Appendix 3

KEY ACTIONS BY OBJECTIVE – NOVEMBER 2014

OBJECTIVE 1 – PROMOTING UNDERSTANDING BETWEEN COMMUNITIES AND ORGANISATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OBJECTIVE 4 – SUPPORTING EVERYONE TO CONTRIBUTE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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