SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held on Friday 1 October 2021 at 12.00pm in the Council Chamber, Sunderland Civic Centre

ITEM		PAGE
1.	**Welcome**	
2.	**Apologies for Absence**	
3.	**Declarations of Interest**	
4.	**Minutes and Action Log of the Meeting of the Board held on 25 June 2021** (attached).	1
	ITEMS FOR DECISION	
5.	**Sunderland Joint Strategic Needs Assessment (JSNA) 2021/2022** Report of the Executive Director of Public Health and Integrated Commissioning (attached).	17
6.	**Developing Our Approach to Improving Health and Reducing Health Inequalities** Report of the Executive Director of Public Health and Integrated Commissioning (attached).	69
7.	**The North East and North Cumbria Integrated Care System and Integrated Place-Based Arrangements** Joint report of the Executive Director of Public Health & Integrated Commissioning and Chief Officer/Chief Finance Officer of Sunderland CCG (attached).	75
	ITEMS FOR DISCUSSION	
8.	**Covid-19 in Sunderland - Update** Report of the Executive Director of Public Health and Integrated Commissioning (attached).	105

For further information and assistance, please contact by Teams or Email:
Gillian Kelly, Principal Governance Services Officer gillian.kelly@sunderland.gov.uk
Tel: 07919 509178

9.	**Health and Wellbeing Delivery Boards Assurance Update**	107
	Joint report of the Chief Executive of Together for Children, Executive Director of Public Health and Integrated Commissioning and the Executive Director of Neighbourhoods (attached).	
10.	**Sunderland Safeguarding Adults Board (SSAB) Annual Report**	
	Report of the Independent Chair of Sunderland Safeguarding Adults Board (attached).	
	ITEMS FOR INFORMATION	
11.	**Health and Wellbeing Board Forward Plan**	129
	Report of the Senior Policy Manager, Sunderland City Council (attached).	
12.	**Dates and Times of Future Meetings**	-
	The Board is asked to note the proposed schedule of meetings for 2021/2022: - Friday 10 December 2021 Friday 18 March 2022 All meetings to start at 12.00pm and will take place in the Civic Centre, Sunderland.	

ELAINE WAUGH
Assistant Director of Law and Governance

Civic Centre,
Sunderland

23 September 2021

Item No. 4a

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 25 June 2021

Meeting held in the Council Chamber, Sunderland Civic Centre

MINUTES

Present: -

Councillor Kelly Chequer (in the Chair)	-	Sunderland City Council
Councillor Louise Farthing	-	Sunderland City Council
Councillor Fiona Miller	-	Sunderland City Council
Ken Bremner	-	South Tyneside and Sunderland Foundation Trust
Fiona Brown	-	Executive Directors of Neighbourhoods, Sunderland City Council
David Chandler	-	Chief Officer, Sunderland CCG
Dr Yitka Graham	-	University of Sunderland
Dr Tracey Lucas	-	Member, Sunderland CCG
Dr Ian Pattison	-	Chair, Sunderland CCG
Chief Superintendent Sarah Pitt	-	Safer Sunderland Partnership
Gerry Taylor	-	Executive Director of Public Health & Integrated Commissioning, Sunderland City Council

In Attendance:

Dr Shaz Wahid	-	Medical Director, South Tyneside and Sunderland Foundation Trust
Scott Watson	-	Lead for Mental Health, Sunderland CCG
Lisa Forster	-	Sunderland CCG
Paul Weddle	-	Vice-Chair, Healthwatch Sunderland
Jane Hibberd	-	Senior Manager - Policy, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

HW1. Welcome

Councillor Chequer welcomed everyone to the meeting and invited Board Members to introduce themselves. She particularly welcomed the new Members; Councillor Fiona Miller; Councillor Dominic McDonough, Patrick Melia, Dr Yitka Graham and Chief Superintendent Sarah Pitt.

HW2. Apologies

Apologies for absence were received from Councillor McDonough, Jill Colbert, John Dean, Patrick Melia, Ralph Saelzer and Dr Martin Weatherhead.

HW3. Declarations of Interest

There were no declarations of interest.

HW4. Minutes and Matters Arising

The minutes of the meeting of the Health and Wellbeing Board held on 19 March 2021 were agreed as a correct record.

HW5. Update on Phase 2 Path to Excellence Programme – Working Ideas

The Medical Director, South Tyneside and Sunderland Foundation Trust submitted a report providing an update on the ongoing pre-consultation process which the Path to Excellence programme was following in order to involve NHS staff, patients and stakeholders in developing options/proposals for change which would be subject to a wider public consultation later in the year.

Phase 1 of the Path to Excellence had been implemented in August 2019 and had considered stroke care, maternity and gynaecology services and acute paediatrics. Phase 2 was concerned with how the Trust looked after people in an emergency or who had an urgent health care need in Medical and Surgical specialities and how planned care was provided.

Clinical teams had considered a wide range of options and developed working ideas for each service. For Trauma and Orthopaedics, there were two working ideas: in the first all emergency in-patient survey would be provided at Sunderland Royal Hospital (SRH), planned orthopaedic surgery would take place at South Tyneside District Hospital (STDH), complex orthopaedic surgery would be provided at SRH, most planned day case surgery would occur at STDH and urgent day case surgery would be provided at SRH; the second working idea was similar but both urgent and planned day case surgery would be provided locally.

General Surgery included surgery to the upper and lower gastrointestinal tract and bariatric surgery and there were three working ideas for this area mainly related to how in-patient planned surgery was provided. The first idea would see all in-patient emergency surgery provided at SRH, all planned in-patient surgery at STDH and planned day case surgery at both sites. The second working idea would have both emergency and planned surgery provided at SRH and day case surgery at both sites. The third idea was for planned in-patient surgery to be split between the two sites depending on the specific type of surgery and planned day cases being dealt with on both sites.

Dr Wahid advised that the working ideas were still being refined and were not yet developed to a stage for public consultation but a pre-consultation business case would be developed, informed by the working ideas and stakeholder feedback and including external assessments by the Clinical Senate, a Travel and Transport Impact Analysis and an Integrated Impact Analysis.

Councillor Farthing commented that it was an interesting paper and that the travel factor was very significant for patients and relatives; people in hospital would often recover more quickly if they had more visitors, however a large number of these might be older people who were likely to struggle more with accessing transport to hospitals.

Dr Wahid noted that the Trust was working with external partners in relation to accessibility and looking at good practice from other areas in similar circumstances. The equality part of the assessment would drive the viable options for the changes.

Dr Pattison highlighted that it was an impossible task to meet public expectation when reviewing services but he understood the necessity of the work as a clinician. With the majority of surgery now being day cases, he noted that this would see a large number of Sunderland patients travelling to South Tyneside. Dr Wahid said that ultimately patients would get access to surgery more quickly and the split between emergency and elective would mean that there could be a focus on one area for a more consistent period.

Dr Lucas asked what would the critical impact be, as she did not feel that this came over strongly at this point. Performance at STDH was higher at the present time and this was a crucial element to consider going forward.

Dr Wahid stated that some working ideas would allow performance to be improved and enable patients to access specialist surgeons straight away. It was a complex situation and the overall impact and performance measures would form part of the business case for the consultation.

The Chair queried how health inequalities would be considered and the timeframe for the next stage of the process. Dr Wahid explained that the timeframe was being reviewed as part of the process and this would become clearer in the next few months. Inequalities would be one of the key things in the 'business as usual' approach to the work.

Having thanked Dr Wahid for his report, it was: -

RESOLVED that the update on Phase 2 of the Path to Excellence Programme be noted.

HW6. Health and Wellbeing Board Membership and Terms of Reference

The Executive Director of Public Health and Integrated Commissioning submitted a report setting out the updated membership and terms of reference which had been agreed by Annual Council on 19 May 2021.

The membership of the Board had been amended to include the Chief Executive, Sunderland City Council, the Chair of the Health and Care Executive, the Chair of a place based provider alliance and a representative of the Safer Sunderland Partnership. The additional membership would assist in strengthening the leadership capacity of the Board to secure effective joint working between the NHS, Local Authority and wider delivery partners to improve health outcomes.

Changes had been made to the Terms of Reference to reflect the current role of the Board in overseeing the delivery of the Healthy City Plan.

Dr Pattison expressed surprise at the Chair of All Together Better being only an interim member of the Board as ATB was a key part of the health system in Sunderland. Gerry Taylor explained that the membership was intentionally flexible so that it could be added to as provider arrangements further developed.

RESOLVED that the changes to the membership and Terms of Reference of the Health and Wellbeing Board be noted.

HW7. Healthy City Plan Grant

The Chief Officer of Sunderland Clinical Commissioning Group and the Executive Director of Public Health and Integrated Commissioning submitted a joint report seeking approval for the proposed approach to agreeing the distribution of resources allocated from NHS health funding to support delivery of the Healthy City Plan.

£750,000 funding had been allocated as a grant from the CCG to support the delivery of the Health City Plan and to respond to the negative impacts of the Covid-19 pandemic on the health and wellbeing of Sunderland residents. £50,000 had been earmarked for behavioural insight work, health equity audits and other initiatives to inform the key priorities and workstreams within the Healthy City Plan. The residual £700,000 was to support investment into capacity and capability to deliver projects contributing to the achievement of the Plan.

It was proposed that the Chair of the Health and Wellbeing Board, the Executive Director of Public Health and Integrated Commissioning and the CCG Chief Officer be delegated to consensually agree the allocation of the grant to schemes.

There would be specific criteria to be applied when considering approvals and the three delivery boards would be invited to put forward proposals. It was envisaged that the resource would be allocated over a two to three year period and regular reports on the deployment of the resource would be provided to the Health and Wellbeing Board for information.

RESOLVED that: -

(i) the update on the Healthy City Grant be noted; and

(ii) the proposed approach with regard to the distribution of resources in support of delivering the aims of the Healthy City Plan be agreed.

HW8. The North East and North Cumbria Integrated Care System and Integrated Place Based Arrangements

The Executive Director of Public Health and Integrated Commissioning and the Chief Officer of Sunderland CCG submitted a joint report providing the Board with an overview of the preparations by the North East North Cumbria Integrated Care System to take on its statutory responsibilities from April 2022 and an overview on the development of integrated place based arrangements.

David Chandler advised the design framework for the Integrated Care System had now been published and was summarised in a presentation which would be circulated to Board Members after the meeting. The framework set out the four key elements of the new system: -

- The ICS Health and Care Partnership
  This would have the responsibility for developing the 'integrated care strategy' for their whole population and members would include local authorities responsible for social care services in the ICS area as well as the local NHS.

- The ICH NHS Body and its board membership
  This body would be responsible for developing a plan to meet the health needs of the population and allocating resources to deliver the plan. The ICS NHS bodies would take on all the functions of CCGs and would have a unitary board with shared corporate accountability for the delivery of the functions and duties of the ICS.

- Place-based health and care partnerships
  These partnerships were for local determination and partners within each ICS would decide how best to bring together parties to address the needs of the place.

- Provider collaboratives working at scale
  Each collaborative would agree specific objectives with one or more ICS to contribute to the delivery of that system's strategic priorities. Trusts and Foundation Trusts would be expected to join provider collaborative arrangements from April 2022.

NHS England would allocate funding to the ICS Body and the ICS NHS Board would be responsible for the utilisation of the resources. Budgets allocated to 'place' could include primary services and Section 75 pool arrangements and the guidance was indicating that if something could be done at place level the it should be.

Councillor Farthing asked about the scrutiny of the arrangements, noting that this would be a very large body and elected Members would like to be able to guarantee to local people that they were getting a fair share. David Chandler said that he understood that scrutiny powers would not be changed or affected by the new structure and there would be some engagement sessions with the ICP area footprints.

Gerry Taylor highlighted that within all of the changes, partners had been working on the integrated approach for health and social care across Sunderland and section 4

of the report outlined the current position. The two elements of provision and commissioning were expected to take into account the whole gamut of what was expected. The strategic approach in the future would be based on the JSNA and providers were looking at how they would work together to deliver the outcomes the city wanted to achieve.

Gerry noted that chief executives had been meeting to talk about governance arrangements over the last few months and it was expected that reports on the Integrated Care System would come back regularly for the Board to have oversight of the system and new ways of working.

The Chair asked how place based arrangements would interact with the integrated model and if there was further detail on the funding element.

David Chandler said the ICS had not yet engaged with place but the overriding philosophy was that if it could be done at place, then it should be. The funding allocations were currently based on a national formula and it was thought that funding to the ICS would also be based on a formula model; the ICS would then determine what was allocated. It was not yet known what the impact would be but there was a desire to protect place base budgets and some areas would require more short term support.

The Chair noted that it was reassuring that this was on the agenda and David stated that everyone in Sunderland would be fighting to get the required resources. Dr Pattison commented that the issue was one of transparency and accountability and it was important to see the ICS allocation being mapped back to place.

RESOLVED that: -

(i) the report be received and noted;

(ii) the proposed arrangements be supported; and

(iii) an updated position be received at the next Board meeting.

HW9. Adult Mental Health Strategy

The Director of Contracting, Planning and Informatics, Sunderland CCG submitted a report seeking endorsement from the Board for the Adult Mental Health Strategy for Sunderland. It was noted that the Governing Body of NHS Sunderland CCG had ratified the strategy on 22 June 2021.

Scott Watson and Lisa Forster were in attendance to talk to the report and deliver a presentation. There had been four phases in the development of the strategy and the first and second phases had involved engagement with stakeholders, public, service users, staff and employers.

A draft engagement report was published at phase three for comments and feedback and findings were tested through focus groups. The fourth and final phase was the

drafting of the strategy during March to June 2021 and the draft strategy was shared for feedback and comment in June. The vision of the strategy was: ‘Everyone’s Mental Health Matters: Empowering people by supporting individuals, families and communities to improve and maintain mental and physical health, so they can lead fulfilling and healthy lives.’

There were three strategic priorities: -

- An ounce of prevention is better than a pound of care;
- Right Response, Right Time, Right Place; and
- Working with you on what matters to you.

In terms of measuring the success of the strategy, officers would continue to work to develop and finalise and evaluation framework to underpin the strategy in order to assess progress and achievement of the vision and work would continue with key partners to co-produce a delivery plan which underpins the commitments of the strategy.

Councillor Miller asked about health inequalities and that there seemed to be an issue in accessing counselling for deaf patients. Lisa Forster agreed that this had come across in the consultation and would be picked up in the delivery plan.

Fiona Brown said that she would like to see more around social prescribing, community assets and the voluntary and community sector. Scott noted that message had been coming through as part of the engagement process and would be part of the delivery plan.

Dr Graham noted that it was important to have a sense of communities as well as individuals and to have that built into the strategy in the context of wellbeing. Issues of stigma and shame had to be borne in mind and positive messages promoted.

Lisa said that again, this was recognised in the consultation and would be built in. Scott added that there had been a view that things were improving in relation to stigma but there had been significant challenges in BAME communities and the strategy would be tailored due to these variations.

Gerry Taylor was pleased to see the increased emphasis on prevention, however noted that it was quite difficult to achieve and queried how attention could be turned to prevention. Lisa commented that Mental Health Concordat would shortly be in place and messages would also be conveyed through the Healthy Workplace Alliance.

Dr Lucas commended the strategy, felt that the integration was very welcome and liked the idea of a ‘no wrong door’ approach. Those who had been involved in the development of the strategy deserved extra recognition for the efforts which had been made during the pandemic and the outputs reflected what happened on the ground on a day to day basis.

Chief Superintendent Pitt said that the strategy was welcome from a policing point of view and that pathways and signposts were very important. She asked if engagement would continue or be reviewed if the strategy worked.

Scott said that now the strategy was in place, the key question was 'so what?'. There would be follow up with communities to show that the strategy was delivering.

The Chair noted that it was an extremely welcome report and looked forward to the next stage of its implementation. The strategy would be monitored through the Living Well Delivery Board.

RESOLVED that: -

(i) the contents of the report be noted; and

(ii) the Adult Mental Health Strategy for Sunderland be ratified for publication.

HW10. Covid-19 in Sunderland – Update

The Executive Director of Public Health and Integrated Commissioning submitted a report providing an update on the Covid-19 situation in Sunderland.

Gerry Taylor delivered a presentation to the Board and in doing so highlighted that most new cases in the city were in older children and young adults. The current case rate was 185 per 100,000 population and it was expected that this would be up to 200 by the weekend, much of this increase in infections was due to the Delta variant. The presentation provided an update on the vaccine programme in the city and action being taken to ensure equity across Sunderland. Venues for pop-up clinics were being sought in Hendon and Millfield wards as they had some of the lowest levels of uptake.

The most up to date information on hospitalisations was that there were four Covid patients in Sunderland Royal Hospital and none in South Tyneside.

Ken Bremner asked if it was now compulsory for staff and residents in care homes to be vaccinated and Gerry advised that it would be compulsory for staff. Fiona Brown added that the vaccination status of any other workers who might come into homes would be considered but there had not been a lot of care home staff who had refused the vaccine.

Dr Lucas noted that, in the general population, people seemed to think that taking a Lateral Flow Test was enough if they had symptoms and they could then be falsely reassured. She asked if there were any communications planned on this.

Gerry agreed that there was a different message to get over about different types of testing and she often referred to that in her videos and the information on the Council website. People also forgot to register tests and these messages would be repeated as part of the ongoing communications strategy. Councillor Farthing endorsed the

need for communication on this as people assumed that everything was okay because of a negative Lateral Flow Test but this was not always the case.

Dr Lucas also commented on the impacts being seen on education and asked if more information was needed before a decision was made on how much of a school class had to isolate. Gerry said that discussions took place with the school and advice was given on who needed to self-isolate and who did not; there were some elements of what would happen in September which were still awaited.

Fiona Brown noted that there was a reassuringly small number of cases currently in hospital, but many workplaces were now feeling the pressure due to the numbers of staff self-isolating.

RESOLVED that the update and the presentation be noted.

HW11. Shared Vision of Equality, Diversity and Inclusion

The Chief Superintendent, Area Commander Southern, Northumbria Police submitted a report informing the Health and Wellbeing Board of the equality, diversity and inclusion work being led by Northumbria Police, share information on an overarching shared vision agreed by the City Board and encouraging the Board to support the vision.

Equality, diversity and inclusion within police forces was driven by a national toolkit and integrated into Northumbria Police's strategic priorities. Northumbria Police had engaged with six local authorities, Tyne and Wear and Northumberland Fire and Rescue, the North East Ambulance Service, the Police and Crime Commissioner and other partners to determine commitment to a joint way of working and a shared vision.

The Sunderland City Board had agreed to an overarching shared vision and individual bodies were being asked to consider how this could be included in their terms of reference. There was massive potential in the work of the Health and Wellbeing Board to drive improvements in disparity and inequality and it could ultimately help to drive work to tackle the social determinants of health.

The vision was: -

"As strategic partners in the North East we understand the diversity and difference found within our vibrant region. We recognise that as a partnership we have a key role in terms of enhancing and promoting the huge benefits diversity, equality and inclusion play in ensuring the region remains an inclusive place to live, work and visit.

Through closer working arrangements, improved community engagement and effective use of current, relevant information, we will strive to identify and safeguard those most at risk of harm and understand and eliminate any disparity in the joint services we deliver. This shared knowledge will assist in providing equal opportunities for everyone and a service that meets the needs of all communities irrespective of their backgrounds.

We will provide an inclusive and diverse workforce that reflects the community we service, ensuring that our staff are appropriately trained, equipped and empowered to meet the needs of our communities.

Areas of responsibility and key deliverables will be identified within the partnership and we will develop pledges which we will share with our communities and on which they will hold us to account.

The Partnership will continue to work together, robustly reviewing working practices and making sure diversity, equality and inclusion are central to our response.

We are fully committed to making sure our region is a safe and inclusive place for everyone."

The Chair thanked Chief Superintendent Pitt for bringing the vision to the Board and accordingly it was RESOLVED that: -

(i) the shared vision be acknowledged and its application throughout the Boards and member organisations' work be supported;

(ii) the inclusion of the statement in Health and Wellbeing Delivery Board Terms of Reference be supported;

(iii) it be ensured that equality, diversity and inclusion were central to partnership and organisational responses; and

(iv) links to Northumbria Police be strengthened to ensure that opportunities to respond to local needs and delivering on partnership objectives were being maximised.

HW12. Health and Wellbeing Board Delivery Boards

The Executive Director of Public Health and Integrated Commissioning submitted a report seeking approval for the terms of reference of the delivery boards and providing a summary of the key points discussed at the inaugural meetings of the three delivery boards.

Gerry Taylor advised that it was intended to come back with regular updates on the work of the three boards but following the initial meetings, the boards had suggested some changes to their terms of reference.

Fiona Brown referred to the vice-chair arrangements for the boards and that it was proposed that this should be spread across all organisations and not restricted to the local authority or health partners.

The Board therefore RESOLVED that: -

(i) the finalised terms of reference for the delivery boards be formally agreed;

(ii) the meeting summaries from the inaugural meetings of the delivery boards be noted; and

(iii) it be agreed to receive regular updates from the delivery boards.

HW13. Healthwatch Sunderland Annual Report 2020/2021

The Chair of Healthwatch Sunderland submitted a report providing the Board with an overview of activity conducted by Healthwatch Sunderland throughout 2020/2021. Paul Weddle, Vice-Chair of Healthwatch Sunderland was in attendance to talk to the report.

Highlights of the activity undertaken by Healthwatch Sunderland throughout the year included: -

- Provided feedback to service providers over 700 people's experiences of using health and social care services during the pandemic.

- Worked with local NHS Breast Screening service providers to utilise patient feedback, so that information provided by the services in the future, would be more accessible to all patients across England.

- Involvement in the North East and Cumbria Integrated Care System NHS initiative had been strengthened and the development of a network of chairs across the region had been initiated.

- Feedback reports had been published in relation to peoples' experiences of the COVID-19 vaccination programme across the city and these had been well received by the CCG.

- Healthwatch Sunderland had represented patients in the development of a new app developed by the Local Authority, to support people's ability to remain independent in their own home.

- There had been increased Healthwatch Sunderland presence on social media and developed virtual forums on national health campaigns, where members of the public could come along to gain information and ask providers questions directly.

- Relationships had been built with organisations who represented those people from diverse backgrounds.

For the forthcoming year, Healthwatch would be supporting All Together Better, reviewing domiciliary care and looking at supporting and developing young people.

The Chair thanked Paul for presenting the report and particularly commended the work which had been done in relation to breast screening.

RESOLVED that the contents of the Healthwatch Sunderland Annual Report 2020/2021 be noted.

HW14. Sunderland 2020/2021 Better Care Fund Technical Submission

The Executive Director of Neighbourhoods submitted a report for information providing an update in relation to the 2020/2021 annual Better Care Fund (BCF) submission for Sunderland.

The submission was signed off by the Chief Officer of Sunderland CCG and was made to NHS England and Improvement in line with national expectations for the deadline of 24 May 2021.

RESOLVED that the 2020/2021 Sunderland BCF return be received for information.

HW15. Health and Wellbeing Board Development Session: Introduction to Behavioural Insights

The Executive Director of Public Health and Integrated Commissioning submitted a report providing an overview of the 'Introduction to Behavioural Insights' Health and Wellbeing Board Development Session held on 23 March 2021.

The report set out the topics covered and findings of the workshop activities and the next steps for the piece of work.

RESOLVED that: -

(i) the content of the report be noted; and

(ii) the final report of the Sunderland Behavioural Insights Programme be received for consideration of the findings via the Starting Well Delivery Board.

HW16. Forward Plan

The Senior Policy Manager submitted a report presenting the forward plan of business for 2021/2022.

Members of the Board were encouraged to put forward items for future meeting agendas either at Board meetings or by contacting the Council's Senior Policy Manager.

RESOLVED that the Forward Plan be received for information.

HW17. Dates and Time of Next Meetings

The Board noted the schedule of meetings for 2021/2022: -

Friday 1 October 2021
Friday 10 December 2021
Friday 18 March 2022

All meetings were to start at 12.00pm and would take place in the Civic Centre, Sunderland.

(Signed) K CHEQUER
In the Chair

Item No. 4b

HEALTH AND WELLBEING BOARD ACTION LOG				
Board Meeting ID	**Action**	**Responsible**	**Timescale**	**Completed/Action Taken**
11/12/20				
HW35.	Health and Wellbeing Board to sign up to the Prevention Concordat for Better Mental Health for All	Jane Hibberd Julie Parker-Walton	Revised timescale April 2022	A number of scheduled actions will lead to the sign up of the Concordat.
25/06/21				
HW7.	Regular 'for information' reporting to be provided to the Health and Wellbeing Board on the deployment of the Healthy City Grant	David Chandler Gerry Taylor		No grant allocated to date.
HW8.	An updated position on the development of the Integrated Care System and Integrated Place-Based Arrangements to be presented to the Board	David Chandler Gerry Taylor	October 2021	Scheduled agenda item.
HW11.	Support the inclusion of the Shared Vision for Equality, Diversity and Inclusion in Delivery Board Terms of Reference.	Jane Hibberd	October 2021	Complete.
HW12.	Terms of reference for Delivery Boards to be amended to reflect that Vice-Chair positions are not restricted to the local authority or health representatives.	Jane Hibberd	October 2021	Complete.

Item No. 5

SUNDERLAND HEALTH AND WELLBEING BOARD 1 October 2021

SUNDERLAND JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2021/2022

Report of the Executive Director Public Health & Integrated Commissioning

1.0 Purpose of the Report

1.1 To present the draft Sunderland Joint Strategic Needs Assessment (JSNA) to members of the Health and Wellbeing Board.

2.0 Background

2.1 The development of a JSNA is a statutory requirement. Local authorities and Clinical Commissioning Groups have equal and joint duties to produce JSNAs and Joint Health and Wellbeing Strategies (JHWSs) through the Health and Wellbeing Board. JSNA is not an end in itself, but is a continuous process of strategic assessment to support the development of local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.

2.2 JSNA is the process by which Sunderland City Council and Sunderland CCG, working in collaboration with partners and the wider community, identify the health and wellbeing needs of the local population. It provides an insight into current and future health, wellbeing and daily living needs of local people and informs the commissioning of services and interventions. It supports a Health in All Policies approach to the development of strategic priorities, aiming to improve health and wellbeing outcomes and reduce inequalities.

2.3 The draft JSNA has been presented at the Starting Well, Living Well and Ageing Well Delivery Boards for feedback and to identify officers who can help develop the next iteration of the JSNA.

3.0 Overview of the 2021/22 Assessment

3.1 The JSNA includes consideration of the social determinants of health, deprivation, health risks, disease and disability, major causes of mortality and the impact on life expectancy. It acknowledges some of the key impacts of the Covid-19 pandemic and references more detailed work on this.

3.2 The social determinants of health, including income, housing and homelessness, crime, domestic violence, the living environment, social isolation and accident prevention, all impact on inequalities and affect people's health and happiness. The 2021/22 JSNA has an increased focus on the social determinants of health compared with previous years.

3.3 High level challenges identified are:

- Ensuring a system-wide understanding of the health and social determinant impacts of the **Covid-19 pandemic** on health outcomes and health inequalities.

- **Inequalities**, relating to both **socio-economic position** and **protected characteristics**, have a significant impact on the health of people in Sunderland and should be considered for all interventions and policies, recognising that socio-economic inequalities are a continuum across the population and that some people are impacted by multiple inequalities.

- **Poverty** levels within the city continue to have an impact and should be tackled by increasing levels of **employment** in good work through attracting more jobs into the city, increasing educational and skills attainment of Sunderland residents and ensuring as many people as possible are supported to stay in work, despite having a health condition.

- Responding to **health protection** (infectious diseases) threats requires prevention work, rapid identification and a swift response to complex cases in high risk places, locations and communities.

- **Children and young people** in Sunderland face some significant health challenges and inequalities across the social determinants of health. Lower **household income**, increased **food poverty**, higher **employment deprivation**, and lower **levels of educational achievement** contribute to poorer outcomes including higher levels of **teenage conceptions**, **smoking during pregnancy**, **unhealthy weight**, **alcohol related hospital admissions**; low levels of **breastfeeding**; and **poor oral health** and **mental health outcomes**. Partners need to work together and with children, young people and families to address these issues and build resilience.

- The four main health risk factors – **smoking**, **diet**, **alcohol** and **physical activity** – lead to poor health outcomes and increase health inequalities and so programmes need to continue to be developed, in partnership with local people, to make it easier to make the healthy choice.

- There are more people in Sunderland living with, and prematurely dying from, **cancer**, **cardiovascular disease** and **respiratory disease** than elsewhere in the country. Partners need to be clear that primary, secondary and tertiary prevention programmes are in place that ensure that no opportunities are missed to prevent these diseases and stop them progressing.

- The **ageing population** as well as the high numbers of people with **long term, often multiple, conditions** has a significant impact on local people and services. This needs to continue to be addressed through integrated care and supporting people to self-care as well as a transparent, whole system approach to preventing service failure.

- People in Sunderland have **poor mental wellbeing** and suffer from a higher burden of **mental ill health** than the rest of England. This should be tackled through a preventative programme alongside recognition of the needs of people with poorer mental health and wellbeing and the impacts this has on their **physical health**.

4.0 Next Steps

4.1 The overarching JSNA will be finalised following feedback from Board members.

4.2 An infographic summary and film to support the overarching JSNA is under development.

4.3 These documents will be published on the council website and circulated to key partners.

5.0 Recommendations

5.1 The Health and Wellbeing Board is recommended to:

a) note the findings of the draft Sunderland JSNA;
b) agree that the Executive Director of Public Health and Integrated Commissioning is delegated to finalise the JSNA;
c) consider whether there any specific additional topics which need to be included in this iteration of the JSNA, or any topics for development over the next year;
d) take account of these findings when considering the commissioning plans of all partners;
e) take account of these findings when developing plans for the Delivery Boards and workstreams identified as priorities by the Board; and
f) support the continual refresh of the JSNA to ensure emerging needs and challenges are widely understood across the city.

Sunderland Joint Strategic Needs Assessment 2021-22
October 2021 Review

DRAFT

Contents

1.1 Introduction 4
1.2 Population profile and demography 5
1.3 Life expectancy 5
1.4 Social Determinants of Health 9
1.4.1 Income 11
1.4.2 Employment 13
1.4.3 Education, skills, qualifications 15
1.4.4 Housing and Homelessness 15
1.4.5 Crime 17
1.4.6 Domestic violence and abuse 17
1.4.7 Living Environment 18
1.4.8 Physical Activity 19
1.4.9 Accident Prevention 20
1.4.10 Social isolation 21
1.5 Health risks 22
1.5.1 Smoking 22
1.5.2 Alcohol 23
1.5.3 Substance misuse 25
1.5.4 Gambling 27
1.5.5 Healthy Weight 29
1.5.6 Sexual Health 30
1.5.7 Teenage conceptions 31
1.5.8 Breastfeeding 32
1.5.9 Oral health 32
1.6 Cancers 33
1.7 Long-term conditions 34
1.7.1 Cardiovascular disease 34
1.7.2 Hypertension 35
1.7.3 Atrial Fibrillation 35
1.7.4 Diabetes 36
1.7.5 Chronic Kidney Disease 37
1.7.6 Chronic Obstructive Pulmonary Disease 37
1.7.7 Dementia 38
1.8 Disability 38
1.8.1 Learning Disability 39
1.8.2 Physical Disability 40

DRAFT

1.9 Mental Health and Mental Wellbeing 40
1.10 Summary of health needs analysis 43
1.11 Key health challenges 44
Hyperlinks 46

DRAFT

1.1 Introduction

One of the statutory functions of the Health and Wellbeing Board (HWB) is to prepare Joint Strategic Needs Assessments (JSNAs), which are duties of local authorities and clinical commissioning groups (CCGs). The JSNA is the process by which the Council and CCG, working in collaboration with partners and the wider community, identify the health and wellbeing needs of the local population. It provides an insight into current and future health, wellbeing and daily living needs of local people and informs the commissioning of services and interventions to improve health and wellbeing outcomes and reduce inequalities.

The findings of the JSNA are based on:

- Consideration of the JSNA topic summaries, which identify health, social care and well-being indicators, including the results of local Lifestyle Services;
- Comparison of our local population against regional and national averages and, in some cases, statistical neighbours which helps us to understand if a particular health issue is significant; and
- A summary of local needs analysis that has been carried out, identification of effective interventions (what works) and any other rationale for action e.g., a national 'must do' or service users', carers' and public views.

This overarching JSNA provides a summary of the health needs of Sunderland and highlights relevant issues for the commissioning of services. Individual chapters of the JSNA can be accessed at: https://www.sunderland.gov.uk/article/15183/Joint-Strategic-Needs-Assessment

On 12 January 2020 the World Health Organisation (WHO) announced a novel coronavirus, SARS-CoV-2, had been identified.[1] This was first identified in Wuhan City, Hubei Province, China. The virus is now readily transmitting from person to person in the community. Build Back Fairer: The Covid-19 Marmot Review[2] describes the impacts of Covid-19 on the social determinants of health in adults focusing on employment and good work, standards of living and income, places and communities, and public health. The Covid-19 Health Inequalities Strategy[3] sets out more information on Sunderland's response to Covid-19 and the impact it has had on health inequalities locally. Covid-19 has adversely impacted life expectancy. Mortality has been directly and indirectly affected by Covid-19, with mortality potentially increased by many factors including over-stretched health services and delays in hospital treatment, fear of accessing care, undiagnosed cancer and the impacts of long Covid-19. Covid-19 is expected to have a significant effect on preventable mortality but the scale of this will become more evident over future years.

1.2 Population profile and demography

Sunderland has a population (mid-2020) of around 277,846.[4] The population has fallen from close to 300,000 in the early 1990s, due in part to outward migration of younger working age people. Recently, this fall has levelled out and the population is predicted to remain stable at around 277,000 by 2031.[5]

Compared to England, the population of Sunderland has a higher proportion of older people who use health and social care services more intensively than any other population group and may require more complex treatment due to frailty and the presence of one or more long term conditions. Deaths from Covid-19 in Sunderland mostly affected the older age groups. 19.9% of Sunderland's population are aged 65 years and older, higher than the England average (18.8%). The population aged 65 years and over is projected to rise to 24% by 2031. The proportion of the population aged 80 years and over is also projected to rise from 5.1% in 2020 to 6.5% in 2031.

Sunderland has also seen an increase in the population of people from black and minority ethnic communities, though the city is less ethnically diverse than the England average. The age distribution of people from black and minority ethnic communities is generally younger than for white communities in the city. [6] Predicted patterns of migration suggest that the increase in the ethnic diversity of the population of Sunderland is likely to continue over the next 20 years.[5]

A Census was undertaken in March 2021, and it is anticipated that more detailed demographic information will be available from 2022 onwards.

1.3 Life expectancy

Whilst average life expectancy at birth has improved over a number of years, the city continues to lag behind the England position and the people of Sunderland live, on average, shorter lives than the England average[7]. They also live, on average, a greater part of their lives with illness or disability which limits their daily activities.

Life expectancy is a barometer of the health and social determinants of health within an area, and Covid-19 has directly and indirectly impacted on life expectancy due to the very high level of excess deaths last year due to the pandemic. Provisional estimates of life expectancy at birth[1] for 2020 from Public Health England[8] suggest that compared with 2019, life expectancy at birth in England was 1.3 years lower for males and 0.9 years lower for females. In the North East, male life expectancy has fallen from 78.2 in 2019 to 76.8 in 2020, a fall of 1.4 years. For females, the fall has been from 82.0 to 80.8, a fall of 1.2 years.

[1] The average number of years a newborn would live if they experienced the regional age-specific mortality rates for 2020 throughout their life

DRAFT

Notably, the gap between life expectancy for Sunderland and for England has widened for both males and females between 2015-2017 and 2017-19.

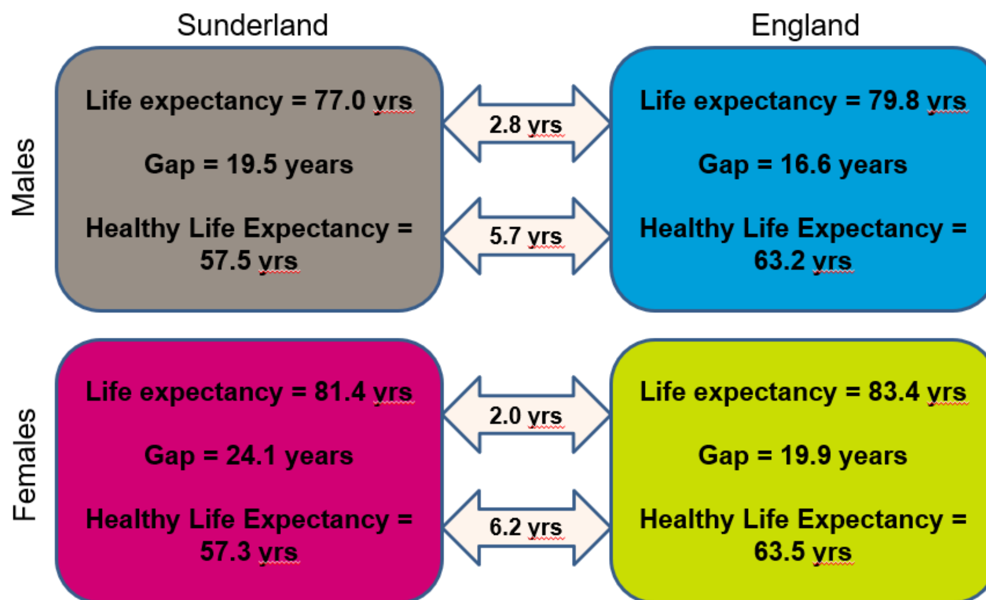


Fig 1: Gaps in Life Expectancy and Healthy Life Expectancy, Sunderland compared to England, 2017-2019 (Healthy state life expectancy, UK, 2017-2019. [9])

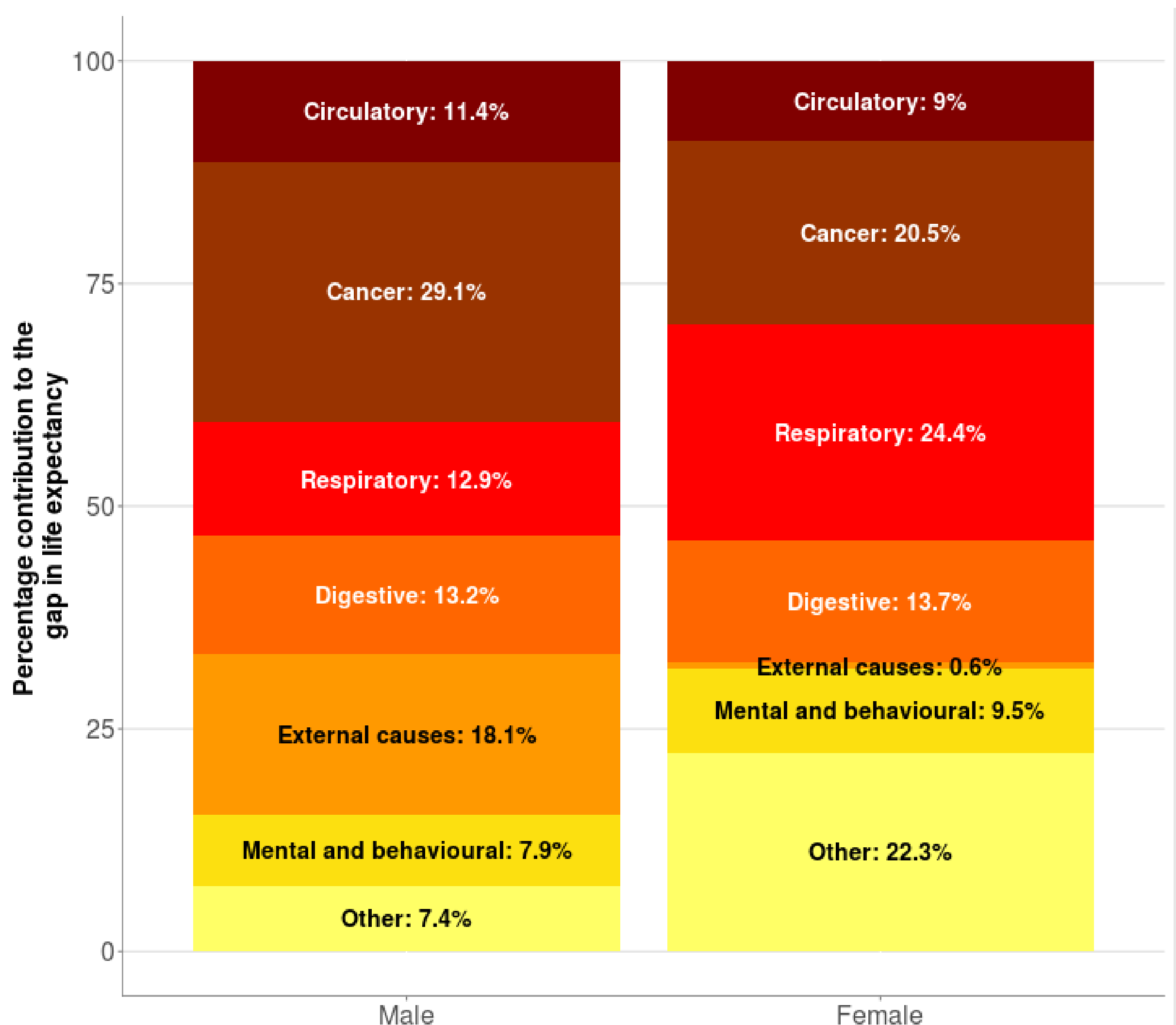
Health inequalities within Sunderland result in significant variations in mortality and life expectancy at birth between wards.

- The gap in life expectancy across wards has widened in Sunderland between 2013-2017 and 2017-2019.
- This has widened for males from 11.8 years to 12.4 years (Hendon 69.7 years compared to Fulwell 82.1 years), and for females it has widened from 9.4 years to 10.8 years (Hendon 75.9 years compared to Washington South 86.7 years).[10]

Fig 2: Differences in life expectancy by ward within Sunderland, 2015-2019

Based on published data[11], around 59%[12] of the life expectancy gap between Sunderland and England is due to higher rates of mortality from cardiovascular diseases (mainly coronary heart disease), cancers (mainly lung cancer) and respiratory diseases (particularly chronic obstructive airways disease); smoking is a key contributory risk factor that will impact on all three of these causes.

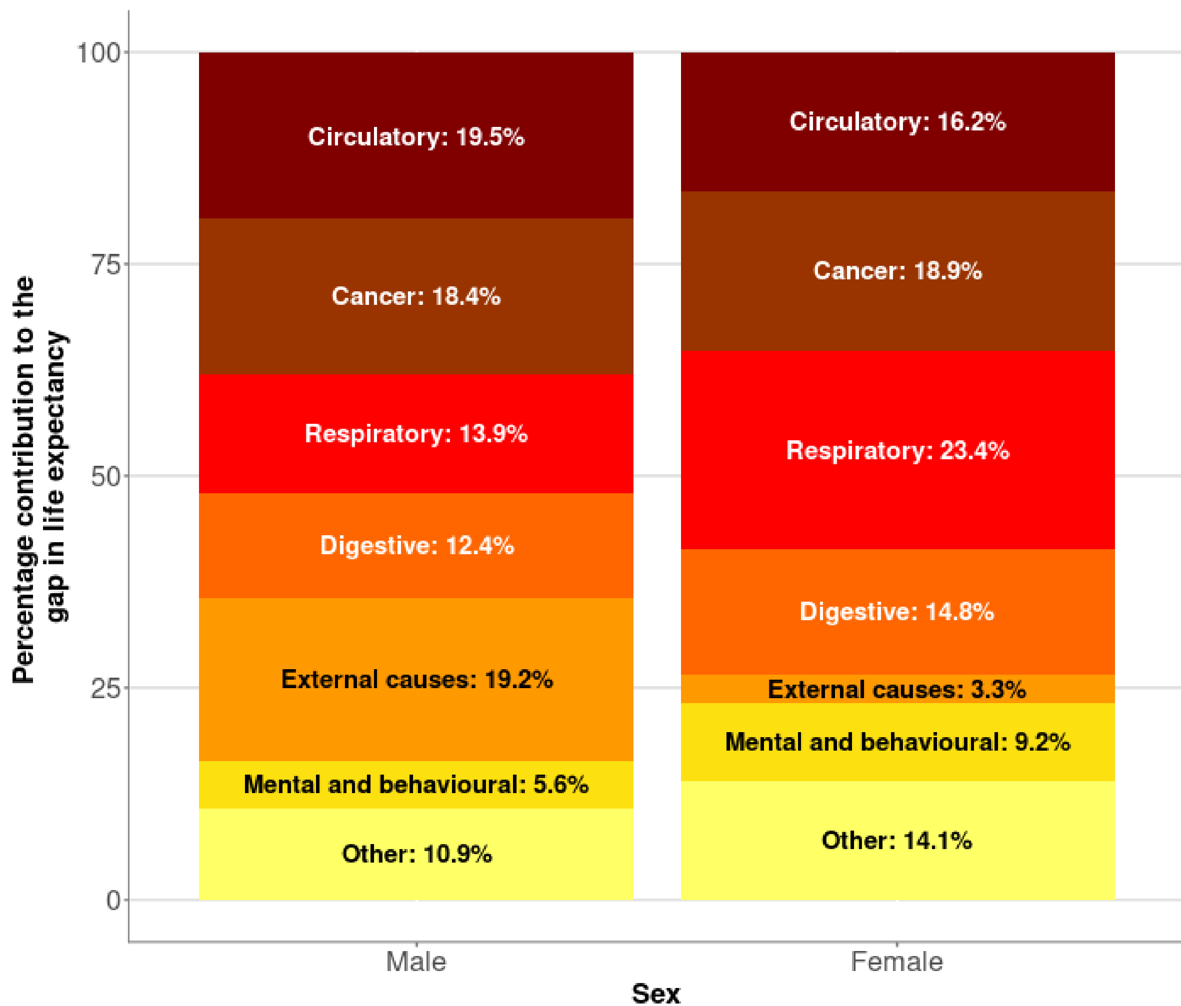
Fig 3: Gaps in Life Expectancy between Sunderland and England, by cause of death, 2015-2017



Data Source 5: The Segment Tool - Segmenting Life Expectancy Gaps by Cause of Death (Latest update, Jan 2020), Public Health England

In Sunderland, life expectancy in the most deprived quintile is lower than life expectancy in the least deprived quintile, and this gap is segmented below to show the broad causes of excess deaths. Within Sunderland, 61.2% of the life expectancy gap (excess deaths) between the most deprived quintile and least deprived quintile of Sunderland is due to circulatory, cancer and respiratory diseases.[13]

Fig 4: Gaps in Life Expectancy between the most deprived quintile and the least deprived quintile of Sunderland, by cause of death, 2015-2017



1.4 Social Determinants of Health

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. There is general consensus that the social determinants of health are more important than healthcare in ensuring a healthy population.

(McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) The case for more active policy attention to health promotion. Health Affairs 21 (2) pp.78-93)

Figure 5: What makes us healthy[14]

The reason there are different health outcomes in different areas of the city is because health inequalities are underpinned by deprivation. There is a substantial amount of evidence which shows that people living in the most deprived areas have worse health and health outcomes than those in the more affluent areas. People in deprived areas are likely to have a higher exposure to negative influences on health, and to lack resources to avoid their effects.

The Index of Multiple Deprivation 2019 measures socioeconomic disadvantage across seven domains:

- income;
- employment;
- health;
- education;
- barriers to housing and services;
- crime, and;
- living environment.

The overall IMD2019 is a weighted average of the indices for the seven domains. Levels of deprivation remain high within Sunderland. Data is published by Lower Super Output Area (LSOA) - Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics; Lower Super Output Areas have an average population of 1500. Seventy five (about 40%) of Sunderland's 185 Lower Super Output Areas (LSOAs) are among the most disadvantaged fifth of all areas across England, and 40.6% of the Sunderland population lives within these

DRAFT

super output areas.[15] This position has worsened relative to IMD2015 when 71 of Sunderland’s LSOAs were among the most disadvantaged fifth of all areas across England, and 38% of the population lived within those LSOAs. The five Sunderland wards with the levels of deprivation in 2019 were: Hendon, Redhill, Southwick, Sandhill and Pallion, and deprivation levels across Sunderland are illustrated on the map below.[16]

Index of Multiple Deprivation 2019

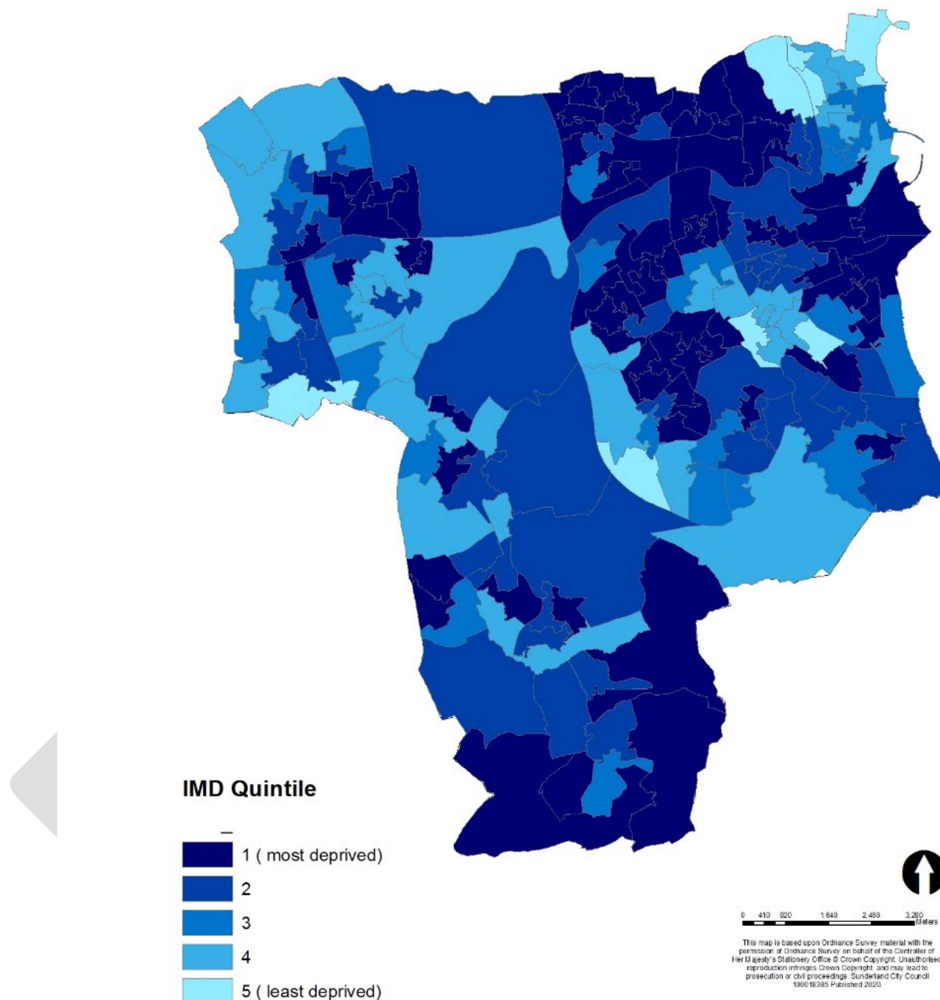


Figure 6: Index of Multiple Deprivation

Locally, work is being planned to gain more insight into equity within the social determinants of health in Sunderland, with consideration given to the areas of public life the Equality and Human Rights Commission examines to understand fairness and life chances in our country, including health.[17] This work will contribute to progressing the Equality Framework for Local Government[18] which is explicit in the expectation that organisations are working to improve outcomes. This includes reducing inequality and health inequality. The social determinants of health are

interconnected and do not exist in isolation, but some examples are set out below for Sunderland.

1.4.1 Income

The impacts of economic disadvantage and low income are far-reaching. Households in employment may still be in poverty, as income may not be sufficient to meet the costs of accommodation and daily living. Low income households are particularly vulnerable to changes in the cost of living and suffer the social exclusion and increased health risks of poverty. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.[19] Average full-time earnings for workers who are Sunderland residents is £496.80 per week; this is below the average for the North-East (£523.50) and Great Britain (£587.20).

Child poverty:

Socioeconomic disadvantages can lead to wider health inequalities and are one of the primary risk factors linked to many maternal and infant health outcomes.

- 27.3% of children are living in low income families in Sunderland compared to 26.8% regionally and 19.1% nationally.
- Children born to teenage mothers have a 63% higher risk of living in poverty[20] Sunderland has a higher proportion of teenage mothers (1.4% compared to 1.2% in North-East and 0.7% in England) Children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight which impacts on the child's long-term health. Teenage mothers are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth.

Detailed information on Best Start in Life and the 0-19 Full JSNA profile are available online at: Children and young people - Sunderland City Council

Food poverty:

- The Food Foundation reported that food banks were experiencing a surge in demand due to the impact of the Covid-19 crisis on household income and employment.[21] Sunderland Council undertook a Food Poverty Scoping Report which found that food poverty among children and young people has increased significantly over the pandemic. In Sunderland there has been an 18% increase in food parcels delivered to families from April to September 2020.[2]

- Covid-19 has highlighted the importance and increased need to access food and reduce food insecurity in the city. There is also an increased demand for advocacy and support to manage financial pressures on families.

[2] Sunderland Food Poverty Scoping Report. (2021).

- Data from Sunderland Foodbank (SFB) (comprising of 10 distribution centres) shows that there has been an annual increase in the average number of food parcels and minimum number of people fed in the past three years.

Financial Year	Average Monthly Food Parcels - SFB	Minimum People Fed -SFB
2018-19	223	389
2019-20	261	485
2020-21	291	579

- The data below shows the increase in support that has been required to access crisis food support during Covid-19 (from the beginning of April 2020) from either Sunderland City Council Local Welfare Provision Scheme or from the 6 Foodbanks that now provide weekly figures.

	April – Jun Q1	**July - Sept Q2**	**Oct – Dec Q3**	**Jan – March Q4**
Number of food cards issued by council	65	129	166	118
Value of food cards issued by council	£2,840	£5,805.00	£7,670.00	£5,440.00
Number of people council food cards have fed	123	263	346	256
Number of food parcels issued by council	560	152	343	370
Number of people council parcels have fed	922	244	631	655
Number of Food parcels issued by 6 local foodbanks	2379	2278	2826	2998
Number of people fed by 6 local foodbanks	4494	4101	5484	5595

f

- The North East of England has the highest rates of pupils eligible for Free School Meals, with more than 26 per cent of pupils eligible. For 2020/21 Autumn Term, Sunderland had 40,694 pupils and 27.1% of them were eligible for Free School Meals.

- Public health has worked with teams across the council to shape recovery solutions, worked in partnership with Strategic Advice Services and has developed the Food Poverty scoping paper. Further work is recommended to gain greater understanding of the longer-term impact of food insecurity in the city and to inform the future planning of sustainable services.

DRAFT

Fuel poverty

A household is considered to be fuel poor if they have required fuel costs that are above average (the national median level) and, were they to spend that amount, they would be left with a residual income below the official poverty line. Fuel poverty is distinct from general poverty: not all poor households are fuel poor, and some households would not normally be considered poor but could be pushed into fuel poverty if they have high energy costs.

- In 2019, 15.3% of households in Sunderland were classed as fuel poor, which is higher than the North East figure of 14.8% and the England figure of 13.4%.[22] [23]

Evidence shows that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups; furthermore, studies have shown that more than one in five (21.5%) excess winter deaths in England and Wales are attributable to the coldest quarter of housing.[24]

- The excess winter deaths index (aged 85+) in Sunderland for August 2018 to July 2019 was 16.3, which was similar to the regional (16.7) and national (18.2) figures.

Older residents living in poverty

People living in more deprived areas have a greater need for health services. Those living in poverty may experience fuel poverty; living in cold homes is associated with poor health outcomes and an increased risk of morbidity.[25] People who are poorer in later life have worse health, across a wide range of physical and mental health conditions, than those who are affluent. Older people living in disadvantaged areas having less access to health care than those living in more affluent communities.

- The percentage of adults aged 60 or over living in income-deprived households (out of all adults aged 60 or over) in 2019 in Sunderland was 21.7%, which is significantly higher than the figure for England of 14.2%.

1.4.2 Employment

Good work improves health and wellbeing across people's lives and protects against social exclusion. Conversely, poor work and unemployment is bad for health and wellbeing, as it is associated with an increased risk of mortality and morbidity.

Evidence highlights that good work improves health and wellbeing, not only from an economic standpoint but also in terms of quality of life. The government's command paper *Improving lives: the future of work, health and disability* focuses on reducing health inequalities by promoting good work as a determinant of good health and advocates employers to proactively include and enable people with ill health and/or

disability to access and stay in work.[26] This has been further reinforced by the Marmot review (2010), Marmot review 10 years on (2020) and Build Back Fairer (2020).

Employment rates in Sunderland compare unfavourably to both England and the wider North East. The Employment Deprivation Domain measures the proportion of the working age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.

Low-income groups and part-time workers are most likely to have been furloughed due to Covid-19, and furloughed staff have experienced 20 percent wage cuts from their already low wages.[27] This is likely to push many people into poverty as many do not have sufficient savings or other means to withstand the loss of income.

- The percentage of out of work benefit claimants aged 16-64 in Sunderland in May 2021 was 7.3%, higher than the North East figure of 6.8% and the national figure of 6.0%.[28]

Unemployment rises were seen in all age groups in Sunderland but there is a larger impact on young people.

- Between March 2020 and March 2021 – the claimant count for 18-24 year olds rose by 46%, from 1,890 to 2,760 and for 25-29 year olds rose 38% from 1,280 to 1,765.

Approximately 2 million adults are not in work in the UK because of their health – this is a quarter of all people who are economically inactive (i.e. 8.3m 20.9%). Many of these people could be in work but need support; they are the 'hidden unemployed.'

- In Sunderland 136,100 people (76.2% of the population) are economically active, with 23.6% economically inactive.
- 41.6% in Sunderland who are economically inactive are on long term sick, compared with 28.8% in NE who are economically inactive. Labour Market Profile - Nomis - Official Labour Market Statistics (nomisweb.co.uk) Economic inactivity (Oct 2019-Sep 2020)

The percentage of 16-64 year olds in employment is 70.3% (2019/20), but there are stark differences in employment rates for particular groups:[29]

- gap in employment between those with long term conditions and the overall employment rate 15.3% (2019/20);
- gap in employment between those in secondary mental health services and the overall employment rate 61.2% (2019/20); and
- gap in employment between those with a learning disability and the overall employment rate 66.7% (2019/20).

1.4.3 Education, skills, qualifications

Education and health and wellbeing are intrinsically linked. Education is strongly associated with life expectancy, morbidity, health behaviours, and educational attainment plays an important role in health by shaping opportunities, employment, and income.[30] Low educational attainment is correlated with poorer life outcomes and poor health. While higher educational attainment can play a significant role in shaping employment opportunities, it can also increase the capacity for better decision making regarding one's health and provide scope for increasing social and personal resources that are vital for physical and mental health.[31]

The average levels of education, skills and qualifications in Sunderland are lower than the regional and national average:

- Although educational attainment is generally poor in Sunderland, 62.6% of children eligible for free school meals are achieving a good level of development at the end of Reception; this is higher than the region level of 57.7% and national level of 56.5% (according to 2018/19 data). However, the figure is lower than the corresponding percentage of children achieving a good level of development at the end of Reception, which is 72.6% for Sunderland, 71.8% for both the North East and England.
- Attainment 8 is the results of pupils at state-funded mainstream schools in 8 GCSE-level qualifications, measuring how well children do in key stage 4. A pupil's Attainment 8 score is calculated by adding up the points for their 8 subjects, with English and maths counted twice. A school's Attainment 8 score is the average of all of its eligible pupils' scores. In February 2021 the average attainment 8 score in Sunderland was 48, lower than that national average of 50.2 in 2019/20.[3]
- In 2019 there was a higher percent of 16/17-year-olds in Sunderland not in education, employment, or training (NEET) (10.6%) than in the region (5.9%) and in England (5.5%).
- In 2019 there was a lower percent of 16–64-year-olds in Sunderland who were qualified to at least NVQ Level 4 or higher (27.4%) compared to the region (31.9%) and in England (33%).[32]

1.4.4 Housing and Homelessness

A Strategic Housing Market Assessment (SHMA)[33] in 2020 reported the results of the 2019 Sunderland household survey which indicated that:

- 10.2% of households in Sunderland (12,675 households) were classified as households in need (including insecure tenure, overcrowding, house too difficult to maintain, unfit dwelling amenities or health or social needs – see Figure 7 below).

3

- In the private rented sector, 25.9% of households are in housing need, compared to 11.7% of those in affordable housing and 6.1% of those in owner occupation.
- Over a quarter of households in need in Sunderland are single adults aged under 65 years (27.0%).
- Couples with no children represent a further 24.4% of households in need.
- The data also shows that over half, 52.1%, of lone parents with 3 or more dependent children are in housing need, compared to 26.1% of couples with 3 or more dependent children. The SHMA also examines the needs of different groups:
- Age-related housing need – this concerns the position of particular age groups in the housing market due to life events and the demand this creates for accommodation units of a certain size or affordability;
- Health-related housing need – a household's health may be a determining factor in the type of accommodation they require or the support they need to receive. For most in this group the need for specialist accommodation or support is likely to be a lifelong need;
- Life-experience related housing need – supported accommodation may be needed by those affected by life experiences which may have disadvantaged their ability to live independently. The support required here may be shorter term with the intention of promoting independence in the longer term; and
- Cultural heritage related housing need – for those from a minority ethnic background there may be cultural heritage or religion related determined needs which impact on the type of accommodation required.

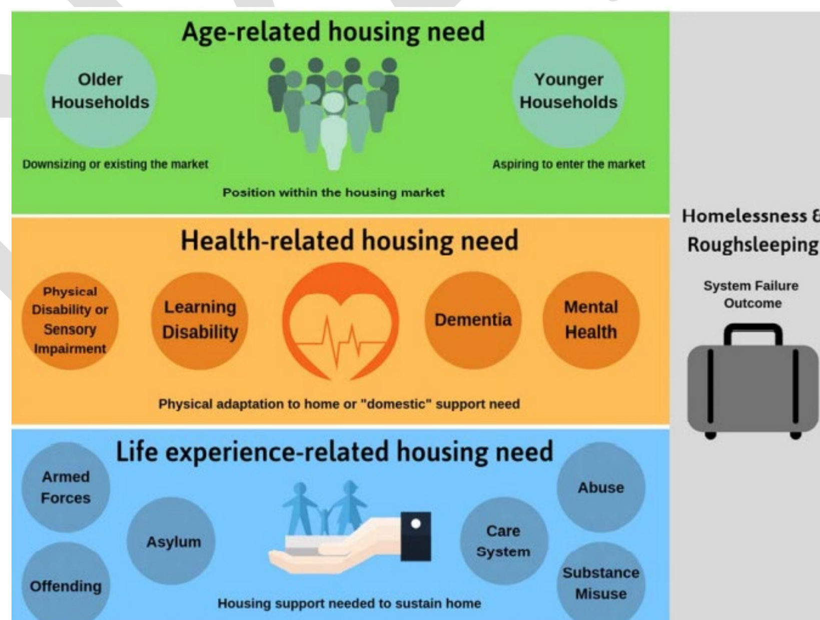


Fig 7: Housing needs of different groups

Local data shows us that there is an increasing challenge due to an increase in number of support needs presenting in those needing temporary accommodation.

With average support needs per case at 3.06 there are issues in managing cases and enabling timely and effective accommodation solutions.

The figure above also makes a link to homelessness and rough sleeping. Homelessness and rough sleeping can be a failure outcome of not providing appropriate accommodation for residents, along with an often complex interplay of one or more of the following; poverty, unemployment and life events including relationship breakdown or the end of a tenancy. These triggers are often coupled with other issues such as mental health needs or substance misuses (or both) which result in a 'tip' into homelessness. The *Sunderland rough sleeping and homelessness prevention strategy 2019-21* reports that in Sunderland, the homeless population:[34]

- Is younger, more ethnically diverse, and has a higher proportion of males than the general population;
- Has higher levels of key unhealthy behaviours (such as smoking, alcohol misuse and drug misuse) than the general population;
- Has significantly higher number of disabled people compared to the national average;
- Has high levels of both mental and physical health conditions, developing long term conditions earlier than the general population;
- Has the following top five physical health needs: joint and muscular problems, dental health, eye health, fainting and blackouts, respiratory and circulation problems;
- Has the following top five mental ill health conditions: depression, anxiety/phobia, PTSD, schizophrenia, personality disorder; and
- Access to GP services is between 1.5-2.5 times more and access to hospital services is around four times more than for the general population.

1.4.5 Crime

Crime can have a wide-ranging effect on people's health. In Sunderland, indicators relating to crime, including re-offending rates and hospital admissions for violent crime (including sexual violence) are higher than England as a whole, though comparable to the wider North-East.

- Total recorded crime in Sunderland stood at 99 per 1000 in 2020/21, above the North East (91.7) and England average (77.2).
- Hospital admissions for violence (including sexual violence) in Sunderland for 2017/18-19/20 were 71.2 per 100,000, which is similar to the regional figure of 63.4 and significantly higher than the national figure of 45.8.[35]

1.4.6 Domestic violence and abuse

Health and domestic violence and abuse (DVA) are inextricably linked. DVA has a profound and long-term impact on physical and mental health, with effects ranging from injury to stress and anxiety, as well as more severe psychological effects. It is

DRAFT

also a root cause of many other social problems including substance misuse, homelessness, sexual exploitation, and future involvement in criminal behaviour.

- There were 8,434 domestic abuse incidents reported to the police in 2020/21, however this is likely to be under reported. Over 40% of incidents involved children.
- Incidents of domestic abuse rose in 2020/21 from 7,969 incidents in 2019/20.
- Police recorded crime data shows an increase in offences flagged as domestic-abuse related during the Covid-19 pandemic.
- 2020/21 also saw increases in incidents involving children and an increase in the number of repeat crimes.
- Most domestic abuse survivors were female. Recorded figures show that women are significantly more likely than men to experience repeated and severe forms of abuse, including sexual violence. 73.1% of victims in Sunderland were female. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt or killed than male victims of domestic abuse.[36] Those referred to support services in Sunderland were primarily females between 21-40 years old. Many have multiple support needs including mental ill health, physical disabilities, learning disabilities, substance, and alcohol misuse.

The Domestic Abuse Act 2021 will provide improved protection for the many victims of domestic abuse (DA) as well as strengthened measures to tackle perpetrators. Key provisions include: For the first time, a new wide-ranging statutory definition of DA, incorporating abuses beyond physical violence, such as emotional abuse, coercive or controlling behaviour and economic abuse.

Evidence on the impact of Covid-19 on domestic abuse is at an early stage, and work is being undertaken nationally and locally to address domestic abuse.

The Government's VAWG strategy, Strategy to end violence against women and girls: 2016 to 2020 - GOV.UK (www.gov.uk), is currently being refreshed.

More information on community safety in Sunderland is available at: Community safety - Sunderland City Council

1.4.7 Living Environment

The quality of the built and natural environment such as air quality and the quality of green spaces also affect health.[37] Key points to note include:

- Sunderland City Council has set out ambitious targets to be a carbon neutral local authority by 2030 and is working with partners across Sunderland for the city to be carbon neutral by 2040 and deliver against the city's Low Carbon Framework.[38]
- Sunderland has a Green Infrastructure Strategy which aims to protect a range of district and inter-Green Infrastructure Corridors and assets which provide multiple benefits to people and wildlife across the city.[39]

DRAFT

- Sunderland prepares a Local Flood Risk Management Strategy every 5-6 years, which has the target of decreasing the number of properties at high flood risk.[40]
- Sunderland also adheres to the England Heatwave Plan, which has the target of reducing the harm to health from severe heat and heatwaves. Sunderland also adheres to the Cold Weather Plan (CWP) for England, which aims to prevent avoidable harm to health, by alerting people to the negative effects of cold weather and enabling them to prepare and respond appropriately. The CWP also aims to reduce pressure on the health and social care system during winter through improved anticipatory actions with vulnerable people.
- All local authorities monitor local air quality and produce annual reports and updates to DEFRA. The 2019 Air Quality Report for Sunderland found that the air quality in Sunderland is good and that there has been a general decline in some of the pollutants measured.[41] In 2019, the fraction of mortality attributable to particulate air pollution was 3.7 in Sunderland, which was similar to the North East figure of 3.6 and lower than the England figure of 5.1.

1.4.8 Physical Activity

Physical activity contributes to a wide range of health benefits, including reducing the incidence of some long term conditions. It also has benefits for mental wellbeing including improved self-esteem, mood, sleep quality and energy, as well as reducing the risk of stress, depression, dementia and Alzheimer's disease. Regular physical activity can improve health outcomes irrespective of whether individuals lose weight.[42]

The Sunderland Children and Young People's Health Related Behaviour Survey collects information on health and related behaviours from primary school children aged 8 to 11 and 12 secondary pupils aged 12-15. The 2021 survey found that:

In Sunderland primary schools:
- 47% of pupils walked or scooted to school
- 10% of pupils describe themselves as 'unfit' or 'very unfit'
- 81% of pupils enjoyed physical activity at least 'quite a lot' – 83% for boys, 78% for girls
- 38% exercised enough to make them breathe harder and faster at least five times in the last week – this was 33% for girls and 42% for boys.

In Sunderland secondary schools:
- 48% of pupils walked or scooted to school
- 64% of pupils enjoyed physical activity at least 'quite a lot' – 79% for boys, 54% for girls
- 22% exercised enough to make them breathe harder and faster at least five times in the last week – this was 16% for girls and 29% for boys.

There is significant inequality in physical activity in children between boys and girls, particularly as children get older.

DRAFT

The Adult Lifestyle Survey (2017) suggested 19.2% of adults aged 18 and over in Sunderland are physically inactive, i.e. they report doing at least 30 minutes of moderate physical activity on 0 days in a typical week.

The UK CMOs' guidelines provide recommendations on the frequency, intensity, duration and types of physical activity at different life stages, from early to later years.[43] Benefits are accrued over time, but it is never too late to gain health benefits from taking up physical activity.

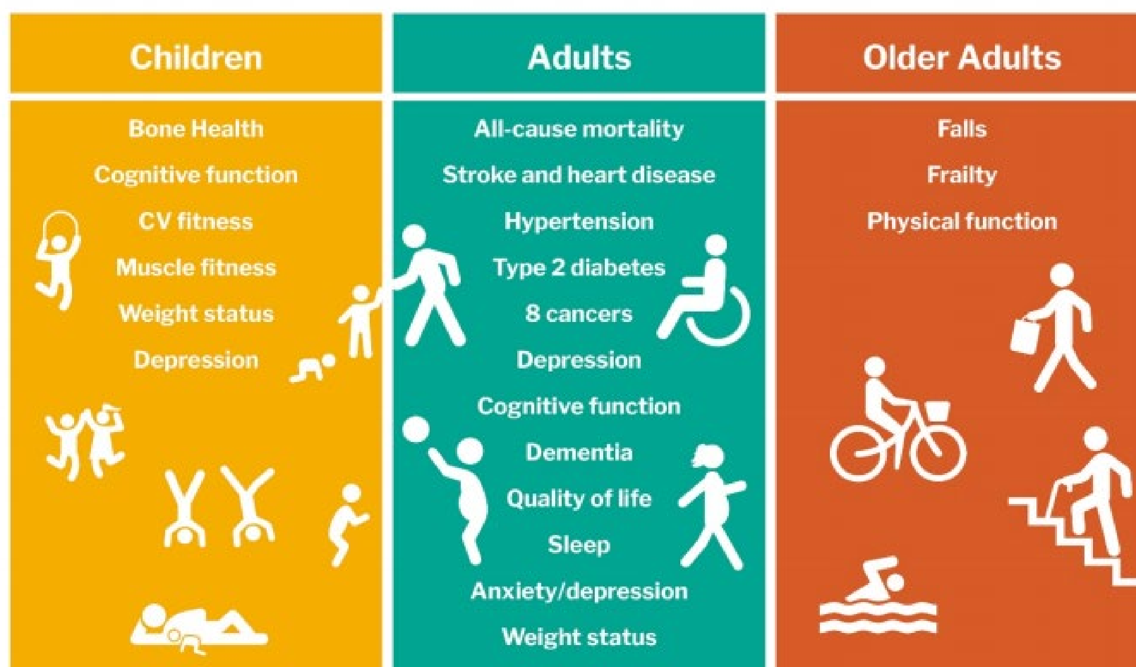


Fig 8: Moderate or strong evidence for health benefit[43]

Sunderland’s Joint Strategic Needs Assessment for Healthy Weight sets out plans to undertake a whole systems approach to support a healthier environment and lifestyle. This is available at: JSNA - Healthy Weight

1.4.9 Accident Prevention

Reducing accidents and hospital admissions due to unintentional injury in the early years of life is a nationally recognised ‘High Impact Area’ which can make a significant difference to the safety, wellbeing and future life chances of babies and young children growing up in Sunderland. The High Impact Areas, with additional information for maternity, provide an evidence-based framework for those delivering maternal and child public health services from preconception onwards.[44] Local data for children and young people in Sunderland for 2019/20 is set out below:

- The rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years was 203.1 per 10,000, which was the 6th worst in the country, with the England average at 117.

- The rate of hospital admissions caused by injuries in children aged 0-14 years was 145.9, which is the second worst in the country, with the England average at 91.2.
- The number of children killed and seriously injured in road accidents in Sunderland in 2017-19 was 20, a rate of 13.6 per 100,000, which is similar to, but lower than the England rate of 18.

An Accident Prevention needs assessment is currently being developed for Sunderland.

- The directly standardised rate per 100,000 people of emergency hospital admissions due to falls in people aged 65 and over was 2,628 in Sunderland in 2019/20. This is significantly higher than the regional (2,412) and national (2,222) figures.
- The rate (directly age standardised rate per 100,000) of hip fractures in people aged 65 and over in 2019/20 in Sunderland was 664, which is significantly higher than the national figure (572) and higher than the regional figure (635).

1.4.10 Social isolation

There is clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family.

- The percentage of adult social care users (aged 18+) who have as much social contact as they would like in Sunderland in 2019/20 was 55.1%, which was significantly higher than the national figure of 45.9% and higher than the regional figure of 49.9%.[45]

DRAFT

1.5 Health risks

1.5.1 Smoking

Smoking remains the greatest contributor to premature death and disease across Sunderland. It is estimated that up to half the difference in life expectancy between the most and least affluent groups is associated with smoking.[46]

Smoking during pregnancy remains high.

- In 2019/20, 448 women in Sunderland were recorded as smokers at the time of delivery; this equates to 18.3% of pregnant women compared to the England average of 10.4%.[47]
- The percentage of women recorded as smoking at time of delivery in Sunderland to the end of quarter 3 of 2020/21 is 15.5%. This represents an improvement from 18.3% the previous year. If data for the last quarter of 2020/21 is in line with the previous three quarters, then this would be the lowest percentage for the last 10 years and the biggest year on year decrease.

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40%.[48] Reducing rates of pregnant women smoking is a high priority in the Best Start in Life work stream, and partners are working closely together to address the challenges in this area.

- The latest WAY Survey (2014/15) showed that young people aged 15 are more likely to smoke in Sunderland than nationally. 11.6% of the age 15 population currently smoke in Sunderland, compared to 8.2% nationally.[49]

Considerable progress has been made over the last eight years, according to the national Annual Population Survey which showed that:

- The proportion of adults that smoke in Sunderland fell between 2011 and 2019 from a high of 24.3% to 16%. This is higher than both the regional (15.3%) and national (13.9%) figures. It should be noted, though, that smoking prevalence estimates by local authority from this survey can fluctuate widely due to small sample sizes.[50] Nevertheless, smoking continues to be the greatest contributor to premature death in the city and there is still much to do to reach the target of 5% prevalence by 2025.
- Smoking prevalence remains high in routine and manual occupations age 18-64 in 2019 was 25.7% in Sunderland compared to 23.2% nationally.[51]

When compared to the general population, adults with a common mental health disorder (such as depression or anxiety) are twice as likely to smoke and adults with schizophrenia or bipolar disorder are three times more likely to

DRAFT

smoke.[52] High smoking rates among people with mental health problems are the single largest contributor to their 10 to 20-year reduced life expectancy.

- Smoking prevalence in adults with long term mental health conditions was 29.7% in 2019/20, higher than the regional (27.0%) and national figures (25.8%).

Supporting people to give up smoking will make a significant contribution to reducing health inequalities between Sunderland and England.

- In 2019/20, 45.5% of people setting a quit date had successfully quit at four weeks.[53]

The Specialist Stop Smoking Service, GP Practices and Pharmacies continue to support residents to stop smoking across the city. However, the impacts of Covid-19 on capacity within primary care and offering behavioural support face to face are presenting a challenge around offering services which are responsive to local need and demand.

Sunderland has significantly higher levels of smoking-attributable mortality and smoking-attributable hospital admissions than the England average.[54]

- Smoking remains a key risk factor for lung cancer and deaths rates due to this disease are 60% higher in Sunderland than the England average for 2017-2019.[55]

The full Tobacco JSNA is available at: Tobacco - Full Joint Strategic Needs Assessment - Sunderland City Council

1.5.2 Alcohol

Alcohol use is another major risk factor. Alcohol misuse is a major problem within Sunderland in terms of health, social and economic consequences which affect a wide cross section of the city at a considerable cost.

- Under 18's hospital admissions for alcohol specific conditions (2017/18-2019/20) were 82.4 per 100,000 for Sunderland (a reduction from 2016/17-2018/19 when the figure was 85.8 per 100,000). This is significantly above the England and North East averages. The respective figures are 55.4 for the North-East and 30.7 for England.

The Sunderland 2021 Health Related Behaviours Survey (HRBS), for secondary school pupils, it found that:

- 38% have never drunk alcohol at all
- 37% have drunk alcohol once or twice
- 19% drink alcohol occasionally (less than 1 drink a week)
- 3% drink alcohol regularly and don't want to stop

DRAFT

- 21% had had an alcoholic drink in the past 7 days.

These figures show very little change in each category compared to the previous survey carried out in 2019.

Data from a local lifestyle survey found that:

- The proportion of Sunderland adults aged 18 years and over who drink alcohol is 66.4%[103].
- Men are more likely to drink alcohol than women. Men aged 45-64 and women aged 35-54 are most likely to drink alcohol.
- There is also a socio-economic gradient with adults in managerial and professional occupations being most likely to drink alcohol and those who have never worked or who are long term unemployed being least likely to drink alcohol.
- Overall, 33.6% of adults are abstinent, 44.8% of adults are lower risk drinkers (i.e., they drink up to 14 units of alcohol per week), 16.7% of adults are increasing risk drinkers (i.e., they drink more than 14 units and up to 35 units of alcohol per week), and 5.0% of adults are higher risk drinkers (i.e., they drink in excess of 35 units of alcohol per week).
- In Sunderland 21.6% of adults exceed the current recommended safe limits for alcohol consumption.
- At ward level, the highest rates of drinking above the recommended safe limits are seen in Washington South, Washington East, St Michael's and St Chad's.

- Additionally, 26.3% of adults binge drink (i.e., they drink more than 6 units of alcohol on their heaviest drinking day in a typical week). Men are more likely to binge drink than women. Contrary to the commonly portrayed image, binge drinking is not confined to young adults; in Sunderland men aged 35-64 and women aged 35-54 are most likely to binge drink. At ward level, the highest rates of binge drinking are seen in Washington West, Ryhope, Washington East and Fulwell.

Covid has also impacted on drinking levels. Alcohol consumption increased during lockdown. In March 2020, nationally sales of alcohol increased by 30 per cent and around 20 per cent of adults were already drinking at harmful levels before the pandemic. Although those from affluent backgrounds were more likely to drink and drink at high levels, there was a greater impact from alcohol related diseases on those from lower income backgrounds.[56]

- In Sunderland there was a rise in admissions for alcohol specific conditions between 2014/15 (752 per 100,000) and 2018/19 (1078 per 100,000) and again in 2019/20 (1171 per 100,000).[57]

The data also demonstrates:

- Admission episodes for alcoholic liver disease (Broad) have risen from 151.1 per 100,000 in 2010/11 to 228.8 per 100,000 in 2017/18, and again to 253.3

DRAFT

per 100,000 in 2018/19. Sunderland has the 10th highest rate in England in 2018/19.
- Alcohol-related mortality in Sunderland for 2018 was 57.6 per 100,000, a reduction from 67.8 in 2017.
- Mortality from chronic liver disease was 22.0 per 100,000 in 2017-2019, the second highest in the North-East (after South Tyneside at 22.6), higher than the North-East average (18.3) statistically significantly higher than England (12.0).
- Incidence rate of alcohol-related cancer in Sunderland is 39.43 per 100,000 for 2015-17. This is similar to the regional figure of 39.85 but higher than the England figure of 37.82 during the same period.

  (Source: Public Health Profiles and LAPE- Local Alcohol Profile for England, "Fingertips")

The Alcohol JSNA for Sunderland is available at: Alcohol - Sunderland City Council

1.5.3 Substance misuse

Drug addiction leads to significant crime, health and social costs. Drug misuse is strongly associated with a range of social issues including school absenteeism, safeguarding concerns, troubled families, homelessness and unemployment. It can also lead to significant crime and disorder. Sunderland faces multiple challenges with substance misuse related harm due to several complex issues associated with poverty, unemployment, and criminal justice involvement. Substance misuse can have profound and negative effects on communities, families, and individuals, limiting the ability to work, to parent, and to function effectively in society. Evidence-based drug treatment can reduce these and deliver real savings, particularly in relation to crime, but also in savings to the NHS through health improvements, reduced drug-related deaths and lower levels of blood-borne disease.

Data from the National Drug Treatment Monitoring System (NDTMS) for the year April 2020 to March 21, shows there were 89 young people under the age of 18 in treatment during the year (a reduction of 21% from the previous year).
This figure (89) accounted for 21 females and 68 males.

- 75 (84%) were in treatment due to cannabis use
- 36 (40%) for alcohol use
- 16 (18%) for cocaine use
- 16 (18%) for ecstasy use
- 2 (2%) for crack use.

(Some of these service users are included in more than one category, so the overall percentage figure will be higher than 100%).

Of those exiting treatment during the year (40), 93% (37) successfully completed their treatment journeys; this is compared to 79% nationally.

DRAFT

In the 2021 Sunderland Health Related Behaviours Survey (HRBS), for secondary school pupils, it was found that:

- 18% had been offered drugs, (16% for cannabis)
- 6% had taken drugs (3% during the last month, a further 2% during the last year, 1% more than a year ago)
- 80% had never smoked
- 11% had tried smoking once or twice
- 4% used to smoke but had now stopped
- 2% smoke occasionally (less than 1 cigarette a week)
- 2% smoke regularly but would like to give it up
- 2% smoke regularly and don't want to give it up.

These figures show very little change in each category compared to the previous survey carried out in 2019.

There is a significant positive correlation between higher deprivation levels and the prevalence of problematic drug users. The United Nations Office on Drugs and Crime warned of the potential for the Covid-19 crisis to worsen the drug situation and that increasing unemployment and reduced employment opportunities resulting from the pandemic were more likely to affect poorer individuals, which could consequently make them more vulnerable to drug misuse.[58]

Estimates of the prevalence of opiate and crack cocaine in over-15-year-olds, reviewed in 2019 and covering 2016/17,[59] suggest that Sunderland has:

- Prevalence of 9.2 per 1,000 population aged 15-64 opiate and/or crack cocaine users or an estimate of 1,652 people, compared to an England rate of 8.9 per 1,000;
- Prevalence of 8.3 per 1,000 population aged 15-64 opiate users or an estimate of 1,493 people, compared to an England rate of 7.4 per 1,000;
- Prevalence of 4.0 per 1,000 population aged 15-64 crack users or an estimate of 712 people, compared to an England rate of 5.1 per 1,000.

When engaged in effective treatment, people use fewer illicit drugs, commit less crime, improve their health and manage their health better. Preventing early drop-out and keeping people in treatment long enough to benefit contributes to these improved outcomes.

In the financial year 2019/20 there were 1,293 adults in effective drug treatment, of which, 840 (65%) were new treatment journeys.

During 2019/20:

- 96.3% of opiate users were retained in effective treatment, (national - 94.9%)
- 94.8% of non-opiate users, (national 84.4%)
- 94% of alcohol and non-opiate users, (national 85.6%)

DRAFT

The percentage of clients successfully completing treatment and not re-presenting were:

- Opiate users 4.1%, (national 5.5%)
- Non-opiate users 28.9%, (national 33.8%)
- Alcohol users 31.4%, (national 37.4%)

From 1st July 2021, Sunderland Wear Recovery Substance Misuse & Carers Services are now provided by Change Grow Live in partnership with Recovery Connections.

The Substance Misuse (drugs) JSNA is available online at: Substance Misuse (drugs) JSNA, Sunderland, 2020

1.5.4 Gambling

The Gambling Act 2005 defined gambling as betting, gaming or participating in a lottery.[60] Gambling includes a wide range of activities from arcades to lotteries and football pools to online betting. Whilst some people may experience no apparent negative consequences, for a minority of problematic gamblers, significant negative consequences can impact on their lives and the lives of those around them. These can include negative impacts on physical and mental health, relationships and finances, not just for the individual, but also for a wide range of people including their families, colleagues and wider local communities. Screening tools and signposting can help identify people with problematic gambling.

The Select Committee on the Social and Economic Impact of the Gambling Industry (2019-21) found that nationally:[61]

The young (for whom gambling is illegal) are most at risk:

- 55,000 problem gamblers are aged 11–16;
- For girls aged 11–16, the rate of problem gambling is twice that of any other female age group;
- For boys, the rate is three times the rate for adults;
- The rate of problem gambling among 11–16 year old children is twice as high as for adults; for boys alone it is three times as high.[62]

The increase in online gambling is making the problem worse.

- In 2012, 14% of people took part in online gambling;
- Seven years later, in 2019, the figure was 21%, half as many again.[62]

GamCare, a gambling support charity, has reported that online gambling is a growing issue for callers to the National Gambling Helpline. They have seen a significant impact on gambling behaviour during the Covid-19 pandemic, and it is not clear whether this will have a long-term or short-term effect.[63]

According to the Health Survey for England, 2018:[64] (definitions are in footnote 4 below[4])

- 5.4% of people aged over 16 in the north east were estimated to be at-risk gamblers (PGSI score of 1 or above). Applying this figure to the number of over-16 year olds in Sunderland (228,445) means there could be around 12,300 people at risk of gambling-related harm in Sunderland.
- The prevalence of problem gambling in the north east (according to DSM-IV or PGSI) was 0.7%, which was the second highest region after London at 1.8%. In Sunderland, this means that there are potentially 1,600 problem gamblers.
- Nationally the number of problem gamblers (according to DSM-IV, PGSI or either) was 245,634. A further 377,242 people were deemed as being moderate risk gamblers, and 1,213,830 were classed as low risk gamblers (as measured by PGSI status).
- Gambling prevalence is strongly patterned on deprivation and employment. National data also shows that there are higher gambling rates among men compared to women.[65]
- A higher percentage of BAME are problem gamblers than white/white British or mixed/other.
- Routine and manual workers are also over-represented, with 0.9% of routine and manual workers being classified as problem gamblers, compared with 0.3% of people in managerial and professional roles. 1.9% of the unemployed cohort were classified as problem gamblers, compared with 0.4% of those in employment, self-employment or government training.
- Levels of problem gambling also show a clear gradient with deprivation.
- Due to limitations in how this data is collated, it is likely these estimates are conservative, and may not reflect some of the vulnerable population groups such as homeless people and students.

Citizens Advice carried out an investigation which found that 6 to 10 people are directly affected by a single problem gambler.[66] Applying the above to the estimated figure of 1,600 problem gamblers in Sunderland could suggest that between 9,600 and 16,000 people are adversely affected by problematic gambling in Sunderland.

A revised Gambling Statement of Principles is being recommended to Sunderland Council for approval in November 2021 which sets out licensing objectives.

---

[4] The Health Survey for England, 2018, measures the level of risk attached to gambling using the findings from two different measures as below:
DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth version (1994). This screening instrument is based on ten diagnostic criteria ranging from 'chasing losses' to 'committing a crime to fund gambling.' A score of 3 or more is indicative of problem gambling.

PGSI: Problem Gambling Severity Index. The PGSI consists of nine items ranging from 'chasing losses' to 'gambling causing health problems' to 'feeling guilty about gambling.' Each item is assessed on a four-point scale: never=0, sometimes=1, most of the time = 2, almost always=3. A score of 1-2 is indicative of low-risk gambling, a score of 3-7 is indicative of moderate-risk gambling. A score of 8 or more is indicative of problem gambling. A score of 1 or more is indicative of at-risk gambling.

1.5.5 Healthy Weight

The latest data from the National Childhood Measurement Programme for the school year shows that in Sunderland for 2019-20:[67]

- 22.1% of Reception class children were recorded with excess weight, compared to 23.0% for England;
- 36.9% of Year 6 children were recorded with excess weight, compared to 35.2% for England;
- 10.1% of Reception class children were recorded as obese compared to 9.9% for England;
- 23.6% of Year 6 children were recorded as obese, compared to 21.0% for England;
- 3.0% of Reception class children were recorded as severely obese, compared to 2.5% for England;
- 6.1% of Year 6 children were recorded as severely obese, compared to 4.7% for England;
- 0.5% of Reception class children were recorded as underweight, compared to 0.9% for England; and
- 1.5% of Year 6 children were recorded as underweight, compared to 1.4% for England.

Based on Reception data for 2017/18 to 2019/20:

- The Hendon ward (16.7%) for obesity prevalence was significantly higher than the Sunderland average (11.0%).
- The wards with the 5 highest rates were: Hendon (16.7%), St Chad's (14.3%), Redhill (13.6%) St Anne's' (13.2%) Southwick (12.5%).

Based on Year 6 data for 2017/18 to 2019/20:

- The Sandhill ward (31.2%) for obesity prevalence was significantly higher than the Sunderland average (24.5%).
- The wards with the 5 highest rates were: Sandhill (31.2%), Pallion (29.5%), Hendon (29.3%), Washington North (29.1%), Southwick (28.6%).

Based on the 2021 Sunderland Health Related Behaviours Survey (HRBS), for secondary school pupils, it was found that 64% of secondary school pupils enjoy physical activities at least 'quite a lot', this is similar to the 65% 2019 survey figure.

In Sunderland, 73.5% of adults are classified as overweight or obese, according to 2019/20 data from Public Health England, based on the Active Lives survey undertaken by Sport England. This is higher than the North East figures (67.6%) and the England figure (62.8%).[68] Men are more likely than women to be overweight and obese.[103] Men aged 65-74 and women aged 55-64 were most likely to be overweight; men and women aged 55-64 were most likely to be obese. People from routine and manual groups were most likely to be overweight, whilst people in intermediate occupations were most likely to be obese. At ward level, the highest prevalence of obesity was seen in Hetton, Castle, Redhill, Washington North and Ryhope.

DRAFT

The underlying causes of obesity are the ready availability of high calorie food, more sedentary lifestyles caused by a reduction in activity and manual labour, and greater use of the car as a means of transport. Obesity is associated with a range of health problems including Type 2 diabetes, cardiovascular disease and cancer.

Obesity places a burden on the healthcare system.

- In 2019/20, there were 270 admissions to hospital where the main reason for admission was recorded as obesity in Sunderland.[69] The rate of admissions, at 99 per 100,000 population and is significantly higher than the England average of 20 per 100,000. It should be noted that the North East region has significantly higher admission rates than the rest of the country (46 admissions per 100,000 population) and that South Tyneside and City Hospitals Sunderland NHS Foundation Trust hosts the regional centre for bariatric surgery and surgical weight management.

- In addition, in 2019/20, 2789 prescription items for the treatment of obesity were prescribed in primary care and dispensed within Sunderland. The rate of prescribing at 10 prescription items per 1,000 population is well above the England average of 6 per 1,000.

The Healthy Weight JSNA is available online at: Healthy Weight, Sunderland JSNA

1.5.6 Sexual Health

Good sexual health is fundamental to general wellbeing and health; it is also an important public health issue. Poor sexual health imposes social, economic, emotional and health costs. Key population groups can be identified who are more likely to experience health inequalities and have higher need for sexual health services and support. These are as follows: young people; gay, bisexual or other men who have sex with men; black and minority ethnic groups; and women of reproductive age.

Sexually transmitted infections can affect anyone but are more common among those aged under 25 years. Many sexual infections have long lasting effects on health, including cervical cancer and infertility.

Sunderland has relatively low rates of HIV diagnosis and a relatively high uptake of HIV testing in eligible persons attending specialist sexual health services. Despite this, between 2017-2019, 60.9% of all HIV diagnoses made for people from Sunderland were made late, when their immune system had already been damaged (compared with 42.5% for the North East and 43.1% for England).[70] This is worse than the previous figure for Sunderland for 2016-18, when the percentage with late diagnosis of HIV was 55.2%.

Reducing the burden of poor sexual health requires sustained approaches to support early detection, successful treatment and partner notification in conjunction with access to a full range of contraception choices alongside safe sex health promotion and the promotion of safer sexual behaviour.

DRAFT

The Sexual and Reproductive Health services JSNA is available at: Sexual and Reproductive Health services JSNA for Sunderland, 2018

1.5.7 Teenage conceptions

Areas of deprivation often have the highest teenage conception rates and the lowest percentage of conceptions leading to abortions. Consequently, deprived areas have the highest number of teenage maternities and are therefore disproportionately affected by the poorer outcomes associated with teenage conceptions.

Children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight which impacts on the child's long-term health. Teenage mothers are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth. Teenage parents and their children are at increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.[71]

- The proportion of teenage mothers (aged 12-17) in Sunderland in 2019/20 was 1.4%, which was significantly higher than the England figure of 0.7% and higher than the regional average of 1.2%.[72]

Data for 2016-2018 shows that in Sunderland, Hetton was the only ward where the teenage conception rate remains significantly above the Sunderland average. Sunderland has seen a 61% decrease in under 18 conception rates since 1998, however rates in Sunderland remain above the North-East and England average.

The North East has also seen a 61% decrease in its teenage under 18 conception rate between 1998 and 2019 (from 56.5 to 21.8. per 1,000), although it consistently has had the highest rate of all the regions in England.

Annual conception data for 2019 was published by the ONS on 5 August 2021.
Under 18 conception rates, per 1000 women aged 15-17 years:
[73]

- Sunderland 24.3
- North East 21.8
- England 15.7

Under-18 conceptions was 24.3 per 1,000 females aged 15-17 for Sunderland compared to 21.8 per 1,000 in the North East and 15.7 per 1,000 for England.

The under-16 conception rate was 6.0 per 1,000 females aged 13-15 in Sunderland in 2019, compared to 3.9 per 1,000 in the North East and 2.5 per 1,000 in England.[74] This represents 26 conceptions in 2019, compared to 20 conceptions in 2018 and 19 conceptions in 2017.

The rate of abortions per 1,000 females under-18 in Sunderland in 2020 was 7.5, which was similar to the regional figure of 7.6 and higher than the national figure of 6.8.

Young people's services and healthy settings work with schools continues to support the sexual health and wellbeing of young people, including access to relationship and sexual health advice and access to emergency contraception and long acting contraception. However, the impacts of Covid-19 on services and young people are presenting a challenge to continuing this pace of change, with some local services experiencing an increase in demand.

1.5.8 Breastfeeding

Breastfeeding rates in Sunderland are significantly lower than the England average.

- The latest published data for 2018/19 shows the percentage of babies whose first feed is breastmilk was 48% in Sunderland compared to an England average of 67.4% and a North East average of 50.6%.[75]

- Similarly, breastfeeding continuation rates, measured at 6-8 weeks, are significantly below the England average. The latest annual data from 2019/20 show a Sunderland rate of 25.7% compared to an England average of 48% and North East average of 34.4%.

Babies that are not breastfed are more likely to acquire infections such as gastroenteritis and respiratory tract infections. Hospital admission for gastroenteritis in infants aged under one year for Sunderland is significantly above the England average with a rate of 220.7 per 10,000 in 2019/20 compared to an England average of 151.4 per 10,000, but below the North East average of 272.3 per 10,000.[76]

There is growing evidence that not breastfeeding might increase the risk of obesity later in life.

1.5.9 Oral health

Oral health is about more than just an absence of disease. Oral health has an important role in the general health and wellbeing of individuals.[77] There is a widely accepted disparity between socio-economic groups in relation to oral health.[78] Tooth decay is a predominantly preventable disease. High levels of consumption of sugar-containing food and drink is also a contributory factor to other issues of public health concern in children – for example, childhood obesity.

- The prevalence of incisor caries in three year olds in Sunderland was 4.9%, compared with 3.1% regionally and 3.4% nationally in 2019/20.[79] According to a 2018/19 dental survey, the mean number of decayed, missing or filled teeth in five year olds in Sunderland was 1.1, which was the third highest level in the north east, and higher than the national figure of 0.8.

The prevalence and severity of disease at age five can be used as a proxy indicator for the impact of early years services and programmes to improve parenting, weaning and feeding of very young children.

DRAFT

1.6 Cancers

Death rates from all cancers have decreased significantly over the last two decades due to a combination of early detection and improved treatment. However, within Sunderland, cancer remains a significant cause of premature death and health inequalities. Cancer is the commonest cause of premature death in Sunderland with a death rate of 76.5 per 100,000 persons aged under 75 in 2017-2019. The rate of premature mortality from cancer considered preventable in the North East is 68.5 per 100,000 population aged under 75 for the same period. Both rates are significantly higher than the England average of 54.1, but not significantly different from the regional average.

Collectively, cancers account for 29.1% of the gap between Sunderland and England for male life expectancy and 20.5% of the gap between Sunderland and England for female life expectancy.

Evidence from the Centre for Cancer Prevention at Queen Mary University of London and Cancer Research UK suggested that 37% of cancers (38% in males and 36% in females) that occurred in 2015 were linked to a range of major lifestyle and other factors as follows:[80]

- Smoking (14.7%)
- Being overweight or obese (6.3%)
- Exposure to UV radiation (3.8%)
- Occupational exposures (3.7%)
- Infection (3.5%)
- Drinking alcohol (3.3%)
- Diet low in fibre (3.2%)
- Exposure to ionising radiation (1.9%)
- Diet including processed meat (1.5%)
- Air pollution (1.0%)
- Not Breastfeeding (0.7%)
- Insufficient physical activity (0.5%)
- Post-menopausal hormones (0.4%)
- Oral contraceptives (0.2%)

As cancers are caused by multiple factors acting simultaneously, the same cancers can be attributed to more than one cause and therefore summing the impacts of all risk and other factors would overestimate the total burden of cancer. In order to prevent cancer, it is therefore likely that intervening across multiple risk factors will be required.

Since combinations of factors are linked to different cancers, different proportions of different cancers are preventable. The proportion of preventable cases is high for cervical cancer (due to the link with human papilloma virus (HPV) infection), oesophageal and lung cancers (due to the link with smoking), and malignant melanoma (due to the link with ultra-violet (UV) radiation from sunlight and sunbeds). Many of the most common cancers have a large proportion of preventable cases.

DRAFT

Prostate cancer is a notable exception because it is not clearly linked to any preventable risk factors.

1.7 Long-term conditions

A long-term condition is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies. The NHS Long Term Plan has a strong focus on the treatment and prevention of illness by supporting patients to adopt improved healthy behaviours.[81] This will both help people to live longer, healthier lives, and reduce the demand for and delays in treatment and care focusing on services to support patients to overcome tobacco addiction, treat alcohol dependence and to prevent and treat obesity – particularly in areas with the highest rates of ill health. The prevalence of long-term conditions increases with age and the proportion of the population with multiple long term conditions also increases with age. People from lower socio-economic groups have increased risk of developing a long term condition; better management can help to reduce health inequalities. The Ageing Well JSNA is available online at: JSNAAgeingWell.pdf (sunderland.gov.uk).

People with long-term conditions are intensive users of health and social care services, including community services, urgent and emergency care and acute services. They account for:[82]

- 50% of all GP appointments;
- 64% of outpatient appointments;
- 70% of all inpatient bed days;
- Around 70% of the total health and care spend in England.

For all of the conditions listed below, the identification of people who already have or who are at risk of developing disease followed by successful management of their conditions is important to the efforts to reduce premature mortality, morbidity and inequalities in health. Information about how well the Sunderland health system delivers against the evidence based standards of care for these conditions can be found in published disease profiles.

1.7.1 Cardiovascular disease

Cardiovascular disease (CVD) covers a number of different problems of the heart and circulatory system, such as coronary heart disease (CHD), stroke and peripheral vascular disease (PVD). It is strongly linked with other conditions such as diabetes and chronic kidney disease and is more prevalent in lower socio-economic and minority ethnic groups.

Death rates from cardiovascular disease have decreased significantly over the last two decades due to a systematic approach to secondary prevention and improved treatment. However, within Sunderland, cardiovascular disease remains a significant cause of premature death and health inequalities. Cardiovascular disease is the second commonest cause of premature death in Sunderland (after cancer) with a death rate of 89.0 per 100,000 persons aged under 75 in 2017-2019. The rate

DRAFT

of premature mortality from cardiovascular disease considered preventable is 37.9 per 100,000 persons aged under 75 for the same period (2019 definition). Both rates are significantly higher than the England average, but not significantly different from the regional average.[83]

The recorded (diagnosed) prevalence for key cardiovascular long-term conditions is higher for Sunderland than the England average as follows:

- For coronary heart disease, recorded prevalence in Sunderland is 4.6% in 2019/20 (around 13,119 persons) compared to a prevalence of 3.1% in England;
- For stroke, recorded prevalence in Sunderland is 2.3% (around 6,500 persons) compared to a prevalence of 1.8% in England for 2019/20.

1.7.2 Hypertension

A measurement of blood pressure indicates the pressure that circulating blood puts on the walls of blood vessels. A blood pressure of 140/90 mmHg or greater is usually used to indicate hypertension (high blood pressure) because persistent levels above this start to be associated with increased risk of cardiovascular events. Uncontrolled hypertension is a major risk factor for stroke, heart attack, heart failure, aneurysms and chronic kidney disease.

The recorded (diagnosed) prevalence for hypertension is higher for Sunderland than the England average as follows:

- For hypertension, recorded prevalence in Sunderland is 17.4% (around 49,498 persons) compared to a prevalence of 14.1% in England in 2019/20.[84]

The prevalence estimate based on the published evidence suggest that the underlying prevalence in the population – including both diagnosed and undiagnosed disease – is more likely to be as follows in Sunderland:

- For hypertension, 27.8%[85] of the population or around 63,550 persons – this means that there could be around 14,052 persons in the population whose condition is undiagnosed.

1.7.3 Atrial Fibrillation

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. It can affect adults of any age, but it becomes more common as you get older and is more common in people with hypertension, atherosclerosis or heart valve problems. People with atrial fibrillation are at risk of blood clots forming, they therefore have an increased risk of having a stroke. Persistent atrial fibrillation may weaken the heart and in extreme cases can lead to heart failure.

The recorded (diagnosed) prevalence for atrial fibrillation is higher for Sunderland than the England average as follows:[86]

DRAFT

- For atrial fibrillation, recorded prevalence in Sunderland is 2.4% (around 6,945 persons) compared to a prevalence of 2.1% in England in 2019/20.

The prevalence estimate based on the published evidence suggest that the underlying prevalence in the population – including both diagnosed and undiagnosed disease – is more likely to be as follows in Sunderland:

- For atrial fibrillation, 2.7%[87] of the population or around 7,690 persons – this means that there could be around 745 persons in the population whose condition is undiagnosed.

1.7.4 Diabetes

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. It can affect infants, children, young people and adults of all ages, and is becoming more common. Diabetes can result in premature death, ill-health and disability, yet these can often be prevented or delayed by high quality care. Preventing Type 2 diabetes (the most common form) requires action to identify those at risk who have non-diabetic hyperglycaemia and prevention activities to tackle obesity, diet and physical activity.

The recorded (diagnosed) prevalence for diabetes is higher for Sunderland than the England average as follows:[88]

- For diabetes, recorded prevalence in Sunderland is 7.8% (around 18,134 persons aged 17 and over) compared to a prevalence of 7.1% in England in 2019/20.

The prevalence estimate based on the published evidence suggests that the underlying prevalence in the population – including both diagnosed and undiagnosed disease – is more likely to be as follows in Sunderland:[89]

- For diabetes, 9.0% of the population or around 20,798 persons aged 17 and over – this means that there could be around 2,664 persons in the population whose condition is undiagnosed.

The NHS Diabetes Prevention Programme (DPP) has collated data on people who are registered in GP practices who have non-diabetic hyperglycaemia. Non-diabetic hyperglycaemia involves blood glucose levels that are above normal levels, but not in the diabetic range. For Sunderland, 3.9% of GP practice list size (aged 17 and over) or 9,080 persons over 17 were registered as having non-diabetic hyperglycaemia.[90] Of these, 3,380 (1.5% of the total) were recently diagnosed (diagnosed between 1/1/2019 to 31/3/2020). The comparative figure for England is 4.4%, with 1.2% being recently diagnosed.

DRAFT

1.7.5 Chronic Kidney Disease

Chronic kidney disease is the progressive loss of kidney function over time, due to damage or disease. It becomes more common with increasing age and is more common in people from black and south Asian ethnic communities. Chronic kidney disease is usually caused by other conditions that put a strain on the kidneys such as high blood pressure, diabetes, high cholesterol, infection, inflammation, blockage due to kidney stones or an enlarged prostate, long term use of some medicines or certain inherited conditions. People with chronic kidney disease are at increased risk of cardiovascular diseases.

The recorded (diagnosed) prevalence for chronic kidney disease is higher for Sunderland than the England average as follows:[91]

- For chronic kidney disease, recorded prevalence in Sunderland is 4.8% (around 11,086 persons aged 18 and over) compared to a prevalence of 4.0% in England in 2019/20.

1.7.6 Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a progressive disease which covers a range of conditions, including bronchitis and emphysema. Its symptoms include cough and breathlessness; over time it can become increasingly severe, having a major impact on mobility and quality of life as it impacts on people's ability to undertake routine activities. In the final stages it can result in heart failure and respiratory failure. Because of its disabling effects, it impacts not only on the person with the disease but also on those who provide informal care to that person. The biggest risk factor for the development and progression of COPD is smoking, so prevention is linked to smoking cessation activities and broader tobacco control.

Within Sunderland, respiratory diseases are a significant cause of premature death and health inequalities. Respiratory disease is a common cause of premature death in Sunderland with a death rate of 45.3 per 100,000 persons aged under 75 in 2017-19.[92] The rate of premature mortality from respiratory disease considered preventable is 30.9 per 100,000 population aged under 75 for 2017-2019 (2019 definition).[93] Both rates are significantly higher than the England average but not significantly different from the regional average. Collectively, respiratory diseases account for 12.9% of the gap between Sunderland and England for male life expectancy and 24.4% of the gap between Sunderland and England for female life expectancy.[11]

The recorded (diagnosed) prevalence for COPD is higher for Sunderland than the England average as follows:

- For COPD, recorded prevalence in Sunderland is 3.5% (around 9,720 persons) compared to a prevalence of 1.9% in England in 2019/20.

1.7.7 Dementia

Dementia is a group of related symptoms associated with an on-going decline of brain functioning. This may include problems with memory loss, confusion, mood changes and difficulty with day to day tasks.

The biggest risk factor for dementia is age; the older you are the more likely you are to develop the condition. But dementia is not an inevitable part of ageing. Although it is not possible to completely prevent dementia, leading a healthy lifestyle and taking regular exercise can lower the risk of dementia.[94]

There are different types of dementia; all of them are progressive and interfere with daily life. Alzheimer's disease and vascular dementia together make up the vast majority of cases. Although there is no cure for dementia, early diagnosis and the right treatment can slow its progress, help to maintain mental function, and give time to prepare and plan for the future. The estimated dementia diagnosis rate (aged 65 and over) for Sunderland in 2021 is 61.5%, which is similar to the north east (66.2%) and national (61.6%) position.

The recorded (diagnosed) prevalence for dementia is lower for Sunderland than the England average as follows:

- For dementia, recorded prevalence (aged 65 years and over) in Sunderland is 3.75% compared to a prevalence of 3.97% in England for 2020.

Locally the number of cases of dementia is predicted to increase as the proportion of older people in the population grows. Even after diagnosis, people continue to live at home for many years, often with support from family carers. Accurate diagnosis of dementia is the first step to getting help and support.

1.8 Disability

The Equality Act 2010 defines disability as having a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to perform normal daily activities. Substantial means more than minor or trivial, for example, it takes much longer than it usually would to complete a daily task like getting dressed. 'Long-term' means 12 months or more, for example, a breathing condition that develops as a result of a lung infection. There are special rules about recurring or fluctuating conditions, for example, arthritis.

A progressive condition is one that gets worse over time. People with progressive conditions can be classed as disabled.

However, a person would automatically meet the disability definition under the Equality Act 2010 from the day of diagnosis with HIV infection, cancer or multiple sclerosis.[95]

1.8.1 Learning Disability

A learning disability affects the way a person understands information and how they communicate, which means they can have difficulty understanding new or complex information, learning new skills and coping independently. They are caused by something affecting how the brain develops.

Learning disabilities can be mild, moderate or severe. Some people with a learning disability live independently without much support; others need help to carry out most daily activities. Many people with learning disabilities also have physical and/or sensory impairments, and some might behave in a way that others find difficult or upsetting (called behaviour that 'challenges').

People with learning disabilities can become socially excluded and vulnerable. They have greater health needs than the rest of the population as they are more likely to have:

- Mental illness;
- Chronic health problems;
- Epilepsy;
- Physical disabilities and sensory impairments.

The recorded prevalence of learning disability for Sunderland is as follows:

- For learning disabilities, recorded prevalence in Sunderland is 0.8% compared to a prevalence of 0.5% in England.[96]

Based on local lifestyle data[103] for Sunderland adults aged 18 years and over, we can see that people with a learning disability:

- Are significantly more likely to smoke (26.7% compared to 15.9%);
- Are significantly less likely to drink alcohol (49.1% compared to 67.0%) and less likely to binge drink (20.0% compared to 26.5%);
- Are as likely to meet the recommended 30 minutes of moderate intensity physical activity at least five times a week (38.4% compared to 39.3%);
- Are less likely to eat the recommended 5 or more portions of fruit and vegetables each day (44.8% compared to 47.6%);
- Are significantly more likely to be of excess weight (74.8% compared to 58.0%); and
- Have significantly lower average mental wellbeing scores (44.3 compared to 52.9).

Based on their greater health needs, it is critical that people with a learning disability have full access to health and care services and full access to preventative services. In Sunderland in 2018/19, 42.5% of eligible adults with a learning disability had a GP health check, which is significantly lower than the national figure of 52.3% and the regional figure of 61.8%.[97]

1.8.2 Physical Disability

Physical disabilities are physical conditions that affect a person's mobility, physical capacity, stamina, or dexterity. They are wide ranging and include musculoskeletal conditions, neuromuscular conditions and sensory impairments. People with physical impairments face many barriers to living a fulfilling and independent life. Not only do they have the practical problems of everyday life to contend with but also they have to face negative public perceptions, problems gaining access to everyday facilities and services, and prejudice. The support required for people with physical impairment may be multi-dimensional and needs to be tailored to address their specific individual needs.

Published national prevalence figures for 2019-20 for some types of physical disability are shown below and applied to the Sunderland population to estimate local prevalence[98]:

- 7.0% of persons have mobility issues – an estimated 19,439 people in Sunderland;
- 5.1% of persons have impairments affecting stamina, breathing or fatigue – an estimated 14,163 people in Sunderland;
- 3.5% of persons have impairment affecting dexterity - an estimated 9,720 people in Sunderland;
- 1.9% with hearing impairments - an estimated 5,276 people in Sunderland;
- 1.6% with visual impairments - an estimated 4,443 people in Sunderland. In 2019/20 there were 1,735 people registered with partial sight or sight impairment and 740 blind people or people with severe sight impairment.[99]

Physical disability can be caused by a wide variety of diseases, illnesses or circumstances and may impact on health in a number of ways.

1.9 Mental Health and Mental Wellbeing

In recent years, there has been increasing recognition of the impact of mental illness on the population. Differences in the allocation of resources between mental health and physical health, with historic underinvestment in mental health care across the NHS, are being addressed through the ambition of “parity of esteem”. This seeks to improve investment in mental health services to ensure that mental health and physical health are equally valued. At the same time, the interplay between physical and psychological symptoms is becoming better understood, and the very real inequalities in health outcomes for people with mental health problems are being quantified. We know that people with long term physical illnesses suffer more complications if they also develop mental health problems.

As many of the risk factors for mental illness are linked to deprivation, it is not surprising that Sunderland experiences a relatively high burden from mental ill health, higher recorded prevalence of depression on GP systems, high levels of prescribing antidepressants, and a high burden on mortality. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations. Data on mental health in children shows that:

DRAFT

- One in ten children aged 5-16 years nationally has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14.
- Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders – with ten per cent of 15-16 year olds having self-harmed.
- The percentage of school pupils with social, emotional and mental health needs (school age) in Sunderland in 2020 was 3.18%, which was higher than the north east figure of 3.03% and significantly higher than the national figure of 2.7%.[100]
- The inpatient hospital admission rate for mental health disorders per 100,000 population aged 0-17 years in Sunderland in 2018/19 was 183.3, which was significantly higher than both the national (88.3) and regional (105.7) figures.[101]

The 2021 Sunderland Health Related Behaviours Survey (HRBS), for secondary school pupils, found that:

- 54% of females and 28% of males worry *quite a lot, or a lot*, about their mental health and wellbeing. Compared to the previous 2019 survey, these figures are a rise in percentage points of: 11 for females and 3 for males.

For females and males combined:
- 15% worry a *little* about everyday life aspects
- 26% worry *quite a lot*
- 55% worry *a lot*
- Only 4% worry *never or hardly never.*

When asked, 'If you wanted to share any of the problems relating to your mental health and wellbeing, to whom would you turn'?

- 38% stated family
- 13% friends
- 4% teacher/carer/ or other adult
- 2% school nurse
- A high 41% said they would keep it to themselves; this is 12 percentage points up since the 2019 survey.

Since having to stay at home due to Covid:
- 19% said they have felt happier than before
- 31% said they have felt generally sadder than before.

As part of Sunderland CCG's Community Mental Health Transformation, the CCG has led on a recent Adult Mental Health Strategy. The strategy highlights likely increase in demand for MH services over next 5 years following the impact of Covid-19. The Strategy will aim to respond to the increase and take into consideration the key highlight from across the needs assessment with added focus on prevention. Key highlights from the Strategy show:

- The majority of the general public feel able to manage their mental wellbeing through engaging in certain activities and behaviours relating to their health;
- Covid-19 pandemic has tested the resilience of individuals;
- Feelings of isolation, loneliness, anxiety, depression, fear and concern for others were common;
- The engagement with large employers showed Covid-19 has had an effect on the mental wellbeing of their workforce not only affected those who already struggle with their mental health, but those with no history, including new cohorts of younger individuals;
- There is an increase on residents seeking support for better mental health; and
- The term *Mental Health* can be perceived negatively in BAME communities and as a result can stop people getting help.

People from Sunderland report poorer outcomes for aspects of the self-reported wellbeing score than the England average, although these are not statistically significant:[102]

- 23.04% report a high anxiety score, compared to 21.94% across England;
- 13.52% report a low happiness score, compared to 8.72% across England;
- 6.5% report a low satisfaction score compared to 4.68% across England;
- 6.01% report a low worthwhile score compared to 3.81% across England.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), which creates an overall score based on responses to 14 positively worded items, allows us to describe mental wellbeing in the general population. For each individual, scores are between 14 and 70 and a higher score represents better mental wellbeing. Average (mean) scores are used to compare the results of different groups. Data from the 2017 Adult Lifestyle Survey for Sunderland[103] found that:

- For Sunderland adults aged 18 years and over, the average WEMWBS score is 52.7 compared to 49.9 for England adults aged 16 years and over.[103]

- Within Sunderland men have a higher average mental wellbeing score than women. Men and women aged 25-34 have the lowest average mental wellbeing scores, whilst men and women aged 65-74 have the highest average mental wellbeing scores. There is also a socio-economic gradient with adults in managerial and professional occupations having the highest average mental wellbeing scores and those who have never worked or who are long-term unemployed having the lowest average mental wellbeing scores.

- At ward level the highest average mental wellbeing scores are seen in St Peter's, Fulwell, Ryhope and Washington West, whilst lowest average mental wellbeing scores are seen in Southwick, Hetton, St Anne's and Hendon.

DRAFT

The Mental Health Needs Assessment for Sunderland is available at: https://www.sunderland.gov.uk/media/24026/JSNA-Mental-Health/pdf/JSNAMentalHealth.pdf?m=637628965863100000

The Adult Mental Health Strategy is available at: Adult Mental Health Strategy - Sunderland Clinical Commissioning Group (sunderlandccg.nhs.uk)

1.10 Summary of health needs analysis

Sunderland experiences higher levels of deprivation than the national average. Social disadvantage is also associated with increased risk of a range of health conditions.

Large increases are predicted in the number of older people in Sunderland, and particularly the very elderly, populations. This has significant implications for health care over the next five, ten and twenty years. Even if the general levels of health in these age groups continue to improve, the shape and structure of health services will need to change to meet the needs of this growing population.

Sunderland has higher levels of health risk than England as a whole. This is directly linked to a range of social, economic and environmental factors. Lower household income, increased food poverty, higher employment deprivation, and lower levels of educational achievement all contribute poorer outcomes. While health behaviours contribute to the causes of non-communicable diseases, it is the social determinants of health that cause inequalities in these behaviours – the causes of the causes.[104]

The 'Build Back Fairer: the Covid-19 Marmot Review' report urges the Government to learn the lessons of the pandemic, prioritise greater equality and health, and works urgently to reduce the severity of the health crisis caused by the economic and social impacts of the pandemic and the societal response.[105] In recognising the recommendations in the 10 Years On and the Marmot 2020 reports, this JSNA assesses data that can support action to address the Marmot recommendations to:

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

Recent data from the Sunderland Adult Health and Lifestyle Survey[103] shows the number of people who engage in four lifestyle risk factors[106] (smoking, excessive alcohol use, poor diet, and low levels of physical activity):

- 13.9% of adults aged 18 and over have none of these risk factors;
- 36.8% of adults aged 18 and over have one of these risk factors;
- 35.2% of adults aged 18 and over have two of these risk factors;
- 12.1% of adults aged 18 and over have three of these risk factors;

- 1.9% of adults aged 18 and over have all four of these risk factors.

The Kings Fund report concluded that in order to improve health in lower socio-economic groups a holistic approach is needed encompassing multiple unhealthy behaviours. A recent update by the Kings Fund[107] has confirmed that as the number of unhealthy lifestyle behaviours increases so does the impact on mortality, morbidity and quality of life. Whilst the evidence is still emerging, it appears that success in changing one behaviour may be related to success in changing another. It is not yet clear, though, whether changes are more effective when undertaken together or in sequence. The exception to this is in relation to stopping smoking, where evidence shows that this is more effective when delivered in sequence rather than being delivered at the same time as other behaviour change interventions.

Unhealthy behaviours continue to drive higher prevalence of long term conditions and increased rates of premature death across the city. A key challenge for the Sunderland health economy is the need to manage the high and increasing levels of long term conditions in the population, including increasing proportions of people with multiple long term conditions.

Preventing premature deaths due to cancer, cardiovascular disease and respiratory disease remains a priority for health partners across the city. This requires a targeted approach to reducing the gap in life expectancy.

1.11 Key health challenges

A summary of the high level health challenges for Sunderland is therefore as follows:

- Ensuring a system-wide understanding of the health and social determinant impacts of the Covid-19 pandemic on health outcomes and health inequalities.
- Inequalities, relating to both socio-economic position and protected characteristics, have a significant impact on the health of people in Sunderland and should be considered for all interventions and policies, recognising that socio-economic inequalities are a continuum across the population and that some people are impacted by multiple inequalities.
- Poverty levels within the city continue to have an impact and should be tackled by increasing levels of employment in good work through attracting more jobs into the city, increasing educational and skills attainment of Sunderland residents and ensuring as many people as possible are supported to stay in work, despite having a health condition.
- Responding to health protection (infectious diseases) threats requires prevention work, rapid identification and a swift response to complex cases in high risk places, locations and communities.[108]
- Children and young people in Sunderland face some significant health challenges and inequalities across the social determinants of health. Lower household income, increased food poverty, higher employment deprivation, and lower levels of educational achievement contribute to poorer outcomes including higher levels of teenage conceptions, smoking during pregnancy, unhealthy weight, alcohol related hospital admissions; low levels of breastfeeding; and poor oral health and mental health outcomes. Partners

need to work together and with children, young people and families to address these issues and build resilience.

- The four main behavioural risk factors – smoking, diet, alcohol and physical activity – lead to poor health outcomes and increase health inequalities and so programmes need to continue to be developed, in partnership with local people, to make it easier to make the healthy choice.
- There are more people in Sunderland living with, and prematurely dying from, cancer, cardiovascular disease and respiratory disease than elsewhere in the country. Partners need to be clear that primary, secondary and tertiary prevention programmes are in place that ensure that no opportunities are missed to prevent these diseases and stop them progressing.
- The ageing population as well as the high numbers of people with long term, often multiple, conditions has a significant impact on local people and services. This needs to continue to be addressed through integrated care and supporting people to self-care as well as a transparent, whole system approach to preventing service failure.
- People in Sunderland have poor mental wellbeing and suffer from a higher burden of mental ill health than the rest of England. This should be tackled through a preventative programme alongside recognition of the needs of people with poorer mental health and wellbeing and the impacts this has on their physical health.

DRAFT

Hyperlinks

[1] WHO. Novel Coronavirus – China. January 2020
[2] Build Back Fairer: The COVID-19 Marmot Review | The Health Foundation
[3] Sunderland Covid-19 Health Inequalities Strategy
[4] Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)
[5] Population projections for local authorities: Table 2 - Office for National Statistics
[6] KS201EW: Ethnic Group
[7] Public Health Profiles - PHE
[8] Life expectancy in England in 2020 - Public health matters (blog.gov.uk)
[9] Public Health Profiles - PHE
[10] Local Health - PHE
[11] Segment Tool (phe.gov.uk)
[12] SegmentData.csv – internal document
[13] SegmentData.xlsx
[14] JSNA High Level Summary, the story so far (sunderland.gov.uk)
[15] English Indices of Deprivation, 2019, SunderlandIMD Deciles (internal use only); and https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[16] Local Health - Data - PHE
[17] Is Britain Fairer? (2018) | Equality and Human Rights Commission (equalityhumanrights.com)
[18] Equality Framework for Local Government | Local Government Association
[19] Public Health Profiles - PHE
[20] Your parents' support framework (publishing.service.gov.uk)
[21] COVID-19: latest impact on food - Food Foundation
[22] Annual Fuel Poverty Statistics LILEE Report 2021 (2019 data) (publishing.service.gov.uk)
[23] Sub-regional fuel poverty data 2021 - GOV.UK (www.gov.uk)
[24] the-health-impacts-of-cold-homes-and-fuel-poverty.pdf (instituteofhealthequity.org)
[25] Public Health Profiles - PHE
[26] Improving lives: the future of work, health and disability - GOV.UK (www.gov.uk)
[27] Build Back Fairer: The COVID-19 Marmot Review | The Health Foundation
[28] Labour Market Profile - Nomis - Official Labour Market Statistics (nomisweb.co.uk)
[29] Public Health Profiles - PHE
[30] Education: a neglected social determinant of health - The Lancet Public Health.
[31] IJERPH | Free Full-Text | Education as a Social Determinant of Health: Issues Facing Indigenous and Visible Minority Students in Postsecondary Education in Western Canada (mdpi.com).
[32] Labour Market Profile - Nomis - Official Labour Market Statistics (nomisweb.co.uk)
[33] Sunderland_Strategic_Housing_Market_Assessment_-_Final_Report_-_July_2020.pdf
[34] oce21556 Sunderland Rough Sleeping and Homelessness Prevention Strategy 2019-2021 A4.qxp
[35] Local Authority Health Profiles - Data - PHE
[36] Domestic abuse is a gendered crime - Womens Aid
[37] Chapter 6: wider determinants of health - GOV.UK (www.gov.uk)
[38] Low Carbon Framework, City of Sunderland
[39] SD.46_Sunderland_Green_Infrastructure_Strategy_2018.pdf
[40] 2021_CDP_Report.pdf (sunderland.gov.uk)
[41] Executive summary (sunderland.gov.uk)
[42] ALS_2017_Profile_-_Physical_Activity.pdf (sunderland.gov.uk)
[43] UK Chief Medical Officers' Physical Activity Guidelines (publishing.service.gov.uk)
[44] Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)
[45] Public Health Profiles - PHE
[46] fair-society-healthy-lives-full-report-pdf.pdf (instituteofhealthequity.org)
[47] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0/gid/1938132886/pat/6/par/E12000001/ati/102/are/E08000024
[48] Review of the Health Inequalities Infant Mortality PSA Target (perinatal.nhs.uk)
[49] Public Health Profiles - PHE
[50] Local Tobacco Control Profiles - Data - PHE
[51] Public Health Profiles - PHE
[52] smoking_and_mental_health_-_full_report_web.pdf (shopify.com)

DRAFT

[53]Statistics on NHS Stop Smoking Services in England April 2020 to September 2020 - NHS Digital,
[54] Local Tobacco Control Profiles - PHE
[55] Public Health Profiles - PHE
[56] Watershed moment to tackle widening health inequalities as a result of COVID-19 | Imperial News | Imperial College London
[57] Local Alcohol Profiles for England.
[58] World Drug Report 2021 (unodc.org) cited in Build Back fairer - the COVID-19 Marmot review (health.org.uk)
[59] Estimates of the prevalence of opiate use and/or crack cocaine use, 2016/17. https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations
[60] http://www.legislation.gov.uk/ukpga/2005/19/section/3
[61] Gambling Harm— Time for Action (parliament.uk)
[62] Gambling Commission website - Gambling Commission
[63] GamCare responds to new statistics from the Gambling Commission July 2021 - GamCare
[64] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018/health-survey-for-england-2018-supplementary-analysis-on-gambling
[65] https://www.gamblingcommission.gov.uk
[66] Out of Luck - An exploration of the causes and impacts of problem gambling - Home (citizensadvice.org.uk)
[67] Obesity Profile - PHE
[68] Percentage of adults (aged 18+) classified as overweight or obese
[69] NHS Digital, Admissions directly attributable to obesity, May 2021
[70] Public Health Profiles - PHE
[71] Local Authority Health Profiles - Data - PHE
[72] Child and Maternal Health - Data - PHE
[73] Conceptions in England and Wales - Office for National Statistics
[74] Public Health Profiles - PHE
[75] Public Health Profiles - PHE
[76] Public Health Profiles - PHE
[77] Delivering_better_oral_health.pdf (publishing.service.gov.uk)
[78] Health_inequalities_Oral_health.pdf
[79] Child and Maternal Health - PHE
[80] The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015
[81] NHS Long Term Plan » Treating and preventing ill health
[82] Long-term conditions compendium of Information: 3rd edition, cited by The Kings Fund
[83] Public Health Profiles - PHE
[84] Cardiovascular Disease - PHE
[85] Hypertension prevalence estimates for local populations - GOV.UK (www.gov.uk)
[86] Public Health Profiles - PHE
[87] Atrial fibrillation prevalence estimates for local populations - GOV.UK (www.gov.uk)
[88] Public Health Profiles - PHE
[89] Diabetes prevalence estimates for local populations - GOV.UK (www.gov.uk)
[90] National Diabetes Audit, Non-Diabetic Hyperglycaemia, 2019- 2020, Diabetes Prevention Programme, Data Release - NHS Digital
[91] Public Health Profiles - PHE, CKD: QOF prevalence (18+)
[92] Public Health Profiles - PHE
[93] Public Health Profiles - PHE
[94] Can dementia be prevented - NHS (www.nhs.uk)
[95] Definition of disability under the Equality Act 2010 - GOV.UK (www.gov.uk)
[96] Learning Disability Profiles - PHE
[97] Learning Disability Profiles - Data - PHE
[98] Family Resources Survey: financial year 2019 to 2020 - GOV.UK (www.gov.uk)
[99] Registered Blind and Partially Sighted People, England 2019-20 - NHS Digital
[100] Children and Young People's Mental Health and Wellbeing - PHE
[101] Public Health Profiles - PHE

DRAFT

[102] Annual personal well-being estimates - Office for National Statistics (ons.gov.uk)
[103] Sunderland Adult health and lifestyle survey 2017
[104] Inclusion health: addressing the causes of the causes - ClinicalKey
[105] Build Back Fairer: The COVID-19 Marmot Review | The Health Foundation
[106] Clustering of unhealthy behaviours over time | The King's Fund (kingsfund.org.uk)
[107] Tackling multiple unhealthy risk factors | The King's Fund (kingsfund.org.uk)
[108] Sunderland Covid-19 Control Plan, Sunderland Council June 2020

DRAFT

Item No. 6

SUNERLAND HEALTH AND WELLBEING BOARD **1 October 2021**

DEVELOPING OUR APPROACH TO IMPROVING HEALTH AND REDUCING HEALTH INEQUALITIES

Report of the Executive Director of Public Health and Integrated Commissioning

1.0 Purpose of the Report

1.1 The purpose of the report is to:

i) provide an overview of the Health Inequalities priority within the Healthy City Plan;

ii) describe a systemwide approach to improving health and reducing health inequalities; and

iii) seek the commitment from partner organisations to help further develop the city's approach to reducing health inequalities.

2.0 Background

2.1 Our Healthy City Plan sets the context for our health ambitions. There are notable successes in the city in improving health outcomes and reducing health inequalities. As a Board we have acknowledged we must scale up and accelerate change and improvement for the decade ahead if we are to make long lasting health improvements, particularly as Covid-19 has exacerbated many health inequalities. Our six Healthy City Plan shared values and behaviours will help guide our approach:

- **Focusing on prevention** – helping people to stay healthy, happy and independent
- **Tackling health inequalities** – challenging and taking action to address the inequalities and social determinants of health
- **Equity** – ensuing fairness in access to services dependent on need
- **Building on community assets** –recognising individual and community strengths that can be built upon to support good health and independence
- **Working collaboratively** – everyone playing their part, sharing responsibility and working alongside communities and individuals
- **Being led by intelligence** – using data and intelligence to shape responses

2.2 The December 2020 Marmot report 'Build Back Fairer: The Covid-19 Marmot Review' highlighted how the pandemic has not only increased existing inequalities, but suggests new inequalities have emerged. Going forward there is the potential for widening disadvantage, potentially inequality gaps will widen as we emerge from the pandemic and into recovery, with disadvantaged communities having suffered its impact disproportionately, for example:

- Increased community mortality and morbidity directly as a result of Covid-19.
- Accumulation of health concerns and morbidity due to Covid-19 impact on disease management and the late presentation of non-Covid conditions such as cancer symptoms.
- Damage to family relations and cohesion from bereavement and the consequences of isolation, for example, domestic abuse.
- Worsening of social determinants, for example, educational disadvantage, debt, job loss and housing insecurity.
- Impact of damaging health conditions, for example, food poverty and poor access; poor diet and under nutrition; and reduced physical activity.
- Impact of damaging health behaviours; raised alcohol/drug consumption; and tobacco and passive smoking.
- Increased suicides and mental health issues.
- Disadvantage from loss of early years and parenting support, and missed formalised education.

2.3 Our Covid-19 Health Inequalities Strategy (2020) sets out Sunderland's response to Covid-19 and the impact on health inequalities. The strategy has four strategic aims, to:

i) raise awareness of the importance of health inequalities in both the response to and recovery from Covid-19;
ii) follow the key principles set out in the Healthy City Plan and use data, intelligence, and evidence to systematically understand the natural and unintended consequences that may have widened health inequalities;
iii) support local organisations and communities to consider how their work may impact on health inequalities as described in the Healthy City Plan's 'framework for reducing health inequalities and preventing poor health'; and
iv) consider the evidence to ensure that any recommendations will prevent or mitigate health inequalities widening as part of the Covid-19 pandemic.

2.4 The implementation plan for the Covid-19 Health Inequalities Strategy is summarised in the Healthy City Plan Implementation Plan whereby Covid-19 healthy inequalities is one of the nine workstreams of the implementation plan.

3.0 Systemwide Approach to Improving Health and Addressing Health Inequalities

3.1 As part of our core business there has been significant work undertaken across Sunderland in response to Covid-19 which contributes to reducing health inequalities, from supporting those most vulnerable, from shielded through to business support. However, the impact of Covid-19 continues to disproportionately impact on specific populations and geographies which

presents future challenges and requires both a population and targeted response.

3.2 The council has identified four priority areas for action that will support the delivery of the Healthy City Plan, these being:

i) Better understanding of our population
ii) Asset based community development - ‘residents as participants’
iii) Economic Activity – skills, aspirations and wealth building
iv) Health in All Policies approach

3.3 **Better understanding of our population** using the following approaches which includes:

- Embed a population health management approach across the Sunderland health and care system, use consistent approaches to population segmentation, to share and layer data and agree system wide outcomes.
- Integrate public health into place based Primary Care Network (PCN) work in priority wards (e.g. SARA project) and explore the use of data display tools.
- Examine existing data and intelligence to determine our current baseline, raise awareness of existing good practice in the city and how this can support our aspirations, complimented by lived experiences of residents.
- Build on employee insights so we can respond to our workforce and use employee insight to tackle health inequalities.
- Establish consistent minimum standards for consultation, engagement and involvement.

3.4 **Asset based community development with ‘residents as participants’** using the following approaches which includes:

- Use an asset-based community development approaches to address inequalities, promote resilience and support communities to identify their own health needs at the earliest point and mobilise themselves into action, with the aim of empowering communities to tackle the social determinants of health by targeting general health and wellbeing.
- Work with Partner organisations, the VCS Alliance and communities to develop an agreed approach to capacity building to deliver on our city priorities.
- Consider the wider use of Crowd Fund Sunderland.
- Continue to work with partners to deliver an approach to social prescribing across Sunderland with an agreed shared vision which will be delivered across the lifecourse and at the earliest point of need to encourage healthy lifestyles, and positively impact on social determinants.
- Encourage services to adopt a ‘think family’ approach, recognising that they have a role in taking action to support families they are working with.
- Develop an overall community champion approach for the city which will pull together the various champion programmes (linking with social prescribing).

3.5 **Economic Activity – Skills, Aspirations, Wealth Building** through the following approaches which includes:

- Identify opportunities linked to our Strategic Housing Developments and increasing community engagement.
- Embed Community Wealth Principles through Crowd Funding Sunderland and Community Wealth Charter.
- Identify opportunities for healthy living environments and homes to embed prevention, increase access to healthy living environments and homes, and reduce health inequalities.
- Consider how vulnerable people and people from disadvantaged backgrounds can be supported to enter work and sustain employment (e.g. care leavers, domestic abuse survivors; BAME community; socio-economically disadvantaged groups).
- Focus on skills for the future, linked to the strategic vision and need for the city.
- Consider career routes and career progression for young people.

3.6 **Health in All Policies (HiAP)** using the following approaches which includes:

- Working with the Local Government Association (LGA) to develop and build local capacity to take a HiAP approach to different policy areas and opportunities across the city. Developing a relationship with the LGA on this area of business will allow learning and sharing practice with others nationally.
- Engagement and communication to motivate action through stakeholder identification, champions and resources to support increased awareness and understanding of health inequalities, and consideration of these within everyday business.
- Undertake Health Impact Assessment (HIA) technical training so we can utilise and integrate impact assessment tools for considering health inequalities within decision making.

3.7 There is support from the Living Well Delivery Board to work together on these four priority areas for action, recognising this will result in better understanding our population and further build on our ability to support and enable improvements in health outcomes and health inequalities. A systemwide partnership approach will maximise our ability to get the best possible outcomes and ensure are approaches are equitable and consistent with our Healthy City Plan shared values and behaviours. There was strong support from partners for the proposals, specifically: common technical tools to support how we work together on a 'Health in All Policies approach'; support for a consistent way to engage and communicate with our communities; common data sets that are layered together to improve our collective understanding of those communities facing health inequalities; asset-based ways of working; and ensuring we engage partners where they can best make a contribution, including the VCS Alliance.

3.8 We will seek to develop a sector wide and consistent approach to tackling health inequalities in the city, recognising we need to work at both an Integrated Care System (ICS) and at a place level to make a difference. The

North East and North Cumbria ICS is committed to developing a systematic health inequalities approach for the ICS, looking for opportunities at what can be done at scale. The ICS has established a Health Inequalities Advisory Group, this is looking at how we can deliver differently.

4.0 Next Steps

4.1 For the city to achieve the scale required to address the impact of Covid-19 on our communities, economy and partners it will require us to work together through the refreshed governance framework of the HWB.

4.2 Through the approach described above we should consider the contributions we can all make to reducing health inequalities and to consider opportunities to improve health and the social determinants of health by building on a health in all policies approach.

4.3 The Living Well Delivery Board will take forward this work on behalf of the Health and Wellbeing Board and will report back to future meetings.

5.0 Recommendations

5.1 The Health and Wellbeing Board is recommended to:

i) note the contents of the report;
ii) agree to support the development of a systemwide approach to reducing health inequalities; and
iii) commit to individual partner organisations involvement in developing the city's approach further.

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD 01 October 2021

THE NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE SYSTEM AND INTEGRATED PLACE-BASED ARRANGEMENTS

Report of the Executive Director of Public Health & Integrated Commissioning and Chief Officer/Chief Finance Officer of Sunderland CCG

1.0 Purpose of the Report

1.1 The purpose of this report is to:

a) Appraise the Board on the preparations by the North East and North Cumbria Integrated Care System to take up its statutory responsibilities from April 2022.
b) Provide an updated position regarding the development of integrated place-based arrangements.

2.0 Background

2.1 On 6th July, the Health and Care Bill (the "Bill") was published. The Bill introduces new measures to promote and enable collaboration in health and care, building on recommendations made by NHS England and NHS Improvement (NHSE/I) in November 2020 and in February 2021.

2.2 The reforms in the Bill will support integration by formalising integrated care systems (ICSs). Local councils, NHS organisations and wider partners have been working together as integrated care systems (ICSs) since 2018. Sunderland is part of the North East and North Cumbria ICS (NENC ICS), a regional partnership of local authorities and NHS commissioners, NHS providers and wider partners working together to improve the health of the 3.1 million people it serves.

2.3 Under this legislation each ICS will be a statutory body made up of two parts, an integrated care board (ICB) and an integrated partnership (ICP):

a. ICBs will be tasked with the commissioning and oversight of most NHS services and be accountable to NHSE for NHS spending and performance.
b. ICPs will bring together a wider range of partners to develop a plan to address the broader health, public health and social care needs of the local population.

2.4 The Government's White Paper, that preceded the Bill, emphasised the need for flexibility in the local, place-based joint-working arrangements recognising that much of the work to integrate care and improve population health will happen locally in the places where people live, work and access services. The

Bill supports a permissive approach to place-based arrangements avoiding a one-size-fits-all approach, subject to any changes as it is debated in Parliament in the autumn and winter.

2.5 The Board received an update at its 25th June meeting on the indicative timeline for the establishment of ICSs and a proposal in relation to the development of the place-based partnership arrangements for Sunderland. The proposal comprised the establishment of an Integrated Care Executive, supported by a strategic commissioning partnership and Sunderland provider partnership.

2.6 Since the update to the Board in June, a Transition Steering Group (TSG) has started to meet to support the Integrated Care Executive to develop its place-based, integrated approach to the commissioning and provision of services within the context of the emerging NENC ICS and national guidance, covered in sections 3 and 4 of this report.

2.7 A summary of ICS development in general and the progress made by the NENC ICS in its development in particular is appended to this report.

3.0 North East North Cumbria Integrated Care System (NENC ICS)

3.1 NHSE have published a number of key documents to support ICSs during August and September. These are:

1. Thriving Places: guidance co-produced by NHSE/I and the Local Government association on the development of place-based partnerships as part of statutory integrated care systems
2. ICS implementation guidance on working with people and communities
3. ICS implementation guidance on effective clinical and care professional leadership
4. ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector
5. Interim guidance on the functions and governance of the integrated care board
6. HR framework for developing integrated care boards
7. Building strong integrated care systems everywhere: guidance on the ICS people function
8. Working together at scale: Guidance on Provider Collaboratives

These are available at NHS England: Integrated Care Systems.

3.2 The documents provide support and guidance for ICSs and build on the expectations set out in the ICS Design Framework, which was published in June 2021 and presented to the Health and Wellbeing Board in June.

3.3 The NENC ICS is working through these documents as it manages the transition processes to the new ICS arrangements. There are important key actions which ICSs/ICBs need to plan to do in relation to the guidance

documents (section 3.1, 1 to 8 above) to support transition to the new statutory integrated care boards.

3.4 The Thriving Places guidance is co-produced by NHSE/I and Local Government Association and seeks to support to place-based partners by describing the activities place partnerships may lead, the capabilities required and potential governance arrangements. Key points include:

- Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.
- Place-based partnerships will remain as the foundations of ICSs as they are put on a statutory footing (subject to legislation), building on existing local arrangements and relationships.
- It will be for system partners to determine the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.

3.5 In June 2021 the NENC ICS established a Development and Transition Programme Board, leading a number of key workstreams, for example Contracting, Commissioning and Procurement, to plan for and progress the transition to the new arrangements from April 2022.

3.6 Following recommendation by NHSE, the Secretary of State has agreed Sir Liam Donaldson to be the NHS ICB Chair Designate for the North East and Cumbria, ready to take up the post from April 2022, subject to legislation.

3.7 NHSE have started a recruitment process to appoint a designate chief executive of the NENC ICB subject to legislation. The advertisement went out at the beginning of September with a closing date of 26 September 2021. It is anticipated that ICS chief executives will be appointed by the end of October 2021.

3.8 In July Sir Liam Donaldson met with each Integrated Care Partnership (ICP) across the NENC ICS. The engagement event with Central ICP, which covers County Durham, South Tyneside and Sunderland, took place on 2 July and provided an opportunity to share our place-based arrangements and show the difference being made to patients/local people.

3.9 The Chair of the ICS has established a management executive working group with representatives from the NHS and Local Authorities across the North East and North Cumbria. The Council, CCG and NHS providers in Sunderland will be represented on the executive working group which will meet three times during September and October to take forward the implementation of the next phase of the NENC ICS. The appended letter from Sir Liam Donaldson sets out the membership of the working group.

4.0 Sunderland's Integrated Place-Based Arrangements

4.1 A Sunderland Integrated Care Executive (the 'Executive') has been established with chief executive representation from a number of key partners across the Sunderland system including from Sunderland City Council, Sunderland CCG and NHS provider organisations. The Executive has agreed terms of reference and meets monthly.

4.2 It is proposed that the Executive would lead and support the transition to new place-based arrangements within Sunderland resulting from the establishment of the NENC ICS as a statutory body from April 2022 and the transfer of NHS functions from the CCG to the ICS following the close-down of Sunderland CCG.

4.3 Regular meetings have been taking place with representatives from the Council, SCCG and NHS providers from across Sunderland on an informal basis to collaborate on developing place-based partnership working and integrated commissioning arrangements. A proposal has been developed by the partners attending the system meeting to formally establish a Transition Steering Group (TSG) to get place-based arrangements in place as soon as possible. This was supported by the Executive.

4.4 The membership of the TSG would be drawn from Sunderland City Council, Sunderland CCG with involvement of wider partners.

4.5 The TSG would support the Executive and would lead, monitor and report progress across the following key workstreams to deliver Sunderland's place-based partnership arrangements, including the future form of integrated commissioning:

- **Governance** – incorporating for example structures, risk management, oversight, assurance and accountability.
- **Finance** – including for example financial leadership and governance at place, operating principles, place-level financial planning (Sunderland £), financial oversight and financial risk.
- **Provider collaboratives/partnerships** – to develop place provider partnerships/collaboratives, including alignment to commissioning model.
- **Commissioning development and Business Intelligence** - to develop an integrated commissioning model identifying opportunities to change how we commission to improve outcomes and service provision.
- **Leadership (clinical and professional) and people -** to ensure leaders are involved and invested in the vision, purpose and place-based partnership work as it develops.

Each workstream would be led by a Senior Responsible Officer Executive lead with management support.

4.6 The TSG would be time-limited, advisory and would make proposals and recommendations to the Executive in relation to place based arrangements from a commissioning perspective. Its first meeting was 20 September 2021.

5.0 Recommendations

5.1 The Health and Wellbeing Board is recommended to:

- receive the report;
- support the progress to date; and
- receive an updated position at the next Board meeting.

Annexes:
- ICS Executive Group Participants (Sept 21)
- ICS Background slides (Sept 21)

NHS England and NHS Improvement
Waterfront 4, Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

Email: necsu.icspartnership@nhs.net

7th September 2021

BY EMAIL

Dear Colleagues,

Thank you for your very positive responses to my recent letter of 28 July 2021 about taking forward the implementation of the next phase of the Integrated Care System (ICS) for the North East and North Cumbria (NENC).

I am committed to building our work on the important principles of equal partnership, co-production and subsidiarity and, in this spirit, I am looking forward to chairing the meetings of our management executive working group.

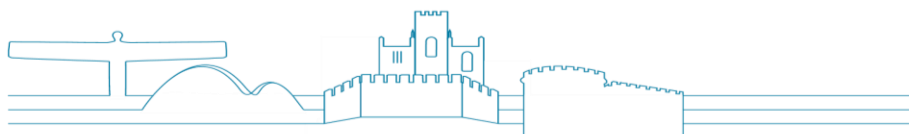
As you know, to keep the size of the meeting to a manageable size, representatives are being assembled from the NHS and Local Authorities. We have a very small team, including myself and Alan Foster, that will be supporting the process.

The NHS group will be:
- Sir Jim Mackey – Chief Executive of Northumbria Healthcare NHS Foundation Trust (representing the North ICP area)
- Ken Bremner – Chief Executive of South Tyneside and Sunderland NHS Foundation Trust (Central ICP area)
- Julie Gillon – Chief Executive of North Tees and Hartlepool NHS Foundation Trust (Tees Valley ICP area)
- Lyn Simpson – Chief Executive of North Cumbria Integrated Care NHS Foundation Trust (North Cumbria ICP area)
- John Lawlor – Chief Executive of Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (Mental Health provider sector)
- Dame Jackie Daniel – Chief Executive of Newcastle upon Tyne Hospitals NHS Foundation Trust (Tertiary provider sector)
- Mark Adams – Accountable Officer for Newcastle Gateshead, North Tyneside, Northumberland and North Cumbria NHS Clinical Commissioning Groups
- Dr Neil O'Brien – Accountable Officer for County Durham, South Tyneside and Sunderland NHS Clinical Commissioning Groups
- Dave Gallagher – Accountable Officer for NHS Tees Valley Clinical Commissioning Group

The local authority representatives will be as follows.

From Cumbria:
- Gill Steward - Chief Executive, Cumbria County Council

From the Tees Valley group of local authorities:
- John Sampson – Managing Director, Redcar & Cleveland Council



- Erik Scollay – Director of Adult Social Services, Middlesbrough Council
- James Stroyan – Director of People, Darlington Council
- Ann Workman – Director of Adults and Health, Stockton-on-Tees Council
- Craig Blundred – Director of Public Health, Hartlepool Council
- Mark Adams – Director of Public Health, Redcar and Cleveland and Middlesbrough Councils

From the LA7 group of local authorities:

- John Hewitt - Chief Executive of Durham County Council
- Daljit Lally - Chief Executive of Northumberland County Council
- Paul Hanson - Chief Executive of North Tyneside Council (or Jacqui Old, Director of Services for Children and Adults, depending on dates and availability)
- Alice Wiseman - Director of Public Health at Gateshead Council
- Al McDowell - Director of Adult Social Care and Integrated Services at Newcastle City Council
- Jon Ritchie - Executive Director of Corporate Services at Sunderland City Council (also representing Local Authority Finance Directors)
- Nicola Robason - Head of Corporate and External Affairs at South Tyneside Council (also representing Local Authority Monitoring Officers)

I appreciate that it will be a challenge to manage all our diaries. We will start with a virtual meeting format to maximise opportunities to attend, but with the possibility of face-to-face meetings later.

We do have to be mindful of the overall timescale for these changes to ensure that we can present our proposals in a timely way to the many groups whose views will be essential to the final approach.

I very much look forward to working with you on this important task.

Kind regards,

Sir Liam Donaldson
Chair Designate
North East and North Cumbria Integrated Care System

ICS development briefing

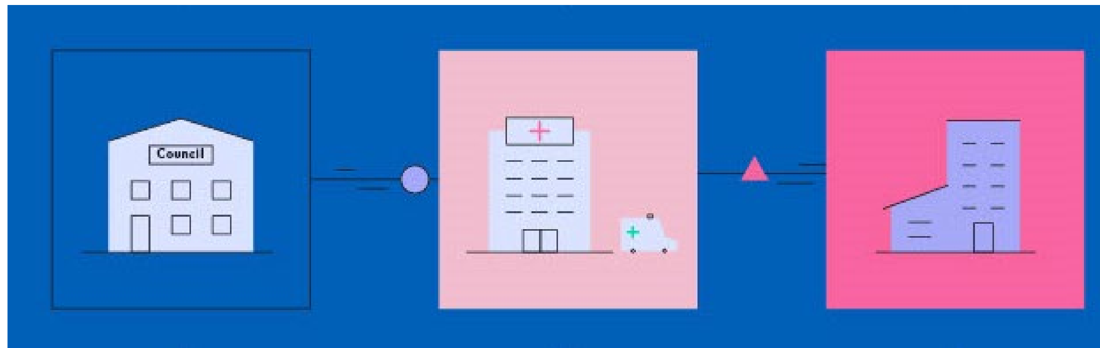
Dan Jackson
ICS Director of Governance and Partnerships

OFFICIAL - SENSITIVE

iCS
Integrated Care System
North East & North Cumbria

ICSs have four key purposes:

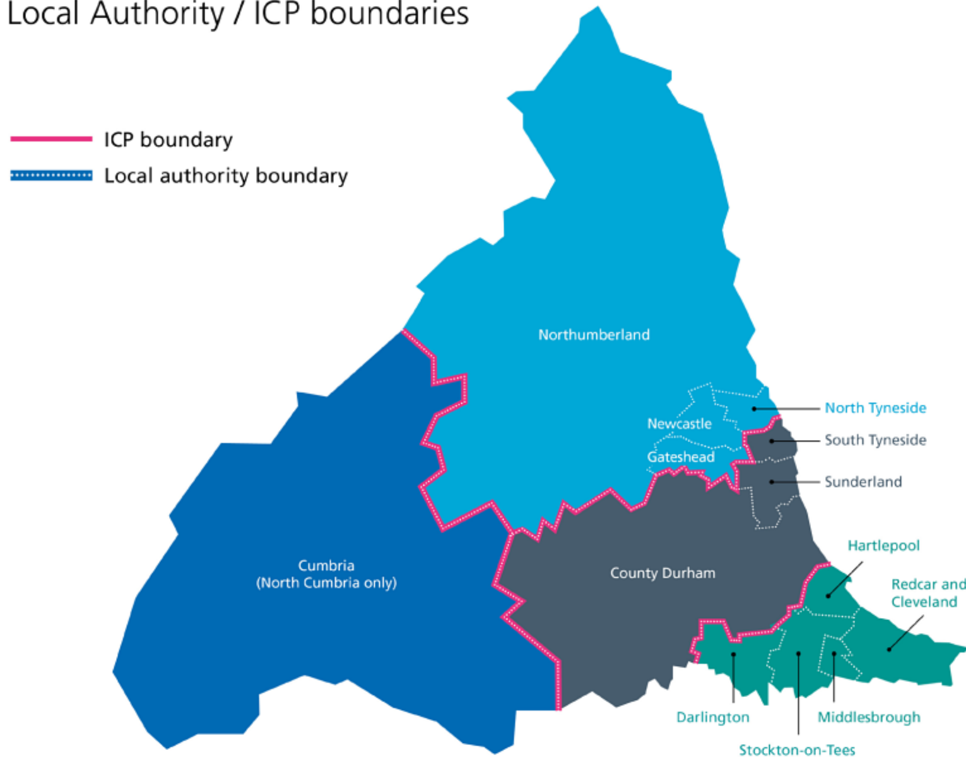
- **improving outcomes** in population health and healthcare;
- **tackling inequalities** in outcomes, experience and access;
- **enhancing productivity** and value for money;
- supporting broader **social and economic development**.



iCS Integrated Care System
North East & North Cumbria

Working at place and system

North East and North Cumbria
Local Authority / ICP boundaries



North Cumbria ICP
Population: 324,000
1 CCG: North Cumbria
Primary Care Networks: 8
1 FT: North Cumbria Integrated Care NHS Foundation Trust (NCIC)
1 Council Area: Cumbria County Council (with 4 District Councils)
North West Ambulance Service

NENC ICS-wide
North East Ambulance Service FT covers: North of Tyne and Gateshead ICP; Durham, South Tyneside and Sunderland ICP; Tees Valley South ICP
CNTW Mental Health FT covers: North Cumbria ICP; North of Tyne and Gateshead ICP; plus part of South Tyneside and Sunderland ICP
TEWV Mental Health FT covers: Tees Valley ICP; plus part of South Tyneside and Sunderland ICP
Newcastle upon Tyne Hospital FT: provider of highly specialised and specialised national and regional services (including transplant, paediatric specialisms and major trauma)
South Tees Hospitals FT: provider of highly specialised north of England and regional services (including cardiothoracic, spinal, cochlear implant neurosciences, gynaecology, urology and major trauma)

North of Tyne and Gateshead ICP
Population: 1.079M
3 CCGs: Northumberland, North Tyneside, Newcastle Gateshead
Primary Care Networks: 22
3 FTs: Northumbria, Newcastle, Gateshead
4 Council Areas: Northumberland, North Tyneside, Newcastle, Gateshead

Durham, South Tyneside and Sunderland ICP
Population: 997,000
3 CCGs: South Tyneside, Sunderland, County Durham
Primary Care Networks: 22
2 FTs: South Tyneside & Sunderland, County Durham and Darlington
3 Council Areas: South Tyneside, Sunderland, County Durham

Tees Valley ICP
Population: 701,000
1 CCG: Tees Valley
Primary Care Networks: 14
3 FTs: County Durham and Darlington, North Tees & Hartlepool, South Tees
5 Council Areas: Hartlepool, Stockton on Tees, Darlington, Middlesbrough, Redcar & Cleveland

iCS
Integrated Care System
North East & North Cumbria

Interdependence of our ICS

Existing functions at whole North East level

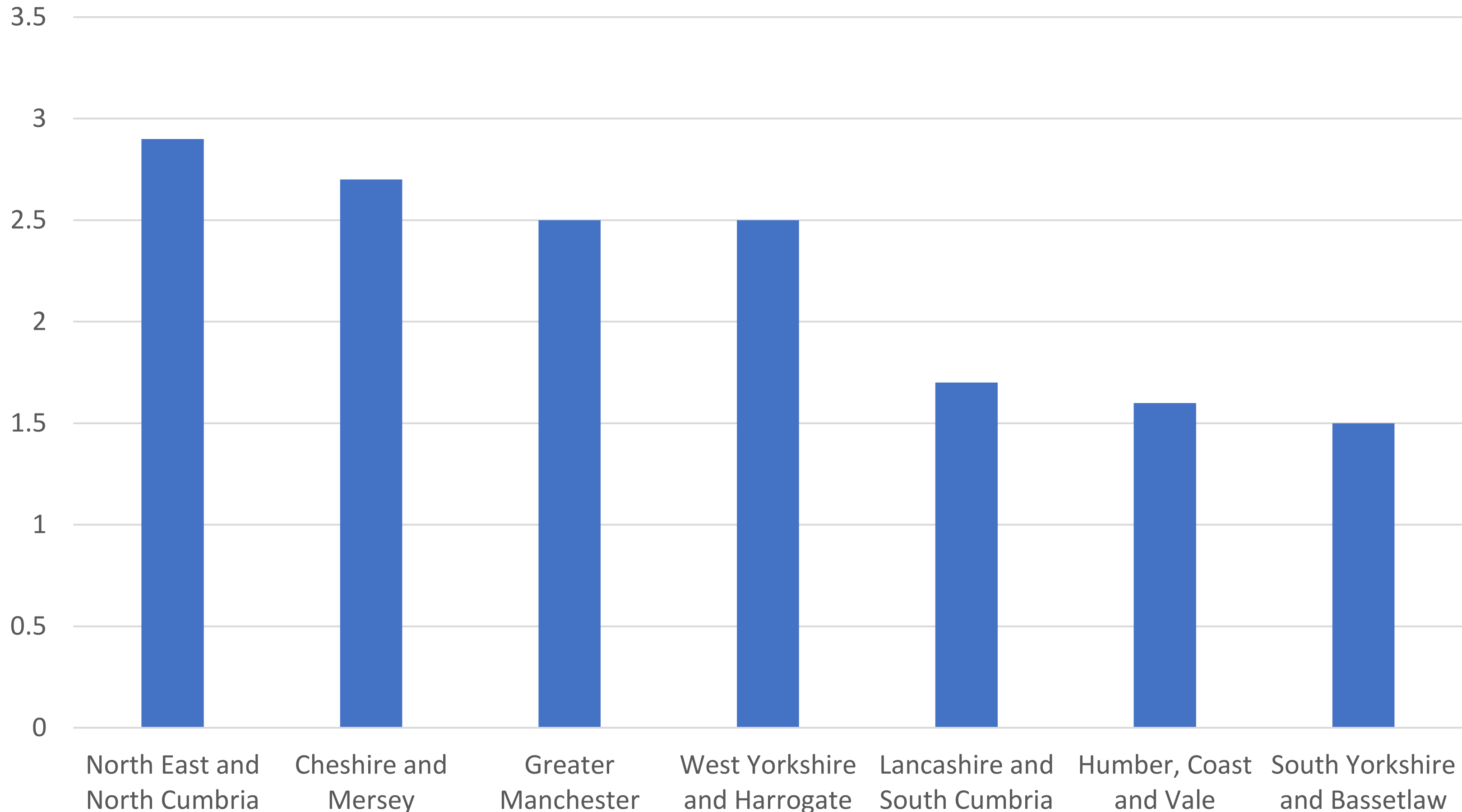
- One ambulance service – NEAS – for the whole of the North East
- One highly specialist tertiary provider (NUTH) – with historic patient flows from Teesside
- One integrated COVID hub and Nightingale Hospital for the ICS
- 16 clinical networks – including the Northern Cancer Alliance
- One Joint CCG Committee for joint policy decisions and strategic commissioning decisions
- Workforce Planning via HENE (Health Education England North East)
- One NHS Digital network – coordinating cyber-security and the Great North Care Record
- One NHS Comms Network to manage our shared campaigns (eg COVID, Winter)
- One Academic Health Science Network (AHSN NE) and Applied Research Collaborative (ARC)
- NHS England/NHS Improvement Locality Team – regulatory and assurance oversight
- One main provider of NHSE delivery support services: NECS (North East Care System Support)

Partner networks at whole North East level

- Public Health England North East – plus the NE Tobacco and Alcohol control offices
- North East Directors of Public Health Network
- North East ADASS and ADCS networks
- VONNE (Voluntary Organisations Network North East)

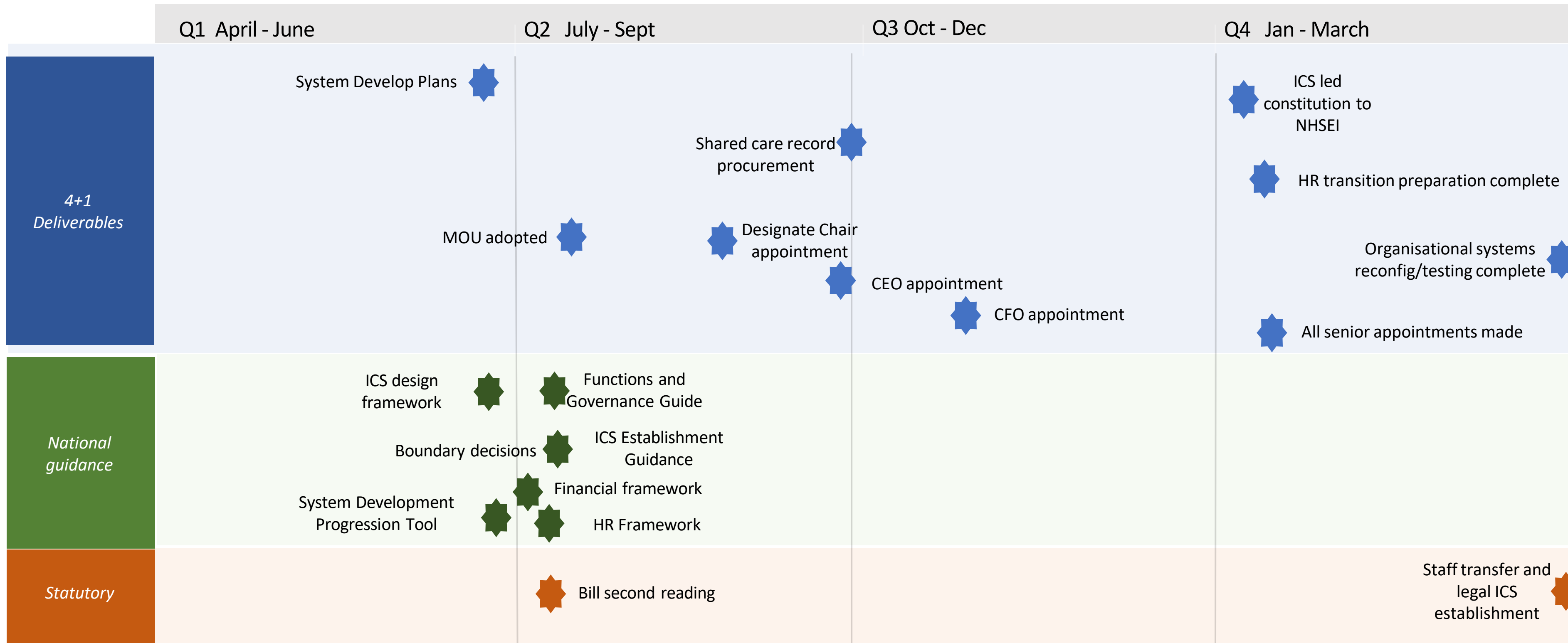
iCS Integrated Care System North East & North Cumbria

Scale of our ICS



OFFICIAL - SENSITIVE

National ICS development timeline



iCS
Integrated Care System
North East & North Cumbria

The Health and Care Bill - overview

- Designed to reform the delivery of health services and promote integration between health and care, repealing the 2012 Health and Social Care Act.
- Promotes integration rather than competition and includes the specifications of integrated care systems (ICSs), with distinct statutory functions for the **integrated care board (ICB)** and **integrated care partnership (ICP)**.
- Increases the Secretary of State's powers over various aspects of the NHS's operation, notably including local service reconfigurations.
- Powers are introduced for NHSE (notably including commissioning functions) to be exercised by Integrated Care Boards.
- The government may direct NHSE (and subsequently ICSs) to use particular allocations of funding for the purposes of service integration.
- These reforms cannot be considered in isolation and their success will rely upon several factors not contained within the bill. The future of social care, for example, remains uncertain.

ICS Integrated Care System North East & North Cumbria

Key elements of an ICS

From the national ICS operating framework:

ICSs comprise all the partners that make up the health and care system working together via:

- an ICS NHS body overseen by an **Integrated Care Board**, an organisation bringing the NHS together locally to improve population health and care.
- an **Integrated Care Partnership** – a body comprising local organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS

Other Important ICS features are:

- **place-based partnerships** between the NHS, local councils and voluntary organisations, residents, people who access services, carers and families – these partnerships will lead design and delivery of integrated services.
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

iCS
Integrated Care System
North East & North Cumbria

Integrated Care Partnership

- The ICP will be established locally and jointly by the relevant local authorities in the ICS area and the ICB, with mutual agreement on its terms of reference, membership, ways of operating and administration.
- Chair is jointly selected by NHS and local authority; can be same chair as ICB – approach to be determined locally.
- Members must include all local authorities and the local NHS (represented at least by the ICB).
- The ICP will have a specific responsibility to develop an **'integrated care strategy'** for its whole population (covering all ages) using the best available evidence and data – including patient experience. The ICP strategy will need to cover health and social care (both children's and adult's social care), health inequalities and the wider determinants which drive these inequalities.

iCS Integrated Care System North East & North Cumbria

Expectations of ICPs

Key expectations

- No intent to produce detailed guidance for ICPs, but all systems will need to have at least Interim ICPs by April 2022.
- ICPs should be founded on the principle of equal partnership across the NHS, local government, and the communities they serve.
- They should be open an inclusive, setting the tone and culture for each system
- There should be a dynamic relationship between the ICB and the ICP. The ICB helps to form the ICP and to have regard to its strategy.
- ICPs should be strongly connected to existing governance structures such as HWBs and place-based partnerships, and their JSNAs and local strategies
- ICPs will create a dedicated space for the NHS, local government, and local communities to tackle the issues that no one organisation can address alone:
  - Improving healthy life expectancy;
  - Supporting people to live fulfilling and independent lives for longer;
  - Improving people's overall wellbeing;
  - Addressing health and wellbeing inequalities.
  - Exploring the wider connections between health and socio-economic development, housing, environment, education and transport

iCS Integrated Care System North East & North Cumbria

ICP membership options

Membership

- ICSs may appoint a single Chair of the ICP and ICB
- The only core members will be the ICB and Local Authorities in an ICS area
- ICPs can build their membership over 3-6 months, but will likely include:
    - Representatives from each of our 13 Local Authorities – e.g. HWBB chairs, Lead members with Heath and Care portfolios, and/or Senior Officers
    - Directors of Public Health
    - Key Health Sectors – e.g. Primary, Community, Acute Care
    - Key Networks – e.g. the ADASS, ADCS and DsPH network chairs
    - Independent representatives of people and communities, e.g. HealthWatch
    - Voluntary Sector – e.g. via VONNE
    - Universities and other education and skills providers

ICS Integrated Care System North East & North Cumbria

Integrated Care Board (ICB)

- ICBs will (i) bring the NHS together locally to improve population health (ii) establish shared strategic priorities within the NHS and connecting to partnership arrangements at system and place.
- The ICB must **develop a plan to meet the health needs of the population** (all ages) within the area, having regard to the Partnership strategy. The ICB must involve each relevant Health and Wellbeing Board in preparing or revising the plan.
- It is expected that the ICB will be able to delegate functions to statutory providers, place-based partnerships or provider collaboratives to enable this.

ICB Governance

- Our CCGs will need to propose an **ICB Constitution** for approval by NHSE that should confirm, ICB governance and board membership, functions and arrangements for managing conflicts of interest
- ICBs will need to publish a **Scheme of Reservation and Delegation (SoRD)** setting out (i) those functions that are reserved to the ICB (ii) those functions that have been delegated to an individual or committees (iii) those functions delegated to another body or to be exercised jointly with another body.
- ICBs must also develop a **Functions and Decision Map** by the end of Q4 that:
  - is locally defined.
  - sets out where decisions are taken and outlines the roles of different committees/partnerships.
  - is easily understood by the public.

iCS Integrated Care System North East & North Cumbria

ICB key functions

- **Developing a plan** to meet the health needs of the population
- **Allocating resources** (revenue and capital) to deliver the plan and agree contracts with providers
- Establishing **joint working** and **governance** arrangements between partners
- Leading **major service transformation programmes** across the ICS
- Implement the **NHS People Plan**
- Leading system-wide action on **digital and data**
- Joint work on **estates** and **procurement**
- Leading **emergency planning and response**

iCS
Integrated Care System
North East & North Cumbria

ICB statutory duties

Duty to ….

- Promote the NHS Constitution
- Obtain professional advice in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health
- Improve the quality of services
- Promote integration
- Reduce inequalities
- Promote effectiveness and efficiency
- Promote patient choice
- Promote patient involvement
- Promote education and training
- Promote research and innovation
- Have regard to wider effect of decisions

Integrated Care System
North East & North Cumbria

Other ICB commissioning functions

Expectation is that from April 2022 ICBs will:

- assume delegated responsibility for Primary Medical Services (excluding 7A Public Health functions);
- take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and appliance contractors); and
- establish mechanisms to strengthen joint working between NHS England and Improvement and ICSs, including through joint committees, across all areas of direct commissioning

By April 2023, all ICBs will have:

- taken on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services;
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies set nationally
- worked collaboratively with our organisation to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

iCS Integrated Care System North East & North Cumbria

ICB Membership

- **The ICB will be the senior decision-making structure for the ICS NHS body, providing strategic leadership. All members of the board will make decisions as a single group with collective accountability for delivery of the ICS's functions and duties and the performance of the organisation. In most cases they will include:***

- **Independent Chair** plus a minimum of two other independent non-executive directors. (These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.)
- **Chief Executive**
- **Director of Finance**
- **Director of Nursing**
- **Medical Director**
- at least one member drawn from **NHS trusts and foundation trusts** who provide services within the ICS's area
- at least one member drawn from **general practice** within the area of the ICS NHS body
- at least one member drawn from the **local authority**, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

(*subject to statutory confirmation)

iCS
Integrated Care System
North East & North Cumbria

Place-based partnerships: governance options

- **Consultative forum**, *informing* decisions by the ICB, local authorities and other partners
- **Committee of the ICB** with delegated authority to take decisions about the use of ICS NHS body resources
- **Joint committee of the ICB** and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee
- **Individual directors of the ICB** having delegated authority, which they may choose to exercise through a committee
- **Lead provider** managing resources and delivery at place-level under a contract with the ICB

iCS
Integrated Care System
North East & North Cumbria

Current place governance

CCG	Local Authority	Partnership Forum
Cumbria	**Cumbria County Council**	North Cumbria ICP Leaders Board
		North Cumbria ICP Executive
		(Whole of) Cumbria Joint Commissioning Board
		(Whole of) Cumbria Health and Wellbeing Board
Newcastle Gateshead	**Newcastle City Council**	Collaborative Newcastle Executive Group
		City Futures Board (formerly Health and Wellbeing Board)
	Gateshead Council	Gateshead Care (System Board and Delivery Group)
		Gateshead Health and Wellbeing Board
Northumberland	**Northumberland County Council**	Northumberland System Transformation Board
		BCF Partnership
		Northumberland Health and Wellbeing Board
North Tyneside	**North Tyneside Council**	North Tyneside Future Care Executive
		North Tyneside Future Care Programme Board
		North Tyneside Health and Wellbeing Board
Sunderland	**Sunderland City Council**	All Together Better Executive Group
		Sunderland Health and Wellbeing Board
South Tyneside	**South Tyneside Council**	S Tyneside Alliance Commissioning Board & Exec Cttee
		South Tyneside Health and Wellbeing Board
Durham	**Durham County Council**	County Durham Care Partnership/Joint finance Group
		County Durham Health and Wellbeing Board
Tees Valley	**Middlesbrough Council**	South Tees Health and Wellbeing Board
	Redcar & Cleveland Council	Adults Joint Commissioning Board
	Hartlepool Council	Hartlepool BCF Pooled Budget Partnership Board
		Hartlepool Health and Wellbeing Board
	Stockton-on-Tees Council	Stockton BCF Pooled Budget Partnership Board
		Stockton-on-Tees Health and Wellbeing Board
	Darlington Council	Darlington Pooled Budget Partnership Board
		Darlington Health and Wellbeing Board

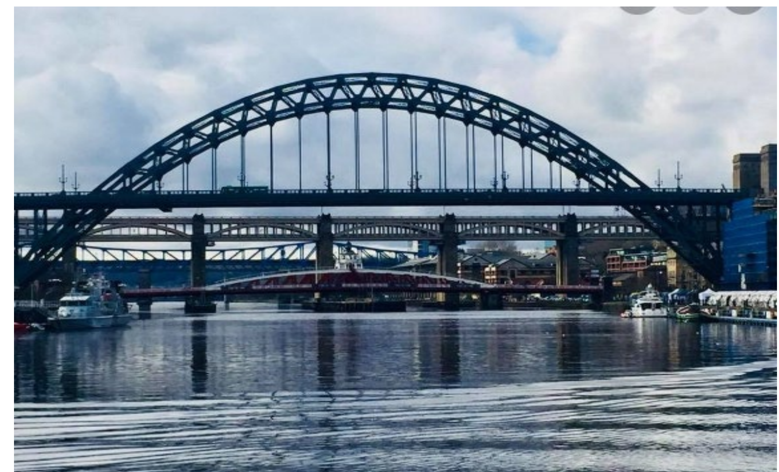
iCS Integrated Care System North East & North Cumbria

ICP engagement Events

1 July

2 July

13 July



15 July

Integrated Care System
North East & North Cumbria

Key stakeholders in our ICS

- Health and Wellbeing Boards
- Primary Care Networks
- NHS Foundation Trusts
- Provider Collaborative
- Clinical Networks
- HealthWatch and other patient voice organisations
- VCSE organisations – e.g. VONNE
- NHS England's regional teams
- Universities and research networks

iCS
Integrated Care System
North East & North Cumbria

Next steps

- Executive Design Group meetings to take place in September/October
- Focus of these sessions:
  - Feedback and key themes from the ICP engagement sessions
  - Overview of national ICS guidance
  - System governance – agreeing the membership of the twin boards
  - Place working models – what works well, what could be repurposed
  - Schemes of delegation – functions and resources at place and ICP level
  - Agreeing the ICS operating model – how to reach consensus and ratify our proposals
- Development of ICS operating model and Constitution for approval by NHS England
- Ongoing due diligence work on CCG close down and staff and property transfer to new system

Item No. 8

SUNDERLAND HEALTH AND WELLBEING BOARD **1 October 2021**

COVID-19 IN SUNDERLAND – UPDATE

Report of the Executive Director of Public Health & Integrated Commissioning

1.0 Purpose of the Report

1.1 To provide the Health and Wellbeing Board with an update of the Covid-19 situation in Sunderland.

2.0 Background

2.1 The Public Health Consultant will provide the committee with an ongoing update of the Covid-19 situation in Sunderland. This will include a summary of the current position regarding cases and actions being taken to combat the pandemic locally.

2.2 The Health Protection Board, Outbreak Control Board and Gold Command Group are meeting, in line with the arrangements set out in the Local Outbreak Management Plan.

3.0 Current Position

3.1 The Covid-19 pandemic remains a challenging and uncertain situation and the presentation will provide the opportunity for the Board to receive an up-to-date overview of the situation in Sunderland.

3.2 Due to the ongoing and constantly evolving nature of the Covid-19 situation, a presentation will be shared at the time of the meeting.

3.3 At the time of writing (17/09/2021), Sunderland has been seeing a rise in the number of daily cases and has a 7-day average rate of 277.9 per 100,000.

4.0 Recommendation

4.1 The Health and Wellbeing Board is recommended to receive the update and presentation on the Covid-19 pandemic and comment on the information provided.

Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 1 October 2021

HEALTH AND WELLBEING DELIVERY BOARDS ASSURANCE UPDATE

Report of the Chief Executive of Together for Children, Executive Director of Public Health and Integrated Commissioning and Executive Director of Neighbourhood Services.

1.0 Purpose of the Report

1.1 The purpose of the report is to:

i. provide the Health and Wellbeing Board with assurance that the work of the Delivery Boards is progressing in line with their agreed terms of reference; and
ii. provide a summary of key points discussed at their recent meetings.

2.0 Background

2.1 The Health and Wellbeing Board has established three delivery boards to provide strategic oversight of the six Marmot objectives and the nine Healthy City Plan workstreams as outlined in the table below.

Starting Well Delivery Board	**Living Well Delivery Board**	**Ageing Well Delivery Board**
By working together we will: • Give every child the best start in life • Enable all children, young people and families to maximise their capabilities and have control over their lives	By working together we will: • Create fair employment and good work for all • Ensure a healthy standard of living for all • Create and develop healthy and sustainable places and communities • Strengthen the role and impact of ill health prevention (strategic approach)	By working together we will: • Strengthen the role and impact of ill health prevention for older people
Existing Healthy City Plan workstreams: • Best start in life • Young people 11-19	Existing Healthy City Plan workstreams: • Healthy Economy	Existing Healthy City Plan workstreams: • Ageing well

• Children and young people's mental health and wellbeing (strategic approach) • Healthy weight (strategic approach) • Covid-19 health inequalities	• Adult mental health and wellbeing • Addressing alcohol harms (strategic approach) • Smoke free Sunderland (strategic approach) • Covid-19 health inequalities	• Covid-19 health inequalities
Ways of working: • **Focusing on prevention** – helping people to stay healthy, happy and independent • **Tackling health inequalities** – challenging and taking action to address inequalities and the social determinants of health • **Equity** – ensuring fair access to services dependent on need • **Building on community assets** – recognising individual and community strengths that can be built upon to support good health and independence • **Working collaboratively –** everyone playing their part, sharing responsibility and working alongside communities and individuals • **Being led by intelligence** – using data and intelligence to shape responses		

2.3 The delivery boards will provide challenge and support across partnership activity in order to reduce health inequalities and address the social determinants of health. To enable the Health and Wellbeing Board to fulfil its role as system leader for health and wellbeing, the delivery boards will need to be assured that activity being delivered across the three themes of the City Plan (Healthy, Vibrant and Dynamic Smart City) are maximising opportunities to reduce health inequalities and address the social determinants of health. The delivery boards will take a 'health in all policies' approach and provide a conduit for a range of programmes, plans and projects to be considered by the Health and Wellbeing Board.

2.4 The delivery board governance arrangements sit alongside the wider Health and Wellbeing Board governance arrangements, including arrangements for health protection and the emerging place-based integration arrangements.

2.5 All three delivery boards have recently held their second meetings in September 2021, having formed their membership and met for the first time in June 2021. The delivery boards are proposing to meet on a quarterly basis and will hold additional workshops and development sessions subject to their business needs.

3.0 Update from the Starting Well Delivery Board – met 9 September 2021

3.1 A nomination for Vice Chair has been received, this will be considered for approval at the next meeting.

3.2 The Starting Well Delivery Board is currently working on:

i. TfC has submitted a 'Family Hubs – Growing up Well: Local Area Partner (Round two)' expression of interest application. Family hubs will be added as a standard agenda item to the Board's forward plan; and a workshop be scheduled to scope out a Sunderland model for family hubs.

ii. Workstream update: Best start in life
The Best Start in Life Working Group was established prior to Covid and work has continued throughout. The priorities in the Healthy City Plan are smoking status at time of delivery, breastfeeding continuation, the attainment gap between children eligible for free school meals and those who are not. The Delivery Board received a detailed presentation on the work programme, this included updates on:
- Ongoing work around healthy pregnancy messages
- Training for health care professionals in perinatal mental health
- Establishment of a Maternal Mental Health Service (MMHS) in Sunderland
- Communications focused on health effects of consuming alcohol in pregnancy
- Clear service pathways providing support to pregnant women (including maternity and health visiting services) and the drug and alcohol treatment services
- Ensuring all pregnant women and those within the household who smoke are referred to specialist stop smoking services in line with NICE guidance, the local enhanced offer and learning from regional best practice.
- Promoting a culture of breastfeeding
- Undertake a Behavioural Insights Research Project to investigate the effectiveness of digital tools to increase breastfeeding continuation rates

iii. Prevention Offer
A partnership piece of work led by Public Health sets out the services that are available to children and young people for schools and range of other professionals. The document is in draft and will be launched with schools and shared with other partners at the end of September.

iv. Emerging Joint Strategic Needs Assessment (see separate agenda item).

v. Forward Plan – partners were invited to comment on priorities for discussion outside of the meeting. It was agreed a separate workshop on Family Hubs would be convened.

3.3 Key issues:

The Delivery Board remain focused on Covid recovery issues, as well as the cross-cutting issues of alcohol and substance misuse harm that affect considerable numbers of children and young people.

4.0 Update from the Living Well Delivery Board – met 14 September 2021

4.1 Ryan Swiers, Consultant in Public Health, STSFT was agreed as the Vice Chair.

4.2 The Living Well Delivery Board is currently working on:

i. Developing our approach to improving health and reducing health inequalities (see separate agenda item).

ii. Emerging Joint Strategic Needs Assessment (see separate agenda item).

iii. A detailed presentation was received on homelessness and the intrinsic link between housing and health. There is recognition that Covid-19 has brought issues around homelessness to the fore, and this increases the need to strengthen the focus on prevention. There is an increasing trend of people returning to the service and the profile of homeless applicants shows support needs are the greatest challenge, with a rate of 3.06 support needs per case. Mental health is a significant issue, other key issues are offending, physical health and disability, domestic abuse, addictions and challenging behaviours. Providing solutions to support complex needs is challenging and there is limited support to wrap around individual cases at present. However, rough sleeping has increased in the city and there is a desire to move people from the streets into more independent living. Further pressures are anticipated as eviction suspensions are lifted and the impact of rent arrears arising from Covid comes to the fore. The Homelessness Prevention Strategy 2019-2021 will be refreshed with a strong focus on partnership working. A Health Impact Assessment will support the strategy refresh.

iv. Forward Plan – the Delivery Board has a comprehensive forward plan. Future agenda items include social prescribing and continuing discussions on developing our approach to improving health and reducing health inequalities.

4.3 Key issues:

The issues of preventing and responding to homelessness require a partnership approach.

5.0 Update from the Ageing Well Delivery Board – met 13 September 2021

5.1 Prof. Roy Sandbach was agreed as the Vice Chair.

5.2 The Ageing Well Delivery Board received a number of updates on its key priorities. This included:

i. Work to overlay a broad range of data sets within the council to identify potential groups of people with frailty factors over 65 years of age is underway. Improved understanding of cohorts of people with frailty factors who do not already access social care will help to target early intervention and prevention, ensure residents know about the services that are available to them and allow signposting to appropriate support. Discussion took place about broadening the data sets to increase understanding of additional frailty factors e.g. those discharged from hospital who have no current support in place.

ii. The Ageing Well Ambassador Programme will be launched at an Ageing Well event on 1 October, this being International Day for Older Persons. Branding has been designed for the programme. Ageing Well Ambassadors are coming forward from communities and partners are also encouraged to be Ambassadors. A volunteer role description has been developed for the Ambassadors. Discussion took place on identifying local celebrities to champion the role.

iii. An Ageing Well communication campaign was discussed, reflecting on the need to ensure broad principles are agreed by all city partners to reinforce Sunderland's aspirations to be an Ageing Well city through all communication materials and messages.

iv. 'Let's Talk Ageing Well' will start with the Ageing Well event and Sunderland VCS Alliance event, and then wider engagement with residents across the city.

v. SMART Sunderland supporting ageing well has been discussed, with the intention to hold a workshop to further explore how technology can support ageing well. An overview was provided of the housing investment that is taking place that enables technological solutions to be tailored to the needs of the customer.

vi. Emerging Joint Strategic Needs Assessment (see separate agenda item).

vii. Falls prevention – paper discussed. Next steps include establishing what partners are doing to support falls prevention; understanding the local intelligence we have in relation to falls; and determining who needs to take the lead role for falls prevention in the city.

viii. Forward Plan – the Delivery Board has a detailed partnership workplan.

5.3 Key issues:

How we develop a strengths-based approach to many of the issues discussed, for example, reducing frailty factors, addressing digital exclusion and raising awareness of the early intervention and prevention opportunities across the city that support ageing well.

Ensuring falls prevention strategic approach has an agreed lead organisation to ensure delivery of the Falls Prevention Action Plan.

6.0 Recommendations

6.1 The Health and Wellbeing Board is recommended to:

- note the meeting summaries from the recent meetings of the delivery boards;
- be assured that the work of the Delivery Boards is progressing in line with their agreed terms of reference;
- receive specific agenda items from the Delivery Boards for discussion; and
- receive quarterly assurance updates from the Delivery Boards on an ongoing basis.

Item No. 10

SUNDERLAND HEALTH AND WELLBEING BOARD 1 October 2021

SUNDERLAND SAFEGUARDING ADULTS BOARD ANNUAL REPORT

Report of the Independent Chair, Sunderland Safeguarding Adults Board

1. Purpose of the Report

1.1. It is a Care Act requirement for the Independent Chair of the Safeguarding Adults Board (SSAB) to give an annual account of the work of the Board.

1.2. The annual report, attached for members' information, highlights the current work of SSAB during the year 2020-21.

2. Background

2.1. The workings of the Board and its current sub-committees, and importantly what they have achieved, are shown within the body of the report and also the links the Board has with other strategic partnerships within the city.

2.2. The work of SSAB in 2020-21 focused on four strategic priorities, as identified in its Strategic Delivery Plan 2019-24:

- Prevention
- Making Safeguarding Personal (MSP)/ User Engagement
- Partnership (including regional collaboration)
- Key local areas of risk (self-neglect, mental capacity and exploitation)

These priorities informed the Board's local actions to safeguard adults in Sunderland and are underpinned by the Care Act's six key principles of adult safeguarding.

2.3. The report highlights significant progress against its strategic priorities through the work of the SSAB & it's Sub Committees, and through the training offer the SSAB commissions. It also features the Key Achievements; Good Practice, Partnership Working and Making Safeguarding Personal activity undertaken by the SSAB's statutory partners, and a 'Year in Figures' Performance Summary giving the headline activity figures for 2020-21 in relation to the Safeguarding Adults operational process. It highlights how partners worked differently during the COVID-19 pandemic to enable safeguarding adults activity to still be maintained and progressed. It sets out the future direction of travel for the Board with regard to work on focusing on recovery following COVID-19, and implementation of the lessons learned, to ensure good practice and innovation are not lost going forward. In addition, a range of work to strengthen the Safeguarding Adults resources available; the launch and embedding of the Complex Adults Risk Management (CARM) process for managing the most

complex safeguarding adults cases; and participation in National Safeguarding Week in November 2021.

2.4. The report also sets out the new priorities that SSAB has agreed for 2021, following an exercise to review and follow the data, and refresh performance and assurance frameworks, and notes that SSAB will work jointly with the Sunderland Safeguarding Children Partnership (SSCP) on some of these areas. The new priorities are:

- Prevention
- Local Areas of Risk (Self-Neglect; Mental Capacity; Homelessness; Complex Adults Risk Management (CARM) – at Risk / Vulnerable / Complex Cases (including Substance Misuse); Domestic Abuse; Suicide Prevention (particularly in light of the effects of COVID-19)).
- Transitions; Exploitation; Learning from Safeguarding Adult Reviews (SARs) and Local Safeguarding Children Practice Reviews (LSCPRs).

3. Recommendation

3.1. The Health and Wellbeing Board is recommended to note and comment on the content of the Safeguarding Adults Board Annual Report 2020-21.

Annual Report

2020-2021

www.sunderlandsab.org.uk

Contents

Foreword	3
SSAB Role and Vision	4
Strategic Delivery Plan	6
Work of SSAB and its Sub-Committees	8
Partnership Working	10
Our Year in Figures	24
Working Differently During the Covid-19 Pandemic	26
What Does 2021-22 Hold?	27

Foreword—by the Independent Chair of SSAB

I was delighted to be appointed as chair in December 2020 and, as such, this will be my first annual report. As I joined the Board part way through the year, I would like to offer my thanks to the outgoing chair, Paul Ennals, for his support in my transition and his leadership of the Board.

The world of adult safeguarding has always been challenging, however, 2020/2021 has proven even more so. COVID-19 has tested organisations capacity and ability to respond to crisis. Our most vulnerable residents have been at risk and have been isolated and service delivery was required to change quickly to meet new demands and procedures, in order to protect our communities.

Despite all of these challenges, organisations and partners have continued to offer assurances, present and interrogate data and provide actions that ensure adult safeguarding remains a priority. I would like to take this opportunity to thank organisations and their staff for their level of commitment and increased reporting during this time.

Sunderland has been part of the national Insights work and this has enabled the Board and members to scrutinise our position and plan ahead. In addition, we have taken the time in the last quarter of 2020/21 to refresh our priorities and ensure our assurance and performance frameworks reflect our learning.

Whilst I cannot overstate how challenging the next year will be as we enter a recovery stage of the pandemic, bringing new demands on our services and communities, in terms of an increase in presentations and complexity of need, I am confident, given the robust governance and commitment from partners and wider community members, that we will be innovative in our approach and place vulnerable adults at the heart of our planning.

Lastly, I would like to thank Pam Weightman and Amy Paulson for supporting me in my new role and for their detailed work in ensuring the Board runs smoothly.

Vanessa Bainbridge, Independent Chair, Sunderland SAB

Sunderland Safeguarding Adults Board

Sunderland Safeguarding Adults Board (SSAB) is a statutory body which brings together partner organisations in Sunderland to safeguard and promote the welfare of adults at risk of abuse and neglect, and is responsible for ensuring the effectiveness of what partner agencies do. SSAB has a strong focus on partnership working and has representation from the following organisations across the City:

- Sunderland City Council
- Northumbria Police
- Sunderland Clinical Commissioning Group
- South Tyneside & Sunderland NHS Foundation Trust
- Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
- Healthwatch Sunderland

SSAB works closely with other statutory partnerships in Sunderland, including:

- Sunderland Health and Wellbeing Board (HWBB) - responsible for producing the Joint Strategic Needs Assessment (JSNA) and HWBB Strategy. A 'Framework of Cooperation' is in place between SSAB, HWBB and Sunderland Safeguarding Children Partnership, setting out the role and remit of each Board/Partnership and their interrelationship with each other.
- Safer Sunderland Partnership (SSP) - SSP and SSAB work in collaboration on cross-cutting themes, including domestic abuse, violence against women and girls, sexual exploitation, migration/asylum and modern day slavery. SSAB receives updates regarding Domestic Homicide Review activity.
- Sunderland Safeguarding Children Partnership (SSCP) - SSAB and SSCP have worked jointly on a range of common workstreams, and also hold, or contribute towards, learning events highlighting both safeguarding children and adults issues.

Our Vision

In order to improve the effectiveness of SSAB in accordance with its statutory responsibilities, the Board has the following vision:

People in Sunderland are able to live safely, free from neglect and abuse

SSAB's vision for safeguarding adults in Sunderland can only be delivered effectively through the support and engagement of a wide range of partner agencies and organisations across the city.

SSAB continues to work toward achieving its vision through the committed local partnership working between a range of organisations that comprise the membership of SSAB, the SSAB Partnership Group and Sub-Committees, working together with common objectives and commitments.

Strategic Delivery Plan

SSAB's Strategic Delivery Plan details key focus areas for the period of 2019-2024, and identifies how SSAB will ensure its statutory responsibilities are met in accordance with the Care Act 2014 and embedded in practice across the partnership. The Plan is underpinned by SSAB's Multi-Agency Memorandum of Understanding, which describes the Board's remit and governance arrangements.

SSAB established four strategic priorities detailed in the Plan:

- Prevention
- Making Safeguarding Personal (MSP) / user engagement
- Partnership (including regional collaboration)
- Key local areas of risk (self-neglect, mental capacity and exploitation)

These priorities inform the Board's local actions to safeguard adults in Sunderland, and are underpinned by the Care Act's six key principles of adult safeguarding.

The strategic priorities have been progressed through the work of the SSAB's Partnership Group and the Learning and Improvement in Practice (LIIP) and Quality Assurance (QA) sub-committees.

Strategic Delivery Plan:

Progress and Achievements

Prevention

- SSAB Prevention Strategy refreshed in March 2021, to take account of the COVID-19 pandemic
- Successful local campaign in line with National Safeguarding Adults Week, including messages on SSAB's Twitter page and networking events (virtual due to pandemic) and social media messages across the partnership to promote safeguarding adults messages
- During the COVID-19 pandemic, key safeguarding adults information continued to be shared with partners

Making Safeguarding Personal (MSP)/user engagement

- During COVID-19, alternative methods of communication (such as video calls) have been used to ensure individuals could remain engaged
- Development of easy read SSAB Annual Report 2019-20 by self-advocates from Sunderland People First; this has been published on the SSAB website
- Safeguarding adults operational model continues to have MSP at it's heart, meaning figures for meeting MSP targets in 2020-21 were consistently high

Partnership (including regional collaboration)

- SSAB representatives were part of regional work via SAB's, Police & Clinical Commissioning Groups to develop a Missing Adults Protocol, which was launched in November 2020
- Continued representation at the Safeguarding Adults Regional Network
- Key statutory partners met regularly throughout the pandemic period in 2020-21, to provide updates and assurance in relation to COVID-19 and safeguarding adults activity

Key local areas of risk

- How To Assess Mental Capacity training course commissioned for another year and delivered to multi-agency staff
- Self-Neglect was the key theme for Safeguarding Adults Week, and SSAB's Self-Neglect resources were promoted as part of this
- Work undertaken looking at complex safeguarding cases, including those where exploitation is a factor, aiming to develop a consistent multi-agency approach

The Work of SSAB and its Sub-Committees

Governance

- Meeting frequency: quarterly for sub-committees and twice yearly for Board—COVID-19 pandemic meant that the SSAB and sub-committees held virtual meetings (some meetings cancelled where this was unavoidable)
- SSAB governance documents reviewed and refreshed in light of COVID-19 and also new SSAB Independent Chair appointment
- The SSAB newsletter was published & distributed to a wide range of stakeholders once during 2020-21, with the COVID-19 response preventing more, but a return to 3-4 copies per year is planned for 2021-22
- Continued interface with other statutory processes where required, despite the pandemic

Quality Assurance

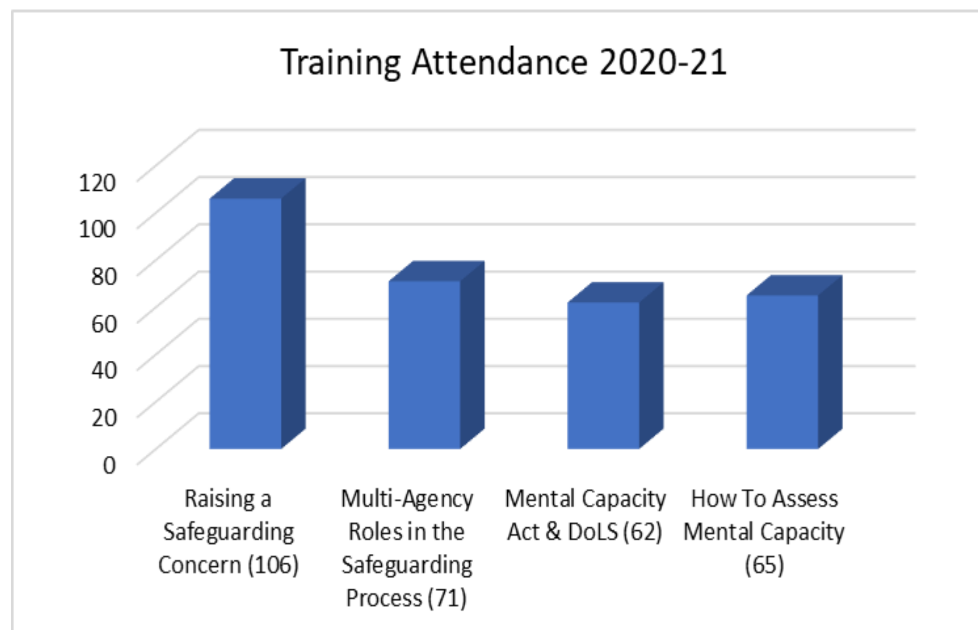
- During the COVID-19 pandemic, audit activity was mostly suspended; however the audit tools themselves were reviewed and updated so they collate data more easily. This will enable SSAB partners to use the results of future audits more effectively to improve processes/services, and to identify areas of good practice more easily
- Audit undertaken of sample of hospital discharge cases during COVID-19
- Progressed the SSAB's Quality Assurance Framework action plan
- Supported Safer Internet Day on 5th February 2021 via social media posts
- Held National Safeguarding Week events— necessarily mostly online-based information events & social media posts due to the pandemic.
- Ensured SSAB Multi-Agency Safeguarding Adults Procedures continued to be up to date
- Progressed Quality Assurance Sub Committee actions identified in the SSAB Work Programme, or agreed new timescales where progression wasn't possible due to the pandemic.
- Refreshed the SSAB Communications & Engagement Activity Plan
- Produced an easy read version of the SSAB Annual Report 2019-20 with Sunderland People First self-advocacy group

Learning and Improvement in Practice

- Kept up-to-date with the upcoming changes from DoLS to Liberty Protection Safeguards (LPS) and the potential implications of this
- Considered 2 cases against the Safeguarding Adult Review (SAR) criteria; one of which met the criteria, and was progressed accordingly

Training

- Re-commissioned the CPD-accredited Safeguarding Adults e-learning package from Social Care Institute for Excellence (SCIE)
- Continued commissioning of multi-agency safeguarding adults training, delivering 34 training sessions across the year
- This continues to be well received & to result in an improvement in the number and quality of safeguarding concerns being raised, as well as the contribution of partner agency attendees at safeguarding meetings, delivering upon the key principles of adult safeguarding: empowerment, prevention, proportionality, protection, partnership and accountability



Statutory Partners' Contribution to Safeguarding

Key Achievements

SSAB partners continue to support the safeguarding adults agenda, meeting key statutory responsibilities and contributing to the work of the sub-committees and Board. Partners have proactively engaged in local and national safeguarding campaigns, and continue to share good practice and learning. Partners also undertake regular governance and assurance activities.

Sunderland Clinical Commissioning Group (CCG)

- Agreed funding to support the continued development of the Adult Multi-Agency Safeguarding Hub (MASH) in March 2021 with health staff co-located in an integrated MASH team. The funding has been increased from 2020 to accommodate a full time post with a further review in September 2021 to support recurrent funding for the post
- Provided grant funding in March 2021 to support the ongoing development of a Trauma-Informed Recovery Unit for women with complex needs
- Provided grant funding March 2021 to support community counselling services for domestic abuse victims
- Provided a further year of grant funding March 2021 to support the health domestic abuse advocate role in primary care providing support to all Sunderland practices. This is an increase from the original programme for 12 practices. This includes training for staff, support for MARAC referral and support to primary care staff who identify victims of domestic abuse
- Provided one off funding March 2021 to Sunderland Council Housing Department to develop and improve health outcomes for the homeless population

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (CNTW)

After a successful business case from the Sunderland Clinical Commissioning Group, a practitioner post has been established and funded to work into the Adult Multi-Agency Safeguarding Hub (MASH) for a 12 month period. CNTW has developed and embedded this role, which has been invaluable throughout the pandemic, providing a patient-centred approach and a strong multi-agency opinion.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

- Utilise Datix as their standardised Informatics reporting system, ensuring a responsive safeguarding culture throughout the organisation. Datix has functionality to generate and send safeguarding referrals securely to the relevant Local Authority
- Effective multi-agency working has continued throughout the pandemic, inclusive of information sharing activity with the Multi-Agency Safeguarding Hub (MASH) and Northumbria Police whilst assisting with Prevent information requests
- The IDVA/DAHA has continued to support staff to recognise and respond to Domestic Abuse. Throughout 20/21 there were a total of 104 IDVA/DAHA referrals across the Trust

Northumbria Police

Northumbria Police recently created a new Safeguarding Strategic Innovation Partnership Team (SIP), and ensures that the same member of the Safeguarding Senior Management Team (SMT) at DCI level attends all 6 six of the Local Authority's Safeguarding Adults boards. This allows wider learning from all Safeguarding Adults Boards and consistency of approach.

Sunderland City Council

- Reviewed and updated relevant parts of the Adult Safeguarding procedures
- A key priority for the Adult Safeguarding Team is raising awareness and empowering staff to recognise signs and symptoms of abuse. The Team continue to provide advice, training and support to staff, in line with their statutory duties so that all staff continue to feel informed and confident to access the team for support and advice. The Safeguarding Adult Team are invested in increasing professional knowledge by staff development and have created an additional Officer post
- Safeguarding Adults Team have dealt with over 3,063 Safeguarding Adult Concerns for 2020/21
- Levels of service and support have been maintained throughout the course of the pandemic. Prior to the pandemic, the MASH was receiving approximately 60 referrals per week. However, as a direct consequence of predominantly Covid related reasons, the average number of MASH referrals has increased to 106 per week and is continuing to rise. This has led to the need for the service to develop of a full-time social work post to respond appropriately to this demand

Statutory Partners’ Contribution to Safeguarding

Good Practice

Examples of good practice across the partnership include attendance at multi-agency safeguarding training and dissemination of learning throughout organisations of local reviews—including news bulletin articles, face-to-face sessions and “7 minute” briefings. Assurance of safeguarding compliance is provided through rigorous audit programmes, internal agency reporting mechanisms and regular reporting to commissioners and regulating bodies, such as the Care Quality Commission.

Sunderland City Council

The Prevent duty requires local authorities to establish or make use of existing multi-agency groups to assess the local picture, coordinate activity and to put in place arrangements to monitor the impact of safeguarding work.

Local authorities now take a greater role in supporting the Channel programme bringing the process more into line with common safeguarding procedures. Sunderland continues to deal with a number of referrals under the Prevent Agenda and has developed a Joint Channel Panel—for Adults and Children/Adolescents. Thus, continuing to be a nationally recognised example of exceptional good practice for the Home Office Channel Team in the Office for Security and Counter-Terrorism, Prevent.

The Strategic Manager for Community & Safety is involved in local and regional forums for Prevent to ensure Sunderland is informed of and engaged in continual practice development including review of the training requirement.

The Prevent programme is currently being reviewed nationally and Sunderland/Newcastle have jointly been chosen to contribute to this via an on-line community event.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

- A rigorous programme of safeguarding audits have continued throughout 2020-21 despite the pandemic, to monitor safeguarding practice across STSFT, e.g. MCA/DoLS, compliance with routine & selective enquiry and self-neglect
- The safeguarding team attend Emergency Department (ED) huddles (Monday-Friday) to share safeguarding practice and provide direct support to ED practitioners
- The safeguarding team undertake an audit of ED attendances to ascertain if there are any missed opportunities. Any learning to arise from missed opportunities is Incident reported and shared at ED Interface meetings and ED huddles
- Safeguarding training compliance has exceeded the 90% organisational target and this has been maintained throughout 2020-21. Following Intercollegiate guidance, a level 3 training needs analysis has been completed and Level 3 training has now been implemented. Compliance is currently at 89% and so is on the correct trajectory to obtain 90% compliance by August 2021. The Trust continues to exceed NHS England's 85% compliance target for WRAP Prevent training and Basic Prevent Awareness training (BPAT)
- Throughout 20/21, safeguarding learning from SARs/DHRs & CSPRs has been cascaded to all departments via the bi-monthly newsletter and quarterly champion’s virtual presentation. Learning has also been made available via ’7-Minute Briefings’ available on the Trust intranet site

Statutory Partners' Contribution to Safeguarding

Good Practice (continued)

Sunderland Clinical Commissioning Group (CCG)

- CCG safeguarding has a full remote training programme in place for level three safeguarding training across primary care. There is noted to be excellent attendance from primary care staff and analysis of all feedback data informing new sessions
- Time in Time out (TiTo) annual safeguarding training level three was delivered to primary care services in March 2021 via Microsoft Teams with a focus on the new Liberty Protection Safeguards and including a presentation from Neil Allen from the Essex Chambers (law firm)
- Self-Neglect training was delivered at a national conference in March 2021 from the Designated Professional for Adult Safeguarding and will also be delivered nationally in September 2021
- Following a recent Safeguarding Adult Review (SAR), actions from the report have been implemented with the Special Allocations Service including specialist safeguarding supervision and improved communications to support complex patients
- The Domestic Abuse Health Advocate Programme has a rolling audit process to monitor practice, outcomes and rates of referral.
- The Named GP Adult Safeguarding chairs the quarterly primary care Safeguarding Leads meeting incorporating safeguarding updates, good practice, complex cases and areas of discussion for safeguarding leads

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (CNTW)

With the introduction of new MASH post the CNTW Safeguarding Adults and Public Protection (SAPP) Team are able to contribute to multi-disciplinary key decision making around information that comes into the MASH, supporting:

- The navigation of client care around a complex mental health system
- Timely review of care and treatment and support
- The Domestic Abuse agenda

Northumbria Police

Within the new SIP team, there is now a learning and improvement function, overseen by a Detective Inspector who will attend all learning and improvement/quality improvement sub groups, to work with partners to drive and share internal and external learning and improvement.

The SIP team will help support the SSAB priorities and provides a consistent and innovative approach to Safeguarding and the development of vulnerable adult procedures.

The Hub Detective Chief Inspector will attend all SAR / DHR panels and the SIP Detective Inspector reviews all SAR / DHR / MAPPA reviews to identify internal and external learning and manages our response to this to ensure learning is embedded in policy and practice and learned throughout the force.

Statutory Partners’ Contribution to Safeguarding

Working with Partners

Partners continue to contribute to multi-agency working, in particular by representation at a wide range of multi-agency safeguarding fora, which includes: MAPPA (now MOSOVO - Management of Sex Offenders & Violent Offenders), MATAC, MARAC, CONTEST Board and Channel Panel.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

- Throughout the pandemic CNTW SAPP team have maintained its key function and continued to contribute to safeguarding adults reviews, learning events and rapid reviews. The learning is taken back into the organisation and used to support the front line teams to embed good multi agency practice and enhancing multi-agency communication in the organisation
- Developed the role of a CNTW MASH worker within the Sunderland MASH. This has worked very well and is being evaluated

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

- STSFT Safeguarding Team continue to be active members of local partnerships ensuring representation and contribution across all meetings & groups. This has been essential throughout Covid-19 to enable partner agencies to identify safeguarding themes and trends and work together to improve outcomes for adults
- The MCA/DoLS Advisor has worked closely with the Local Authority MCA/ DoLS team to safely implement changes to the DoLS process following the Coronavirus Act 2019

Northumbria Police

A key priority for Northumbria Police is to continue to protect and safeguard vulnerable adults, to identify opportunities for early intervention / prevention, and pursue perpetrators who cause harm. We do this with a coordinated partnership response, cognisant of diverse needs and vulnerabilities, to safeguard vulnerable adults and tackle perpetrators. Our ultimate aim is to achieve a safe environment for families to thrive without fear of harm and to ensure perpetrators are identified and targeted, and that the opportunity for them to cause further harm is removed or minimised.

Sunderland City Council

- Safeguarding Adults Team continues to provide information to support a safeguarding and quality discussion with commissioning, CCG and CQC colleagues.
- Strategic Manager for Community Safety and Safeguarding works closely with Violence Reduction Unit who look to improve lives so we can prevent crime, especially violent crime
- Worked with partners to develop Complex Adults Risk Management (CARM) process, providing a framework for professionals to facilitate effective multi-agency working with adults at risk aged 18 or over who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, refusal of services and/or high levels of risk taking activity

Statutory Partners' Contribution to Safeguarding

Working with Partners (continued)

Sunderland Clinical Commissioning Group (CCG)

The CCG have actively supported partnership working across a number of key areas including:

- Representing the CCG and regional health colleagues at the Regional CONTEST Board
- Supporting the development of the combined Chanel Panel for Prevent
- Supporting the Learning and Improvement Partnership (LIPP) with the Designated Professional as chair of the group.
- The Designated Professional Adult Safeguarding, in conjunction with the Safeguarding Adults team manager, reviewed and developed a framework/protocol for the management of complex cases, Complex Adults Risk Management (CARM). The Learning and Improvement in Partnership (LIIP) Sub Committee approved a protocol and process which was presented at the SSAB Partnership Group in March 2021 and agreed as the new framework going forward to support the coordination and management of complex cases. Continued development for 2021 includes a workshop, planned and developed by the Designated Professional and the Safeguarding Adults Team Manager, for all partner agencies, to help the implementation of the new process
- CCG Safeguarding support the Domestic Abuse Working Group and Domestic Abuse Commissioning Group to ensure there is a multi-agency view of domestic abuse strategic developments and commissioning processes
- The Designated Professional Adult Safeguarding and the Safeguarding Adult Team worked together to produce data for the national Self-Neglect training module which also referenced the self-neglect guidelines and policy developed by SSAB
- The named GP Adult Safeguarding, Designated Professional Adult Safeguarding and the Safeguarding Nurse CCG all support the SAR / DHR and LLR processes via the panel processes, scoping reports, IMR reports and the action and implementation of agreed recommendations from the panels. SCCG also offer administrative support for the collation of reports to the SSAB
- The Designated Professional Adult Safeguarding and Named GP adult Safeguarding are working with the housing department following a funding grant from SCCG to develop health and social care outreach posts. These two posts have a clear remit to improve health outcomes for the homeless population in conjunction with partner agencies. This includes access to health care, access to vaccination services, access to GP services and GP registration and improved liaison with health and social care services

Statutory Partners’ Contribution to Safeguarding

Making Safeguarding Personal (MSP)

Making Safeguarding Personal (MSP) has been actively embraced by partners in Sunderland since it was introduced. Partners have taken forward a significant amount of work to incorporate the principles of MSP into their policies and procedures, staff ways of working, staff communications (e.g. newsletters), and single-agency training opportunities.

Sunderland Clinical Commissioning Group (CCG)

The CCG has promoted Making Safeguarding Personal through training it provided to practitioners during 2020-2021 which references MSP throughout. Training also reflects the requirements to risk assess the MSP process if there are high risk to the individual or others. MSP is embedded in safeguarding policy and procedure and referenced throughout safeguarding documents. A person-centred approach is encouraged and advised throughout any advice to primary care services with the emphasis on service user involvement in the safeguarding process. The Health Advocate role supports a person centred approach and the CCG-supported health navigator role in MASH has a clear focus on the individuals needs and rights, involving the service user throughout the process.

South Tyneside and Sunderland Foundation Trust (STSFT)

Throughout Safeguarding Adults week (16-22 Nov 2020), STSFT Safeguarding team focused upon a different safeguarding theme each day. Tuesday was “Think MSP”. Staff were directed to an episode of “Safeguarding Matters” where thinking behind the concept of MSP was explored with practical tips on how to apply MSP in practice.

Northumbria Police

We ensure victim focused investigations are delivered and take the views of victims to the heart of our decision making. Our policy and procedures incorporate Making Safeguarding Personal and we adhere to the Victims Code of Practice to ensure that the views of victims are taken in to account when decisions are made regarding safeguarding and investigation.

Victim personal impact statements presented at Court ensures victims’ views are known to Courts prior to any offender being sentenced.

We support the National Vulnerability Action Plan and we are reviewing how the plan may be implemented to develop coordinated, effective and evidence-based responses to protect vulnerable people.

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (CNTW)

Our safeguarding adults policy has MSP as an appendix for use, and when safeguarding concerns are raised by our service users, we support our clinicians with the use of this tool in the gathering of information. To ensure that the person’s voice is heard throughout and to allow the Local Authority to make the best decision going forward.

Statutory Partners' Contribution to Safeguarding

Making Safeguarding Personal (MSP) (continued)

Sunderland City Council

Making Safeguarding Personal (MSP) is an initiative which aims to develop an 'outcome focus' to safeguarding work and a range of responses to support people to improve or resolve their circumstances. MSP in its simplest form means putting the person at the centre of everything we do during a safeguarding enquiry, from the very beginning to the very end.

MSP seeks to achieve a personalised approach that enables safeguarding to be done with, not to, people. Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'. An approach that enables practitioners, families, teams and safeguarding adult boards to know what difference has been made. Sunderland's Adult Safeguarding Team put MSP at the centre of referral enquiries to the authority.

Sunderland City Council

Case example:

AA was a 65 years female with a learning disability diagnosis living in the community with her partner. AA's escalating behaviour towards her carers, her fellow residents, landlord and her partner were threatening her community tenancy. In particular the care provider was finding it incredibly difficult to provide her with care and support and manage AA's behaviours. The landlord was receiving complaints from tenants and staff are very apprehensive when providing support due to the number of allegations AA was making towards professionals.

A number of Safeguarding Adults Meetings were held to address these concerns and were attended by multi-agency partners involved in AA's care, along with AA and her partner. Specialist behavioural health support was provided as well as social care support and advocacy. AA's partner's support was also engaged. AA with therapeutic support accepted that her behaviours could put her home in the community at risk and expressed that her desired outcome was to remain in her home with her partner in which she felt safe.

AA was engaged with sustained and patient support and care, with AA at the centre. Applying MSP and with AA's full support a number of outcomes were achieved including the introduction of a new health worker for AA at her request. AA also engaged in work in relation to her mental health and support and AA re-engaged with her landlord with the support of professionals involved in supporting AA. This work culminating in AA agreeing and entering into an easy read behavioural contract and social story relating to the contract and her tenancy. AA currently remains in her flat with her partner to date with ongoing support from her family and health and social care professionals.

2020-21 in Figures

3310
Concerns received
50% of cases progressed to an enquiry:
31% Section 42
19% other enquiry

Desired Outcomes
Of those with a completed Enquiry, 86% of individuals or individuals' representatives were asked what their desired outcomes were, of these 86% expressed a desired outcome. 97.5% were either fully or partly achieved

Primary support Reason
Individuals with physical support needs represented almost half of all concerns received

Mental Capacity
In 29% of completed cases the client was identified to lack mental capacity, with the majority being supported by friends and family. 100% of these individuals were supported

Main Location of Abuse
Individuals' own homes: 45%
Residential/nursing homes: 35%
Alleged perpetrator's home: 8%
Concerns raised in a health setting continues to be low at 5%

Main categories of Abuse
Physical abuse: 27%
Neglect: 24%
Psychological abuse: 11%
Self-neglect: 14%
Financial abuse: 10%

Age/Gender
Females account for 60% of all concerns raised, with 51% of these being aged 75+. Males account for 40% of all concerns raised, with 51% of these being aged 18 - 64

Working Differently during the COVID-19 Pandemic

During the COVID-19 pandemic, SSAB has endeavoured to ensure that it's strategic-level business was able to continue, although this has at times been in a reduced or different way. This approach has ensured the safety of staff across the partnership, and also ensured that the partner agencies could refocus their activity and resources on individuals who needed the most care and support in the community, e.g. people who were shielding or who didn't have family support networks.

Examples of work that SSAB partners have been involved in include:

- Coordinating a network of volunteers to help support individuals who were shielding to still access supplies such as groceries or medication prescriptions
- Staff using various available technologies to undertake video calls, texts, etc to keep in touch with service users , including issuing tablets & other devices, or directing people to where they could obtain one through national funding/other sources
- Holding operational safeguarding meetings virtually, to ensure cases continued to be examined in a timely manner, with concerns investigated and issues dealt with
- Holding strategic safeguarding meetings virtually, to ensure continuity of business and that updates and assurance could continue to be sought on a range of safeguarding adults issues, plus 'think family' issues. This has included 2 joint meetings (May & June 2020) of SSAB & SSCP, then a series of Safeguarding Adults & COVID-19 Assurance meetings (held approximately every 6 weeks and continuing into 2021) to gain assurance for SSAB that the key statutory partners have been able to continue their safeguarding adults activity during the COVID-19 pandemic.

What does 2021-22 Hold?

- Recovery from COVID-19 and addressing 'hidden harm' following COVID lockdowns and shielding etc, will be our focus.
- Implementation of the lessons learned from the impact of COVID-19 on the working practices and activity of SSAB partners, to ensure good practice and innovation are not lost going forward; key areas identified include: better use of technology to support safeguarding adults work; more streamlined use of resources; more flexible and agile staff working practices
- Final revision and re-launch of SSAB's Multi-Agency Safeguarding Adults Procedures (postponed in 2020 due to the COVID-19 pandemic), streamlining them and making them easier to navigate and more accessible to professionals and public
- Ongoing development of the SSAB website (postponed in 2020 due to the COVID-19 pandemic), to include a greater breadth of safeguarding resources
- Launch and embed the Complex Adults Risk Management (CARM) process for managing the most complex safeguarding adults cases, to ensure a comprehensive multi-agency response that gains positive outcomes for individuals, in line with Making Safeguarding Personal principles
- Getting back on track (following a pause during the pandemic) with a planned cycle of themed case file audits and assurance exercises
- SSAB will be participating in the National Safeguarding Week in November 2021, with SSAB partners undertaking a range of safeguarding adults awareness-raising activities
- SSAB has agreed new priorities for 2021, following an exercise to review and follow the data, and refresh performance and assurance frameworks: Prevention; Local Areas of Risk (Self-Neglect; Mental Capacity; Homelessness; Complex Adults Risk Management (CARM) – at Risk/Vulnerable/Complex Cases (including Substance Misuse); Domestic Abuse; Suicide Prevention (particularly in light of the effects of COVID-19)). We will work jointly with the SSCP on some of these areas, as well as on Transitions; Exploitation and Learning from Safeguarding Adult Reviews (SARs) and Local Safeguarding Children Practice Reviews (LSCPRs).

Item No. 11

SUNDERLAND HEALTH AND WELLBEING BOARD **1 October 2021**

HEALTH AND WELLBEING BOARD FORWARD PLAN

Report of the Senior Manager - Policy, Sunderland City Council

1.0 Purpose of the Report

1.1 To present to the Board the forward plan of its business for 2021/22.

2.0 Background

2.1 The Health and Wellbeing Board has a forward plan of activity, setting out proposed agenda items for Board meetings and development sessions for the year ahead. Board meetings are held on a quarterly basis and development sessions are held as and when required.

3.0 The forward plan

3.1 The forward plan is attached as appendix 1. The plan is not fixed for the whole year and may be changed at any time, with items being added or removed as circumstances change and to suit the Board's needs.

3.2 Members of the Board are encouraged to put forward items for future meeting agenda's either at Board meetings or by contacting the Council's Senior Policy Manager.

4.0 Recommendation

4.1 The Health and Wellbeing Board is recommended to receive the forward plan for information.

Appendix 1

Sunderland Health and Wellbeing Board – Draft Forward Plan (Note: subject to change. Last updated 20.9.21)

<table>
<tr><th>SEPTEMBER 2021</th><th>OCTOBER 2021</th><th>NOVEMBER 2021</th><th>DECEMBER 2021</th><th>JANUARY 2022</th><th>FEBRUARY 2022</th></tr>
<tr><td></td><td>Public Meeting – 1 October 2021
• JSNA
• Health Inequalities
• ICS and Place-based integration arrangements
• Covid-19 update
• Delivery Boards Assurance
• SSAB Annual Report</td><td></td><td>Public Meeting - 10 December 2021
• Covid-19 update
• Health Protection Assurance Report (TBC)
• Winter Plan
• ICS and Place-based integration arrangements
• Healthy City Plan – 6 monthly performance report
• Delivery Boards Assurance
• Path to Excellence update
• SSCP Annual Report
• Government proposals for health and social care</td><td></td><td></td></tr>
<tr><th>MARCH 2022</th><th>APRIL 2022</th><th>MAY 2022</th><th>JUNE 2022</th><th>JULY 2022</th><th>AUGUST 2022</th></tr>
<tr><td>Public Meeting – 19 March 2021
• Covid-19 update
• Path to Excellence
• ICS and Place-based integration arrangements
• Delivery Boards Assurance
• Director of Public Health Annual Report</td><td></td><td></td><td>Public Meeting - Date to be confirmed
• Covid-19 update
• Path to Excellence
• ICS and Place-based integration arrangements
• Healthy City Plan – 6 monthly performance report
• Delivery Boards Assurance
• Update on Healthy City Plan Grant</td><td></td><td></td></tr>
</table>

Additional key dates for future Board meetings
Pharmaceutical needs assessment (PNA) – to be considered by HWB in Sept. 2022 for publication in October 2022

Potential development sessions
Further sessions on ‘making health everyone’s business / Health in All Policies’
Social prescribing
Behavioural insights