.5 The very real issue of under-age drinking and smoking and the damage this can do to young people is evident throughout the research. The very real concerns that people have about the seemingly spiralling nature of these issues was also highlighted numerous times. The ready availability of cheap alcohol in supermarkets and local shops together with the illicit sales in cigarettes has a direct effect on the health outcomes of individuals in later life. Young people will take risks but these risks need to be informed around the consequence of actions.

7.6 Without the correct knowledge and information the opportunities for making informed decisions becomes limited and positive health outcomes are reduced. This knowledge and information comes from a wide variety of sources including the home, school, friends and communities. All these factors contribute to the choices that are made and the resultant health outcomes. There are clear links between educational attainment and health outcomes and through various settings both within school, the community and the workplace there needs to be as much opportunity as possible to allow for the access to information that can inform the choices people make.

7.7 Unemployment and economic inactivity are directly linked to ill health and this in turn can lead to difficulties in finding or maintaining employment. The status and control people have in their working lives is a contributable factor to their health and wellbeing, being able to have a degree of control or flexibility can reduce stress. In a time of economic instability and a global recession it is difficult to see the aspiration of every job being of this nature. However, there is a lot of important work being undertaken to develop new skills and provide training opportunities to get back to work. The social enterprise schemes are one such example and give employees real control and flexibility as they own the company through the shares they receive. The Working Neighbourhood Fund has also provided the local authority with funding to develop programmes and initiatives which can look to target those most in need of support in returning to work and taking people out of poverty, so they are not trapped in unemployment or earning poverty wages which can impact on their future health.

7.8 The issue of the benefit trap and the complexities of the benefit system are highlighted in the Marmot Review and these issues are not easy to address. However, as can be seen from the London Borough of Newham example, innovative solutions are there to be found. Sunderland offered mortgage rescue plans during the recent financial crisis to help families in the area keep their homes and prevent unnecessary homelessness.

7.9 It is not that people do not want to work rather that they want to be better off for working. Employment can mean many things to a person including development of new skills, better financial standing, increased opportunities and ultimately better health. How we address this over the coming years will take a whole city approach with many of the key stakeholders, enterprises and businesses working together to improve the employment opportunities where they are available.

7.10 The health inequalities agenda is heavily influenced by community and neighbourhood, where a person lives, works and socialises will have a major impact on their lifestyle and health outcomes. So it is important that services have the information to target resources effectively in the right localities. There is already a lot of good work being undertaken at a neighbourhood level through the wellness service, PCT and voluntary sector and this should continue with clear links and a joined up approach. That services are available at low cost in local community venues also helps to remove some of the barriers to participation that may previously have existed.

7.11 Lack of transport links or accessibility to services can only act as a barrier to certain communities or groups within the city. Careful consideration must be given to where services are delivered from to ensure the maximum benefit and that this does not deter those most in need of receiving this support. A similar statement can be applied to the built environment and the importance of access to open and green spaces as well as to a varied choice on the high street.

7.12 Area committees also have an important role to play in bringing together key stakeholders and developing useful data around neighbourhoods for the delivery of strategies and projects. The area committees also have the opportunity to play a major role in the delivery of projects to improve health outcomes on a ward and neighbourhood level. The local knowledge of elected members, the input of local organisations and the opinions of local people can prove vital in the successful implementation of projects on the ground, and this can only be a strength of the area committee role.

7.13 Health impact assessments are an important aspect of assessing the health impacts of policies, strategies and initiatives while health equity audits ensure that access to services is equitable. As well as this the Joint Strategic Needs Assessments (JSNA) can play a crucial role in identifying current and future health needs of local communities, as well as inform the priorities and targets set by Local Area Agreements. JSNA's can also provide focus for scrutiny and area committees to ensure policy direction addresses need within communities. Health needs should be assessed in the delivery of all policies and strategies as inequalities exist in all facets of the life course. It is important to ensure that actions as a result of policy or strategy do not widen the gap in health inequalities but instead strive to create positive health outcomes.

7.14 When we talk of health inequalities and look at the stark figures and statistics for Sunderland these revolve around preventable illnesses. The move from treatment to prevention will be a key challenge for everyone but it is one of the ways identified in the majority of research which can help to reduce health inequalities. Smoking, drinking, teenage pregnancy and obesity all follow the social gradient and if people can make more informed choices through education and early years development there is a greater chance of prevention of such issues in adult life.

7.15 The importance of identifying the health impacts and implications of decisions made by key stakeholders cannot be underestimated. There needs to be a clear understanding of the issues around health for policy and decision makers to ensure informed choices are made that benefit the communities and neighbourhoods of Sunderland. Almost every aspect of life, as can be seen, has an impact on a person's health and the choices they make, therefore it is paramount that Sunderland has the ability to assess strategies and decisions for health outcomes and health equity.

7.16 The total place pilot allows for a new way of working and developing greater links between key stakeholders and communities. It also provides for looking at new ways of engaging and involving all stakeholders in the development of services and initiatives and looks to remove duplications and concentrate efforts on those most in need. Total Place is a new way of thinking and provides for looking at age old problems in a new way, it is this sort of project that could highlight effective measures for tackling health inequalities and narrowing the gap.

## 8 Recommendations

8.1 The Health and Well Being Scrutiny Committee has taken evidence from a variety of sources to assist in the formulation of a balanced range of recommendations. The Committees key recommendations to the Cabinet and partner organisations (where applicable) are as outlined below:-

(a) That 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 be established;

(b) That all Elected Members are 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;

(c) That 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;

(d) That 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) be adopted to ensure that new policies and service designs consider the potential health impacts of implementation;

(e) That the existing joint strategic needs assessment at a City wide, ward and 'natural neighbourhood' level 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;

(f) That mechanisms for ensuring that impact on reducing health inequalities are considered by all scrutiny committees and area committees as part of the work planning process be developed;

(g) 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;

(h) That the City Council become an examplar in ensuring employees benefit through 'Health at Work' Schemes and should engage with the regional workplace health programme.

(i) 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;

(j) That 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, be further explored; and

(k) That in conjunction with our partner organisations; the Council ensures a whole city approach to reducing inequalities through engagement, support and working in partnership to understand the roles and responsibilities including current action plans in relation to the health inequalities agenda;

(l) That the 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.

## 9. Acknowledgements

9.1 The Committee is grateful to all those who have presented evidence during the course of our review. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

(a) Nicola Morrow – Healthy City Coordinator – Sunderland City Council
(b) Lee Cranston – Assistant Head of Corporate Policy – Sunderland City Council
(c) Professor Peter Goldblatt – Lead Researcher - The Marmot Review
(d) Nonnie Crawford – Director of Public Health – Sunderland Teaching Primary Care Trust
(e) Ben Seale – Joint Commissioning Manager – NHS South of Tyne and Wear
(f) Professor Tim Blackman – Dean of Queen's Campus - Durham University
(g) Neil Revely – Director of Health, Housing and Adult Services – Sunderland City Council
(h) Martin Gibbs – Head of the Health Inequalities Unit - Department of Health
(i) Brent Kilmurray – Commercial Director PCT Provider Services - Sunderland Teaching Primary Care Trust
(j) Canon Stephen Taylor – Chair of the Local Strategic Partnership
(k) Alan Patchett – Age Concern and Community Network
(l) Dr Helen Patterson – Executive Director Children's Services – Sunderland City Council
(m) Vince Taylor – Head of Strategic Economic Development – Sunderland City Council
(n) Margaret Elliott - Social Enterprise Scheme
(o) Stephen Wilkinson – Co-ordinator – Sunderland LINk

## 10. Background Papers

10.1 The following background papers were consulted or referred to in the preparation of this report:


(a) The Marmot Review, 2010. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010.

(b) Department of Health 2010. A Smoke Free Future: A Comprehensive Tobacco Control Strategy for England.

(c) Healthy Urban Planning in Practice, 2003. Report of the WHO City Action Group on Healthy Urban Planning.

(d) Director of Public Health Annual Report for Sunderland 2009/10. Sunderland Teaching Primary Care Trust.

(e) Director of Public Health Annual Report for Sunderland 2008/09. Sunderland Teaching Primary Care Trust.

(f) The Local Government Association, 2010. The Social Determinants of Health and the Local Authority.

(g) APHO and Department of Health, 2009. Health Profile Sunderland.

(h) Department of Health, 2009. Tackling Health Inequalities: 10 Years on.

(i)_ Sunderland City Council, 2009. Community Spirit Summer Survey.

(j) Sunderland City Council and NHS South of Tyne and Wear, 2009. Sunderland Joint Strategic Needs Assessment 2009 Refresh.

**Appendix 1 – Community Day**

The Community Day was held at the Stadium of Light on 21st January 2009. Below was the itinerary for the day.

| | | | |
|---|---|---|---|
| | **Buffet lunch** | 12:00-12:45 | (45 mins) |
| **1** | **Cllr Peter Walker, Chair of HWB Scrutiny Committee**<br>Welcome | 12:45-12:50 | (5 mins) |
| **2** | **Martin Gibbs, Health Inequalities Unit – Department of Health**<br>The national policy environment around Health Inequalities | 12:55-13:20 | (25 mins) |
| **3** | **Professor Tim Blackman, Dean of Durham University's Queens Campus**<br>The regional perspective of Health Inequalities | 13:20-13:40 | (20 mins) |
| **4** | **Nonnie Crawford, Director of Public Health**<br>The NHS perspective of Health Inequalities in Sunderland | 13:40– 14:00 | (20 mins) |
| **5** | **Neil Revely, Director of Health, Housing and Adult Services, Sunderland City Council**<br>The Local Authority perspective & the Healthy City | 14:00 – 14:25 | (25 mins) |
| | **Coffee break** | 14:25-14:45 | (20 mins) |
| **6** | **Group discussion** | 14:45-16:00 | (1¼ hrs) |
| **7** | **Cllr Peter Walker, Chair of HWB Scrutiny Committee**<br>Questions and close | 16:00-16:15 | (15 mins) |

The day generated much discussion about the issue of health inequality.

# Appendix 2 – Tackling Health Inequalities Questionnaire Results

182 questionnaires were completed by residents across the city to inform the Tackling Health Inequalities Policy Review. The main findings are shown below.

**Figure 1: To show sex of all respondents**

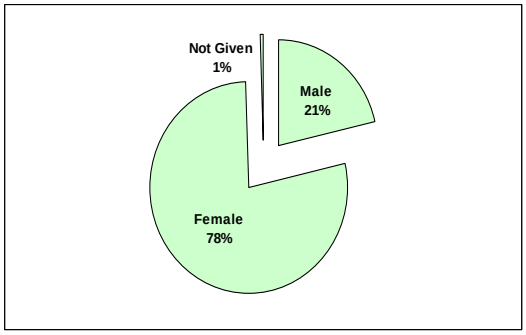



**Figure 2: To show age of all respondents**

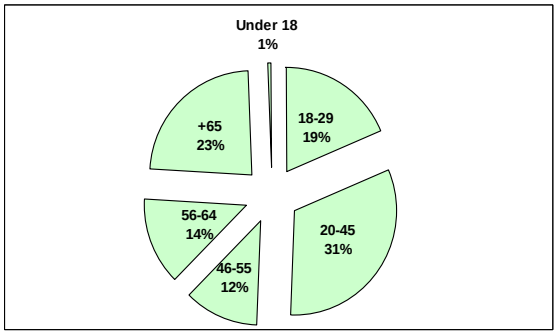



**Figure 3 to show percentage of respondents from each postcode area**

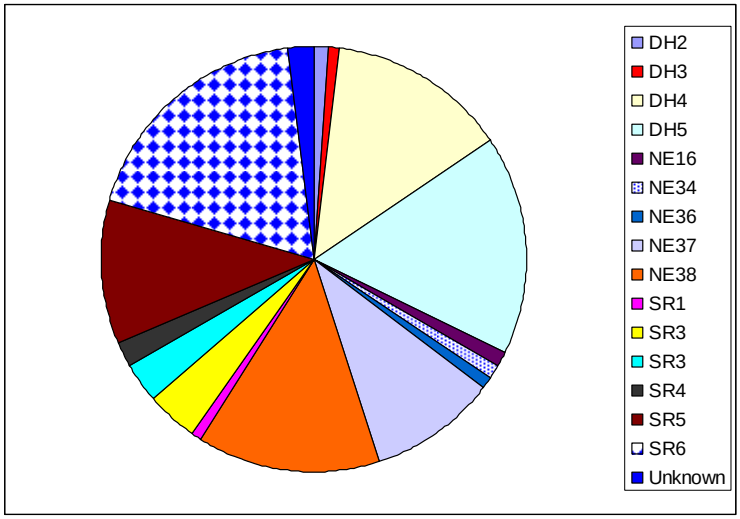



**Figure 4 Percentage of all respondents who consider themselves healthy by age and sex**

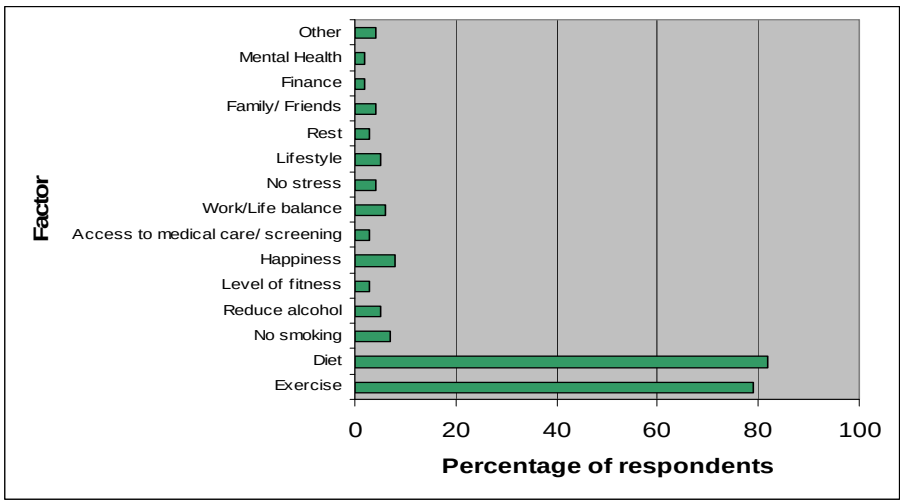
| Age | Total | Male | Female |
|---|---|---|---|
| Under 18 | 100 | - | 100 |
| 18-29 | 96.5 | 100 | 93.3 |
| 30-45 | 82.8 | 77.8 | 83.7 |
| 46-55 | 66.7 | 55.6 | 75 |
| 56-64 | 88 | 83.3 | 89.5 |
| 65+ | 81.4 | 90.9 | 77.4 |
| **Total** | **83.5** | **79.5** | **84.5** |

**Figure 5 Percentage of all respondents who consider themselves healthy by postcode area.**

| Postcode | Total |
|---|---|
| DH4 (Houghton-le-Spring Area) | 96 |
| DH5 (Houghton-le-Spring Area) | 84 |
| NE37 (Washington Area) | 79 |
| NE38 (Washington Area) | 88 |
| SR5 (Sunderland Area) | 60 |
| SR6 (Sunderland Area) | 94 |
| **Percentage of all respondents** | **83.5** |

The 6 postcode areas with the greatest percentage of respondents were selected for comparison in the above figure.

**Figure 6: To show factors all respondents consider important in maintaining a healthy life**




**A selection of comments provided by respondents when they were asked: "Do you think where you live affects your health in a good way or a bad way. What are these?"**

"Both: Bad way- Traffic and mess on the streets. Good way- Open spaces and access to facilities" DH4

"I don't think where I live affects my health either positively or negatively." DH4

"There is access to cheaper fruit and veg and activities for children" DH4

"It is good to have a leisure centre nearby and the school is within walking distance. It would be good to have more facilities near that enabled families to do more physical activities" DH4

"There is nothing to do. There are no parks or places to exercise" SR2

"Living near to GP surgery and shops really helps" NE38

"In a good way, excellent neighbours, neighbourhood watch scheme, it is a semi-rural area with good walking opportunities close to home" SR3

"I think it is up to the individual as to whether they choose to live a healthy lifestyle. i.e. choosing whether to visit the fish and chip shop or the fruit and veg shop" DH4

"Money and the culture in certain areas can affect lifestyle." NE37

"Living in a miserable neglected area can affect your mood and health dramatically." NE38

**Figure 5: To show if respondents are aware of or know how to access variety of services**

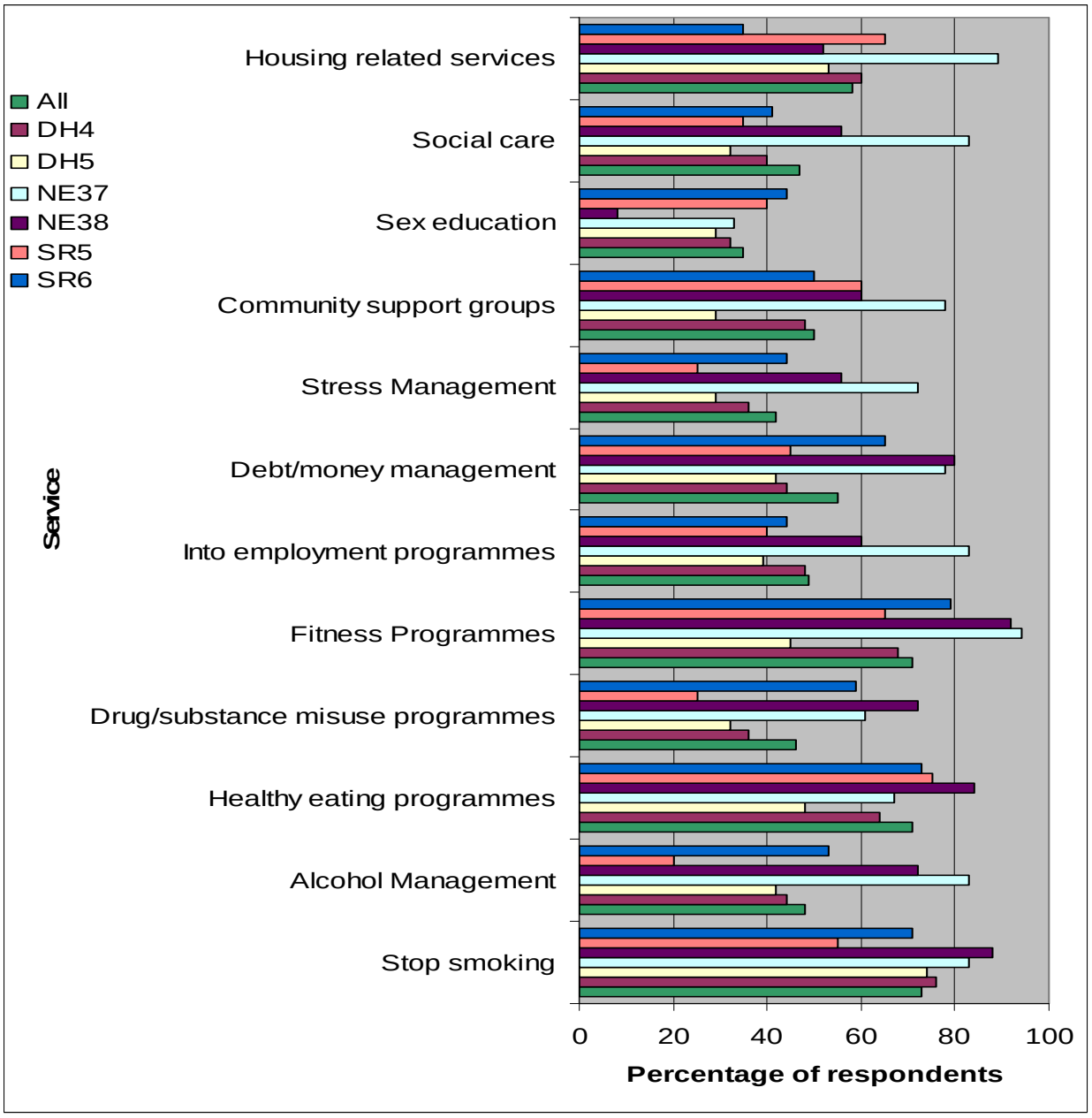



**Figure 6: To show the method respondents considered the best way to be informed about services**

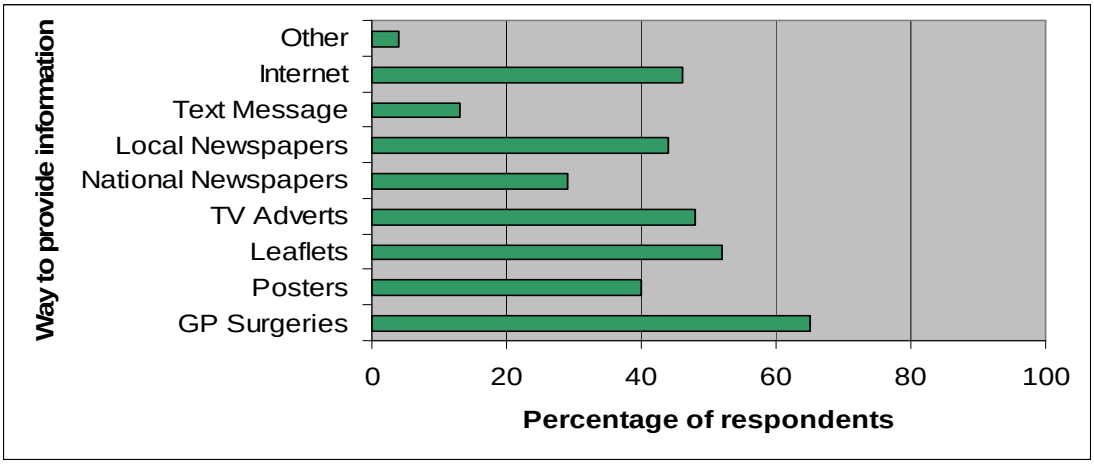



**Figure 7: To show factors which would affect respondents accessing services**

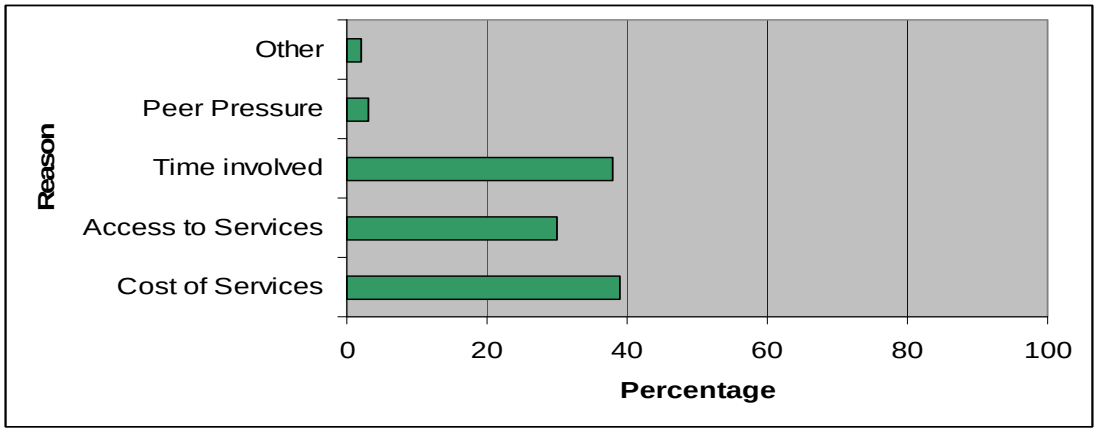
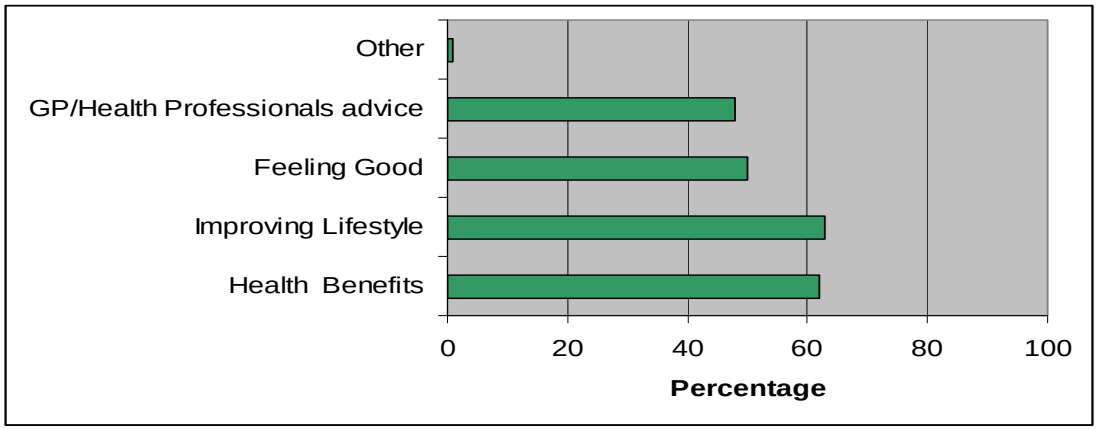



**Figure 8: To show what factors would encourage respondents to access services**



# HEALTH & WELLBEING SCRUTINY COMMITTEE 21 APRIL 2010

## WORK PROGRAMME 2009-10

### REPORT OF THE CHIEF EXECUTIVE

**STRATEGIC PRIORITIES: SP2: Healthy City.**

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

### 1. Why has this report come to the Committee?

1.1 The report attaches, for Members' information, the current work programme for the Committee's work during the 2009-10 Council year.

1.2 The work of the Committee in delivering its work programme will support the Council in achieving its Strategic Priority of a Healthy City, support delivery of the Healthy City theme of the Local Area Agreement, and help the Council achieve Corporate Improvement Objectives CIO1 (delivering customer focussed services) and C104 (improving partnership working to deliver 'One City').

### 2. Background

2.1 The work programme is a working document which Committee can develop throughout the year. As a living document the work programme allows Members and Officers to maintain an overview of work planned and undertaken during the Council year.

### 3. Current position

3.1 The work programme reflects discussions that have taken place at the 10 March 2010 Scrutiny Committee meeting. The current work programme is attached as appendix to this report.

### 4. Conclusion

4.1 The work programme developed from the meeting will form a flexible mechanism for managing the work of the Committee in 2009-10.

### 5 Recommendation

5.1 That Members note the information contained in the work programme.

## 6. Glossary

n/a

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**Contact Officer:** Nigel Cummings, Scrutiny Officer: 0191 561 1006 : nigel.cummings@sunderland.gov.uk

| | JUNE 17.06.09 | JULY 08.07.09 | SEPTEMBER 16.09.09 | OCTOBER 14.10.09 | NOVEMBER 11.11.09 | DECEMBER 9.12.09 | JANUARY 13.01.10 | FEBRUARY 10.02.10 | MARCH 10.03.10 | APRIL 21.04.10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Policy Review | Proposals for policy review (Review Coord) | Scope of review (Review Coord) | Approach to Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Progress on Review (Review Coord) | Draft report (Review Coord) | Final Report |
| Scrutiny | Proposed Restructuring of Community Nurse Teams in Sunderland (TQ)<br><br>Workforce Development in the Independent Care Sector (TWCA)<br><br>Health and Wellbeing Inequalities (NCx)<br><br>Food Law Enforcement Safety Plan. (NJ) | Position Statement on Autism (SL)<br><br>Pandemic Influenza & Measles – Update (NCx) | Beacon Award – Reducing Health Inequalities | NTW Crisis Resolution Team (RP)<br><br>Intensive Rehabilitation & Recovery Services for Men & Women (CW/MW)<br><br>Washington MPC (GK)<br><br>Integrated Care Pilot Scheme (SL) | Annual Home Care Report including Home Care Services Progress Report (SL)<br><br>Shop Mobility Scheme (PB)<br><br>Barmston Medical Practice (LA)<br><br>Ocular Oncology | Quality Standards for Residential and Nursing Homes for Older People (GK)<br><br>Total Place (LC)<br><br>Redesign of Drug and Alcohol Programmes (BS)<br><br>District Nursing Review (CB) | Electronic Prescriptions (LA)<br><br>NHS Constitution (LA) | Provision of Public Services to People with Learning Disabilities (GK/JF)<br><br>Response to Out of Hours Care Query (GK)<br><br>WHO Healthy City (NM) | | Annual Report (Review Coord)<br><br>Sunderland LINk Report (SW)<br><br>Mobility Scooter Consultation (NC) |
| Scrutiny (Performance) | | Acute MH care – bed numbers | Performance & VfM Assessment (Paul Allen)<br><br>Dementia Care in Sunderland Policy Review 08/09 – Progress (SL)<br><br>Quality Commissioning Progress Monitor 07/08 Policy review SL | Acute MH care – bed numbers | Day Opportunities Update | | Dementia Care in Sunderland Policy Review 08/09 – Progress (SL)<br><br>Performance Framework Q2 (GR)<br><br>Strategic Planning Process 2010/11 (JB)<br><br>Acute MH care – bed numbers | Annual Delivery Plan | Quality Commissioning Progress Monitor 07/08 Policy review SL<br><br>Annual Health Check | Performance Framework Q3 (Paul Allen)<br><br>Home Care Services Progress Report (SL) |
| Ref Cabinet | Cabinet Response to the Policy Review-Dementia Care in Sunderland | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Committee business | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord)<br><br>Cooption Report | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) | Work Programme 2009/10 (Review Coord) |
| CCFA/ Members items/Petitions | | | | | | | Review of CCfA | | | |
| Information | | Forward Plan | Conference Attendance<br><br>CfPS Bid<br><br>Forward Plan | Forward Plan | Forward Plan | Forward Plan<br><br>Joint Scrutiny Proposals | Forward Plan | Forward Plan | Forward Plan | Forward Plan |

Scrutiny Items – Carried Forward

Crisis Resolution Team Update – A further update to come back to committee (Sept 10)
Intensive Rehabilitation & Recovery Services for Men & Women (Sept 10)
Futures Team & Supported Living Model – Report in next Municipal Year (GK)
Presentation on interventions and services available to those with alcohol dependency issues (PCT)
City Hospitals – Clinical Governance Report (CH)
MH Reprovision (TR)

# HEALTH AND WELLBEING SCRUTINY COMMITTEE

## FORWARD PLAN – KEY DECISIONS FOR THE PERIOD 1 MAY 2010 – 31 AUGUST 2010

**REPORT OF THE OFFICE OF THE CHIEF EXECUTIVE 21 APRIL 2010**

### 1. Purpose of the Report

1.1 To provide Members with an opportunity to consider those items on the Executive's Forward Plan for the period 1 May 2010 – 31 August 2010 which relate to the Health and Wellbeing Scrutiny Committee.

### 2. Background Information

2.1 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 To this end, it has been agreed that, on a pilot basis, the most recent version of the Executive's Forward Plan should be included on the agenda of each of the Council's Scrutiny Committees.

### 3. Current Position

3.1 Following member's comments on the suitability of the Forward Plan being presented in its entirety to each committee it should be noted that only issues relating to the specific remit of the Health and Wellbeing Scrutiny Committee are presented for information and comment.

3.2 For members information the remit of the Health and Wellbeing Scrutiny Committee is as follows:-

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).

3.3 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 period 1 May 2010 – 31 August 2010

## 4. Background Papers

None

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Contact Officer : Nigel Cummings 0191 561 1006
Nigel.cummings@sunderland.gov.uk

# Forward Plan: Key Decisions from - 01/May/2010 to 31/Aug/2010
# Items which fall within the remit of the Health and Wellbeing Scrutiny Committee

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| 01367 | To recommend Council to adopt the Food Law Enforcement Service Plan for 2010/11 in respect of Environmental Health and Trading Standards. | Cabinet | 09/Jun/2010 | Member with Portfolio for Safer City | Briefing Session | Via Contact Officer by 21 May 2010 – Health and Wellbeing Scrutiny Committee | Report and Plan | Norma Johnston | 5611973 |
| 01394 | To agree the Re-Procurement of Day Care Services | Cabinet | 09/Jun/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 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |
| 01395 | To agree the Re-Procurement of Day Care Services for people with Dementia | Cabinet | 09/Jun/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 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |
| 01396 | To agree the Re-procurement of Home Care Services | Cabinet | 09/Jun/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 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| 01388 | To consider the recommendations of the Health and Well-Being Scrutiny Committee following a review of tackling health inequalities in Sunderland | Cabinet | 09/Jun/2010 | Health, Housing and Adult Services staff, external providers, service users, carers, public | Evidence at Scrutiny Committee, interviews, community event, expert jury event | Via Contact Officer by 21 May 2010 - Health and Well-Being Scrutiny Committee | Policy Review final report | Nigel Cummings | 5611006 |
| 01399 | To agree the Procurement of a Care Provider for Extra Care (for people with Dementia) | Cabinet | 09/Jun/2010 | Cabinet, Service Users and Carer Groups, Portfolio Holder, Adult Services Staff and Health Partners | Briefings and/or meetings with interested parties | Via the Contact Officer by 21 May 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |
| 01397 | To agree the Re-procurement of Short Break Services | Cabinet | 21/Jul/2010 | Cabinet, Service Users and Carer Groups, Portfolio Holder, Adult Services Staff and Health Partners | Briefings and/or meetings with interested parties | Via the Contact Officer by 21 June 2010 - Health and Wellbeing Scrutiny Committee | Full Report | Graham King | 5661894 |