At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on WEDNESDAY 12TH JANUARY 2011 at 5.30 p.m.

Present:-
Councillor Walker in the Chair

Councillors A. Hall, Maddison, Old, Padgett, Shattock, D. Smith and Snowdon.

Also in Attendance:-

Councillor Tate	-	Chairman of Management Scrutiny Committee
Councillor Morrissey	-	Observing
Karen Brown	-	Sunderland Council
Joan Carney	-	Member of the Public
Nonnie Crawford	-	Sunderland Teaching Primary Care Trust
Bill Craddock	-	Member of the Public
Claire Harrison	-	Sunderland Council
Emma Hindmarsh	-	Sunderland Council
Carol Harries	-	City Hospitals
Lorraine Hughes	-	Sunderland Council, TPCT
Sharon Lowes	-	Sunderland Council
Keith Moore	-	Sunderland Council
Raj Singh	-	Sunderland Council

Apologies for Absence

Apologies for absence were received on behalf of Councillors Chamberlin, Fletcher and N. Wright.

Minutes of the last Meeting of the Committee held on 8th December, 2010

1. RESOLVED that the minutes of the meeting of the Committee held on 8th December, 2010 be confirmed and signed as correct record subject to the inclusion of a question from Councillor Smith. He had enquired whether there had been a problem with Direct Payments. Ms. Lowes confirmed there had not.

Declarations of Interest

There were no declarations of interest made.

Prevention on Sexually Transmitted Infections and Promotion of Good Sexual Health

Report of the Commissioning Lead for Sexual Health & Health Improvement Practitioner, Sunderland Teaching Primary Care Trust (copy attached).

(For copy report – see original minutes)

The Chairman advised that the item had been postponed due to the presenting officer being ill.

2. RESOLVED that the committee agree to postpone the item to a future meeting.

Cancer Drugs Fund

The Chief Executive submitted a report (copy circulated) to make members of the committee aware of the proposals for the Cancer Drugs Fund and other supporting measures around cancer services.

(For copy report – see original minutes)

Dr. Nonnie Crawford, Locality Director of Public Health, Sunderland Teaching Primary Care Trust was in attendance at the meeting and presented the consultation document.

Dr Crawford advised the Committee that the North of England Cancer Drug Approval Group (NECDAG) had been established a number of years ago to ensure all patients with cancer in the North East received equitable access to a clinically defined appropriate range of cancer medicines. The PCT were committed to funding this approach and Dr. Crawford advised that the proposals in the consultation would not significantly alter the way Sunderland operated in terms of cancer drugs.

Drawing on her personal experience, Councillor Shattock advised that she had received outstanding cancer treatment in the north east compared to her siblings' experiences elsewhere in the country.

Councillor Shattock enquired whether the fund would be adequate and if pressure was put on drugs companies to reduce the price of drugs.

Dr. Crawford advised that the Coalition Government was working with drug companies regarding cost. Drugs companies argue that new drugs cost a lot of money to bring to the market however commissioners propose that if they cost less, they could buy more.

In response to a question from Councillor Shattock regarding the future of NICE, Dr Crawford advised that the organisation would continue to give guidance on treatments that the NHS in England and Wales would be required to fund until 2014.

From that point a system of value-based pricing of new drugs will be in place and NICE will have an essential role in helping regulate drug prices based on an assessment of their cost-effectiveness at the point the license is granted. She informed the Committee that North of England Cancer Drug Approval Group had approved drugs that NICE had not.

Dr. Crawford advised that cancer drugs were considered as first, second, and third line. First-line treatment is usually the standard treatment given when someone is diagnosed with a particular disease or condition. Second-line treatment is treatment for a disease or condition after the initial treatment (first line) has failed or stopped working. Third-line drugs might be useful but might not be approved possibly because their efficacy had not been proven. Dr. Crawford stated that it was important to get the balance right for everyone.

In response to a question from Councillor D. Smith regarding the possibility for an individual to move freely around hospitals, Dr Crawford advised that the NECDAG approved funding across the 13 PCT's in the North East region and hence that freedom did exist.

The Chairman queried the extent to which the Department of Health funding would be used on early awareness and diagnosis. Dr Crawford advised that there was not clear evidence regarding what works best for certain people. For example, it was still difficult to find a solution to the problem of men not coming forward to receive services sooner. However, it was known that drug treatments work and therefore funding them would provide recognized improvements.

The focus of the work to prevent cancer and promote awareness and early diagnosis would take place at primary care trust level. Public health and primary care teams work closely with local authority partners and communities to build awareness and encourage people to seek advice for symptoms which may be associated with cancer at an early stage.

Having thanked Dr. Crawford for her report it was:-

3. RESOLVED that Members of the Committee note the proposals around cancer services.

Sunderland's Child and Family Poverty Strategy and Action Plan 2010-11 Phase 2

The Executive Director of Children's Services submitted a report (copy circulated) to update the Scrutiny Committee on the progress and achievements of Phase 1 of the Sunderland Model in reducing Child and Family Poverty and seek approval to progress to Phase 2 with a revised and focussed strategy based on the outcomes of the consultation process and the needs assessment.

(For copy report – see original minutes)

The Chairman welcomed Mr. Raj Singh, Extended Services and Attendance Group Manager to the committee and invited him to present his report.

Mr Singh provided a progress update and highlighted changes to the revised Child and Family Poverty Strategy. He outlined the two priorities contained within the Strategy:
Priority 1 – Make child and family poverty everybody's business through adopting an approach to 'child and family poverty proof' Strategic Plans of all partners as routine practice.
Priority 2 – Developing integrated neighbourhood models of service to re-target and deliver Early Years and Early Intervention Action Plan.

Referring to paragraph 2.4 which stated that the Coalition Government had introduced a new NI116 Child Poverty measure and HM Revenue and Customs had produced a national dataset which related to families below 60% of median income, Councillor Walker enquired how the level of Child and Family Poverty in Sunderland of 25.4% compared nationally.

Mr Singh advised that Sunderland compared favourably especially compared to certain areas in London. This was in part as a result of the way the statistics were worked out yet the figure of 25.4% was still unacceptable and was at the higher end in comparison to the region.

The Chairman stated that the Committee's policy review in 2009/10 had looked at health inequalities and he questioned what the main barriers were to improving child poverty.

Mr Singh advised that there were a number of building blocks including health, education, financial inclusion and environmental factors (e.g. quality housing). Income poverty was a very significant contributing factor.

Councillor A. Hall acknowledged that, like health inequalities, child and family poverty was a huge and complicated agenda. In the past focus had tended to centre on the more deprived wards; however it had been increasingly recognised that there were poorer families living in relatively wealthy wards.

Councillor Hall commented that the Sure Start initiative had not fully been accessed by the people it was created to help and she queried how people could be encouraged to engage.

Mr Singh advised that it was important to look at neighbourhoods on a micro level as deprivation within specific localities could differ greatly. One of the key messages from the Marmot Review advised that to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This was called proportionate universalism.

Councillor Hall acknowledged the importance of working with all agencies and partners. She also expounded the importance of utilizing the local understanding ward councillors would have of their locality when looking at poverty within wards.

In response to a question from Councillor D. Smith, Mr Singh confirmed that the Department for Work and Pensions were a statutory partner on the Child Poverty Board.

Councillor Smith advised that National agencies like the Department for Work and Pensions (DWP) and HM Revenue and Customs (HMRC) collect information in relation to the level of resources and income in the household on a regular basis so that specific data sets could be obtained at small area level. However each separate agency was working on different geographical area levels causing gaps and variation in the data.

Mr Singh advised that this problem had been flagged with the respective agencies and conversations were taking place as to how it could be addressed.

Councillor Shattock referred to the fact that income poverty was one of the greatest determinants of UK child poverty and advised that it would be difficult for a significant number of one parent families to work. This would be compounded for many other families by the government cuts in welfare. Accordingly, Councillor Shattock questioned whether the second phase of the Strategy would acknowledge that the situation for families was likely to get worse.

Mr. Singh advised that in partnership with the DWP the authority would work hard to mitigate such circumstances.

Mr. Keith Moore, Executive Director of Children's Services broadened the discussion and advised that secure and effective education was also crucial in the fight against child poverty. He informed the Committee that Sunderland had just published the most recent GCSE figures (5A* - C) and for the first time ever Sunderland had hit the national target of 53%. This acknowledged the excellent work that schools, teachers and parents had done.

On behalf of the Committee, the Chairman offered his congratulations to all those involved in obtaining the excellent GCSE results in the city.

Having thanked Mr. Singh for his report, it was:-

4. RESOLVED that the committee:-

i) Note the progress and the products from Phase 1 of the Sunderland Model to reduce Child and Family Poverty in Sunderland.
ii) Consider and comment on the move to Phase 2 with a revised Strategy reflecting the Consultation and Needs Assessment outcomes.
iii) Consider and comment on the structure of the revised Strategy and priorities as set out.
iv) Receive a further update report on Phase 2

Healthy Lives, Healthy People: Public Health White Paper

The Chief Executive submitted a report (copy attached) to provide a briefing to the Scrutiny Committee about the Public Health White Paper, Healthy Lives, Healthy People: the strategy for public health in England, published on 30 November. The strategy expands on the proposals for public health originally set out in Equity and Excellence: Liberating the NHS.

(For copy report – see original minutes)

Dr. Crawford presented the report and advised the Committee that since the White Paper had been published two further papers had been released. The paper 'Healthy lives, Healthy People: consultation on the funding and commissioning routes for public health' describes in more detail the proposed key public health functions and responsibilities across the public health system and sets out the proposed commissioning and funding arrangements for delivery of public health services. The second document related to an NHS Outcomes Framework. Dr. Crawford advised that the majority of the public budget would be spent on local services, either via local authorities through a ring-fenced grant or via the NHS.

She advised that that local authorities would have a duty to establish Health and Well Being Boards, which were intended to lead on improving the strategic coordination of commissioning across NHS, social care, and related children's and public health services.

In response to a comment from Mr. Craddock, member of the public regarding GP consortia, Dr Crawford advised that the aim was to promote competition, raise standards and make providers more responsive. In the North East all hospitals had achieved Foundation status and had therefore proved their worth. During the transition process the selected GP pathfinders would test the new commissioning arrangements to ensure they were working well before more formal arrangements came into place.

The Chairman queried the feeling in Sunderland with regard to the GP Consortia and was advised by Dr. Crawford that in Sunderland there were 3 practice based commissioning groups and it was acknowledged this would need to be reduced to one.

Having thanked Dr. Crawford for her report it was:-

5. RESOLVED that the Committee note the proposals in the White Paper

Review of the Management of Malnutrition and Dehydration in Hospitals

The Chief Executive submitted a report (copy attached) to provide evidence to the Scrutiny Committee about the Age UK campaign 'Hungry to be Heard' as part of the review of malnutrition and dehydration in hospitals.

(For copy report – see original minutes)

Mr. Alan Patchett, Director of Age UK Sunderland addressed the Committee and advised that Age UK Sunderland had recently carried out a Hospital Meals Survey in support of the national Hungry to be Heard campaign. Mr Patchett took the committee through the results of the survey.

Councillor Maddison enquired whether patients received guidance on malnutrition when they left hospital and was advised by Ms. Carol Harries, City Hospitals that such support was available and if necessary G.P's were also informed.

Mr Patchett stated that Age UK had developed a leaflet and had also produced a fridge magnet reminding people of the importance of eating. As 40% of older people were malnourished when they were admitted to hospital he advised that there was a piece of awareness raising work to be done in the community. He advised that the government had made £70 million available to re-able people who had been discharged from hospital.

Councillor D. Smith questioned the methodology of the survey and cited question 13 as an example. In this question 45 people had advised that they had witnessed people having difficulties at mealtimes. Councillor Smith stated that in theory the 45 people could have been looking at the same individual and the question might have had more accurate results if it had been directed at the individuals.

Mr Patchett advised that the people taking the survey would not be regarded as the most vulnerable because they did not have an assessed need. It was unlikely that 45 people could be looking at the same individual as the wards concerned contained small numbers of people.

A member of the public reflected on his recent stay in hospital and advised that he was never shown a menu and never offered fruit. Ms. Harries acknowledged that there were sometimes problems with choice. The reality was that when the food left the hospital kitchen sometimes communication could break down. Staff were able to contact the kitchen and patients should be informed of this. Better staff training would ensure greater consistency.

Referring to the seven steps to end malnutrition in hospital, Councillor Shattock stated that it was important people always had help and noted the suggestion of using mealtime volunteers.

Ms Harries stated that the issue of volunteers was being looked at. There had been reluctance in the past to use them due to clinical concerns.

Mr. Patchett advised that the use of volunteers at meal times had been successful elsewhere.

Having thanked Mr Patchett for his report it was:-

6. RESOLVED that the Committee note the evidence received about the campaign and the implementation of the seven steps to end malnutrition in hospitals and give consideration to how the campaign issues are complementary to the review

Policy Review: Food in Hospitals – Service User Engagement

The Chief Executive submitted a report (copy attached) to provide a progress report to the Scrutiny Committee about the involvement of service users as part of the review of malnutrition and dehydration in hospitals.

(For copy report – see original minutes)

Ms. Karen Brown, Scrutiny Officer presented the report and informed the Committee that a written consultation was currently taking place with service users asking for their views on various aspects of the hospital food service.

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

Forward Plan – Key Decisions for the Period 1st January, 2011 – 30th April, 2011

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider the Executive's Forward Plan for the period 1st January, 2011 – 30th April, 2011

(For copy report – see original minutes)

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

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

Annual Work Programme 2010 - 11

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

(For copy report – see original minutes)

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

7. RESOLVED that the Committee note the updated work programme.

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

(Signed) P. WALKER,
Chairman.

HEALTH AND WELL-BEING SCRUTINY COMMITTEE 9th FEBRUARY 2011

THE HEALTH OF THE EX-SERVICE COMMUNITY: REPORT OF THE JOINT NORTH EAST SCRUTINY REVIEW

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 In the last year the Council has been involved in a joint scrutiny review, involving all twelve local authorities in North East, into the health of the ex-service community – somewhere between half a million and a million people in the North East (one of the problems the report addresses is that ex-service personnel can be hard to identify).

1.2 The North East Joint Health Overview and Scrutiny Committee agreed its final report on 14 January 2011. It makes 47 recommendations to a wide range of organisations, including local authorities. The Joint Committee is made up of delegates from each of the 12 authorities and has delegated powers to undertake overview and scrutiny of regional health issues independently.

2. Background

2.1 The scrutiny review was carried out throughout 2010 by elected members from all twelve local authorities in North East England. The review has been supported by the Centre for Public Scrutiny, which will be promoting it as an example of good practice in scrutinising health inequalities.

2.2 Those consulted during the course of the review include the Armed Forces, NHS commissioners and providers, the Department of Health and the Ministry of Defence, the Royal British Legion and voluntary organisations both large and small, public health specialists, Directors of Adult Services, housing providers and many others, including focus groups of veterans.

3. Current Position

3.1 The report contains 47 separate recommendations, on the following themes:

- promoting effective communication and co-ordination across agencies, providers and the third sector (including routine information collection, protocols on sharing it, inclusion in health and wellbeing Joint Strategic Needs Assessments, research into health needs both generally and of

specific groups such as offenders, mapping of housing needs, and assessment of economic opportunities);

- improving awareness of the needs of the ex-service community among service providers (including awareness raising among diverse bodies from Job Centre Plus to registered social landlords, and early contact with new GP consortia);

- improving awareness of available services among the ex-service community (including engagement with outreach services, use of directories of services, and better use of digital media);

- improving responsiveness within organisations (chiefly creation of central points of contact);

- improving co-ordination across organisations (including stronger networking, bringing together voluntary organisations, a single contact telephone number, shared practice within housing, training and employment, and possibly a regional Charter);

- the transition of Armed Forces personnel to civilian services following discharge (including promotion of the Transition Protocol, registration with GPs and dentists before discharge, signposting to mental health advice, appropriate housing allocation policies and particular attention to vulnerable early service leavers);

- ensuring equality of access for Armed Forces families (chiefly around housing and particularly low-cost housing);

- veterans' mental health services (including improved training and guidance across the NHS, self-referrals and direct referrals from ex-service charities, planning for new NHS commissioning arrangements, local authority engagement with the NHS Armed Forces forum, national accreditation of charities and local approved lists, and sharing learning from the Community Mental Health Pilot run by the Tees Esk & Wear Valleys NHS Foundation Trust).

3.2 The Action Plan at the back of the report breaks the recommendations down according to the organisations to which they are addressed. Some 27 are addressed to local authorities either alone or, more commonly, in partnership with other organisations. Further work by the local authority and those organisations will be needed to identify how to take them forward.

4. Recommendation

4.1 Members are invited to welcome the scrutiny report and the recommendations and refer the report to Cabinet to endorse the recommendations.

4.2 If the recommendations are agreed by Cabinet, the Council and partners will develop an action plan for monitoring of progress.

5. Conclusion and Next Steps

5.1 The North East Regional Joint Health Overview and Scrutiny Committee will invite all those to whom recommendations have been addressed to attend an event, currently planned for March 2011, to discuss how to take forward an Action Plan for the region.

Contact Officer: Karen Brown
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Final

NORTH EAST JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

REGIONAL REVIEW
OF THE
HEALTH OF THE EX-SERVICE COMMUNITY

REPORT

Contents

Additional reports, by the three workstream groups which conducted the review consider in more detail:

- **Physical Health**
- **Social and Economic Wellbeing**
- **Mental Health**

Foreword

This scrutiny review, which examines the health needs of the ex-service community and their families, represents the culmination of a year of intensive work by the members and officers of the North East Joint Health Overview and Scrutiny Committee working in close partnership with a wide range of individuals and agencies.

In recent years, people have begun to talk about a “military covenant”, but the idea is much older: the members of our armed services put their lives on the line for us, and put special demands on their families and dependents. We must not let them down.

Making sure that the ex-service community does not suffer disadvantage because of the particular experiences of its members requires a lot of detailed thought to support that simple idea. This report represents an attempt by local Councillors across the North East region to supply some of that thought.

This is the first time that Councillors from all the local authorities in the North East have come together in this way, and I would like to thank all my colleagues who have worked so smoothly together in the common interests of our residents. I would also like to thank the huge range of individuals and organisations, military and civil, public and voluntary, who have so thoughtfully and enthusiastically helped us with evidence, ideas and support.

Sometimes scrutiny work raises confusion, even hostility from those who think they might appear badly under the spotlight. But I don’t believe that I have ever seen such a universally positive and enthusiastic response to a review as to this one.

This report is a collaborative effort, and collaborative effort is what is most needed to make the changes which will support our soldiers, sailors, airmen and their families both now and in the future.

We do not intend to let this report sit on the shelf, but will be working actively with all our partners to ensure that real good comes of the recommendations they have helped us to make.

Although our task initially looked very daunting, the importance of the subject, and the quality of the advice and support we received, has resulted we hope in proposals that can make a genuine difference. It is with great pleasure that I commend this report to you.

Councillor Ann Cains
Chair, North East Regional Joint Health Overview and Scrutiny Committee

Summary

The importance of the wellbeing and health of the ex-service community

1. Roughly one person in twelve in the UK is a member of the ex-service community: either a veteran of the armed forces or a carer, dependant or close family member of a veteran. A systematic attempt to understand the effects on the health and wellbeing of the ex-service community of their common life experiences is a necessary step towards ensuring that no-one suffers disadvantage as a result of their service. But in the past, this has not happened.

2. This is changing. This scrutiny review was prompted in part by the publication of the command paper The Nation's Commitment in 2008. While the review was being undertaken, an increased commitment to understanding and adapting to ex-service needs has been demonstrated by the creation of Armed Forces Health Forums in every NHS region, by the government's acceptance of the Murrison report on armed forces mental health, and by the publication of the report by the Task Force on the Military Covenant, among many other developments. We hope that our report will make a further substantial contribution.

North East England health overview and scrutiny

3. All twelve local authorities in the North of England have Health Overview and Scrutiny Committees, made up of Councillors who are not part of the decision-making structures of their Councils, to provide an independent view of the health and wellbeing needs of their residents and of the services provided for them.

4. The twelve committees have a long history of close co-operation across local authorities and in sub-regional groups. They have now formed a single regional Joint Health Overview and Scrutiny Committee, in recognition of the common interests of citizens across the North East. This is the first published report of that Joint Committee.

The Centre for Public Scrutiny Health Inequalities Programme

5. The review has been supported by the Centre for Public Scrutiny, which has provided support, advice and funding through its Health Inequalities programme, having nominated the North East as a Scrutiny Development

Area in January 2010. The Centre will help to make sure that what we have learned from this review is spread across England and Wales.

Aims and purpose of the review

6. The review set out to establish the extent of the available local and regional information about:
    - the health needs and access to services of the ex-Service communities compared with civilians of similar socio-economic backgrounds;
    - the different needs of the ex-Service communities, including, for example, looking at older and younger veterans, veterans of different conflicts; veterans of different Services and the families of those groups, specifically addressing socio-economic wellbeing as well as physical and mental health;
    - the extent to which ex-Service communities are able to access to services and support (including pyscho-social support), access to employment and training, drug and alcohol misuse, family breakdown, housing difficulties and involvement with the criminal justice system;
    - good and bad practice across the region, including specific issues such as priority access to NHS treatment for veterans, but also more generally in terms of the quality of communications between agencies and partnership working and the resulting support for ex-Service communities.
    - what awareness veterans and their families have about the services that are available to them

Organisation of the review

9 The review was responsible to a project board, which was also the standing Joint Health Overview and Scrutiny Committee, made up of the chairs of the committees in each of the twelve local authorities, or their deputies.

10 The review was formally launched with an overview day on 28 June 2010, in which all participating Councillors were able to hear from, and talk to, key stakeholders including the co-Chair of the joint Ministry of Defence/Department of Health Partnership Board and the Surgeon-General's Cross-Government Health Lead, as well as representatives of the armed forces, the Royal British Legion, the regional Strategic Health Authority, one of the Directors of Adult Services in the North East, and the Career Transition Partnership. Councillors then split into three "workstreams", one each dealing with the physical health of the ex-service community, with mental health, and with social and economic wellbeing. Separate reports are being published by each workstream. This report draws together common conclusions.

11 Each workstream was supported by scrutiny officers from four local authorities. The lead officers from each workstream formed a Project Support Group, together with officers from the lead local authority for the review as a whole, which helped to co-ordinate activity.

12 Methods used included presentations, round table discussions, face-to-face interviews, focus groups, questionnaires, reviews of the literature and site visits.

Key participants

13 This review would have been impossible without the enthusiastic co-operation of a wide range of witnesses and contributors from the armed forces, NHS, local government, central government and the community and voluntary sector, as well as ex-service personnel themselves. A full list of those who took part can be found in the acknowledgments on page 84.

Main conclusions

14 The review reached a number of general conclusions, which form the basis of 47 separate recommendations. These include:

- improved ways of identifying the ex-service community (see recommendations 1-4);
- proposals for better communication and sharing of information and more joined up work (see recommendations 5, 21-22, 24-26, 27-29, 37 and 39);
- suggestions for further qualitative research into the needs of the ex-service community (see recommendations 6 and 7);
- approaches to improving health and wellbeing which address wider determinants than the commissioning of health and social care services (see recommendations 8-13, 32 and 36), including improving the take-up of low-cost housing products by the ex-service community (recommendation 33);
- ways to address the need to raise awareness amongst local authorities and other partner organisations, employers and service providers of the very specific needs of the ex-service community (recommendations 17-19, 38 and 40);
- and also ways to address the need to raise the level of awareness within the ex-service community about the wide range of support currently available (recommendations 14-16 and 20);

- on the evidence we have examined, we believe that there is a need for the establishment of a formal network, connecting the voluntary sector, local authorities, the NHS, the Armed Forces and others (recommendations 23 and 42);
- strengthening support for personnel leaving the services, by going beyond signposting for more vulnerable service leavers (recommendations 30, 31 and 49);
- implementing the recommendations of the Murrison report on mental health should be complemented by other steps be taken within the region (recommendations 44-48).

Recommendations

15 We make a number of detailed recommendations below. The Action Plan on page 38 divides these up among those we hope will agree to take them forward. The Joint Health Overview and Scrutiny Committee will examine at regular intervals how far these recommendations have been taken forward and what effect they are having.

Promoting effective communication and co-ordination across agencies, providers and the third sector

Information

Recommendation 1: that local authorities across the region consider what might be the costs, benefits and best methods of collecting in future information about members of the Armed Forces 'soon to leave', their likely destination and the demands that will place on localities.

Recommendation 2: that local authority services should actively ask the question of those they provide services for: 'have you served in the UK Armed Forces?

Recommendation 3: that all organisations providing (or potentially providing) services for ex-service community should encourage veterans to voluntarily identify themselves by asking 'have you served in the UK Armed forces?'

Recommendation 4: that HM Government should consider the potential for an individual's NHS or National Insurance number to be used to identify their veteran status to improve identification of needs and services that may be available. This might be considered alongside the proposal by the Task Force on the Military Covenant for the creation of Veterans' Cards.

Recommendation 5: that formal information sharing protocols and arrangements are established between the armed forces and local authorities across the NE

region. This will enable local authorities to properly assess and plan to meet the needs of the ex-service community as a specific group.

Recommendation 6: local authorities in the North East should consider dedicating a chapter in their Joint Strategic Needs Assessments to vulnerable service leavers and their needs and identifying as a target population the ex service community within their strategic planning processes in relation to social exclusion, anti-poverty, homelessness and offending.

Recommendation 7: that local authorities across the region take research forward as part of the development of Joint Strategic Needs Assessments across the region, and that the North East Public Health Observatory should also consider what data and research support it can provide.

Recommendation 8: that local authorities across the North East request the NE National Housing Federation to carry out a mapping exercise to quantify current provision of ex - service community housing provided by their members and analyse best practice both nationally and within the North East.

Recommendation 9: that the North East Housing Federation works closely with NE local authorities to help plan future provision.

Recommendation 10: that the armed forces and the Career Transition Partnership work more closely with local authorities across the region and provide them with an assessment of the likely level of demand and need for employment and skills related services in order to inform future economic and financial inclusion strategies and future provision.

Recommendation 11: that prison and probation services be encouraged undertake more detailed work on the needs and nature of offending veterans.

Recommendation 12: that prison and probation services should consider how to make available more ‘signposting’ to veteran’s charities of offenders subject to short sentences.

Recommendation 13**:** that prisons, probation trusts and other partners in the statutory and voluntary sectors promote the sharing of best practice and information (data and needs analysis).

Awareness

Recommendation 14: As some sections of the ex-service community are vulnerable and hard to reach it is recommended that local authorities work with third sector bodies which provide an outreach service (such as ex-service charities and Norcare) to raise awareness and improve access to available support mechanisms.

Recommendation 15: that all agencies should make use of and promote local directories of services provided by the voluntary and community sector and statutory provision for those seeking help and for those making referrals, such as the web-based directory provided by Veterans North-East and Finchale College Durham.

Recommendation 16: that North East local authorities examine opportunities for using digital media to improve communication with the ex-service community and raise awareness of available support mechanisms.

Recommendation 17: that the North East National Housing Federation is requested on behalf of local authorities across the region to carry out work with Registered Social Landlords to raise awareness of the housing needs of the ex-service community.

Recommendation 18: that an awareness raising campaign is carried out amongst staff throughout the Tyne and Wear and Tees Valley Unlimited City Regions regarding the importance of asking whether individuals are ex-service to ensure that they can be appropriately referred on to Job Centre Plus and receive their entitlement to early access to New Deal Programmes.

Recommendation 19: PCTs should begin conversations now with the embryonic GP Commissioning Consortia regarding the merits of commissioning for ex-service community. PCTs and Consortia should report back to Members how the needs of the ex-service community are going to influence commissioning strategy during the transitional period and when Consortia have formally taken control of Commissioning budgets.

Improving responsiveness within organisations

Recommendation 20:that local authorities and other key partner organisations across the region should consider identifying a senior figure who can act as a champion for the ex-service community and establishing a central point of contact in each local authority area or sub - region to assist when members of the community experience difficulties. Examples of possible approaches include:

a. Within local authorities, a Member Armed Forces Champion to drive improvements in services for service veterans.

b. Within local authorities, a named senior officer to assist the ex-service community and act as a facilitator and conduit in dealings with Councils and beyond.

c. Within Primary Care Trusts, named senior staff to act as Case officers/co-ordinators in PCTs to act on behalf of the ex-service community whilst assistance is required, and to consider how best to

pass these responsibilities forward to GP consortia and local Health and Wellbeing Boards.

Improving co-ordination across organisations

Recommendation 21: that the Association of North East Councils should be asked to explore with the NHS, the armed forces and other partners across the region how stronger networking within and between existing groups may be taken forward. This should include consideration of joined-up planning and performance monitoring.

Recommendation 22: that local authorities should consider how to bring together voluntary organisations large and small with a specific interest in the welfare of the ex-service community, in the light of the Government's response to the Task Force on the Military Covenant.

Recommendation 23: We strongly recommend that local authorities across the region should explore options for establishing and publicising a central point of contact telephone number - to increase the chances of people getting the help they need and to provide a consistent standard of contact across the region. Ex-service charities, Citizens Advice Bureau operating in the region, the Career Transition Partnership and Job Centre Plus have all indicated that this would be likely to prove beneficial. The model adopted by Hampshire County Council, in which telephone enquiries from the ex-service community are channeled to a specific staff member, is particularly worth consideration.

Recommendation 24: that the Homes and Communities Agency is requested on behalf of local authorities across the region to consider how it may broker assistance and ensure better co-ordination of work across the region to ensure that services are being directed at the right people, including the ex-service community, and how it might assist with sharing examples of best practice as part of its enabling role and within the local investment planning process undertaken with local authorities.

Recommendation 25: that the positive work being taken forward by Job Centre Plus in the Tees Valley is shared with Armed Forces Champions across the rest of the region with a view to ensuring a consistent approach in supporting the training and employment needs of the ex-service community.

Recommendation 26: Local authorities within the North East should consider the developing a regional veterans charter to establish uniform good practice across the region, possibly through existing regional structures such as the Association of North East Councils (ANEC).

The transition of Armed Forces personnel to civilian services following discharge

Recommendation 27: that the Career Transition partnership continues to work with local authorities and Primary Care Trusts (and successor bodies as PCTs are abolished) to ensure that the Transition Protocol is understood and that specific individuals are mandated appropriately to take on these roles.

Recommendation 28: that local NHS organisations work with military colleagues to ensure that people leaving the services are registered with GPs and dentists before formal discharge, so they have a 'foot in both camps' towards the end of their active service. This would ensure a smoother transition to civilian health services.

Recommendation 29: that the armed forces and the Career Transition Partnership work more closely with local authorities and third sector organisations such as ex service charities, Norcare and Mental Health North East with a view to developing a formal process for referring vulnerable service leavers into specific services.

Recommendation 30: That action is taken[by the Armed Forces] on discharge to ensure that Early Service Leavers are provided with effective advice and 'signposting' in relation to the mental health issues they may experience on discharge from service

Recommendation 31: The effectiveness of improvements to the armed forces resettlement provision for early service leavers should be kept under review by the armed forces to ensure there is effective identification of potential vulnerability issues.

Recommendation 32: local authorities should encourage Strategic Housing Authorities and registered social landlords, where possible, to adopt allocation policies which recognise the needs of the ex-service community.

Ensuring equality of access for Armed Forces Families

Recommendation 33: that the Homes and Communities Agency is requested to examine on behalf of local authorities across the region identifying take-up of low-cost housing products by the ex-service community and whether providers are assisting the ex-service community as well as other parts of the community.

Recommendation 34: that the Homes and Communities Agency is requested to examine opportunities for the ex – service community within any revised funding arrangements as an outcome of the comprehensive spending review.

Recommendation 35: that local authorities across the region examine the scope to provide housing related support for ex - service tenants once a property has been identified.

Veterans' mental health services

Recommendation 36: that the new Health and Wellbeing Boards prioritise veterans' mental health issues, taking a lead in ensuring that on day 1 of discharge into civilian life that services are in place to meet the needs of the ex-service community in relation to both NHS and social care provision.

Recommendation 37: that

a Appropriate training is provided and required by commissioners of NHS services;
b Guidance should also be developed specifically for primary care providers and GPs to:
   i) explain the priority healthcare entitlement;
   ii) encourage them to identify ex-servicemen and women (for example, by asking patients to indicate that they have serviced in the UK Armed Forces);
   iii) explain how they can adapt their systems to accommodate priority treatment for ex-service community; and
   iv) how to accept referrals from ex-service charities, including the Royal British Legion and Combat Stress, but also smaller local organisations who are providing for some of the most marginalised/excluded ex-service personnel.

Recommendation 38: Joint Strategic Needs Assessments should specifically identify the mental health needs of the ex-service community including families and dependants.

Recommendation 39: NHS commissioners must ensure that GP consortia arrangements prioritise the needs of the ex-service community

Recommendation 40: Local authorities and GP Consortia should be actively engaged in joint planning and commissioning of services with the NHS.

Recommendation 41: Local authorities should be actively engaged in the NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans mental health issues – perhaps linked to the formation of the new Health and Wellbeing Boards.

Recommendation 42: Consideration should be given by central government to the need for some form of accreditation to be available to ex-service charities (particularly the newly emerging charities). How this might best be taken forward

should be considered in the light of the Government's response to the Task Force on the Military Covenant. Local authorities should consider drawing up approved lists of service providers.

Recommendation 43: that voluntary organisations and the NHS promote self-referral routes for ex-service personnel in a wide range of different ways that will help maximise their opportunity to access services.

Recommendation 44: that primary care and acute trusts should take steps to improve awareness of veterans' mental health issues among health workers generally, including appropriate training and supervision.

Recommendation 45: The Tees, Esk and Wear Valleys NHS Foundation Trust and the Department of Health should share widely the learning from the evaluation of the Community Veteran Mental Health Pilot, and particularly with commissioners, providers and the North East Mental Health Development Unit. Learning from the pilot must help to shape future statutory of provision and the linkages with, and support for, the voluntary sector in the context of the Increasing Access to Psychological Therapies programme.

Recommendation 46: Trusts should provide better basic information to veterans with clear diagnoses of Post Traumatic Stress Disorder about their condition.

Recommendation 47: Prison health services need to identify veterans and evaluate needs with a particular focus on mental health and PTSD.

Next steps

This is a large body of recommendations, addressed to a wide range of organisations. We have emphasised the need for co-operation and co-ordination among the many groups with which the ex-service community comes into contact. In keeping with that spirit, we will invite all those to whom we have addressed recommendations to come together to a single event to discuss how to move forward. We are currently planning to hold this event in March 2011.

Thereafter, we will meet to examine progress after six months and after one year. We ask that the organisations involve help us with those assessments.

The review group appreciates that further developments in support for the ex-service community must take place within the overall resource constraints set by the emergency Budget and Comprehensive Spending Review 2010, which affect not only local authorities, the NHS, the armed forces and other public sector bodies, but also community and voluntary groups. However, we believe that

many of our recommendations can be taken forward for little or no cost, or will generate savings through improved efficiency.

Regional Review of the Health of the Ex-Service Community

Main Report

The Health of the Ex-Service Community

16 People who have served in the armed forces, together with their relatives, dependents and carers, make up a large group of the population whose wellbeing and health needs, and relationship with services, have been affected by a significant common experience.

17 Most people leave the armed services healthy, and make a successful transition to civilian life. Their wellbeing and health needs are often best addressed on an individual basis. But evidence suggests that there are distinct patterns which affect ex-service personnel and their dependents (collectively called here "the ex-service community") which make it worthwhile to understand too their needs as a group.

> "We need to improve our information about how veterans' health needs differ from those of the population generally. Most healthcare professionals do not have direct knowledge of the Armed Forces and may not be sensitive to their particular needs. We will look at whether more needs to be done to assess the healthcare needs of veterans. We will raise awareness among healthcare professionals about the needs of veterans so that these needs are met."
>
> ("The Nation's Commitment", Government Command paper, July 2008, Cm 7424)

The national picture

18 There are very few hard facts available. Because the ex-service community has rarely been approached as a group until recently, the state of knowledge about their numbers, location, identity and needs is patchy. A number of our recommendations are therefore about improving the information available to service providers and others. But a very general picture can be drawn.

19 The Royal British Legion's Welfare Needs Research Programme reported in 2006 that:

- The ex-service community in the UK was made up of about 10.5 million people, of whom just under half were veterans themselves. This number was expected to fall to around 8.5 million by 2020.

- The average age of the ex-service community was 63 years, compared with 47 years for the adult population. The number of people in the community aged over 85 was expected to triple over the period to 2020, with a small increase in the number of 16-24 year olds, and a fall in the numbers of those in-between.

- Over half (52%) of the ex-Service community report having a long-term illness or disability, compared with 35% in the general population.

- In the 16-44 age group:
  - the number of mental health disorders among members of the ex-service community was three times that of the UK population of the same age;
  - there was a higher prevalence of musculo-skeletal complaints.

- In the 45-64 age group:
  - members of the ex-service community were more prone to cardio-vascular or respiratory conditions than their peers;
  - both men and women who are economically inactive reported significantly higher levels of ill-health in the ex-service community than in the general population.

- But members of the ex-service community aged 65-75 report less ill health than their peers in the general population, while those aged over 75 reported similar health to everyone else of that age.

20 The Ministry of Defence and the NHS have a partnership board for working on issues surrounding the health and well-being of the armed forces community – that is, including currently serving service personnel and their families, as well as veterans. In 2009, the Board commissioned the Centre for Military Health Research at King's College London to review recent and upcoming research publications. The King's Centre found that:

- Among the 3.8 million ex-Service personnel in England, overall health was broadly comparable to the general population.

- But there were common mental health diagnoses of alcohol problems, depression and anxiety disorders. In particular, those who leave the Services early and young were up to three times more likely to commit suicide than the general population.

21 These factors were identified by King's as increasing the risk of alcohol misuse and/or mental health problems:

- being young;
- being male;
- being in the Army, rather than another branch of service;
- holding a lower rank;
- experiencing childhood adversity;
- being exposed to combat;
- a deployment length over the "Harmony Guidelines" (in the case of the Army, roughly 12 months front-line service over a 3-year period);
- being a Reserve

- having a mental health problem while in Service
- Being an early service leaver.

22 Post-traumatic stress disorder makes up only a minority of cases of mental health disorders. An earlier study by King's found that "personnel who were deployed for 13 months or more in the past three years were more likely to fulfill the criteria for post-traumatic stress disorder". But this effect was substantially less marked than in similar studies of US personnel.

23 DASA (Defence Analytical Services and Advice), a part of the Ministry of Defence, maintains statistics on war disability pensions and the Armed Forces and Reserve Forces Compensation Scheme (AFCS) which replaced war pensions in 2005. These show that:

- 145,525 War Disablement Pensioners and 29,645 War Widows were receiving pensions at 30 September 2010.

- 225 veterans and 390 surviving dependents were receiving Guaranteed Income Payments under the AFCS.

- 8,645 lump sum payments had been made under the AFCS between 1 November 2005 and 30 September 2010.

- The most common injuries resulting in lump sum payments (mostly made to personnel still in the Services) were:
    - musculo-skeletal disorders (41.3%)
    - fractures and dislocations (29.7%)
    - injury, wounds and scarring (13.5%)

  But "injury, wounds and scarring" was the most common reason for the highest payments, accounting for 39.2% of this category.

North East England

24 The picture in any particular part of the country is harder to establish. The Ministry of Defence does not keep central records of where service personnel are recruited, where they go on leaving the services, or where they move to subsequently. Some may be members of veterans' organisations, but not all. The Department of Health has issued new guidance about identifying veterans on medical records, but this remains optional – patients may prefer not to be identified this way. In addition, the definition of "North East England" used by the armed forces includes areas of Yorkshire and Humberside not included in the definitions used by the Department of Health and the Office of National Statistics. The findings in this section of the report are therefore tentative.

25 The Royal British Legion survey of 2006 found that ex-service personnel were spread roughly evenly around the country, implying an ex-service community in North East England of around 500,000.

26 But estimates of recruitment into the armed forces suggest that around 10% come from North East England, while 10-15% of war pension recipients live here. By comparison, the North East only contains 4% of the general population of the UK. This would seem to imply an ex-service community of 1 million or more.

27 A possible explanation of this discrepancy is that the largest age group among the ex-service community is made up of those who served under conscription, in World War 2 and in subsequent National Service. Conscripts came roughly evenly from around the country. The subsequent professional armed forces seem to have recruited disproportionately from the North East of England.

28 According to figures from the Directorate of Resettlement, in the last two years 5620 service leavers indicated a preference to settle in the North East area (covering Humber to the Borders). These comprised 3700 Army, 1100 RAF, and 820 Navy.

29 There are approximately 1500 early service leavers each year from 15 Brigade at Catterick and 40% of these are from the North of England, the majority young, single men who have been part of the infantry. These are over and above the 5620 service leavers . The garrison at Catterick covers the geographical area Hull to Berwick to Carlisle and is the largest training garrison in Europe, with 40,000 regulars, reserves, cadets and dependents. As will be discussed below, early service leavers, with less than 4 years service, may face particular difficulties returning to civilian life.

Commitments to support the wellbeing and health needs of the ex-service community

> "Only on the basis of absolute confidence in the justice and morality of the cause can British soldiers be expected to give their lives for others. This unlimited liability on the part of the individual in turn demands collective responsibility of the nation for the welfare of all servicemen and women, serving and retired, and their dependants."
>
> ("Soldiers: The Military Covenant", Ministry of Defence, 2000, quoted in "Honour the Covenant", Royal British Legion Policy Briefing, September 2007)

30 Members of the ex-service community draw upon the same services and resources as the rest of the population to support their wellbeing and health: the voluntary sector, the National Health Service, local authority social services, housing associations, schools, Job Centre Plus, and so on.

31 There are also a number of groups working specifically with service leavers, ex-service personnel and the broader ex-service community. These include the Career Transition Partnership, which provides a range of support for service personnel moving into civilian life, the Service Personnel and Veterans Agency, and a number of community and voluntary organisations, large and small, that specialise in this field, including the Royal British Legion, the Soldiers, Sailors, Airmen and Families Association (SSAFA), Forces for Good, Combat Stress, Military Mental Health, Resettlement Armed Forces Training (RAFT) and others.

32 In 2008, the then Government published a review of cross-government support to the armed forces, their families and veterans, called "The Nation's Commitment". The report set the "essential starting point" was the principle of "No disadvantage".

> "The essential starting point is that those who serve must not be disadvantaged by what they do – and this will sometimes call for degrees of special treatment."

33 The Nation's Commitment set out, as "enduring principles", that service personnel and their families should have:

- as much lifestyle choice as any other citizen;
- continuity of public services;
- proper return for sacrifice;
- [recognition that] the Armed Forces' constituency matters.

34 The command paper contained a wide range of specific commitments. It also provided a framework for future development. The Ministry of Defence/NHS

Partnership Board, after consulting with stakeholders, proposed the following key themes for 2010:

- Promoting effective communication and coordination across agencies, providers and the third sector.

- The transition of Armed Forces personnel to NHS care following medical discharge

- Ensuring equality of access for Armed Forces families

- Veterans' mental health services

35 These priorities form the structure of the recommendations in this report.

36 The Coalition Government formed in May 2010 issued a new version of the NHS Operating Framework which made these commitments relating to the ex-service community:

- There is a guarantee that all those seriously injured will receive an early and comprehensive assessment of their long term needs before they leave the Armed Forces;

- There should be high quality care for life for those with continuing healthcare needs based on a regular review of their needs overseen by an NHS case manager;

- There is grant funding with Combat Stress (that they are matching) to work directly with mental health trusts to ensure that the services they provide are accessible to and appropriate for military veterans;

- There will be closer NHS links with a full range of third sector partners and charities with extensive experience of working with veterans, to share advice, knowledge and best practice to improve services for veterans;

- There is an entitlement for all veterans who have lost a limb whilst serving in the Armed Forces to receive, where clinically appropriate, the same standard of prosthetic limb from the NHS that they received or would receive today from Defence Medical Services as a result of major technological advances.

- Responsible Directors are to be identified within each Strategic Health Authority, together with Primary Care Trust champions, will be identified to

ensure the needs of the armed forces, their families and Veterans are fully reflected in local plans and service provision; and

- There should be improved transfer of medical records to the NHS on retirement from the armed forces, including greater GP awareness of veteran status of new patients to ensure veterans receive their entitlement to priority treatment for any injuries or illness attributable to their time serving in the Armed Forces.

37 The Government has also accepted the findings of a report by Andrew Murison MD MP, "Fighting Fit: A mental health plan for servicemen and veterans", whose principal recommendations were:

- Incorporation of a structured mental health systems enquiry into existing medical examinations performed whilst serving.
- An uplift in the number of mental health professionals conducting veterans outreach work from Mental Health Trusts in partnership with a leading mental health charity.
- A Veterans Information Service (VIS) to be deployed 12 months after a person leaves the Armed Forces.
- Trial of an online early intervention service for serving personnel and veterans.

38 In December 2010, the Government published the report of a Task Force on the Military Covenant, chaired by Professor Hew Strachan. The Government is considering the Task Force's recommendations, but has already accepted the proposal that there should be Community Covenants across the country, supported by local authorities. We hope that the recommendation we make here can help add substance to the framework of such covenants.

Conclusions and recommendations

General considerations

39 The review was conducted largely in three workstreams, addressing respectively social and economic wellbeing, mental health and physical health. Full separate reports have been published detailing the findings of each workstream.

40 For the purpose of this report, we have consolidated findings and recommendations into four categories, in line with priorities identified by stakeholders in "The Nation's Commitment":

1. Promoting effective communication and coordination across agencies, providers and the third sector.

2. The transition of Armed Forces personnel to NHS care following medical discharge (which has been expanded here to include discharge generally)

3. Ensuring equality of access for Armed Forces families

4. Veterans' mental health services

41 Many of these recommendations need to be seen in the light of the proposals for reforming the National Health Service set out in the 2010 White Paper "Equity and Excellence: Liberating the NHS". Salient points include proposals that:

- Public health responsibilities will be split off into a new national Public Health Service. Local directors of public health will be appointed jointly by the Public Health Service and local authorities.

- There will be a National Commissioning Board. This will commission and directly fund GP consortia across the country.

- GP consortia will be responsible for commissioning most services for their patients. Patients will have a choice of GP, and GP consortia will be able to commission services from "any willing provider". The right of patients to have a choice of provider will be extended to some mental health services and to long-term conditions.

- The National Commissioning Board will commission directly a number of services where the Government believes it is impractical for GP consortia to do the job. These include dentistry, community pharmacy,

primary opthalmic services, maternity services, national and regional specialised services.

- Local Health and Wellbeing Boards, led by local authorities, will be asked to co-ordinate health services (including health promotion) within their areas. This will include preparation of Joint Strategic Needs Assessments (JSNAs), setting local health priorities.

42 The review group also appreciates that further developments in support for the ex-service community must take place within the overall resource constraints set by the emergency Budget and Comprehensive Spending Review 2010, which affect not only local authorities, the NHS, the armed forces and other public sector bodies, but also community and voluntary groups. However, we believe that many of our recommendations can be taken forward for little or no cost, or will generate savings through improved efficiency.

1 Promoting effective communication and coordination across agencies, providers and the third sector

Information

43 As we have seen, information about the health needs of the ex-service community is patchy. Collecting information has costs as well as benefits, and so does analysing it, storing it and sharing it. But the review group believes that the needs of this community are sufficiently distinctive, and the moral imperative implied by the Military Covenant sufficiently strong, to warrant doing more.

44 Identification of the ex-service community is a key issue. The ex-service community's status is very rarely recorded when individuals access services – there is some evidence that this might be impacting on their current ability to effectively access certain services and that recording this status improves access. Organisations such as the Probation Service, the Prison Service and the housing charity Norcare are now actively seeking to record such information in order to ensure that certain services are effectively targeted towards the specific needs of the ex-service community.

It will also be important to gather intelligence about those 'soon to leave', their likely destination and the demands that will place on localities. This work should be periodically refreshed to ensure it remains relevant.

Recommendation 1: that local authorities across the region consider what might be the costs, benefits and best methods of collecting in future information about members of the Armed Forces 'soon to leave', their likely destination and the demands that will place on localities.

Recommendation 2: that local authority services should actively ask the question of those they provide services for: 'have you served in the UK Armed Forces?

Recommendation 3: that all organisations providing (or potentially providing) services for ex-service community should encourage veterans to voluntarily identify themselves by asking 'have you served in the UK Armed forces?'

Recommendation 4: that HM Government should consider the potential for an individual's NHS or National Insurance number to be used to identify their veteran status to improve identification of needs and services that may be available. This might be considered alongside the proposal by the Task Force on the Military Covenant for the creation of Veterans' Cards.

45 There needs to be **better communication and sharing of information and more joined up work** between the armed forces, local authorities, partners and ex-service charities.

Recommendation 5: that formal information sharing protocols and arrangements are established between the armed forces and local authorities across the NE region. This will enable local authorities to properly assess and plan to meet the needs of the ex-service community as a specific group.

46 Local authorities have a key role in shaping their communities and building the wider determinants of good health and working to support individual families and communities. There is evidence that a proportion of the ex -service community across the region are vulnerable and require targeted support.

Recommendation 6: local authorities in the North East should consider dedicating a chapter in their Joint Strategic Needs Assessments to vulnerable service leavers and their needs and identifying as a target population the ex service community within their strategic planning processes in relation to social exclusion, anti-poverty, homelessness and offending.

47 Given the current lack of hard data regarding the health and well being needs of the ex-service community **there is a need for further qualitative research into the needs of the ex-service community.**

Recommendation 7: that local authorities across the region take research forward as part of the development of Joint Strategic Needs Assessments across the region, and that the North East Public Health Observatory should also consider what data and research support it can provide.

48 Wellbeing depends on wider determinants than the commissioning of health and social care services. Other factors, such as housing and employment, are also vital.

Recommendation 8: that local authorities across the North East request the NE National Housing Federation to carry out a mapping exercise to quantify current provision of ex - service community housing provided by their members and analyse best practice both nationally and within the North East.

Recommendation 9: that the North East Housing Federation works closely with NE local authorities to help plan future provision.

50 As the Marmot report on health inequalities demonstrated, employment is an important factor underlying health and wellbeing, and it is likely to remain a challenge as the country emerges from the recession.

Recommendation 10: that the armed forces and the Career Transition Partnership work more closely with local authorities across the region and provide them with an assessment of the likely level of demand and need for

employment and skills related services in order to inform future economic and financial inclusion strategies and future provision.

51 A thorny issue is the presence of **ex-service personnel in the criminal justice system.** The National Offender Management Service (NOMS) has been taking steps to better understand the situation.

Recommendation 11: that prison and probation services be encouraged undertake more detailed work on the needs and nature of offending veterans.

Recommendation 12: that prison and probation services should consider how to make available more 'signposting' to veteran's charities of offenders subject to short sentences.

Recommendation 13**:** that prisons, probation trusts and other partners in the statutory and voluntary sectors promote the sharing of best practice and information (data and needs analysis).

52 It is crucial that Strategic Health Authorities, and their successor bodies, take a regional lead and commission detailed and accurate work to establish true size and nature of ex-service community.

Awareness

53 Two types of awareness need to be addressed.

54 There is a need to raise **awareness amongst local authorities and other partner organisations,** employers and service providers across the region of the very specific needs of the ex- service community.

55 There is also a need to raise the level of **awareness within the ex-service community** and to communicate effectively with them about the wide range of support currently available to them and how they may access relevant support services and removing any stigma from seeking help and support.

Recommendation 14: As some sections of the ex-service community are vulnerable and hard to reach it is recommended that local authorities work with third sector bodies which provide an outreach service (such as ex-service charities and Norcare) to raise awareness and improve access to available support mechanisms.

Recommendation 15: that all agencies should make use of and promote local directories of services provided by the voluntary and community sector and statutory provision for those seeking help and for those making referrals, such as

the web-based directory provided by Veterans North-East and Finchale College Durham.

Recommendation 16: that North East local authorities examine opportunities for using digital media to improve communication with the ex-service community and raise awareness of available support mechanisms.

Recommendation 17: that the North East National Housing Federation is requested on behalf of local authorities across the region to carry out work with Registered Social Landlords to raise awareness of the housing needs of the ex-service community.

Recommendation 18: that an awareness raising campaign is carried out amongst staff throughout the Tyne and Wear and Tees Valley Unlimited City Regions regarding the importance of asking whether individuals are ex-service to ensure that they can be appropriately referred on to Job Centre Plus and receive their entitlement to early access to New Deal Programmes.

56 General Practice has a new role as future commissioners of health services. It is imperative that General Practice is aware of the priority treatment schemes for veterans and that it is utilised when appropriate if referrals are necessary. PCTs should emphasise this point to General Practice now.

Recommendation 19: PCTs should begin conversations now with the embryonic GP Commissioning Consortia regarding the merits of commissioning for ex-service community. PCTs and Consortia should report back to Members how the needs of the ex-service community are going to influence commissioning strategy during the transitional period and when Consortia have formally taken control of Commissioning budgets.

Improving responsiveness within organisations

Recommendation 20: that local authorities and other key partner organisations across the region should consider identifying a senior figure who can act as a champion for the ex-service community and establishing a central point of contact in each local authority area or sub - region to assist when members of the community experience difficulties. Examples of possible approaches include:

a. Within local authorities, a Member Armed Forces Champion to drive improvements in services for service veterans.

b. Within local authorities, a named senior officer to assist the ex-service community and act as a facilitator and conduit in dealings with Councils and beyond.

c. Within Primary Care Trusts, named senior staff to act as Case officers/co-ordinators in PCTs to act on behalf of the ex-service community whilst assistance is required, and to consider how best to pass these responsibilities forward to GP consortia and local Health and Wellbeing Boards.

Improving co-ordination across organisations

57 Experience throughout the country suggests that considerable improvements in the wellbeing and health of the ex-service community could be achieved by better communication, sharing of information and more joined up work between the armed forces, local authorities, partners and ex-service charities.

58 There is some evidence to support the need for the establishment of **some kind of formal network** involving local authorities which focuses on the needs of the ex-service community. Several different co-ordinatory groups are currently in existence, such as the recently established NHS Armed Services Forum, the NE Regional Veterans Network and the MoD Military / Civil Integration Forum.

Recommendation 21: that the Association of North East Councils should explore with the NHS, the armed forces and other partners across the region how stronger networking within and between existing groups may be taken forward. This should include consideration of joined-up planning and performance monitoring.

59 There is a case more leadership, co-ordination and co-operation across the voluntary sector. This would help to bind what appears to be a fragmentation of provision, to help share good practice, and enable the sector to speak with a stronger voice. It could be assisted by the proposals of the Task Force on the Military Covenant for improved co-ordination,

Recommendation 22: that local authorities should consider how to bring together voluntary organisations large and small with a specific interest in the welfare of the ex-service community, in the light of the Government's response to the Task Force on the Military Covenant.

60 There are also several specific measures which the review group believes could improve co-ordination of services.

Recommendation 23: We strongly recommend that local authorities across the region should explore options for establishing and publicising a central point of contact telephone number - to increase the chances of people getting the help

they need and to provide a consistent standard of contact across the region. Ex-service charities, Citizens Advice Bureau operating in the region, the Career Transition Partnership and Job Centre Plus have all indicated that this would be likely to prove beneficial. The model adopted by Hampshire County Council, in which telephone enquiries from the ex-service community are chanelled to a specific staff member, is particularly worth consideration.

Recommendation 24: that the Homes and Communities Agency is requested on behalf of local authorities across the region to consider how it may broker assistance and ensure better co-ordination of work across the region to ensure that services are being directed at the right people, including the ex-service community, and how it might assist with sharing examples of best practice as part of its enabling role and within the local investment planning process undertaken with local authorities.

Recommendation 25: that the positive work being taken forward by Job Centre Plus in the Tees Valley is shared with Armed Forces Champions across the rest of the region with a view to ensuring a consistent approach in supporting the training and employment needs of the ex-service community.

61 This report has emphasised the need for local authorities to work closely with other partners. They may find this easier to do if they establish common standards.

Recommendation 26: Local authorities within the North East should consider the developing a regional veterans charter to establish uniform good practice across the region, possibly through existing regional structures such as the Association of North East Councils (ANEC).

2 The transition of Armed Forces personnel to civilian services following discharge

62 The evidence suggests that the vast majority of ex-service personnel experience the transition from military to civilian life positively. A range of tailored support is provided both by the services themselves and by the Career Transition Partnership. The National Audit Office concluded that the UK "is at the forefront of providing tailored professional help to military personnel as they leave."

63 There is a Transition Protocol for all those with identified health problems on discharge.

Recommendation 27: that the Career Transition partnership continues to work with local authorities and Primary Care Trusts (and successor bodies as PCTs are abolished) to ensure that the Transition Protocol is understood and that specific individuals are mandated appropriately to take on these roles.

Recommendation 28: that local NHS organisations work with military colleagues to ensure that people leaving the services are registered with GPs and dentists before formal discharge, so they have a 'foot in both camps' towards the end of their active service. This would ensure a smoother transition to civilian health services.

64 There is some evidence that **signposting is not enough for the more vulnerable service leavers** with specific problems and there is a need for more integrated pathways to services for these individuals.

Recommendation 29: that the armed forces and the Career Transition Partnership work more closely with local authorities and third sector organisations such as ex service charities, Norcare and Mental Health North East with a view to developing a formal process for referring vulnerable service leavers into specific services.

65 The risk factors identified by King's College suggest that early service leavers may be among those most likely to be vulnerable. They are also the group most likely to be leaving the services for negative reason. However, unless they are being discharged on medical grounds, early service leavers are entitled only to very limited support from the Career Transition Partnership.

Recommendation 30: That action is taken[by the Armed Forces] on discharge to ensure that Early Service Leavers are provided with effective advice and 'signposting' in relation to the mental health issues they may experience on discharge from service

Recommendation 31: The effectiveness of improvements to the armed forces resettlement provision for early service leavers should be kept under review by the armed forces to ensure there is effective identification of potential vulnerability issues.

66 As always, **it is not only health and social care provision that determines wellbeing**. It is of crucial importance that registered social landlords are aware of the prevalence of the ex-service community in the north east and they ensure that their allocation policies make specific reference to accommodating the ex-service community.

Recommendation 32: local authorities should encourage Strategic Housing Authorities and registered social landlords, where possible, to adopt allocation policies which recognise the needs of the ex-service community.

3 Ensuring equality of access for Armed Forces families

67 Given the time limits on this review, its attention has been focused mostly on housing needs.

68 At the moment there does not seem to be a way of identifying take up of low cost housing products by the ex-service community or identifying whether providers are assisting the ex-service community as well as other parts of the community.

Recommendation 33: that the Homes and Communities Agency is requested to examine on behalf of local authorities across the region identifying take-up of low-cost housing products by the ex-service community and whether providers are assisting the ex-service community as well as other parts of the community.

Recommendation 34: that the Homes and Communities Agency is requested to examine opportunities for the ex – service community within any revised funding arrangements as an outcome of the comprehensive spending review.

Recommendation 35: that local authorities across the region examine the scope to provide housing related support for ex - service tenants once a property has been identified.

4 Veterans' mental health services

69 Significant effort is being put in nationally and locally to improve mental health services for veterans. The review group welcomes Dr Murison's report and the government's response to it.

70 At a local level, the proposals in the NHS White Paper give a strong role to the new local Health and Wellbeing Boards in assessing needs and co-ordinating service provision.

Recommendation 36: that the new Health and Wellbeing Boards prioritise veterans' mental health issues, taking a lead in ensuring that on day 1 of discharge into civilian life that services are in place to meet the needs of the ex-service community in relation to both NHS and social care provision.

71 There is a need for enhanced awareness among primary care providers and GPs of the particular mental health needs of the ex-service personnel and particularly of the need for priority treatment for health care needs arising from their service.

Recommendation 37: that

c Appropriate training is provided and required by commissioners of NHS services;

d Guidance should also be developed specifically for primary care providers and GPs to:

v) explain the priority healthcare entitlement;

vi) encourage them to identify ex-servicemen and women (for example, by asking patients to indicate that they have serviced in the UK Armed Forces);

vii) explain how they can adapt their systems to accommodate priority treatment for ex-service community; and

viii) how to accept referrals from ex-service charities, including the Royal British Legion and Combat Stress, but also smaller local organisations who are providing for some of the most marginalised/excluded ex-service personnel.

Recommendation 38: Joint Strategic Needs Assessments should specifically identify the mental health needs of the ex-service community including families and dependants.

Recommendation 39: NHS commissioners must ensure that GP consortia arrangements prioritise the needs of the ex-service community

Recommendation 40: Local authorities and GP Consortia should be actively engaged in joint planning and commissioning of services with the NHS.

Recommendation 41: Local authorities should be actively engaged in the NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans mental health issues – perhaps linked to the formation of the new Health and Wellbeing Boards.

72 There is a general support across the voluntary sector that there should be some regulation or accreditation of voluntary organisations for the purpose of providing quality assurance of their services. This will ensure confidence that organisations are meeting certain standards in advice or care provided, and thereby instilling confidence that they can be referred to and attract funding support and that they gain the credibility to refer directly to GPs.

Recommendation 42: Consideration should be given by central government to the need for some form of accreditation to be available to ex-service charities (particularly the newly emerging charities). How this might best be taken forward should be considered in the light of the Government's response to the Task Force on the Military Covenant. Local authorities should consider drawing up approved lists of service providers.

Recommendation 43: that voluntary organisations and the NHS promote self-referral routes for ex-service personnel in a wide range of different ways that will help maximise their opportunity to access services.

73 The government has announced an increase in the number of specialised outreach officers working to improve the mental health of veterans, but many of the ex-service community may find themselves, at least initially, in contact with health workers who are not specialised in this field.

Recommendation 44: that primary care and acute trusts should take steps to improve awareness of veterans mental health issues among health workers generally, including appropriate training and supervision.

74 The National Health Service has a programme for Improving Access to Psychological Therapies (IAPT). As part of this the Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a Community Mental Health Pilot scheme.

Recommendation 45: The Tees, Esk and Wear Valleys NHS Foundation Trust and the Department of Health should share widely the learning from the evaluation of the Community Veteran Mental Health Pilot, and particularly with commissioners, providers and the North East Mental Health Development Unit.

Learning from the pilot must help to shape future statutory of provision and the linkages with, and support for, the voluntary sector in the context of the IAPT.

Recommendation 46: Trusts should provide better basic information to veterans with clear diagnoses of PTSD about their condition.

75 Some groups within the ex-service community may need special attention, including prisoners and early service leavers (those who leave the service after less than four years).

Recommendation 47: Prison health services need to identify veterans and evaluate needs with a particular focus on mental health and PTSD.

Undertaking this review

76 This is the first time that the twelve local authorities in the North East of England have combined to undertake a joint scrutiny review about a matter of common concern, and especially about an aspect of health inequalities in the region.

77 There has been a long history of co-operation between the health overview and scrutiny committees in the region. The five authorities in the Tees Valley area have operated a standing joint committee for several years, while the seven local authorities to their north have formed a number of separate scrutiny committees to examine particular health issues under an agreed protocol. The Chairs of individual local authorities have come together in a network to discuss matters of common interest, as have their support officers.

78 In 2009, the network members decided that it was time to move this process on a stage, by undertaking a joint scrutiny review and forming a standing Joint Health Overview and Scrutiny Committee. An invitation by the Centre for Public Scrutiny (CfPS) for joint bids by groups of local authorities to become Scrutiny Development Areas in the field of health inequalities acted as a catalyst. The network's bid was successful and the Centre provided support in the form of £5,000 and 6.5 free days support by a CfPS expert advisor, Shaun Gordon. In return, this review is contributing to the Centre's health inequality scrutiny toolkit.

79 The formal Joint Health Overview and Scrutiny Committee was not set up until partway through the review, so the original bid was agreed by the network in December 2009, and a separate Memorandum of Understanding was drawn up setting up a Project Board for the review. Like the Joint Committee which formed later, this was made up of the chairs of the individual local authority health overview and scrutiny committees, or their deputies. Meetings were chaired variously by Councillors Ann Cains (Stockton-on-Tees), Robin Todd (Durham) and Lawrence Hunter (Newcastle), until Councillor Cains was elected as Chair of the new Joint Committee in September 2010.

80 The Joint Health Overview and Scrutiny Committee has adopted a protocol and terms of reference to formalise its governance arrangements, which will be of value in any future joint scrutiny.

81 The subject of the joint review was quickly agreed, winning support across all twelve local authorities in the region. Reviewing ways to improve the health of the ex-service community was not just a matter which fired the enthusiasm of Councillors, it would bring a local and regional perspective to the initiatives being taken nationally by the Ministry of Defence and the Department of Health and their partners, as set out in the Command Paper The Nation's Commitment.

82 Once the overall direction of the project was set by Councillors, officers started to research background information and to identify contacts.

83 At the end of June, 22 scrutiny Councillors from the 12 different local authorities and 34 guests from a range of national, regional and local organisations gathered in Durham to discuss the health needs of the ex-service community at an evidence-gathering overview day.

84 They listened to and questioned speakers including the Co-Chair of the joint Ministry of Defence/Department of Health Partnership Board and the Surgeon-General's Cross-Government Health Lead, as well as representatives of the armed forces, the Royal British Legion, the regional Strategic Health Authority, one of the Directors of Adult Services in the North East, and the Career Transition Partnership, and they took part in round-table discussion with public health specialists, commissioners and clinicians.

85 Following the overview day, Councillors split into three workstream groups, looking at physical health, mental health, and social and economic wellbeing.

86 A chair and lead authority was identified for each of these workstreams, but they were otherwise open to Councillors from any authority, irrespective of political alignment. Each worksteam was supported by officers from four local authorities. The social and economic wellbeing group was chaired by Councillor Stuart Green (Gateshead), the mental health group by Councilor Robin Todd (Durham) and the physical health group by Councillor Eddie Dryden (Middlesbrough).

87 Each workstream undertook its own work programme, including interviews, focus groups and site visits. These are detailed further in the individual reports of the workstreams. A project support group of officers was set up to help co-ordinate the project and avoid duplication. This was made up of officers from the workstream lead authorities, from Newcastle, which acted as overall project lead, and from Redcar & Cleveland, which handled publicity.

88 All the workstream reports, together with the overall project report, were considered by the Joint Committee in its role as project board, and shared with as many contributors as possible before publication.

89 This has been a long process, which has made demands both on the review group and on the many people from a wide range of organisations who have helped the group reach its conclusions. The group is extremely grateful for the enthusiasm, time and commitment of everyone who contributed and hope that, by participating in this review, those organisations have gained new perspectives, new contacts and new ideas even beyond the scope of this report.

ACTION PLAN BY ORGANISATION

For ease of reference, the recommendations made in this report have been broken down according to the organisations to which they are addressed.

Groups and organisations to which recommendations are addressed will be invited to meet with the Joint Health Scrutiny Committee to discuss ways forward in March 2011.

Thereafter, the Committee will meet to examine progress after six months and after one year. It asks that the organisations involve help us with those assessments.

The Joint Committee asks that each organisation should send it a reply, indicating whether or not it accepts the recommendation, suggesting a timeframe for implementation, and making any other relevant comments, where possible by 1 March 2011, ahead of the planning event, and in any case by 1 September 2011.

Responses should be addressed to:

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE 9 February 2011

PREVENTION ON SEXUALLY TRANSMITTED INFECTIONS AND PROMOTION OF GOOD SEXUAL HEALTH

Commissioning Lead for Sexual Health & Health Improvement Practitioner, Sunderland Teaching Primary Care Trust

1. Purpose of Report

1.1 The report will outline the current services and initiatives operating across the city of Sunderland to promote positive sexual health for young people. The report will provide information on the universal and targeted services including the Chlamydia screening programme.

2. Background

2.1 Sunderland currently has a teenage pregnancy rate of 51.8 as reported from the Q3 conception data for 2009. This is both above the national and regional average. Continued efforts along with a recent national support Visit for Teenage pregnancy are striving to make improvement to young people's sexual health and to reduce the number of teenage conceptions.

2.2 In relation to sexually transmitted infections (STI) Sunderland currently Chlamydia is the most common STI among young people under the age of 25. As a result of this consistently high rate a national screening programme for Chlamydia was launched in 2007/08 which lead to PCT's being asked to screen % of all 15-25 year olds in order to halt an increase on the rising figures of Chlamydia cases.

2.3 In addition to sexual health access to contraception is also a key element of young people's sexual health. Condom card schemes have been operating across the country since the beginning of the teenage pregnancy strategy 10 years ago. Sunderland currently has a condom scheme operating across the city known as the SHOWT card.

2.4 As well as access to condoms, Long acting reversible contraception is considered to be more affective with young people as the method does not rely on the young person remembering to take is as it is a long term contraceptive ranging from 3 months to 10 years, depending on the chosen method.

2.5 To ensure access to contraception is available City Hospitals Sunderland have been commissioned to provide a contraceptive and sexual health service to all people within Sunderland, but have also included a dedicated young people's service to target the provision.

3. Current Position

3.1 To ensure young people understand and practice good sexual health Sunderland currently has the following initiatives in place;

3.2 **Your Health:** is a universal health information initiative for young people within Sunderland. The youth health has a number of elements to the programme to ensure young people have one point of contact for health information including sexual health. The programme has involved the establishment of a website (www.yourhealthsunderland.com) which has provided two sections to date for young people 11-15 and 16-24 to access health information and knowledge of local services available to them.

3.3 In addition to the website a number of resources have been developed for our secondary schools including a display board that promotes the your health brand and website as well as holding the individual health leaflets that have been produced. These boards are in every secondary school and young people's services across the city. A year 7 pupil handbook and year 7 parent handbook have also been produced and given to every year 7 pupil in September 2010. There has also been a resource developed for the college settings.

3.4 The final element of the Your Health communication strategy is the rebranding of the sexual health services dedicated to young people. The long standing young people's service in Sunderland was known as Answers, and consultation with young people agreed to keep the name but to rebrand all young people's contraception and sexual health service provision as Answers.

3.5 **Answers:** is the young people's dedicated contraception and sexual health service in Sunderland. The service is commissioned to offer a full sexual health service to young people under the age of 25. the current intention is to have at least one Answers clinic in each of the 5 areas fo the city. Currently we have a clinic operating in 4 of the 5 areas with the 5 area to come on board Early 2011. The venues hosting the clinics include the royal hospital in Sunderland, Washington Primary care centre, Hylton College and Bede College. The remaining venue to come on board is within the Houghton area in the new primary care centre development.

3.6 The service has undergone a review to extend the provision into the 5 areas as well as communication plan to increase young people's knowledge about the service and what it offers. This is an ongoing strategy to continue to increase access to sexual health services among this age group.

3.7 **Showt Card:** is the current condom card scheme available for all young people in Sunderland 14-24 to access free condoms. The scheme has a number of outlets that have trained staff to support young people to access condoms and Chlamydia screening. The scheme currently operates a paper based system with little electronic data to record uptake and monitor effectiveness of outlets. Therefore a review of the current system has involved

the sourcing of an electronic system to manage the scheme to give robust data on uptake and access as well as effectiveness of venues and stock control. The new system will be in place by March 31st, by when all staff and outlets will have been trained to use the new system.

3.8 In addition to the new electronic system the card will be re-branded to give a fresh and improved look to the scheme. The launch of the image will be in line with the new system.

3.9 **Chlamydia Screening Programme:** in Sunderland the Chlamydia screening programme is currently commissioned through Newcastle PCT until March 2011. The programme manages and co-ordinates the screening, providing treatment, partner notification and data analysis for all screening processed. The programme currently have a target to screen 35% of the total population of 15-24 years old in Sunderland equating to 13,195 screen between April 2010 to March 2011.

3.10 To promote the screening programme within Sunderland a number of marketing initiatives have been developed including a text service for a young person to request a kit, facebook advertising to promote awareness and giving a link to the regional Chlamydia screening website for a testing kit and further information. In addition to this a number of seasonal and holiday campaigns are used to cover key events such as Valentines Day, summer holidays and Christmas.

3.11 **Emergency Contraception Scheme:** access to emergency contraception is offered for free to any woman through pharmacies that have signed up to the local enhanced service. The service allows any young person to access emergency contraception up to 72 hours after unprotected sex. The list of current participating pharmacies is advertised within the Your Health website.

3.12 Although the service is available a branding or communication strategy is not in place to promote the scheme more widely. Although increase in use of emergency contraception is something to advocate, preventing an unwanted pregnancy is, and signposting young women to the service should also include information on other forms of contraception. It is proposed to brand the scheme and develop promotional materials to clearly outline which pharmacies are engaged in the scheme.

4. Conclusion

4.1 To conclude the report a number of actions will be carried out (as outlined within the report) to improve the current services available, and further guidance will be given in the new year around sexual health due to the current release of the Public Health White Paper: Healthy Lives Healthy People.

HEALTH & WELL-BEING SCRUTINY COMMITTEE

9th February 2011

PERSONALISATION AND REABLEMENT IN SUNDERLAND – PROGRESS REPORT

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

1. Purpose of Report

1.1 At the Health and Wellbeing Committee's request, this report provides an update on how Sunderland is implementing the personalisation and reablement agendas, ensuring they complement one another and details how hospital discharges are supported through these agendas (in particular reablement approaches).

2. Background

2.1 **Putting People First: A shared vision and commitment to the transformation of Adult Social Care** (December 2007) set out a "shared vision and commitment to the transformation of Adult Social Care". It stated that, "People who use social care services and their families will increasingly shape and commission their own services''. Personalisation is the process by which state provided services can be adapted to suit the individual receiving them. In social care this means everyone having choice and control over the shape of their support. Personalisation means thinking about public services and social care in an entirely different way – starting with the person rather than the service. It required the transformation of adult social care.

2.2 The personalisation agenda has been further emphasized by the Coalition Government through the publication of **The Vision for Adult Social Care,** in November 2010. This further highlighted the importance of putting people, personalised services and outcomes centre stage of social care. It sets a challenge for councils to provide a personal budget, preferably as a direct payment, for everyone who is eligible by April 2013.

2.3 A consequence of personalisation is that people will increasingly take their own decisions about how to balance their new freedoms with a sensible approach to risk, accessing solutions to meet their eligible needs, which are very different from the services that social care has historically provided.

2.4 The Department of Health, through their revision of the NHS Operating Framework set out the **NHS commitment to reablement**. They describe reablement as….'the use of timely and focused intensive therapy and care in a

person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on reabling people within their homes … so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care'.

2.5 Reablement is not the same as intermediate care. Intermediate care patients have a defined clinical need, and intermediate care services are clinician-led. In contrast, reablement service users have a social care need (which may result from a clinical need) and reablement services are not clinician-led, and tend to adopt a social model of support.

2.6 The overall aim of reablement is to help people regain the ability to live as independently as possible. Everyone involved in reablement services needs to be supporting and motivating users to achieve these changes, every time they work with them.

3. Current position – Personalisation and Reablement in Sunderland

3.1 Over the last 18 months, Health, Housing and Adult Services Directorate have been working on their 3 Year Delivery Plan through a range of projects which were focussed on implementing the policy agendas detailed in the background section. The key projects were 'Reviewing Care Management and Assessment Processes' and 'Development of Reablement at Home Services'.

3.2 A starting point for the directorate has been to review its current arrangements and practices against the philosophy of personalisation in social care, which means everyone having choice and control over the shape of their support and against national best practice which was evidencing how adult social care systems should be set up to enable personalisation to become a reality (See Appendix 1 – ADASS Systems Map)

3.3 As part of the 'Reviewing Care Management and Assessment Processes', a number of developments have been progressed, which continue to see the implementation of personalisation within Sunderland:

3.3.1 Branding of the Directorate – feedback from people who use social care services and members of the public suggested that it was difficult to understand what 'Health, Housing and Adult Services' did or could do for someone. Work is progressing on marketing information that clearly demonstrates how social care can enable and support people to access care and support that meets their needs.

3.3.2 Self Directed Support – a fundamental aspect of personalisation is for people to have the opportunity to identify their needs and have control over how these needs are met. To facilitate this, access to a **self assessment** is now available via the Council's website, where people

can either complete by themselves or with support from a family member/friend, providing information about what their problems are and how they would like their problems to be solved. Another important element is the development of the **personal plan**, which sets outs how a person will spend their personal budget (see 3.3.4)

3.3.3 Right Level of Assessment –ensuring that the right level of social care assessment was applied to individual people was a priority in implementing personalisation, avoiding over complicated processes. To support this, it was decided that the Care Management and Assessment Teams needed to be restructured to reflect different processes that can be used to assess people and their needs. We now have an **Initial Advice and Assessment Service**, which is broken down to 5 geographically linked teams and a **Long Term Complex Service,** with teams focussed on the key client groups (older people, physical disabilities, learning disabilities, mental health and drug and alcohol). Both these services have social workers and care managers within the teams.

3.3.4 Personal Budgets – over the last few years, people have been able to access direct payments, which is a funding mechanism whereby the person themselves employs people to provide the care and support they need. Now, if a person is eligible for social care support they will receive a **personal budget,** which is calculated using the Resource Allocation System (RAS), based on information obtained from their assessment. A personal plan is drawn up with the individual detailing how they will spend their personal budget to meet their support needs and achieve their outcomes. The person has a choice as to how their personal budget is accessed. The person can:

- Take it all as a direct payment; or
- Ask Health, Housing and Adult Services to arrange and pay for their support needs from their Personal Budget; or
- A combination of the above two choices.

People are already using their personal budgets in innovative ways, tailoring services to meet their needs, rather than using traditional provision e.g. going for a weekend away to Amsterdam with their personal assistant rather than a week's stay in respite care.

3.3.5 Reablement – it is important that reablement is not seen as being separate from personalisation; rather reablement is an integral part of implementing the personalisation agenda. Reablement is an approach that focuses on supporting people to do things for themselves, learning or relearning skills necessary for daily living. A pilot Intermediate Care at Home Service was established 12 months ago, which focussed on supporting hospital discharges following a social care assessment for older people by providing therapeutic interventions to people in their own homes.

During this pilot, there was a 37% reduction in the need for ongoing packages of care, demonstrating the importance of providing intensive support following a hospital stay to enable people to do things for themselves and remain independent.

Work has been progressing to further develop this pilot into the ongoing **Reablement at Home service,** which will be available for adults of all ages, capturing customers living in their own homes as well as those leaving or potentially entering hospital. From January 2011, referral pathways into this service have been extended to community therapists and therapists within City Hospitals, therefore reducing the need for a social care assessment – this is particularly important to improve hospital discharges.

People can receive reablement at home services for up to 6 weeks (free of charge) and an assessment of their ongoing care and support needs will not take place until the necessary reablement interventions are completed.

4. Conclusion

4.1 The implementation of personalisation and the integral role reablement plays in the overall agenda continue to be taken forward to ensure that people are at the heart of their decision making in relation to meeting their care and support needs through tailored and personalised services.

4.2 Reablement provides an opportunity for people to learn or relearn skills that support daily living, benefitting people and their carers by improving independence and choice, partner organisations by supporting hospital discharges or stopping unnecessary admissions to hospital and the council by reducing need for ongoing care packages, which are costly with a view to spending this money on more preventative services.

5 Recommendation

5.1 Members are requested to receive this report as an update on progress to date and agree to receive a further update in 6-9 months.

6. Background Papers

6.1 Putting People First, 2007
Vision for Adult Social Care, 2010

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-HEALTH AND WELL-BEING SCRUTINY COMMITTEE

9th February 2011

POLICY REVIEW: MALNUTRITION IN HOSPITALS – FEEDBACK FROM HOSPITAL VISIT

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide a feedback report to the Scrutiny Committee following a visit to Sunderland Hospital as part of the review of malnutrition and dehydration in hospitals.

2. Background

2.1 The Scrutiny Committee has been pursuing a review of the management of malnutrition and dehydration in hospitals since September. The review was selected following national studies highlighting the risks in hospitals across the country.

2.2 The scope of the review is to study the evidence in City Hospitals Sunderland set against those national studies and best practice guidance.

3. Feedback from Visit

3.1 Members were invited to visit Sunderland Royal Hospital on Friday 21st January and view the arrival, preparation and serving of food to patients.

3.2 The hospital comprises 36 wards/patients feeding points of varying specialities and feeds about 1,000 patients per day.

3.3 The visit began in the Central Assembly and Distribution Unit. The purchase, food storage, assembly, and distribution of ready cooked frozen and chilled meals is undertaken from the unit on behalf of all hospitals within Sunderland.

3.4 Following a review in 1992 the Trust introduced a chilled meal assembly production method which would focus on the ward service and not food production. It was noted that many large hotel chains employ a similar system. The chilled meal assembly process means that food products are purchased directly from companies either frozen/chilled in hygienically sealed units. Purchasing is from mostly from local suppliers including local sources of fresh vegetables and meat and branded products are purchased.

3.5 All meals are assembled in insulated boxes, ready for distribution. The delivery of meals to wards is undertaken by catering staff. Insulated boxes are transported by refrigerated vehicles to drop off points at each location where catering personnel ensure correct distribution to each ward regeneration point. Chilled food is then placed into regeneration ovens/trolleys for the food to be heated to the correct temperature as close to the ward as possible.

3.6 At this point the responsibility transfers to ward staff. It is the responsibility of health care assistants to take the meal trolley and to serve meal to patients. Nursing staff provide individual help to patients if a need is indicated by a red serviette on the patient's food tray.

3.7 Members visited three different wards which were selected to provide a cross section of the needs of patients. The wards visited were C33 Head and Neck, E52 Care of the Elderly and D44 / D43 Trauma and Orthopaedics and the 12 noon food service delivery was observed. All wards operated Protected Meal Times.

3.8 It was highlighted that the needs of patients vary greatly across the wards at the Hospital. This may mean there are different arrangements for meal ordering, with a flexible system to account for other activities going on at the same time e.g. diagnostics.

3.9 The patient's named nurse is responsible for ensuring awareness of how much is eaten by the patient at meal times and throughout the day. This information can be relayed via the health care assistant or ward hostess. Supplementary drinks are used for patients who miss a meal. If a patient has not eaten their food then the nursing staff explore the reasons why and resolve any issues there may be. If a patient does not like the food they are offered then alternative choices are available from the catering department.

3.10 It was emphasised that the catering service can supply a meal at any time 24 hours a day and overall responsibility rests with ward managers. Although facilities are in place for a meal to be ordered outside of meal times, it was questioned if this was being utilised appropriately. It was acknowledged that in some instances this may rely on the patient being proactive and asking for help. Discussion was held regarding patients making sure that they asked for food if they needed it. It was noted that some patients have a tendency not to ask as they do not like to trouble busy staff. It was commented that there may be instances when staff could do more to ensure that patients know they can ask for different food or more food.

3.11 The lunch time menu on D43 and C33 was soup accompanied by sandwiches, (jacket potatoes with various fillings were available on request).

3.12 E52, the Care of the Elderly ward has recently reviewed meal provision and introduced a two course hot meal at lunch time and sandwiches/soup at tea time. This reflects the mealtime habits of older people in the community and seems popular with in-patients.

3.13 Liquid refreshments are offered seven times daily and all patients are supplied with a jug of water and a glass on admission (assuming their condition allows them to drink) and it is refilled twice daily and on request.

3.14 Patients who have delirium and dementia require additional support to tempt and reinforce their need to eat and the red serviette system was seen operating on ward E52 with patients receiving help to eat.

3.15 The Care of the Elderly Ward also operates a luncheon club for one day a week (being extended to daily) ensuring adequate nutrition is provided in a therapeutic environment. This appeared to be very popular and successful at encouraging patients to eat a meal. Staff and volunteers facilitate the club, and they are seen as integral to the patient's rehabilitation by promoting normality as they enable patients to sit at the table with others.

3.16 Homely crockery is used and the table is set with a table cloth, which seems more conducive to successful nutrition. Smaller portions are served and fish and chips were served on the day of the visit.

3.17 During this time social activities also take place, when the patients can either watch movies, play games or do some craft work. The lunch club on E52 has been running approximately two years and just recently received the Board of Governors Award at the Trust's Reward and Recognition Celebration in September 2010.

3.18 On wards D43 and D44, both Orthopaedic wards, the patients appeared to be happy with the choice of food on offer. On these wards all of the food was served and then staff would return to patients who might need assistance, using red serviettes.

3.19 Members visiting this ward also observed the Malnutrition Universal Screening Tool (MUST) on the computer system. MUST is used on wards to identify adults who are malnourished, at risk of malnutrition or obese. Patients are weighed when they are admitted to hospital and then on a weekly basis. Appropriate action will be taken dependent on the score from MUST.

3.20 As the needs of patients varies greatly across wards, staff commented that supervision by the Matron and Ward Manager is key to ensuring patients received adequate food and assistance.

3.21 The food that is ordered for the ward is estimated in advance by the staff (this may be a couple of days in advance). There was concern

over the extent to which patients were able to exercise a wide choice but it was highlighted again, that the provision was there to provide alternative food at the patient's request.

3.22 Members questioned whether relatives and friends could assist during meal times. They were informed that this would not be a problem and if relatives spoke to staff on the ward this could usually be accommodated. Members observed that this may not be common knowledge amongst patients or relatives that relatives are able to come in during meal times and provide assistance and encouragement to patients.

3.23 After the meal is served a questionnaire is given to patients regarding the food provided. The catering department issues an average of 100 questionnaires on a weekly basis. Feedback is collated monthly. If there is a complaint, the hostess would be able to address this at the time. The hostess does record the amount of wasted food but this does not show which patients have not been eating the food. This would be identified through MUST. The extent to which a patient's family would be included in the patient feedback was questioned as it was felt relatives may be more prepared to give an accurate assessment of the patient's eating and needs.

4. Conclusion

4.1 The assembly and distribution of such a large quantity of meals was an impressive operation. It was commented that there was a high quality of food provided. Certainly, the food sampled in the staff restaurant was tasty and nutritious. The staff who assisted with the visit ranging from the catering department to the ward staff were undoubtedly dedicated to providing the best nutritional support and they are to be congratulated on the service provided.

4.2 Aspects of the meals service which raised questions during the visit included:

a) The difference in operational standards from ward to ward and the extent to which patients have the full range of choice on the menu.
b) The extent to which patients are involved in the menu design linked to feedback surveys and best use of information from patient feedback.
c) The involvement of a patients' friends / relatives in supporting encouraging patients to take food and passing on information about patients
d) The availability of snacks / fruit and individualised meals and the extent to which patients ask for food or the patients staff offer.
e) Maintaining, monitoring and using data about malnourished patients.

5. Recommendation

5.1 The Committee is asked to receive this feedback report as part of the evidence for the policy review.

6. Background Papers

Health & Well Being Scrutiny Committee Reports

- Work Programme and Policy Review Report 9 June 2010
- Evidence from City Hospitals Sunderland 10 November 2010

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE 9th February 2011

POLICY REVIEW: MALNUTRITION IN HOSPITALS – CASE STUDIES FROM OTHER HOSPITALS

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide information to the Scrutiny Committee about examples of good practice as part of the review of malnutrition and dehydration in hospitals.

2. Background

2.1 The Scrutiny Committee has been pursuing a review of the management of malnutrition and dehydration in hospitals since September. The review was selected following national studies highlighting the risks in hospitals across the country.

2.2 The scope of the review is to study the evidence in City Hospitals Sunderland set against those national studies and best practice guidance.

3. National Inpatient Survey Results 2009

3.1 The in-patient survey of adult inpatients in NHS trusts in England shows how each trust scored for each question in the survey, compared with national average results. The report can be used to understand the trust's performance, and to identify areas where it needs to improve

National Results

3.2 Three questions are included in the survey about Choice of Food, Quality of Food and Help with Eating. Scores based on patients' responses to the survey highlight how each of the scores compares with other Trusts as either 'worse', 'about the same', or 'better'.

3.3 Of those respondents who had hospital food, a fifth (20%) rated it as "very good," no change from 2008 but an increase from 18% in 2002. Just over a third (35%) described the food as "good", a decrease of one percentage point since 2008; 30% of respondents thought it was "fair". There has been a statistically significant increase, of less than one percentage point, from 2008 in the proportion of respondents who rated the food as poor (14%).

3.4 Overall, 78% of respondents reported that they were "always" offered a choice of food, no change from the previous survey, while another 16%

said they were offered a choice “sometimes”. Six percent of respondents said they were not offered a choice of food. However, this question showed differences related to how long respondents had been in hospital for: 13% of respondents who only stayed overnight said they were not offered a choice of food compared with four percent of those who stayed more than one night.

4. Case Studies from other Hospitals

4.1 Hospitals receiving scores of better than average for one or more of the three questions were approached for their comments on how they thought they had achieved the better than average responses from patients. The comments received are set out below:

4.2 ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

Our production kitchen is vital to prepare, cook and serve fresh food on a daily basis. Food is procured locally and with regard to the sustainability and security of that future service it also ensures high nutrition content. 30% of all food is procured locally to the South East, mostly from farmers and the smaller business, this includes organic milk, local breads, free range chicken and seasonal vegetables.

All Food is cooked using fresh food, without the need for convenience foods. This enhances the taste and flavour of food and we also know the ingredients that go into our recipes and dishes. All patients, including those on special diets, are offered freshly cooked food, including patients who require special needs.

The Trust and Senior Management are very supportive to the Catering Department and the Trust policy is that food has a major contribution to the treatment and well being of the patients and staff. Experience shows that all patients enjoy their meals and we ensure that they are included in all discussions regarding the service and menus that we offer. We believe this contributes in reducing patient stress levels and improving the hospital experience.

The Catering Department has the complete responsibility for the catering patient meal service and the Catering Host and Hostesses are employed by the department to work at ward level. They give the menu to the patients as well as all meals and beverages. The food is a bulk food distribution via heated trolleys and served on the ward. This responsibility to the Catering Department ensures that all patients are fed and nourished which is supported by the red tray system.

Our menu is agreed with the dieticians and nursing staff and covers a three week cycle offering a continental breakfast and a three course lunch and supper. A cooked breakfast is offered on a Sunday. Patients enjoy a home made cake every afternoon keeping a British tradition alive. The recipes demonstrate what the majority prefer and importance

is given to providing a healthier food choice. The present cost of food per patient per day is currently at £4.20p

We meet the patients on each ward every other month in an informal meeting with the Dieticians, Domestic Services and Nursing Staff. These meetings are vital for us to get feedback on the positive and negative issues. This is also an opportunity to discuss our sustainable policy and other work we do to help the environment. One of these is our management of wastage keeping a daily record and sending all waste food for composting. Another is reducing our food mileage by reducing deliveries to the hospital to only three per week.

Main points are: listen to the patient, take into consideration their likes and dislikes, use local fresh food where possible, use seasonal vegetables and make food an integral part of the patient treatment.

4.3 ROYAL MARSDEN NHS FOUNDATION TRUST

There are a number of important factors, including:

- A pro-active management team
- A close working relationship between key staff groups, including Catering, Dieticians and Nursing
- The award of an in-house catering service, which ensures the Trust's direct control of service delivery
- Trust investment in catering infrastructure and staffing
- An emphasis on cooking from fresh ingredients (in combination with 'cook-chill')
- Preparation of food as close to the patient as possible (e.g. via ward-level 'finishing' kitchens)
- A high proportion of 'call order' meals (due to the nature of the Trust's patients)

4.4 ROYAL BERKSHIRE HOSPITAL

We currently operate a 14-day menu cycle providing 2 x three-course choice of meals at lunch and supper. This incorporates over 100 different choices in the 14-day period. Additionally, we provide cultural and religious diets: Halal, Afro-Caribbean and Kosher meals. These are not restricted and are open to all our patients if requested.

We also provide an extended patients' menu from the Trust Restaurant for our long-term patients (4 weeks +) with menu fatigue or patients who require encouragement to eat.

Furthermore, a photographic menu book is held by each ward for patients with communication difficulties, or patients who do not speak or read English as a first language.

All this information is provided daily via the patients' menu cards, patient information booklets and the Trust Intranet. Nursing / ward-based staff are kept informed of changes and updates through the Trust's Nutritional Champions Network and the Trust Intranet.

We monitor the menu choice uptake on a monthly basis and note the least popular dishes. These are then reviewed each quarter and amended accordingly. No new dish is introduced to the patients' menu cycle until it has been tested and approved by the Trust Dieticians, Speech and Language Therapist and a nursing representative.

We audit our patients regularly for quality, choice and service, and our latest two surveys show us to be consistently high in our patients' catering satisfaction.

At the Royal Berkshire NHS Foundation Trust we have an in-house catering operation providing a conventional plated / tray meal service. The Catering Department has some of the longest-serving members of the Trust staff, who are committed to delivering the best patient experience and to supporting a patient's recovery, whilst keeping within agreed financial parameters.

4.5 ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES

Menus

Due to the long-stay nature of our patients, the majority of our meals are freshly prepared and cooked on the premises (i.e. home made) using ingredients from a variety of local suppliers.

Our menus change every 18 months. Patients, Catering colleagues and Dieticians are asked for input to the menu choices.

The chosen menus are on a three week rolling programme (increasing to four weeks from 1st April 2011).

Currently these consist of;

Continental Breakfast	prepared by and provided at ward level
Lunch (main meal)	2 courses with 3 home made main meal choices or a sandwich meal Selection of vegetables or salad Hot and cold pudding choices
Supper	3 courses Home made soup Light snack pasties or pizzas or sandwiches Cold dessert such as yogurt, sweets, fruits.

Dietary

All Catering colleagues (Chefs and Catering Assistants) are trained by our Dieticians through a set programme of 1 hour courses in the common forms of dietary requirements (gluten intolerance; nut allergies etc).

Where possible we try to individualise special diets on a case by case basis by manipulating the standard menu to suit individual needs and tastes. This takes place after a consultation between Catering Manager and patient.

Ethnic dietary needs are catered for on an as and when required basis. This may involve a meeting between the Catering manager and the patient to ensure the patient's needs are met in full.

Textured and pureed patient requirements are catered for with the lunch time meal always being home made.

Hygiene standards

Workforce planning in the Catering department ensures that we have cover to prepare and cook the meals as well as the availability of individuals in charge of the cleaning rota of our catering unit and catering utilities such as trolleys and serving dishes. The RNHRD NHS FT Catering team have achieved the Public Protection Food Hygiene Award with merit for the fourth year running.

Patient feedback

Patient feedback forms a crucial part in determining our food and drink offerings to our patients. Feedback from patients is achieved at various times and levels;

- Catering manager walk round – once a month. To ensure direct and face to face contact and feedback from patients.
- Group sessions with Catering team and residential course patients (such as our one month residential courses for AS and Pain Management patients).
- Catering Manager meets with individual patients in cases of special dietary requirements to recognise food allergies and/or ethnicity requirements.
- All in-house patients have ready access to the 'Did you enjoy your meal' feedback folder in our Day room
- All patients are asked to complete the food section as part of our discharge procedure.

Food provision for patients, visitors and colleagues

'Walking' patients, visitors and colleagues are also able to enjoy their meal in our Basement dining room where the Servery opens with a

Breakfast bar at 7.30hr and an extensive lunch menu (including healthy options such as a salad bar) from 11.30hr to 14.00hr. Again the meals are home cooked and available at reduced prices.

4.6 EAST CHESHIRE NHS TRUST

Our actual scores were:

1. How would you rated the hospital food?
   Very good 36%
   Good 40%

2. Were you offered a choice of food?
   Yes always 81%
   Yes sometimes 14%

3. Did you get enough help from staff to eat your meals?
   Yes always 75%
   Yes sometimes 15%
   Did not need help 68%
   No 10%

Looking at a comparison of 2008 and 2009, it is clear to see that assistance with meals is where we have made the biggest improvement, as in 2008 we scored 58% for always and in 2009 it increased to 75%.

Here are some of the things we have done within East Cheshire NHS Trust which I feel have contributed to our result within the National Patient Survey.

LEAN Event
This LEAN event took place 5th November 2009 to explore the oral nutrition process and highlight what works well and which areas could be improved. Over 40 staff from all disciplines attended the event looking at four key areas, these being

- Menus
- Education
- Corporate Policy
- Mealtimes

A lead was nominated for each key area to support the individual projects identified for action within their area. Findings from the key areas were then fed back to complete the overall action plan. Persistence and encouragement were key, as the LEAN event was held over the winter period and the Trust was extremely busy.

All the actions from the LEAN event groups are fed into a nutrition action plan, which continues to be updated and reported back through

our patient meals group and clinical nutrition steering group on a bi-monthly basis.

Improvements continue and have included:

- Increased compliance from 30% - 70% (2008 – 2009) documented MUST screening. To increase compliance still further Key Performance Indicators have been set for the next three years. Results of MUST screening are shown prominently on the wards as part of the 'Knowing How You are Doing' display boards.

- Awareness 'Top Tips' nutrition newsletter for staff circulated. This includes useful information about nutritional needs for patients and update information about overall nutrition performance.

- Increased compliance with protected meal times and the usage of the red tray system.

- Volunteer mealtime helper service implemented.

- Better efficiencies with respect to the timely ordering of food for patients resulting in less wastage.

- Catering leads visit the wards regularly to speak to the patients about their experiences.

- Monthly data collected from services users by house keeper staff and nursing staff regarding assistance with meals. This area was added to the monthly patient perception survey to try and improve the scores relating to assistance at mealtimes. The regularly monthly feedback of performance to ward areas supported the other activities around nutrition and resulted in a clear improvement in results.

- Excellent networking experiences to appreciate other roles – e.g. menu card office / wards etc.

- Less repetition and more streamlining of the mealtime process.

- Raising staff awareness around nutrition, supplements etc.

I cannot emphasise enough how valuable the LEAN event was, particularly with regard to setting aside time for all key stakeholders to get together. This ensured an appreciation of how complex the service is and how important each person's role is to ensure appropriate nutrition is received by our patients. Although many of the issues were already being tackled, the LEAN event brought all those involved together to focus on common aims.

Our statutory and mandatory training within the Trust includes a section on Dignity and Respect. Ensuing patients receive appropriate nutrition and assistance is emphasised in this session.

In terms of the quality of the food this is provided by an external company (ISS) who provide the catering service to the Trust. Clearly a key element of our success is having a good partner in the provision of the service.

4.7 DERBY HOSPITALS NHS FOUNDATION TRUST

Regular surveys are undertaken by our contractor regarding the quality of the food and whilst they have good satisfaction rates (around 90%) we also review any other feedback through our staff reported incident forms and patient feedback both through Nutrition Steering Group and our Patient Experience Group. Each area is required to complete and report upon their action plan as a result of feed back and facilities fall into this.

We hold study days for all non medical staff involved in patient care and nutrition forms part of that day. We use patient stories to get staff to think about how it feels from a patient's perspective.

We have a balanced score card for wards and MUST completion is on this the compliance rate is set at 95% and this is reported to our Trust Board in the public part so the press pick up on it. We have recently re-launched the new MUST as whilst staff were very good at completing the tool they weren't always as thorough when it came to actioning medium or high scores so this is now incorporated into the tool.

The issue of knowledgeable/ trained staff is a constant cycle of delivering training which spans across all staff involved in nutrition. We are in the process of looking at an E-learning package.

We have protected mealtimes embedded across the organisation and as already described we have an effective reporting structure.

4.8 POOLE HOSPITAL NHS FOUNDATION TRUST

There are a number of factors which I believe have contributed to the consistently high scores for the Catering Service in the Trust.

The factors which I believe contribute to the success of Poole Hospital NHS Foundation Trust in the area of catering are as follows:

1. Provision of Service

The current Catering Service at Poole Hospital is an in-house service provided by a team managed and lead by directly employed individuals. This has not been because we took a deliberate view

about this, it has simply been that when benchmarked against alternative provisions the in-house option was both higher quality and significantly cheaper.

2. Leadership

The post of catering manager is filled by an exceptional individual who works really hard to ensure that all his staff deliver the best possible service no matter the aspect that they are involved in. This I s no mean feat given that a majority of catering staff are some of the lowest banded and paid staff in the Trust. The Manager has assembled a strong leadership team with a deputy who is able to step into his shoes and cover his absence. The ethos of quality, of excellence and a work commitment ensures that we are able to maintain a very high quality of service even when there are pressures in the hospital.

3. Production

The meals provided for patients and in the staff restaurant are prepared at the time in the hospital's kitchens and are not brought in or cook/chill or other alternatives to fresh provision. This, coupled with an attention to detail flagged later, ensures that food presented to patients and customers in the restaurant is of a very high standard and presented in the best possible way.

4. Source of Provisions

The team in the department work extremely hard to source both the most cost effective but also the highest quality of provisions. We as a Trust have toyed with the idea of handing over the purchasing of catering provisions to our Central Procurement Team but have always stepped back from that because of the expertise of the Catering Team themselves in knowing both local and national providers and also being able to judge the quality of products has been a significant factor both in negotiating the best deals but also ensuring that the products bought are of the best quality.

5. Attention to Detail

The Catering Team at all levels are pernickety about how food is both handled and presented ensuring that the final product is high quality and delivered in a timely condition. Meals are plated in the Catering Department and taken on heated trays to the wards where they are individually given to patients.

6. Partnership Working with the Nutrition Team

We have a Nutrition Team that meets regularly which includes the Catering Manager as a key member. This Team debates fully both the

nutritional value of the food that we give but also how to encourage patients with nutritional challenges to eat the food that is available.

7. Choice

Despite several projects looking at different options, we have stuck with a rolling menu choice based on a fixed menu over a three week cycle. In addition to this there is the flexibility of patients, through ward staff and directly with the Catering Team being able to adjust menus or obtain food and nutritional support out of the set meal times.

8. Protected Meal Times

We have introduced the national system of Protected Meal Times and been quite rigorous in our implementation of it, ensuring that for both patients and staff the times around meals are protected from unnecessary intrusion. This has worked well in ensuring that there is time to eat and to be helped to eat.

9. Culture

There is something that is a little nebulous around the culture of an organisation where staff eat in the restaurant, staff see and meet the Catering Manager and his Team and staff hear about lots of different events and things going on. Themed meal times etc add to an atmosphere in which people think and believe that the catering provision in the hospital is good, as indeed it is. That leads in a lot of cases to staff not only using the catering facility but recommending it to others and also talking up food when necessary with patients and relatives.

All of the above is my personal view as to why catering in our organisation achieves such excellent results. I do not think there is a magic formula but if I had to put one of the above at the top of the list it would be leadership provided by the Catering Manager.

5. Conclusion

5.1 Key issues emerge as:

- Good quality, fresh, local ingredients
- Including the views of patients in menu design and service delivery
- Close working and high levels of awareness of nutrition across staff groups
- Compliance with MUST screening and use of results

5.2 The Committee is asked to receive this progress report in relation to the contributions from other hospitals in the policy review.

6. Background Papers

Health & Well Being Scrutiny Committee Reports

- Work Programme and Policy Review Report 9 June 2010
- Evidence from City Hospitals Sunderland 10 November 2010

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE 9 February 2011

CfPS REGIONAL CONFERENCE FEEDBACK

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To receive feedback from delegates who attended a CfPS Regional Health Scrutiny event.

2. Background

2.1 As part of the Health Scrutiny Support Programme the CfPS offered a number of Regional Events to look at the challenges facing communities, local authorities and the NHS and how the unique powers of scrutiny can continue to make a difference to local people and services.

2.2 At the Scrutiny Committee meeting on 10 November 2010 members agreed to nominate delegates to attend the CfPS Regional Health Scrutiny event in York in January. Councillors Walker, Snowdon and Padgett attended from the Health & Well-Being Scrutiny Committee in addition to Councillor Tate.

3. Programme

3.1 The title of the event was 'Taking Scrutiny Forward in Times of Change'

3.2 As well as providing the latest position on the progress of the Health Bill, workshops were held on:

- Are we adequately prepared for an ageing society?

  Fiona Campbell, Consultant Policy and Practice, Research Associate Local Government Centre, University of Warwick, co-author of CfPS/LGID 'Ageing guides'.

- Respecting dignity – are we getting it right?

  Anna Gaughan, Anna Gaughan Consulting and co-sponsor of CfPS/LGID guide 'Walk a Mile in my Shoes'

- Reducing health inequalities: a scrutiny resource kit

  Su Turner, Principal Consultant CfPS/LGID

- Using the NHS Constitution as a benchmark for local services

  Sally Brearley, Chair Health Link and CfPS Regional Advocate for London and South East

4. Conclusion

Members are asked to receive and note the feedback from delegates.

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HEALTH & WELL-BEING SCRUTINY COMMITTEE

9th February 2011

FORWARD PLAN – KEY DECISIONS FOR THE 1 FEBRUARY – 31 MAY 2011 PERIOD

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of the Report

1.1 To provide Members with an opportunity to consider the Executive's Forward Plan for the period 1 February – 31 May 2011.

2. Background Information

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

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

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

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

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

3. Current Position

3.1 The relevant extract from the Forward Plan is attached.

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

4. Recommendations

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

5. Background Papers

Forward Plan 1 February – 31 May 2011

Contact Officer : Karen Brown, Scrutiny Officer
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Forward Plan - Key Decisions for the period 01/Feb/2011 to 31/May/2011

E Waugh,
Head of Law and Governance,
Sunderland City Council.

14 January 2011

Forward Plan: Key Decisions from - 01/Feb/2011 to 31/May/2011

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
01438	To agree the Social Care Contributions Policy for Personalisation	Cabinet	09/Mar/2011	Cabinet, Service Users and Ward Members, Portfolio Holders	Briefings and/or meetings with interested parties	via the Contact Officer by 21 February - Health and Wellbeing Scrutiny Committee	Report	Neil Revely	5661880

HEALTH & WELL-BEING SCRUTINY COMMITTEE 9th February 2011

ANNUAL WORK PROGRAMME 2010-11

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

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

2. Background

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

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

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

3. Current Position

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

3.2 A meeting of the North East Joint Health Scrutiny Committee was held on 14 January 2011. The Committee agreed the final report of the Health of the Ex-Service Community Review and a report is included elsewhere on the agenda.

3.3 As part of the Food in Hospitals review members visited Sunderland Hospital on 21 January and a report is included on this agenda giving more details.

3.4 At the scrutiny committee in January members were briefed on the Public Health White Paper, Healthy Lives, Healthy People: the strategy for public health in England and the two accompanying consultation papers on the outcomes framework and funding and commissioning. Since that meeting, Members have been invited to participate in a consultation workshop on 11 February to contribute to a response to the Public Health White Papers.

4. **Conclusion & Recommendation**

4.1 That Members note the updated work programme.

5. Background Papers
None

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

	JUNE 09.06.10	JULY 07.07.10	SEPTEMBER 15.09.10	OCTOBER 13.10.10	NOVEMBER 10.11.10	DECEMBER 08.12.10	JANUARY 12.01.11	FEBRUARY 09.02.11	MARCH 09.03.11	APRIL 06.04.11
Cabinet Referrals & Responses	Article 4: Food Law Enforcement Service Plan. (NJ)	CQC Service Inspection of Safeguarding Adults & Choice & Control for Older People	CQC Service Inspection – Action Plan Response to 'Tackling Health Inequalities in Sunderland' Review			Response to Health Inequalities / Home Care & Dementia Reviews				
Policy Review	Proposals for policy reviews (KJB) Ex-Service Personnel Review (KJB) Regional Health Protocol (KJB)	Scope of review – Malnutrition in Hospitals (KJB)	Appointment of Coopted Member Ex-Service Personnel Review Progress (KJB)		Evidence Gathering – City Hospitals Sunderland		Hungry to be Heard – Age Uk (AP) Service User Engagement	Feedback Hospital Visit Benchmarking other hospitals	Draft Report Ex-Service Personnel Review – Final Report	Final Report
Performance			Performance & VfM Annual Report (GK)			Performance Q2 (GK)				Performance Q3 (GK)
Scrutiny	Mid-Staffordshire NHS hospitals Foundation Trust – Francis Report (CH) Internal Service Development (CW) CfPS Conference attendance (KJB)	TeleCare Services (PF) Total Place (LC) Social Care for Adults with LD (JF)	CAMHS Review (PCT) NHS White Paper Consultation CfPS Annual Conference Feedback	Transforming Community Services NHS White Paper update Wearvmouth View Improvements	Regional CFPS attendance	Pride Project (IH/TR) PNA Consultation Out of Hours Provision (JU)	Public Health White Paper Child Poverty (RS) Cancer Drugs Fund	Young People's Sexual Health Personalised Care (inc Re-enablement/discharge) (SL)	NHS White Paper update Autism Strategy (SL)	Annual Report (KB) CQC (SS)
CCfA/Members items/Petitions								Feedback CfPS Conference		

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