SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 2) on Friday 14 September 2012 at 12.00noon

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

Contact: **Gillian Warnes, Principal Governance Services Officer** **Tel: 0191 561 1041**
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Information contained within this agenda can be made available in other languages and formats.

8.	**Public Health Update** Verbal Update	-
9.	**Sunderland Safeguarding Adults Board – Business Plan** Report of the Executive Director of Health, Housing and Adults Services (attached).	59
10.	**Topic for the next Development Session** Verbal report.	-
11.	**Welfare Reform Update** Report of the Executive Director of Commercial and Corporate Services (attached).	83
12.	**Any Other Business**	-
13.	**Date and Time of the Next Meeting** The next meeting will be held on Friday 16 November 2012 at 12.00noon.	

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

6 September 2012

Item No. 2

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD

Held in Committee Room 2, Sunderland Civic Centre on Tuesday 31 July 2012

MINUTES

Present: -

Councillor Paul Watson (Chair)	-	Sunderland City Council
Councillor Graeme Miller	-	Sunderland City Council
Councillor Pat Smith	-	Sunderland City Council
Councillor Mel Speding	-	Sunderland City Council
Councillor John Wiper	-	Sunderland City Council
Neil Revely	-	Executive Director, Health, Housing and Adult Services
Sue Winfield	-	Chair of Sunderland TPCT
Dr Ian Pattison	-	Sunderland Clinical Commissioning Group
Michael McNulty	-	Sunderland LINk

In Attendance:

Alan Patchett	-	Age UK
Eibhlin Inglesly	-	Carers' Association
Mike Lowthian	-	Sunderland LINk
Pam Lee	-	Sunderland TPCT
Jean Carter	-	Deputy Director, Health, Housing and Adult Services
Beverley Scanlon	-	Head of Commissioning and Change Management, Sunderland City Council
Sonia Tognarelli	-	Head of Financial Resources, Sunderland City Council
Sarah Reed	-	Assistant Chief Executive, Sunderland City Council
Vince Taylor	-	Head of Strategy, Policy and Performance Management, Sunderland City Council
Jane Hibberd	-	Head of Policy, People and Neighbourhoods, Sunderland City Council
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Warnes	-	Governance Services, Sunderland City Council

HW14. Apologies

Apologies for absence were received from Councillor Kelly, Ron Odunaiya, Keith Moore, Nonnie Crawford and Louise Robson.

HW15. Minutes

The minutes of the meeting held on 18 May 2012 were agreed as a correct record.

HW16. Clinical Commissioning Group Update

Dr Pattison reported that the Clinical Commissioning Group continued to make progress and he highlighted the importance of the 360º Stakeholder Survey. There had been a good response rate to the survey so far but the group were keen to make sure as many stakeholders as possible had completed the survey and would offer assistance where required.

The Local Medical Committee had agreed that the CCG constitution was acceptable and this would be presented to the group members this week. David Gallagher had been appointed as the Chief Officer and the CCG would now look to identify a Finance Officer.

A provisional date of 1 November 2012 had been given for the site visit as part of the move to full authorisation.

It was confirmed that the complete list of stakeholders was wider than the initial list on the 360º survey and that the deadline for responses was 3 August. David Robinson at the PCT was working to chase up any outstanding surveys.

Although there were a lack of partner organisations on the list of stakeholders, there was a great deal of partnership working going on behind the scenes to ensure an integrated approach with the CCG. The messages coming through to the CCG from partners were positive.

RESOLVED that the Clinical Commissioning Group update be noted.

HW17. Feedback from Advisory Boards

Adults Partnership Board

Councillor Miller reported that he had been elected Chair of the Adults Partnership Board. Nominations had been requested for the position of Vice Chair and these would be considered at the next meeting of the Board.

The main items considered by the Adults Partnership Board at its meeting on 10 July 2012 had been: -

- Sunderland Initial Response Team
- Suicide Action Plan
- Personalisation – Update
- Health and Wellbeing Board – Agenda
- 50+ Strategy and Age Friendly City
- Autism Strategy – Verbal Update
- Local Accounts
- Plain Packaging for Tobacco

With regard to the 50+ Strategy, Neil Revely stated that the importance of getting partners involved in the process was recognised and once the timeframe was in order, the broader partnerships would be asked to take responsibility for what had been agreed by the Sunderland Partnership.

Members queried the information on the Sunderland Initial Response Team and asked for clarification on the type of referrals which had reduced waiting times. The referral time of under one hour was in relation to the time it took to allocate the initial call, however the next part of the process, which was to identify the correct service for the patient, and the time it took, was an area for concern. Dr Pattison was picking up these concerns through the CCG and Neil Revely advised that Council officers had regular meetings with Northumberland and Tyne and Wear Mental Health Trust to discuss any issues of concern.

The Board were reminded that the consultation on plain packaging for tobacco ended on 10 August. Karen Graham advised that a response was being drafted on the Health and Wellbeing Board's behalf.

Children's Trust

Councillor Smith stated that the Children's Trust had welcomed Jan van Wagtendonk to the Trust as an observer and reported that the main agenda items considered by the Trust at its meeting on 12 July 2012 had been: -

- Health and Wellbeing Board update
- Consultation on revised safeguarding guidance
- Sunderland Safeguarding Children Board
- YOS Plan
- Health Visitor Review

Councillor Smith also advised that the Sunderland Youth Parliament had been meeting with the local Police at Gilbridge station and were very enthusiastic about their joint working going forward.

RESOLVED that the information be noted.

HW18. Public Health Transition Update

Funding Formula

Sonia Tognarelli delivered a presentation on the funding for public health when the local authority took responsibility in April 2013.

The funding would be a ring fenced grant and the Advisory Committee on Resource Allocation was developing proposals for the funding formula which were out for consultation. The main proposals from the Committee were that the allocations should be based on population and Standardised Mortality Rate.

From 2015/2016, local authorities would receive a single grant to prioritise locally which would be built up from two components; a mandated services allowances and a health premium.

The main issues in the consultation which had been identified by the local authority were as follows: -

General

- Significant impact on deprived areas/unintended consequences
- Basis of quantum proposed to be distributed to local authorities flawed
- Formula allocation thereafter flawed
- North East hardest hit – double impact – quantum and formula
- Funding protection – 2013/2014 and 2014/2015 – important given CSR reductions
- DoH approach to pace of change need to ensure earlier agreements met
- Strategic discussion about national total – investment in public health
- Current spend reflects need and improved outcomes can be demonstrated

Local/Regional Impact

- North East share of baseline is £177.6m
- Sunderland current baseline is £19.468m
- North East potential share of future allocation = £124.0m (30% reduction)
- Potential losses for 10 of 12 councils in North East (between 21% and 46%)
- Sunderland potential circa £31% loss of £5.860m 2014/2015

Sonia highlighted that Sunderland were high spenders on public health by choice and this was reflected in the improved outcomes which had been achieved for the population.

Responses to the consultation were required by the Department of Health by 14 August and Councils would be submitting individual responses as well as collectively though ANEC. The NHS would also respond and political lobbying would be carried out through MPs. In the meantime there was a need to review existing contracts to consider prioritisation and work with the CCG to better meet health needs and to manage within a significantly reduced funding envelope.

The Chair noted that he had raised this issue with a Minister who had indicated that because the North East did spend more on Public Health, then the cut was likely to

be greater. Neil Revely added that this would be more understandable if there had previously been a national arrangement, but it had been for the PCTs to determine how their money was allocated.

The Board felt that they had a clear understanding of the arguments which needed to be put forward and that these were not merely technical or financial issues but were overarching factors for the whole of Public Health.

RESOLVED that the presentation and proposed response to the consultation be noted.

Proposals for Delivering Public Health Services currently shared across Gateshead, South Tyneside and Sunderland

Pam Lee introduced a report describing the public health functions which were currently delivered across the three South of Tyne and Wear districts through a 'shared services' agreement.

The 'shared services' include:

- Health Protection
- Emergency preparedness
- Healthcare advice and epidemiology
- Public Health Primary care support
- Health improvement information and resources.

The Board was asked to support in principle arrangements for these functions during 2013/2014 and during this time, local authorities working with the CCG and other partners would be able to consider how and if the shared services would be delivered after April 2014.

It was confirmed that the relevant posts would be paid for through the PCT budget, with the proportions being included within the £19m being passported from the PCT to the local authority. The liability for each employee would also be transferred.

There were queries raised as to why the position with these arrangements was not being reviewed during the current financial year and Sarah Reed highlighted that because of the changes in Public Health, the focus was very much on what was currently being commissioned and how this would be done alongside the CCG. It was recognised that a year was a long time, but this would allow the focus to be on the core business of Public Health in the initial stage. Pam highlighted that the posts would be under review from 1 April 2013 so it was not a long term issue.

Neil Revely cautioned against creating a longer period of instability and that if the positions could be reviewed during 2012/2013, then this should be done.

Accordingly the Board RESOLVED that: -

(i) the Board support in principle, that Sunderland City Council continue to hold the Information and Intelligence Function , possibly located in the North East Commissioning Services with a SLA detailing the support available to local authorities, CCGs and NECS;

(ii) the Board support, in principle, that Gateshead Council continue to host the Public Health Primary Care Support Post working across Gateshead, South Tyneside and Sunderland during 2013/2014; and

(iii) the Board support, in principle, that South Tyneside Council continue to host the Public Health Improvement Information Team working across Gateshead, South Tyneside and Sunderland during 2013/2014.

HW19. Strengthening Families

Jane Hibberd presented a report providing the Board with an update on the approach to Strengthening Families in Sunderland.

The Government had launched the payment by results 'Troubled Families' initiative in December 2011 and Sunderland had renamed this as the Family Focus project. This was an opportunity to look at the way in which the Council worked with families and a multi agency Board had been established to lead on this work. An inclusive definition of family had been developed and the strategic principles underpinning the approach were:

- Early intervention and prevention
- Building capacity and reducing dependence
- Asset based approach
- Whole systems thinking – whole family, whole life, whole community
- Responsive local services and publicly valued outcomes
- Multi agency and integrated working

It was intended to produce the Strengthening Families Strategy through a partnership approach and the vision of the strategy will also be presented to the Health and Wellbeing Board.

Details of how the Family Focus Project and how the payment by results would work were attached to the report. The Strengthening Families Board and working group would continue to develop the Family Focus Project and Strategy and a draft service delivery model for the project was to be developed by September with a view to the Family Focus project being piloted in the autumn.

It was commented that the outline service delivery model did not mention the voluntary sector and it was queried if they were involved. Jane advised that the voluntary sector were involved in both the Board and the working group and one key organisation which was working on the project was the Foundation of Light. It was acknowledged that families would be more accepting of voluntary sector organisations and this would be important in developing the service delivery model and key workers.

The Strengthening Families Board was chaired by Councillor Smith and the membership included the Executive Directors of Children's Services and Health, Housing and Adults Services, the Assistant Chief Executive, representatives from Health, Gentoo, JobCentre Plus, Probation, Police, the voluntary sector and schools.

RESOLVED that the contents of the report be noted.

HW20. Health and Social Care Systems Diagnostic

Neil Revely introduced a report outlining the latest developments with regard to the NHS Institute diagnostic.

The full report had been published in early June and circulated to the Health and Wellbeing Board and partners who were involved in the review. A session had been held on 21 June to launch the report and Neil advised that he had met separately with the Chief Executive of the South Tyneside Foundation Trust as the Trust had not been present at the launch event.

There had been a positive discussion at the event and partners' views were coalescing around a common outcome but they had been frustrated about how this would be achieved. A number of recommendations were considered by those present and proposed actions to address them identified. The actions were outlined within the report. It was also proposed that a second workshop session be held to further develop the actions.

The Board therefore: -

RESOLVED that: - (i) a second session be held to consider the way forward for implementing the recommendations in the Diagnostic report: and

(ii) the proposed actions detailed within the report be agreed.

HW21. Health and Wellbeing Strategy Update

Vince Taylor presented a report updating the Board on the process and timetable for the development of the Health and Wellbeing Strategy.

The Health and Wellbeing Strategy was to be completed by October 2012 and had been developed in the context of the changing environment within which the local authority and its partners were now working. Two further engagement sessions had been held at the Stadium of Light since the last meeting of the Board and attendees had given their views on the vision, aims and priorities and how to use assets to change service delivery and empower communities. These views had been incorporated into the latest version of the outline strategy which was attached as

Annex 1 to the report. The next engagement event was scheduled to be held on Friday 10 August at the Stadium.

The following six strategic objectives had developed from work with the Board and partners: -

1. Mutual understanding between communities and organisations
2. Ensure that children and young people have the best start in life
3. Supporting and motivating everyone to take responsibility for their health and that of others
4. Supporting everyone to contribute
5. Supporting people with long term conditions and their carers
6. Supporting individuals and their families to recover from ill health and crisis.

It was considered that these six objectives were now the right ones to develop action plans underneath and the plans would come to the Health and Wellbeing Board for decision and direction.

RESOLVED that the Strategy development process and progress made be noted.

HW22. National Learning Sets

The Board received an update on the publication of the findings from the National Learning Sets for Health and Wellbeing Boards.

The findings of the learning sets had been condensed into a number of products and had been formally launched at the NHS Confederation conference in June. The products summarise each learning set's key points of learning and were designed to provide useful points of reference for shadow Health and Wellbeing Boards. It was suggested that they should be used for the development of the Board, the Health and Wellbeing Strategy and also for the Adults Partnership Board and the Children's Trust.

The final report of the learning set on 'Making Best Use of Collective Resources' was provided for the Board and this would be considered alongside other learning sets and the recommendations integrated with those from the NHS Institute diagnostic tool. It was then proposed that an action plan be developed with responsibilities shared between the Heath and Wellbeing Board and the Adults Partnership Board and Children's Trust.

Michael McNulty highlighted that one issue arising from the action learning sets had been how to hardwire public and patient involvements and that this should be part of the role of the members of the Health and Wellbeing Board. Achieving this at the beginning of the Board's development augured well for the future.

RESOLVED that: - (i) the content of the report be noted; and

(ii) the development of action plan bringing together actions from the learning sets and NHS Institute report be agreed.

HW23. Board Development Session

The next Board Development Session was to be based around influence and relationships and decision making. It was scheduled to take place on Thursday 30 August 2012 at 10.00am, however as this was during the summer holiday period, members would be contacted to ascertain if they were able to attend before the arrangements were finalised. If it was not worthwhile going ahead with the session in August then it would be re-arranged for September 2012.

RESOLVED that the information be noted.

HW24. Public Health England

This item was deferred to the next meeting.

HW25. 'Caring for our Future: Reforming Care and Support' White Paper

Neil Revely presented a briefing on the White Paper, published in July 2012 on 'Caring for our Future: Reforming Care and Support'.

The White Paper was published together with the draft Care and Support Bill which aimed to create a single law for adult care and support, replacing more than a dozen different pieces of legislation. The two core principles of the White Paper were on promoting people's wellbeing and independence and for people to be in control of their own care and support. It was noted that these principles were in line with how the Council had already been operating and Neil outlined the main themes of the White Paper as listed below and also described the context within Sunderland: -

- Strengthening support within communities
- Early intervention and prevention
- Housing
- Better information and advice
- Assessment, eligibility and portability for people who use care services
- Carers' support
- Defining high quality care and improving quality
- Keeping people safe
- Expanding the care market
- Workforce
- Personalised care and support
- Integration

There were no real surprises within the paper and direction of travel would assist Sunderland with the journey it had already established. The Board would receive further updates in relation to the White Paper in due course.

RESOLVED that the content of the report be noted.

HW26. Other Business

There was no other business.

HW27. Date and Time of Next Meeting

The next meeting will be held on Friday 14 September 2012 at 12.00noon in Committee Room 1, Sunderland Civic Centre.

Item No. 3a

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **14 September 2012**

SUNDERLAND ADULTS PARTNERSHIP BOARD - 28 August 2012

ITEM

3 Matters Arising

- **Licensing update (from Alcohol prevention event)**

An update on the Government's intentions to introduce a minimum unit price (MUP) for alcohol, to highlight the next steps for this work and to seek support from partners to participate in consultation on minimum unit pricing.

As part of the Police Reform and Social Responsibility Act 2011 the Government made provision for two new powers to be used as part of the revised Licensing Act 2003. These powers are to be used to tackle problems associated with the night time economy and are a 'late night levy' (LNL) and 'early morning restriction orders' (EMROs). Both powers will be available from October 2012 due to the need for local consultation prior to their introduction, it is not anticipated EMROs will be in use before March 2013 and June 2013 for the Late Night Levy.

4 Vice Chair Election

Due to need of clarification on the Boards membership, the vice chair elections have been postponed to the next meeting.

5 White Paper 'Caring for the Future'

The White Paper 'Caring for our future: reforming care and support' sets out the vision for a reformed care and support system. There are two core principles underpinning the vision of social care and support presented in the White Paper:
1) focus of care and support will be on promoting people's wellbeing and independence instead of waiting for people to reach a crisis point;
2) People should be in control of their own care and support.
Age UK noted that the importance of advocacy support (which would complement choice)
Voice for Carers and Neil Revely to look into involvement/ contribution to the national Carer & Support Transformation Groups.

6 Working Group Update

- **Forward Planning**
- **50+ Working Group**

The Forward Planning meeting has been scheduled for 12.30 – 13.30 on 4th September.
50+ working group - focused workshops will be organised from end Sept - end Oct along the themes of the WHO Age Friendly City criteria.

7 Local Accounts

Update to the board on the development of local accounts to measure adult social care. The document for review/ comments was distributed at the meeting. Members of the group to provide feedback on the proposal to Mike Lowe by 7th September.

8 Carers Strategy Update

The Carers strategy is now being put out for formal consultation and is planned to be brought to the October Adults Board for approval.

11 AOB

Eibhil Inglesby will represent voice for Carers.
Dr Valerie Taylor will represent (alternating with Dr Ford) the Medical Committee

Item No. 3b

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **14 September 2012**

CHILDREN'S TRUST

The last meeting of the Children's Trust took place on 12 July 2012 and the issues were reported by the Lead Member for Children's Services to the Health and Wellbeing Board of 31 July 2012. The next meeting of the Children's Trust took place on 13 September 2012 and noted below is the agenda and brief comment relating to each item

CHILDREN'S TRUST

Meeting to be held in the Civic Centre (Committee Room No. 1) on Thursday 13 September 2012 at 2.00 pm

ITEM PAGE

1. **Declarations of Interest**

2. **Apologies for Absence**

3. **Minutes of Meeting held on 18 October 2011**

4. **Matters Arising**

5. **Health and Well-being Board Update (Beverley Scanlon)**

   Health Visitor Review (Sandra Mitchell/Beverley Scanlon) – the outcomes from the review undertaken on behalf of the Health and Well-being Board into the current arrangements for health visiting and to consider how the future service might look. The report will be formally submitted to the Health and Well-being Board meeting on 16 November.

6. **Presentation: Welfare Reform Act**
   Christine Caine (Job Centre Plus) / Fiona Brown (SCC) – to provide the Children's Trust with an update for the Trust on the work the Council and Job Centre Plus are involved in planning for the implementation and impact of the Welfare Reform Act

7. **Sunderland Safeguarding Children Board – Verbal Update (Meg Boustead) –** this is a regular report received by the Children's Trust which provides an update on the work of the SSCB.

8. **Provisional Exam Results 2012**
(Mike Foster) - to provide Children's Trust with information on the very positive performance of Sunderland pupils in statutory Key Stage assessments and Early Years Foundation Stage Profile in 2012.

9. **Child Sexual Exploitation**
(Meg Boustead) – following recent national coverage in relation to sexual exploitation, this report will set out the work and progress of both the regional strategic and operational groups who meet in relation to sexual exploitation, the self assessment and the development of a regional action plan. There would also be reports presented to the SSCB, Adult Safeguarding Board and Safer Sunderland Partnership

10. **Children's Trust Advisor Network Update**
(Jane Wheeler) - To inform the Children's Trust of the progress of the recently reformed and renamed Children's Trust Advisory Network (CTAN), which is a consultation group established by the Children's Trust to ensure that the views and voices of children and young people in Sunderland are heard and taken into account when services are designed and delivered.

The next meeting of the Children's Trust is scheduled to take place on Thursday 1 November 2012, 2.00 – 4.00 pm, Civic Centre Committee Room 2

Item No. 5

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **14 September 2012**

ACCELERATING THE BIGGER PICTURE - DISCUSSION DOCUMENT

SEPTEMBER 2012

Introduction

The purpose of this paper is to share with members of the Health and Wellbeing Board a discussion document on the 'Accelerating the Bigger Picture' (ABP) programme of work.

Background & Purpose

ABP was setup with the aim of ensuring that we create a system where residents across South of Tyne and Wear (Gateshead, South Tyneside & Sunderland) and beyond will have access to the best healthcare available.

Bigger Picture is fundamentally a collaborative process, with the three Foundation Trusts (Gateshead Health NHS FT, South Tyneside NHS FT and City Hospitals Sunderland NHS FT) and NHS South of Tyne and Wear being equal partners, working towards a shared vision of how services may look in the future.

By utilising the strengths of each organisation the aim is to balance healthcare provision across South of Tyne and Wear, thereby using all of our resources most effectively to create sustainable quality services for the future. Through this approach, the aim is to ensure that hospital services continue successfully in each of the three localities.

Discussion Document

You will see from reading this document that work has started in some areas, but not all. The work so far has started to shape how things may look in the future and what this means for each hospital in practice.

The document highlights a high level, strategic vision for the future and what this means for each of the Foundation Trusts and aims to help to paint the picture so far, so staff working in each organisation and key stakeholders can continue to contribute to the process.

Engagement Events

A series of engagement events are being held across South of Tyne and Wear, in each of the local hospitals, with Clinical Commissioning Groups and local Health and Wellbeing Boards.

The purpose of the events is to information share with staff and stakeholders and to understand where further partnership working may be required and how the ABP strategy can link in with the strategy of partner agencies.

Conclusion

The discussion document is there to inform and help facilitate discussion with key stakeholders, and members of the HWB are invited to contribute to this process.

Appendix

ACCELERATING THE "BIGGER PICTURE" – THE WAY FORWARD

A DISCUSSION DOCUMENT

NHS South of Tyne and Wear

CONTENTS

Working Together

Within the South of Tyne and Wear (SOTW) area there has always been a strong track record of partnership working, clinical networks and a general willingness to engage with each other to help overcome the many challenges that arise when working within the NHS.

Building on this history of working together, each of the three Foundation Trusts, Gateshead Health Foundation Trust (GHFT), South Tyneside Foundation Trust (STFT) and City Hospitals Sunderland Foundation Trust (CHSFT) and NHS SOTW agreed to work together on a much wider and bigger scale than previously attempted; this work is known as “The Bigger Picture”.

The Case for Change

Back in 2008, the Strategic Health Authority (SHA) published ‘Our Vision, Our Future’. Before publishing the strategy the SHA reviewed a number of distinct elements, including work undertaken by eight clinical pathway groups each looking at a major area of NHS care with input from over 300 of the north east’s leading doctors, nurses and other clinical staff; therefore clinical engagement and, in particular, the views of clinicians who participated in the clinical pathway groups, were central to the strategy.

The SHA stated:

‘Our vision sets out an agenda for putting the patient at the heart of everything we do and, through a new sense of common purpose, describes systematically how we intend to transform services for the benefit of both patients and our 74,000 staff.

We know that some of the improvements we describe are complex and will take time. Change is always difficult and it is essential that we proceed at the right pace so that everyone affected has the chance to be involved and have their say so we get things right. This includes patients, staff and our partners.’

They also concluded that:

1. We have the worst health in England.
2. Our population both requires and makes more use of hospitals than any other part of England.
3. Our dependence on hospitals limits the resources we have to do more in preventing poor health and we have to do more for patients who have long term problems.

‘These three features we call the cycle of missed opportunities and we must change the way we do things to break this cycle.’

The document provided a high level view of the entire health economy, and described some of the unique issues facing the NHS in the North East. Locally, within SOTW there are a number of additional pressures or drivers for change, which are particularly relevant to acute Trusts and these are highlighted below.

Local Sustainability

Across the three hospitals there are a number of clinical specialties where each organisation may have only one or two consultants or other specialists providing certain services. This poses obvious problems in relation to sustainability, for example covering the service as soon as the consultants take annual leave, go on external courses, or if they were sick for any period of time. Small departments are sometimes not that attractive in terms of recruiting new consultants and are therefore continuously running services which only just keep going and which require large amounts of energy and resources to sustain.

Critical Mass

There are publications from Royal Colleges, the Department of Health and other bodies in relation to population figures for certain specialties. This guidance is for patient safety, to ensure that when a doctor is treating a patient he or she has enough experience to treat complex conditions. Research shows that something is more likely to go wrong when a patient is treated in a unit where the doctors are not seeing sufficient volumes of certain types of conditions.

It is different for different specialties, but across the three sites there are some specialties, or individual doctors, which don't treat certain conditions frequently enough to maintain their skills (according to published guidance) for certain procedures.

Some of these are discussed later, for example Vascular Surgery, where guidance is suggesting further centralisation based on population figures and minimum numbers of certain operations.

Quality Standards

Similar to critical mass, over the coming years the NHS will have to achieve numerous quality standards with, for example, the National Institute for Clinical Excellence (NICE) expected to release 150 standards over the next few years. This is good news for patients, as previous quality standards have saved lives across a range of areas.

Commissioning for Quality and Innovation (CQUIN) has been introduced into standard contracts over recent years, and if applied appropriately do set challenging targets each year to improve services.

However, to meet some of these standards hospitals will be required to make significant investments, whether that is new technology, new ways of working or more doctors and nurses. For example, it is expected that hospitals will have to increase the number of senior doctors present at weekends in hospitals as it is a fact that people admitted on a weekend on average have a poorer outcome than those admitted during the week. Other standards exist for example in maternity, where again it is expected that consultants will be required to be present on the delivery suite overnight and on weekends, as again evidence shows outcomes for women are poorer when consultants are not physically present.

For some specialties there are simply not enough senior doctors available for every hospital to implement these standards. For some hospitals the number of patients (depending on the specialty) can be very few, so there could be occasion where there are senior doctors available but no patients in that part of the system to treat.

Workforce

As highlighted earlier, recruitment to small teams can often be a problem. Newly qualified consultants will often want to work in a large team, which will offer them a number of opportunities to experience the wide ranging aspects of their chosen discipline. Also, issues such as onerous and unsustainable on-call rotas are unattractive for a consultant to work on. For example in a small hospital a consultant may have to be on-call 1 week in every 4 or 5, whereas in a larger unit this is more likely to be 1 week in 6-8 or even more. These are important work-life balance issues that the workforce will increasingly consider when choosing where they will work. This document describes some of the work already undertaken in relation in stroke and breast services, which are two specialties that have small numbers of consultants across the three hospitals in SoTW.

Other changes to workforce rules and regulations are also putting pressure onto the local system. The introduction of the European Working Time Directive (EWTD) meant additional costs and cover arrangement had to be found when junior doctors reduced their working hours. The restrictions on overseas recruitment provides further pressure as this has often been used, in the past, as a way of covering gaps in rotas. With the expectation that training numbers will be reduced over the coming years, all of these taken together, point to a genuine problem facing all the local hospitals.

Care Closer To Home

The national strategy for the NHS is one of prevention and, wherever possible, trying to keep patients out of hospital. Though there has been mixed success in this area nationally, it is undoubtedly the direction of travel for future years and if successful will have a major impact on hospitals.

Partners in primary care and social care will continue to drive this agenda forward and there are many opportunities to improve upon the existing care pathways, allowing patients to be treated safely in their own environment.

The “patient choice” policy also poses challenges with respect to care closer to home. Across SOTW there are patients who choose to, or are signposted/advised, to have their treatment away from their local hospital, even when the service is available locally. This is completely in line with government policy and all of the FTs support “patient choice”. However, there are certain specialties (and these are different for each FT) where each Trust wishes to work with local commissioners to understand referral patterns and patient decision-making in greater detail.

Each organisation understandably wants to understand why either GPs refer or patient themselves choose alternative hospitals when local services exist. If these issues relate to quality or safety, then each FT will work with commissioners to address these concerns, to ensure patients and GPs have the confidence to use local services.

There are also other specialties, which are only provided by the tertiary hospitals, where there is great potential for outpatient clinics and even daycase work to be provided in each locality, again meaning patients have to travel less.

The ultimate aim of this work would be to attract back local residents into local services (regardless of the provider). There are no financial issues for the wider health system as commissioners are currently paying for this activity and it would provide further financial sustainability for local hospitals going forward.

Financial

Even though the NHS has been comparatively protected in terms of government spending, the financial challenge facing the NHS is huge. Billions of pounds need to be saved over the coming years, so it can be reinvested into areas such as care closer to home, new treatments, new drugs and technological advances and the changing demographics of the area.

The DH launched Quality, Innovation, Productivity and Prevention (QIPP) 2-3 years ago and this agenda remains very live across all healthcare sectors and is something colleagues in the CCGs will be taking forward.

Simple year-on-year cost cutting will not achieve the required savings and may lead to patient safety issues if each hospital across SOTW continues to try and provide all the services they currently offer on their own.

What Does This Mean For Our Local Hospitals?

The multiple challenges described above set the scene for the “Bigger Picture” work in SOTW. The collaborative and “Bigger Picture” thinking was setup to look at service integration across the three Foundation Trusts, so that we could genuinely improve the services each hospital currently offers to local people.

“Bigger Picture” is fundamentally a collaborative process, with all organisations being equal partners, working towards a shared vision of how services may look in the future. One thing is certain, if the organisations don’t work together then some services may fail and we will begin to put patients at risk. This work is designed to do the opposite; the aim is to strengthen and improve the services we offer to our patients by building on the different strengths of each partner; we want to create a system where residents across SOTW and beyond will have access to the best healthcare available.

By utilising the strengths of each organisation the aim is to balance healthcare provision across SOTW thereby using all of our resources most effectively to create sustainable quality services for the future. This will mean that one organisation may stop providing some services but provide others; in short, for each of the FTs, there needs to be “a give” and “a get”. Through this approach, the aim is to ensure that hospital services continue successfully in each of the three localities.

You will see from reading this document that work has started in some areas, but not all. The work so far has started to shape how things may look in the future and what this means for each hospital in practice.

The programme is starting to gather momentum and more areas may be affected in the future; this document aims to help to paint the picture so far, so staff working in each organisation and other key stakeholders can continue to contribute to the process.

Vision - What Could the Future Look Like – A View From the CEs

At a time of unprecedented uncertainty and financial pressures across the NHS, the Foundation Trusts and Commissioners across South of Tyne have agreed to set out in one overarching document the future state we believe gives us all the best chance of delivering sustainable quality, and finance.

We agreed that having three primarily acute hospitals is no longer viable going forward so each of the three faces a different future.

For South Tyneside Foundation Trust the future focus will be on delivering world class diagnostic, screening, rehabilitation and out of hospital services for the whole of South of Tyne & Wear and possibly beyond. It will be the prime contractor for these services working together with other Foundation Trusts, Local Authorities and Primary Care.

Within South Tyneside itself local hospital services will move away from complex unplanned surgical care which will be provided as part of wider clinical networks together with other complex care pathways. The population will continue to have local access to emergency medical services including elderly and end of life care supported by the new emergency and assessment centre facilities for adults and children.

For Gateshead, its main surgical focus will be on providing capacity for non-specialist elective activity across the South of Tyne, using the Treatment Centre as a commercial hub to handle high volume contracts for low complexity surgery. It will retain its status as a Cancer Centre for Gynaecology Oncology and will increasingly develop a Breast Cancer Service, and continue to provide and develop a range of national screening services. Gateshead residents will have local access to a full range of emergency medical services, including Elderly Care and Old Age Psychiatry, A&E Services – enhanced by a brand new development locally and supplemented by more same day assessment facilities.

For City Hospitals, its focus will be on becoming the third specialist Centre (or main hub) across the North East and it will increasingly specialise in the more complex/specialised services, both elective and non elective. More complex Colorectal, Vascular and Stroke services will start the beginning of a Cardiovascular, Renal and Metabolic Service being developed to work alongside Primary Care. Its focus as a Trauma Unit will be supplemented by a world class Critical Care unit and it will offer complex diagnostics (a full interventional radiology service for example). Local access to emergency medical services will also be available complimented by a brand new A&E department and admission pathway(s).

CHS will continue to enhance and expand its Medical Education role through its responsibility as the hub for the Wear based (Sunderland, South Tyneside and Durham) educational unit.

An overall model of 'hub and spoke' where relevant would make sure that local access is preserved where justified and by prime contracting it will be clear to commissioners where the overall responsibility and governance for service delivery lies against contract. Discussions about tariff sharing will also be handled primarily at provider level. All of the above relates to clinical services, but back of office functions are similarly being reviewed and it is anticipated that these functions (service by service) will be led by one of the Foundation Trusts as agreed.

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Reconfiguration Test

You will see from reading this document, that the actual or proposed scale of change is different depending on the area, with some describing the creation of more formal networks, whilst others describe more fundamental changes, such as altering clinical pathways or service provision.

In 2010, the Secretary of State identified four key tests for service change, which are designed to build confidence within the service, with patients and communities. The tests were set out in the revised Operating Framework for 2010-11 (and still apply now) and require existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice

These tests will be applied where relevant and have already been used in areas such as Paediatrics. However, the application of the tests will be different in different areas. For example, the creation of a formal stroke network covering all three sites did not go out to formal public consultation but did have patient engagement during the clinical workshops, whereas, given the significant changes proposed in relation to Paediatrics, this went to full public consultation.

The important point to note is that when proposed changes are outlined and examined the above tests need to be considered and acted upon in the appropriate way, but this may be different for different areas.

Progress to Date – What Has Been Achieved So Far

A number of areas were initially looked at, with some not progressing past an early scoping phase, whilst others went further as they appeared that they faced a number of the 'case for change' challenges described above. Below are the areas that have been taken forward to date.

Paediatrics

Advances in paediatric medicine mean that serious childhood illnesses are very rare and children and young people seldom have to stay in hospital overnight. However, children and young people suffer from more chronic illness now than in the past; for example, conditions like asthma and diabetes. These types of childhood illness can be managed safely and more appropriately in the child's own home with support from healthcare staff. It is often the case that children attend hospital when they could have been treated closer to home by their own general practitioner (GP) or in a walk-in service – for example, children with gastroenteritis.

What's more, some of these children are admitted overnight when their medical needs could actually have been resolved without a hospital stay. We know that unnecessary admissions can disrupt family life and children's education. Last year, more than 12,000 children and young people were admitted to local hospitals. Many of them could have been managed in the community.

At the moment, children and young people who need an overnight stay can use services in Gateshead, Sunderland or South Tyneside. Spreading the paediatric expertise across the region in this way means that we are unable to provide the very high level of care we believe is required. Smaller units are not able to employ a wide range of paediatric staff and some experience difficulty recruiting and retaining doctors and nurses. Having three inpatient facilities in the area also results in a poor use of resources as beds are often unoccupied.

The agreed solution is the implementation of a range of service developments including:

- walk-in services available to children of all ages
- children's community nursing team support for acutely ill and injured children and young people
- children's short-stay assessment units in hospitals in Gateshead, Sunderland and South Tyneside, available for 24 hours each day
- inpatient care available at Sunderland Royal Hospital and the Great North Children's Hospital at the Royal Victoria Infirmary, Newcastle.

Stroke Medicine

There have been a number of quality standards released with respect to caring and treating patients who have had a stroke. These standards deliver improved outcomes for patients who suffer a stroke but do require teams to work differently compared to their historical ways of working.

One of these standards related to providing a treatment called thrombolysis to patients who have just had a stroke. This requires a stroke consultant to be available 24/7 to review radiology images and make an immediate decision on treatment.

None of three hospitals could have implemented such cover arrangements without working together as a single dedicated stroke team covering each location on the evenings and weekends.

The proposed solution was a network arrangement and a joint rota covering all 3 hospitals and this went live in the summer of 2011 and is delivering genuine improvements to stroke patients across SOTW.

A further development is the provision of a weekend TIA clinic, the clinic will be based at Sunderland Royal Hospital and will serve all residents within SOTW. The service will be delivered by the consultants from all 3 hospitals and form part of the duties of the weekend joint rota.

Pathology

In 2006 a national review of pathology services was undertaken by Lord Carter of Coles. The key recommendation of the report was that significant financial savings could be made without comprising on quality if pathology networks were established.

With an increasing amount of technology and automation available in this area of work there is a clear case that savings could be made if pathology laboratories joined together and looked at splitting work between 'hot' (what must be done on a hospital site for patient safety reasons) and 'cold' (more routine work, such as GP samples).

With three laboratories offering similar services across the three hospitals in SOTW it was obvious that opportunities existed locally.

The solution is to have one centre of excellence laboratory working on behalf of the three hospitals, with a 'hot' laboratory on each site. The proposed site for the centre of excellence is GHFT and how this will work in practice is currently being worked through in more detail.

Breast Services

Breast Services is an area that has problems in relation to local sustainability. In Sunderland and South Tyneside the teams are very small and both have had problems covering the service in the past and therefore sustainability is a real concern. Also, service provision is different on each site with some residents having access to a wider range of treatment options.

The proposed solution to ensure a high quality, sustainable service is provided going forwards is that the teams come together form one larger team. The proposal is that GHFT would become the hub (main centre) as it already provides the breast screening service across all of SOTW, with existing services in South Tyneside and Sunderland still being provided as normal. This will ensure sustainability and will not alter what is provided locally, and will in fact protect local provision.

Community Services

Within SOTW and across the country, community services that were provided by Primary Care Trusts (PCTs) had to be transferred to a partner organisation, normally a local acute hospital.

As part of the "Bigger Picture" work, even though each hospital could see elements of the community service that would integrate well with their own services, it was agreed that keeping community services together under one provider would deliver higher quality services to patients in the long term.

It was also obvious that community services have some of their greatest links, not with hospitals (though they clearly exist), but with primary care and other local authority services. It was crucial that the organisation leading community services would be able to strengthen such partnerships and develop more integrated pathways so patients are provided with a smooth care pathway, no matter who is the provider.

Looking ahead and taking into account the vision for SOTW and each hospital within the patch, it was clear that the range of services provided by the community teams had the greatest links to STFT and bringing the community services into STFT will complement and significantly strengthen the future service provision for all healthcare providers across SOTW.

STFT are committed to working with all partners to develop community services and during 2012/13 will look to establish a Partnership Board, where local providers and commissioners have a real say in how these services are taken forward.

It should also be noted that these few words do not begin to cover the breadth and depth of services offered by the community teams which, when brought together with STFT's vision for the future, provide a fantastic platform to tackle the various challenges ahead.

24/7 Surgery – Out of Hours

Currently, each of the three hospitals provide an emergency surgery service 24 hours a day, seven days a week. The number of patients who actually require an immediate operation during the night is very small. National guidance states that patients should only be operated on during the night if their life or a limb(s) is threatened.

In STFT, looking across a full year, the number of patients who required an operation out of hours (9 p.m. – 8 a.m.) is extremely small, less than 1 per week. The numbers for GHFT are slightly more, but again very small and not more than 2 per week.

In terms of local sustainability, this is a real issue as some local hospitals have to run rotas where surgeons are covering 1 in every 4 nights. Again, national guidance states the ideal minimum should be 1 in 6-8. This can't be achieved unless teams work together.

Having surgeons, anaesthetists, theatre teams and other support services on stand-by for 1 case per week is also not cost effective due to the number of patients

affected being so small. The proposed solution is to create a hub and spoke model, where those patients who do require an operation out of hours would go to a main centre, which would be CHSFT. As GHFT and STFT will still admit emergency patients, local access for urgent cases would still exist and it is crucial that urgent surgical assessments are available in all locations.

Vascular Surgery

Currently there are several national initiatives and published guidance that are aimed at driving up quality and safety standards in relation to Vascular Surgery. These cover many of the 'case for change' headings described earlier in this document. For example, a centre providing vascular services should cover a population of approximately 800,000. There is also guidance with respect to minimum numbers of certain operations– for example, 33 aneurysms per year (and this is likely to go up).

Vascular Surgery will also become a separate specialty (it is currently part of General Surgery) in 2013 which will have workforce implications with respect to trainees and this will also have a significant impact on rotas.

In order to achieve these standards, existing teams will have to come together to cover a larger population and to ensure minimum numbers of operations are met.

The proposed solution for Vascular Surgery is slightly more complicated and unclear compared to some of the other areas outlined above. This is partly because of the population figures required, as the population across SOTW is approximately 650,000, slightly short of the required 800,000. Therefore this area of work may require a solution wider than just SOTW, with potential arrangements being established with County Durham and Darlington FT (a working relationship on Vascular already exists between GHFT and Durham).

CHSFT are also committed to providing a Cardiovascular, Renal and Metabolic Service to work alongside Primary Care, therefore there will be clear links to this work, with Vascular Surgery being an integral part of this.

Trauma

Trauma is an area that, similar to Vascular requires solutions wider than SOTW. A designation process has recently been undertaken across the country, with hospitals having to apply to become 'Trauma Centres' or 'Trauma Units'. Within the North East, due to the range of services provided by Newcastle Upon Tyne Hospitals and South Tees Hospitals, these two hospitals will be the trauma centres.

GHFT, CHSFT and STFT were all successful in applying to be trauma units, but it was recognised by all parties, including STFT, that certain patient groups such as poly-trauma (multiple body parts being severely injured) would have to be managed via a local network, with such patients being transferred to CHSFT for example (as is currently the case).

North East Ambulance Service are also crucial partners in this work, as it will be their protocols and triaging processes that will ultimately dictate where patients are taken for their treatment.

Therefore although work will be undertaken across SOTW on Trauma, this has to be seen as part of a wider change process across the North East.

Medical Physics

During 2011/12 Newcastle upon Tyne Hospitals served notice on a number of Trusts across the North East that they would no longer be providing a regional Medical Physics service.

For each of the local hospitals this meant a small number of staff being transferred into each FT. With such small numbers it appears there are clear advantages (local sustainability) for the 3 FTs to work together in this area and the creation of a single managed service would provide a more sustainable solution going forwards.

Back Office Functions

Back office is a term used to describe a number of the administrative functions that support the running of any large organisation. This includes departments such as Human Resources, Finance, Information Technology, Estates and many more.

With each of the organisations generally facing comparable pressures and trying to achieve similar objectives across these areas, there may be an opportunity for these functions to be done once, led by one organisation on behalf of all three.

The proposed approach, therefore, is to look at each area, the current ways of working and to consider whether standardisation of processes or implementing a single managed service is appropriate in a number of such departments.

Other Areas – Could They Be Affected?

A number of other services/specialties have not been taken forward as part of the "Bigger Picture" work programme. This does not mean that they could not change in the future. A number of areas not already covered will face or are currently facing some of the challenges outlined in the 'case for change'. This section describes the potential challenges facing some of the other specialties/services and how they may change in the future.

Maternity

The Clinical Innovation Team (CIT) have discussed the provision of maternity services for some time and a further clinical engagement event (accelerated solution event) has been undertaken across the entire North East looking at some of the quality challenges facing Maternity and how this may lead to a reconfiguration of services.

Some of the challenges ahead include workforce issues with respect to the potential reduction in Obstetric trainees, quality and safety issues, which are likely to request an increase in consultant presence on labour wards and the move to 1:1 midwifery care, as well the general pressure on NHS funding.

If national standards dictate (or local agreement is reached) that extended consultant presence is required, the current configuration of three consultant led units is not viable, as there simply won't be enough consultants to deliver this level of cover on each site.

No work has started in this area, however, various options and configurations have already been discussed across the North East and it may be an area that being pro-active and agreeing the best model for SOTW would stop intervention from outside the local patch at a later date.

Gynaecology

Obstetrics and Gynaecology are intrinsically linked, with the majority of the consultant workforce working in both specialties. Similar clinical engagement events have been held in relation to Gynaecology and the emerging view is that some of pressures outlined for services above, also exist for Gynaecology.

Quality standards may be introduced in relation to minimum standards for certain procedures such as VVF, workforce issues may mean on call arrangements will have to cover a number of hospitals and linked to the above, emergency gynaecology may only be provided by those units that have consultant led maternity cover.

Gynae-oncology is provided by GHFT for all three hospitals and this service will continue to be provided by GHFT.

Undoubtedly, if any work in relation to maternity is taken forward then Gynaecology services would also have to be looked at as well.

Neonates

With the obvious links to maternity, clinical engagement events have also been held across the entire North East looking at some of the quality challenges facing Neonates and how this may lead to a reconfiguration of services. The challenges ahead for neonatal services include workforce issues with respect to the potential reduction in trainees, the number of middle grade staff available for rotas and the move to ensure neonatal cots are staffed to certain quality standards (BAPM).

In SOTW, all hospitals offer neonatal services, but to different levels of care, with GHFT and STFT providing special care beds and CHSFT offering intensive care. At present there is increasing pressure from outside SOTW to reconfigure neonatal services throughout the North East which could result in a loss or reduction of services on any of the sites.

At present, no work has started in relation to neonates, however, similar to maternity, various options and configurations have already been discussed across the North East and it may be an area that being pro-active and agreeing the best model for SOTW would stop intervention from outside the local patch at a later date.

Medical Specialties

Currently each site provides a range of medical specialties, including Elderly Medicine, General Medicine, Gastroenterology, Thoracic Medicine and each has an A&E department.

Looking to the future, quality standards may be introduced into certain medical specialties that identify that additional consultant presence is required later in the evenings or on weekends. This is to reduce the variation of outcomes that exist for those patients who are admitted at weekends compared to those admitted Monday-Friday.

Similar to some of the surgical specialties, joint on-call arrangements may also be necessary for areas such as Gastroenterology, to manage GI bleeds and other conditions.

New ways of working in relation to A&E attendances and emergency admissions (front of house) are being taken forward in each location and in partnership with primary care. If these projects are genuinely successful by improving outcomes and increasing patient satisfaction, whilst reducing demand for inpatient beds, then further work may be required with respect to the medical specialties. However, at this stage the **planned, long term** view is to maintain three A&E departments with the supporting medical specialisms.

To date, no formal work has been undertaken with respect to the medical specialties, though clinical discussions have started in some areas about how joint working could deliver improvements to the current ways of working.

This area of work will also closely link to planned developments within primary care and CCGs and therefore will require close working relationships going forward.

Surgical Specialties

A number of surgical specialties are already part of the "Bigger Picture" workstreams, with separate work ongoing in relation to Breast and Vascular. Out of hours ways of working in Trauma and Orthopaedics and General Surgery are also being picked up as part of the 24/7 workstream and the Trauma workstream. At this stage no work has been undertaken with respect to the elective elements of these specialties.

However, as described in the vision, GHFT may play a key role in some of the physical provision, i.e. theatres and beds in the future for elective surgical patients. With the North East Surgery Centre, GHFT have an excellent facility for elective patients and one option is to take certain procedures which are high in volume and relatively low in terms of complexity to this facility from across SOTW. Concentrating on a small number of procedures, which have large volumes, would allow the centre to develop pathways for patients that have world class outcomes and are extremely efficient at the same time. Evidence is available from similar setups around the country that patient feedback is extremely positive and the clinical outcomes can be some of the best in the country.

Diagnostics

Diagnostics play a crucial role in many of the workstreams listed above and have already had/or will have to implement new ways of working in areas such as Stroke, Vascular, 24/7 etc.

The demand for high quality diagnostics tests will only increase over the coming years and there is likely to be an increasing shift towards rapid turnaround of performing the test and reporting the results, particularly if ambulatory care pathways are successfully implemented. Primary care may also increase their demands over the coming years, supporting the move of care closer to home and keeping people out of hospitals.

The only area of work in relation to diagnostics that is being looked at is Medical Physics, which is due to the service moving out of Newcastle and back to each of the local hospitals and it appears there are clear advantages (local sustainability) to working together in this area.

Looking at the vision described earlier, there is strong support for STFT developing more diagnostic services, specifically for patients who are on planned (elective) pathways, whether that is from GP or secondary care referral. From a patient experience and capacity/demand point of view this makes sense, as for example if CHSFT is providing an increasing amount of trauma services on behalf of the patch, then their diagnostic equipment will be increasingly used for emergency patients.

If STFT develop services which are significantly protected from the demands of emergency patients then the quality of the patient experience, with respect to waiting times, parking and environment should be significantly enhanced.

Rehabilitation

Care closer to home will undoubtedly increase the focus on creating a world class rehabilitation service for many clinical pathways – both elective and non-elective. Rehabilitation services can be provided in a range of ways and settings which includes a person's home, in outpatient facilities, daycare, as well as rehabilitation beds.

Allowing one organisation to focus their efforts on creating such a service for all partners seems a sensible way forward, otherwise each hospital may 'dabble' in certain aspects of rehab, but never address the full system and service.

In the future and given the obvious links to the community services STFT now operate, the natural choice to take forward these developments would be STFT. Working with the community services they provide and other partners in primary care and local authorities, fully integrated rehabilitation pathways could be developed delivering better outcomes for patients and their families across SOTW.

Screening Programmes

Over the past few years a number of screening programmes have been established across the country. Within SOTW, GHFT currently provide the screening service for Breast, Bowel and AAA. GHFT have a strong track record in delivering successful screening services, therefore going forwards GHFT should continue to provide and develop screening services for the population of SOTW.

Where existing screening services are already working well and there is no obvious pressure for change, for example in community services or specialties such as Obstetrics and Gynaecology there are no plans to alter the current service provision.

Interventional Radiology

Interventional Radiology (IR) refers to a range of techniques which rely on the use radiological image guidance (X-ray fluoroscopy, ultrasound, CT or MRI) to precisely target therapy. Most IR treatments are minimally invasive alternatives to open and laparoscopic (keyhole) surgery. The range of conditions which can be treated by IR is enormous and continually expanding. IR supports a number of specialties, with particular links to Vascular Surgery, Nephrology, Oncology and Obstetrics and Gynaecology.

At present, no hospital within SOTW has a comprehensive IR service and providing such as service in many localities is proving a significant challenge across the country. Having a comprehensive IR service available 24/7 would be significant step forward and provide a genuine improvement to the quality of care offered to local residents. To have any chance of making this happen, IR would have be centred on one site and given the strong links to specialties such as Vascular and Nephrology, this would logically be CHSFT.

Chemotherapy and Radiotherapy

Presently, patients have access to Chemotherapy in all three hospitals and, going forward, there is a strong commitment from all partners to maintain this provision. However, one area that may change would be access to Radiotherapy.

Currently all patients who require Radiotherapy have to travel to Newcastle for any Radiotherapy treatment. Apart from Newcastle, only one other centre provides Radiotherapy in the North East – South Tees Hospital. For a number of years the cancer network has recognised there is sufficient demand for a third centre to provide Radiotherapy in the region and their own analysis (based on population figures and travel times) suggests this would be somewhere in SOTW. A procurement exercise will be undertaken by the North East Cancer Network during 2012 to address this.

It is important to note that for those residents who would prefer to be treated at Newcastle due to travel, patient choice will always be at the forefront of discussions and patients will be able to choose where they are treated.

Specialist Services

Specialist services which require larger populations (critical mass) are already provided by a smaller number of hospitals. Within SOTW, CHSFT is the main provider of acute specialist services, operating services such as Ophthalmology, Urology, Oral Surgery, ENT, Haematology and Renal Medicine. A number of these services already work closely with partners in GHFT and STFT and clinics are provided locally.

The vision in this document supports a continuation and further enhancement of this arrangement, with CHSFT potentially expanding the range of services they provide, but most importantly continuing to provide local services across all three localities. Future developments would not include those areas where it is already recognised that GHFT provides a first class service – for example, in areas such as Breast and Gynae-Oncology.

Other specialist services which have strong links to the acute sector such as Palliative Care, Pyschology and Pyschiatry will need to continue to provide an integrated service to those specialties that require it.

The important point to note in relation to specialist services is the commitment that wherever possible and practical in terms of patient safety there is a genuine commitment to providing services in each locality, so local residents have good access to care in settings such as outpatient clinics and daycase theatres.

Critical Care

Currently, all three hospitals provide critical care to local patients, at both HDU and ITU level. Looking ahead, this may change. With more of the specialist work potentially being done at CHSFT and large volumes of elective work being undertaken at GHFT on behalf of the other units then the use of critical care facilities may have to be examined in the future.

Other support services

If changes are made to current patient pathways, then services which input heavily into certain pathways will also need to change around the needs of our patients. It is difficult to state at this stage how such services will look in the future, but where proposed changes are outlined above and these heavily rely on services such as Physiotherapy or Occupational Therapy for example, then changes to these service may also occur.

These will be different, depending on the area, but the work described above is about creating networks, new clinical teams and new ways of working across the traditional geographical and organisational boundaries and therefore support services, as with all the other services/specialties described above may also change.

Other Opportunities

Partnership working could be taken forward in other areas as well. In terms of Research and Development combining the three hospitals' R&D functions together, may make it viable to open a clinical trials unit; the population served by the patch would mean that the SoTW area could contribute more to the R&D arena.

With CRLN funding decreasing, more units are looking to commercial trials as a viable way forward and again setting up such as unit would enable the hospitals to compete as a collective for such work. In terms of future recruitment such a setup would also make jobs more attractive for potential employees.

Junior doctor training could also be enhanced, as some of work described above may provide opportunities for greater exposure for juniors and increase their learning. The juniors could rotate and have blocks of time focussing purely on emergency work in one location, with another rotation at a different location looking at purely elective pathways.

Does This Mean Merger?

The question of whether GHFT, STFT and CHSFT should merge and become one organisation has been asked many times over many years. The honest answer is – maybe.

As you can see from the work described above, partnership working does not necessarily require a merger and the three FTs already have a strong tradition of collaborative working and this already exists in a number of areas.

It is well documented that mergers are often unsuccessful, productivity decreases, mistrust increases and people actually behave in ways that are damaging to all. Therefore forcing each organisation into one may actually be counter-productive and make the current situation worse. A merger can create a negative culture of perceived 'winners and losers', which takes years to be broken down.

A counter argument is that one organisation can create economies of scale (if managed appropriately) and may be able to cope with future financial challenges more successfully. One organisation may deliver some of the work described above more swiftly and provide greater clarity over many practical issues. It is also important to note that a number of the Trusts in the North East have recently joined together with their respective community services or in the case of Northumbria, with another Trust, therefore, the FTs in SOTW are becoming smaller in comparison to their neighbours and competition is likely to increase from these organisations in the future.

However, the most important issue for the immediate future is sustaining and developing high quality services for all of our patients. It may be appropriate to form one or more organisations once the majority of the work described above is complete, this would be because many of the teams would be working as one service or department across the three locations. There also may be other models of organisational partnership working that could be explored using the freedoms that each hospital has with their foundation status.

It may also become apparent that each organisation was so dependent on each other that a merger was the natural next step and people felt positively about it, rather than anxious and suspicious as would probably be the case now. It is clear from the visions set out at the beginning that each organisation needs the others to be a success going forward.

A decision about merger could then be taken based on solid evidence, as hopefully, clinical teams and other departments have successfully integrated together and are providing first class services to all our patients. This would give people the confidence that one organisation would be a success based on the work our clinical teams had achieved.

Timescales

The work described above is complex, and is often inter-linked with other issues. For example changing Paediatrics may have a knock-on into maternity, changing the Breast service may impact on rotas for General Surgery etc etc. Therefore each area is working to different timescales agreed by the people leading the work. The work that has already started is at various stages, with some already implemented, some just about to start, others have agreement in principle and a few are just starting to be explored.

In terms of the case for change, some of those drivers are already upon us - quality standards are gradually being introduced, more and more guidance highlights certain figures in relation to critical mass of populations and some of the consultant teams are no longer viable as they stand. The financial outlook is certainly not going to improve in the short to medium term, therefore it can be argued that doing nothing is no longer an option and time is of the essence.

Your views

What a number of people have raised over recent months is where all of the “Bigger Picture” work will end up; what is driving this work and what will things look like in the future? This document attempts to paint a part of a possible future picture, so that all stakeholders can start to understand how things may change, why they need to change and what that means for future service provision at each hospital. This document cannot answer all the questions as many areas are still unclear and work has not yet started in a number of other areas.

However, as work is now starting on more and more areas and is beginning to gather momentum, it is important to share these thoughts and plans with people and to seek views. To help understand and gather views in more detail a number of engagement events will be held over the coming weeks in each of the three hospitals and with local Clinical Commissioning Groups and Health and Wellbeing Boards, followed by a SOTW wide clinical engagement event at the beginning of October.

Item No. 6

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **14 September 2012**

Sunderland Health & Wellbeing Strategy – Progress and Forward Plan

Report of the Executive Director of Health Housing and Adult Services & Head of Strategy, Policy and Performance Management

1. Purpose of the Report

1.1 To gain the Board's approval for the draft initial strategy and to update the Board on the proposed process and timetable for further development and consultation.

2. Background

2.2 As previously approved by the Shadow Health and Wellbeing Board, the Health and Wellbeing Strategy has been developed to take a whole systems and an assets based approach to the improvement of health and wellbeing in Sunderland. The strategic objectives that have been set in the strategy are ambitious and challenging and to achieve them will require a considerable change in the way that services are developed, delivered and specifically how we engage with our communities to empower them to take control over the decisions affecting their health and wellbeing.

2.2 This sits alongside other strategic approaches within the City including the Community Leadership programme, the Community Resilience Plan and the strengthening families approach – all of which the Board have received previous reports about and must be seen in the context of large scale change to the way public services are being delivered and in an environment of reducing resources.

2.3 The outline strategy (attached as Appendix 1) aims to describe the three main components of an assets based approach to health and wellbeing namely:

- design principles – those ways of working which must underpin all commissioning decisions and ultimately ways of working for which the Board holds responsibility – including consideration of the Clinical Commissioning Group's commissioning plans
- assets – the core assets which can be built upon in Sunderland to impact on the health and wellbeing of residents
- strategic objectives – the ultimate goals of the strategy which will focus the development of high level actions and commissioning plans that will follow.

Assuming that the Board approves the strategy as attached, it will become operational at this stage in terms of informing commissioning plans, financial strategic planning and to inform the Clinical Commissioning Group's forward plans.

3. Forward Plan

To take forward the initial strategy as outlined in Appendix 1, there are four stages that need to be completed:

3.1. Developing the strategic objectives into actions

Taken from the membership of the Health and Wellbeing Strategy sub group, lead officers have been proposed for each of the strategic objectives as highlighted in Table 1 below. With support from the Council's Policy & Performance service, they will be responsible for bringing together partners to shape activity which will achieve the strategic objectives and highlight how we will know that these objectives have been achieved. The deadline for the completion of this task is mid October 2012.

3.2. Consulting on the strategy and actions

As the strategy has been developed through a year long process of open engagement events including representatives from the voluntary and community sectors, providers and public sector officers and members, it is evident that there is a broad understanding and acceptance of the content of the strategy. As such it is not proposed that the final draft strategy be open for the 3 month consultation window that is recommended through the Sunderland Compact.

It is, however, important that a more inclusive range of partners are given the opportunity to comment on the strategy. As such, following the completion of the action planning task in October, a further engagement event will be held alongside a programme of engagement sessions with different groups – including, but not limited to, the Council's area forums, area committees and people boards, The Sunderland Partnership equality forums, the youth parliament and GP patient participation groups running through to December 2012.

3.3. Formal approval

Following the consultation process detailed above, the Strategy needs to be formally approved by the end of March 2013. As the Health and Wellbeing Board at this stage will not be a formal committee of the Council, the Board will need to ratify the Strategy and Action Plan before it is taken to Council Cabinet for formal approval. It is proposed that that the Health and Wellbeing Board on the 25th January 2013 receives the final draft strategy and action plan and subject to approval this is taken to Cabinet on the 13th February 2013. It is also anticipated that the Strategy will also be taken to the board of the clinical Commissioning Group for approval.

3.4. Ongoing Ownership

Each strategic objective has also been allocated 2 sponsors – both senior representatives, one of whom is a Board member, as highlighted in Table 1.

Their role, with the support of the lead officer is to lead the delivery of the objective through the appropriate partnership working. It is also the sponsor that will be report to the Board for the achievement of progress against their Strategic Objective.

Table 1

Strategic Objective	Lead officer	Sponsors
1. Promoting understanding between communities and organisations	Jane Hibberd	Sarah Reed & Sue Winfield (until appointment of HealthWatch Board member)
2. Ensuring that children and young people have the best start in life	Sandra Mitchell	Keith Moore & Gerry McBride
3. Supporting and motivating everyone to take responsibility for their health and that of others	Gillian Gibson	Neil Revely & Cllr Pat Smith
4. Supporting everyone to contribute	Vince Taylor	Cllr Graham Miller & Nonnie Crawford
5. Supporting people with long-term conditions and their carers	Graham King	Ian Gillmour & Cllr Mel Spedding
6. Supporting individuals and their families to recover from ill-health and crisis	Dave Gallagher	Ian Pattison & Carole Harries

4. Recommendations

The Board is recommended to:

- Agree the draft strategy attached in Appendix 1
- Agree the proposed process for developing actions which will achieve the strategic objectives
- Agree the proposed consultation process and approval schedule.
- Agree the nomination of lead officers and sponsors and the responsibilities associated with these roles

Appendix 1

SUNDERLAND'S JOINT HEALTH AND WELLBEING STRATEGY

VISION

The vision for is to have the:

> **Best Possible Health and Wellbeing for Sunderland**
>
> **….by which we mean a City where everyone is as healthy as they can be, people live longer, enjoy a good standard of wellbeing and we see a reduction in health inequalities**.

Faced with reducing public resources and increasing demand and expectations many current ways of delivering services are recognised as no longer appropriate. Large scale changes to the way public services are being delivered are well under way. Although challenging, the changing environment offers an opportunity to fundamentally review and improve the way agencies will work with residents and communities in the future. There is also growing recognition of existing but often untapped assets and potential within communities that can enhance and complement the public sector's offering.

Consideration will need to be given to relationships between agencies and the communities they serve and how services can be delivered in the future to make best use of all resources in order to achieve better health and wellbeing outcomes. Ultimately we want to enable and support individuals, families and communities in Sunderland to enjoy much better health and wellbeing, with less reliance on the public sector in the longer term. This involves being responsive not only to local needs but also to community strengths and exploring how these can be better harnessed to help address local needs. By building on and utilising the resources and energy of our communities, we can support people to take greater control of their lives to bring about better health and wellbeing outcomes that matter to them, their families and communities.

The Health and Wellbeing Strategy, Community Resilience Plan and the Strengthening Families approach are together aiming to achieve the transition to a new way of working and at the same time achieve improved outcomes for the people of Sunderland.

DESIGN PRINCIPLES

We have established a set of design principles that will underpin our new approach to health and wellbeing and upon which action planning and ultimately commissioning throughout the health and social care system will be built. These design principles are:

- **Strengthening community assets**

Empowering individuals, families and communities, increasing their capacity and involving them in co-producing services. This will enable residents to mobilise and build on existing community strengths and potential to help them address their own, their family's and their community's needs. This asset-based approach does not ignore needs – instead, it distinguishes between those needs that can best be met by families and friends, those best met by communities working in partnership with public services, and those that can only be met by public sector providers.

- **Prevention**

Using local intelligence and experience to identify risks to health and wellbeing effectively and to work within communities to prevent people developing problems

- **Early intervention – actively seeking to identify and tackle issues before they get worse**

We know that early intervention with children, young people and adults can reduce more complex health issues in the longer term. Identifying and tackling issues at an early stage can prevent them escalating into more problematic and complex needs.

- **Equity – providing access to excellent services dependent on need and preferences, that are also based on evaluated models and quality standards**

The conditions in which people are born, grow, live, work and age are responsible for the (avoidable) differences in peoples health. Equity in health means everyone being able to achieve their full health potential regardless of their personal circumstances. To achieve this there needs to be fair distribution of resources and opportunities for health as well as fairness in the support offered to people when they are ill.

Health inequalities exist within Sunderland itself, and between Sunderland and England. These health inequalities are often related to obesity, alcohol related diseases and smoking rates. We know that we have particular communities where these health inequalities are most evident and we need to address this.

- **Promoting independence and self care – enabling individuals to make effective choices for themselves and their families**

The increasing emphasis on personalisation of services and of individual health and care budgets means that we must focus on creating alternative types of services that can be sustained within the community. We will continue to support our most vulnerable individuals, families and communities. Wherever possible and appropriate, our interventions will enable and re-able people to function effectively without the need for recurring agency support.

- **Joint Working – shaping and managing cost effective interventions through integrated services**

Working together to make best use of our strengths and assets so that we can provide flexible and tailored services that respond to local conditions and focus on what matters to residents to achieve more for our communities.

- **Address the factors that have a wider impact on health – education, housing, employment, environment, and address these proportionately across the social gradient**

Differences in peoples health result from differences in the opportunities that people are able to take advantage of during their lives. Action on the wider impacts of health requires action across all the social determinants of health. A government commissioned independent review of health inequalities identified a number of social determinants which increase inequalities in life expectancy across the life course. The review identifies six key objectives to reduce health inequalities caused by these determinants. These are:

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Ill health prevention
- Create and develop healthy and sustainable places and communities.

To see a sustainable improvement in life expectancy for all of the population, including a reduction in inequalities, the wider determinants of health need to be addressed – this includes a major focus on achieving the best start in life to break the cycle of health inequalities.

- **Lifecourse – ensuring appropriate action throughout an individual's life with a focus on early years and families**

Intervention and support should be available throughout our lives, recognising that triggers for crisis can occur at different points in people's lives (particularly at key transition points). It is important that we set in place the foundations in early years and encourage families to play a strong role in developing their own resilience..

ASSETS

There are community and individual assets that we share and that need to be developed, nurtured and supported including:

- the practical skills, capacity and knowledge of local residents
- the passions and interests of local residents that give them energy for change

- the networks and connections – known as 'social capital' – in a community, including friendships and neighbourliness
- the effectiveness of local community and voluntary associations
- the resources of public, private and third sector organisations that are available to support a community.

There are interdependencies between these and a number of strategic assets which come together to make Sunderland unique – these should be built on where they exist and be improved and developed where they are weaker or missing. These are:

- **Strong and stable family and community relationships**

Sunderland is characterised by low movement of people – families and communities are relatively stable and as such there is potential to use local informal support networks to promote healthier choices and healthy lifestyles

- **The coast and countryside and a passion for sport and activity**

Sunderland has an attractive coast and easy-to-reach countryside and urban green spaces that provide opportunities for promoting an active lifestyle. The city's passion for sport and exercise should be nurtured and developed to ensure broader involvement with more wide reaching health impacts.

- **Potential for Sunderland's employers to offer swift access to a large proportion of the workforce and understanding of different communities**

The economy in Sunderland is characterised by a small number of large employers employing the majority of the workforce. By developing relationships with these employers we can tap into their understanding of the communities in which they operate and the people they employ to promote healthy workplaces and healthy lifestyles.

- **A vast number of contacts with residents through daily provision of a wide range of services**

Sunderland's many organisations and support groups are in touch with residents across the whole range of service delivery. Hard-wiring health improvement into these day-to-day contacts will reinforce and bring support to those people who need it so that every contact is a health contact.

- **At the leading edge of putting new technology to work in the public interest**

Sunderland is at the leading edge of using new technologies and making sure that the whole city can make best use of this resource. There exists great potential to use new technologies to enable people to take more control over their own health and wellbeing through technological solutions and by improving information sharing.

- **A huge variety of local organisations, partnerships and networks with a strong track record of effective delivery**

We are starting from a strong position whereby there has been a long history of joint working to deliver real changes. We will build on this to ensure that the achievement of better health outcomes involves individuals, communities and providers..

The following Strategic Objectives describe how we will achieve our vision for health and wellbeing. Detailed action plans will be developed for each. Each strategic objective utilises one or more of the assets and applies all of the design principles.

STRATEGIC OBJECTIVES

1. Promoting understanding between communities and organisations

- **Communities being able to understand what they can expect of service providers and what other organisations can offer**
- **Making best use of local intelligence to identify emerging risks to health and wellbeing**
- **Harnessing individuals, communities and service providers views to inform and challenge provision**
- **Understanding the strengths and diversity of our communities and reflecting this in our commissioning**

If the health of local people is to improve then we must all pull together and play our part. Relationships between agencies and local people, including patients and service users, need to be much more dynamic and enable local people to have a much greater influence on which services are provided, as well as how and when they are provided. Equally, individuals and communities need to develop an understanding of the strengths that they have and can draw upon collectively, enabling them to take control of their own health.

If we do these things then we will all have a much better understanding of our own health needs and how best we can address these, either through our own endeavours or with the help of others if we need it. This will give us confidence in ourselves and in the services that we rely upon in times of need.

2. Ensuring that children and young people have the best start in life

- **Encouraging parents and carers of children to access early years opportunities**
- **Supporting children and families throughout the whole of a child's journey, including the transition into adulthood**

Many of us understand and acknowledge the influence (directly and indirectly) that families and schools have on the development and life chances of children and young people. These two important factors can have a huge impact upon the health, education and future employment opportunities of a child or young person.

To ensure a positive future for our children and young people there needs to be

effective joint working across agencies to encourage individuals and families to achieve their full potential by addressing their physical and emotional health issues. Schools in particular are in a position where they are able to support the physical and emotional development of their pupils and their immediate family.

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

- **Encouraging people to take the first steps towards healthy lifestyles**
- **Making healthy lifestyle choices easy**
- **Promoting and sustaining interest in healthy lifestyle options**
- **Raising self-esteem, confidence and emotional health and wellbeing**

The most powerful influences upon how we behave come from our family and friends. They shape our knowledge, perspectives, experiences and preferences and as a consequence can either encourage or discourage us to lead a healthy lifestyle. It is important that we realise this affect on ourselves as well as the effect we can have on those around us. However there are also a range of options open to agencies that can help to make a healthy lifestyle an easy option, for example this can be through health education, provision within schools, mentoring programmes, as well as providing easy access to the city's natural assets such as open and green spaces. Our agencies also need to consider how they can encourage and sustain people's interest in a healthy lifestyle through local and national events, cultural activities, and through Sunderland's major employers.

4. Supporting everyone to contribute

- **Work together to get people fit for work**
- **Understanding the health barriers to employment and training, and supporting people to overcome them**
- **Actively working with local businesses to ensure a healthy workforce**
- **Supporting those who don't work to contribute in other ways**

Those of us that find ourselves unemployed will realise already the detrimental affect this can have on our health, indeed it is known that poorer health can be found amongst those who are unemployed for longest. The effects of poor health can be divided into the short-term (resulting from the immediate impact of unemployment) and the long-term more complex health impacts that can develop. The potential health and wellbeing impacts of unemployment are:

- Distress, anxiety and depression that may also impact upon other family members
- Worsening health behaviours in the form of increased smoking, increased alcohol consumption and a decrease in exercise.
- Financial problems that can reduce living standards, increase the likelihood of social isolation and lower self-esteem.

So it is important that agencies work together to build confidence and

motivation and provide pathways into training and employment. But we must also work with employers so that they understand how the policies they implement can have a significant effect on both the health of their employees and their employee's families. Good health in this environment can be promoted through healthier working conditions and more flexible employment.

For those of us not in work there will be the opportunity to contribute to those communities that can benefit from our skills and talents. This will enable us to improve the lives of those around us and enable us to build community pride through a variety of volunteer roles.

5. Supporting people with long-term conditions and their carers:

- **Supporting self-management of long-term conditions**
- **Providing excellent integrated services to support those with long-term conditions and their carers**
- **Support a good death for everyone**

We realise that those people with long term conditions can be experts in their own care because they understand better than anyone the problems they encounter on a daily basis. Our agencies need to reflect on how they can work together and redesign their service provision in order to incorporate the preferences of patients and service users, as well as self-management of their condition where this is possible. We will ensure that this approach incorporates a range of services that are reliable, consistent and maximise the quality of life for those people with long-term conditions as well as their families and carers.

6. Supporting individuals and their families to recover from ill-health and crisis:

- **Supporting individuals and families to have emotional resilience and control over their life**
- **Providing excellent integrated services to support people to recover from ill health and crisis**
- **Winning the trust of individuals and families who require support**

Any of us may find ourselves in need of support in a crisis situation. This may result from ill health or injury where we are suddenly unable to undertake everyday tasks, or where our main carer's own health and ability to carry on caring has suddenly broken down. Where this is the case our agencies will identify the best service pathways that will facilitate rehabilitation by working together through a mixture of appropriate integrated services.

Item No. 7

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **14 September 2012**

REPORT FROM THE HEAD OF STRATEGY AND PERFORMANCE

AN ASSET APPROACH – CHANGING DELIVERY IN SUNDERLAND

1.0 The need for new ways of working

1.1 Faced with diminishing public resources and increasing demand, many current delivery methods are recognised as no longer affordable. At the same time, there is also growing recognition of existing but often untapped assets and potential within the City and its communities that can enhance and complement the public sector's offering. The challenge is to develop new ways of working and thinking that promote the best use of all resources available locally to achieve better outcomes.

2.0 Traditional 'deficit' approach: Glass half-empty

2.1 Our recent history is one of reasonably well funded services, which some argue has led to a tendency to over support people and the creation of a model that has inadvertently reduced individual, family and community resilience and increased dependence on the formal (state) support system. Not only are many current models of providing services unsustainable financially, they are not particularly desirable or successful in helping people to develop a wide network of family, friends and acquaintances and with their communities – all of which are essential to a person's overall sense of happiness and wellbeing.

2.2 Traditional ways of working often start with organisations identifying the problems, needs and deficiencies in an individual or community, and then designing services to fill the gaps and resolve the problems. This can lead to:

- Individuals and communities developing negative self perceptions – people begin to define themselves and their community in terms of its deficiencies, which could negatively impact on people's sense of self worth
- People and communities feeling disempowered and dependent
- People becoming passive recipients of services rather than active agents in their own lives
- Individual, family and community resources, capacities and strengths being overlooked
- A perception that only outside experts can provide the help needed, weakening the importance of social support systems, neighbourliness and community spirit
- Targeting support and intervention on individuals, rather than considering them within the context of their family or community who may be able to contribute

3.0 Asset based approach: Glass half-full

3.1 An asset-based approach seeks to identify and build on the assets and strengths of individuals, families and communities, empowering people to play an active role in improving their own lives and the lives of others. This approach seeks to redress the balance between meeting needs and nurturing the strengths and resources of

people and communities. Local assets are identified, connected and mobilised, and the abilities and insights of residents become resources for solving local problems.

3.2 From an asset based perspective, people are not viewed primarily as passive recipients of services ('service users', 'clients', 'customers') but as active contributors and essential partners in achieving desired outcomes ('co-creators', 'co-designers', 'co-producers'). There is recognition that professionals as well as individuals/families/communities each offer resources, capacities, knowledge and priorities, and both parties are engaged in a mutually reciprocal partnership. This means that organisations work *with* people, not just *for* them – 'doing *with*' not 'doing *to*'.

What is an 'asset'?

3.3 In this context, the term 'asset' refers to an advantage, resource or capability, and includes anything that contributes to (or could potentially contribute to) the delivery of a desired outcome (e.g. health and wellbeing, strong families, economic growth)

3.4 Assets can be held by, or associated with, different entities including individuals and families; communities and neighbourhoods; organisations (public, private and voluntary and community sector); or the city as a whole.

3.5 Some examples of Sunderland's assets include:

- **People** (both individual and community) – the skills, knowledge, time, interests and passions of people living and working in the city; formal and informal networks and connections in a community, including friendships and neighbourliness; a strong sense of community and belonging.

- **Place** – physical and natural assets such as the seafront and riverside, parks and other green space; local culture and heritage; key infrastructure such as Sunderland Strategic Transport Corridor (New Wear Crossing), the Port, super-connectivity and the Cloud.

- **Economy** – local business parks and commercial centres; the city's workforce; the University and College; key development sites such as Stadium Village and the former Vaux site; large employers such as Nissan; the potential for new industry (e.g. low carbon technologies); SMEs and local entrepreneurs; key transport links (e.g. rail and Metro).

- **Organisational/Institutional** – the Sunderland Partnership and its governance structures; voluntary and community sector organisations; co-terminous area based working and local governance structures including the CCG; the myriad of day-to-day contacts between residents and frontline staff.

Values and principles of an asset based approach

3.6 In an asset-based approach…
- Strengths and assets are identified, valued and made visible
- Efforts are made to find out what is already working and generate more of it
- Individuals, families and communities are seen as 'co-producers' rather than recipients of services

- Dialogue occurs between people and practitioners on the basis of each having something to offer
- Services are intentionally directed towards building capacity, increasing resilience and promoting independence (reducing dependence on public services in the longer term)
- Individuals, families and communities are empowered to control their own future and take ownership of change
- Individual wellbeing is supported through confidence building, coping strategies, skills development, and strengthening of relationships
- Positive social networks and relationships that can provide caring, mutual support and access to resources and opportunities are promoted
- Projects are promoted based on what it is trying to achieve, not the problem it is trying to address – e.g. 'making Sunderland a smoke free city', rather than 'reducing high number of smokers in the city, and 'strengthening families', rather than 'tackling troubled families'
- The 'whole system' is involved from the beginning, encouraging family members and communities (including local institutions and businesses) to play a role in improving outcomes for local people

4.0 A complementary approach

4.1 A traditional needs analysis will generally conclude the need for outside professional intervention. However, including information on assets and strengths – what individuals, families and communities have and what they do well – alongside data on risk and needs can produce a richer picture of an area and raise awareness of all of the resources available to improve outcomes.

4.2 Asset based working does not ignore needs – rather, it distinguishes between those needs that can best be met by families and friends, those best met through cooperation between services and communities, and those that can only be delivered through professional services. An asset based approach therefore does not replace investment in improving services or tackling the structural causes of inequality. It is about harnessing the inherent assets and support that exists within communities which may enhance and complement the public sector's offering. While it may help reduce demands on services in the longer term, it is important to recognise that it is not a no-cost option and many communities will need initial capacity building support.

4.3 The aim of an asset based approach is to achieve a better balance between service delivery and capacity building, encouraging more community-led initiatives with public sector organisations acting in an enabling and support role.

Moving from a deficit approach to an asset approach	
A deficit approach	**An asset way of thinking**
Start with deficiencies and needs in the community, often as defined by external data	Start with the strengths and assets in the community, often as defined by people themselves
Respond to problems and reduce risk factors	Identify opportunities and strengths and enhance protective factors
Provide services to users	Work with people as equal partners with something to offer

Moving from a deficit approach to an asset approach	
A deficit approach	**An asset way of thinking**
Emphasise the role of agencies	Emphasise the role of civil society
Focus on individuals in isolation from their social structures	Focus on individuals within the context of their families, communities and neighbourhoods
View people as passive recipients of services	Empower people take control of their lives
Try to 'fix' people'	Support people to develop their own solutions
Implement programmes with short-term funding as the answer	Recognise that existing untapped assets in communities and the city may hold the answer

5.0 An asset based approach in practice

5.1 A range of health initiatives in Sunderland and across the country have been designed to make better use of existing resources and potential within communities. The following case studies provide some examples of an asset based approach in the context of health and wellbeing and as such potential ways of delivering the Health and Wellbeing Strategy.

5.2 Asset mapping

NHS Wakefield District and Wakefield Council's Joint Public Health Unit piloted an asset based approach as part of the national JSNA refresh programme, gathering information about both assets and needs. They explored the use of asset mapping to provide a rich picture of local people's assets and how knowledge of those assets could support co-production and inform a community based commissioning framework – one which builds and strengthens community assets to best address 'needs'. Through workshop events in communities, local people were asked to identify what they saw as their assets, how they saw them being supported and reinforced, and how they think they contribute to wellbeing. This process also helped the community appreciate their assets and their potential, and helped the agencies to see the potential value of the resources in the community.

5.3 Timebanking

Spice is a social enterprise in South Wales that develops timebanking systems for communities and public services. People are thanked with credits for contributing time to their community (putting 'Time In'), and they can then redeem their credits to access events, training and leisure services, or to trade time with neighbours (getting 'Time Out').

- *'Time In' Menu* – Public services and local community groups identify current and new opportunities for people to contribute their time – for example, running a self-help group, befriending, or organising a mother-toddler group.
- *Time Out Menu* – Organisations identify 'spare capacity' within services and facilities to that can be used to thank people for their contribution and at the same time encourages behaviour that promotes and protects health and wellbeing – for example, free swims, dance lessons, further education training.

AgeUK Isle of Wight is piloting a 'care4care' scheme which provides support for older people through mutual exchange: 'support provided by me now in return for support for me later'. Care4care members earn 'care credits' by supporting/caring for an older person in their local community. The hours of support members provide

are recorded in their individual care credit account for their own future use or to support a relative or friend now. The main aim of the scheme is to help people prepare for their own older age without depending on financial savings or pensions schemes.

5.4 Social prescribing

Social prescribing links patients in primary care with non-medical sources of support within the community. These are usually local voluntary and community organisations that have signed up to the scheme. Many social prescribing schemes use asset mapping tools in order to identify the potential sources of support so that GP practices and others can refer their patients. Research in the North West found that prescriptions were being written for exercise and sport, book clubs, places to take part in the arts, green gyms, volunteering, mutual aid, befriending and self-help, advice on debt, legal problems and parenting support. The benefits included:

- increased awareness of what would improve wellbeing and how to take positive steps towards this
- increased uptake of healthy activities by vulnerable and other groups
- increased levels of social contact among marginalised groups.

5.5 Peer support

Sunderland's Health Champion training programme recognises that front line staff, community workers and volunteers are often best placed in the heart of communities to offer advice and support due to their long-established relationships with residents, who are comfortable talking to them. Training modules are delivered by local voluntary and community sector organisations and equip 'Health Champions' with the skills and knowledge they need to recognise health issues and offer appropriate help, advice and information as part of their everyday work.

Through the Knowsley Volunteer Family Mentor scheme, local volunteers are trained to provide support and encouragement to vulnerable families in their area to help them increase their stability, confidence and self esteem so that they can start to improve their circumstances themselves. An evaluation found that families respond better to help from people in their own community than to professional help; they have benefited from taking up training, applying for jobs, getting help with drug use or health issues for example. The volunteers also benefit by using the training they receive as the springboard to get qualifications and jobs.

As a result of Sale West and Ashton Partnership's asset mapping exercise, they have set up an 'alcohol human library'. This community-based project offers residents with risky drinking habits support from volunteers who themselves have had problems with alcohol in the past. These volunteers can use the 'asset' of their previous struggles and experiences to help others in similar situations; they can help someone understand what causes them drink, help prevent risky drinking and offer support with the issues that people face.

5.6 Taking a whole systems approach

The Sunderland approach to strengthening families is one which is concerned with building their capacity to achieve positive outcomes for themselves and their community, with less dependence on the public sector. By coordinating and simplifying support packages, it seeks to ensure that families in Sunderland can easily access the right support, at the right time and in the right way to enable them to meet their needs and achieve their goals. This includes identifying and building

on families' strengths, helping them to recognise and fulfil their potential and make a positive contribution to their community.

6.0 Recommendations:

6.1 Members of the Board are recommended to:

a) Receive the report on developing an assets approach in Sunderland
b) Agree that all future health and wellbeing commissioning in Sunderland should be done in cognisance of this approach as recommended in the Health and Wellbeing Strategy

Item No. 9

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **14 September 2012**

SUNDERLAND SAFEGUARDING ADULTS BOARD – BUSINESS PLAN

Report of the Executive Director of Health, Housing & Adult Services

Background

The Sunderland Safeguarding Adults Board (SSAB) is the partnership body with collective responsibility for ensuring that vulnerable individuals are protected from abuse. The multi agency partnership is chaired by an Independent Chair with membership drawn from the Council, NHS partners, the Police Authority, Probation, providers of services and representatives of user interest groups.

A significant requirement of the work of SSAB is to agree its business plan and associated delivery plan.

As safeguarding adults is seen as a key component of any approach to Health & Well Being it is felt prudent to seek views from the HWBB on the draft business plan.

Context

The Sunderland Safeguarding Adults Board (SSAB) Business Plan is the strategic document that identifies how Safeguarding Adults work will be delivered within Sunderland by the collective working together of the key partner agencies within the City. The Plan sets out how the SSAB will meet its strategic aims and will be regularly monitored and reviewed as part of the SSAB Business monitoring process.

The fundamental purpose of the Plan is to drive forward the work of Safeguarding Adults during the coming years and to inform all partner agencies and the public about the work undertaken by the SSAB to make Sunderland a safer place for vulnerable people.

The Business Plan will assist the SSAB to support, monitor and review the contribution made by agencies, both individually and collectively, in order to fulfil their safeguarding duties.

Key Outline of the Business Plan

The Key Aims of the SSAB are to

1. **Develop and deliver a shared vision for safeguarding adults** firmly rooted in the wider vision for Sunderland and the promotion of individual human rights, dignity and respect

2. **Develop and maintain strong links with relevant partnerships across the City** and ensure the inclusion of safeguarding adults in their strategies and business plans

3. **Promote the active involvement of services users, their carers, their families and their advocates** and adopt an inclusive approach to secure wider community understanding, awareness and feedback on safeguarding adults arrangements

4. **Oversee and monitor operational safeguarding adults activity** and ensure the production of timely and accurate performance and safeguarding information

5. **Secure citywide consistency in safeguarding** and ensure all staff and stakeholders know and use policies and procedures effectively

6. **Secure effective operational engagement and integration** through robust governance arrangements and continued Board development and growth

7. **Promote a learning culture around safeguarding** by supporting and participating in Serious Case Reviews, through shared learning, by learning and contributing to relevant national policy and research, through the dissemination of information, advice, feedback, reviews, research, best practice in prevention and learning through joint quality assurance processes.

For each of the aims a series of key actions have been developed which are set out in the main body of the plan.

In addition SSAB has agreed to adopt the following key principles in delivering its aims.

- The provision of strong , effective Leadership
- Support communications, collaboration, innovation and raising awareness
- Embrace partnership working
- Promote quality, performance and 'learning lessons'
- Develop and implement training and workforce development
- Prevent and respond to abuse
- Develop and implement robust governance arrangements

The past year has set down significant challenges for Safeguarding Adult arrangements in Sunderland. Continued high volumes of referrals, the completion of its first adult Serious Case Review , and reviewing the way in which safeguarding is managed have all placed significant pressures on statutory and third sector partners . All this comes at a time when all stakeholders are faced with challenging resource constraints which potentially impact on the resources available to be deployed on important issues like safeguarding.

With this in mind partners have become more focussed on providing more effective and efficient ways of providing safeguarding services. Whilst there is still 'road testing' to be completed, a new set of thresholds have been developed to ensure that those most in need of safeguarding assistance are able to access such help. The Board is also currently reviewing its manner of operation to ensure it gains maximum impact from the contributions of all the partners. Such work is not taking place in isolation – but alongside colleagues in children's safeguarding to explore whether there are potential efficiencies to be gained by either the two systems working closer together or indeed undertaking some activities in a joined up manner. This all makes the 2012/13 Business Plan a significant piece of work.

Recommendations

The Shadow Health and Wellbeing Board is therefore recommended to:

- Receive a presentation from the Independent Chair of the Sunderland Safeguarding Adults Board

- Agree that the formal sign off and subsequent monitoring of progress against the business plan is undertaken by the Adults Partnership Board in its advisory capacity to the Health and Wellbeing Board.

Sunderland Safeguarding Adults Board

SUNDERLAND SAFEGUARDING ADULTS BOARD

Business Plan, 2012 /2015

Including Delivery Plan, April 2012/ March 2013

INTRODUCTION

The Sunderland Safeguarding Adults Board (SSAB) Business Plan identifies how Safeguarding Adults work will be delivered within Sunderland by working together with key partner agencies within the City. The Plan sets out how the SSAB will deliver against its strategic aims and will be regularly monitored and reviewed as part of the SSAB Business monitoring process.

Purpose of the Plan

The Plan sets out the purpose and key aims of the SSAB and describes how these key aims will be achieved by the setting of clear priorities for the Board at a strategic level. It will also demonstrate how all relevant stakeholders will participate in achieving these priorities.

The fundamental purpose of the plan is to drive forward the work of Safeguarding Adults over the coming year and to inform all partners and the public about the work undertaken by the Sunderland Safeguarding Adults Board to make Sunderland a safer place for vulnerable people.

The Business Plan will assist the SSAB to support, monitor and review what partner agencies do individually and collectively to fulfil their safeguarding duties.

Sunderland Safeguarding Adults Board (SSAB) – what is it and what does it do?

The strategic members of the Board are committed to achieving 'zero tolerance' in terms of abuse of vulnerable adults, and to operate effective safeguarding processes underpinned by the following values:

- **Everyone has a right to be protected against harm and exploitation, and a right to dignity and respect**
- **It is everyone's responsibility to safeguard vulnerable adults within our society**

The Sunderland Safeguarding Adults Board (SSAB) is the leader of safeguarding, frame the activities of a range of organisations and ensure that there are effective interfaces between them to safeguard the full range of people who may be more at risk or in

circumstances that make them vulnerable. Whilst the Council, NHS Partners, the Police Authority and others hold ultimate responsibility of the safeguarding within their individual organisations, it is the Board that brings their critical interdependence together and maximises the effectiveness of their activity.

The purposes of the SSAB are:

To lead and hold to account partners for safeguarding adults in the city in order to maximise positive safeguarding outcomes for the those living in the City of Sunderland. The SSAB will ensure that it has a shared strategic vision that is embedded in the strategies and plans of the Council and its partners and that the work of the board interfaces and is complimentary to the Community Safety Partnership and Health and Well Being Board both strategically and operationally.

The SSAB must have active partners who are able to influence and direct their organisations in ensuring adults are and feel safe, and are supported to challenge and change abusive situations, lead and support the development and implementation of safeguarding practices and procedures within their own organisations, take forward agreed action plans which prevent and minimise abuse, protect individuals and support the delivery of fairness to all.

To lead work in the city to ensure that for adults who are at risk or in vulnerable situations, the partners or agencies that support them and the wider community can:

- Develop a culture that will not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does happen, support and safeguard the rights of people harmed to:
    - stop abuse continuing
    - access services they need
    - gain improved access to justice.

The plan sets out 7 key aims for the SSAB that are underpinned by a number of key principles. The key aims are overseen by the Board, which also ensures that its work is fully embedded in, and supportive of, a range of other key strategic aims and priorities across the City. This Plan needs to be read in conjunction with the SSAB Risk Register which is monitored and updated on a regular basis by the Board.

The key aims and principles are critical to the success of the Board. They guide the work of the Board and provide a focus for safeguarding adults activity across the City.

The Key Aims of the SSAB are to

1. **Develop and deliver a shared vision for safeguarding adults** firmly rooted in the wider vision for Sunderland and promotion of individual human rights, dignity and respect

2. **Develop and maintain strong links with relevant partnerships** and ensure inclusion of safeguarding adults in their strategies and business plans

3. **Promote the active involvement of services users, their carers, their families and their advocates** and adopt an inclusive approach to secure wider community understanding, awareness and feedback on safeguarding adults arrangements

4. **Oversee and monitor operational safeguarding adults activity** and ensure the production of timely and accurate performance and safeguarding information

5. **Secure citywide consistency in safeguarding** and ensure all staff and stakeholders know and use policies and procedures effectively

6. **Secure effective operational engagement and integration** through robust governance arrangements and continued Board development and growth

7. **Promote a learning culture around safeguarding** by supporting and participating in Serious Case Reviews, through shared learning, by learning and contributing to relevant national policy and research, through the dissemination of information, advice, feedback, reviews, research, best practice in prevention and learning through joint quality assurance processes

The Board will work to and promote the following key principles:

- Provide effective leadership
- Support communications, collaboration, innovation and raising awareness
- Embrace partnership working
- Promote quality, performance and 'learning lessons'
- Develop and implement training and workforce development
- Preventing and responding to abuse
- Develop and implement governance arrangements

SSAB Delivery Plan

Key Aim 1: Develop and deliver a shared vision for Safeguarding Adults

Delivery on Key Aim 1

The following action plan identifies the key actions for 2012/13 in relation to developing and delivering a shared vision for Safeguarding Adults

Key Aim 1: Develop and deliver a shared vision for Safeguarding Adults					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
Develop a Communication Strategy	Chair Communication	May 2012	Achieved	Communication Strategy ratified by SSAB	Green

	& Marketing Sub-committee				
Ensure key safeguarding messages are shared with statutory and non-statutory partners, the general public and service users	Chair Communication & Marketing Sub-committee	April 2013	Ongoing – distribution cycle agreed using distribution lists and safeguarding champions		Amber
Work in partnership with SSCB to host an annual safeguarding conference	Chair Communication & Marketing Sub-committee	December 2012	In Progress. Conference Planned for November 13th 2012 on Safeguarding and the Whole Family Approach	Feedback from conference. This will also influence next year's conference	Amber
SSAB website to be updated to ensure it delivers the key safeguarding messages in a corporate manner to: • Practitioners and their managers in statutory and non statutory organisations • Carers • Service Users	Chair Communication & Marketing Sub-committee	April 2013	In Progress. Sunderland City Council to host the website and SSAB to commission the Council to manage and update the content of the website.	Increased number of "hits" to the website	Amber
Current marketing/information to be reviewed and updated in line with corporate changes and review of the Sunderland model of working	Chair Communication & Marketing Sub-committee	April 2013	In Progress. Website information to be updated in line with changes to the model Tri X commissioned to develop web enabled	All information distributed by SSAB is of high quality and meets the needs of service users, carers and practitioners	Amber

			procedures All promotional materials to be reviewed		

Key Aim 2: Develop and maintain strong links with relevant partnerships

Delivery on Key Aim 2

The following action plan identifies the key actions for 2012/13 in relation to Developing and maintaining strong links with relevant partnerships

Key Aim 2: Develop and maintain strong links with relevant partnerships					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
Work with SSCB regarding Communication and Marketing	Chair Communication & Marketing Sub-committee	June 2012	Achieved. Sub-committee has merged with SSCB Terms of reference agreed. Joint conference agreed for November 2012	Business plan updated	Green
SSAB to influence the Safer Sunderland Partnership Communication Plan	Chair Communication & Marketing Sub-committee	April 2013	In Progress. Virtual Communications Team developed; SSAB have members on this.	Co-ordination of safeguarding messages with other agendas	Amber

			Contributions added to their plan		
Briefing papers to be developed from learning and shared locally and Nationally	Chair Communication & Marketing Sub-committee	August 2012	Achieved. 1st briefing from Mrs AM SCR distributed via ADASS and Regional Health Group	Learning is shared nationally	Green
Ensure work of Board is regularly reported to relevant strategic partnerships	Chair of SSAB	October 2012	Achieved. Plan to report to Health and Well Being Board in September 2012	Ensure work of SSAB is embedded within other strategic partnerships	Green
Ensure relevant links are made to emerging clinical commissioning group post CCG authorisation	Chair of SSAB	November 2012	Achieved. CCG authorisation due in Oct 12	CCG take up membership of SSAB	Green

Key Aim 3: Promote the active involvement of service users, their carers, their families and their advocates

Delivery on Key Aim 3

The following action plan identifies the key actions for 2012/13 in relation to Promoting the active involvement of service users, their carers, their families and their advocates

Key Aim 3: Promote the active involvement of service users, their carers, their families and their advocates					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
SSAB website to be updated to	Chair	April 2013	In Progress.		Amber

ensure it is easily accessible for service users, their carers, their families and their advocates	Communication & Marketing Sub-committee		Sunderland City Council to host the website and SSAB to commission the Council to manage and update the content of the website.		
Service users, their carers, their families and their advocates to be offered opportunities to feedback about the work of SSAB and their experience of Safeguarding in Sunderland	Chair Communication & Marketing Sub-committee	April 2013	In Progress. Consultation completed with a range of customer groups Research involving people previously involved in the safeguarding adults process completed Joint report of findings to be reported to SSAB in September	Feedback to be provided to consultees in a 'You said….We did' format	Amber
Undertake audit of existing advocacy schemes in Sunderland	Chair Communication & Marketing Sub-committee	April 2013	In Progress. Reviewing past audits in this area	Gaps in current provision identified and fed to Commissioners Training needs of existing advocates identified and planned for	Amber

Key Aim 4: Oversee and monitor operational Safeguarding Adults activity

Delivery on Key Aim 4

The following action plan identifies the key actions for 2012/13 in relation to Overseeing and monitoring operational Safeguarding Adults activity

Key Aim 4: Oversee and monitor operational Safeguarding Adults activity					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
Develop a programme of audit to monitor and assure SSAB re safeguarding activity	Chair of QA Sub Group	March 2013	Achieved Cycle of audit has commenced. Further audits to be undertaken between September 2012 and March 2013	QA reports to SSAB Feedback to individual agencies re lack of compliance and good practice	Green
Develop an overarching audit process and Audit Tool to measure compliance with Safeguarding Adults process/procedures	Chair of QA Sub Group	July 2012	Achieved Framework and five Audit Tools have been developed and agreed by SSAB	Audit Framework review of interface between other agencies Review of tool for fit for purpose	Green
Ensure QA processes interface appropriately with Safeguarding Children and if required over other partnerships e.g. SSP	Chair of QA Sub Group	March 2013	In Progress. Shared representatives attending Safeguarding Children's QA Sub Group Consideration to be given to integrate Sub	Measure partners contribution to QA processes Report to SSAB to indicate an increase in level of compliance Appropriateness of	Amber

			Groups Chair of QA Sub Group to liaise with SSP re their Assurance Framework.	referrals can be demonstrated to other agencies	
Formalise process for key messages from audits to be passed to appropriate Sub Committees	Chair of QA Sub Group	October 2012	In Progress. QA Sub Group to develop formal process/form for feedback from audits	Practitioners knowledge and understanding Workforce fully up to date re audit measures Audit findings to be passed to other groups within 14 days	Amber
Produce an overarching performance report demonstrating trends and analysis of activities	Chair of QA Sub Group	July 2012	Achieved. Reports tabled Partners have robust information Performance report influences future QA activity	Partners' contribution to QA process. Reports to SSAB re levels of compliance Ensuring key principles from audits are presented to other sub committees/groups for action,	Green
Produce six monthly individual agency reports to go to CCG Exec, Trust Boards etc	Chair of QA Sub Group	October 2012	First draft reports to be published following discussion with business intelligence teams	Ensure sponsorship and ownership of key issues at board level in individual organisations	Green

Key Aim 5: Secure citywide consistency in safeguarding

Delivery on Key Aim 5

The following action plan identifies the key actions for 2012/13 in relation to Securing citywide consistency in safeguarding

Key Aim 5: Secure citywide consistency in safeguarding					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
Oversee and review the development and implementation of a new Safeguarding Adults Model in Sunderland	Chair of SSAB and Head of Strategic Commissioning	Not sure what to put here???	In Progress • 17 05 2011, Report taken to SSAB. The Board approved and agreed to a formal Review of the Safeguarding Adults Model in Sunderland • Formal review process took place which included consultation with staff, carers, service users and partner	More effective and robust safeguarding arrangements in the City of Sunderland. Gaps/limitations in current model addressed including performance information. Consistency in process. Better outcomes for individuals.	Amber

			agencies • October 2011, an internal 'To Be Service Re-Design' Report was commissioned by Sunderland City Council • This Report was presented to the Sunderland Safeguarding Adults Board on 17th January 2012. • A number of workshops with partner agencies and meetings with Health colleagues have taken place after this meeting. • The Board approved a revised/preferre		

			d model at the March Board meeting • July 2012, Briefing Report to Board members for sign off from agencies		
Review and revise Safeguarding Adults process in line with new Safeguarding Adults Model and update current Safeguarding Adults Procedures	??? Not sure who you want here – me??	December 2012	In Progress. • Procedural updates being provided by TriX – process reviewed • First draft back from TriX in September 2012	Up-to-date Procedures and new process available via web-enabled procedures	Amber
Merge appropriate sub groups of SSAB with SSCB sub committees to promote the 'whole family approach, joint learning and consistent approaches	SSCB Business Manager and Strategic Safeguarding	June 2012	Achieved.	New Joint Sub Committees established: 1. Training and Workforce Development	Green

	Manager			2. Legal, Policy and Procedures 3. Marketing and Communications All regularly report to SSAB and SSCB	
Establish Trainers Working Group as a Sub Group to the Joint Training Sub Committee	Chair of Trainers Working Group	September 2012	In Progress. Agencies contacted for representation on the Group	Group in place and training is facilitated by members of group which endorses multi-agency involvement. Group is used to monitor Training Programme, update and review as required	Amber
Review of current Safeguarding Adults Multi-Agency Training Programme	Chair of Trainers Working Group	September 2012	Achieved. Revised Training Programme to be delivered from September 2012	Revised multi-agency Training Programme is updated and reflects new safeguarding arrangements	Green
Review and update SA Training Strategy and develop a one-year Implementation Plan	Chair of Trainers Working Group	September 2012	In Progress. On target to be completed for next Joint Training Sub Committee meeting in	Implementation Plan includes training standards	Amber

			September		
Devise and arrange Threshold/New Safeguarding Model Workshops	Chair of Joint SSAB and SSCB Training and Workforce Development Sub Committee	December 2012	Workshops to be arranged when new Model signed off and new procedures/process agreed and written	Staff are aware of thresholds and their responsibilities linked to the new Safeguarding Model/process/procedures	Amber
Put in place data quality plan to improve timeliness of recording and outcome recording	Head of Strategic Commissioning	September 2012	In Progress. New business processes to be implemented	Significant improvements in recording of outcomes	Amber

Key Aim 6: Secure effective operational engagement and integration through strong governance arrangements and Board development

Delivery on Key Aim 6

The following action plan identifies the key actions for 2012/13 in relation to securing effective operational engagement and integration

Key Aim 6: Secure effective operational engagement and integration/Governance and Board Development					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
Exploit opportunities for closer working between Childrens and Adults Safeguarding	Chair of SSAB??	Not sure what to put here??	Ongoing. • Joint Sub Committees	What do you want to put here?????	???

			with SSCB established • Joint Development Days and Conferences with SSCB established		
Develop and establish a formal Risk Register that is regularly monitored, reviewed and updated by SSAB	Chair of SSAB??	June 2012	Achieved.	What do you want to put here??	Green
Review effective governance arrangements in view of changes to NHS	Chair of SSAB??	???	???	???	???
Review effectiveness of the Board, Board members and the Chair of the Board	???	April 2013	In Progress. Audit Tools for Board member development and Effectiveness of Board implemented	???	Amber
Board members will brief the Board on any significant developments that are likely to have an adverse affect on safeguarding	Chair of SSAB??	???	???	???	???
Individual agencies will be held to account	Chair of SSAB??	??	????	????	???

Key Aim 7: Promote a learning culture around safeguarding

Delivery on Key Aim 7

The following action plan identifies the key actions for 2012/13 in relation to Promoting a learning culture around safeguarding

Key Aim 7: Promote a learning culture around safeguarding					
Actions	**Lead**	**Deadline**	**Progress**	**Outcome Measures**	**RAG Rating**
Share and disseminate lessons learned from Sunderland Serious Case Reviews and benchmark learning from SCR's in other localities	Chair of SSAB	January 2013	Achieved: • Lessons learned identified • Executive Summary published In Progress: • Multi-Agency Workshops to disseminate lessons learned arranged for September/October 2012	Procedural and practice amendments and revisions agreed and implemented	Amber
Implement additional agency specific recommendations endorsed by the SCR Report	Agency leads	As per agency Action Plans	In Progress. Independent audits of individual agency recommendations to take place in September 2012	Recommendations agreed and implemented	As per agency Action Plans

Revised SA Training programme incorporates learning from SCR	Chair of Trainers Working Group	September 2012	Achieved	Lessons learned are shared as part of Training and good practice reinforced	Green

NOTE

1. Leads have been identified against actions in the Delivery Plan. They are responsible for ensuring that actions have been completed in timescale. Identified leads will be supported by multi-agency partners to complete the work.
2. This Business Plan will be overseen by an Accountable Officer, who is identified as the Head of Strategic Commissioning in Health, Housing and Adult Services. The Accountable Officer will liaise with the identified leads to oversee the Plan and report to the SSAB.

Welfare Reform Act 2012

REPORT BY: Executive Director Commercial and Corporate Services

SUBJECT: Welfare Reform and Localisation of Council Tax Project Update

DATE: July 2012

1 Purpose

To provide an update of the work ongoing by the council and its partners, in respect of preparing for the impact of the Government's Welfare Reform Programme, together with details of work undertaken so far.

2 Background

The Government's Welfare Reform Programme is the biggest change to the benefits system in at least 60 years. It aims to reduce overall spending on the welfare system by £18 billion per year by 2014-2015 and aims to reduce benefit dependency and 'to make work pay' for more people by ensuring that those on benefits are not better off than those with modest incomes.

Furthermore, it was announced in the 2012 budget that if in the next spending review the same rate of reductions is maintained there would need to be a further saving in welfare of £10 billion by 2016. Recent reports have also indicated that an additional £25billion savings could be needed in future years.

The majority of changes therefore will impact on:

<u>People of working age</u>

- Increase in the tax credit withdrawal rate from 39% to 41%
- Reduced amount of child care costs that can be covered from 80% to 70%
- Incapacity Benefit claimants expected to lose out through ongoing conversion to Employment and Support Allowance and 'tougher test'
- Contribution based Employment and Support Allowance limited to 1 year for most people
- Introduction of Universal Credit – a single means tested benefit / income replacement benefit for those out of work (unemployed or sick) or those in low paid work
- Proposed benefit cap of approximately £26,000
- Increased conditionality and increased range of sanctions proposed

- Less scope for challenging unfavourable benefit decisions

Children and Young People

- Child Benefit frozen for 3 years and withdrawn from higher rate tax payers (2013)
- Free school meals extension for Working Tax Credit recipients cancelled
- Health in Pregnancy Grant (£190) abolished
- Child Trust Fund payments cease
- Education Maintenance Allowance replacement provides approximately one third of the money that EMA did

People with a disability and carers

- Disability Living Allowance (DLA) replaced by new Personal Independence Payment with 20% cut in budget. Proposed changes include:
  - all claimants subject to review under new assessment criteria
  - longer qualification period before benefit can be paid
  - reduction in number of potential award levels
- Carers
  - knock on effect from above changes for those getting Carers Allowance / Carers Premiums – if DLA stops
  - additional allowance for 'live in' carers within 'Housing Benefit'
  - recognition that Carers Allowance is inadequate

Pensioners

- Protection for pensioners confirmed:
  - winter fuel payments and free TV licenses will continue
  - future assistance to help meet Council Tax costs should be no less than under current Council Tax Benefit System
  - basic pension triple guarantee – other benefit payments and housing costs linked to Consumer Price Index rather than Retail Price Index
- State pension equalisation from 2018 and raised retirement age to 66 from 2020.
- Savings credit freeze for 4 years
- Proposal to introduce 'flat rate' State Pension of £140 per week

Housing Benefit / Local Housing Allowance

- Private Housing Benefit rates based on the lowest third of market rents rather than the 50th percentile
- Changes to rules about topping up housing benefit in certain cases
- LHA benefit capped at the 4 bedroom rate.
- Potential increase in Non-dependant Charges
- Single claimants under 35 will receive benefits based on the shared room rate
- Size Criteria rules introduced in the Social Housing Sector - rent only paid for the minimum size of accommodation required

The programme also involves a major change in responsibilities in relation to administering benefits for those of working age, with councils losing responsibility for the current housing benefit system, but gaining responsibility for developing and implementing localised Council Tax Support and for providing support to vulnerable people in emergency situations, which was previously met by the Social Fund.

A number of changes have already been implemented with the majority of the rest due for implementation between now and 2013, however the specific detail for many of these is still to be developed, may still be subject to change, and transitional arrangements between the old and the new are expected to be in place in relation to some benefits for a number of years.

Work undertaken so far, using fair presumptions, indicates the net loss of income to the City over the period 2011-2013 could be in the region of £52m for individual benefits. This includes Disability Living Allowance, Incapacity Benefit, Jobseekers Allowance, Child Tax Credit and Working Tax Credit.

Work is ongoing to identify further impacts due to multiple effects, for example, as the changes progress it is apparent that residents could be personally affected three times e.g. by:

- dwelling size criteria,
- reduction in Housing Benefit to 50p per week due to the benefits cap of £26k pa with effect from April 2013.
- the introduction of Universal Credit in October 2013

From data modelling and scenario planning undertaken, the following case studies have been designed to demonstrate the possible impact of welfare reform on individuals/families currently in receipt of benefits and support available to them.

Individual

John is single and aged 30. He has worked in the past, mainly on casual contracts where he was sent home if there was no work. He is currently signing on and gets £71.00 in Job Seekers Allowance per week.

He has previously been sanctioned (lost his benefit) for two weeks because he was late signing on and he did not have a good enough reason for not doing so. Because of this he didn’t receive JSA for two weeks and, as he was not in a priority group, he was not entitled to a hardship payment or Crisis Loan.

His Housing Benefit has also been affected by changes introduced in January 2012. He now only receives Housing Benefit based on a shared accommodation rate rather than enough for his one bed roomed flat. He has to try to make up the shortfall himself from his Job Seekers Allowance, which leaves him less money each week to pay for other essentials and bills, and he is going further into debt as a result.

In order to try to improve his situation he is taking part in the work programme and is on a training course that he hopes will increase his chances of finding a job.

People / the retired

Mr and Mrs Jones are both aged 63. Mr Jones had been receiving Employment and Support Allowance, based on his National Insurance Contributions but this stopped at the beginning of May due to a change in the rules for many people getting ESA. Mrs Jones only has a small occupational pension. Both are in ill health and were worried about how they were going to manage, as they only have limited savings.

Mr Jones made enquiries at his local Customer Service Network; where he was advised by council staff about his entitlement to Housing and Council Tax Benefit.

They also recommended that he access the council web pages in relation to checking how the changes brought about by welfare reform could affect him, www.sunderland.gov.uk/benefitchanges and to check on other potential benefit entitlements.

He was assisted to find the pages and was able to learn a lot about the proposed changes and this reassured him that he knew what to expect.

He also found out that he and his wife could be entitled to Pension Credit due to his and his wife's low income and limited savings

He was able to contact the Pension, Carers and Disability Service (DWP) about this claim, but he also took the telephone number of his local advice centre, in case he needed further advice with this.

Mr Jones felt empowered and confident following his visit, and more able to be able to access information / services in the future

Children and Families,

Mr and Mrs Smith live in local authority accommodation with rent of £80 per week. They have two children. Mr Smith currently earns £350 per week but has been told his hours are to be reduced to 22 per week for the foreseeable future. They owe a loan of £2,000, catalogue debt of £600 and a credit card with £1200 outstanding. The family have never claimed benefits other than Child Benefit and now don't know which way to turn.

Mr Smith was in his local library when he saw someone using the computer to access Sunderland City Council www.sunderland.gov.uk/benefitsandyou . He decided to have a look and quickly realised that he could get help. He took numbers for his local advice provider and an organisation that could help him look at his finances.

The local advice provider informed Mr Smith that he could be entitled to Child Tax Credit and also to Housing Benefit/ Council Tax Benefit to reduce their rent and council tax payments. He was advised to inform Housing Benefit and Council Tax Benefit if their tax credit claim was successful

Mr Smith contacted the Money Advice Service and using their resources was able to negotiate lower monthly payments on all of his debts, and also make the money that the family had coming in to go further.

3 Actions taken so far

The aim of the project is to prepare the council, its partners, employees and other stakeholders for the impending changes. The following workstreams have been designed to identify specific responsibilities, cross-overs, links and dependencies to existing strategies and ongoing or planned work programmes. Parameters are also set for where activity needs to be jointly delivered or where it should be delivered discreetly, whilst also avoiding duplication and seeking minimisation of barriers to delivery.

Across the project, initial risks have been identified and financial resources are being identified.

1. Preparation for the Introduction of Universal Credit

   Universal Credit (UC) is a single means tested benefit/income replacement benefit for working age people out of work (unemployed or sick) or those in low paid work. From September 2013 UC will be administered centrally by the Department for Work and Pensions (DWP) and will replace six other means tested benefits and tax credits which are:

   - Housing benefit (HB)
   - Income support (IS)
   - Income based jobseeker's allowance (JSA)
   - Income related employment and support allowance (ESA)
   - Child tax credit (CTC)
   - Working tax credit (WTC)

   It is intended that the introduction of UC will enable the Government to increase and better target the support that is provided through the benefit system in order to ensure that work always pays and the most vulnerable are protected. By creating a single, integrated benefit, households who claim UC will automatically receive everything they are entitled to.

   Activity Completed:

   - Data sets of live benefit caseload is available and being utilised to enhance data modelling and scenario planning
   - Data sets of those that are not known to us (i.e. residents not claiming council benefits) are being developed
   - Agreement with Job Centre Plus (JCP) to work jointly on work incentives
   - Admin Grant under review
   - Local Presence models under review
   - e-enablement of Benefit Applications available and being rolled out by using advocates throughout the city to help with self service/supported self service.

This includes partners such as Gentoo and other Registered Social Landlords, Private Landlords, Citizens Advice Bureau, Age Concern etc. in the process of mapping support networks throughout the city and then utilising corporate communications to maximise support and take up.

2. Policy Changes and Impacts and Analysis, Impact on Council Services Performance and Outcomes and Increased Demand for work

   The purpose of the workstream is to keep abreast of potential and actual changes that the Welfare Reform Programme may have for customer services provided by Local Authorities (Local and Regional) and local partners and the impact on customers e.g. capping of benefits. To understand the affect upon Council services and to enable interventions, and process updates to be made. To make links with other stakeholders e.g. Job Centreplus, to enhance access / data share re national and local employment market data to determine the likelihood of additional impact.

   Activity Completed:

   - Various stages of data analysis have been completed giving a snapshot of affected areas in the city by proposed changes
   - A SPPM working group has been set up to look at policy and performance implications

3. Working with Landlords

   This workstream includes the setting up of a working group with landlord representatives/groups to discuss issues that will impact on landlords and their tenants such as potential increase in rent arrears, collection costs, evictions and to also explore areas for tenant support by creating affordable tenancies and considering rent reductions for model tenants.

   Activity completed:

   - Presentation by the Benefit Section at Landlord Forums, the Child Poverty Working Group and Homeless Group
   - Joint working with Landlords to assist tenants impacted by the single room rate change
   - 3 monthly landlords forum arranged with Private Rented Sector Landlords

4. Single Financial Assessment and Benefit take-up

   A single financial assessment system is being developed to produce a single notification of potential entitlements for residents, with clear links to applications. This includes Council benefits and also identifies potential entitlement to a range of other benefits and identifies entitlements linked with UC. This will therefore

maximise benefit take-up whilst also reducing time and cost for the Council and the customer.

Activity completed:

- The Council has procured a tool to support improved customer access across all information, advice and guidance levels, including increasing the capacity and involvement of mediated access partners, via e-learning modules and tools.

- Phased introduction is taking place to allow the Council to address priority areas first whilst also allowing for some quick wins.

5. Community Care Grants and Crisis Loan

Responsibility for administering Community Care Grants and Crisis loans is to transfer to the Council in April 2013. This workstream will develop processes to consider applications and provide support to the City's customers.

Activity completed:

- A briefing has been drawn up to highlight potential options for this work stream
- Current provision within the City is being mapped out to identify potential lead providers and/gaps in service
- Discussion is ongoing with other regional LA's regarding potential best practice/call for evidence data

6. Design and Implementation of the Localisation of Council Tax Support Scheme

This work stream will deliver a new localised Council Tax support scheme, replacing the current Council Tax Benefit system the council currently delivers.

Activity completed:

- A tool has been identified that will help with the analysis required to determine the new scheme
- Discussions are ongoing with neighbouring councils around best/shared practice
- Options are being developed toward identifying a preferred scheme for further consultation

7. Housing Policy and Alignment

The desired outcome of this work stream will give us a full understanding of the impact welfare reform has on the housing stock within the city.

Data is currently being analysed to understand the impact at individual/family, community, organisational and economic levels. Partnership working will then be developed with other stakeholders e.g. Gentoo, third sector, RSL and private

sector to further understand the needs of the different groups and their likely preferences in terms of engagement and to inform the development and/or deployment of assets to better support these groups.

8. Assumed consent for Free School Meals

This workstream includes 2 phases. Phase 1 is complete with regard to the involvement through this project, producing a major uptake of free school meals and therefore also helping to maximise of benefits.

Phase 2 is currently developing and further considers the impact of the welfare reform impacts on both those that are currently in receipt of free school meals and also the Council's school meal service.

9 Working with Jobcentre Plus

The purpose of this work package is to describe how the Welfare Reform Board will work closely with JCP to ensure that both parties are aware of issues that may affect them as a consequence of the new approach to conditionality and sanctions and that all actions and measures put in place are subject to joined up working where possible. This is especially important to help with understanding how such changes may impact upon advice given and services provided by the Council i.e. eligibility for the Council Tax Support Scheme, Crisis Loans and Community Care Grants.

10 Communications and Links with others

A welfare reform communications plan has been developed to raise awareness of continuing changes and responsibilities, encourage self service, and to support dissemination of key messages around money management, debt advice and illegal money lending.

The 'Stay informed, plan ahead' campaign was launched in June 2012 to communicate the changes to residents, landlords businesses and other key stakeholders. It includes:

- creating and maintaining an informative on-line portal. This will also act as signpost facility for residents to direct them to the most appropriate agency producing and distributing a range of materials to direst those affected to the on-line portal e.g. posters, newspapers, radio and social media
- promotional materials e.g. via libraries, leisure centres, schools, GPs and electronic village halls
- member communications e.g. area committee briefings and ward bulletins

As the Welfare Reform Project progresses, further workstreams will come on line to enhance the aims of the project, for example potential working with GPs and Schools.

Appendix A gives a visual indication of how the Project aims to collate data, make links with others, communicate messages across the City in relation to welfare

reform and also in preparation for the introduction of Universal Credit from September 2013.

Welfare Reform Project
Preparing the City for Welfare Reform