SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held remotely on Friday 19 March 2021 at 12.00pm

The meeting will be livestreamed for the public to view on the Council's YouTube channel, 'sunderlandgov' at: https://youtu.be/na5wUfA64C0

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

ITEMS FOR DISCUSSION

8.	**Health and Social Care White Paper and the Next Steps for Integration of Place Based Arrangements** Joint report and presentation of the Executive Director of Public Health and Integrated Commissioning, Executive Director of Neighbourhoods and the Deputy Chief Officer/Chief Finance Officer of Sunderland CCG (attached).	77
9.	**Update on Phase 2 of the Path to Excellence** Report of the Executive Medical Director STSFT and Chair of Clinical Service Review Group (attached).	81
10.	**South Tyneside and Sunderland Foundation Trust: Health and Wellbeing Strategy** Report of the Chief Executive of South Tyneside and Sunderland Foundation Trust (attached).	107

ITEMS FOR INFORMATION

11.	**Developing an Adult Mental Health Strategy for Sunderland** Report of the Director of Contracting, Planning and Informatics, NHS Sunderland CCG	125
12.	**Health and Wellbeing Board Development Session Overview: Making health inequalities our business** Report of the Executive Director of Public Health and Integrated Commissioning (attached).	129
13.	**Health and Wellbeing Board Forward Plan** Report of the Senior Policy Manager, Sunderland City Council (attached).	139
14.	**Dates and Times of Future Meetings** The Board is asked to note the proposed schedule of meetings for 2021/2022: - Friday 25 June 2021 Friday 17 September 2021 Friday 10 December 2021 Friday 18 March 2022	-

All meetings to start at 12.00pm. Please note that these dates are provisional and will be formally agreed at the Annual Meeting of the Council on 19 May 2021.

Development Session – Behavioural Insights Approach – Tuesday 23 March 2021, 1.30pm – 3.30pm

Session to be led by the Best Start in Life Working Group

ELAINE WAUGH
Assistant Director of Law and Governance

Civic Centre,
Sunderland

11 March 2021

Item No. 4a

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 11 December 2020

Meeting held remotely via MS Teams

MINUTES

Present: -

Councillor Geoff Walker (in the Chair)	-	Sunderland City Council
Councillor Kelly Chequer	-	Sunderland City Council
Councillor Louise Farthing	-	Sunderland City Council
Councillor Shirley Leadbitter	-	Sunderland City Council
Ken Bremner	-	South Tyneside and Sunderland NHS Foundation Trust
David Chandler	-	Deputy Chief Officer, Sunderland CCG
Jill Colbert	-	Chief Executive, Together for Children
Dr Ian Pattison	-	Chair, Sunderland CCG
Gerry Taylor	-	Executive Director of Public Health & Integrated Commissioning, Sunderland City Council

In Attendance:

Martin Weatherhead	-	GP Chair, All Together Better
Professor Tony Alabaster	-	University of Sunderland
Lucy Caplan	-	Workplace Health Alliance
Scott Watson	-	Lead for Mental Health, Sunderland CCG
Deborah Cornell	-	Head of Corporate Affairs, Sunderland CCG
Graham King	-	Assistant Director, Adult Services
Kath Bailey	-	Public Health Specialist, Sunderland City Council
Yusuf Meah	-	Public Health Practitioner, Sunderland City Council
Jane Hibberd	-	Senior Manager, Policy, Sunderland City Council
Gillian Kelly	-	Governance Services, Sunderland City Council

HW28. Welcome from the Chair

Councillor Walker welcomed everyone to the third remote meeting of the Health and Wellbeing Board. He particularly welcomed Gerry Taylor, the newly appointed Executive Director of Public Health and Integrated Commissioning to her first meeting of the Health and Wellbeing Board and asked all Board Members to introduce themselves.

HW29. Apologies

Apologies for absence were received from Fiona Brown, Lisa Quinn, Ralph Saelzer and Michael Young.

HW30. Declarations of Interest

Dr Weatherhead declared an interest in relation to Item 6 – Healthy Economy Update: Workplace Health – as he was a non-Board medical director of a private organisation providing health and wellbeing services to industry.

HW31. Minutes and Matters Arising

The minutes of the meeting of the Health and Wellbeing Board held on 18 September 2020 were agreed as a correct record.

HW32. 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 there had been a significant reduction in cases through the second national lockdown, however the cases in Sunderland had stabilised since Tier 3 restrictions had begun but not really reduced. This was a better picture than previously seen but numbers were still relatively high.

The key weekly data regarding Sunderland would be published on the Council website from the following week and deaths would continue to be reported on a daily basis. Opportunities for symptomatic testing had increased significantly in the last few weeks and there were opportunities for key workers and staff to access at home testing. There was regular testing for care home staff and residents and care homes had been offered access to lateral flow devices.

Contact tracing was largely being managed and led nationally but consideration was being given to how this could be taken forward locally. There were currently two approaches for locally enhanced contact tracing which were being looked at.

The Pfizer vaccine had now been approved for use and the Oxford/AstraZeneca vaccine was currently under consideration. This was an ever-changing position and there were logistical issues related to the Pfizer vaccine which meant that it could only be delivered from hospital settings and mass vaccination sites. A suitable site had been identified in Sunderland and vaccinations could commence next week.

The health inequalities existing in the city had been demonstrated starkly by Covid and some of these issues would be picked up at future development sessions. In terms of communication and engagement with residents, detailed insights work was

being undertaken to help understand the thoughts and perceptions around Covid restrictions in the city. A new campaign ‘BeatCovidNE’ was being launched this week which would focus on thanking people for what they had been doing and reinforcing positive behaviour.

David Chandler provided an update on the vaccine rollout stating that this would be based in primary care with a GP led element. There were approximately 284,000 people in Sunderland, 115,000 were over 50 and eligible for the vaccine. 14,000 people were over 80 and 2,000 were in care homes.

The Pfizer vaccine was frozen and then defrosted prior to use; between 14 and 21 December it would be administered at six sites in Sunderland with 975 vaccines being made available at each site. GP practices would invite approximately 6,000 over 80-year olds for their vaccine and fully trained staff would administer the dose. Patients would be given an initial injection and this would be followed up with a second jab 21 days later. David highlighted that plans did change by the hour but this was the current position.

Building on the information provided, Dr Pattison said that as a GP in the city, he wished to reiterate that the vaccine was considered safe by all GPs in Sunderland. However, it was necessary to remain vigilant, keep to the rules and it would take time for the benefits to be seen. This was a massive piece of work but primary care providers were very satisfied that there was the capacity to vaccinate all eligible people.

Councillor Farthing commented that in relation to the lateral flow tests, there had been some media coverage about care homes being unable to deliver these. She noted that there had been cases of contact tracers contacting individuals who were already in hospital and local tracing might avoid this and have a more sensitive approach.

Gerry Taylor said that she had heard similar reports and that local contact tracing would give a lot of benefits, although it would be difficult to know the whole background of an individual, local contacts and knowledge could help to build on what was happening in the NHS system.

Ken Bremner highlighted that the NHS Foundation Trust had received no indication of when hospital staff would be vaccinated and this was extremely disappointing and detrimental to the morale of staff. Dr Pattison stated that he had been in touch with Sean Fenwick at the Foundation Trust and said that if the primary care networks could access the vaccine then they would offer this to the NHS staff.

The Chair asked if this was something which could be raised regionally, however it was noted that Ken had raised this through the NHS hierarchy. Councillor Farthing said that she was sure that all of the Health and Wellbeing Board would want to support NHS staff receiving the vaccine and the lack of clarity on this was an indictment of the Government’s lack of planning.

The Board RESOLVED that the update on the Covid-19 pandemic be received and noted.

HW33. Healthy Economy Update: Workplace Health

The Healthy Economy Working Group submitted a report providing an update on the work of the group and raising awareness of the Workplace Health Alliance Charter and the Mental Health at Work commitment.

Ken Bremner was the Healthy Economy Lead and introduced a presentation on the report. The Healthy Economy Working Group was developing a programme of activity which would tackle: -

- Workplace health – employers' role in improving employees' health
- Healthy labour force – the health of those in work and seeking work
- Employment in the health and social care sector – understanding and tackling recruitment issues and wider workforce opportunities

The focus of the presentation was workplace health and there was a lot of evidence to show that promoting and managing the health and wellbeing of staff provided benefits for both employers and employees. For each pound invested in appropriate workplace health initiatives, £2 to £34 could be returned to the employer. Workplace health was about promoting and managing the health and wellbeing of staff with clear leadership buy in. Workplace health interventions were undertaken by the employer to address identified health issues faced by staff and to address health and safety risks.

The Sunderland workplace offer was under two headings; the Better Health at Work Award and the Sunderland Workplace Health Alliance. The Better Health at Work Awards recognised efforts of local employers in addressing health issues in the workplace and was endorsed by Public Health England as an exemplar of good practice. The award had five levels, each with appropriate criteria to support the compilation of an award portfolio. There were 38 businesses in Sunderland currently on the Better Health at Work Award and the interventions carried out by these businesses reached a total of 22,924 employees. Sunderland City Council was one of three local authorities regionally to have reached the highest level of the award and given Ambassador status and in the city itself Sunderland College and Pentland Brands had also achieved this status.

Lucy Caplan, Vice-Chair of the Sunderland Workplace Health Alliance was in attendance and she advised that the Alliance was a network of local businesses working collaboratively to improve health and wellbeing within Sunderland workplaces. The purpose of the group was to engage with a wider range of workplaces that those participating with the Better Health at Work Award and who wanted to improve workplace health without having to undertake the process of building the evidence required for the award.

The Alliance provided a wealth of resources and asked members to demonstrate their commitment by signing up to the Sunderland Workplace Alliance Health Charter which set out how organisations would improve the health and wellbeing of employees by:

- Identifying a named health advocate in the organisation, and once a year, establish for internal use, the key health issues affecting staff and the organisation
- Create an action plan setting our priorities for workplace health policies and interventions
- Commit to creating a healthy workplace environment
- Provide health information and support to staff
- Actively contribute to meetings

As part of this signing up to the Alliance and Charter the organisation would receive one to one support to identify the key health and wellbeing challenges faced by the organisation and staff; bespoke support, tools and techniques to help address challenges successfully; and capacity building training and workshops to better equip the business and its staff to meet health and wellbeing challenges arising in the future.

There were currently 90 businesses who were part of the Alliance and the Board was asked to support the Sunderland Workplace Health Alliance Charter by committing to it on an individual organisational level and to discuss ways wider city leaders and anchor organisations could be encouraged to support it.

Prior to Covid, mental health had been identified as the key health challenge within workplaces and this challenge had only become more significant post-Covid. The Mental Health at Work Commitment had been launched to encourage employers of all sizes to join the movement and improve standards of mental health care among the workforce at a national scale. The six standards of the Commitment were: -

1. Prioritise mental health in the workplace by developing and delivering a systematic programme of activity
2. Proactively ensure work design and organisational culture drive positive mental health outcomes
3. Promote an open culture around mental health
4. Increase organisational confidence and capability
5. Provide mental health tools and support
6. Increase transparency and accountability through internal and external reporting

Lucy highlighted that with the support of Yusuf Meah and the team at Sunderland, the Alliance had gone from strength to strength and was able to communicate with a wide range of businesses and help companies to engage in a meaningful way.

Councillor Farthing praised the work of the Alliance, which was now moving at pace, and made reference to the promotion of the Healthy Schools Award which was focused on pupils and wondered whether it would be quite straightforward to ask schools to sign up to the Better Health at Work Award. Yusuf noted that this was an area for development which would be built into the action plan.

Having thanked Ken, Lucy and Yusuf for their report and presentation, the Board RESOLVED that: -

(i) the role of anchor organisation in improving health and wellbeing and reducing health inequalities by using the Social Value Act (2013) to embed workplace health in all commissioning and procurement resulting in wider social, economic and environmental benefits be acknowledged;

(ii) a focus on engaging local SMEs in the workplace health agenda be supported;

(iii) support for the Sunderland Workplace Health Alliance Charter on a Board and individual organisation level be endorsed;

(iv) support to the Mental Health at Work Commitment be endorsed and individual organisations sign up to the commitment; and

(v) partner organisations be encouraged to participate in the Better Health at Work Award, ideally starting this process in 2021.

HW34. Healthy City Plan

The Executive Director of Public Health and Integrated Commissioning and Deputy Chief Officer/Chief Finance Officer of Sunderland CCG submitted a report intended to: -

- update the Board on the proposed changes to the Healthy City Plan before the plan was finalised;
- share the draft performance framework for the Healthy City Plan with the Board; and
- seek endorsement to delegate approval of the Healthy City Plan to the Chair of the Board, in consultation with the Executive Director of Public Health and Integrated Commissioning and the Deputy Chief Officer/Chief Finance Officer of Sunderland CCG.

David Chandler advised that the draft Healthy City Plan had been developed in partnership with an aim to seek Board approval in June 2020, however due to this pandemic work had been delayed and the draft Plan had been presented to the Board in September with a view to having this approved in December.

There had been changes in the lead officers for the Plan since the initial drafting and also the city context continued to be affected by the pandemic so it was felt to be important to pause and to reflect on the plan to ensure it reflected current context. For example, the Board's eight priorities remained relevant but some of the key messages would be strengthened to reflect the impacts of the pandemic on Covid-19 related inequalities.

The current draft of the Healthy City Plan would be refreshed to: -

- Draw explicit links to other key strategies such as the Covid-19 Health Inequalities Strategy and a range of strategies within the Vibrant and Dynamic themes of the City Plan.

- Emphasise the impact of Covid-19 on the social and economic factors that contribute to poor health, recognising for some people Covid-19 would have exacerbated existing inequalities.
- Be more explicit on how the city would work differently (for example, taking an asset-based approach, building on the strengths within communities, championing a 'health in all policies' approach and strengthening the role that employers and anchor institutions can play in the city).
- Append the Healthy City Plan performance framework as an annex to the plan.
- Clarify the arrangements for implementation of the plan, namely the structure and responsibility for delivering the plan and how the board will have oversight, impact and outcomes.

The associated governance arrangements for the Healthy City Plan would be presented to the Board in March 2021 and a public facing summary of the Plan would be developed once the plan was finalised.

Councillor Farthing welcomed the emphasis which was to be placed on social and economic factors and felt that the link between employment, prosperity and health should be stressed.

The Board therefore RESOLVED that: -

(i) the update report be noted;

(ii) final approval of the Healthy City Plan be delegated to the Chair of the Health and Wellbeing Board in consultation with the Executive Director of Public Health and Integrated Commissioning and the Deputy Chief Officer/Chief Finance Officer of SCCG; and

(iii) the approved plan for information be received at the March 2021 Board meeting, along with the associated governance arrangements.

HW35. Update on the Emerging Mental Health Strategy

Scott Watson, Director of Contracting, Planning and Informatics at Sunderland CCG, delivered a presentation providing an update on the progress being made on the development of the CCG's mental health strategy.

The Clinical Commissioning Group did not currently have a Mental Health Strategy and mental health and wellbeing was a priority for both CCG and Health and Wellbeing Board and it was felt that it was now an appropriate time to move forward with developing the strategy. There was also the availability of transformation funding which would allow the CCG to get into some service transformation and redesign over the next two to three years.

It was anticipated that the impact of Covid-19 would see an increase in demand for mental health services of up to 30% and services would be needed to meet this demand and provide good outcomes for patients. Sunderland had one of the highest

rates of hospital admissions for mental health concerns in the country and the highest level of prescribing of anti-depressants.

The aim of the work was to understand what was important for stakeholders and how providers and services could deliver better outcomes to improve mental health and support a seamless transition through ages and services.

The first phase of the development of the strategy was to engage on the proposed scope and this had taken the form of engagement with a range of stakeholders to seek views on the key issues to be addressed and what was important for mental health services. This work had been concluded in November 2021 with a presentation to the CCG Governing Body who had signed off on the scope of the work.

The second stage was now in progress which involved reviewing and the intelligence which had been gathered and commencing formal engagement. This stage would end on 22 January 2021 and phase three would test these findings and use them to develop the strategy prior to it being presented and published in April 2021. It was noted however that, given the current pressures on the system, the publication date may slip to May 2021.

Key messages which had come out of the engagement process included: -

- Integrated/joined-up/partnership working
- Clear and transparent service provision
- Shifting the balance to focus on self-care and prevention with a lifelong focus on mental health
- Mindful of the consequences of Covid-19
- Transition between children and adults' services
- No gaps in service provision
- Maintain accessibility and patient choice
- Need for a skilled, trained workforce
- Improvements needed to children's services

The scope of the strategy would include adult mental health services, the transition from Children and Young People's services to adult services and integration with Primary Care Networks and General Practice. It would not include Children's Mental Health Services and Learning Disabilities and Autism as these had their own transformation plans. It would also exclude in-patient units and bed-based services as these were commissioned regionally.

For phase two, the CCG were in the process of conducting in depth interviews with individuals including providers and clinicians and would also be carrying out paper and online surveys for the public, patients, staff and large employers. Asset based focus groups would be consulted and participants from the surveys would be recruited to run focus groups with the general public, staff and employers.

All current mental health providers had been encouraged to share links to, and paper copies of, the survey with service users, carers and staff. Large employers had also been asked to complete a survey on behalf of their organisation and there was a

social media campaign encouraging the public to engage and this had reached 40,000 individuals across the city.

A lot of work was being done to ensure that the consultation was as inclusive and as accessible as possible. Healthwatch were playing a key part in facilitating this and surveys were being distributed through VCSOs, food banks and refugee centres. The Chair welcomed the scoping and review exercise for the strategy and agreed that the end date of the work would have to be movable in the current circumstances.

Gerry Taylor was pleased to see the level of engagement which had been undertaken and queried if a needs assessment had already been undertaken. More widely, Gerry referred to the Prevention Concordat for Better Mental Health for All which had recently been updated and suggested that this might be something which the Health and Wellbeing Board could endorse. An action plan would be required relating to the programme framework and the partnership alignment and multi-agency approach would fit in with what was being described as part of the work to improve mental health in the city.

Councillor Farthing commented that the prescribing of anti-depressants was quite shocking and that people often did not link the medication to mental health. She asked what was being done to reduce the usage of anti-depressants and noted that it would be interesting to see how Sunderland compared to its statistical neighbours in this regard.

Dr Pattison stated that patients experienced depressive states for various reasons and he was concerned that Covid would worsen this. In relation to anti-depressant usage, efforts had been made to reduce this but demand outstripped efforts. There were wider determinants which were not all within the health practitioner's remit and he felt that the strategy was well-timed.

Dr Weatherhead agreed with Dr Pattison and highlighted that another factor was the ability to access other therapies and it could be assumed that the high levels of prescribing were an over-medicalisation of the issue. General practitioners were attempting to reduce the reliance on medication and the Mental Health Strategy would be crucial to this.

The Chair asked if the Board were happy to support the Prevention Concordat and it was therefore RESOLVED that: -

(i) the update on the emerging mental health strategy be noted; and

(ii) the Board agree to sign up to the Prevention Concordat for Better Mental Health for All.

HW36. Update on the Path to Excellence

Dr Shaz Wahid, Executive Medical Director of South Tyneside and Sunderland Foundation Trust and Chair of the Clinical Service Review Group submitted a report updating the Board on the status of the Path to Excellence Programme, the learning from Covid-19 and the impact on the Programme.

The Path to Excellence was one of the three pillars of transformation for the local health economy focusing on in hospital transformation, alongside system wide work on Out of Hospital care and on Prevention. The programme aimed to create outstanding future services and the first phase had considered stroke care, maternity and gynaecology services and acute paediatrics.

Changes to Stroke pathways were made in December 2016, centralising all acute in-patient stroke care at Sunderland Royal Hospital in a dedicated stroke unit. This change had resulted in significant improvements and acute stroke services were now rated at level A, the highest level available. Previously services in South Tyneside had been rated at level E and Sunderland level D.

The implementation of changes to Obstetric and Gynaecology services had taken place in August 2019 with the opening of a new midwife-led birthing centre at South Tyneside and the centralisation of consultant-led birth and in-patient gynaecology at Sunderland.

The midwife-led birthing centre had seen 220 births in its first year which compared well with other similar units and this number was expected to grow. The transfer rate from the centre to hospital was low; all appropriate measures were put in place and the average transfer time was 15 minutes with no adverse effects for mothers or babies.

The new model of emergency paediatric care had also come into operation in August 2019; the Special Care Baby Unit had closed at South Tyneside and staff transferred to the neonatal unit at Sunderland and the Paediatric Emergency Department had been closed between the hours of 10pm to 8am.

There had been a robust communication plan around the overnight closure of children’s emergency services and there had been very few incidents of patients presenting when the service was closed. There had been no quality issues reported and the second phase of the model would now move forward with the intention to implement a nurse-led urgent care centre for children at South Tyneside District Hospital in August 2021.

The Path to Excellence programme had been paused in April 2020 in response to the Covid-19 pandemic and plans to reset the programme had commenced in October 2020. The second phase would consider how people were looked after in an emergency or who had an urgent healthcare need in Medical and Surgical specialities. Timelines for phase two would be clearer in the new year and stakeholder and public consultation would be re-designed to adhere to the Covid safety requirements.

Having thanked Dr Wahid for his presentation, the Board RESOLVED that the update on the Path to Excellence Phase 1 and Phase 2 be noted.

HW37. Health Protection Assurance 2020

The Executive Director of Public Health and Integrated Commissioning submitted a report providing a summary of health protection arrangements and relevant activity across the city of Sunderland during 2020.

Kath Bailey was in attendance to talk to the report and advised that although 2020 had not been a typical year, there had been more focus on health protection than ever. Some routine health protection programmes had been paused or subject to delays due to the pandemic and capacity had been diverted away from other work towards responding to the pandemic.

Responsibilities for health protection were distributed across the health system, however the local authority's public health team was now managing a large number of the programmes.

In recent months it had been announced that Public Health England would be abolished and replaced by a National Institute for Health Protection which would bring together health protection functions with a single agency responsible for protecting people from external threats to the country's health. All Public Health England staff were expected to transition to new arrangements by 1 October 2021.

The major issues in Health Protection were vaccination and immunisation schemes. cancer screening programmes, non-cancer screening, surveillance and control.

It was likely to be some time before the full impact of Covid-19 on health protection activities was understood but where there had been interruptions to services, these had been from an initially strong position and plans had been put in place to return to business as quickly as possible. The Executive Director of Public Health and Integrated Commissioning was satisfied that the Health Protection Assurance arrangements in Sunderland were adequate to deal with various aspects of health protection. She would keep the arrangements under review and would seek to make improvements as and when was necessary.

RESOLVED that: -

(i) the information provided be noted;

(ii) it be noted that the Executive Director of Public Health and Integrated Commissioning was satisfied that the Health Protection Assurance arrangements in Sunderland were adequate to deal with various aspects of health protection; and

(iii) it be agreed that a local Health Protection Board with a broad health protection remit be maintained once the end of the pandemic was reached.

HW38. Sunderland Safeguarding Adults Board (SSAB) Annual Report 2019-2020

The Chair of the Safeguarding Adults Board submitted the Annual Report of the Sunderland Safeguarding Adults Board. (SSAB)

The Care Act requires the Independent Chair of the Safeguarding Adults Board to give an annual account of the work of the Board and the annual report highlighted the work carried out during 2019/2020.

The work of SSAB focused on four strategic priorities: -

- 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 were underpinned by the Care Act's six principles of adult safeguarding.

RESOLVED that the content of the Safeguarding Adults Board Annual Report 2019/2020 be noted.

HW39. Sunderland Safeguarding Children Partnership (SSCP) Annual Report 2019-2020

The Independent Chair of Sunderland Safeguarding Children Partnership (SSCP) submitted the Annual Report of the SSCP.

The production of an annual report was a statutory requirement under Section 14a of the Children Act 2004 and covered a period of time when the Local Safeguarding Children Board (SSCB) ended and the Sunderland Safeguarding Children Partnership began on 5 August 2019.

The report set out the achievements of the SSCB/SSCP throughout the year including the development of multi-agency safeguarding arrangements for the SSCP and an interim structure for the operational arrangements for the SSCP; the implementation of Operation Endeavour; and influencing regional safeguarding developments.

The SSCP had identified the following areas as service priorities for the coming year: -

- Complex Adolescents
- Neglect
- Mental Health

RESOLVED that the content of the report be noted and it be accepted as assurance of the current effectiveness of the local safeguarding arrangements.

HW40. Children's Integrated Commissioning Update

The Head of Integration for Children's Commissioning submitted a report updating the Board on the work of the Sunderland Children's Integrated Commissioning Team.

Due to time constraints, the Chief Executive of Together for Children suggested that the report be taken as read and a more detailed update be presented to a future meeting.

RESOLVED that: -

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

(ii) the Board receive six monthly update reports.

HW41. Forward Plan

The Senior Policy Manager submitted a report presenting the forward plan of business for 2020/2021.

The Chair commented that the work on the forward plan and the reports which had been received at the meeting demonstrated that everyone was operating at a very high level under difficult circumstances and deserved due recognition for their efforts.

RESOLVED that the Forward Plan be received for information.

HW42. Dates and Time of Next Meetings

The Board noted that the next meeting would take place on Friday 19 March 2021 at 12noon.

(Signed) G WALKER
In the Chair

Item No. 4b

HEALTH AND WELLBEING BOARD ACTION LOG				
Board Meeting ID	**Action**	**Responsible**	**Timescale**	**Completed/Action Taken**
25/06/20				
HW9/1.	Consider holding a closed session on the issue of Domestic Abuse	Jill Colbert Jane Hibberd	Date to be confirmed	Added to forward plan
18/09/20				
HW19/2.	Monitor the Covid-19 Health Inequalities Strategy action plan and key performance indicators through a six-monthly update report.	Jane Hibberd	March 2021	Complete – key actions from the Covid-19 Health Inequalities Strategy have been integrated into the Healthy City Plan Implementation Plan. Monitoring will take place through the Delivery Boards into the Health and Wellbeing Board, and the Healthy City Plan performance reports will include inequality measures.
11/12/20				
HW33/1.	Encourage partner organisations to participate in the Better Health at Work Award	All	March 2021	Complete - members have been approached and where possible partners have signed up to the Better Health at Work Award. If

				Better Health at Work Award is not possible then partners have joined the Sunderland Workplace Health Alliance.
HW33/2.	Promote the Healthy School Award in schools	Yusuf Meah	March 2021	Complete - Built into the Sunderland Workplace Health action plan.
HW34.	Final Approval of the Healthy City Plan.	Chair Gerry Taylor	March 2021	Agenda item - Approved Plan to be presented to the Board for information in March 2021.
HW35.	Health and Wellbeing Board to sign up to the Prevention Concordat for Better Mental Health for All	Jane Hibberd Julie Parker-Walton	January 2021	Progressing - Application has been received from Public Health England. This will be submitted in collaboration with the CCG once the Adult Mental Health Strategy is in place.

Item No. 5

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 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 Executive Director of Public Health & Integrated Commissioning 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, actions taken to combat the pandemic and planned actions both locally and in concert will colleagues across the region.

2.2 The Health Protection Board and Outbreak Control Board continue to meet, in line with the arrangements set out in the Covid-19 Control Plan.

3.0 Current Position

3.1 The progress of the Covid-19 pandemic continues to present significant challenges 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 pandemic, a presentation will be shared at the time of the meeting to ensure that it represents the most recent summary of the situation in Sunderland.

3.3 At the time of writing (10/03/2021), Sunderland has been seeing a steady decline in the number of daily cases of Covid-19 and has a 7-day rate of 83.5 cases per 100,000. This represents a significant improvement since the high levels of cases seen immediately after Christmas 2020, though the rate remains the 6th highest the North East and is higher than England as a whole.

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. 6

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 2021

HEALTHY CITY PLAN GOVERNANCE ARRANGEMENTS

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. formally share with the Board the finalised Healthy City Plan; and
ii. seek agreement on appropriate governance arrangements to ensure delivery of the Healthy City Plan.

2.0 Background

2.1 The Healthy City Plan 2020-2030 is the revised statutory Health and Wellbeing Strategy of the Health and Wellbeing Board. The Healthy City Plan was developed in partnership, with an aim to seek Board approval in June 2020. Due to the Covid-19 pandemic work was delayed, and a draft Healthy City Plan was presented to the Board in September 2020 and an update provided in December 2020.

2.2 At the December meeting the Board agreed to (1) delegate final approval of the Healthy City Plan to the Chair of the Health and Wellbeing Board in consultation with the Executive Director of Public Health and Integrated Commissioning and the Deputy Chief Officer/Chief Finance Officer of SCCG; and (2) receive the approved plan for information at the March 2021 Board meeting, along with associated governance arrangements.

3.0 Healthy City Plan documents

3.1 The finalised Healthy City Plan is presented as two documents:

a) 'Healthy City Plan 2020-2030' – this document sets out the strategic ambitions of the Board – see Annex A
b) 'Healthy City Plan: Implementation Plan' – see Annex B

3.2 The two documents that comprise the Healthy City Plan have been approved as delegated by the Board in December 2020 and are now being formally shared with the Board. [The details of the new chair will be added to the foreword once Council has agreed the new Healthy City Portfolio Holder].

3.3 The Healthy City Plan 2020-2030 document has been refreshed to:

- strengthen alignment with the six Marmot objectives and our commitment to a Marmot approach;

- be more explicit on how we will work differently i.e. our shared values and behaviours;
- emphasise the impact of Covid-19 on the social and economic factors that contribute to poor health;
- draw explicit links to the Covid-19 Health Inequalities Strategy and the role that the Vibrant and Dynamic themes of the City Plan will play in addressing the social determinants of health;
- emphasise what will be done differently to achieve our aspirations, and how everyone has a role to play in delivering the ambitions of the plan; and
- clarify the arrangements for implementation of the plan, namely the structure and responsibility for delivering the plan and how the board will have oversight of delivery, impact and outcomes.

3.4 The plan includes a high-level performance indicator dashboard that will be used to help monitor progress and understand the impact of the Covid-19 pandemic. The Board in consultation with the people of Sunderland will set ambitious targets. Further performance measures to improve the other eight workstreams of the Healthy City Plan sit behind this overarching framework. Performance data, including the detail for each priority, will be updated periodically and published on the council's website. The Board will receive progress updates via the Delivery Boards (proposed in section 4 of this report).

3.5 The implementation plan summarises nine workstreams, the Covid-19 Health Inequality actions and the Boards eight other workstreams, these being:

- Best start in life
- Smoke Free Sunderland
- Healthy weight
- Mental health and wellbeing
- Young people aged 11-19
- Addressing alcohol harms
- Healthy economy
- Ageing well

3.6 The implementation plan will remain a live plan and will continually develop to take into account emerging needs, challenges and system changes. It will be reviewed as the full impact of the Covid-19 pandemic is further understood.

4.0 Healthy City Plan – Governance Arrangements

4.1 At present each of the nine Healthy City Plan workstreams (including Covid-19 healthy inequalities) reports directly to the Board, on a rolling programme of updates. The intention is to rationalise these arrangements and put in place delivery boards to provide challenge and support outside of the formal Board meetings.

4.2 There are many different governance options, the proposal is to take a life course approach based on the Marmot objectives, establishing three delivery boards:

- Starting Well
- Living Well
- Ageing Well

Between the three delivery boards they will have strategic oversight of the six Marmot objectives and the nine Healthy City Plan workstreams (see 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 • Children and young people's mental health and wellbeing (strategic approach) • Healthy weight (strategic approach) • Covid-19 health inequalities	Existing Healthy City Plan workstreams: • Healthy Economy • Adult mental health and wellbeing • Addressing alcohol harms (strategic approach) • Smoke free Sunderland (strategic approach) • Covid-19 health inequalities	Existing Healthy City Plan workstreams: • Ageing well • 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		

4.3 The delivery boards will provide challenge and support 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 through Vibrant and Dynamic is maximising opportunities to reduce health inequalities and address the social determinants of health. The delivery boards will take a 'health in all policies' approach in the planning, implementation and evaluation of activity that contributes to health and wellbeing. The delivery boards will also provide a conduit for a range of programmes, plans and projects to be considered by the Health and Wellbeing Board, for example, the STSFT Health and Wellbeing Strategy (later on this HWB agenda) could report into the Board via one of the Delivery Boards in future.

4.4 These governance arrangements will sit alongside the wider Health and Wellbeing Board governance arrangements, including arrangements for health protection and the emerging place-based integration arrangements.

4.5 Draft Terms of Reference have been prepared for the Delivery Boards (see annex C).

4.6 It is proposed the Delivery Boards are chaired by Executive Officers, or in their absence their nominated deputy.

- Starting Well Delivery Board – chaired by the Chief Executive of Together for Children / Director of Children Services.
- Living Well Delivery Board – chaired by the Executive Director of Public Health and Integrated Commissioning.
- Ageing Well Delivery Board – chaired by the Executive Director of Neighbourhood Services.

4.7 The detail of how the delivery boards will operate and how they will prioritise and organise themselves will evolve. It is proposed an update on the development of the Delivery Boards is brought to the June 2021 meeting of the Board.

5.0 Recommendations

5.1 The Health and Wellbeing Board is recommended to:

- note the update report;
- formally receive the finalised Healthy City Plan;
- agree to the Healthy City Plan being amended to name the Health and Wellbeing Board chair in the foreword and show wider governance arrangements once the emerging place-based integration arrangements are agreed;
- agree to establish three Delivery Boards (Starting Well, Living Well and Ageing Well) to support the delivery of the Healthy City Plan;

- provide feedback outside of the meeting on the draft Terms of Reference for the Delivery Boards, including views on Board membership from across the city and Board members own organisations; and
- receive finalised Terms of Reference at the June 2021 Board meeting.

Annexes:
Annex A - Healthy City Plan 2020-2030
Annex B - Healthy City Plan – Implementation Plan (March 2021)
Annex C – Draft Terms of Reference for the Health and Wellbeing Board Delivery Boards

Sunderland City Council

Sunderland Healthy City Plan

2020 – 2030

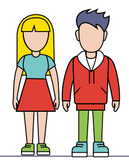
(Published March 2021)

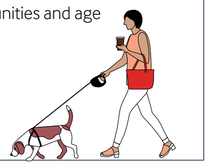
CONTENTS

OUR PLAN

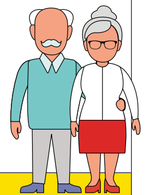
Our vision: Everyone in Sunderland will have healthy, happy lives, with no one left behind

Starting Well Laying the foundations for a healthy life from pre-conception to young adulthood	Living Well Ensuring people have the opportunity to live a healthy life	Ageing Well Ensuring people have the opportunity to live a healthy old age
Our priorities		
• 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	• 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 prevention	• Strengthen the role and impact of prevention for older people
We will have		
• High quality services for all children and families, with targeted additional support to proportionately meet different families' needs • Reduced inequalities from birth, through to reduced inequalities in school readiness and educational attainment • All young people with the knowledge and tools to make healthy choices	• Increased fairness, with reduced health inequalities across the life course through a relentless focus on the causes of the causes of poor health • Tackled barriers to good health and wellbeing and reduced the scale and impact of alcohol harms, tobacco and unhealthy weight throughout the life course • More employers supporting employee health and wellbeing, including more real living wage employers • More vulnerable people entering and sustaining employment	• Tackled barriers to good health and wellbeing for older people and reduced the scale and impact of preventable disease, injury and dependence • Overcome recruitment challenges in the health and social care sector • Age friendly communities and age friendly services





Starting Well Laying the foundations for a healthy life from pre-conception to young adulthood	Living Well Ensuring people have the opportunity to live a healthy life	Ageing Well Ensuring people have the opportunity to live a healthy old age
Key outcome measures will include		
↓ smoking at the time of delivery ↑ breastfeeding continuation ↓ school readiness gap, between children eligible for free school meals (FSM) and non-FSM ↓ childhood obesity rates ↑ young people's emotional health and wellbeing ↓ teenage pregnancy ↓ young smokers ↓ hospital admissions for alcohol specific conditions ↑ young people progressing into sustainable education, employment or training	↑ healthy life expectancy ↓ children aged under 16 in low income families ↓ households that experience fuel poverty ↓ the inequality gap narrowed, specifically for tobacco, obesity, physical activity, unhealthy nutrition and alcohol harms ↑ people aged 16-64 in employment ↓ employment gap between the population and for people with long term health conditions, those accessing secondary mental health services or have a learning disability	↓ rates of social isolation ↑ emotional health and wellbeing across the life course ↓ emergency hospital admissions due to falls ↓ mortality rate from causes considered preventable



Our shared values and behaviours

- **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

OUR PLAN

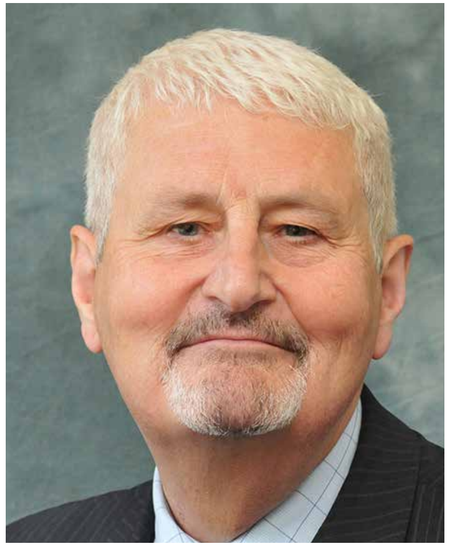
City Plan priorities contributing to a healthy place	
Vibrant Smart City	**Dynamic Smart City**
We will have	
• More resilient people • More people feeling safe in their homes and neighbourhoods • More residents participating in their communities • More people visiting Sunderland and more residents informing and participating in cultural events, programmes and activities • Cleaner and more attractive city and neighbourhoods	• A lower carbon city with greater digital connectivity for all • More and better jobs • More local people with better qualifications and skills • A stronger city centre with more businesses, housing and cultural opportunities • More and better housing • A city with great transport and travel links
Key outcome measures will include	
• More resilient and resourceful families able to respond to challenges and achieve the best possible outcomes for their children • More people enjoy independent lives • Launch a new domestic abuse services model • Households maximising their income and having improved financial wellbeing • More opportunities for volunteering and social action • Improved community wealth, including increasing connections and participation within communities and drawing on existing assets All communities feeling safe and being able to access and benefit from cleaner and more attractive city and neighbourhoods	• More employers paying the real living wage • More local people benefitting from a stronger local economy • More and better housing, to meet the current and future needs of all residents • More people walking and cycling as a means of travel • Better walking and cycling routes linking communities • Better transport links • Key housing sites delivered

ACKNOWLEDGEMENT

We pay tribute to Councillor Dr Geoff Walker who was the council's cabinet member for Healthy City and Chair of Sunderland Health and Wellbeing Board until his sudden passing in January 2021. Geoff was a true gentleman. His passion and commitment to address social injustices and improve life for the people he served always shone through.

Geoff was instrumental in driving forward the development of this Healthy City Plan, and played a key role in tackling the city's fight against Covid-19. He was determined that everyone should play their part in addressing health inequalities and that we do this by working with the communities we serve, supporting everyone to have good health.

Thank you Geoff, for the immensely positive contributions you have made to our city.



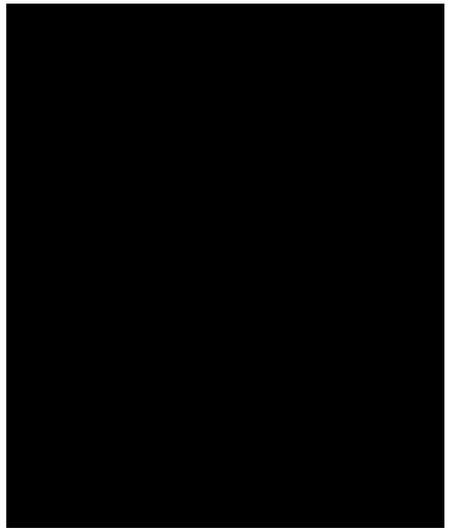
Councillor Dr Geoff Walker
Chair of Sunderland Health and Wellbeing Board
May 2019 - January 2021

FOREWORD

The Healthy City Plan is our refreshed Joint Health and Wellbeing Strategy, informed by insight and intelligence gained through our Joint Strategic Needs Assessment. It supports the delivery of the City Plan and its vision "By 2030, Sunderland will be a connected, international city with opportunities for all", addressing the interlinked challenges that exist between good health and other key issues in the city.

Although great developments are underway in the city, this Healthy City Plan was finalised during unprecedented times locally, nationally and globally. We already recognised that good health is fundamental to residents fulfilling their potential, that social inequalities result in health inequalities, and that Sunderland faces challenges in terms of economic deprivation. However, the Covid-19 pandemic crystallised the importance of these issues as it shone a spotlight on the impact of poverty and inequality on health outcomes. As this plan is agreed, the full impact of the virus and the scale of the associated economic shock is yet to be fully realised; but we know the impacts have fallen heavier on those already experiencing inequality. The importance of the response to and recovery from the pandemic cannot be overstated when working to reduce health inequalities. This Healthy City Plan is aligned with our Covid-19 Health Inequalities Strategy, which in turn recognises that our City Plan ambitions to create a dynamic, healthy and vibrant smart city will have a significant impact on the issues, or the social determinants, that influence good health.

Our approach focuses on tackling the social determinants, 'the causes of the causes' of poor health throughout the life course – starting well, living well, ageing well and addressing inequalities for key vulnerable populations. Sunderland has much to offer with great neighbourhoods, infrastructure and most importantly great people. Together, these assets can help to support good health, wellbeing and happiness but addressing health inequalities requires a whole system approach, so we must all make it part of our business.



Councillor TBC
Chair of Sunderland Health and Wellbeing Board
Sunderland City Council Cabinet Member and Healthy City Portfolio Holder

Large public sector organisations, our 'anchor organisations', are well positioned to positively influence the social determinants of good health, for example, widening access to good jobs; using their purchasing and commissioning power to improve social value; leading carbon reduction; and as local partners working with others across the city. We will be adopting a 'health in all policies' approach which will promote collaboration across the public sector, help us all to consider the health implications of the work we do and the decisions we make and ultimately, influence the social determinants of health to reduce health inequalities.

A relentless focus on 'the causes of the causes' of poor health will increase fairness and reduce health inequalities across the life course. Together we have a real opportunity to build back fairer and make a difference to the health and wellbeing of everyone in our city. In this plan we set out a case for change, where the responsibility for the health and wellbeing of our residents goes beyond the health and social care system, with all organisations in the city playing a role in preventing ill health and supporting all our residents to help themselves to be healthy. In turn, residents' engagement in the five ways to wellbeing and access to healthier lifestyles will bring mutual benefits in communities, enhanced health and happiness and a reduction of health inequalities.

We have already had some successes that provide good foundations for our health ambitions. However, we must now 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 both shone a light on and increased health inequalities. Our Board is committed to leading this change and harnessing the wealth of assets that exists across the city and within neighbourhoods to support people to have resilience and live healthy and happy lives, with no one left behind.

Vice Chair of Sunderland Health and Wellbeing Board
Executive GP and Clinical Chair Sunderland Clinical Commissioning Group

OUR VISION

Our 2030 vision for health and wellbeing in Sunderland is:

Everyone in Sunderland will have healthy, happy lives, with no one left behind

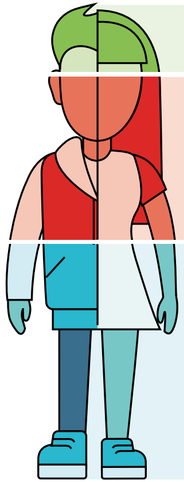
The following shared values and behaviours will guide our approach:

- **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

OUR UNDERSTANDING OF WHAT MAKES US HEALTHY AND HAPPY

Good health is determined by a complex interaction between individual characteristics, behaviours and the physical, social and economic environment. Here we explore the relationship between social determinants and health inequalities; the impact of healthy behaviours on our health; and key factors for health and happiness.

What makes us healthy and happy?



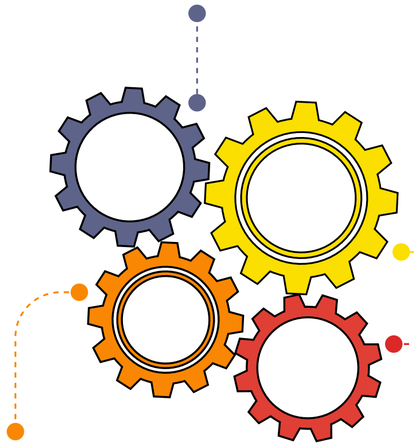
15% Health and social care	Services aimed at preventing and treating illness and help with day-to-day living due to illness or disability
40% Healthy Behaviours	What we eat and drink Whether we are physically active Whether we smoke and how much Whether we use drugs or misuse alcohol Sexual behaviour
45% Social determinants	Circumstances in which we are born Where we live and our physical environment What we got from our education Whether we are employed and what our income is Being safe and secure Having positive relationships

(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)

Social determinants and health inequalities

Social determinants have the greatest impact on our physical and mental health. These are the core elements into which we are born, how we grow up, where we live and the homes we live in, if and where we work and how much money we have to spend. Poverty and social inequalities are major drivers of poor health, with significant social inequalities remaining both between Sunderland and the rest of the country and within the city itself; we are likely to see an increase in the numbers of people experiencing social inequalities in the city in light of Covid-19.

Health inequalities are documented between population groups across at least four overlapping dimensions. Action on health inequalities requires equity - access to services dependent on need and preferences to improve the lives of those with the worst health outcomes, fastest.



Equality and diversity
e.g., age, sex, race, religion, sexual orientation, disability, pregnancy and maternity

Socio-economic/ deprivation
e.g., unemployed, low income, deprivation

Geography
e.g., urban, rural

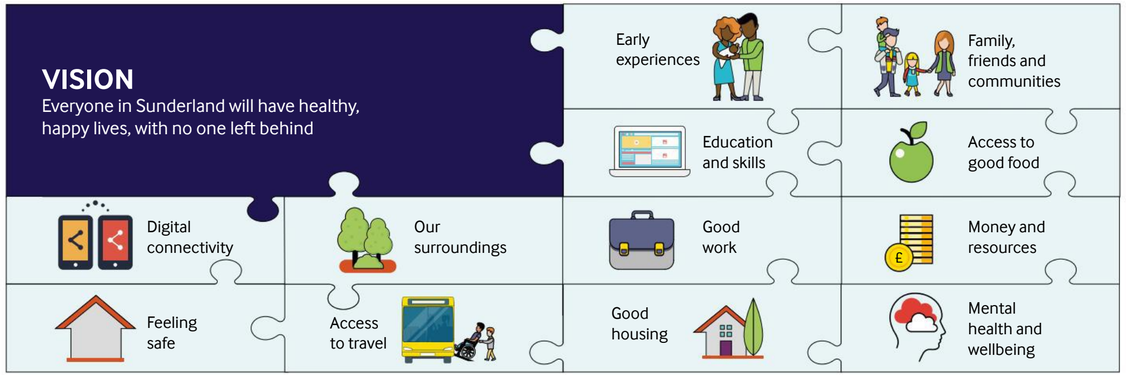
Inclusion health and vulnerable groups
e.g., homeless people, gypsy, roma and travellers, sex workers, vulnerable migrants, people leaving prison

Access to Healthy Behaviours

Our own behaviours also play a major role in how healthy we are. We can all take some responsibility for looking after our own health, such as not smoking or drinking too much alcohol, eating a healthy diet and regularly exercising. Unfortunately, because of health inequalities many people don't have the same opportunities to be as healthy as others; unhealthy behaviours are correlated with social determinants in people's lives. Poor health behaviours are often thought of as the causes of illness, poor mental health and an ageing population with more years in poor health. Although poor health behaviours do cause ill health, social determinants are often the causes of these poor health behaviours – the causes of the causes. The infographic on the following page demonstrates how a person's opportunity for health and happiness is influenced by factors outside of the health and social care system.

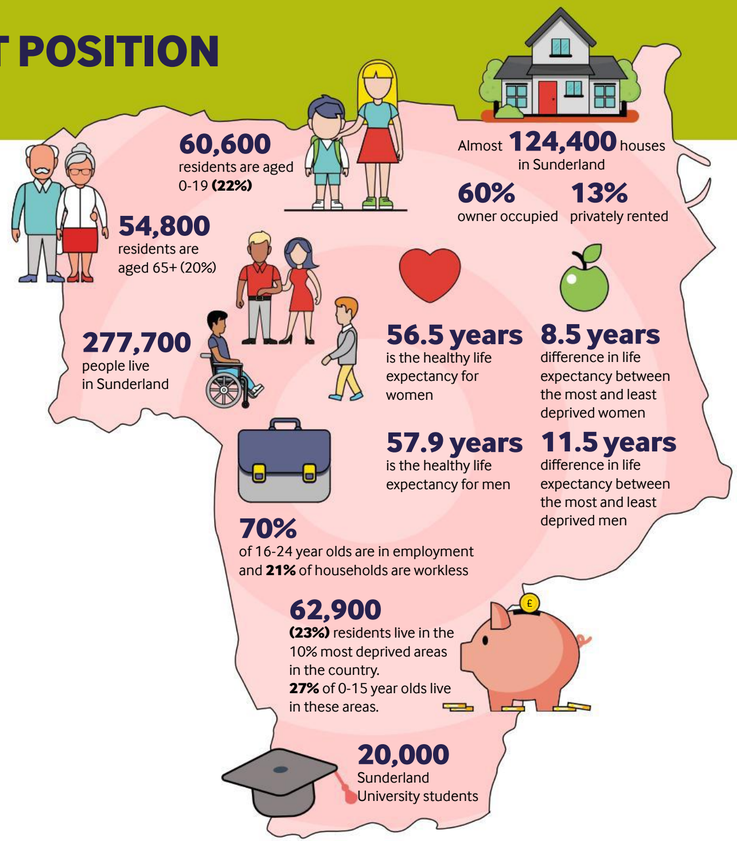
Key factors for health and happiness

In reflecting on the six Marmot objectives we consider the following factors to be key to taking a preventative approach to improving health and happiness and reducing health inequalities.



OUR CURRENT POSITION

The Sunderland population



Key health challenges in Sunderland

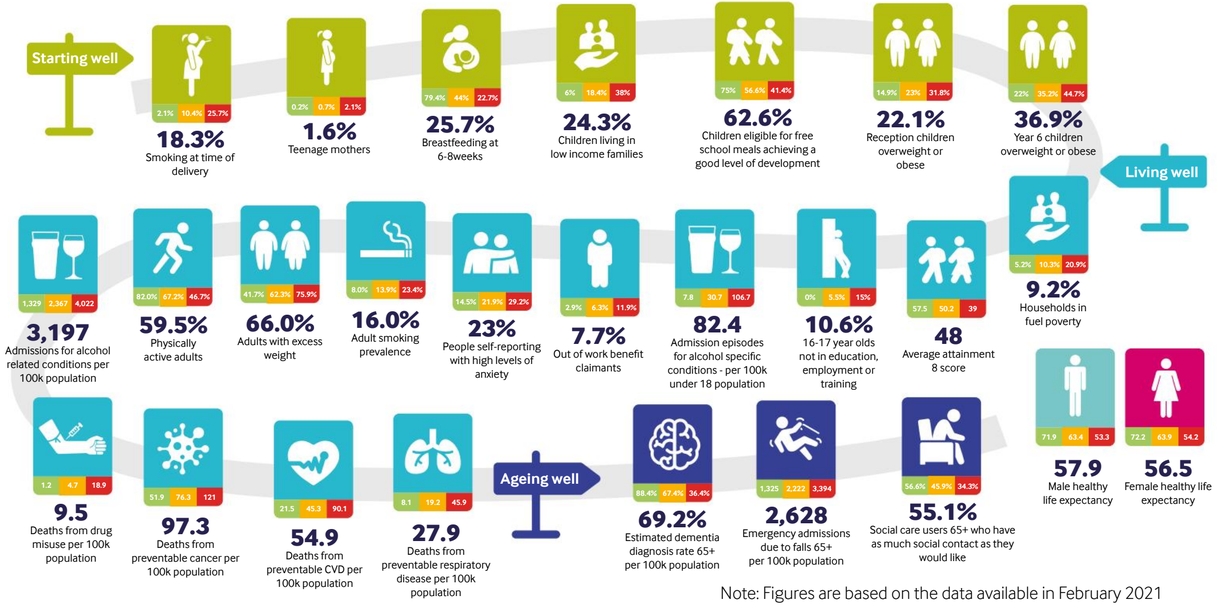
Summary points:

- Our key health challenges are informed by our Joint Strategic Needs Assessment (JSNA)
- Social determinants and poverty set a pattern of poor lifestyle behaviours that compound poor health
- We must take a preventative approach to poor health and tackle the social determinants, whilst supporting people to have positive behaviours

Our 'Walk through the key life course challenges in Sunderland' is informed by our Joint Strategic Needs Assessment. By following a life course journey of Starting Well, Living Well and Ageing Well it is easy to see where the key health challenges are for the city. Many of these health challenges are compounded by the overlapping dimensions of health inequalities, resulting in some significant variations in life chances within the city.

Sadly, the social determinants of health and poverty set a pattern of lifestyle behaviours that increase the risk of and compound ill health - and this accumulates across the life course.

Walk through the life course challenges in Sunderland

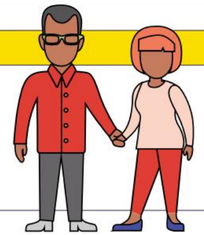


Note: Figures are based on the data available in February 2021

OUR APPROACH

Summary points:

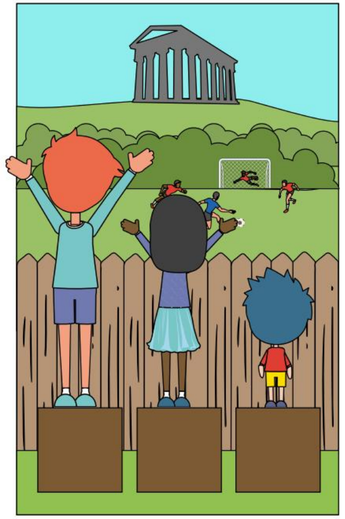
- We will adopt a life course approach to reducing health inequalities and preventing poor health
- Starting well is essential for enabling future generations to be healthy
- A whole system approach to understanding health inequalities and their causes is needed
- Our City Plan will have the greatest impact on people's lives in relation to social determinants of health
- Encouraging activity that builds on our assets and supports resilience and mental wellbeing is important
- We will build on the city's assets – our people, our neighbourhoods, our infrastructure



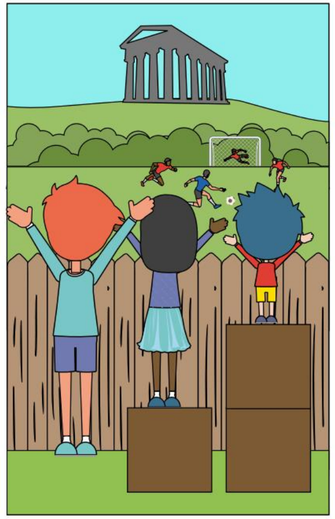
We believe the most effective way to achieve our ambitions is to focus on a life course approach, recognising people of all ages can be affected by poor health and wellbeing and the social determinants of health. In adopting a life course approach we have applied the six policy objectives set out in the 'Marmot Review: Fair Society, Healthy Lives' (2010) and subsequent 'Health Equity in England: the Marmot Review' (2020) and 'Build back Fairer: The Covid-19 Marmot Review' (2020), as a framework to help deliver our vision where Everyone in Sunderland will have healthy, happy lives, with no one left behind. The six Marmot objectives are:

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

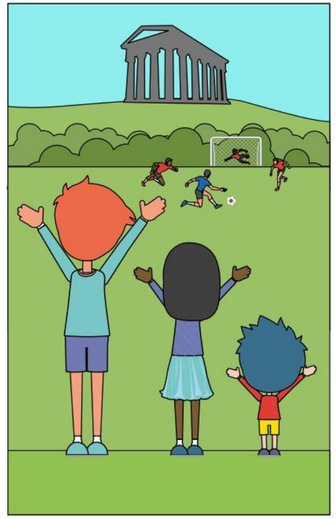
We strive to be a 'Marmot City' and are fully committed to these six policy objectives. We are determined to address inequalities; we know this will be challenging because of the complexity of peoples' lives, but this is something we should aspire to. To achieve our ambition we need everyone to play their part. Real success will come from us working together with our communities to build on all our assets and maximise what we already have in place. We will encourage equitable place-based approaches that are directed and influenced by peoples' needs. This is different to equality of treatment, where everyone receives the same support.



Equality
everyone has received the same support



Equity
the support has been tailored to need



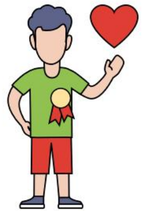
Inequality addressed
systemic barriers removed

OUR APPROACH

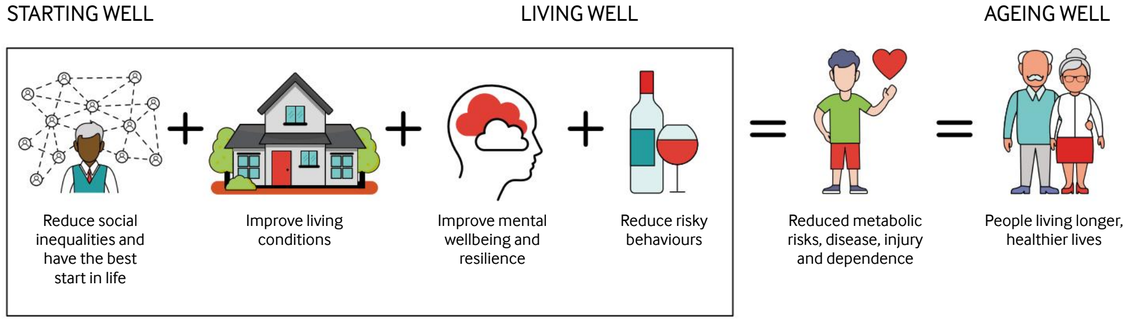
Inequalities and Prevention Framework

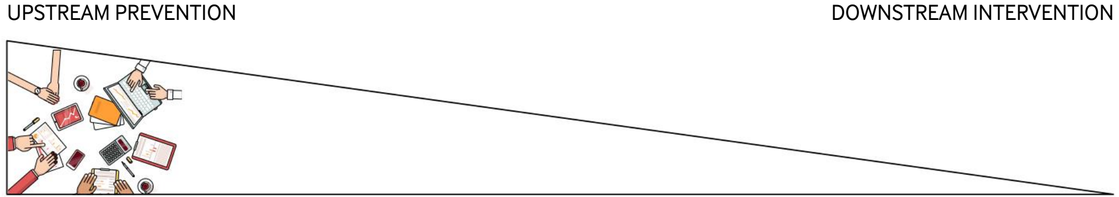
Action to reduce health inequalities must start before birth and be followed through the life of the child, ensuring equity in access to services dependent on need and preferences. Only by reducing early disadvantage can we create a fairer city and improve outcomes throughout life. Starting well begins in the family context, so we also recognise the importance of improving the lives and health of people who are already working age and beyond. More than ever before we need services and activities that promote the health, wellbeing and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care. Such approaches will make a significant contribution to ameliorating health inequalities.

Our framework opposite sets out our approach for reducing health inequalities and preventing poor health. It demonstrates our desire to have a much greater focus on understanding particular inequalities for different groups of people, and putting protective measures in place early in the life course to address inequalities to help people maintain or improve their health before it is compromised. This will take a whole system approach to better understand health inequalities, their causes and identify collective action. This contrasts with the traditional role of the health and social care system which focuses on treatment of poor health once it has already materialised. A preventative life course approach involves addressing the social determinants of health but can also include promoting positive behavioural choices and encouraging activity that supports resilience and mental wellbeing. Often multiple actions are needed to address any single issue.



Framework for reducing health inequalities and preventing poor health



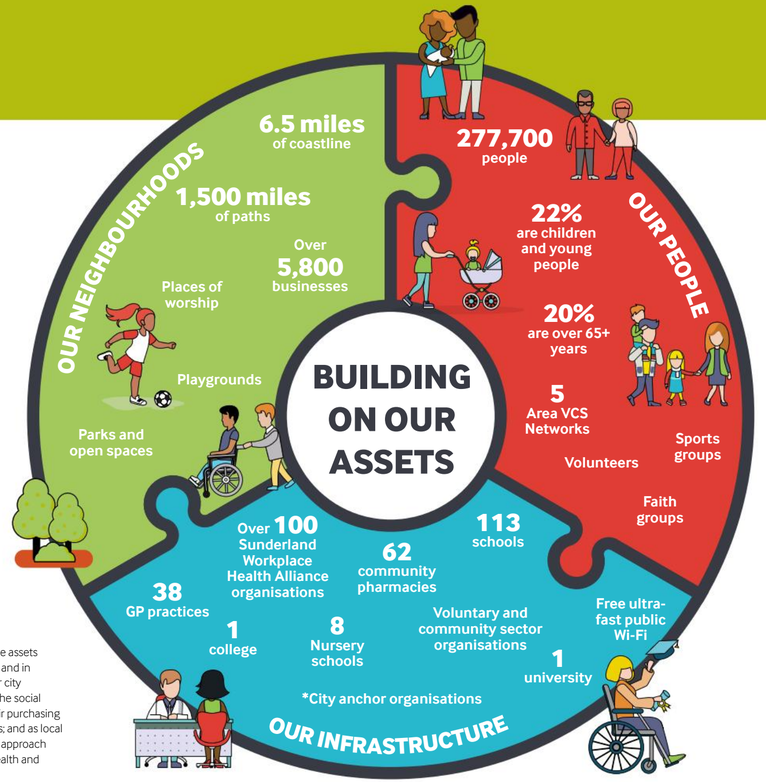


Anchor organisations taking action upstream to address the causes of health inequalities

Building on our assets to support improvement

We have many assets in Sunderland that can support and protect health, some of these are set out here.

All these assets can contribute to positive health, but it is our people that are our greatest asset, holding a wealth of skills, knowledge and passion to bring about positive change within their communities. The importance of colleagues, friends, neighbours and communities supporting one another cannot be underestimated in the pursuit of a healthy city.



*Anchor organisations refers to large, public sector organisations with sizeable assets that could be used to support community wealth building and development, and in doing so, advance the welfare of local people. The size, scale and reach of our city anchor organisations means they are well positioned to positively influence the social determinants of health, for example, widening access to good jobs; using their purchasing and commissioning power to improve social value; leading carbon reductions; and as local partners working with others across the city. Through a "health in all policies" approach we can help different sectors of different organisations to understand that health and inequalities is everyone's business.

OUR GOVERNANCE

Our work is set in the context of our City Plan with its ambitions to create a Dynamic, Healthy and Vibrant Smart City. We recognise that the interaction between these three themes will have a great impact on people's lives in relation to the social determinants of health. The partnership City Board has reviewed the City Plan to ensure it is responding to the impacts of the pandemic, in both the short and long term. We recognise that all the City Plan themes have an inextricable link to the Healthy City Plan vision.

The Health and Wellbeing Board will have strategic oversight of the Healthy City Plan, and will provide assurance to the City Board on progress being made to deliver the Healthy City Plan.

Three delivery boards will be established to oversee the delivery of the Healthy City Plan: starting, living and ageing well. Between the three delivery boards they will have oversight of the six Marmot objectives and Healthy City Plan workstreams, of which there are currently eight. The delivery boards will provide challenge and support to reducing health inequalities and addressing the social determinants of health.

All of our City Plan ambitions will contribute to a Healthy City. By 2030 we will have:

Reduced health inequalities enabling more people to live healthier longer lives

A stronger city centre with more businesses, housing and cultural opportunities

Cleaner and more attractive city and neighbourhoods

A Dynamic Smart City

More and better jobs

More residents informing and participating in cultural events, programmes and activities

Cleaner and more attractive city and neighbourhoods

A lower carbon city with greater digital connectivity for all

A Vibrant Smart City

More residents participating in their communities

More resilient people

A city with great transport and travel links

A Healthy Smart City

People enjoying independent lives

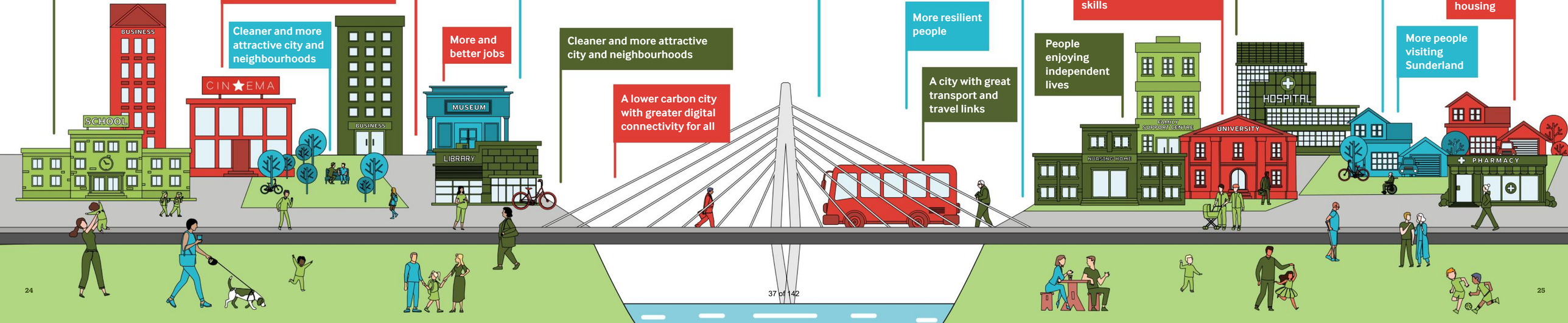
More local people with better qualifications and skills

Access to equitable opportunities and life chances

More people feeling safe in their homes and neighbourhoods

More and better housing

More people visiting Sunderland



OUR GOVERNANCE

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 through the Vibrant Smart City and Dynamic Smart City elements of the City Plan are maximising opportunities to reduce health inequalities and address the social determinants of health. There will be a relationship from such activity into the delivery boards, allowing a two-way relationship . The delivery boards will take a 'health in all policies' approach in the planning, implementation and evaluation of activity that contributes to health and wellbeing. The three delivery boards will also have oversight of the appropriate elements of the Sunderland Covid-19 Health Inequalities Strategy. The boards will ensure we take every opportunity to mitigate the impact that Covid-19 has had on our communities.

These governance arrangements will sit alongside the wider Health and Wellbeing Board governance arrangements, namely the Health Protection Board and emerging place-based integration arrangements.

Health and Wellbeing Board

Starting Well Delivery Board

Living Well Delivery Board

Ageing Well Delivery Board

Healthy City Plan workstreams:

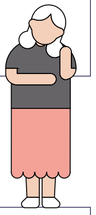
- Best start in life
- Young people aged 11-19
- Children and young peoples mental health and wellbeing (strategic approach)
- Healthy weight (strategic approach)
- Covid-19 health inequalities

Healthy City Plan workstreams:

- Healthy Economy
- Adult mental health and wellbeing
- Addressing alcohol harms (strategic approach)
- Smoke free Sunderland (strategic approach)
- Covid-19 health inequalities

Healthy City Plan workstreams:

- Ageing well
- Covid-19 health inequalities



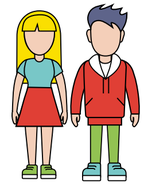
Reporting relationship with the Vibrant Smart City and Dynamic Smart City elements of the City Plan

OUR PERFORMANCE FRAMEWORK

The following performance indicator dashboard with up-to-date figures at February 2021, will be used to help the Health and Wellbeing Board and its delivery boards monitor progress and understand the impact of the Covid-19 pandemic on health. The Health and Wellbeing Board in consultation with the people of Sunderland will set ambitious targets. Further performance measures to improve the workstreams of the Healthy City Plan sit behind this overarching framework. Performance data, including the detail for each priority, will be updated periodically and published on the council's website.

PERFORMANCE INDICATOR DASHBOARD				
INDICATOR	**PERIOD**	**SUNDERLAND**	**REGION**	**ENGLAND**
Male healthy life expectancy at birth	2016-18	57.9	59.4	63.4
Female healthy life expectancy at birth	2016-18	56.5	59.7	63.9
Male life expectancy at birth	2017-19	77.0	78.0	79.8
Female life expectancy at birth	2017-19	81.4	81.8	83.4
Inequality in life expectancy at birth (male)	2017-19	11.0	12.2	9.4
Inequality in life expectancy at birth (female)	2017-19	8.7	9.7	7.6
STARTING WELL				
Smoking status of mothers at time of delivery	2019/20	18.3%	15.2%	10.4%
Breastfeeding continuation - prevalence at 6-8 weeks after giving birth (current method)	2019/20	25.7%	34.4%	44.0%
Children eligible for free school meals achieving a good level of development at the end of Reception	2018/19	62.6%	57.7%	56.5%
Proportion of children aged 4-5 years (end of Reception) classified as overweight or obese	2019/20	22.1%	24.8%	23.0%

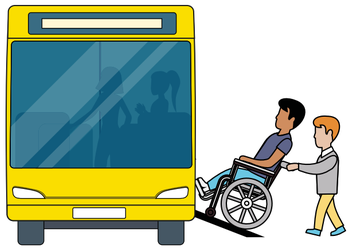
INDICATOR	**PERIOD**	**SUNDERLAND**	**REGION**	**ENGLAND**
STARTING WELL				
Year 6 prevalence of overweight (including obesity)	2019/20	36.9%	37.5%	35.2%
Hospital admissions for alcohol specific conditions in under 18s (per 100k population)	17/18-19/20	82.4	55.4	30.7
Proportion of children in low income families aged under 16	2018/19	24.0%	23.8%	18.4%
Teenage pregnancy (under 18 conception rate) per 1,000 of the under 18 population	2018	29.0	24.9	16.7
Hospital admissions for mental health conditions in under 18 year olds (per 100k population)	2018/19	183.3	105.7	88.3
% of school pupils with social, emotional and mental health needs (School age)	2018	3.08%	2.77%	2.39%
Proportion of 16/17 year olds not in education, employment or training (NEET)	2019	10.6%	5.9%	5.5%



OUR PERFORMANCE FRAMEWORK

INDICATOR	PERIOD	SUNDERLAND	REGION	ENGLAND
LIVING WELL				
Proportion of the population aged 16-64 qualified to at least NVQ Level 4 or higher	2019	27.4%	31.9%	33.0%
Admission episodes for alcohol-related conditions (Broad measure) per 100k population	2018/19	3197	2927	2367
Prevalence of smoking among persons aged 18 and over	2019	16.0%	15.3%	13.9%
Smoking prevalence in routine and manual workers	2019	25.7%	24.3%	23.2%
Percentage of adults aged 18 and over classified as overweight or obese	2018/19	66.0%	64.9%	62.3%
Proportion of people aged 16 and over with a high anxiety score according to a self-reported wellbeing indicator	2019/20	23.0%	23.6%	21.9%
Percentage of people aged 16-64 in employment	2019/20	70.3%	71.1%	76.2%
Percentage of out of work benefit claimants (% is number of claimants as a proportion of resident population of area aged 16-64)	Dec-20	7.7%	7.1%	6.3%

INDICATOR	PERIOD	SUNDERLAND	REGION	ENGLAND
LIVING WELL				
Gap in employment between those with a long-term health condition and the overall employment rate	2019/20	15.3%	14.2%	10.6%
Gap in employment between those in secondary mental health services and the overall employment rate	2019/20	61.2%	61.1%	67.2%
Gap in employment between those with a learning disability and the overall employment rate	2019/20	66.7%	66.0%	70.6%
Percentage of households that experience fuel poverty	2018	9.2%	9.5%	10.3%



OUR PERFORMANCE FRAMEWORK

INDICATOR	PERIOD	SUNDERLAND	REGION	ENGLAND
AGEING WELL				
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2019/20	55.1	49.9	45.9
Emergency hospital admissions due to falls in people aged 65 and over	2019/20	2628	2412	2222
Mortality rate from causes considered preventable per 100k population	2016-18	232.6	223.9	180.8
Hip fractures in people aged 65 and over per 100k	2019/20	664	635	572
Estimated dementia diagnosis rate (aged 65 and over)	2020	69.2%	73.3%	67.4%
Excess winter deaths index (age 85+)	Aug 18 - Jul 19	16.3%	16.7%	18.2%

Sunderland City Council

Sunderland Healthy City Implementation Plan

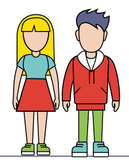
2020 – 2030

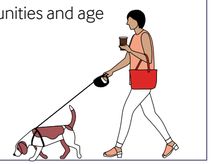
(Published – March 2021. To be reviewed as the full impact of the Covid-19 pandemic is further understood)

OUR PLAN

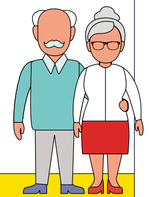
Our vision: Everyone in Sunderland will have healthy, happy lives, with no one left behind

Starting Well Laying the foundations for a healthy life from pre-conception to young adulthood	Living Well Ensuring people have the opportunity to live a healthy life	Ageing Well Ensuring people have the opportunity to live a healthy old age
Our priorities		
• 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	• 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 prevention	• Strengthen the role and impact of prevention for older people
We will have		
• High quality services for all children and families, with targeted additional support to proportionately meet different families' needs • Reduced inequalities from birth, through to reduced inequalities in school readiness and educational attainment • All young people with the knowledge and tools to make healthy choices	• Increased fairness, with reduced health inequalities across the life course through a relentless focus on the causes of the causes of poor health • Tackled barriers to good health and wellbeing and reduced the scale and impact of alcohol harms, tobacco and unhealthy weight throughout the life course • More employers supporting employee health and wellbeing, including more real living wage employers • More vulnerable people entering and sustaining employment	• Tackled barriers to good health and wellbeing for older people and reduced the scale and impact of preventable disease, injury and dependence • Overcome recruitment challenges in the health and social care sector • Age friendly communities and age friendly services





Starting Well Laying the foundations for a healthy life from pre-conception to young adulthood	Living Well Ensuring people have the opportunity to live a healthy life	Ageing Well Ensuring people have the opportunity to live a healthy old age
Key outcome measures will include		
↓ smoking at the time of delivery ↑ breastfeeding continuation ↓ school readiness gap, between children eligible for free school meals (FSM) and non-FSM ↓ childhood obesity rates ↑ young peoples' emotional health and wellbeing ↓ teenage pregnancy ↓ young smokers ↓ hospital admissions for alcohol specific conditions ↑ young people progressing into sustainable education, employment or training	↑ healthy life expectancy ↓ children aged under 16 in low income families ↓ households that experience fuel poverty ↓ the inequality gap narrowed, specifically for tobacco, obesity, physical activity, unhealthy nutrition and alcohol harms ↑ people aged 16-64 in employment ↓ employment gap between the population and for people with long term health conditions, those accessing secondary mental health services or have a learning disability	↓ rates of social isolation ↑ emotional health and wellbeing across the life course ↓ emergency hospital admissions due to falls ↓ mortality rate from causes considered preventable



Our shared values and behaviours

- **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** – ensure 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

INTRODUCTION

This implementation plan supports the delivery of our Healthy City Plan and our Covid-19 Health Inequalities Strategy. The implementation plan will remain a live plan and will continually develop to take into account emerging needs, challenges and system changes.

Key influences in the refresh of this implementation plan will include clarity on the full impact and pressures of Covid-19, an increased focus on health equalities as we further develop our insights and forge stronger relationships with our communities, as well as organisational changes within the NHS and integrating commissioning between the NHS and council.

In delivering the ambitions set out in the Healthy City Plan and Covid-19 Health Inequalities Strategy, we present nine workstreams within this implementation plan:


Covid-19 health inequalities


Best start in life


Young people aged 11-19


Smoke free Sunderland


Addressing alcohol harms


Healthy weight


Healthy economy


Mental health and wellbeing


Ageing well

Some of the workstreams focus on healthy lifestyles (smoking, alcohol and healthy weight), whilst others are considered fundamental to achieving good health (addressing Covid-19 health inequalities, mental health and wellbeing, best start in life, young people 11-19 and ageing well). Healthy Economy supports employers' role in improving employee health and seeks to address challenges associated with the health of those seeking work, as well as recruitment challenges in the health and social care sector.

Our Covid-19 health inequalities workstream is Sunderland's response to addressing the health inequalities amplified during the pandemic. Other workstreams have been established because our Joint Strategic Needs Assessment identifies that these are all key issues for the city, for example:

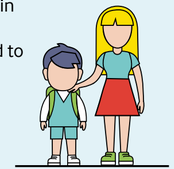
- Our breastfeeding rate is amongst the lowest in the country, while smoking at the time of delivery is amongst the highest
- Teenage pregnancies are significantly higher in Sunderland than in other areas
- Premature death in Sunderland as a result of smoking and alcohol harms is amongst the highest in the country
- Excess weight, obesity and inactivity greatly affects some of our poorest communities

For each workstream we set out why the area of focus is important, key areas for improvement and some key activity to demonstrate what will be different. All the data is the most recent data at the time of publication.

COVID-19 HEALTH INEQUALITIES

21%
households living in low-income, compared to **14.6% nationally.**

23.6% children in low-income families (under 16s), compared to **17.0% nationally.**

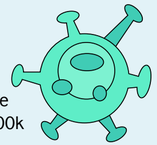


82.4
admission episodes for alcohol specific conditions per 100k under 18 year olds, compared to **31.6 nationally.**

7.7%
of working age population claiming out of work benefits, compared to **1.9% nationally.**

71.2
hospital admissions for violence (including sexual violence) per 100k population, compared to **45.8 nationally.**

27.9
deaths from a preventable respiratory disease per 100k population, compared to **19.2 nationally.**



574
admissions to residential/ nursing care homes per 100k population aged 65+, compared to **580 nationally.**

24.7%
older people in deprivation, compared to **16.2% nationally.**

Why is this important?

Tackling health inequalities requires system wide collaboration and actions to address the underlying root causes which impact on ill health. Strengthening integrated partnership working with local government, NHS and the voluntary and community sector is a key component of making an impact at population level as demonstrated in the Public Health England document, 'Reducing health inequalities: system, scale and sustainability' (2017).

As highlighted by 'Health Equity in England: The Marmot review 10 years on' report, health is affected by the environment and community in which we live. Some of the key messages from the report include:

- Life expectancy follows the social gradient
- Place matters (essentially the place where you live) – the more deprived the area the shorter the life expectancy
- Living in a deprived area of the North East is worse for your health than living in a similarly deprived area of London, to the extent that life expectancy is nearly five years less
- Improvements in life expectancy have stalled for the first time in over 100 years, and actually declined for the poorest 10% of women

These inequalities have been further exacerbated by the Covid-19 pandemic. The Covid-19 Health Inequalities Strategy sets out Sunderland's response to Covid-19 and its eight priorities frame the key areas for improvement.

Key areas for improvement	What will be different?
Maximise the use of data, intelligence and evidence to systematically understand the impact and consequences of Covid19 on health inequalities.	• The approach to JSNA will be reviewed and as a result: maximises co-production, uses innovative ways to understand local need, creates a more user friendly JSNA that is effectively communicated and crucially, informs activity that brings about change in people's lives. • The development of locality profiles will increase understanding of neighbourhood health inequalities and inform local transformation plans and local partner delivery. • There will be improved understanding of our most at risk communities enabling effective partnership improvement planning to meet local needs. • Further research into the ICS population health management findings will inform our understanding of why the four Sunderland priority wards have varying health outcomes. A range of asset-based interventions will be piloted and evaluated.

Key areas for improvement	What will be different?
To integrate health inequalities into a range of council and partners plans and services by systematically considering a Health in All Policies (HiAP) approach.	• Health inequalities will be embedded into the social values framework of commissioned services. • A HiAP and Health Impact Assessment training programme will be rolled out within the council and offered to partners to support health considerations being embedded into policy making.
To strengthen a place-based approach to improving the health of the most of the most disadvantaged communities.	• Behavioural insights research will improve partners understanding of the high-risk vulnerable groups identified in the Covid 19 inequalities evidence base. • There will be a food partnership approach to reducing food poverty. • There will be increased access and support to benefits advice for our most disadvantaged communities.
To build on community assets to support good health and independence, recognising individual and community strengths that can be built upon.	• There will be an expanded and sustained programmes of Covid Champions, Community Champions and Health Champions enabling a focus on neighbourhoods and communities in greatest need. • Voluntary and community sector organisations will be supported to deliver preventative interventions which contribute to improved health outcomes and self-management. • Sunderland anchor organisations will be supported to adopt a Healthy Settings Approach.

BEST START IN LIFE

62.6%
of children eligible for free school meals achieved a good level of development at the end of Reception, 12 percentage points behind those not eligible. **Nationally the gap is 17 percentage points.**

25.7%
of babies are breastfed at 6-8 weeks, compared to **44% nationally.**

18.3%
of women smoke at the time of delivery, compared to **10.4% nationally.**

97.6%
of 2 year olds received the MMR vaccination, compared to **90.6% nationally.**

22.1%
of children in Reception are overweight, compared to **23% nationally.**

29
per 1,000 women under the age of 18 become pregnant, compared to **16.7 nationally.**

203.1
per 10,000 0-4 year olds are admitted to hospital due to injury, compared to **117 nationally.**

32.5%
of five year olds experience obvious dental decay, compared to **23.4% nationally.**

Why is this important?

There are still many children who start school who are unable to make the most of their years at school and as a consequence are more likely to be unemployed, low paid, experience adverse experiences and have worse health. This cycle of disadvantage is largely linked to financial poverty, while during pregnancy and the first two years of life, the mother and child will have increased risks of health problems from smoking, alcohol, poor diet and nutrition.

This has a lasting impact on the health, wellbeing and attainment of a child. Childhood poverty is increasingly a problem for families who are in low paid work and these families are least resistant to a fall in income or a rise in living costs, even by a small margin. Given the economic impact of Covid-19 on low income families, it has become more important to give children the best start in life to ensure they are more likely to be happy, secure, healthy and experience positive outcomes in later life. We know that for those who start from a position of disadvantage compared to their peers, the inequality gaps widen throughout their lives. We need to make sure that prevention and health improvement are recognised as being essential to giving every child the best start in life.

Key areas for improvement	What will be different?
Smoking at time of delivery (SATOD) Smoking during pregnancy increases the risk of health problems for developing babies, including preterm birth, low birth weight and a number of birth defects. Smoking during and after pregnancy also increases the risk of sudden infant death syndrome. In Sunderland 18% of pregnant women smoke at the time they give birth compared to 10% nationally, and there are significant differences in areas of deprivation within the city where rates are considerably higher.	• All pregnant women who smoke will be offered specialist stop smoking support to overcome their addiction to nicotine (opt-out referral process), both during and after the birth of their child. • A Smoke-free pregnancy app will be in place, promoted by maternity services and stop smoking services. It will be targeted at those women and their partners who smoke and either opt out of referral at booking or who do not engage with stop smoking services following referral. • The regional Local Maternity Systems Tobacco Dependency Pathway will be embedded in local practice.

BEST START IN LIFE

Key areas for improvement	What will be different?
Breastfeeding continuation Breastfeeding has many benefits for both mother and baby. Breastfeeding contains immunity-boosting antibodies that reduces the risk of babies developing allergies, eczema, digestive conditions, viruses and infections and can help prevent obesity later in life. It also promotes positive attachment. In Sunderland, just over a quarter of babies are breastfed at 6-8 weeks compared to almost half nationally.	• Key agencies will achieve UNICEF Baby Friendly accreditation, with Maternity Services and Health Visiting Services reaching level 2 as a minimum. • A regional infant feeding touchpoint pathway will be implemented. • Findings and recommendations from the city's Infant Feeding research project regarding the barriers to breastfeeding for women in Sunderland, will be used to enhance support services and promote the benefits of breastfeeding. • Behavioural insights work will be undertaken with a focus on increasing breastfeeding rates through the use of digital support.

Key areas for improvement	What will be different?
Narrowing the school readiness gap between children eligible for Free School Meals (FSM) and those not eligible for FSM. One of the key inequalities that children and young people face is in education. It is well known that children from low income backgrounds tend to do less well than their more affluent peers. It is important therefore to address this issue. Sunderland continues to perform well with 72.6% of children achieving a Good Level of Development (GLD) at the end of Reception, currently above the England average of 71.8%. Around two-thirds of children eligible for free school meals achieved GLD compared to three-quarters of non-free school meals children. This is significantly higher than the national rate of 56.5% and the achievement gap in the city has reduced to just 12 percentage points. Nevertheless, there are significant inequalities in some areas of the city where the achievement gap is significantly higher than the average gap for the city.	• An effective integrated developmental review process at 2 years old will be established by Health Visitors and Early Years settings. • There will be increased take-up of early education places for disadvantaged two-year olds

YOUNG PEOPLE AGED 11-19

29
per 1,000 women under the age of 18 become pregnant, compared to **16.7 nationally.**

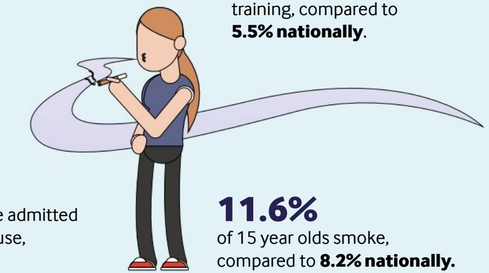
1,791
per 100,000 15-24 year olds were newly diagnosed with Chlamydia, compared to **2,043 nationally.**

183.3
per 100,000 under 18s were admitted to hospital for mental health conditions, compared to **88.3 nationally.**

93.8%
of 12-13 year olds received the HPV vaccine, compared to **88% nationally.**

82.4%
per 100,000 under 18's were admitted to hospital for alcohol specific conditions, compared to **30.7 nationally.**

10.6%
of 16-17 year olds are not in education, employment or training, compared to **5.5% nationally**.



329.3
per 100k 10-14 year olds were admitted to hospital due to self-harm, compared to **226.3 nationally.**

100.4
per 100,000 15-24 year olds were admitted to hospital due to substance misuse, compared to **83.1 nationally.**

11.6%
of 15 year olds smoke, compared to **8.2% nationally.**

834.6
per 100,000 15-19 year olds were admitted to hospital due to self-harm, compared to **659.5 nationally.**

Why is this important?

As well as providing children with the best start in life, it is important to support young people to be healthy throughout their lives, providing them with the knowledge and the tools to be able to make healthy choices. We know that as young people approach their teenage years and throughout these years, many engage in risk taking behaviour such as smoking, drinking alcohol, using illegal substances and sexual activities. Almost all behavioural factors that impact on physical and mental health later in life are established before the age of 21. It is important to take a preventative approach in these areas to help young people make good choices now so that they can take these positive behaviours through to adulthood.

We are mindful of how Covid-19 will have disproportionately impacted our most disadvantaged young people, including their mental health and wellbeing, their education through lost learning, and the impact on family and personal finances through lost earnings. As we look to 'build back better', it is vital that young people are placed at the heart of our approach. We will set out a clear offer of support for all young people, and additional provision for when more support is needed.

Key areas for improvement	What will be different?
Sexual health including teenage pregnancy Teenage pregnancy does not always lead to poor outcomes, however it is strongly associated with factors such as disadvantage in educational attainment, unemployment and engagement in unhealthy behaviours such as smoking and alcohol misuse. Teenage pregnancy is significantly more common in Sunderland than in England as a whole. There has been a good reduction in Sunderland in the under 18 conception rate from 34.6 per 1000 of the population to 25.7. However, this is still significantly higher than the national rate of 17.8, and some areas within the city experience teenage pregnancy rates higher than the Sunderland average. Sunderland has twice as many teenage mothers as the England average.	• A dedicated Relationships and Sex Education post will be established to work with schools. They will embed consistent,, evidence-based relationships and sex education. • The sexual health offer will be enhanced to include pregnancy options advice and direct access to a Young People's Contraception Nurse. • Outreach and educational services will be delivered to boys and young men aged 11-18 through one-to-one and group-based sessions. These will promote healthy relationships and an understanding of acceptable behaviours and attitudes associated with relationships and sexual health. • The teenage pregnancy pathway will be reviewed and promoted to ensure early identification and intervention of teenage conceptions. • More schools will sign up to and achieve the Relationship and Sex Education Charter Mark, as part of the Sunderland Healthy Schools Award.

YOUNG PEOPLE AGED 11-19

Key areas for improvement	What will be different?

Emotional health and wellbeing
 	
The emotional health and wellbeing of children is a leading priority when trying to improve self-efficacy and the health of our local population, reduce health inequalities, and reduce demand now and in the future for health and social care services.
 	
There are some significant challenges in Sunderland, not least that our inpatient admission rates for mental health disorders for young people are significantly higher than regional and national averages, and the access rate for treatment falls short of national expectations. Average waiting times for children and young people with significant mental health concerns to access a service, is more than double that of the South of Tyne area.
	• A Child and Adolescent Mental Health Services (CAMHS) Joint Strategic Needs Assessment will be produced to assess current and future needs and inform future commissioning.
	• A new children and young people's mental health service model will be implemented, based on the i-THRIVE needs led framework, which includes:
	  • Thriving - prevention and mental health promotion
	  • Getting advice - advice and signposting
	  • Getting help - focused goal-based input
	  • Getting more help - more extensive and specialised goal-based help
	  • Getting risk support – where children and young people have not benefitted from or are unable to use help, but are still in contact with services
	• A CAMHS Trailblazer project will be implemented from November 2021. A mental health support team will deliver the project to 8,000 children (or 20 schools) to improve mental health and wellbeing for children, young people and their families. The impact of this is expected to be a reduction in referrals for high-need mental health services.
	• More schools will sign up to and achieve the Mental Health Charter Mark and the Anti-Bullying Charter Mark, as part of the Sunderland Healthy Schools Award.
	• Professionals working with children and young people will have access to a wider range of emotional health and wellbeing training and resources to support the integration of emotional health and wellbeing into day to day practice.
	• Children, young people and their families will have improved access to information, advice and support services.

Key areas for improvement	What will be different?
Drugs and alcohol Many young people will experiment with alcohol or drugs at some point during adolescence. Using drugs or alcohol can lead young people to taking risks or engaging in behaviour they wouldn't ordinarily consider. However, for some it becomes a problem that impacts negatively on their lives. It is important that young people develop healthy opinions and attitudes towards drugs and alcohol by understanding the harms they can cause. Young people in Sunderland are more likely to drink alcohol than most other parts of the country. They perceive alcohol as a normal part of their lives. Such normalisation reduces young peoples' resilience to alcohol and evidence shows they can suffer the associated harms of alcohol misuse from any early age.	• Young person specific Drug and Alcohol training will be developed and delivered to frontline practitioners working with young people to ensure early identification of young people at risk of drug and alcohol misuse, and provide interventions at the appropriate level. • A model of implied consent will be adopted so that all young people attending A&E for drug and alcohol related conditions will be referred directly into treatment to support their recovery journey and prevent repeat admissions. • Work will be undertaken with Balance and young people to lobby alcohol companies to change their branding. • Explore ways to reduce accessibility of alcohol and proxy purchasing. • As part of the broader Alcohol-Free Childhood agenda, all schools will be encouraged to sign up to an alcohol-free school pledge, which will support a standardised approach to school-based alcohol policies.

NB Information relating to smoking prevalence in young people is presented in the section on Smoke Free Sunderland; information relating to healthy weight for children and young people is presented in Healthy Weight.

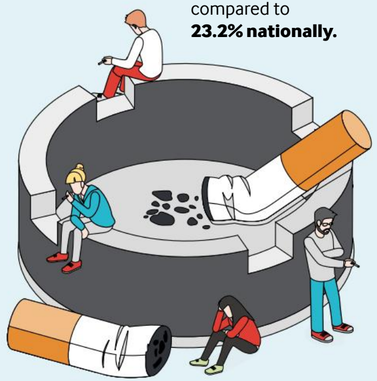
SMOKE FREE SUNDERLAND

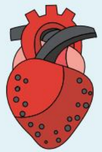
16%
of people aged 18+ smoke, compared to **13.9% nationally.**

27.9
per 100k under 75s die from preventable respiratory disease, compared to **19.2 nationally.**

25.7%
of 18-64 year olds in routine and manual occupations smoke, compared to **23.2% nationally.**

45.65%
of adults with serious mental illness smoke, compared to **40.5% nationally.**





54.9
per 100k under 75s die from preventable cardio-vascular disease, compared to **45.3 nationally.**

18.3%
of women smoke at the time of delivery, compared to **10.4% nationally.**

3036
per 100k hospital admissions can be attributed to smoking, compared to **1612 nationally.**

371.8
per 100k deaths can be attributed to smoking, compared to **250.2 nationally.**

Why is this important?

We are signed up to the ambition to reduce local smoking prevalence to 5% by 2025. This is a challenging target for the city, and one that we are committed to. 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. There are high numbers of people in the city with Cardiovascular and Respiratory Diseases considered preventable, in which smoking is strongly linked as the cause. Lung cancer registrations are also very high.

We know that in Sunderland there are a number of key groups that are more likely to smoke than others. These are young people; people from LGBT communities; those affected by substance misuse; those with long term conditions; BME groups; routine and manual workers; those with poor mental health; and people with complex needs.

Key areas for improvement	What will be different?
Adult smoking prevalence rate Considerable progress has been made over the last seven years with smoking prevalence dropping from a high of 24.6% to 16%. Nevertheless, smoking continues to be the greatest contributor to premature death in the city and there is still much to do to ensure we reach the target of 5% prevalence by 2025.	• All city anchor institutions will be smoke free by 2025. • A multi-channel local media campaign focusing on quitting will be delivered; this will enhance and amplify the regional and national work. • We will work with the NHS, including secondary care, to implement a smoke free NHS, supporting patients and staff to become smoke free. • The Health and Wellbeing Board will sign up to a "Roadmap to a smoke free 2030." • A 'Smoke-free Families' programme will be developed.

SMOKE FREE SUNDERLAND

Key areas for improvement	What will be different?
Smoking prevalence among routine and manual workers Smoking prevalence in routine and manual occupations age 18-64 is 25.7% in Sunderland compared to 23.3% nationally. There was a 2.8% points reduction in 2019.	• More employers will sign up to the Better Health at Work Award to support their staff to stop smoking. • Specialist Stop Smoking Service will work with local businesses to develop an evidence based model to deliver a local stop smoking service in workplaces. • Residents in high prevalence localities across Sunderland will be presented with more opportunities to stop smoking.
Smoking prevalence among young people The latest WAY Survey showed that young people aged 15 are more likely to smoke in Sunderland than nationally. 11.6% of the age 15 population currently smoke, compared to 8.2% nationally; and 8.9% of 15 year olds are regular smokers compared to 5.5% nationally.	• There will be increased awareness of smoking harms amongst children and young people through greater access to advice and information. • There will be increased provision of Stop Smoking Services within youth organisations and schools. • Work with retailers will be undertaken to stop illicit sales and supplies of cigarettes, including work local retailers to stop the sale of cigarettes to children and young people.

ADDRESSING ALCOHOL HARMS

3197
people per 100k population are admitted to hospital with broad alcohol related conditions, compared to **2,367 nationally.**

1078
people per 100k population are admitted to hospital for alcohol specific conditions, compared to **644 nationally.**

2.08%
of the adult population (11th highest in the country) are dependent drinkers compared to **1.39% nationally.**

14.7%
of adults abstain from drinking compared to **15.5% nationally.**

28.9%
of adults drink more than 14 units per week compared to **25.7% nationally.**

18.6
people per 100k population die from alcohol related reasons, compared to **10.9 nationally.**

One in 20
adults regularly drink more than 35 units of alcohol per week.

22
people per 100k population died from chronic liver disease compared to **12 nationally.**

82.4
per 100k under 18s (3rd highest in the country) are admitted to hospital for alcohol specific conditions, compared to **30.7 nationally.**

Why is this important?

The harms caused by alcohol are another key driver of health inequality in the city and place a significant burden across our whole system, costing every resident around £403 per year. Addressing alcohol harms requires the commitment and contributions from all agencies across the city to work together to have a positive impact on outcomes.

The prevalence of drinking alcohol in Sunderland has decreased over a number of years and is now lower than the national average. However, more adults in Sunderland who do drink exceed the recommended 14 units of alcohol a week and more adults fall into the higher risk category.

The CLeaR Alcohol self-assessment has informed our key areas for improvement and a detailed plan of action for the Sunderland Alcohol Partnership.

Key areas for improvement	What will be different?
Reducing alcohol harms Sunderland residents experience significant health problems because of alcohol. The city has some of the highest rates in England for alcohol-related hospital admissions, premature deaths and ill health caused by alcohol. The impact of harmful drinking and alcohol dependence is greater for those in the lowest income bracket and experiencing the highest levels of deprivation. In more deprived areas of Sunderland there are also higher standardised rates of alcohol related hospital admissions. Alcohol misuse impacts not just on the drinker but also those around them. Children affected by parental alcohol misuse are more likely to have physical, psychological and behavioural problems.	• The Tier Two Alcohol Service will be implemented as part of the new adult Substance Misuse Service. • Integrated care pathways for alcohol users will be developed between community and secondary care services as part of the new alcohol care team developments. • The Sunderland Statement of Licencing Policy will follow the evidence base set out in Public Health England's Alcohol Evidence Review. • A Responsible Retailers scheme will be introduced whereby retailers are committed to do everything they can to prevent age restricted products reaching children. • More people will be aware of alcohol related harms and will be enabled to make informed choices about their alcohol consumption.

ADDRESSING ALCOHOL HARMS

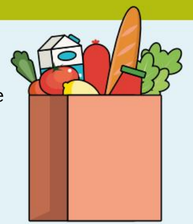
Key areas for improvement	What will be different?
Reducing alcohol related violent crimes Crime and disorder linked to alcohol costs Sunderland an estimated £34m per annum. There were 3460 alcohol related crimes recorded in 2018, with assault and common assault being the highest.	• All elements of alcohol related offending will be addressed through a wide range of intelligence-led enforcement activity. • There will be increased provision of early intervention and treatment services for those involved in crime, disorder or antisocial behaviour. • Everyone in Sunderland involved in crime, disorder or antisocial behaviour will be able to access early interventions and treatment.
Reducing alcohol harms in under 18-year olds	The detail around this priority is presented in the section on Young People aged 11-19.

HEALTHY WEIGHT

22.1%
of children in Reception are overweight, compared to **23% nationally.**

10.1%
of children in Reception are obese compared to **9.9% nationally.**

49.5%
of the adult population are eating the recommended 5-a-day on a usual day compared to **54.6% nationally.**



36.9%
of children in Year 6 are overweight, compared to **35.2% nationally.**

23.6%
of children in Year 6 are obese compared to **21% nationally.**

20.1%
of adults are walking for travel at least three days per week. compared to **22.7% nationally.**

0.8%
of adults are cycling for travel at least three days per week compared to **3.1% nationally.**

66.0%
of adults are overweight (including obese) compared to **62.3% nationally.**

45.0%
children and young people are physically active compared to **46.8% nationally.**

59.5%
of adults are physically active in Sunderland compared to **67.2% nationally.**

28.7%
of adults in Sunderland are physically inactive compared to **21.4% nationally.**

Why is this important?

Excess weight and obesity are significant and complex societal challenges, intrinsically linked to a balance between healthy food intake and regular physical activity. Taking this into account, a whole system approach to supporting good health and wellbeing, enabling positive choices to support maintaining a healthy weight and, accessing physical activity to reduce sedentary behaviour, are all key components in achieving a healthy weight and reducing health inequalities.

Access to healthy and unhealthy food choices has increased but with this there is evidence to suggest that people are over-consuming foods high in fat and sugar, which are now easily accessible. As a result we see an increase in both child and adult unhealthy weight, increasing the probability of developing a range of health related problems including Type 2 diabetes, coronary heart disease, some cancers and mobility problems.

Research shows it is three times more expensive to get the energy we need from healthy foods than unhealthy foods, therefore many low-income households struggle to access a healthy diet. The impacts of poverty on diet and food choices is significant. The environment in which live, work and play - such as food availability, school meals, high streets and access to green spaces - all impact on a healthy weight.

Being physically active also affects weight. Physical activity helps to burn off the energy provided by the food we eat. It is recommended that adults take 150 minutes of moderate-intensity activity per week, such as walking, cycling or other cardio-vascular activity, demonstrating the important role that leisure facilities, parks and green spaces play in supporting people to sustain a healthy weight.

HEALTHY WEIGHT

Key areas for improvement	What will be different?
Healthy weight for children and young people When children enter primary school in Sunderland the proportion that are overweight is similar to the proportion across England. However, by the time they leave primary school 23.6% are overweight compared to 21% nationally. So, as they grow up, inequalities are beginning to emerge. As well as the physical health risks mentioned above, being overweight can cause significant self-esteem issues. Similarly, having poor mental health can cause people to eat unhealthily and gain weight. We know that children who are overweight are more likely to be overweight as adults. We also know that children whose parents are overweight, are also likely to be overweight. It is therefore of the utmost importance to support children and families to be a healthy weight.	• There will be increased take up of Healthy Start Vitamins in Sunderland and an increased awareness of their benefits . • Change4Life Sunderland will deliver preventative services within communities and tailored lifestyle support for children, young people and families in areas of greatest need. • More schools will sign up to and achieve the Great Active Sunderland Schools Charter and the Food and Nutrition Charter Mark, as part of the Sunderland Healthy Schools Award.
Healthy weight for families and adults In Sunderland 66% of adults are overweight or obese, which is higher than the national average. Excess weight and obesity are significant contributors to ill health and so we need to prevent families becoming an unhealthy weight to avoid ill health	• Public Health campaigns will support people to manage their own healthy weight. • 'This mum moves' programme, which supports women to be active and have a healthy diet during and after pregnancy, will be promoted. • Those with long term conditions will be supported to sustain their health through participating in physical activity programmes. • Healthy weight interventions will be co-produced with our communities.

HEALTHY WEIGHT

Key areas for improvement	What will be different?
Influence the environment to support a healthy weight We know that the environment in which we live influences food consumption and food choices.	• Develop the commitment to the Food Active Local Authority Declaration on Healthy Weight. This includes the delivery of a city-wide Healthy Weight Plan. • Consult with partners and prioritise five commitments from the Healthy Weight Declaration for 2020-22. • Implement the Hot Food Takeaway guidance in the local plan. • Implement the healthy weight recommendation in the health inequalities strategy by working with a wide range of partners. This includes improved access to healthy food for vulnerable groups. • Increased number of allotment plots and edible community gardens. • Increased opportunities for people to be more active.

HEALTHY ECONOMY

3.9%
of supported working age adults with learning disability are in paid employment, compared to **5.9% nationally.**

66.7%
gap in the employment rate between those with a learning disability and the overall employment rate, compared to **70.6% nationally.**

131 million
days are lost to sickness absence.

100+
organisations are members of the Sunderland Workplace Health Alliance.

15.3%
gap in employment between those with a long-term health condition and the overall employment rate compared to **10.6% nationally.**

61.2%
gap in the employment rate for those in contact with secondary mental health services and the overall employment rate, compared to **67.2% nationally.**

10.6%
of 16-17 year olds are not in education, employment or training, compared to **5.5% nationally.**

Why is this important?

Good quality employment is a known factor of good health and wellbeing. Employment rates in England were historically high, having increased steadily since 2011 before the Covid-19 pandemic. in addition to considering the impact of the Covid-19 pandemic on employment, it is important to recognise that difficult working conditions, for example, zero-hour contracts, low paid work, under-employment and limited job security, can impact on health outcomes. Stressful work can be as damaging to health as being unemployed.

Work is underway to improve the city's economy, offering new and more secure employment opportunities. The Health and Wellbeing Board's focus on 'healthy economy' is to raise awareness in workplaces of the positive impacts that protecting the health and wellbeing of the workforce has on productivity and sickness levels. It will be more important than ever to use a city-wide, multi-agency approach to identify and map the problems where they are arising and to support resilience in our communities through a coherent programme of activity. This will have a crucial impact on employment, mental health and health behaviours through engagement, socialisation, self-esteem, reducing anxiety and resilience building.

Key areas for improvement	What will be different?
Workplace Health: employers' role in improving employee's health In Sunderland 136,100 people (76.2% of the population) between 16 and 64 years are eligible to work, but economic inactivity due to short-term and long-term sickness rates are significantly worse in comparison to the regional and national averages. Raising the profile of health and wellbeing interventions in the workplace will result in business benefits, such as reduced sickness absence, improved staff morale, increased productivity and performance.	• More employers will be supported to have healthy workplaces through: a. The Better Health at Work Award (BHAWA), achieving Gold, Silver and Bronze awards b. The Sunderland Workplace Health Alliance and by implementing the Alliance Charter. • Members of the BHAWA and Alliance will be able to access key services and training opportunities to support healthy workplaces and employee health and wellbeing. • There will be an online Health Needs Assessment that identifies key issues for individual organisations, helping them to establish plans to improve employee health and wellbeing. • Businesses that are members of the BHAWA and Alliance will be encouraged to have a named workplace health champion and their own health advocates. Health advocate training and lead practice sharing sessions will be provided to help build capacity across these organisations.

HEALTHY ECONOMY

Key areas for improvement	What will be different?
Healthy labour-force: the health of those in work and seeking work Vulnerable people, such as those with learning disabilities and other disabilities, care leavers and people from disadvantaged backgrounds, can find it difficult to enter the world of work and sustain employment.	• There will be increased opportunities for vulnerable people to access work experience, internships and paid employment. This includes people with SEND, mental health conditions, people who are long term unemployed and those in the care system. • Businesses will be encouraged to become Disability Confident employers and leaders and sign up to the Mental Health at Work commitments. • There will be an annual programme of learning days providing training and development opportunities and pathways into work for vulnerable people. • Social value opportunities that expand job opportunities for vulnerable people will be maximised; a practical social value guide will be developed and shared with anchor organisations across the city.
Employment in the health and social care sector: understanding and tackling recruitment issues and wider workforce opportunities The health sector in Sunderland regularly faces recruitment difficulties and current shortages are due to a number of factors including: the fragmentation of responsibility for workforce issues at a national level; poor workforce planning; cuts in funding for training places; restrictive immigration policies exacerbated by Brexit; and high numbers of doctors and nurses leaving their jobs early.	• Avenues into employment and training in the health and social care sector for all sections of society will be assessed and promoted, particularly for minority communities. • Apprenticeships in the health and social care sector will be maximised through the apprenticeship levy. • More opportunities will be created for vulnerable people to gain employment in the health and social care sector. • An annual Work Discovery Sunderland programme of workshops, inspirational lectures and exciting demonstrations raises young people's and target groups' awareness of workforce opportunities in the health and social care sector. • Careers advice in schools will clearly signal pathways into health and social care, drawing on positive role models where possible.

MENTAL HEALTH AND WELLBEING

23%
of people in Sunderland self-report as having high anxiety, compared to **21.9% nationally.**

55.1%
of adult social care users report they have as much social contact as they would like (18+ yrs), compared to **45.9% nationally.**

19.3%
of people over the age of 16 are estimated to have a common mental health disorder, compared to **16.9% nationally.**

12.1%
of people aged 65+ are estimated to have a common mental health disorder, compared to **10.2% nationally.**

3.1%
school age pupils have social, emotional and mental health needs, compared to **2.39% nationally.**

44.8
per 1,000 population claim Employment Support Allowance for mental and behavioural disorders, compared to **27.3 nationally.**

183.3
hospital admissions per 100,000 population are for mental health conditions, compared to **88.3 nationally.**

12.4
per 100k population die due to suicide, compared to **10.1 nationally.**

170.1
hospital admissions per 100,000 population are for mental and behavioural disorders due to use of alcohol, compared to **75.6 nationally.**

26.6%
of adults with anxiety or depression smoke, compared to **25.8% nationally.**

Why is this important?

Mental wellbeing is fundamental to achieving a healthy, resilient and thriving population. Mental health and wellbeing are inextricably linked as both a cause and a consequence of physical health, educational attainment, employment and productivity, relationships, community safety, community cohesion and quality of life.

NOTE: This section of the implementation plan will be reviewed as work to improve care for adults and older adults with severe mental illnesses is undertaken. This will involve transformation and co-production of the Community Mental Health services by a range of key stakeholders to ensure patients are able to access the support and help they need to continue to live their lives well. A key action is to produce and implement an Adult Mental Health Strategy for Sunderland.

Key areas for improvement	What will be different?
Prevention of poor mental health and the promotion of positive emotional health and wellbeing. Mental health is a common condition which can impact on anyone at any point throughout the life course. It is estimated that 1 in 4 people will experience some mental health issue throughout their life. Implications of common mental health conditions have consequences for the wider system e.g. NHS waiting lists, sickness absence in workplaces and productivity. In 2018/19, it is recorded that approximately 17.5 million working days were lost due to mental health-related sickness absence. The impact of Covid 19 will play a significant part in mental health and wellbeing, not only from a physical aspect but taking into account bereavement, loss and social economic effects throughout and following the pandemic.	• Regional and national mental health and wellbeing resources and programmes will be actively promoted. • Anchor organisations across the city will deliver positive emotional health and wellbeing messages. • Positive emotional health and wellbeing messages will be co-produced with communities. • Inter-agency support will be provided to ensure employers are equipped to support employees with mental health and wellbeing concerns in both a preventative and supportive capacity • There will be a redesign of how community mental health services are accessed and delivered to ensure that they are able to provide patients and services users with the help and support they need to continue to live their lives well. • A no wrong door service will be provided to ensure patients can access the support they require at a single point of entry and receive a seamless package of care. • Social prescribers will be provided in community settings to encourage patients to engage with preventative and self-care methods of supporting their own mental health. • A Reduction in the reliance of medication to improve mental health. Instead provide alternative support mechanisms such as talking therapy will be provided.

MENTAL HEALTH AND WELLBEING

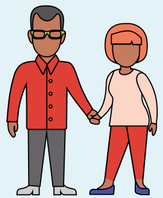
Key areas for improvement	What will be different?
Supporting people with poor mental health to improve their physical health People with serious mental illness (SMI) die 10-20 years earlier than the general population. Although survival is improving the gap between people with SMI and the general population is widening. The most prevalent physical health conditions include obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD), cancer and coronary heart disease.	• People with SMI will be identified and supported to manage their mental and physical health needs through strengthened partnership working across the system. • Support for mental health service users will be embedded within commissioned services • Psychological support will be made available to patients with long term conditions to help manage their condition.

Key areas for improvement	What will be different?
Reducing stigma and discrimination associated with poor mental health Even though so many people are affected, there is a strong social stigma attached to mental ill health and people with mental health problems can experience discrimination in all aspects of their lives. People with mental health problems are amongst the least likely of any group with a long-term health condition or disability to: - Find work - Be in a steady, long-term relationship - Live in decent housing - Be socially included in mainstream society Stigma and discrimination can also worsen someone's mental health problems, and delay or impede their getting help and treatment and their recovery.	• Messages regarding mental health and wellbeing stigma and discrimination will be actively promoted. • Anti-stigma and discrimination programmes, promoting a city-wide approach, will be developed. • There will be a reduction in suicide achieved by working with local and regional suicide prevention networks and groups • Inter-agency support will be provided to ensure employers are equipped to support employees with mental health and wellbeing concerns in both a preventative and supportive capacity • There will be a redesign of how community mental health services are accessed and delivered to ensure that are able to provide patients and services users with the help and support they need to continue to live their lives well. • A no wrong door service will be provided to ensure patients can access the support they require at a single point of entry and receive a seamless package of care. • Social prescribers will be provided in community settings to encourage patients to engage with preventative and self-care methods of supporting their own mental health. • A Reduction in the reliance of medication to improve mental health. Instead provide alternative support mechanisms such as talking therapy will be provided.
Young people's mental health and emotional wellbeing	• The detail relating to this priority is presented in the section on Young People aged 11-19.

AGEING WELL

57.9 years
Healthy life expectancy for men in Sunderland, compared to **63.4 years nationally.**

56.5 years
Healthy life expectancy for women in Sunderland, compared to **63.9 years nationally.**



The inequality between the lowest and highest life expectancy in Sunderland is **11.5 years** for men and **8.5 years** for women. Nationally this is at **9.5 years** for men and **7.5 years** for women.

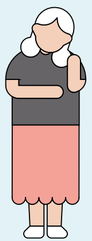
2,628
Emergency hospital admissions due to falls in people aged 65+ (per 100k population) compared to **2,222 nationally.**

6,627
Emergency hospital admissions due to falls in people aged 80 and over (per 100k population) compared to **5,644 nationally.**

664
per 100k aged 65+ fractured hips, compared with **572 nationally.**

70.3%
of adult social care users satisfied with care and support services (65+) compared to **61.5% nationally.**

55.1%
of adult social care users have as much social contact as they would like, compared to **45.9% nationally.**



69.2%
of people aged 65+ are estimated to be diagnosed with dementia, compared to **67.4% nationally.**

232.6
per 100k people die from preventable causes, compared to **180.8 nationally.**

16.3%
Excess winter deaths index (age 85+) from Aug 17-July 18 in Sunderland, 45.8% in the region and **18.2% nationally.**

81%
of adult social care users feel they have control over their daily lives (65+) compared to **74% nationally.**

*The data for 2020 has been impacted by COVID19, although it is not possible to quantify the full impact at this time it is likely to be a contributing to the drop in the estimated dementia diagnosis rate.

Why is this important?

As a nation, we are living longer. In Sunderland, in the ten years between 2020 and 2030, the number of people aged 65 and over is projected to rise by around 20% from 55,200 to 66,300. As more people live longer, what we perceive to be an older person and what ageing well means has changed. Greater numbers of older people continue in employment and plan for an active retirement. Others support their families by providing care to grandchildren enabling their own children to participate in the economy. The contribution of older people to the community and economy is well evidenced and the contribution the environment plays in healthy ageing such as healthy towns, cities and settings is well recognised.

Although we are adding years to life, healthy life expectancy describes a different picture with significant variations and marked inequalities between the least and the most deprived communities across the city. Covid-19 has magnified these inequalities, with older people and those with underlying health conditions being most significantly affected.

Key areas for improvement	What will be different?
Develop age-friendly neighbourhoods	• £59m will be invested in new social housing over a 5-year period, delivering improvements in housing for older people and those with physical disabilities and other support needs. • Age-friendly considerations will be incorporated in all outdoor spaces, buildings and transport developments. • Active Sunderland will support, enable and connect residents into sport and physical activity opportunities. In particular targeting 'inactivity' and supporting people in communities that are benefiting least from being active.

AGEING WELL

Key areas for improvement	What will be different?
Develop age-friendly services	• A preventative, proactive and person-centred integrated neighbourhood operating model will be developed. • Social prescribing will be offered more widely to reduce social isolation, improve the physical and mental wellbeing of residents and support them to adopt prevention strategies to improve self-care. • Primary care networks will work within a neighbourhood model to improve integrated working, joined up care pathways for patients and population health approaches. • The Recovery At Home service will be reviewed to maximise service user independence. • People are supported to reduce their over dependence on unscheduled care and reduce emergency admissions to hospital. • Additional age-friendly sport and physical activity programmes will be delivered with key partners.
Promote age equality	• A Health in All Policies framework will ensure that age-friendly considerations are incorporated into policy, projects and services.

Sunderland Health and Wellbeing Board:

Delivery Board

DRAFT Terms of Reference

1. Context

The Healthy City Plan is the new statutory Health and Wellbeing Strategy of the Health and Wellbeing Board. The Health and Wellbeing Board will have strategic oversight of the Healthy City Plan.

The Healthy City Plan is set in the context of the Sunderland City Plan with its ambitions to create a Dynamic, Healthy and Vibrant City. We recognise that the interaction between these three themes will have a great impact on people's lives in relation to social determinants of health. The City Board has reviewed the City Plan to ensure it is responding to the impacts of the pandemic, in both the short and long term. We recognise that all the City Plan themes have an inextricable link to the Healthy City Plan vision.

This document sets out the Terms of Reference for Delivery Boards that will support the statutory Health and Wellbeing Board.

The Delivery Boards will bring together senior officers from the council, as well as key partners from statutory, private and voluntary sector organisations to provide challenge and support outside of the formal Health and Wellbeing Board meetings.

The Delivery Boards will take a life course approach:

- Starting Well Delivery Board
- Living Well Delivery Board
- Ageing Well Delivery Board

The Delivery Boards will sit alongside wider Health and Wellbeing Board governance arrangements, namely the Health Protection Board and emerging place-based integration arrangements.

2. Aim of the Delivery Boards

On behalf of the Health and Wellbeing Board the Delivery Boards will drive improvements in Sunderland's health and reductions in inequalities by striving to ensure the delivery of the Healthy City Plan vision is achieved, this vision being:
Everyone in Sunderland will have healthy, happy lives, with no one left behind.

In adopting a life course approach, we have applied the six policy objectives set out in the 'Marmot Review: Fair Society, Healthy Lives' (2010) to be our priorities. The Delivery Boards have responsibility for these Marmot policy objectives as follows:

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

The Delivery Boards will also have oversight of the appropriate Healthy City Plan workstreams that will support the delivery of our priorities. Current workstream responsibilities are as follows:

Starting Well Delivery Board	**Living Well Delivery Board**	**Ageing Well Delivery Board**
Existing Healthy City Plan workstreams: • Best start in life • Young people 11-19	Existing Healthy City Plan workstreams: • Healthy Economy • Adult mental health and wellbeing	Existing Healthy City Plan workstreams: • Ageing well • Covid-19 health inequalities

• Children and young people's mental health and wellbeing • Healthy weight (strategic approach) • Covid-19 health inequalities	• Addressing alcohol harms (strategic approach) • Smoke free Sunderland (strategic approach) • Covid-19 health inequalities	

3. Objectives of the Delivery Boards

The Delivery Boards will provide leadership to promote effective partnership working to deliver the ambitions of the Healthy City Plan and reduce health inequalities. Key objectives of the Delivery Boards include:

i. Maintain oversight of progress being made to deliver the Healthy City Plan and identify areas for action.
ii. Understand the 'lived experience' and use this insight to champion and advocate for tackling health inequalities through assets-based approaches.
iii. Delegate accountability for the implementation plan workstreams to responsible groups and ensure governance arrangements are in place for all activity. Receive regular updates on the Healthy City Plan workstreams, monitor their workplans and performance.
iv. Have oversight of the appropriate elements of the Sunderland Covid-19 Health Inequalities Strategy
v. Take every opportunity to mitigate the impact that Covid-19 has had on our communities.
vi. Invite the strategic leads for the Vibrant Smart City and Dynamic Smart City elements of the City Plan to meetings to make recommendations and take action, in order to link common issues and implications for other developments taking place across the city.
vii. Be assured that activity being delivered through the Vibrant Smart City and Dynamic Smart City elements of the City Plan are maximising opportunities to reduce health inequalities and address the social determinants of health, provide challenge and support where appropriate.
viii. Lead and support a 'Health in All Policies' approach to the planning, implementation and evaluation of activity that contributes to health and wellbeing, ensuring opportunities to reduce inequalities and improve health are maximised across the system
ix. Identify risks and opportunities, and appropriate mitigation of those risks. Escalate risks to the Health and Wellbeing Board, or City Board, where appropriate.
x. Ensure there is good linkage with emerging place-based integration arrangements.

xi. Provide assurance to the Health and Wellbeing Board that work is progressing within the required timescales, underpinned by six-monthly performance reporting.

4. Shared values and behaviours

The Delivery Boards will champion the Health and Wellbeing Board's shared values and behaviours:

- **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

5. Charing and membership

The Delivery Boards will be chaired by Executive Officers, or in their absence their nominated deputy.

- Starting Well Delivery Board – chaired by the Chief Executive of Together for Children / Director of Children Services
- Living Well Delivery Board – chaired by the Executive Director of Public Health and Integrated Commissioning
- Ageing Well Delivery Board – chaired by the Executive Director of Neighbourhood Services

Membership of the Delivery Boards will need to be determined by each Board, but may include:

- Chairs and lead officers of the Healthy City Plan workstreams
- Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust
- Northumbria Police
- Sunderland City Council – Relevant Portfolio Holders, Public Health, Neighbourhood Services, Communications, Partnerships, Performance
- Sunderland Clinical Commissioning Group
- Sunderland Healthwatch
- South Tyneside and Sunderland NHS Foundation Trust

- Sunderland Workplace Health Alliance
- Together for Children
- University of Sunderland
- Voluntary and Community Sector

It is expected people who attend the meetings will be able to make decisions on behalf of their organisation.

The full membership of each group will be appended to these Terms of Reference when the Delivery Boards are established.

Members will agree to send a nominated representative if the named individual is unable to attend.

The membership of the Delivery Boards will be reviewed regularly. The Delivery Boards may agree to co-opt members or invite attendees as and when necessary for specific knowledge and expertise.

6. Governance arrangements and decision making

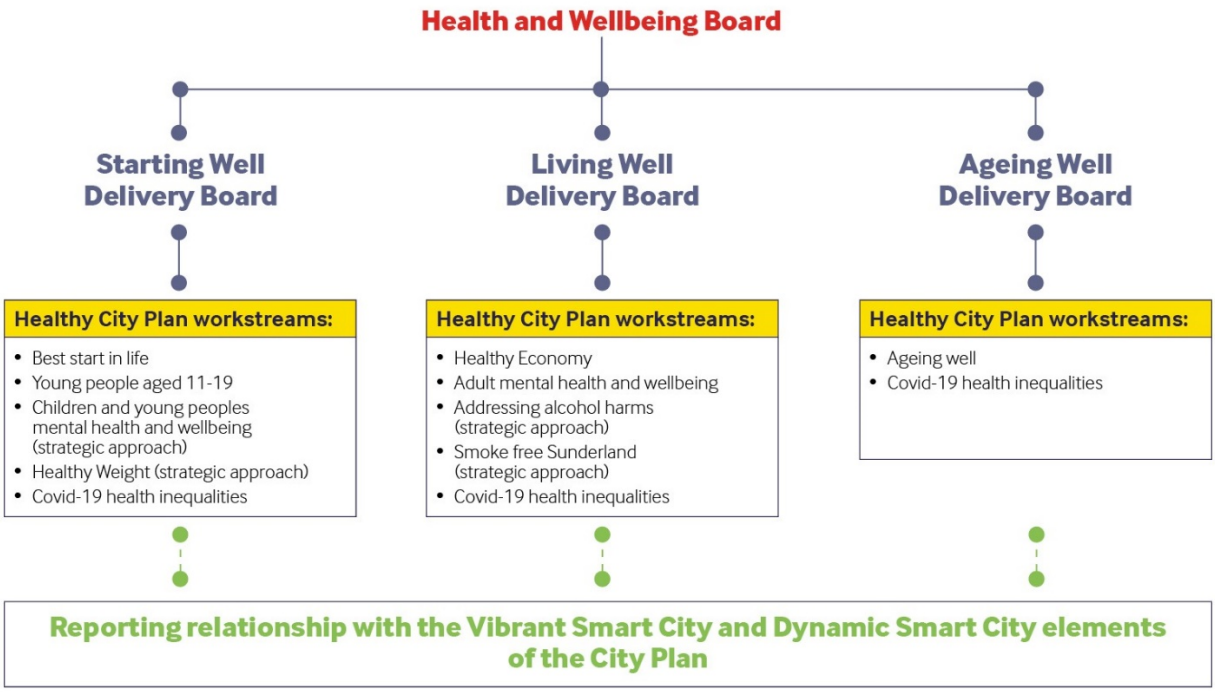
The Delivery Boards will be directly accountable to the Health and Wellbeing Board.

The Delivery Boards will be decision making boards, with decisions being ratified where appropriate by the Health and Wellbeing Board or through the governance arrangements of the bodies represented which will retain their decision-making sovereignty.

The Delivery Boards will provide detailed proposals so that informed decisions can be made. Proposals will be specific and individual organisational support will be needed at the appropriate times.

7. Structure and accountability

The Delivery Boards will report directly to the Health and Wellbeing Board and will sit alongside wider Board governance arrangements, namely the Health Protection Board and emerging place-based integration arrangements.



8. Operation of the Delivery Boards

Frequency - The Delivery Boards will meet, as and when required, as deemed appropriate by the Chair. The Chair may change the frequency depending on prevailing circumstances.

Medium – The Delivery Boards will meet remotely, via Microsoft Teams until it is deemed appropriate or necessary to meet face-to-face.

Quorum – At least the chair or nominated deputy, plus representation from two other organisations. It is the responsibility of each organisation to send an appropriate deputy if the principle member cannot attend.

Servicing arrangements – Action notes of meetings will be shared with members of the groups. Papers will be distributed five working days before each meeting.

Agenda management – Agenda setting, in consultation with the Chair. Members of the Delivery Boards may request an agenda item to be considered at the Chair's discretion.

9. Review of Terms of Reference

These will be reviewed annually.

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 2021

FUTURE ARRANGEMENTS FOR SUNDERLAND JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

Report of the Executive Director Public Health & Integrated Commissioning

1.0 Purpose of the Report

1.1 The purpose of this report is to:

- Establish the Joint Strategic Needs Assessment (JSNA) as central to planning, decision making and resource allocation;
- Set out a process for JSNA and PNA development and management;
- Recommend a rolling programme of JSNA refresh with a maximum review date of 3 years;
- Support the necessary programme of work to fulfil this duty; and
- Remind the Health and Wellbeing Board (HWB) of its statutory duty to undertake a PNA and the requirement to produce an updated and approved PNA for Sunderland for publication by 1st April 2022.

1.2 Local authorities and Clinical Commissioning Groups have equal and joint duties to produce JSNAs and Joint Health and Wellbeing Strategies (JHWSs) through the HWB.

1.3 The HWB has previously delegated leadership for activities relating to the PNA to the Director of Public Health.

2.0 Background

2.1 This paper sets out a reviewed approach to the JSNA. This will maximise co-production, use innovative and creative ways to understand local need and tackle health inequalities, taking a life course approach, in line with *The Marmot Review*. The JSNA will be user friendly and communicated effectively to act as the overarching primary evidence base for the Board's priorities and all partners' / partnership priorities.

2.2 The development of a JSNA work programme will support the HWB in discharging its duty to produce a JSNA and PNA. It will increase the Board's visibility of the JSNA sections to be developed during the time period of each work programme and it will enable relevant commissioners and providers to plan to release the capacity required to develop JSNA content and scheduled PNA refreshes.

2.3 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, underpinning overall spending and activity decisions. It supports a Health in All Policies approach, and will be at the heart of strategic priority development, aiming to improve health and wellbeing outcomes and reduce inequalities. The assessment includes consideration of deprivation, behavioural risk factors, disease and disability, major causes of mortality and the impact on life expectancy. Data and intelligence from the JSNA inform the PNA.

2.4 The PNA process was introduced to define the pharmaceutical needs in a specific area, for use by NHS England in determining entry onto the pharmaceutical list to ensure the adequate and appropriate provision of NHS pharmaceutical services in England. It can also be used to:

- Help commissioners to commission services from community pharmacists to meet local need;
- Support commissioning of high-quality pharmaceutical services;
- Ensure that community pharmacy services are commissioned to reflect the health needs identified in the JSNA and the ambitions set out in the Joint Health and Wellbeing Strategy; and
- Facilitate opportunities for pharmacists to make a significant contribution to the health of the population of Sunderland.

2.5 A person who wishes to provide NHS pharmaceutical services must apply to NHS England proving they are able to meet a pharmaceutical need or improve access as set out in the relevant PNA. There are exceptions to this, such as applications to provide NHS pharmaceutical services on a distance-selling basis.

2.6 The HWB is not responsible for deciding how many pharmacies there should be or where they should be sited. NHS England will use the PNA document to make such decisions. In doing this, NHS England will need to balance population needs and available financial resources with current provision and considerations of the free market.

3.0 The statutory role of HWB regarding JSNA

3.1 The development of a JSNA is a statutory requirement. Local authorities and Clinical Commissioning Groups have equal and joint duties to produce JSNAs and JHWSs through the HWB. 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.

4.0 Arrangements for delivering the JSNA

4.1 The JSNA process will involve the following steps:

- Establish a JSNA Steering Group to oversee the process;
- Agree the content of the JSNA and the associated chapters;
- Develop a workplan to include identifying lead authors, reporting arrangements and timescales;
- Work collaboratively with partners, undertaking engagement to understand views and needs;
- Work with partners to share intelligence, including the data repository workstream at the Council. Identify supporting data sharing arrangements and agreements which may be required;
- Ensure the JSNA is easily accessible and user-friendly for a wide audience; and
- Seek endorsement of the draft JSNA from the JSNA Steering Group.

4.2 The JSNA review process will be as follows:

- The overarching JSNA summary will be taken to HWB on an annual basis;
- The requirement to update a particular JSNA chapter will depend on specific triggers such as population changes, or contract changes, but there is an expectation that the maximum period for review will be 3 years;
- The lead author and contributors will keep abreast of emerging guidance and the evidence base, which may require a refresh or full update of a JSNA. The lead author will update or nominate a lead for updating relevant parts; and
- The lead author will review how the previous JSNA has made an impact.

5.0 The statutory role of the HWB regarding the PNA

5.1 The duty to carry out the PNA transferred to HWBs under the Health and Social Care Act 2012; this duty came into effect on 1st April 2013. The process is guided by *The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013* and any subsequent updates or amendments. These state that HWBs were to agree and publish their first PNA by 1 April 2015 and then publish a revised assessment within three years of publication of this assessment, or sooner in response to significant changes to the availability of pharmaceutical services.

5.2 The HWB is required to produce the PNA as part of its broader responsibility for developing a shared understanding of the current and potential future health needs of the City's population. The PNA is an integral part of the JSNA and is aligned to the JHWS.

5.3 *The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016* includes provisions to allow mergers or consolidations of closely located, community pharmacies. This

allows two pharmacies to make an application to merge and provide services from one of the two current premises. HWBs have two statutory duties in relation to this:

(i) When NHS England notifies a HWB about an application to consolidate two pharmacies, the HWB must make a statement or representation back to NHS England within 45 days stating whether the consolidation would or would not create a gap in pharmaceutical services provision. NHS England will then convene a panel to consider the application to consolidate the two pharmacies, taking into account the representation made by the HWB.

(ii) Once NHS England has made a determination on the application to consolidate two pharmacies, it will inform the HWB. Where a Pharmacy's premises are removed from the pharmaceutical list as a consequence of granting a consolidation application and if, in the opinion of the HWB, the removal does not create a gap in pharmaceutical services provision that could be met by a routine application then the HWB must:

- Publish a supplementary statement saying that removal of the pharmacy which is to close from the pharmaceutical list will not create a gap in pharmaceutical services; and
- Update the map of premises where pharmaceutical services are provided.

A supplementary statement forms part of the PNA and is a statement of relevant changes since the PNA was published, which may affect an application for a new pharmacy.

5.4 In May 2020, the Department of Health and Social Care announced that the requirement to publish renewed PNAs would be suspended by a year. This was in recognition of the fact that most resources had been diverted to the COVID-19 pandemic response, and therefore suspension for one year would reduce pressure on local authorities and Local Pharmaceutical Committees. HWBs would still retain the ability to issue supplementary statements to respond to local changes and pharmaceutical needs during this time. The DHSC has stated that the NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013 will be updated to reflect this derogation in due course.

6.0 Arrangements for producing Sunderland PNA 2022-2025

6.1 The PNA process will involve the following steps:

- Assess current and future health needs;
- Undertake public engagement to assess views about community pharmacy services;
- Collate information about existing services including a survey of community pharmacies;

- Develop the narrative for the consultation draft PNA, draw initial conclusions, make initial recommendations and gain approval from HWB;
- Undertake the required statutory consultation for a minimum of 60 days;
- Develop the final post-consultation version of the PNA, with final conclusions and recommendations; and
- Gain approval from HWB for the final version of the PNA for Sunderland for publication by 1st April 2022.

6.2 Governance arrangements will be as follows:

A Steering Group will be established (March 2021) to support the PNA process. This will include representation from:

- The Council's public health team, including analytical support;
- The Council's communication and engagement teams e.g. community resilience team;
- The CCG's medicines optimisation team;
- Sunderland Local Pharmaceutical Committee; and
- Healthwatch Sunderland.

- NHS England and Sunderland Local Medical Committee will be invited to have a representative on the Steering Group. Both are statutory consultees and will be consulted in line with the regulations and as set out in the timeline.

- The Steering Group will be chaired by a Public Health Pharmacy Adviser who reports to the Executive Director Public Health & Integrated Commissioning. Progress will be reported to the Board in September 2021, December 2021 and March 2022.

- The Steering Group will meet as appropriate until the consultation draft PNA is produced. It will then meet once more following the statutory consultation to finalise the PNA.

7.0 Recommendations

7.1 The Health and Wellbeing Board is recommended to:

- Approve the process for JSNA development and review;
- Support the JSNA Steering Group to undertake the necessary programme of work to fulfil this duty;
- Note the information about its statutory role in relation to the PNA, and the requirement to produce an updated and approved PNA for Sunderland for publication by 1st April 2022;
- Confirm that leadership for activities relating to the PNA should continue to be delegated to the Executive Director Public Health & Integrated Commissioning.

Item No. 8

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 2021

HEALTH AND SOCIAL CARE WHITE PAPER AND THE NEXT STEPS FOR INTEGRATION OF PLACE BASED ARRANGEMENTS

Report and presentation of the Executive Director of Public Health and Integrated Commissioning, Executive Director of Neighbourhood Services and Deputy Chief Officer/Chief Finance Officer of Sunderland CCG

1.0 PURPOSE OF THE REPORT AND PRESENTATION

1.1 The purpose of the report and presentation is to:

a) Provide the Board with an overview of the proposals set out in the Department of Health and Social Care's legislative proposals for a Health and Social Care Bill
b) Provide an overview of progress to date and next step proposals for an integrated place-based health and care system

2.0 NHS White Paper – Integration and Innovation: working together to improve health and social care for all – the Department of Health and Social Care's legislative proposals for a Health and Care Bill.

2.1 Introduction

On 11 February the government published a white paper setting out proposed reforms to health and care. Proposals will be set out in a Health and Care Bill with legislation in place for implementation in 2022. A link to the published white paper is here: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all . The proposals in the white paper cover four themes:

1. **Working together to integrate care** – Integrated Care Systems (ICSs) are to be put on a statutory footing
2. **Reducing bureaucracy** – removing requirements on competition and procurement in the NHS
3. **Improving accountability and enhancing public confidence** – the formal merger of NHS England and NHS Improvement and new powers for the Secretary of State
4. **Additional proposals** relating to public health and adult social care

2.2 This report will focus on themes one and four only.

2.3 Theme 1: Working together to integrate care

2.3.1 The white paper proposes that the forthcoming Health and Care Bill will support two forms of integration:

1. **Integration within the NHS** – to remove some of the barriers to collaboration within the NHS and to make '*working together an organising principle'*.
2. **Between the NHS and others** – the NHS and local authorities will be given a **duty to collaborate** with each other to improve health and wellbeing outcomes for local people

2.3.2 Statutory ICSs will comprise an **ICS NHS body** (board) and an **ICS Health and Care Partnership** bringing together NHS, local government and partners. The proposals in the white paper give local government a mainstream role in ICSs.

2.3.3 For the North East and Cumbria there will a single large ICS covering a population of around 3 million people – making the NENC ICS one of the largest in the country. The timeline for the creation of the ICS and the dissolution of CCGs is expected to be April 2022.

2.3.4 The **ICS NHS body** will be responsible for the day to day running of the ICS. It will take over the functions and funding of CCGs and be accountable for NHS spend and performance within the system. It will be able to '*delegate significantly to place level and provider collaboratives'*. It will take also over the CCG's responsibilities in relation to overview and scrutiny committees. There will be a more clearly defined role for social care in the structure of ICS NHS boards to '*give adult social care a greater voice in NHS planning and allocation'*.

2.3.5 The **ICS Health and Care Partnership** (the 'Partnership') will bring together the NHS, local government and wider partners, such as voluntary and community sector and Healthwatch to *develop 'a plan to address the system's health, public health and social care needs'* at a system level and to support closer integration and collaborative working between health and social care. Membership and functions of the Partnership will be determined locally.

2.3.6 There will be legislation to make it easier for organisations to work closely together through setting up **joint committees** between ICSs and NHS providers or between NHS providers and could include representation from other bodies, such as primary care networks, local authorities and the voluntary sector.

Place based arrangements

2.3.7 The white paper emphasises the importance of 'place'. Place based arrangements should be left to local organisations to arrange in order to best meet local circumstances. Place level commissioning will align geographically to a local authority boundary and the Better Care Fund (BCF) plan will provide the tool for agreeing priorities.

2.3.8 Health and wellbeing boards (HWBs) will remain in place and continue to have an important responsibility at place level. ICSs will work closely with health and wellbeing boards as HWBs have the experience as '*place-based planners'*. The ICS NHS body will need to have regard to Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy produced at place. The HWB will need to have regard to the ICS Partnership plan.

2.3.9 ICSs are to support places to integrate services and improve outcomes and will need to consider how they can align allocation and functions with place, for example through joint committees. Models are to be determined locally.

2.4 Theme 4: Additional proposals

These proposals are to address specific barriers or problems rather than form a comprehensive reform package.

2.4.1 Social Care

On social care, the proposals reflect the themes of the white paper of supporting integration, reducing bureaucracy and improved accountability:

- Integration will be enhanced through the position of social care in the ICS.
- There will be a new standalone legal basis for the Better Care Fund. separating it from the NHS mandate setting process – a technical change.
- A new 'Discharge to Assess' model is proposed to provide greater flexibility as to at what point assessments for care can be made.
- An 'enhanced assurance framework' and improved data collection will be introduced to ensure oversight on the provision and commissioning of social care including a new duty for the Care Quality Commission to assess local authorities' delivery of adult social care duties.
- A legal power to make emergency payments directly to all social care providers in exceptional circumstances is proposed in order to provide additional support to the sector.

2.4.2 Public health

For public health the white paper sets out a number of measures to:

- make it easier for the Secretary of State to direct NHS England to take on specific public health functions.
- help to tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods as well as a new power for ministers to alter food labelling.
- streamline the process for the fluoridation of water in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government.

2.4.3 Other additional proposals in the white paper relate to safety and quality.

2.5 Observations and reflections on the white paper will be made during the presentation.

3.0 Emerging integrated place-based arrangements

3.1 The white paper emphasises the importance of place and links two but distinct objectives: integration within the NHS, and equal partnership between the NHS, local government and other partners to both address the social determinants of health and deliver better and more coordinated health and care services for local people.

3.2 Partnership working is underway to develop an integrated health and care system in line with the place-based arrangements proposed in the White Paper. Current partnership developments within the city focus on our strategic approach to commissioning to improve health and reduce inequalities.

3.3 The future place-based approach will seek to build upon existing good practice in the city, including the work of the All Together Better alliance, which is an alliance of health and care providers and commissioning organisations, (Sunderland City Council and CCG) working collaboratively to design and deliver the most personalised, pro-active and joined-up care possible for people in the city. Here the approach is very much about All Together Better stakeholders, patients and the public giving their views to help develop the alliance and improve services and the care provided.

3.4 A cross system partnership working group has been formed to develop proposals for a potential Lead / Integrated Care Provider. This includes how services could be commissioned and contracted for in future.

3.5 The presentation to the Board will provide an update on emerging local arrangements for an integrated health and care system, with a further update to be considered by the Board at the next meeting in June 2021.

4.0 Recommendations

4.1 The Health and Wellbeing Board is recommended to:

- receive the report and presentation;
- note the proposals set out in the NHS White Paper; and
- receive an updated position on the arrangements for place-based integration at the next Board meeting.

Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 2021

UPDATE ON PHASE 2 OF THE PATH TO EXCELLENCE

Report of the Executive Medical Director STSFT and Chair of Clinical Service Review Group

1.0 Purpose of the Report

1.1 This report updates the Board on the status of Phase 2 of Path to Excellence Programme, the learning from COVID-19 and the impact on the Programme.

2.0 Background

2.1 The Path to Excellence Programme is one of the 3 pillars of transformation for the local health economy, focusing on in-hospital transformation; alongside system-wide work on Out of Hospital care and on Prevention:

2.2 The programme aims to create outstanding future services, which offer high quality, safe patient care and clinical excellence for the local population of South Tyneside and Sunderland, and the population of north and east Durham who consider Sunderland as their local hospital. The programme is in 2 phases:

- Phase 1 – considered stroke care, maternity and gynaecology services and acute paediatrics – implemented in August 2019

- Phase 2 – considered how we look after people in an emergency or who have an urgent healthcare need in Medicine and Surgical specialties and how we provide planned care.

2.3 A temporary 6 month pause on the programme was introduced in April 2020 due to the global pandemic COVID-19. This involved introducing a pause to the design work associated with working ideas for Medicine, Emergency Care and Surgery in Phase 2.

3.0 Update on Phase 2

3.1 An update was brought to the December 2020 Health and Wellbeing Board on the status of Path to Excellence Programme, the learning from COVID-19 and the impact on the Programme.

3.2 It set out that a temporary 6 month pause on the programme was introduced in April 2020 due to the global pandemic COVID-19. This involved introducing a pause to the final step of implementation of the paediatric model (Phase 1) and the design work associated with working ideas for Medicine, Emergency Care and Surgery in Phase 2.

3.3 Plans to reset the programme commenced in October 2020, informed by a situational analysis which reported:

- The reasons for the programme are more relevant as a consequence of the pandemic, and accelerate the need for transformation
- The pandemic had brought many positive working solutions with new ways of working established extremely quickly, i.e. introduction of 'virtual' out-patient appointments
- The original programme objectives remain valid, and should be extended to include the ability to manage COVID-19 (or similar) and objectives around addressing health inequalities; which have been exposed during the pandemic
- There is a need to work closely with staff to understand their experiences of the pandemic, as well as closer working with community and primary care partners
- Given the on-going response to COVID-19 and recovery of elective activity, staff and clinical capacity is likely to be an issue in relation to the delivery timescale of the programme.
- Work was needed to understand the current state. While the original data may still be valid, there is a view that the situation has changed significantly and public and staff views may have changed as a result of this.

3.4 This report in March 2021 updates the situation as described above and describes how the programme is continuing with a renewed focus on planned and emergency surgery.

The Case for Change

3.5 Following the pause due to COVID-19 the programme restarted in October 2020 with a situational analysis, which confirmed the need for change is more relevant as a consequence of the pandemic, and that original programme objectives remain valid.

3.6 The main drivers for change are closely interlinked with each other and have been identified from involvement activity with staff, patients and stakeholders; they are:

- Workforce
- Quality Improvement
- Future demand
- Financial constraints

3.7 The pandemic has impacted on the drivers for change:

Workforce

3.8 The past year has had a huge impact on the entire NHS workforce. We recognise the enormous contribution that NHS staff have made with compassion, competence and professionalism to deliver patient care during the pandemic and understand that COVID-19 has increased the mental and physical pressure on many NHS staff. They have had to think about the risk of infection to themselves and their family, as well as their duty of care to patients.

3.9 Staff sickness rates due to COVID-19 and staff absence due to shielding has put extra pressure on front line clinical teams. Maintaining safe staffing levels has meant that staff have had to be flexible both with working patterns and their areas of work, with many of our surgical teams working in support of other wards and departments. As a result of these combined pressures staff health and wellbeing is now even more of a concern.

Quality Improvement

3.10 Hospital services are recognised as being safe and high quality (CQC report 2020), however we recognise these could be even better if organised differently.

3.11 The pandemic required improved standards of infection and prevention and control, which we now need to embed to ensure they are sustainable in the long term and that we can continue to protect our patients from COVID-19.

3.12 In addition, the national decision to postpone all non-urgent operations has left the trust, like hospitals across the UK, with a backlog of patients awaiting surgery. Recovering from COVID-19 includes reducing our waiting lists of people who need planned operations.

Future Demand

3.13 Thanks to medical advances and improvements in technology more people than ever before are successfully treated by the NHS and as a result living longer; the ageing population means that demand for services will continue to grow.

3.14 The pandemic resulted not only in reductions in planned care but also in fewer patients attending hospitals with urgent or unplanned health needs. With reports that that one in three people with an existing health condition delayed seeking help from the NHS, rising to two in five for people with diabetes, lung disease and mental health conditions.

3.15 We also know that COVID-19 has impacted more negatively on certain groups than others. The health inequalities exposed by COVID-19 mean we must work harder than ever to close the gaps that exist, to ensure that everyone has access to the same high quality care. The pandemic has only accelerated the need for change

Phasing the Programme

3.16 As we entered the winter period (November 2020) and experienced increasing pressure associated with a second wave of COVID-19, it was clear that clinical and administrative capacity would be limited and that a realistic approach needed to be taken to what was achievable within the programme.

3.17 As a consequence it was agreed that a phased approach would be taken, with surgical changes being pursued in advance of those in Medicine and Emergency Care.

3.18 Whilst the pressures on medicine and emergency care continue the phased approach has the benefit of allowing more time to consider the impact and learning from COVID-19 on future working ideas and demand for these services

3.19 The surgical specialties being considered as part of the new Phase 2 are:

- General Surgery (including upper GI and bariatrics, general surgery and colorectal services)
- Trauma and Orthopaedics

3.20 Other surgical specialties currently centralised at SRH as part of a regional service, i.e.,Opthamology, Urology, Vascular and Head and Neck are not within the programme scope.

3.21 Out-patient care has seen a significant transformation during the pandemic with large numbers of patients now receiving virtual (telephone or video) appointments. In order to 'lock in' this positive change, which reduces the need for patients to travel to hospitals, work on out-patient care will be managed as part of our routine business and not as part of the Path to Excellence programme.

3.22 The trust continues to have an ambition to develop an integrated imaging centre to meet the increasing demand for tests and scans; however this will no longer be considered as part of the Phase 2 programme and will be pursued as part of normal business planning.

Surgical Working Ideas

3.23 The working ideas for both General Surgery and Orthopaedics are being developed in more detail by our clinical leaders; however, working ideas in both specialties involve providing emergency/unplanned care from a single site:

- All emergency/unplanned operations at Sunderland Royal Hospital
- South Tyneside District Hospital focusing on providing planned operations
- Some planned operations will continue at Sunderland
- Out-patient care will continue to be provided from both sites

3.24 Similar models of care are successfully provided across the country and offer a number of benefits including:

- fewer cancellations or delays to planned operations for patients
- protected pathways supporting infection control principles
- improved care pathways for common injuries and conditions leading to better individual care
- better use of our theatre resources
- increased staff satisfaction
- improved training opportunities for staff

The working ideas are now being refined by clinical teams, considering feedback from wider staff engagement and other stakeholder feedback.

4.0 Public, patient and staff communications and engagement

4.1 An updated draft case for change document has been published to explain the current position and to ask people for feedback on key questions which are included below.

4.2 Communications and engagement activities include:

- Public information media release and social media
- Animation to explain the change in focus
- Live briefing sessions with staff
- Updates in staff newsletters and other communications channels
- Informal session's with Durham, South Tyneside and Sunderland Joint Health Overview and Scrutiny Committee (JHOSC) (formal sessions being planned)
- Briefing to programme Stakeholder Panel representing key partners
- Briefing sessions with Hospital Trust Governors
- Update to Clinical Commissioning Group Governing Bodies
- Updates to Primary Care teams (TITO)

Gaining views

4.3 We are gathering views about the plan to focus on developing proposals for changes to the way surgery services are arranged.

4.4 We are asking people to look at the updated case for change and tell us what they think are the important issues the Path to Excellence programme should consider by answering the six key questions below.

- How do you think the pandemic has impacted NHS surgery services?
- Has the pandemic changed the way you access NHS surgery services?
- Has the pandemic caused or highlighted any issues with travel and transport to NHS surgery services?
- What inequalities and/or disadvantages have you become aware of during the pandemic? How might these be addressed?
- What else do you think is important to take into account about surgery?
- What other ideas should the programme be considering about surgery?

You can do this via our on-line survey:
https://involvement.sunderlandccg.nhs.uk/surveys/23

You can view our Updated Draft Case for Change (February 2021)
https://pathtoexcellence.org.uk/wp-content/uploads/2021/02/NHS-PTE2-UCFC-Feb-2021.pdf

4.5 Work to engage with staff, the public and stakeholders will continue as working ideas are further developed, and feedback used to inform our plans as we approach public consultation.

4.6 There are plans to brief all three Health and Wellbeing Boards week beginning 15th March 2021. The views from each Health and Wellbeing Board will be taken into account by the programme in developing it's pre-consultation business case for change and developing proposals.

4.7 Board members are encouraged to provide views in line with the questions set out in section 4.4.

5.0 Next Steps

5.1 A pre-consultation business case is being developed; informed by the working ideas and stakeholder feedback, along with external assessments of our ideas by the Clinical Senate, a Travel and Transport Impact Analysis and an Integrated Impact Analysis (considering equality, health and health inequalities).

6.0 Recommendations

6.1 The Health and Wellbeing Board is asked to:

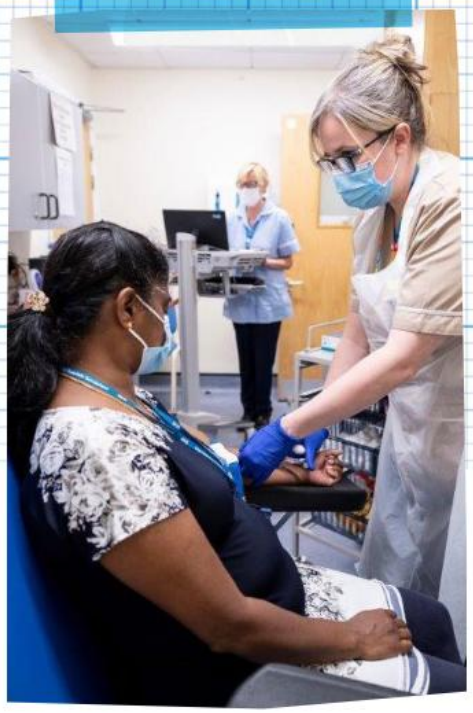
- Note the update on Path to Excellence Phase 2
- Review the updated case for change document
- Agree to provide views individually on the six questions via the on-line survey link https://involvement.sunderlandccg.nhs.uk/surveys/23
- Consider the updated case for change and agree to provide a Board view on the six questions

Working together

Phase Two Updated Draft Case for Change February 2021

to improve hospital services in South Tyneside and Sunderland

Understanding the impact of COVID-19



NHS partners working together:
South Tyneside and Sunderland NHS Foundation Trust
South Tyneside and Sunderland Clinical Commissioning Groups
County Durham Clinical Commissioning Group

The path to excellence

Introduction

This document provides an update on Phase Two of the Path to Excellence programme. It outlines key issues to consider due to the global COVID-19 pandemic. It follows three previous 'Draft Case for Change' documents.

These are all available at **www.pathtoexcellence.org.uk/publications**

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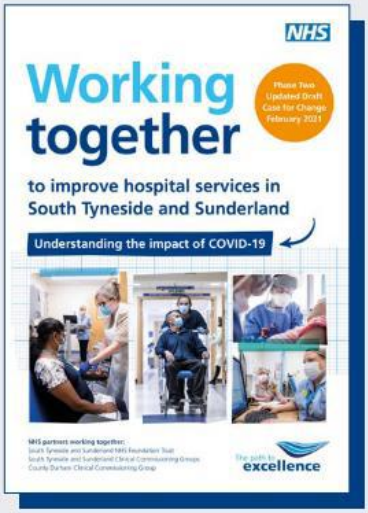
February 2019

Autumn 2019



February 2021

Background to Phase Two

Our local hospitals provide great care to thousands of people. Our NHS staff are highly dedicated. They want to make sure we always provide the highest quality of care.

Over the last five years, the Path to Excellence programme has been working to build upon these successes. We need to prepare for the future and the ever increasing demand for health and care services.

Our ambition is simple. We want to create outstanding hospital services for the future. We want everyone who uses South Tyneside and Sunderland hospitals to receive the best care possible. Our patients deserve no less.

Since 2018, frontline staff have been developing ideas for Phase Two of the programme. This work was paused in March 2020 to allow NHS staff to focus on the emergency response to COVID-19.

"Our ambition is simple. We want to create outstanding hospital services for the future."

A reminder - why is change needed?

The reasons why we need to improve hospital services have not gone away. The impact of COVID-19 has made the drivers for change more, not less, urgent than ever before:

Workforce

NHS staff are working under significant pressure. Even before COVID-19, we relied on the goodwill of staff to work longer hours and cover extra shifts due to vacancy gaps. This has increased even more during the pandemic. This is not good for staff health and wellbeing. We could improve this if we arrange hospital services differently.

Future demand

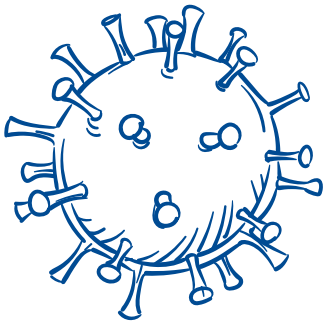
The pressure on staff links directly to the growing pressure on the whole NHS. Most hospital patients are aged over 80 with more health needs. More people than ever before are successfully treated by the NHS. This is thanks to medical advances and more technology. An aging population means demand will grow even more in the future.

Quality improvement

We deliver great care but it could be even better. Some of our hospital services do not meet the highest standards of quality and safety. We want to improve this. For example, we know some emergency patients are not seen quick enough by the right specialist. This is the case for some patients who may need emergency surgery.

Financial constraints

Our hospital services cost more to deliver than the funding we have. We run many duplicate services stretched across two sites. This means we rely on expensive temporary staff to fill rota gaps at short notice. If we changed some hospital services, we could maximise staff time and expertise. This would be a much better use of valuable resources and attract more permanent staff. Quality of care would also improve.



The impact of COVID-19

In March 2020, Phase Two was paused to allow staff to focus on managing COVID-19. The pandemic has impacted all aspects of NHS care. This includes GP services, community services, as well as hospital care. We have seen fantastic teamwork. Our staff have had to adapt quickly to a rapidly changing situation to keep everyone safe.

Some of the positive changes made because of the pandemic have been in our ambitions for a long time. COVID-19 meant we had to introduce new ways of working to reduce the spread of the virus and meet infection control guidelines. These changes had to happen quickly. For example:

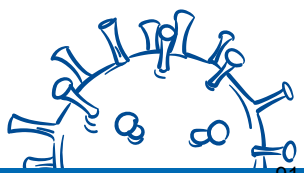
- **More hospital appointments now take place over the phone or using video.** This means less people need to come into hospital for new or routine appointments. Before COVID-19, less than 1% of planned hospital appointments took place over the phone or by video. This has increased to 44% (around 16,500 appointments) now taking place virtually every month.*
- **More people who need routine blood tests now have these done closer to home.** Patients can call a single booking line to arrange a blood test at a local community venue. This means less people coming to hospital. Previously, patients had to attend hospital to have their blood taken if this was required as part of their treatment.
- **Patients with COVID-19 are cared for in separate areas of the hospital to help stop the virus spreading.** This means other hospital patients, without COVID-19, can also be safely cared for. For example, people who need urgent operations, tests, scans and cancer treatments. This is vital for infection control purposes. It means planned treatments can carry on with less disruption.

Not all change has been so positive. At the start of the pandemic, the NHS postponed all non-urgent care to focus on COVID-19. As a result, many patients have had to wait much longer for routine treatment or operations. In South Tyneside and Sunderland we are making good progress to reduce these waiting lists but there is still much more to do.

Throughout the pandemic, we have continued to provide all urgent cancer treatment. Patients have also continued to receive other vital and time sensitive treatments.

You can find the latest information on waiting times at
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/

* Data correct as at January 2021



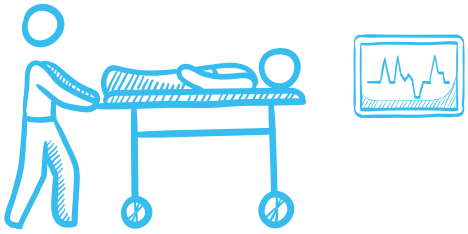
Impact on staff

The past year has had a huge impact on the entire NHS workforce. We recognise the enormous contribution that NHS staff have made with compassion, competence and professionalism to deliver patient care during the pandemic.

COVID-19 has increased the mental and physical pressure on NHS staff. They have had to think about the risk of infection to themselves and their family, as well as their duty of care to patients. Some staff even lived away from family and friends just to continue working.

Staff sickness rates due to COVID-19 have put extra pressure on front line clinical teams. Many staff have also been off work 'shielding'. Maintaining safe staffing levels has meant that staff have had to be flexible both with working patterns and their areas of work.

Staff health and wellbeing is now even more of a concern. The impact of COVID-19 makes the reasons for changing hospital services more urgent. Clinical leaders are keen to reflect learning from the pandemic. Good infection control is vital so that our hospitals can continue to safely manage.



Impact on patients

The pandemic has also changed how patients access NHS services. During the first wave, less people accessed emergency care and many patients did not attend planned appointments. People were worried about catching the virus. The NHS has given a very clear message that it is there for anyone who needs it.

Feedback about some of the changes made during COVID-19 has been positive. Over 82% of local people surveyed in September 2020[1*] would be happy to accept a virtual (phone or video) appointment. These can be more convenient for patients and reduce the need to travel to hospital.

The national decision to postpone all non-urgent operations has left the NHS with a backlog of patients. Many people are still waiting for surgery. This means we must continue to innovate and change to keep up with demand. We must also meet the ongoing need for strict infection prevention and control measures. This is vital so that we minimise the ongoing impact on planned services.

82%

of local people surveyed in September 2020[1*] would be happy to accept a virtual appointment.

[1] STSFT - Outpatient feedback on virtual consultations
* The survey asked 146 people for their views on virtual appointments.

Patient, public and stakeholder views

We have had fantastic support from patients, the public and our stakeholders. Overall, 80% of local people surveyed across South Tyneside, Sunderland and North and East Durham have told us they are satisfied with how South Tyneside and Sunderland NHS Foundation Trust has managed COVID-19. 85% of patients who have used the Trust's local services during the pandemic were also satisfied with their care. The public also remain optimistic about NHS standards. Over half of local people expect the Trust's services to improve further over the next two years.[2]

For patients with long-term conditions, the pandemic has undermined a perception that the NHS will always be there for them.[3] One in three people with an existing health condition delayed seeking help from the NHS. This rose to two in five for people with diabetes, lung disease and mental health conditions.

Results from the national patient access survey show that 59% of respondents were worried about their health condition. NHS staff are also worried that many patients are going without the support they need.[3]

80%

of local people have told us they are satisfied with how local services have managed COVID-19.

Impact on health inequalities

COVID-19 has impacted more negatively on certain groups than others. We know that people from black and ethnic minority groups were reluctant to get tested. This was due to fear of diagnosis and even death from the virus. They also did not seek help for symptoms. Asylum seekers and people from refugee communities were also reluctant to seek help.

The health inequalities further exposed by COVID-19 means we must work harder than ever to close the gaps that exist. We want to make sure everyone has access to the same high quality care. The pandemic has only accelerated the need for change.[3]

[2] South Tyneside and Sunderland NHS Foundation Trust Perceptions Research November 2020
[3] Path to Excellence Programme Reset COVID-19 Patient Insight Report December 2020

Which hospital services are involved in Phase Two?

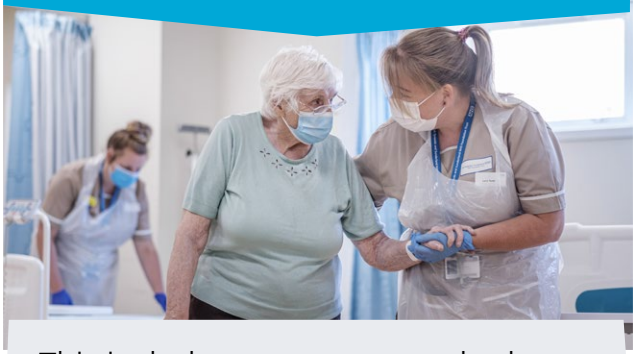
Emergency care and acute medicine

This is when people are admitted to hospital in an emergency and need life-saving treatment. It includes care in the Emergency Department (A&E).

Emergency surgery and planned operations

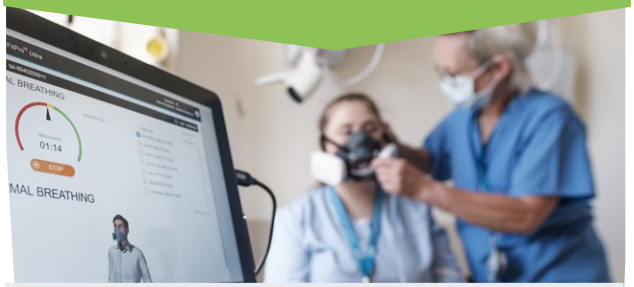
This includes patients who require an emergency operation and patients waiting for planned operations.

Planned care and outpatients

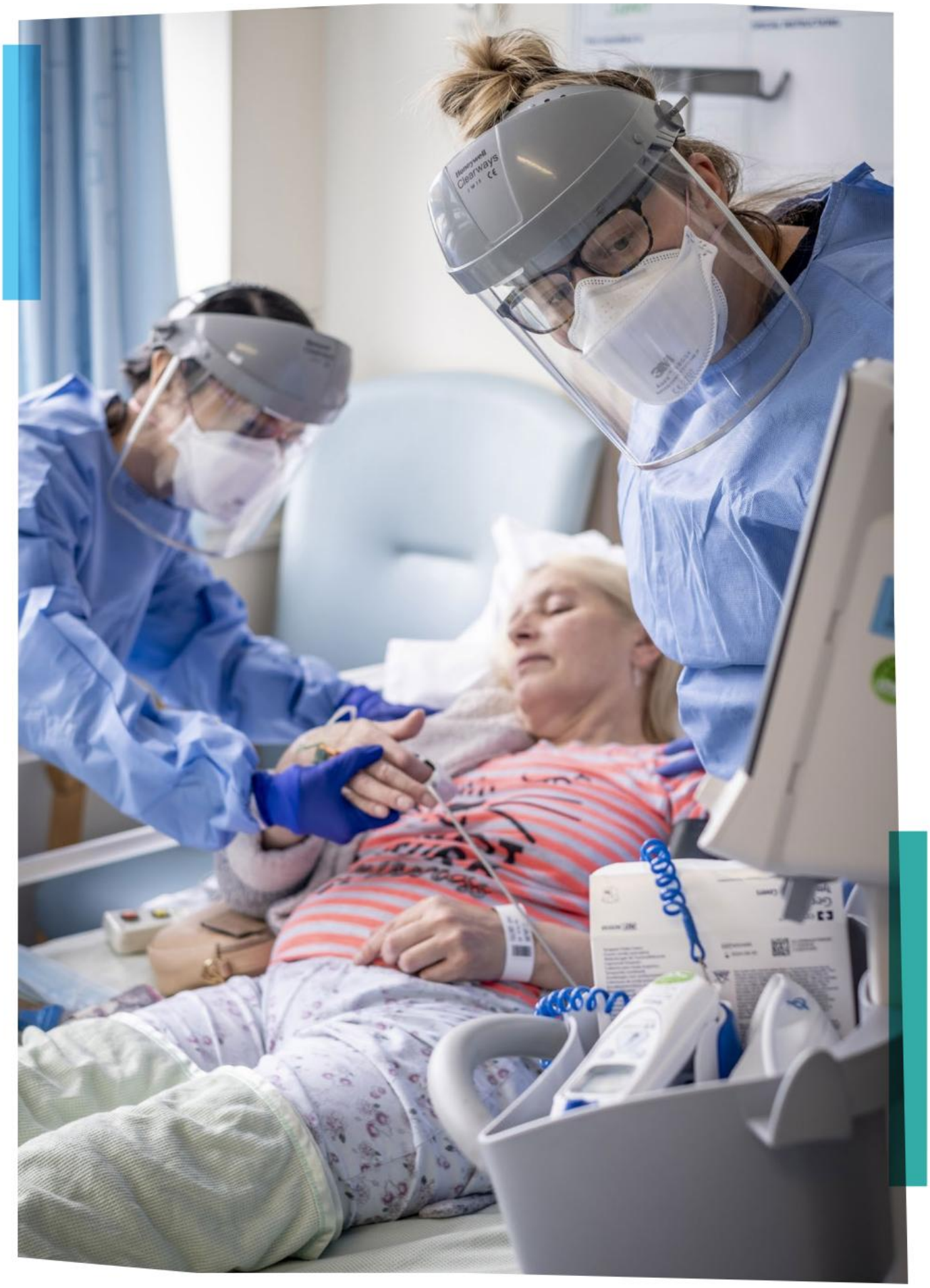


This includes tests, scans and other planned treatments.

Clinical support services (radiology, therapies and pharmacy)



This includes physiotherapy, occupational therapy, speech and language therapy, as well as clinical pharmacy and radiology or diagnostic services (scans and x-rays).


Honeywell
Clearways

Summary of working ideas

In February 2019, we published the 'working ideas' for Phase Two. These ranged from:

- **'least' change** by improving current models of care
- **'some' degree of change** by creating new models of care
- **'greater' change** by thinking radically about how to improve services for the future

We can only progress ideas that are realistic and are genuine proposals for change. This doesn't include keeping things as they are. We are open to ideas on how we can solve these problems - please see page 20 for how to get involved.

Least change

South Tyneside

Sunderland

Emergency care and acute medicine

24/7 access to urgent and emergency care services as per current service model but with enhanced 'same day emergency care'.

24/7

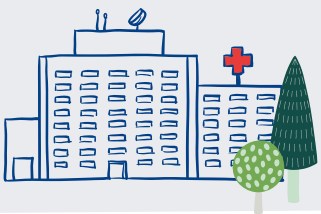
24/7 access to urgent and emergency care services as per current service model but with enhanced 'same day emergency care'.

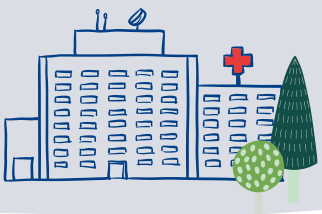
Emergency surgery and planned operations

Planned day case and inpatient operations.

All emergency and some planned operations.

Develop a new state-of-the-art Integrated Diagnostic and Imaging Centre at South Tyneside District Hospital which would offer world-class diagnostics and serve both local populations.

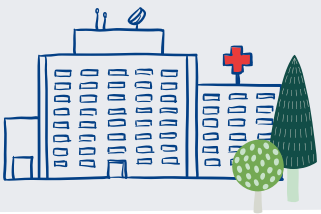


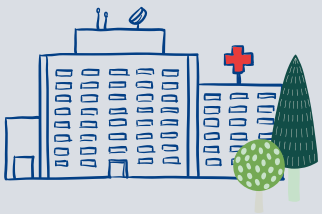


Some change

South Tyneside	Sunderland
Emergency care and acute medicine	
24/7 urgent access for patients with less serious emergencies.	24/7 access to specialist emergency care for patients with serious or life-threatening problems.
Same day emergency care / emergency ambulatory care 12 hours a day, seven days a week.	Same day emergency care / emergency ambulatory care 12 hours a day, seven days a week.
Local acute medical admissions via managed pathways of care with paramedics and GPs.	Acute medical admissions across all specialities.
Front-door 'frailty assessment' for older people.	Front-door 'frailty assessment' for older people.
Emergency surgery and planned operations	
Planned day case and inpatient operations.	All emergency and some planned operations.

Develop a new state-of-the-art Integrated Diagnostic and Imaging Centre at South Tyneside District Hospital which would offer world-class diagnostics and serve both local populations.

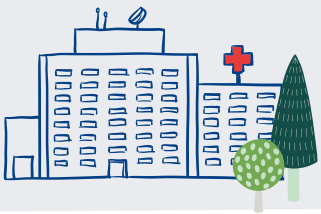


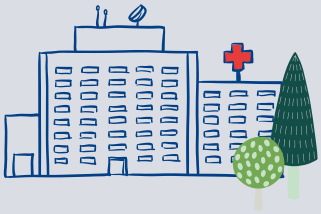


Greater change

South Tyneside	Sunderland
Emergency care and acute medicine	
24/7 urgent access for patients with less serious emergencies.	24/7 access to specialist emergency care for patients with serious or life-threatening problems.
Pathway led same day emergency care / emergency ambulatory care 12 hours a day, seven days a week.	Same day emergency care / emergency ambulatory care 12 hours a day, seven days a week.
Continued acute inpatient medical rehabilitation.	Acute medical admissions across all specialities.
Next day rapid review clinics in a range of specialities to improve timely access to a specialist opinion.	Front-door 'frailty assessment' for older people.
Emergency surgery and planned operations	
Planned day case and inpatient operations.	All emergency and some planned operations.

Develop a new state-of-the-art Integrated Diagnostic and Imaging Centre at South Tyneside District Hospital which would offer world-class diagnostics and serve both local populations.





Reviewing the impact of COVID-19 on our 'working ideas'

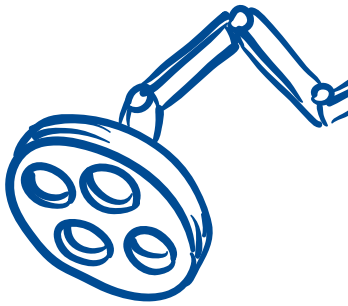
It is clear that the challenges faced by our hospitals remain. So does our ambition to create outstanding hospital services for the future.

COVID-19 has increased the pressures on staff and services. We cannot lose focus on the vital quality improvements we still need to make. We also cannot delay making some progress.

Given the ongoing challenge of COVID-19, we must also be realistic. The scale of service change in Phase Two is huge. Our clinical teams do not have time to consider everything, at once, during a global pandemic.

We have therefore agreed to focus on our 'working ideas' for surgery. This will give us the best chance of supporting staff and managing ongoing COVID-19 pressures. Most importantly, it will mean we can provide the highest quality of care and timely access to all patients who need an operation.

Why are we progressing with just surgery at this point?



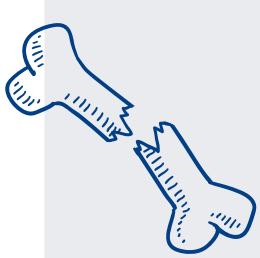
Our 'working ideas' for surgery have been discussed for a very long time. Surgical teams first began talking about this in 2016. They want to move forward and deliver the best possible care for patients.

When we talk about 'surgery' or 'surgical services', **this covers two main areas**:

Surgical services

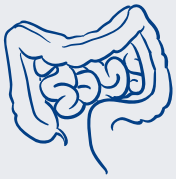
Trauma and orthopaedics

This type of surgery is to do with bones, joints and muscles. Trauma is the word we use to describe emergency operations to fix badly broken bones or injuries. For example, a broken hip. Orthopaedics is the word we use to describe planned operations on bones joints or muscles. For example, a new hip or knee replacement.



General surgery

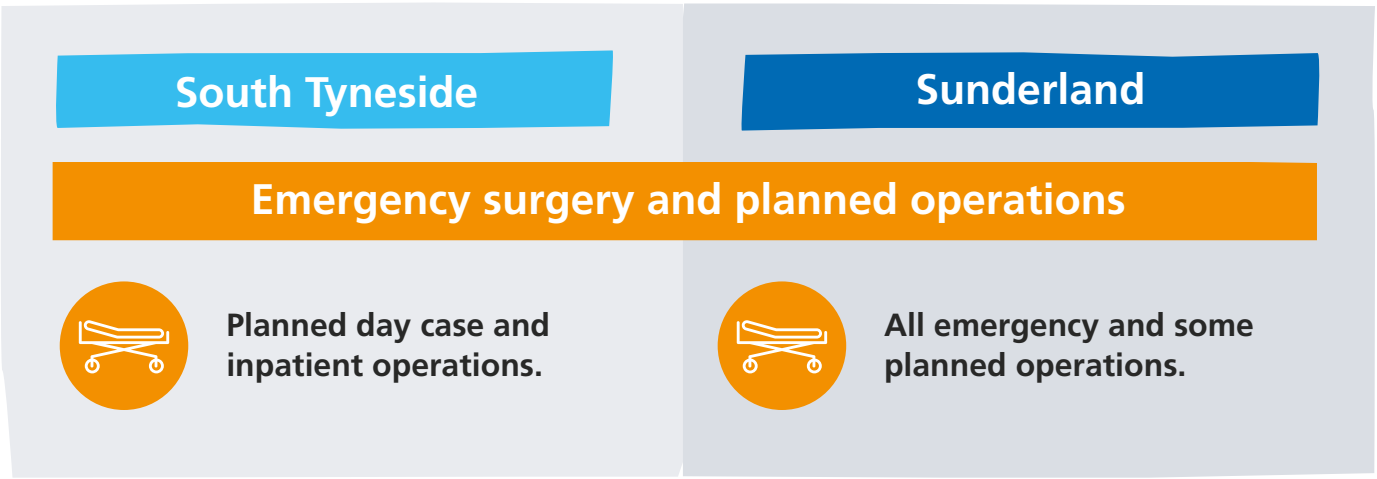
This type of surgery covers many parts of the body. Patients with cancer will often undergo general surgery as part of their planned treatment. The main operations we do are on the stomach (tummy), colorectal (bowels) and surgery to fix hernias. We also provide a specialist bariatric surgery service to help people with obesity. Some common emergency operations include gallbladder removal or removing a swollen or painful appendix. Most of our general surgery is now 'keyhole' surgery, which means a shorter stay in hospital and a quicker return to normal activities.



Our 'working ideas' would mean the majority of planned operations taking place on one hospital site. Emergency operations and some planned operations would take place on the other hospital site. Our 'working ideas' for General Surgery and Trauma and Orthopaedics would mean:

- **Emergency operations taking place on the Sunderland Royal Hospital site**
- **South Tyneside District Hospital focusing solely on elective 'planned' care**
- **Some planned care continuing on the Sunderland Royal Hospital site**
- **Outpatient care and diagnostic tests and scans would continue on both hospital sites.**

Both hospital sites would continue to deliver aspects of General Surgery and Trauma and Orthopaedics in the future. We will also need to consider how clinical support services such as physiotherapy and occupational therapy may also need to adapt.



By organising surgery in this way there are many benefits and it is a tried and tested model which many other parts of the NHS have already done this with great success. The main benefits are:

- **less cancellations or delays to planned operations for patients**
- **helping to prevent and control infection**
- **improved patient journey for common injuries and conditions leading to better individual care**
- **better use of our theatre resources**
- **creating services that attract and retain more staff and newly qualified staff.**

COVID-19 is another reason why we need to move forward quickly. Some patients have already had their operation in a different location to help us safely manage during the pandemic. We need to proactively plan how we do this in future.

As the NHS recovers from COVID-19, we also need to reduce our waiting lists of people who need planned operations. We do not want people to experience any further delays or cancellations. The NHS has been given clear guidance to change and redesign services to help recovery.

We do not want to delay our plans for surgical services any further. This will be vital on the road to recovery from COVID-19. As we progress these plans, we must make sure that any decisions we make around General Surgery and Trauma and Orthopaedics services do not negatively impact or influence how we deliver emergency care and acute medicine in the future – this is vital and really important.

What about other services in Phase Two?

Pressure on our Emergency Departments and medical wards has not gone away. The challenges are bigger than ever. However, we need more time to debate and discuss the impact of COVID-19. Frontline staff do not have time to do this right now. Further work will need to take place once the COVID-19 pressures ease. This will be subject to the same rigorous process, including public consultation, in future.

Many of our ambitions for planned care and outpatients are already becoming reality. COVID-19 has been a welcome catalyst for these positive changes. The benefits for patients and staff (see page 5) are obvious. We are now providing more services locally than ever before. We will always do this where this is safe to do so. This work will now continue as part of our normal planning/business.

The Trust's ambition for a new Integrated Diagnostic and Imaging Centre also has not gone away. The aim is to carry out more tests and scans, as we know demand is ever increasing. This will also be vital to help services recover from the pandemic and help reduce waiting lists. These plans have also been on hold during the pandemic. The Trust will continue this work as part of our routine planning/business and the ongoing need to increase diagnostic capacity.

Patient and public involvement

We have already collected **over 17,000 responses** during Phase Two.

People have responded to a survey or attended a meeting or event. Many have responded via social media such as a like, share, view or comment.

This includes feedback from NHS staff and patients who have used hospital services. We have also involved key stakeholders to help set evaluation criteria and assess the 'working ideas'. Local MPs, councillors and Healthwatch have also told us about key issues they would like us to consider. All feedback is very important and continues to influence our thinking.

You can read all of our feedback reports here:
https://pathtoexcellence.org.uk/publications/feedback-reports/

We value everyone's views and are always open to new ideas. No matter what stage of the programme we are in, you can discuss what you think with us. We can also connect you with other people who are interested in this work. Please get in touch with us with the details below.

Next steps

Over the next few months we will be fine-tuning our 'working ideas' for surgical services. We will also consider the impact of COVID-19.

As we do this, we want to hear the views of staff, patients and stakeholders. We want to know what is important to you to make hospital services better.

We hope to launch a public consultation later in the year.

Providing your views

Please tell us what you think are the key issues to consider. Think about the following questions.

How do you think the pandemic has impacted surgical services?

Has the pandemic changed the way you access surgical services?

Has the pandemic caused or highlighted any issues with travel and transport to surgical services?

What inequalities and/or disadvantages have you become aware of during the pandemic? How might these be addressed?

What else do you think is important to take into account about surgery?

What other ideas should the programme be considering about surgery?

Please tell us the reason for your views. Please tell us if you have any evidence to support your views.

How to get involved

There are lots of ways to get involved and give your views. The best way to find out what is going on is to look at our dedicated website. This includes up-to-date documents, links to surveys and details of up and coming events. We also widely promote activities through the media, online and via key partners and stakeholder groups. You can us any time via:

www.pathtoexcellence.org.uk

nhs.excellence@nhs.net

facebook.com/nhsexcellence

@nhsexcellence

We need your views
please get involved

Get involved

www.pathtoexcellence.org.uk

Item No. 10

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 2021

SOUTH TYNESIDE AND SUNDERLAND FOUNDATION TRUST HEALTH AND WELLBEING STRATEGY

Report of the Chief Executive of South Tyneside and Sunderland Foundation Trust

1.0 Purpose of the Report

1.1 Provide an overview of the South Tyneside and Sunderland Foundation Trust (STSFT) Health and Wellbeing Strategy.

1.2 Receive comments and feedback from the Health and Wellbeing Board.

2.0 Background

2.1 STSFT is committed to playing an active role in supporting the Sunderland Healthy City Plan and improving health outcomes across the city. The NHS Long Term Plan makes clear that NHS organisations have a key role in the prevention agenda and include examples of positive ways secondary care can contribute. STSFT appointed a Consultant in Public Health in December 2019 and have continued to develop their plans around prevention, working in partnership with others. STSFT will be key members of the Health and Wellbeing Delivery Boards.

2.2 Health inequalities have gained significant prominence in the national discourse over the last 12 months. NHS organisations, including STSFT, are committed to providing high quality care in a way that is appropriate and fair. As such, and in line with the plans of other key stakeholders, the STSF Health and Wellbeing Strategy has a central theme of reducing health inequalities.

2.3 The STSFT Health and Wellbeing Strategy is intended to compliment other strategic plans both within the Trust and beyond whilst providing areas of focus to ensure STSFT maximises opportunities to improve the health of the local population and reduce unfair differences in access, experience and outcome. The strategy is owned by STSFT and reports internally to the Executive Board, however its successful implementation will require effective partnership working across our local health economy.

3.0 Content of the STSFT Health and Wellbeing Strategy

3.1 The strategy has a central theme of reducing health inequalities and six areas of focus;

- Workforce Health
- Best Start in Life
- Patient Engagement

- Reducing Harms from Alcohol
- Healthy Environment
- Smokefree NHS

3.2 The themes were selected to align with the work of partners and national priorities. In addition they reflect some of the major health challenges faced by the local population.

3.3 Engagement from the workforce was seen as vital to success and STSFT staff were consulted early in 2020 to agree the priority areas. These were subsequently approved at the Trust Executive Board and the Trust Prevention group which includes representation from partners including the Local Authority and CCG.

3.4 Each theme of the strategy is overseen by an operation group which includes representation from across STSFT and beyond.

3.3 Further details of the objectives and measures used are included in the attached strategy (appendix A).

3.4 It should be noted that the reading age of the strategy has been assessed using validated tools and, following revisions, is now in line with the population reading age suggested by ONS (9-11 years).

4.0 Recommendations

4.1 The Health and Wellbeing Board is recommended to:
- Note the content of the STSFT Health and Wellbeing Strategy
- Provide comments and any feedback on the implementation of the strategy
- Agree to receive updates on the progress of the strategy via the Health and Wellbeing Board's Living Well Delivery Board

South Tyneside and Sunderland
NHS Foundation Trust

Health and Wellbeing Strategy

2020-2023

Contents

Foreword

South Tyneside and Sunderland NHS Foundation Trust is committed to meeting the aims of the NHS Long Term Plan. We will be putting prevention at the core of our work.

As such, I am very proud to launch our first Health and Wellbeing strategy. This plan sets out some of our Health and Wellbeing goals and the steps we will take to make them happen.

Giving great care to local people will always be our number one aim. But, the NHS is changing and we want to go further than ever before in helping patient's lead healthy lives. We also want to reduce the impact of ill health on local people and on our services.

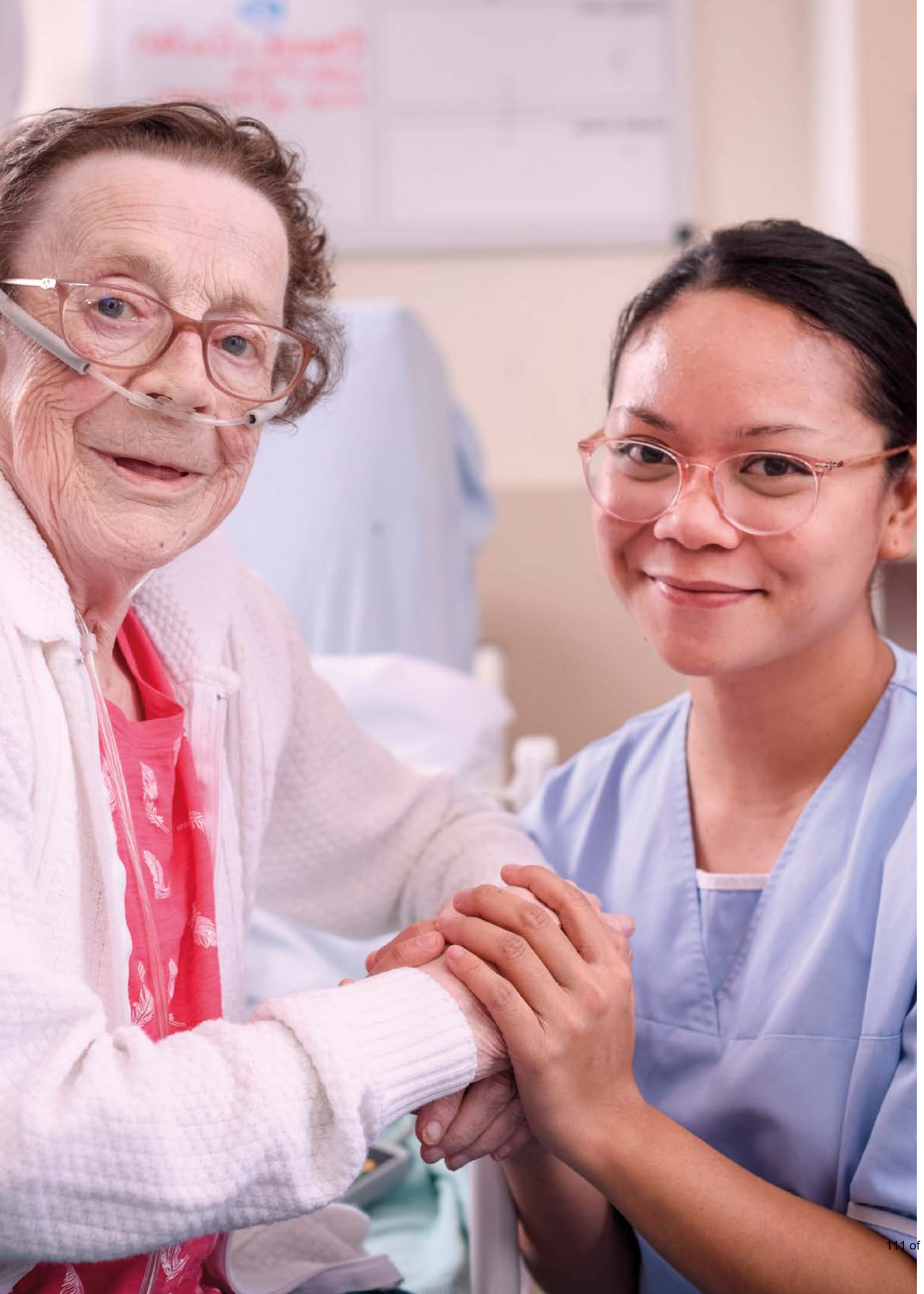
This is not the start of the journey for our Trust. Work such as our Path to Excellence and plans around Quality and Inclusion have helped us to focus more on prevention. The staff networks we have set up will also help to make sure we are inclusive in this work. Our Health and Wellbeing Strategy will support these projects and others.

To make real progress on the prevention agenda we cannot act alone. As such, this strategy fits in with the plans of our partners. These include the Health and Wellbeing strategies for South Tyneside and Sunderland. This helps us support a 'place based approach' that makes clear a patient's journey does not start and end in our Trust. Our Trust is a key part of our communities and we have a vital role to play in the health and wellbeing of our local people.

2020 has been the toughest year for the NHS and this includes our Trust. Now, more than ever, it is important for us to think about how we best serve our local people. A greater focus on prevention is not an extra thing to do. It also isn't the role of a single team or group. Rather, it must become part of business as usual for the Trust and for all of us working within it. I hope you will join me in supporting this plan as the next step in our journey to being a Trust that leads the way on prevention.

Ken Bremner MBE
Chief Executive
South Tyneside and Sunderland NHS Foundation Trust

Ryan Swiers
Consultant in Public Health
South Tyneside and Sunderland NHS Foundation Trust



Introduction

Our Health and Wellbeing Strategy will help us to improve and protect the health of staff and patients.

We want to focus more on preventing poor health and the impact it has on people. But, prevention can mean different things at different times. Because of this, we often split it into primary, secondary and tertiary prevention.

The NHS has a role to play in all three and exists to;

- Improve our health and wellbeing.
- Support us to keep mentally and physically well.
- Help us to get better when we are ill.
- When we cannot fully recover, to stay as well as we can to the end of our lives.

The table below gives some examples of prevention to help show how we, and our partners, are already involved.

	Description	Examples
Primary prevention	Seeking to avoid or reduce the chances of disease or risk factors	• Car seat belts • Smoking ban • Minimum Unit Alcohol pricing • Increased condom use • Childhood immunisation
Secondary prevention	Identify disease and risk factors early then reduce their impact and the development of disease	• Screening programmes • Medication (e.g. statins) • Smoking cessation • Referral to alcohol treatment services
Tertiary prevention	Achieve the best quality of life when living with disease	• Cardiac rehabilitation • Improved self care • Home adaptations

Prevention also means preventing health inequalities. These are **unfair** and **avoidable** differences in health. Because of them, some local children can expect to live up to 11 years less than their classmates. This unfairness is also the main reason why some groups of patients have better outcomes than others.

This plan aims to reduce health inequalities for local people. We want to make the things we do fairer for local people. The COVID-19 pandemic has highlighted these unfair differences. But these issues are long standing and will take time and effort to tackle. Our Trust will play a leading role in doing this.

The following health profile shows that there are many challenges to good health. But, we also have many local strengths; including our staff. By working with partners and local communities on this plan we can help to protect and improve health as well as reducing unfair differences in health.

Local profile

Our current local facts and figures 2020...

430,000

people living across
South Tyneside and Sunderland

Mortality for all cancer, cardiovascular health and all causes of death is significantly higher than the national average

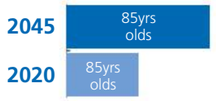
Life expectancy is:

77yrs men

81yrs woman

(both lower than the national average)

Healthy Life Expectancy (number of years someone can expect to live in good health) across South Tyneside and Sunderland is around 58 years. This is lower than the figure for England and the North East.



Our population is older than the national average. This difference is likely to increase more in the future. The percentage of people over 85 may almost double in the next 25 years.

Our local population is ethnically less diverse with around 95% seeing themselves as White British

Our Trust's facts and figures...

Over **8000 staff** who are part of our community plus over **1 million** opportunities to impact positively on the health of our patients.

A&E attendances
193,471
Adults = 150,876 Paeds = 42,595

Outpatient appointments
(new and review)
925,982

Planned day case procedures
70,063

Planned operations and procedures
(overnight stay)
7,363

Total inpatients
(overnight stays)
60,590

Beds unavailable due to delayed transfer of care
1,504

Average length of stay
2.38 days

Births
4,011

Clinical trials and research
358 studies
3,446 patients per year

Wards
42 approx

Beds
1,034 approx

Diagnostic tests
179,383

Turnover
£530m

Patients likely to recommend our services

	South Tyneside	Sunderland
Inpatients	98%	97%
Outpatients	99%	96%

Missed appointments
93,665
DNA rate = 8.8%

STSFT Health and Wellbeing Priorities

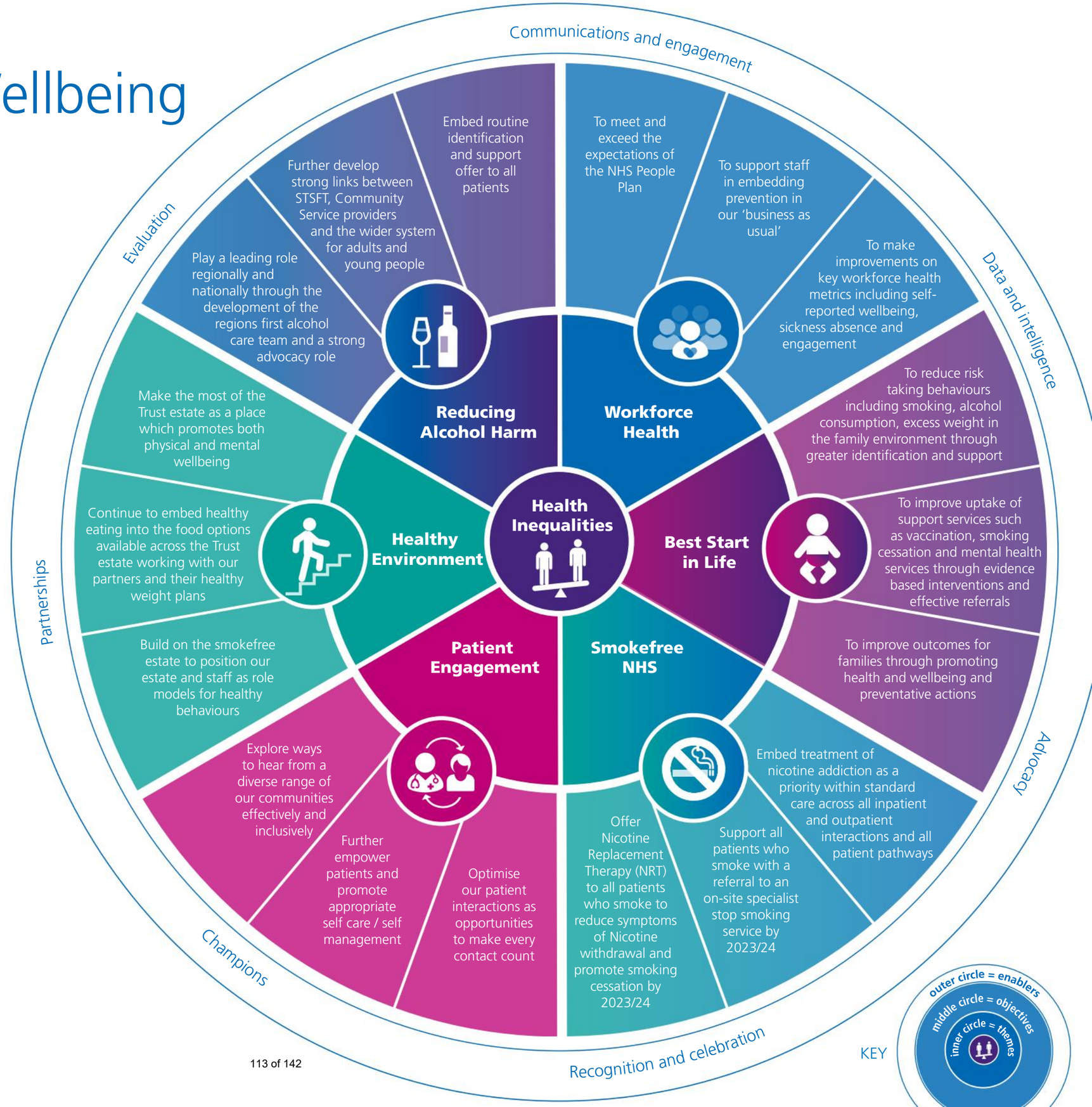
Our Health and Wellbeing strategy has six key themes. They are based on the health of local communities and the plans of our partners. We believe that these are areas where we can have a positive impact.

Our work to improve health and wellbeing will go beyond these areas but we want to have some key areas of focus.
The six themes are;

- **Workforce Health**
- **Best Start in Life**
- **Smokefree NHS**
- **Patient Engagement**
- **Healthy Environment**
- **Reducing Alcohol Harms**

We will also have a theme which aims to reduce health inequalities. Each theme will need to show that it is also tackling unfairness in that area. We will collect data and set targets that help us understand how we are doing. This includes data to understand if we are making things fairer.

The image opposite shows how our themes fit together. Reducing health inequalities is at the core of our work. Also shown are key 'enablers' which will help us deliver our plans. The following pages give more detail on our themes.



Health Inequalities...

Aim: To systematically embed the reduction of health inequalities in our way of working.

Context:

Health inequalities are unfair and avoidable differences in health between different groups. These differences are a result of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health. They affect how we think, feel and act. This shapes our health and wellbeing. Examples where health inequalities are known to exist include;

- Social and economic factors such as low income, poor housing and lack of green space.
- Factors such as age, sex and race. As well as sexual orientation and disability.
- At risk groups in society including migrants; homeless people; and sex workers.
- Geography such as in access to services between urban and rural areas.

Inequalities are found in access, experience and outcomes. We have the chance to reduce them in the services we provide.

Profile:

Many health outcomes in South Tyneside and Sunderland are worse than the rest of England. These differences are not set in stone. We can help to reduce them and make things fairer.

Local life expectancy is lower than the national average. Local people often live more of their lives in poor health too. In some local areas, people can expect to be in good health for just 50 years. Unfair differences in health exist between local people and the national average. They also exist within our own neighbourhoods.

COVID-19 has shown that different groups experience health and disease in different ways. COVID-19 has affected us all. Groups who already suffer many health and social inequalities have been hit hardest.

Health Inequalities	Executive Lead: Peter Sutton, Executive Director for Business Development and Planning	
Aim	To systematically embed the reduction of health inequalities in our way of working	
Objectives	• Improve use of intelligence to understand health inequalities in relation to the services we provide • Take action to reduce avoidable health inequalities in the services provided by the Trust • Promote a culture whereby reducing health inequalities is prioritised and scrutiny is on a par with safety and finance	
Indicators	Trust inequalities dashboard established. Annual improvement in data collection of ethnicity. Health inequalities update provided to executive and board annually (to include reductions in health inequalities and financial impact). Intelligence led interventions aimed at reducing inequalities delivered and evaluated. Annual increase in number of staff completing Trust prevention training. Health Inequalities considered in all Trust business cases. Workforce reporting to include data on potential inequalities.	
Actions	• Development of a Trust dashboard relating to inequalities (utilise existing and emerging tools such as the Public Health England tool) • Mortality review pilot to consider inequalities and opportunities for action • Review trust data and agree a plan for embedding measures of inequality as standard • Embed consideration of health inequalities in Trust processes such as business cases • Develop reporting mechanisms around inequalities in staff sickness • Health Equity Audits undertaken in target areas such as provision of support to stop smoking	
Subgroup membership	• Group Chair: Consultant in Public Health • Prevention Programme Lead • Inclusion Lead • South Tyneside CCG Lead • Sunderland CCG Lead	• South Tyneside Local Authority Lead • Sunderland Local Authority Lead • STSFT Prevention Analyst • PHE inequalities Lead • STSFT Operational Lead • Communications Representative

Workforce Health...

Aim: To improve the health and wellbeing of our workforce and become the 'employer of choice' in the North East.

Context:

Workforce health is a priority for the whole NHS. The Long Term Plan and the NHS People Plan stress that our people are our greatest asset. Looking after the health of our staff helps them and the communities we serve.

We know that our staff work hard to deliver great care and put patients' needs first. We also know that more staff take time off due to sickness than other sectors in the UK. We want to provide an environment and a culture that is supportive and inclusive.

Making STSFT the 'employer of choice' in the region is an aim of the Trust. This plan will support that goal becoming a reality.

Profile:

Staff report stress and mental health issues as a major concern. Many of our staff are not physically active. One in four do less than an hours activity per week. Two thirds of staff drink less than the advised two litres of water daily.

Staff would like to see a 'healthier' food offer at our sites. Staff have also made clear that they value being listened to. We know that recognition for hard work is important.

Workforce	Executive Lead: Kath Griffin, Executive Director for Human Resources
Aim	To improve the health and wellbeing of our workforce and become the 'employer of choice' in the North East.
Objectives	• To meet and exceed the expectations of the NHS People Plan • To support staff in embedding prevention in our 'business as usual' • To make improvements on key workforce health metrics including self-reported wellbeing, sickness absence and engagement
Indicators	Reduction in the rise of sickness absence (days lost and average length of time per episode). Improved staff physical and mental wellbeing (evidenced by bi-annual survey feedback). Improved staff engagement (evidenced by annual increase in staff survey completion). Annual increase in staff reporting that the Trust takes positive action on health and wellbeing. Increased uptake of staff psychological support services. Annual increase in number of staff completing Trust prevention training. Improved workforce culture as measured by regular cultural surveys. Annual increase in membership of the staff prevention network. Continued progress through Better Health at Work Award scheme. Tenfold increase in the numbers of staff offered support to stop smoking.
Actions	• Develop an action plan to meet the proposed metrics from the NHS People Plan • Continue to provide and develop workforce support around physical health (including management of long term conditions), mental health and wellbeing (including access to support services such as counselling and financial advice) as well as welfare (including health and safety assessments and training) • Establish a psychologically led staff support service to replace our current Employee Assistance Programme (EAP). This would support the organisation to have a more compassionate and inclusive culture with increased focus on a preventative approach to staff health • Develop reporting mechanisms around inequalities in staff sickness • Develop 'prevention in secondary care' training package for STSFT utilising STSFT staff. In addition staff Health and Wellbeing information and support to be covered the e-handbook • Continue to deliver and evaluate targeted health promotion activities • Establish a prevention network to engage with staff around Health and Wellbeing • Undertake an bi-annual workforce health needs assessment to inform action (Better Health at Work Award) • Review existing support and encouragement offered to staff around inactivity, alcohol consumption, smoking cessation, screening and wider determinants of health such as financial insecurity
Subgroup membership	• Group Chair: Deputy Director of Human Resources & Organisational Development • Head of Occupational Health and Wellbeing • Public Health Consultant • Occupational Health MSK and Wellbeing Manager • Head of Facilities, Health & Safety • Communications Representative • Equality, Diversity and Inclusion Lead • Directorate Manager • Matron • Staff Governor • Freedom to Speak up Ambassador • Staff Side Representative • Consultant Representative • Staff Network Chairs

Best Start in Life...

Aim: To play a leading role in the wider system effort in supporting children and families have a positive and healthy start in life.

Context:

Giving children the best start in life is a goal across South Tyneside and Sunderland. It is an key way to improve the health of our population. Much of our development (physical, emotional and educational) takes place in our early years.

What happens early in life (starting in the womb) has a lifelong effect on health and well-being. A child's start in life affects things including obesity, heart disease and mental health.

Profile:

Rates of smoking in pregnancy are high with one in six pregnant women smoking. Alcohol consumption in homes with children in is also high. Rates of breastfeeding are very low in local mothers.

Many women are overweight and not physically active when they are pregnant. Too many local women still suffer mental health problems before and after childbirth.

Best Start in Life	Executive Lead: Melanie Johnson, Executive Director for Nursing, Midwifery and Allied Health Professionals
Aim	To play a leading role in the wider system effort in supporting children and families have a positive and healthy start in life.
Objectives	• To reduce risk taking behaviours including smoking, alcohol consumption, excess weight in the family environment through greater identification and support • To improve uptake of support services such as vaccination, smoking cessation and mental health services through evidence based interventions and effective referrals • To improve outcomes for families through promoting health and wellbeing and preventative actions
Indicators	UNICEF baby friendly accreditation achieved at all our sites. Annual increase in the percentage of pregnant women who smoke making a quit attempt. Percentage of mothers smoking at time of delivery below the regional average. Annual increase in the percentage of smokefree households amongst pregnant women. Annual increase in the percentage of women achieving a healthy weight in pregnancy. Breastfeeding initiation to exceed the regional average. Annual reduction in alcohol consumed by pregnant women. Annual increase in number of staff completing Trust prevention training. Annual increase in vaccination in pregnancy uptake. Successful implementation of screening and referral for mental health during pregnancy.
Actions	• Take a leadership role in delivering system wide plans such as the Local Maternity System and Best Start in life Action Plans • Develop a measure for recording physical activity levels in pregnant women • Ensure robust and evidence-based systems are in place to support the identification, in pregnancy and postpartum, of behaviours that can harm health • Continue to promote and support pregnant women and their families around staying healthy. This could include the promotion of vaccinations, maintaining a healthy weight, positive mental health and tackling the risks from smoking and drinking alcohol • Register our intent to implement UNICEF baby friendly accreditation across our sites and continue to promote the benefits of breastfeeding
Subgroup membership	• Chair: Group to Project Lead • Head of Maternity • Public Health Midwife • Local Maternity System Lead • Consultant Paediatrician • Consultant in Public Health • Public Health Practitioner Sunderland and South Tyneside • Health Visitor • Community Midwife • Alcohol specialist midwife • Communications Representative

Smokefree NHS...

Aim: To create a smokefree culture where smoking is seen as a long term condition and addressing tobacco addiction is 'business as usual'.

Context:

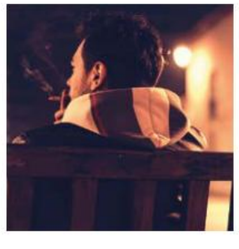
Smoking is the single biggest cause of ill health and death in our communities. One in two smokers will die from a smoking related illness. Smoking costs the NHS in the North East over £127 million a year.

The impact of smoking is not the same for everyone. It accounts for half the difference in life expectancy between the most and the least well off. Giving brief advice and nicotine replacement therapy (NRT) are highly cost effective interventions.

Profile:

One in six adults locally is a smoker. In routine and manual workers this number is one in four. Each year we provide care to thousands of smokers. Many of them are given NRT and over 400 were given support to stop smoking.

Hundreds of our staff have had brief advice training around tobacco. 80% of staff feel they have a role to play in helping the Trust become smokefree.



Smokefree NHS	Executive Lead: Sean Fenwick, Director of Operations
Aim	To create a smokefree culture where smoking is seen as a long term condition and addressing tobacco addiction is 'business as usual'.
Objectives	• Embed treatment of nicotine addiction as a priority within standard care across all inpatient and outpatient interactions and all patient pathways • Support all patients who smoke with a referral to an on-site specialist stop smoking service by 2023/24. • Offer Nicotine Replacement Therapy (NRT) to all patients who smoke to reduce symptoms of Nicotine withdrawal and promote smoking cessation by 2023/24
Indicators	Achieve over 90% identification of inpatient smokers. Achieve over 90% identification of outpatient smokers. Less than 20% of patients opting out of support offered via referral. 80% of smokers provided inpatient Nicotine Replacement Therapy. 50% of smokers provided Nicotine Replacement Therapy as part of discharge. Successful implementation of NICE Public Health Guidance (PH48). Annual increase in number of staff completing Trust prevention training. Annual increase in % staff identifying tobacco control as part of their role. Actions agreed for reduction of inequalities in quit attempts/success (year on year reduction in inequality).
Actions	• Continue to embed the smokefree policy through awareness raising, training and enforcement • Comprehensive programme of engagement around the role of staff in supporting a treating tobacco addiction approach • Further embed the treatment of tobacco dependency in clinical pathways • Streamline reporting of inpatient smoking status into a single report • Revise the staff smoking cessation offer to increase quit attempts • Work with smoking services and commissioners to manage increased demand on services
Subgroup membership	• Group Chair: Prevention Programme Lead • Consultant in Public Health • Public Health Practitioner South Tyneside • Public Health Midwife • Public Health Practitioner Sunderland • Communications Representative • Respiratory Nurse Practitioner • Emergency Care Consultant • Smoke Free NHS Strategic Manager (FRESH) • Pharmacist • Wellbeing Practitioner • Cardiology Nurse Practitioner • Specialist Stop Smoking Service Lead

Patient Engagement...

Aim: To continue to develop services with our communities aimed at providing the right service at the right time in the right way.

Context:

People have better experiences and improved health and wellbeing when they are involved in their own care. As such, we will keep listening to our communities and involve them in the way we work. We will aim to do this for all groups, including those who are not always heard.

We will continue to give patients the best care possible while we help them be 'active' in their care. This often means asking 'what matters to them' and not just 'what's the matter with them'.

Profile:

As a Trust, we have a number of ways to hear from patients and carers. Their views affect the way we work. We also carry out patient surveys and feedback to staff to help us improve patient experience.

We are working to involve patients more in their own care. The use of Patient Activation Measures (PAMs) is an example of this. This approach helps our patients be involved at a level which is right for them. This theme will support the work of the Trusts Quality Strategy.

Patient Engagement	Executive Lead: Liz Davies, Director of Communications
Aim	To continue to develop services with our communities aimed at providing the right service at the right time in the right way
Objectives	• Explore ways to hear from a diverse range of our communities effectively and inclusively • Further empower patients and promote appropriate self-management • Optimise our patient interactions as opportunities to make every contact count
Indicators	All patient and staff materials to mirror our local reading age. Patient feedback available by measures of inequality e.g. deprivation. Annual increase in number of staff completing Trust prevention training. Increased community involvement in Trust approaches to reducing health inequalities. Improved response rate to the NHS friends and family test. Improved response rate to the NHS annual patient survey.
Actions	• Map and consolidate existing patient engagement activity • Support and learn from existing areas of work such as the TOPIC project and use of Patient Activation Measures (PAMS) • Explore how best to hear the voice of our communities in different ways that focus on being inclusive and reducing health inequalities • Involve patients in STSFT prevention staff training resource • Reading age assessment process agreed • Develop ways of including measures of inequality in patient experience data
Subgroup membership	• Chair: Consultant in Public Health • Patient Representation • PAMS Project Lead • Clinical Psychologist • Young Persons Group Lead • Equity, Diversity & Inclusion Lead • Lead from TOPIC project • CCG patient engagement leads • Communications Representative

Healthy Environment...

Aim: To make STSFT a healthy environment which promotes health and wellbeing for patients, visitors and staff.

Context:

The places around us have an impact on our health. The World Health Organisation wants hospitals to be 'health promoting'.

To do this they need to support physical activity and positive wellbeing. They also need to be places which are dementia and disability friendly.

We want our Trust to be a place that supports a healthy life. Asking all patients if they smoke and then giving advice and support is an example of this. We know that these steps are good for staff, patients and the wider community.

Profile:

A third of local adults are not physically active enough. Two thirds of local adults are overweight or obese. Around a quarter of our year 6 pupils are obese.

Data on the mental health of our residents is limited. But, we do know that one in four people will suffer with a mental health condition at some stage. Locally, rates of depression and people coming to hospital due to self-harm are high.

Healthy Environment	Executive Lead: Steve Jamieson, Director of Estates
Aim	To make STSFT a healthy environment which promotes health and wellbeing for patients, visitors and staff
Objectives	• Make the most of the Trust estate as a place which promotes both physical and mental wellbeing • Continue to embed healthy eating into the food options available across the Trust estate working with our partners and their healthy weight plans • Build on the smokefree estate to position our estate and staff as role models for healthy behaviours
Indicators	Positive staff and patient feedback regarding Trust food offer and environment. Annual increase in levels of active travel in staff and patients. Dietary information available on selected menu choices every day in Trust restaurants. 80% of staff undertaking over 60 minutes of exercise per week. Annual increase in staff reporting that the Trust takes positive action on health and wellbeing. Annual increase in number of staff completing Trust prevention training. Annual increase uptake of cycle to work scheme. Annual increase in the use of Trust staff gym. An improved supported walking environment.
Actions	• Walk and cycle leader training offered annually to staff • Review staff uptake of active travel, exercise classes and gym facilities to inform actions • Conduct an assessment of estate walkability to inform improvements in signage, safety and promotion • Utilise in house expertise (dietetics, psychology, estates) to review the food offer in canteens, shops and vending machines and support agreed actions • Promote designated reflective quiet spaces inside and outside Trust buildings • Apply a behavioural insights approach to restaurant layout and promotion
Subgroup membership	• Group Chair: Public Health Registrar • Catering Lead • Dietician input • Estates Lead • Consultant in Public Health • Occupational Health Representative • CCG healthy weight/mental health leads • Tyne and Wear Sport • Bicycle User Group Lead • Physical Activity Leads (Local Authorities) • Communications Representative

Reducing Alcohol Harm...

Aim: To reduce the harmful impacts of alcohol on our communities and services.

Context:

Alcohol plays a direct role in over 60 diseases. This includes some cancers, heart and liver disease, as well as depression. For many, alcohol can be part of a healthy life. But, there are over 10 million people in England who drink at harmful levels.

In people aged 15 to 49; alcohol is the main risk factor for ill health, disability and early death. Since 1980, alcohol has become much cheaper for most people. In this time, alcohol sales in England and Wales have gone up by 42%. The North East suffers the highest levels of harm from alcohol.

Profile:

More people come to our hospitals due to alcohol than almost anywhere else in the country. This is true for adults and young people locally. Alcohol misuse costs the North East over £1.3 billion a year. Alcohol is also a factor in more than half of all violent crime.

To cut down on alcohol harms we need to challenge the stigma around how much we drink. We will also need to talk about how much we drink more often with our colleagues and patients.



Reducing Alcohol Harm	Executive Lead: Shaz Wahid, Medical Director
Aim	To reduce the harmful impacts of alcohol on our communities and services
Objectives	• Embed routine identification and support offer to all patients • Further develop strong links between STSFT, Community Service providers and the wider system for adults and young people • Play a leading role regionally and nationally through the development of the regions first alcohol care team and a strong advocacy role
Indicators	Annual increase in % of patients screened for alcohol use. Annual increase in % of patients referred for support around alcohol use. Number of patients engaged per month by the Alcohol Care Team. Annual reduction in avoidable alcohol-related hospital admissions by reducing severe health risk among dependent drinkers. Annual reduction in alcohol admissions in under 18s. Reduction in average length of stay for alcohol related admissions. Successful implementation of an alcohol care team as per the national specification (indicators to be confirmed). Annual increase in number of staff completing Trust prevention training. Annual increase in % staff identifying reducing alcohol harm as part of their role.
Actions	• Provide appropriate, timely and meaningful education and support for those attending or being admitted with alcohol-related problems • Facilitate joined-up alcohol care between secondary, primary and community care providers • Embed alcohol screening as a mandatory inpatient question supported by evidence based brief advice to patients • Analysis of the impact of screening for alcohol harms to inform cost benefit assessment and address potential gaps in provision • Develop and recruit Alcohol Care Team (ACT) and agree patient pathways to ensure the team is effective • Programme of staff engagement around our role in tackling alcohol harms in low, medium and high rise drinkers
Subgroup membership	• Group Chair: Prevention Programme Lead • Public Health Consultant • Public Health Strategic Manager South Tyneside Local Authority • Public Health Specialist Sunderland Local Authority • Consultant Gastroenterologist • Emergency Care Consultant • Directorate Manager • Liver Nurse Specialist • Community Alcohol Service Sunderland • Community Alcohol Services South Tyneside • Children and Young People Services Leads • Communications Representative

Enablers

There are a number of enablers which will help us achieve the ambitions of this plan. They will apply to all the health and wellbeing themes.

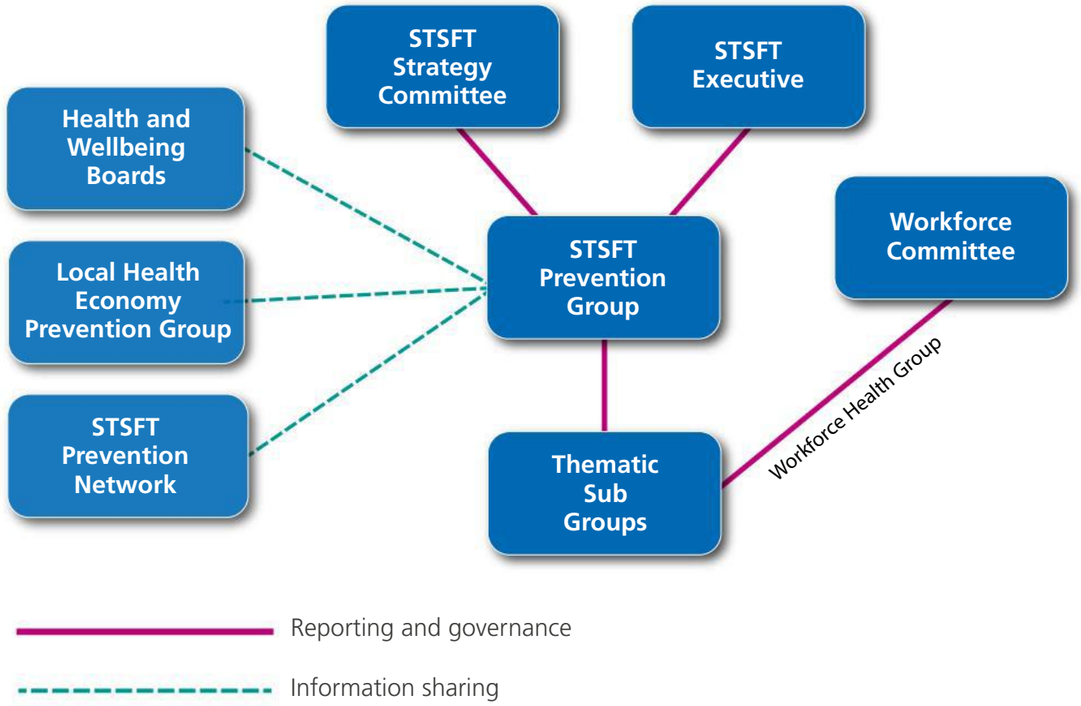
Enablers	
Communications and engagement	• Structured campaigns aligned to the HWB themes aimed at increasing awareness and supporting positive behaviour change. Patient facing communications to pay regard to existing inequalities and tailor messaging.
Data and intelligence	• Continuing development of a population approach to data which can inform our planning, delivery and outcomes along with the systematic consideration of health inequalities.
Advocacy	• Use our position as a system leader effectively to push for change and further support the prevention agenda (example - Minimum Unit Pricing).
Recognition and celebration	• Annual celebration event to include awards for staff that have made a significant contribution to furthering the Trust's work on prevention.
Champions	• Establishment of a Trust prevention network and the development a 'champion' role description to build capacity and skills.
Partnerships	• Continue to play an active role in local, regional and national forums working closely with our partners across the system (ensuring our work contributes to 'the bigger picture').
Evaluation and research	• Evaluation training for staff to ensure an evaluation of HWB strategy and themes in addition to developing our portfolio Public Health research.
Evaluation	• Development of a tiered prevention training approach to equip staff with the skills, motivation and confidence to embed prevention activities in 'business as usual'.

Governance

The STSFT Prevention Group will oversee this strategy. This group is supported by a working group for each of the themes. The Trusts Consultant in Public Health chairs the group. The Executive Lead is the Medical Director.

The STSFT Prevention Network will also link in to the group. This a growing group of staff involved in the prevention agenda.

The Prevention group will report to the STSFT Strategy committee and Executive Board. This will happen via meeting minutes and face to face (or virtual) updates. The Trust Non-Executive Directors will receive an annual update. Partners will also receive a regular update via the Health and Wellbeing Steering Groups.



Get in touch; get involved

For more information about this strategy or to get involved in the prevention work STSFT is developing please contact the Prevention Team at stsft.prevention@nhs.net

Useful Links

NHS Long Term Plan

https://www.longtermplan.nhs.uk/online-version/

Local Health and Wellbeing Plans

South Tyneside Health and Wellbeing Strategy:
https://www.southtyneside.gov.uk/article/58747/Health-and-Wellbeing-Strategy

Sunderland Health and Wellbeing Strategy:
https://www.sunderlandpartnership.org.uk/sites/default/files/files/page/health_and_wellbeing_strategy.pdf

Health Inequalities

The Marmot Report - 10 years on:
http://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on

Workforce Health

NHS People Plan 2020:
https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

Best Start in Life

PHE Guidance- Best Start in Life (2016): https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life

Patient Engagement

Kings Fund- Patient Engagement Webpage:
https://www.kingsfund.org.uk/topics/patient-involvement?gclid=EAIaIQobChMI56fl946-6wIVCbTtCh3PHA9OEAAYASAAEgK9IPD_BwE

Healthy Environment

PHE Active Hospitals Case Study:
https://www.gov.uk/government/case-studies/active-hospitals

Reducing Alcohol Harms

North East Regional Alcohol Programme (Balance):
http://www.balancenortheast.co.uk/

Smokefree NHS

North East Regional Tobacco Control Programme (FRESH):
http://www.freshne.com/

Please note many of the photos used throughout this document were taken pre-covid.

Item No. 11

SUNDERLAND HEALTH AND WELLBEING BOARD 19 MARCH 2021

DEVELOPING AN ADULT MENTAL HEALTH STRATEGY FOR SUNDERLAND

Report of the Director of Contracting, Planning & Informatics, NHS Sunderland CCG

1.0 Purpose of the Report

1.1 The purpose of this report is to provide the Sunderland Health and Wellbeing Board with an update in relation to the recent work undertaken to develop an Adult Mental Health Strategy for Sunderland.

2.0 Background

2.1 As presented to the Health and Wellbeing Board in December 2020, Sunderland CCG has committed to developing an Adult Mental Health Strategy for the city. Members may recall that the strategy development was broken down into four key phases.

2.2 This report will provide a summary of the work concluded in phases one and two of the development and the plans in place to work through phases three and four.

3.0 Phase One – Engagement on the Scope

3.1 Whilst we carefully considered the scope of the strategy, we invited a wide range of stakeholders to provide feedback. We therefore held conversations with representatives from the following groups of people to work collaboratively to develop the scope. This included clinical leaders within the CCG, All Together Better Programmes, Together for Children, representatives from GP Practices, providers, CAMHS Strategic Partnership and Sunderland City Council elected members and officers.

3.2 The feedback received from key partners confirmed their agreement that the scope was appropriate. However, it was noted that whilst children's services were out of scope for this strategy, it was extremely important to capture the transition process from children and young people's services to adult services to ensure that this was streamlined and that the experience from a patient perspective was positive and without disruption to care. In addition, there was commitment to continue to listen to feedback through the public engagement as to whether the strategy would include or exclude children and young people's services.

4.0 Phase Two – Involving People

4.1 On 23rd November 2020, the engagement phase of the strategy development commenced. This was the beginning of a large scale engagement exercise to capture the thoughts, views and experiences of not just partner organisations but patients/service users, carers, staff working in mental health services, employers and the general public.

4.2 A suite of questionnaires were publicised covering four key cohorts:

Public survey – this survey explored public perception of mental health services, including awareness of available services and access.
Service users and carers – this survey explored experience of mental health services from a service-user and carer perspective**.**
Large employers – a survey was circulated to large employers in Sunderland to explore work-based mental health support.
Staff survey – this survey explored the views from people who work with the service, to understand what works and what needs improving from a staff perspective.

In addition, approximately 1,300 public paper surveys and 200 service users paper surveys (complete with reply-paid envelopes) were distributed to assisted living accommodations, care homes, food banks, refugee and asylum seeker support organisations and other voluntary and community sector organisations (VCSOs). Additional paper copies and easy-to-read versions were also made available should they have been required. In total, there were eight hundred and forty six respondents to the survey.

4.3 One-to-one interviews were held with a range of key staff to understand from their perspective; what works well, where improvements could be made and their overall thoughts of how mental health services operate. Individual interviews were held with:

- Sunderland CCG Clinical Lead
- Providers – Sunderland Counselling Service
- Providers – Washington Mind
- Providers – Cumbria, Northumberland, Tyne and Wear Mental Health FT
- Sunderland City Council – Adult Services
- Sunderland City Council – Public Health
- All Together Better
- Sunderland GP Alliance
- General Practice representatives

4.4 A number of focus groups and interviews were held with Sunderland patients, residents, and service users from VCSOs, including a specific public and a male only focus group. It was hoped that a staff focus group would also be held, however due to pressures and constraints as a result of Covid, this was

not possible, therefore staff were offered the opportunity to take part in an individual interview.

4.5 To maximise engagement from all members of the community and to receive a diverse wealth of feedback, VCSOs were approached to run asset-based focus groups with their service users on behalf of the CCG. Two independent focus groups were also held in response to gaps in responses from these groups. The following focus groups with eighty-six participants provided feedback:

- African Women Voices – supporting African Women in Sunderland
- Age UK Sunderland – Essence Service (x2 groups)
- Sunderland Bangladeshi International Centre (specifically covering Women's BAME)
- Becoming Visible – providing support for the deaf community
- Crest - supporting Black, Asian and Minority Ethnic (BAME) groups
- Healthwatch Sunderland volunteers
- HOPs Wellbeing service – supporting people with mental disabilities and carers
- Pregnancy and maternity – independently ran
- Race and religion – independently ran
- Sunderland People First - supporting people with autism and learning disabilities
- True Colours – LGBT support group for 16/17-year-olds (through Sunderland College)

4.5 The public and partner organisations were invited to provide feedback via email, public (virtual) meetings, social media, or other avenues. Where the public has commented on social media, they were offered the opportunity to email in any specific comments or participate in a 1:1 interview; these offers were not taken up.

4.6 It had been planned to close the engagement phase on 22nd January 2021, however following the publication of an article in the Sunderland Echo highlighting the engagement work the closing date was extended until 27th January 2021.

4.7 Regular briefing notes have been shared with key stakeholders to ensure they were kept abreast of the work underway and to seek assistance in publicising and encouraging participation in engagement.

4.8 In total 1018 members of the public, services users and carer, staff, employers, VCSO and other organisations participated in the research.

5.0 Phase Three – Review of Findings

5.1 In order to check the research captured, the draft report will be shared for comments and feedback. A final report will be produced after receiving this feedback.

The draft report will be shared in a number of ways:

Sharing with stakeholders - A draft report will be shared on the CCG website, and circulated to stakeholders, partner organisations, people who took part (if consented), and through social media. People will be invited to provide comments on the report and an opportunity to ask any questions they may have.

Sharing at meetings – A draft report will be shared with various groups, including the clinical leaders, All Together Better, Children's Integrated Commissioning Group, Equality, Diversity, and Inclusion Network, Sunderland Involvement Partnership, and the Patient and Public Involvement Committee.

Online feedback session – A short presentation with key findings will be shared widely, and people will have the opportunity to submit questions or comments. A list of common questions and answers will be compiled. Responses to the questions and comments raised will be shared and publicised via the CCG website.

Focus Groups - Some focus groups will be held with people from protected characteristic groups in order to sense check the research findings.

5.2 In addition to the substantial engagement work, we have worked with Public Health colleagues to refresh the 2019 Mental Health and Wellbeing Joint Strategic Needs Assessment. It is anticipated that the intelligence gathered from the Health Needs Assessment will support the development of the vision and content of the strategy.

6.0 Phase Four – Present and Publish the Strategy

6.1 Using the analysis generated from the engagement phase, work will begin to develop the content of the strategy. The key themes that have emerged from feedback will be reviewed and incorporated to ensure that the needs of the city are reflected in the strategy.

6.2 It is anticipated that the Mental Health Strategy for Sunderland will be published in the spring of 2021.

7.0 Recommendation

7.1 The Board is asked to note the content of this update for information.

Item No. 12

SUNDERLAND HEALTH AND WELLBEING BOARD 19th March 2021

HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION OVERVIEW: MAKING HEALTH INEQUALITIES OUR BUSINESS

Report of the Executive Director Public Health and Integrated Commissioning

1.0 Purpose of the Report

1.1 This report provides an overview of the *Introduction to Making Health and Inequalities Our Business*, Health and Wellbeing Board Development Session held on 21 January 2021. It sets out the topics covered and findings of the workshop activities.

1.2 The Health and Wellbeing Board are asked to note the content of this report and consider how health inequalities are considered within everyone's business.

2.0 Background

2.1 Health inequalities are unfair differences in health status between different groups. These differences are seen nationally and locally, with the most disadvantaged living shorter lives, in poorer health than those in the least deprived areas.

2.2 These differences in health and life expectancy are determined by the social, economic and environmental circumstances in which we are born, grow, learn, work, live and age. They happen across different stages of life and can accumulate over time.

2.3 Covid-19 has exacerbated existing health inequalities and introduced new ones. Whilst the pandemic has affected us all, some groups have been disproportionately affected. Sunderland's Covid-19 Health Inequalities Strategy highlighted the need for a health in all policies approach to address some of the root causes of health inequalities.

3.0 Findings of the Development Session – the social determinants of health

3.1 The development session looked in detail at the social determinants of health, and how these factors are responsible for a large proportion of health outcomes. Where you live has a significant impact on health inequalities, and persons living in the most deprived parts of Sunderland are expected to live a shorter life, than those living in a similarly deprived area of London. Healthy life expectancy (the average number of years an individual is expected to live in a state of good or very good health), is 57.9 years for a Sunderland male compared to an English best of 71.9 years, for females it's 56.5 years in comparison with an English best of 72.2 years.

Infographic: *What Affects our Health?*

3.2 Health inequalities also exist within in Sunderland with a life expectancy difference at birth of 11.5 years for males and 8.5 years for females between the most and the least deprived areas.

3.3 The session explored how these social determents relate to health outcomes, using the example of an average family in Sunderland. It explored the barriers to physical activity and the impact excess weight in childhood has on health, the importance of educational attainment, and how women with lower attainment have higher mortality, and how healthy diet may be influence by income and the importance of this in relation to cardiovascular disease and diabetes.

3.4 **Findings of the Development Session – Covid-19 and Health Inequalities**

3.5 The session went on to examine how the pandemic had increased existing inequalities and introduced new ones. The findings of Sir Michael Marmot's Build Back Fairer report[1] highlighted how existing health inequalities led to high and unequal mortality in England.

3.6 The report highlighted how the loss of learning has been greater for children from less wealthy backgrounds, how unemployment is disproportionately rising among young people, and that low paid workers, BAME groups, disabled workers, women, part-time workers and the self-employed are also disproportionately affected. It highlighted the importance of housing and how costs associated with housing remained high, despite incomes falling. Those in poor quality housing, living in unhealthy conditions, would find lock down particularly hard.

[1] http://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review

3.7 Covid-19 itself has had a direct impact on health inequalities with higher risk of mortality among older age groups, males, Black and Asian ethnic groups, those with underlaying health conditions such as cardiovascular disease, diabetes or kidney disease, and some occupational groups (particularly those where individuals cannot work from home, or with a greater risk of exposure).

3.8 A recommendation of the Covid-19 Health Inequalities Strategy[2] is to take a whole system and Health in All Policies approach to addressing some of the social determinants of health. This would support the recovery from Covid-19 and work to reduce health inequalities in the long term, building a healthier and more resilient population.

3.9 Findings of the Development Session - Health in All Policies

3.10 Health in All Policies is an internationally recognised approach to public policies across sectors that systematically takes account of the health and equity implications of decisions and seeks to find synergies and opportunities to maximise positive health benefits and avoid negative impacts.

3.11 The approach requires strong partnership work and collaboration. To be successfully implemented a shared language is required, with those across differing sectors needing to understand the opportunities, structures and processes of others. The approach should engage stakeholders and aim to create structural and procedural change, so that consideration of health inequalities becomes embedded and a part of normal, everyday decision making.

3.12 There are several methods and tools that can be used to support the approach including Health Impact Assessment, Health Lens Analysis, Health Equity Assessment, and Health Inequalities Impact Assessment.

3.13 Findings of the Development Session – Participant Workshops

3.14 There was participation in the development session from 52 individuals. Participants included members of the Health and Wellbeing Board and

[2] Draft COVID-19 Health Inequalities Strategy

partners from across sectors including business, health and social care, education, planning, housing, transport, and emergency services.

3.15 Participants attended one of six breakout groups to consider key initiatives and opportunities in Sunderland that impact on health inequalities and discuss ideas for making health inequalities everyone's business moving forward.

3.16 From the workshop discussions and pledges, several themes were identified:

3.17 These themes highlighted sectors in Sunderland that influence health equalities and opportunities to consider this in decision making. The discussions also identified resources important to supporting a Health in All Policies approach, such as utilising data to understand inequalities and demonstrate impact, and the use of tools, such as Health Impact Assessment (HIA).

3.18 Pledges from 32 stakeholders were made (appendix A). They included pledges to make procedural changes, such as including health inequalities as a standing agenda item, as well as using the learning from the session to champion the approach. Use of Health Impact Assessment as method of implementation was highlighted in multiple pledges.

3.19 Next steps

3.20 Using the findings of the development session, and a mapping exercise conducted with Public Health, Officers will look at how at how some of the methods shared could be used to build capacity and develop the approach, such as use of data and intelligence, and Health Impact Assessment. A paper will be presented to Public Health SMT with implementation options for consideration.

3.21 For a Health in All Policies approach to be successful, it must be adopted, supported and owned across departments and sectors. This includes those, where health may not have historically been considered as a primary goal but whose work has a significant impact on the social determinants of health. Therefore, this will be considered within governance arrangements that will be put in place to support the Healthy City Plan and other policy areas. This way, we can tackle the root causes of health inequalities.

4.0 Recommendations

4.1 The Board is recommended to:

- Note the content of the report and support the next steps outlined.
- To champion consideration of health inequalities through a Health in All Polices approach which will be led by the Health and Wellbeing Boards Living Well Delivery Board.
- Contact Louise Sweeney, Public Health Registrar, if Board members have further ideas or feedback.

Appendix 1: Pledges

1. All Together Better Executive group has made a firm commitment to make *Measurable improvements in population health and reduced inequalities*, its first priority. My pledge is to explore with Louise Sweeney how to use the HI Impact assessment for ATB.
2. Pledge to undertake Health Impact Assessments on all future iterations of the Local Plan to improve health outcomes of planning policies
3. To talk to senior colleagues in my organisation about adopting the health impact assessment approach.
4. My pledge is to work with partners to support work around developing health impact tools so that we can work more upstream and have a more preventive approach across the City.
5. Pledge to undertake review of hospital food available plus explore avenues to display calorific content of meals.
6. Pledge to work in partnership on the wider solutions to Homelessness in all its forms and ensure everyone has access to accommodation and support they need across the City.
7. Take the learning of partners working together and feedback from residents to shape the future delivery of services across the City. I think we should appreciate and praise staff who have kept the City going.
8. Pledge to think about co-production as a matter of course when planning work.
9. My pledge is to re-double efforts to look at how we can support the Digital disadvantage in Sunderland due to its potential negative impact on health and people's economic position. Secondary pledge is to make every effort to support other's pledges.
10. I pledge to take forward the ideas from the group discussion around piloting of work in areas of most need.
11. Pledge 1 - Healthwatch will include health inequalities as a standing agenda item for its board meetings. Pledge 2 - Healthwatch will engage more with socially deprived by engaging at food banks where practical.
12. Pledge to ensure the profile of health and its importance to residents, employers etc isn't lost post-covid but it a key part of what we do in recovery.
13. Pledge to a targeted approach to dealing with deprivation and the associated health inequalities.
14. My pledge is to explore existing tools which will enable the system to embed health inequalities into core business.
15. I pledge to take the insightful and valuable information I have learned today and embed some of them into my organisation.
16. My pledge through the work of the Smart Cities Strategy is to continue to maximise social value contributions within contracts, to reduce digital exclusion across the city and to maximise digital training, enterprise and employment opportunities.
17. I pledge to explore opportunities for more insight based targeted communications.
18. Pledge to work with partners so our current students can contribute to real-life challenges and projects as part of their studies or research
19. My pledge is to ensure health is a cross cutting theme in strategic housing role and to gain assurance from RPs operating the city that they are working proactively to reduce health inequalities too.

20. Pledge to make reducing health inequalities part of the organisation's way of thinking, culture and processes.
21. I pledge to be an enabler in understanding of what success looks like.
22. Pledge to support the development of social enterprise to improve community resilience, alongside delivery of the community wealth strategy and neighbourhood investment plans. Ensure residents are able to share their views to influence services to improve health and wellbeing.
23. Pledge to ensure that we continue to engage and further involve organisations in the development of our active travel and other transport proposals and plans
24. In Occupational Health we deal with effects of health on work and work on health – The nature of health conditions some of which are more common in certain social groups do have an impact on the individual's ability to maintain work which has a direct correlation to personal wealth and economic power. The work Occupational Health does in supporting individuals with disabilities in remaining in work by providing advice around adjustments and mitigating the negative adverse impact of health conditions helps address social inequalities brought on by loss of earning power through unemployment.
    - Employment rates amongst disabled people reveal one of the most significant inequalities in the UK today: less than half (48%) of disabled people are in employment compared to 80% of the non-disabled population. Occupational Health provides a window to the nature and impact of health conditions some of which are often unrecognised until discussions in Occupational Health consultations. The Occupational Health practitioner can signpost employees to appropriate services including primary care so that early treatment can be accessed in reducing medical complications which can result in loss of employment and a slide in social hierarchy through financial incapability.
    - We provide a preventive and rehabilitative service to anyone in any employment.
    - By working collaboratively with Sunderland's chamber of commerce/CCG etc., SCC's Oh service can provide good quality, cost effective Oh service to local businesses and other organisations
25. Pledge to ensure that City Board review of City Plan in March reflects discussion today in terms of health inequalities and health impact assessments. Really enjoyed the session and looking forward to working across the partnership to see how we can collaboratively make an impact on Health inequalities.
26. My pledge is to support partners to embed the principles and tools and continuing the conversation.
27. I will ensure children and young people are involved in decision making, identify how we have reduced inequalities by showing the 'difference made' and celebrate our successes!
28. Pledge to work with partners on developing metrics and tools for better measuring any impact we're having on reducing inequalities
29. Pledge to use City Plan development / delivery as a tool to encourage reducing health inequalities as a focus under all themes.
30. I pledge to connect Chamber members and Sunderland business owners with the occupational/mental health support that is available as I now have an understanding of the support available.

31. Pledge to undertake review of HIA outcome in conjunction with commissioners at pre-procurement stage and explore how to raise more specific awareness with external suppliers to link social value opportunities.
32. I pledge to work with partners to improve those neighbourhoods in greatest need - to improve housing standards and environmental conditions and listen carefully to residents.

Item No. 13

SUNDERLAND HEALTH AND WELLBEING BOARD 19 March 2021

HEALTH AND WELLBEING BOARD FORWARD PLAN

Report of the Senior Policy Manager, Sunderland City Council

1.0 Purpose of the Report

1.1 To present to the Board the forward plan of its business for 2021/2022.

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.

Sunderland Health and Wellbeing Board – Draft Forward Plan (Note: subject to change. Last updated 10.3.21)

MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	AUGUST 2021
Public Meeting – 19 March 2021 • Covid-19 update • Healthy City Plan governance • Future arrangements for JSNA, incorporating the PNA • NHS White Paper and next steps for integration of place based arrangements • Path to Excellence • STSFT HWB Strategy • Update on the development of the Mental Health Strategy • HWB Development Session Feedback **Development Session – Behavioural Insights Approach** Session to be led by the Best Start in Life Working Group – 23 March			**Public Meeting - 25 June 2021 (TBC)** • Covid-19 update • Update on ICS and place-based integration arrangements • Delivery Boards – agree terms of reference, for information report updating on work of last 3 months, and any substantial items • Path to Excellence update • Mental Health Strategy approval (TBC) • Health Watch Annual Report • Health Protection Assurance Report • JSNA progress report		
SEPTEMBER 2021	**OCTOBER 2021**	**NOVEMBER 2021**	**DECEMBER 2021**	**JANUARY 2022**	**FEBRUARY 2022**
Public Meeting – 17 September 2021 (TBC) • Covid-19 update • ICS and Place-based integration arrangements • Delivery Boards – for information report updating on work of last 3 months, and any substantial items • Path to Excellence update • JSNA progress report			**Public Meeting - 10 December 2021 (TBC)** • Covid-19 update • Health Protection Assurance Report • Winter Plan • ICS and Place-based integration arrangements • Healthy City Plan – 6 monthly performance report • Delivery Boards – for information report updating on work of last 3 months, and any substantial items • Path to Excellence update • SSCP Annual Report • SSAB Annual Report • JSNA progress report		

Additional key dates for future Board meetings
Pharmaceutical needs assessment (PNA) – to be considered by HWB in March 2022 for publication in April 2022
Director of Public Health Annual Report 2021/22 (Sept 2022)

Potential development sessions
Further sessions on 'making health everyone's business / Health in All Policies'
Social prescribing (ATB)
DPH Annual Report draft recommendations (DPH)
Domestic abuse – request for HWB to be involved (TfC - JC)
LGA When Worlds Collide – separate workshops for local government and NHS to explore organisational differences (LGA facilitated)