At an Extraordinary meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on MONDAY, 22ND FEBRUARY, 2010 at 9.15 a.m.

Present:-

Councillor P. Walker in the Chair

Councillors Paul Maddison, Old, Shattock and M. Smith

Also Present:-

Yvonne Crawford	-	Director of Public Health
Margaret Elliot	-	Sunderland Home Care Associates
Brent Kilmurray	-	Director of Service and Strategy Development, Sunderland TPCT
Alan Patchett	-	Director of Age Concern Sunderland
Helen Paterson	-	Executive Director of Children's Services
Neil Revely	-	Executive Director of Health, Housing and Adult Services
Canon Stephen Taylor	-	Chair of Sunderland Partnership
Vince Taylor	-	Head of Strategic Economic Development
Ann Dingwall	-	Care Manager, Health, Housing and Adult Services
Nicola Morrow	-	Healthy Cities Officer, Health, Housing and Adult Services

Declarations of Interest

There were no declarations of interest.

Policy Development and Review: Tackling Health Inequalities in Sunderland – Expert Jury Day

The Chief Executive submitted a report (copy circulated) to support evidence gathering for the 2009/10: Tackling Health Inequalities in Sunderland – Expert Jury Day.

(For copy report – see original minutes).

The Chairman welcomed everyone to the Committee and introduced Ann Dingwall, Care Manager, Health, Housing and Adult Services and Nicola Morrow, Healthy Cities Officer, Health, Housing and Adult Services and advised that they would facilitate the flow of information and discussion by Members.

Mr. Nigel Cummings, Scrutiny Officer, outlined the Schedule for the day.
Mr. Cummings referred to the meeting that Members of the Committee had recently held with Professor Peter Goldblatt who was a member of the Marmot Review Team that had undertaken a Strategic Review of Health Inequalities in England post 2010.

The Review recommended 6 policy objectives as follows:-

1. Giving every child the best start in life (highest priority recommendation) – increasing the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

2. Enabling all children, young people and adults to maximise their capabilities and have control over their lives – reducing social inequalities in pupils' educational outcomes; prioritise reducing social inequalities in life skills.

3. Creating fair employment and good work for all.

4. Ensuring a healthy standard of living for all minimum income for healthy living.

5. Creating and developing sustainable places and communities.

6. Strengthening the role and impact of ill-health prevention – core efforts of public health departments focused on interventions related to the social determinants of health proportionately across the gradient.

Mr. Cummings advised that the Expert Jury Day was the second part of the Committee's major Policy Review and was designed to allow Members to question internal staff, service users, carers and external providers in addition to the opportunities presented at Committees and the Community Day.

At this juncture the Chairman welcomed Brent Kilmurray, Director of Strategy and Service Development, Sunderland City Hospitals NHS Foundation Trust to the Committee and invited them to respond to the four questions posed from an NHS perspective.

Question 1 – What does the term Health Inequalities mean to you?

Mr. Kilmurray outlined the broad Sunderland context. Average health status in Sunderland was poorer than across England as a whole with life expectancy lower than for England. However, there was a ten year variation in life expectancy between those wards with the best and poorest health in Sunderland. Between 2% and 70% of households in the City were receiving worklessness benefits and 50% of the City's smokers lived in the most deprived areas; the largest proportion coming from the lowest social economic groupings.

Health status was strongly linked to social and economic disadvantage, as measured by factors such as income, housing, culture and education. Mr. Kilmurray stated that the health of the City was also determined by the City's industrial heritage.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Mr. Kilmurray advised that Sunderland Teaching Primary Care Trust had a vision contained within its Strategic Plan which consisted of 3 strands:-

1) better health;
2) better patient experience;
3) better use of your money.

By 2015 it was hoped that people would live longer and have better access to prevention services; there would be a reduction in negative lifestyle choices and a reduction in the number of long term conditions. It was important to close the inequality gap between Sunderland and England, 5% was seen as a realistic target. There needed to be better alignment with partners, with greater joined up working. A key aspect of the Trust's policy was to ensure that patients received care and advice in the most appropriate setting.

Some of the expected outcomes would be to improve life expectancy, reduce childhood obesity and reduce alcohol related admissions.

A number of initiatives were taking place. These include tiered obesity services (tier 1 consisting of population wide basic intervention and prevention, tier 2 - specialist obesity services and tier 3 – special services for chronic obesity). Improvement of alcohol services, the reintroduction of school health checks and cancer awareness were also initiatives to improve outcomes.

All strategic plans had a financial strategy. A lot of money was tied up in treatment services and there would be a move to invest as much as £80 million in prevention.

Maximizing the effectiveness of Equality Impact Assessments as a tool to manage performance was extremely important and a more systematic approach to them needed to be taken.

Questions 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Mr. Kilmurray advised that NHS services were universal rather than area based, however, certain services such as community matrons had differing numbers of patients in a given area depending on need. The use of social marketing would ensure a more targeted approach to get underneath groups of patients. GPs had a critical role to play in personalisation.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Mr. Kilmurray advised that if the 5 year vision was delivered then the outcome of closing the health inequalities gap would be successful but challenging. There would be a reduction in the variations between wards and between the City and England.

Key to realising this success would be far greater engagement with people who make poor lifestyle choices with more screening interventions. Mr. Kilmurray advised that he would like to see more outreach and accessible services to catch vulnerable groups. This could be delivered by decommissioning specific hospital services (a transfer of resources) to prevention, for example, emergency admissions for long term conditions could be reduced by enabling the individual to better manage their condition at home with the help of the community matron service and urgent care teams.

As part of the Digital Challenge a new high technology initiative pilot, Telehealth, would help patients with long term health conditions to monitor their own vital health signs without repeated visits to their GP or hospital. The Telehealth equipment enables users to undertake agreed tests such as blood pressure, blood oxygen saturation levels which are then relayed electronically to health professionals through the telephone line. Any results falling outside of agreed parameters trigger an automatic alert for the appropriate response to be made.

Referring to Local Enhanced Services, the Chairman questioned how they were reviewed and how it was decided which services would be provided within an area.

Mr. Kilmurray advised that enhanced services plug a gap in essential services or deliver higher than specified standards, with the aim of helping the PCT to reduce demand on secondary care. There was a mechanism in place for contracting out to GPs and they were subject to a performance system.

In order to decide what is needed in an area, a whole raft of information was collected upon which to base a decision. Some services might be locally developed to meet local health needs or a piece of work may be commissioned.

Councillor Smith queried whether there were any planned changes to single practice GPs.

Mr. Kilmurray advised that as all GPs were involved in clinical governance there would be a desire to partner.

Following Mr. Kilmurray's attendance, the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Vince Taylor, Head of Strategic Economic Development, Sunderland Council to the meeting and invited him to respond to the questions from an economic development perspective.

Question 1 – What does the term Health Inequalities mean to you?

Mr. Taylor advised that there was a distinct difference between morbidity and mortality, the causes of such being very complicated. Lifestyle choices such as smoking, lack of physical activity and poor diet were contributory factors, however, these behaviours, although modifiable by the individual, were heavily influenced by socio economic position and the social environment.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Mr. Taylor explained that he worked within the Office of the Chief Executive Directorate and was responsible for the International Team which co-ordinates implementation of the City's International Strategy, the Area Co-ordination Team which develop Local Area Plans for the 5 Regeneration Areas in the City, as local interpretations of the Sunderland Strategy and Local Area Agreement and co-ordinate partnership responses to issues and opportunities contained within them.

The Sunderland Partnership Health Priority had a vision to ensure everyone in Sunderland will have the opportunity to live long, healthy, happy and independent lives. The Economic Masterplan for Sunderland included health considerations particularly with regard to healthy urban planning. Mr. Taylor stated that the Masterplan had identified key industries for growth in which there was a hope of encouraging new businesses to come to Sunderland and a high number of jobs created. Improvement in economic conditions in Sunderland would have a direct impact on the City's health.

Mr. Taylor referred to the importance of technological innovation and improvement in social care. The Council owned Telecare network was installed in 20,000 homes throughout the City.

Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Mr. Taylor advised that the Council's Area Committees had moved into a new process of Local Area Plans based on a partnership model. Each Area Committee had a Local Area Plan and an investment budget. The primary aim of the service was to co-ordinate and enable Sunderland's corporate and partnership response to the social regeneration issues facing the City to endeavour to narrow the gap between the most deprived areas of the City and the rest of the City and Country as a whole.

Community Chest funding was social capital that encouraged social interaction.

The working neighbourhood fund was paid to Local Authorities and communities to help tackle worklessness and increasing skills and enterprise levels. Evidence showed that work could improve individuals' health. People on incapacity benefit and income support were helped to gain employment.

Local Multi Agency Problem Solving Groups (LMAPS) were in place as multi agency response groups to address local crime and disorder problems.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Mr. Taylor advised that success would be a reduction in mortality and morbidity which would take a long time.

In terms of Mr. Taylor's role, he advised that his aim was to increase prosperity within the City. However, given the current economic climate there would not be the luxury of new initiatives coming through.

The number of people in lower paid jobs was not out of line with the rest of Tyne and Wear, however, there were a lot of people in Sunderland that were not engaging in any type of employment. As a City centre, there were relatively few people who worked in it.

Following Mr. Taylor's attendance the facilitators and Members drew out key issues from the responses to the questions. A full list of the key issues identified by the Committee can be found at the end of these minutes.

The Chairman welcomed Neil Revely, Executive Director of Health, Housing and Adult Services, and invited him to respond to the four questions posed.

Question 1 – What does the term Health Inequalities mean to you?

Mr. Revely advised that the term meant unfairness, disadvantage and differences in opportunities. The Marmot Review concluded that wealth and health were inextricably linked.

Mr. Revely stated that on some occasions health inequalities would be a symptom not a cause. It was important to consider what could be done to minimise the impact in the short term and eradicate it in the long term.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Mr. Revely advised that in his statutory role as Director of Adult Social Services, a Joint Strategic Needs Assessment (including a Housing Needs Assessment) was carried out with the Director of Public Health. Mr. Revely felt that there was not enough impact assessment work being carried out; although some joint commissioning occurred with the PCT to this regard it tended to be more disease specific.

Mr. Revely recognised the need to do more in relation to impact assessments and advised that he would like to see more assessment at neighbourhood level.

Questions 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Mr. Revely felt that there was not enough neighbourhood specific work, particularly in those areas perceived as 'disadvantaged'.

More in depth investigation was happening which could measure greatest need and where there was most input of services. Mr Revely stated that equality of access may not result in equality of outcomes. In order to achieve this, services would not be uniform across the City.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Mr Revely stated that he would want the highest ambitions for the City and to expect the best health outcomes in the world in the long term. In the short term very specific targets would be set in shorter time periods.

Targeting key groups of people could make a huge impact. For example the knock on effect of reducing trips and falls could be highly significant given the long term physical, psychological and social consequences of such preventable occurrences.

Councillors Shattock and M. Smith both cited examples of ward based experience with constituents who had problems with obtaining suitable housing. Housing was a key to the broader aspects of health, for example the correlation between warm homes and winter deaths. Mr Revely advised that the Directorate would be investing in thermal imaging technology to determine badly insulated homes. Consequently individual streets could be targeted.

The Chairman questioned what was being done to encourage people off benefits and into work.

Mr Revely advised that Working Families Tax Credit had gone a long way to helping people in the benefit trap.

Following Mr. Revely's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Canon Stephen Taylor, Chair of the Sunderland Partnership, to the Committee and invited him to respond to the questions.

Question 1 – What does the term Health Inequalities mean to you?

Referring to the Marmot report, Canon Taylor advised that in England the many people who were currently dying prematurely each year as a result of health inequalities, would otherwise have enjoyed in total between 1.3 and 2.5 million extra years of life. When surveyed, 66.2% of people in Sunderland reported that they felt they were healthy.

Approximately 5 years ago an analysis was undertaken of developing countries, those countries that targeted health inequalities as opposed to economic growth saw the greatest impact.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Canon Taylor advised that as a delivery partnership, the Healthy City partnership currently they only measured what the TPCT did as opposed to measuring impact, this was not as good as it could be. The capacity existed to achieve a fairer distribution of health but there needed to be better collaborative working to make change happen. The delivery plans were in place, however, joined up action to obtain activity had some way to go.

Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Canon Taylor felt that neighbourhoods were not tackled effectively. Area Committees could act as an intelligence hub to identify hot spots in wards and consider the appropriate action.

He also felt that some schools were now like 'fortresses' as a result of the safeguarding agenda. Consequently groups and organisations that had an important message to deliver to young people around risk taking behaviour or health were barred from talking to them in the school setting.

Canon Taylor was extremely worried about the increase in alcohol consumption and associated anti social behaviour. He felt that instances of liver disease will be a huge problem in the future. Alcohol pricing was a contributory factor and Canon Taylor would favour local pricing policies to control this.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

The Local Area Agreement (LAA) set out the health targets which were among the worst in North East. He felt that as part of Community Leadership it was Councillors' duty to lead by example.

Following Canon Taylor's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Alan Patchett, Age Concern, to the Committee and invited him to respond to the four questions posed.

Question 1 – What does the term health inequalities mean to you?

Mr. Patchett stated that health inequalities were the differences in health between different sections of the population. Life expectancy was a big indicator but inequalities manifest themselves in many ways throughout Sunderland.

Mr. Patchett reminded the Committee that he represented the over 50 age group within the City. He stated that it appeared inequality grew as people got older, for example, there were instances where older people were denigrated by their GP when they presented with an illness by being told 'What do you expect at your age?'

Mr. Patchett advised that a postcode lottery is applicable in the provision of many healthcare services. The current NHS health checks that were being actively promoted were aimed at 40-74 year olds. While there may be a very good medical reason for the age bracket it looked like institutional inequality.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Mr. Patchett advised that Age Concern's mission statement was 'to promote the well being of all older people throughout the City of Sunderland, improve their quality of life and help them maintain independence'.

Health Impact Assessments were not used as the resources were not available.

Age Concern had an Involving Older People policy, which meant they involved and listened to older people and asked them what they wanted and needed to tailor services appropriately.

By working with the Older People's Partnership Board (OPPAG), 50+ forums and the World Health Organisation, Age Concern ensured that the interests of those aged 50 and over were empowered to address health issues.

Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Mr. Patchett advised that his organisation was Citywide and delivered to a community of interest – older people – rather than a geographical location. They provided a number of services, including:-

- Information and advice, specifically in relation to helping people maximise their income – there was a recognised link to low income, poor health and low life expectancy.

- Social focus groups for people with mental health problems.

- Tea with Dorothy Group which provided support for gay, lesbian and transgender groups.

- Men's groups – older men were particularly hard to reach.

- Day and lunch clubs.

- Good neighbour promotion.

Mr. Patchett commented that nutrition was a major factor affecting the health of older people. He stated that a neighbourhood focus was good but care must be taken not to target only 'deprived areas' and ignore the rest which may lead to health inequality.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Mr. Patchett advised that a lot of god work had been carried out in Sunderland with regard to the 50+ population. These included the Healthy Ageing City Profile for WHO Healthy Ageing Network, the introduction of age friendly City self assessment, the 50+ Strategy and OPPAG.

Success would mean every individual having the opportunity to live a long, healthy, happy and fulfilling life with access to appropriate health interventions when they needed them.

This would be achieved by:-

- Involving and empowering people as well as informing and educating.

- Enable people to make choices by providing accessible and appropriate support services.

- Prevention was the key. There was a need to adopt a preventative approach – Age Concern aimed to work with 50-65 year olds to help them plan for the future by improving their health, building up social networks and activities and planning for their financial future so that when they retire they are in control of their own lives.

- Evidence exists to show there is a direct link to low income and poor health and this can be addressed by helping older people to maximise their income. From January 2009 to January 2010 Age Concern had helped 3,649 people aged 60+ to claim approximately £2.3 million of benefits and this has a major impact on their lifestyle and health.

- There was a need to stop being driven by central government targets but use those targets as a mechanism to engage people and communities to take charge of their own lives.

- Poor life expectancy and poor health starts in childhood and goes right through into adulthood and old age and therefore adopting a Life Course Approach, as recommended by the WHO could achieve the above.

- There are many determinants of health and the Life Course Approach would help to address all issues that affect a person's health and help prevent poor health.

- The VCS can play a major role in helping statutory partners to get to those 'hard to reach' communities and also deliver low level prevention services in the community.

Following Mr. Patchett's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Dr. Helen Paterson, Executive Director of Children's Services, to the Committee and invited her to respond to the four questions posed from a Children's Services perspective.

Question 1 – What does the team Health Inequalities mean to you?

Dr. Paterson advised that social class and social scale led to poorer outcomes in lower socio economic groups. She informed the Committee that children in lower social classes were twice as likely to die under the age of 15.

The Every Child Matters approach aims that every child, whatever their background or circumstance, to have the support they need to:-

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution;
- achieve economic well being;

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Dr. Paterson stated that the Local Authority's vision was to ensure young people receive the help and support they need to achieve their potential and get the best out of life.

Comparisons needed to be made with children in other parts of the Country.
A recently published national report indicated that for children living in a deprived area, 8% were likely to be obese, 9% would have a low birth rate and were 12% more likely to have an accident.

Child health inequality in Sunderland was being tackled in a number of ways: health improvement was well established as part of the Children and Young People's Plan

and the Child Poverty Strategy aimed to show a demonstrable reduction in child poverty via activities that stem from a number of work streams including worklessness.

The Children's Trust regularly challenged performance delivery.

Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Dr. Paterson advised that there were newly commissioned obesity services which will target hot spots in wards, low income families and BME communities. Children's Centres were universal in offer, but targeted individual activities at a local level. A different range of partners worked at the children's centres.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Dr. Paterson stated that she would like to see young people to be more informed and educated in relation to risky behaviour. She would like to see better lifestyle opportunities for young people and access to medical and sport facilities that would improve mental well being.

She would hope that all youngsters would live the same length of time as the longest living in the rest of the world.

Councillor Smith questioned how children's centres monitored the people using the service to ensure they were targeting vulnerable and hard to reach groups.

Dr. Paterson advised that the TPCT tracked the live birth list. She stated that children's centres were excellent but parents needed to be willing to attend, accordingly much more outreach work was being carried out.

In response to Members' queries regarding health checks in school, Dr. Paterson advised that health and weight checks were carried out for reception and year 5 children along with the inoculation programme, however, there was not the same level of screening that used to take place within the actual school setting.

Following the questioning of Dr. Paterson, the facilitator and Members of the Committee drew out the key issues from the responses.

The Chairman welcomed Nonnie Crawford, Director of Public Health, to the Committee.

Question 1 – What does the term Health Inequalities mean to you?

Dr. Crawford advised that health inequalities meant the unfair and unnecessary differences among groups in Sunderland and between wards and neighbourhoods.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Dr. Crawford advised that a key focus would be to extend life expectancy and obtain fair access to services. Public Health has carried out a Health Impact Assessment that helped inform the prioritisation of health needs.

Question 3 – What 'neighbourhood' specific work is underway and how is that aligned with the work of other services or organisations and how do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Dr. Crawford stated that neighbourhoods were not specifically targeted as well as they could be. She advised that there were 65 natural neighbourhoods in the City and 9 were lower than the national average. It was important to engage with the people in the 9 neighbourhoods to determine what needed to be done differently.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Dr. Crawford showed Members a map of the region which indicated in green areas where the health inequalities gap had been reduced. Sunderland was red.

Dr. Crawford would like to see the two year life expectancy gap between men and women in the City close alongside the overall gap between Sunderland and England as a whole. A reduction in teenage pregnancy rates and fantastic breast feeding figures would also be extremely desirable.

In response to a question from Councillor Shattock, Dr. Crawford advised that she believed Gateshead had been more successful in closing the gap because over the last 5 years they had created a community driven vision for health and well being and a focus on neighbourhoods. Changes to practice based commissioning had been implemented in Gateshead which ensured all GPs worked together effectively. Gateshead Council's portfolio holder chaired the strategic committees on health.

Dr. Crawford stated that she would like to see a minimum price for alcohol and felt that Elected Members were in an ideal position to drive the proposal forward.

With regard to Area Committees, Dr. Crawford felt that resources should be utilised and delivered in the pockets where it was most needed as opposed to trying to distribute funding equally. It should be borne in mind that the defined area frameworks for the Council might not fit geographically with those of PCT.

There needed to be a corporate approach to tackling the problems; although there was a lot of good work taking place by organisations, they were often not working together.

Health Equity Audits were a key tool to embed evidence on equalities in planning commissioning and service delivery.

Following Dr. Crawford's attendance the facilitators and Members drew out key issues from the responses to the questions.

The Chairman welcomed Margaret Elliot, Executive Director of Sunderland, Homecare Associates to the Committee and invited her to respond to the four questions posed from a provider perspective.

Ms. Elliot advised the Sunderland Homecare Associates was an employee owned social enterprise employing over 300 people.

Question 1 – What does the term Health Inequalities mean to you?

Ms. Elliot defined health inequalities in terms of specific morbidity conditions that would contribute to differences in the health of people such as obesity, alcohol and liver damage and smoking and lung cancer.

Question 2 – Is there a vision for addressing inequalities within your directorate or organisation and do you use health impact assessments or any other form of assessments to examine the effects of your strategic planning upon health?

Ms. Elliot advised that the organisation had approximately 500 service users and impact assessments were carried on, for example, fall management. All review and assessments take into account any improvements.

Question 3 – What neighbourhood specific work is underway and how is that aligned with the work of other services or organisations and do you feel that we target the neighbourhoods and/or areas of most disadvantage?

Ms. Elliot advised that the organisation worked in partnership with health and social care partners and Gentoo.

Ms. Elliot described some of the organisations Sunderland Homecare Associates worked with, including Sit n b Fit – which provided seated exercise for people with mobility problems. Such organisations needed to be encouraged.

Question 4 – What do you think success would look like in Sunderland in relation to tackling health inequalities and how would you see this being achieved?

Ms. Elliot advised that there must be definite measurable improvements. Forums for listening to people were extremely important.

Following Ms. Elliot's attendance the facilitators and Members drew out key issues from the responses to the questions.

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

(Signed) P. WALKER,
Chairman.