SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held in the Civic Centre (Committee Room No. 1) on Friday 16 November 2012 at 12.00noon

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

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

8.	**Safeguarding Children** Presentation by the Chair of the Sunderland Safeguarding Children Board	-
9.	**Review of Health Visiting Services** Report of the Children's Trust (attached).	65
10.	**Transforming Health and Wellbeing through Integrating Wellness Services** Joint report of Community Services, Sunderland City Council and Sunderland PCT (attached).	71
11.	**HealthWatch and NHS Complaints Advocacy Update** Report of the HealthWatch Transition Lead (attached).	87
12.	**Risk and Resilience – Public Health Protection** • **Seasonal Flu Plan** Presentation.	-
13.	**Health and Wellbeing Board Development Plan** Report of the Head of Strategy, Policy and Performance Management (attached).	93
14.	**Date and Time of the Next Meeting** The next meeting will be held on Friday 25 January 2013 at 12.00noon.	

ELAINE WAUGH
Head of Law and Governance

Civic Centre
Sunderland

15 November 2012

Item No. 2

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD

Held in Committee Room 1, Sunderland Civic Centre on Friday 14 September 2012

MINUTES

Present: -

Councillor Paul Watson (Chair)	-	Sunderland City Council
Councillor Graeme Miller	-	Sunderland City Council
Councillor Mel Speding	-	Sunderland City Council
Councillor John Wiper	-	Sunderland City Council
Neil Revely	-	Executive Director, Health, Housing and Adult Services
Keith Moore	-	Executive Director, Children's Services
Dave Gallagher	-	Chief Officer, Sunderland CCG
Sue Winfield	-	Chair of Sunderland TPCT
Dr Ian Pattison	-	Sunderland Clinical Commissioning Group
Dr Gerry McBride	-	Sunderland Clinical Commissioning Group
Michael McNulty	-	Sunderland LINk

In Attendance:

Councillor Dave Allan	-	Sunderland City Council
Councillor Peter Walker	-	Sunderland City Council
Gillian Gibson	-	Sunderland TPCT
Martin Rutter	-	North East Ambulance Service
Ken Bremner	-	City Hospitals Sunderland NHS Trust
Peter Sutton	-	NHS South of Tyne and Wear
Colin Morris	-	Chair of Sunderland Adult Safeguarding Board
Sarah Reed	-	Assistant Chief Executive, Sunderland City Council
Vince Taylor	-	Head of Strategy, Policy and Performance Management, Sunderland City Council
Karen Graham	-	Office of the Chief Executive, Sunderland City Council
Gillian Warnes	-	Governance Services, Sunderland City Council

HW28. Apologies

Apologies for absence were received from Councillor Kelly, Councillor Smith and Nonnie Crawford.

HW29. Minutes

The minutes of the meeting held on 31 July 2012 were agreed as a correct record.

HW30. Feedback from Advisory Boards

Adults Partnership Board

Councillor Miller informed the Board that the Adults Partnership Board had met on 28 August 2012 and the main items considered had been: -

- Licensing Update
- White Paper 'Caring for the Future'
- Working Group Updates
- Local Accounts
- Carers Strategy Update

Councillor Miller also reported that the elections for the Vice Chair of the Adults Partnership Board had been postponed due to the need for clarification on the membership of the Group. The Board welcomed two new members to the group; Eibhlin Inglesby would represent the voice for Carers and Dr Valerie Taylor would represent the Local Medical Committee.

Children's Trust

Keith Moore reported that the Children's Trust had met on 13 September 2012 and had considered a number of issues including: -

- Joint Health and Wellbeing Strategy
- Health Visitor Review
- Welfare Reform Act
- Sunderland Safeguarding Children Board Update
- Provisional Exam Results
- Child Sexual Exploitation
- Children's Trust Advisor Network Update

Sue Winfield added that the Trust had discussed the provisional exam results in relation to the health of the city and the relationship between improved educational achievement and health. In response to a query from Dr Pattison, Keith Moore stated that there had been some young people in the city affected by the issues with English GCSEs, however, overall Sunderland had appeared to have bucked the trend in this subject area.

The Board expressed their wish to convey how pleased they were with the achievement of young people in the city to the Sunderland Youth Parliament and also the wider Council.

RESOLVED that the information be noted.

HW31. Clinical Commissioning Group Update

Dr Pattison updated the Board on the latest developments regarding the Clinical Commissioning Group (CCG). He began by thanking the Council for the invitation to be part of the State of the City debate once again and introduced Dave Gallagher, who was the Interim Chief Officer for the CCG.

The CCG continued to move forward and work was ongoing on developing joint working and the structures were maturing whilst placing a real emphasis on quality and safeguarding.

The CCG constitution had been issued as a formal consultation, with all GP practices in the city signing up to it, which was an excellent achievement. The results from the 360º had now been received and they had provided positive feedback overall, particularly from GP practices, and the benchmarks were well above the national average. Dr Pattison thanked partners for responding to the survey, stating that the total response rate was 85% and that the response rate from GP practices was 80%.

The CCG would be having a walk through of the areas where feedback had been lower than they would have liked, to assess the issues and how they could be addressed.

The formal documents for authorisation had now been submitted and the site visit would take place on 1 November 2012. The outcome and confirmation of the authorisation status would be received by 30 November.

Regarding the public consultation on the reconfiguration of urgent care services, Dr Pattison reported that a first consultation event had been held at the Sandhill Centre and this had promoted an open and frank discussion. There would be three other events taking place where the public could feed in their views.

Neil Revely asked if there had been any slippage in the timescale for authorisation, as he was aware of different experiences around the country, however Dr Pattison stated Sunderland CCG was as far advanced as it could be and remained on line for the second wave of authorisations.

Neil also advised that he had been to an NHS Commissioning Board event which was looking at the links to Health and Wellbeing Boards. Dave Gallagher explained that the NHS Commissioning Board would establish two local area teams for the North East and whilst Directors for a number of local area teams had been appointed, this had not been the case for the Northumberland and Tyne and Wear region. Chris Reed had agreed to act as Interim Director until a permanent appointment was made, in order to ensure that momentum and speed was not lost. The site visit on 1 November would be a key milestone in starting to develop the relationship between the CCG and the Commissioning Board.

RESOLVED that the Clinical Commissioning Group update be noted.

HW32. Accelerating the Bigger Picture

Ken Bremner, Chief Executive of City Hospitals Sunderland and Peter Sutton, Director of Service Transformation, NHS South of Tyne and Wear were in attendance to present a discussion document to the Health and Wellbeing Board on the 'Accelerating the Bigger Picture' (ABP) programme of work.

ABP is a collaborative process with the three Foundation Trusts (Gateshead, South Tyneside and City Hospitals Sunderland) and NHS South of Tyne and Wear being equal partners working towards a shared vision of how services may look in the future. There were six key drivers influencing the work: -

- Local sustainability
- Critical mass
- Quality Standards
- Workforce
- Care Closer to Home
- Financial

Within the context of these drivers, organisations have worked together to develop the work and the next stage would be to take this for wider consultation and input from partners.

The discussion document outlines where the hospitals might see themselves in the future, how services might be concentrated and where Sunderland Royal Hospital might position itself. The document also describes changes and re-organisations which have already taken place and attempts to illustrate how the authors see the landscape moving forward.

The Foundation Trusts and NHS South of Tyne and Wear were now in the middle of a consultation process and were gathering views to take to a wider event in October.

Gillian Gibson commented that impacts for local people did not come through in the document, particularly in terms of health inequalities and the financial impacts on the other parts of the system, like primary and social care. She suggested that a health impact assessment could be carried out in relation to the document.

Ken Bremner acknowledged that the work had been quite insular so far and although health outcomes were referenced, there was still some work which they wanted to do in this area.

Dr McBride highlighted that there was likely to be a significant impact on primary care as there would be further to travel for a number of patients and their families and this also had cost implications. Whilst supporting the principle of quality health improvement, there were some immeasurables for the CCG in the proposals. Peter Sutton stated that within all the work which was going on, it was a priority to preserve local access to services and in fact this had already become more localised in areas such as stroke care, where consultants went out to patients. Sue Winfield also noted that with respect to local access, there was a significant amount of outpatient activity taking place at primary care centres.

Sue went on to explain that the ABP work had originated from the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) requirements and this had been approached jointly by the Hospital Trusts and PCT. This way of operating was unique in the country and demonstrated the strength of partnerships in the region.

Dr Pattison referred to the question of whether re-organisation would lead to a merger and Peter advised that the general view was that it was most important to resolve the clinical services initially and it was not yet decided how things might develop in the future. The document was intended to be open about this possibility.

Ken stated that none of Foundation Trusts felt that moving into a competitive position would be good for patients but there would have to be a debate about the risks of trying to maintain everything at as local a level as possible. However, as the Foundation Trusts were for three of the smaller hospitals in the region, there were concerns about the competitive threat from larger hospitals.

David Gallagher commented that the ABP document started to bring things together and enabled things to be looked at in the round. The key thing would be to focus on the patient and to ensure that the safest and most robust system was developed. Neil Revely added that it was an opportune time for the document to come to the Board, as it was in the final stages of developing the Health and Wellbeing Strategy. Within this broader engagement it was the remit of the Board to look at the patient and citizenship aspect of services.

Michael McNulty noted that there was some awareness raising to do with patients, but if the message was clear that in order to run a high class and efficient service, it had to be provided on a larger scale, patients would accept this.

The issue of the impact on ambulance transport was raised and Peter stated that this was assessed at each individual workstream level. Martin Rutter advised that the North East Ambulance Service carried one million journeys each year and a lot of these were home to hospital and hospital to home. The service experienced considerable pressure in terms of the number of locations it had to serve.

Councillor Wiper made reference to the park and ride scheme which was in place for Sunderland Royal Hospital and asked if there were any plans for a similar scheme in Gateshead or South Tyneside as this would help with some of the access issues experienced by patients and their families. Peter advised that there were specific issues with the QE at Gateshead but there may be a possibility of a park and ride scheme being developed there.

Following discussion, the Board: -

RESOLVED that the Accelerating the Bigger Picture discussion document be noted.

HW33. Health and Wellbeing Strategy

The Board received a report asking for approval of the draft initial Health and Wellbeing Strategy and updating them on the proposed process and timetable for further development and consultation.

The outline strategy aims to describe the three main components of an assets based approach to health and wellbeing:

- Design principles
- Assets
- Strategic objectives

To take forward the initial strategy, there were four stages to be completed; developing the strategic actions into objectives, consulting on the strategy and actions over the next three months, formal approval by the Council's Cabinet before 1 April 2013 and ongoing ownership by Board Members. It was proposed that the lead officers and sponsors for each objective be as follows: -

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

It was now approaching the time for the Strategy to be tested as a strategic guide for partners across the city and the Health and Wellbeing Board would have a statutory duty to hold partners to account to ensure that they were adhering to the objectives of the strategy. It was suggested that the Board could consider if the strategy was clear enough about what was collectively expected from the city.

Mike McNulty commented that Strategic Objective 1 had terrific potential but would also involve a lot of work, particularly around how communities would respond to a reduced level of resources. He was pleased to see members of the Health and Wellbeing Board acting as sponsors.

Sarah Reed noted that the strategy should be clear about where a difference was going to be made and suggested that it should be very specific about key outcomes so that lead officers would have a focus. Vince Taylor added that a more detailed session could be held on the targets for the action plan for Board Members.

Sue Winfield complimented those who had been involved in writing the strategy document but highlighted that it would only be as good as the actions which would come out of it. Discussions now needed to be about what people could do to achieve the objectives. Sue also commented that the role which the lead officers and sponsors undertake should be reflected within the table.

Following consideration of the report, it was: -

RESOLVED that: -

(i) the draft strategy at Appendix 1 of the report be agreed;

(ii) the proposed process for developing actions which will achieve the strategic objectives be agreed;

(iii) the proposed consultation process and approval schedule be agreed; and

(iv) the nomination of lead officers and sponsors and the responsibilities associated with these roles be agreed and any final amendments to these be agreed in consultation with the Chair.

HW34. An Asset Approach – Changing Delivery in Sunderland

Vince Taylor presented a report which set out the approach which had been taken to the development of the Health and Wellbeing Strategy in Sunderland.

The report outlined the traditional ‘deficit’ approach and the alternative ‘asset-based’ approach which seeks to identify and build on the assets and strengths of individuals, families and communities, empowering people to play an active role in improving their own lives and the lives of others.

Within this approach an ‘asset’ is an advantage, resource or capability and includes anything that contributes to the delivery of a desired outcome and Sunderland’s assets include People, Place, Economy and Organisational/Institutional.

The values and principles of an asset based approach were set out within the report and the aim of the approach was to achieve a better balance between service delivery and capacity building, encouraging more community led initiatives with public sector organisations acting in an enabling and support role.

The asset based approach had been fundamental to the Health and Wellbeing Strategy and there were a range of health initiative across the country which had used this approach and these were potential examples of how the strategy may be delivered in Sunderland.

The Shadow Health and Wellbeing Board: -

RESOLVED that the report be noted and that all future health and wellbeing commissioning in Sunderland be done in cognisance of this approach as recommended in the Health and Wellbeing Strategy.

HW35. Public Health Update

Gillian Gibson updated the Board on the transition of Public Health from the PCT to the local authority.

There were a number of workstreams in place which were progressing. The human resources process for the transfer of functions was beginning and it was hoped that the finance issues would be resolved by October 2012. With regard to information and ICT, there were safeguards in place so that access to NHS information would continue after 1 April 2013. There was also a requirement to complete a quality transition document for the process.

New guidance had been received on health protection and some areas were beginning to become clearer. It was suggested that it may be useful for someone from the Health Protection Agency to make a presentation to the Board on the new arrangements at a future meeting.

Councillor Speding queried if responsibility for major incident planning was to be transferred to the Public Health function and Gillian reported that there was intended to be some joint working but officers were still going through the guidance document to determine at what level this would be.

RESOLVED that the update be noted.

HW36. Sunderland Safeguarding Adults Board – Business Plan

Colin Morris, Independent Chair of the Sunderland Safeguarding Adults Board (SSAB), presented the draft SSAB Business Plan and also gave an overview of the work of the SSAB.

The SSAB is the partnership body with collective responsibility for ensuring that vulnerable individuals are protected from abuse. It a multi agency partnership and was one of the fist in England to appoint an independent Chair two years ago. The priority of the Board is to keep adult safeguarding placed high on the agenda and the key aims of the Business Plan are to:

1. Develop and deliver a shared vision for safeguarding adults
2. Develop and maintain strong links with relevant partnerships across the City
3. Promote the active involvement of service users, their carers, their families and their advocates
4. Oversee and monitor operational safeguarding adults activity
5. Secure citywide consistency in safeguarding

6. Secure effective operational engagement and integration
7. Promote a learning culture around safeguarding

There had been a large number of referrals in the last year, with the largest category of abuse being physical and the location of the abuse usually being in an individuals home.

The SSAB had fully implemented and signed off an action plan as the result of a Care Quality Commission inspections and was now focusing on getting the right systems in place and closer working with the Sunderland Safeguarding Children's Board. Monitoring and performance management was at a high level and the Board wished to continue to exploit opportunities to learn and improve. A key future development would be the placing of adult safeguarding on a statutory footing.

The Chair asked that Colin take back the thanks of the Health and Wellbeing Board to the SSAB for the work they were doing. There had been a step change in addressing safeguarding issues over recent years and Dr Pattison commented that the CCG had recognised this and confirmed places in its structure for both adults and children's safeguarding.

Sue Winfield asked how it could be ensured that the Business Plan was communicated as broadly as possible and how it could be taken forward with voluntary organisations. Colin Morris responded that it was the aim of the SSAB to raise the profile of adult safeguarding and that each member of the Board would be held to account for their work on this.

Neil Revely reported that he had attended a meeting the previous day where he was informed that a bill would be introduced next May and implemented in 2014 which would make adult safeguarding a statutory responsibility. There would be the opportunity to comment on the proposed legislation but authorities would be expected to act as the responsibility was already in law.

Having thanked Colin Morris for his presentation, the Board: -

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

(ii) the formal sign off and subsequent monitoring of progress against the business plan be undertaken by the Adults Partnership Board in its advisory capacity to the Health and Wellbeing Board.

HW37. Topic for next Development Session

Karen Graham reported that the next development session on 18 October 2012 had been due to be facilitated by Mike Grady from the Marmot team and would look at the wider determinants of health. However, the Board had also agreed to hold a second session on the NHS Institute Diagnostic report and there may have to be some changes to the current arrangements.

The full detail of the next development session would be circulated to Board Members within the next week.

RESOLVED that the information be noted.

HW38. Welfare Reform Update

The Board had previously received a presentation on Welfare Reform and the Localisation of Council Tax Project and had agreed to receive regular updates. The first update report was submitted for information.

Dr Pattison commented that he was seeing patients in his surgery who were in distress due to the welfare reforms and a direct link could be observed between poverty and good health. It was highlighted that a new information system showing which benefits people could access was being rolled out and it was proposed to make it available in GPs surgeries.

RESOLVED that the update be noted.

HW39. Date and Time of Next Meeting

The next meeting will be held on Friday 16 November 2012 at 12.00noon in Committee Room 1, Sunderland Civic Centre.

Item No. 3a

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

SUNDERLAND ADULTS PARTNERSHIP BOARD – UPDATE

The Adults Partnership Board met on the 30th October.

ITEM

3 Matters Arising

Vice Chair Election

At the Full Council meeting in September it was agreed that the Cabinet Secretary (Cllr Speding) who has a strategic lead for Adult Social Care and Housing would replace the Leader of the Council on the Adults Partnership Board.

3 nominations were received for Vice Chair – Alan Patchett, Carol Harries and Cllr Speding. The Board appointed Cllr Speding.

Alcohol Minimum Unit Pricing

The Board agreed to take part in forthcoming consultations on alcohol minimum unit pricing as requested by Balance and in partnership with the Safer Sunderland Partnership Board.

4 Forward Plan update

The Board looked at the documentation produced from the review of the forward plan that took place on 4th September and agreed the work plan to March 2013.

5 Adult Safeguarding Development Plan

The report outlining the Safeguarding Adults Board Business Plan for 2012-2015 was presented to the Board.

Age UK expressed their willingness help to improve 65+ involvement

It was noted that growing relationship with the Childrens Safeguarding Board is a positive step.

6 Intermediate Care Strategic Direction

The Board received a presentation on the development of the Strategic Direction for Intermediate Care in Sunderland 2012 – 2015.

Sunderland LMC raised a question how the messages would be filtered to GPs. The principles should be firmly embedded in the HWBB strategy and shares a common preventative focus.

Voice for Carers noted that link with the identification of the carers should be made a bit more clear/ recognised.

7 Accelerating the Bigger Picture

Carol Harris presented an update on the 'Accelerating the Bigger Picture' programme. This is a piece of work in which three Foundation trusts (Gateshead Health NHS FT, South Tyneside NHS FT and City Hospitals Sunderland NHS FT) and NHS South of Tyne Wear work together towards the shared vision of how services may look in the future ensuring quality of services is maintained and improved through joint provision where appropriate. The first overnight cases from the paediatric review will come to Sunderland from 1st November. Sunderland LMC highlighted the issue that national standards for patient to consultant ratios need to be reviewed in a local context as there is higher disease prevalence in the north east as opposed to other regions.

8 Local Accounts – final draft

The Board have previously agreed to the production and publishing of a Local Account for 2011/12. The final version of the document was presented to the Board for approval.

The Board approved the document with proviso that comments submitted by Friday 2.11.12 deadline are incorporated and there are no significant issues raised. If any issues are raised then the document will be brought to the next meeting to discuss and approve then.

The format in which the document will be accessible was discussed. The document will be available on-line but paper copies are expected to be produced to make the document more accessible. It was suggested that an easy read version of the document is created. It is envisaged that a more multimedia/ interactive format of the document will be created as well.

The document will be forwarded to LINK for their consideration.

9 Health and Wellbeing Board

Standing item to look at and comment on the HWBB agenda and items on it. Specific Items on: Intermediate Care Strategic Direction; PCT Transition Assurance; Safeguarding Children; Health Visitor Review – Report from Children's Trust; Integrated Wellness; HealthWatch Update, Welfare Reform Update and Health and Wellbeing Strategy were outlined.

It was suggested and the Board agreed that the changes are made to the way of dealing with HWWB papers and tasks to take on more of an agenda shaping role – looking at the HWBB forward plan to provide support and challenge earlier in the process.

10 Dementia Commissioning Group - Update

An update on Dementia Commissioning Group (formerly the Older People Mental Health Group) and progress made in Sunderland on meeting the objectives of the National Dementia Strategy were to be presented. However, it was agreed that rather than then looking at the document in detail, the updates on the main challenges will be brought to the next meeting.

11 50+ & Age Friendly City – Update

An update on the self- assessment process in baselining Sunderland against the WHO Age-Friendly City criteria was made in relation.

In general there was a lot of positive work noted across the themes, although there were a number of issues to be clarified or showing as red.

The question about the ways in which the work will be integrated with other systems was raised. The Board requested that the working group looking at the 50+ Strategy keep meeting and monitoring the progress and report back to the Board as required.

12 Carers Strategy – Final Draft

The final version of the refreshed Multi-agency Carers Strategy presented for Board's approval. The Board signed off the Strategy.

It was suggested that the easy read version of the executive summary is produced.

13 AOB

Eibhlin Inglesby informed that Graham Burt has been appointed as a manager of the Sunderland Carers Centre and he might be the representative for Voice for Carers at future Adult Partnership Board meetings.

Item No. 5

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

DEVELOPMENT OF THE STRATEGIC DIRECTION FOR INTERMEDIATE CARE IN SUNDERLAND 2012 - 2015

Report by Executive Director, Health, Housing & Adult Services & Chair Sunderland Clinical Commissioning Group

1.0 PURPOSE OF THE REPORT

To inform the HWBB of the development of the Strategic Direction for Intermediate Care in Sunderland 2012 – 2015.

2.0 JOINT WORKING

For the purposes of this paper the term 'joint working' is used to reflect collaboration, co-operation and integrated working across health and social care and other key partners.

2.1 National Policy Context

The need for previously fragmented services to be better co-ordinated and integrated in order to provide supportive, person centred care was reinforced in the White Paper *Equity and Excellence: Liberating the NHS* (July 2010) It has received further attention with changes to the Health and Social Care Bill. These changes include a number of bodies being given duties to promote better integrated care such as the NHS Commissioning Board, economic regulator Monitor, clinical commissioning groups and health and wellbeing boards.

Joint working is also supported by the 2012 White Paper *Caring for our future: reforming care and support* which describes lack of joined-up care as the biggest frustration for patients, service users and carers.

2.2 Local Policy Context

Sunderland has a long and positive history of joint working to provide and commission the best possible services and options for the people of Sunderland.

This has been further reinforced by the establishment of the Shadow Health and Wellbeing Board which oversees the development of the joint Health and Wellbeing Strategy for the city.

The strategic direction embodies a number of design principles of Sunderland's Joint Health and Wellbeing Strategy, such as prevention, equity, strengthening community assets and promoting independence and self care. The joint

working approach to shape and manage cost effective interventions through integrated services is also a key design principle, and is central to the approach in developing Intermediate Care services in Sunderland.

The Sunderland Clinical Commissioning Group Clear and Credible Plan 2012-2017 detailing health's commissioning intentions and the 15 year Strategy for the City Council's Health, Housing and Adult Services, clearly promote joint working to commission the delivery of co-ordinated effective and efficient services.

3.0 INTERMEDIATE CARE

The principles of joint working have been applied to develop a comprehensive strategy for intermediate care in Sunderland

3.1 Background

The Strategic Direction for Intermediate Care in Sunderland 2012-15 (final draft attached) has been developed drawing on key national frameworks including the original intermediate care guidance issued by the Department of Health in 2001 and subsequent updated guidance in 2009 *Intermediate Care – Halfway Home*, which sets out the national requirements for intermediate care. Whilst the 2009 update provided additional clarification relating to intermediate care the fundamental principles and definitions remained unchanged. The consistencies in the two documents are as follows:

> *"Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living"*

3.2 Supporting Strategies

The Strategic Direction has been developed in response to and influenced by a range of national health and social care policies and strategies, including:

- Our Health Our Care Our Say: A New Direction for Community Services[1]
- The Local Government and Public Involvement Act 2007[2]
- Transforming Community Services: Enabling New Patterns of Provision[3]
- Think Local, Act Personal – Next Steps for transforming Adult Social Care [4]
- National Dementia Strategy[5]

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[1] HM Government and Department of Health 2006. Our health, our care, our say: a new direction for community services. Health and Social Care Working in Partnership
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4130229.pdf

[2] The Local Government and Public Involvement in Health Act 2007
http://www.legislation.gov.uk/ukpga/2007/28/pdfs/ukpga_20070028_en.pdf

[3] Department of Health 2009. Transforming Community Services: enabling new patterns of provision
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf

[4] Department of Health November 2011. Think Local, Act Personal – Next Steps for transforming Adult Social Care
http://www.puttingpeoplefirst.org.uk/_library/PPF/NCAS/Partnership_Agreement_final_29_October_2010.pdf

[5] Department of Health 2009. Living well with dementia: A National Dementia Strategy

- Valuing people now: a new three year strategy for people with learning disabilities [6]
- Healthcare for All [7]
- Recognised, valued and supported: Next steps for the Carers Strategy[8]
- Caring for our Future : reforming care and support[9]

'Think Local Act: Personal' provides a framework for partner agencies to develop a co-ordinated approach to the personalisation of services. Using this framework for intermediate care allows for the development of services that are tailored to meet individual needs, rather than provision of a range of targeted specialised services.

The recommendations from the Health and Well-being Overview and Scrutiny Committee review of *Rehabilitation and Early Supported Discharge from Hospital* have been incorporated into the Strategic Direction and implementation plan.

A number of the recommendations within the Emergency Care Intensive Support Team (ECIST) Report, following an invited whole system review of services in Sunderland, will be addressed within the key activities of the Intermediate Care Strategic Direction.

The national policy drivers provide a framework for the further development of health and social care in Sunderland and the implementation of a coordinated approach to the personalisation of services across health, social care and partner agencies.

We aim to change the shape of health and social care services in the future to focus on:

- Prevention and promotion of health and wellbeing and away from an emphasis on ill health.
- Active identification of individuals at risk of developing illness, deterioration or crisis providing early intervention such as reablement and case management to support individuals to remain at home and avoid hospital admission.
- When people do need care and support, ensuring this is high quality and provided in the right setting at the right time, as close to home as possible

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf

[6] HM Government and Department of Health 2009. Valuing people now: a new three year strategy for people with learning disabilities
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf

[7] Department of Health July 2008. Health Care for All
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf

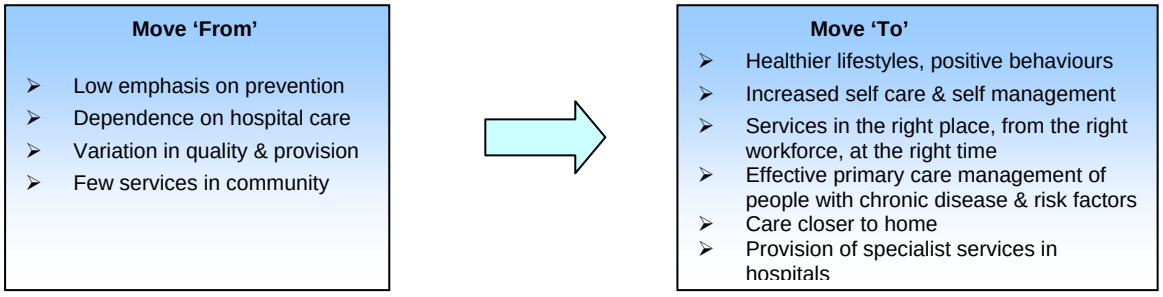
[8] Department of Health November 2008. Recognised, valued and supported: Next steps for the Carers Strategy.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122393.pdf

[9] Department of Health July 2012. Caring for our Future: reforming care and support
http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

- Providing services that are personalised to meet needs so that individuals have choice, flexibility and control over the care and support they receive.

Figure 1 highlights the strategic shift in services and resources that we aim to achieve through implementation of our wider health and social care strategies.

Figure 1



3.3 Vision for Intermediate Care in Sunderland

Our vision for the future of intermediate care in Sunderland is:

To develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.

3.4 Strategic Aims for Intermediate Care

The strategic aims are to:

- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to Long Term Residential Care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce
- Measure success from the view point of all

Each of the strategic aims have a number of key activities that have been drawn from engagement activities with services users, staff, carers and other partners.

3.5 Strategy and Working Groups

This Strategic Direction has been developed jointly by Sunderland's City Council, Teaching Primary Care Trust, Clinical Commissioning Group, Intermediate Care Partnership and other key partners from the Sunderland Intermediate Care Strategy Group.

The Intermediate Care Strategy Group has been supported by working groups and short term task and finish groups.

It is a joint health and social care strategy which details how Sunderland intends to commission and redesign intermediate care, and within that, reablement services, over the next three years (2012-2015) to meet the needs of Sunderland residents. It outlines the principles that will guide development and implementation of the Strategic Direction and also sets out aims and objectives, and plans for delivery.

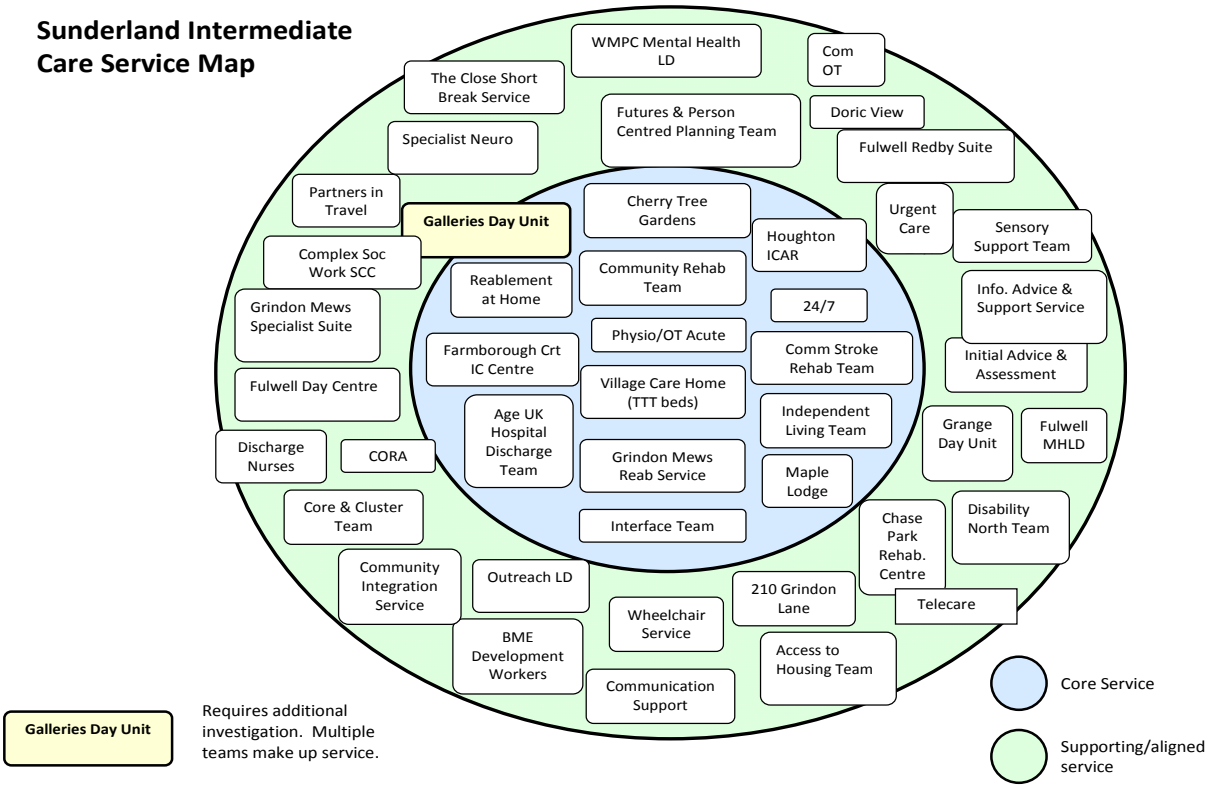
3.6 Current Services

A self assessment exercise was initiated in Sunderland, with services believed to be providing intermediate care options in order to provide clarity and identify any gaps in provision. The outcome of the review resulted in the development of **Figure 3** below, which depicts the feedback from the self assessment exercise in terms of a set of 'core' intermediate care options, with surrounding 'supporting services', reflecting the current picture in Sunderland. These services are delivered by a range of providers, within health, local authority and the third sector.

As a result of their organic development over ten years, services are delivered at a variety of facilities or by various teams, and at times this can prove difficult to navigate. It was noted that there are some duplications in function which is not conducive to a streamlined pathway.

Services are working hard to deliver and support the intermediate care agenda, despite the mosaic of providers and teams and have developed strong links where possible, but few can describe the whole system or articulate how this is accessed.

Figure 3



3.7 Ideas for Change

The self-assessment process initiated a number of ideas for change as did engagement events that took place throughout the development of the Strategic Direction.

Information was also drawn from the national and local policy contexts described earlier in this paper.

3.8 Future Model

The overarching Model for Intermediate Care Services will be one where the emphasis is on delivering care closer to home as illustrated in the diagram below **Figure 4**.

Figure 4

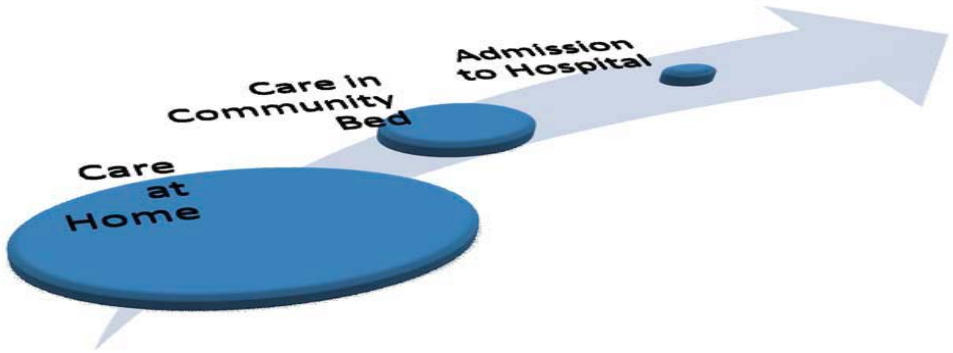


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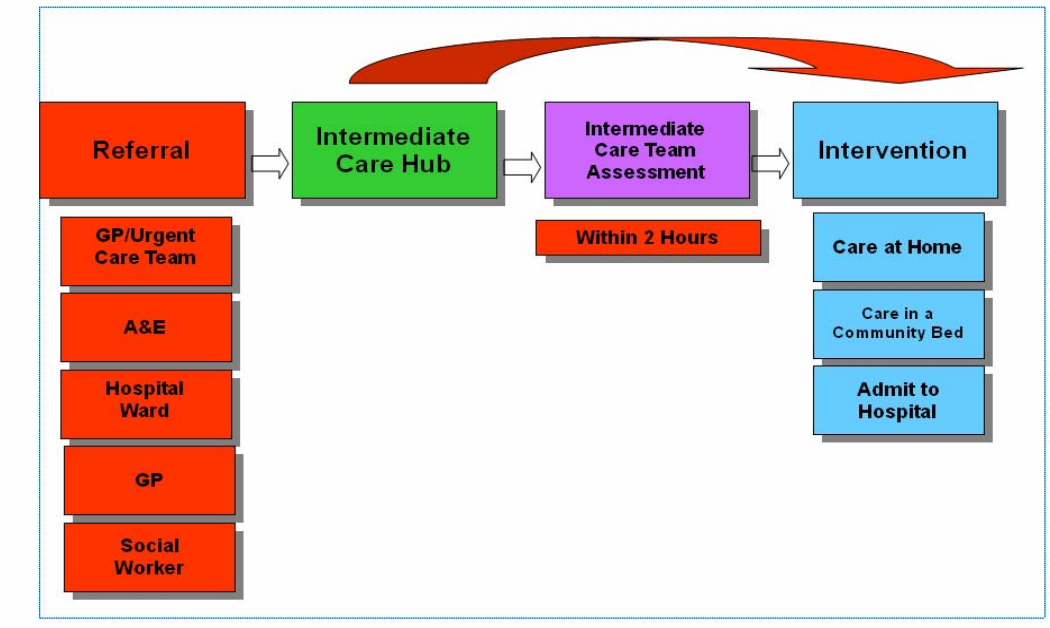
Figure 5 shows the flow through the intermediate care services via the Intermediate Care Hub where multi-agency assessment takes place ensuring the person receives the right intervention in a timely manner.

Figure 5 – Flow through the Intermediate Care Services



3.9 Strategic Objectives for Intermediate Care

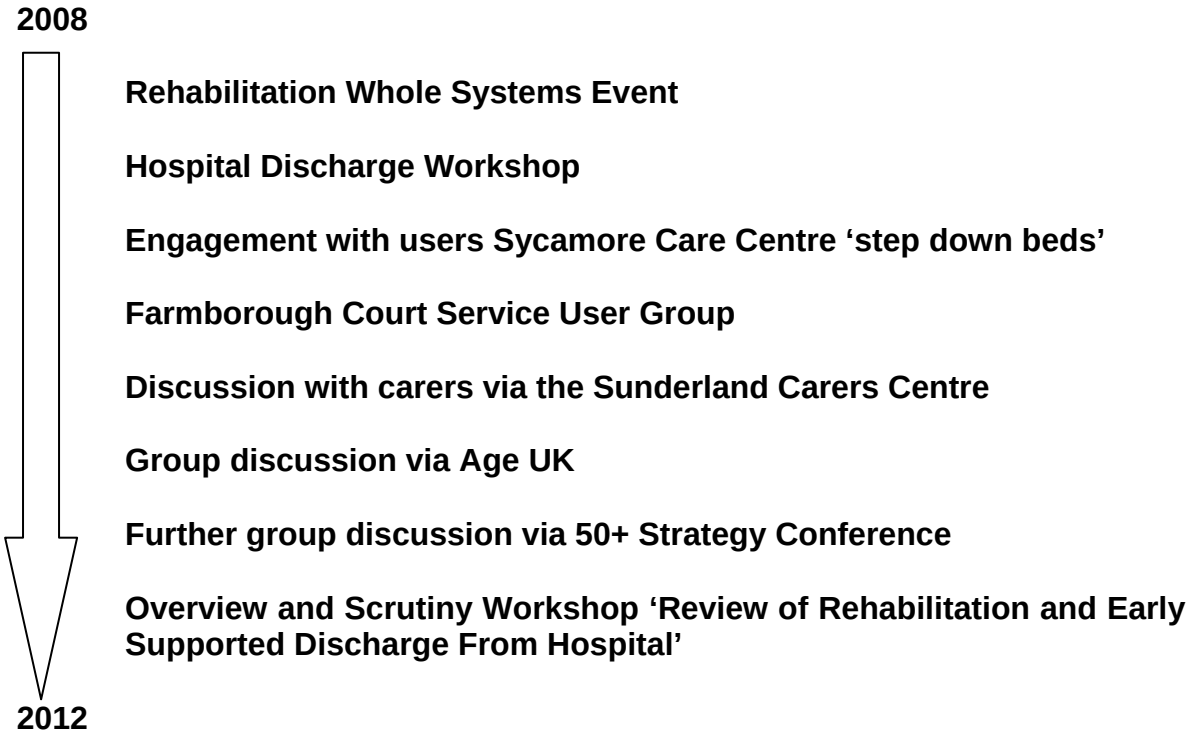
From our engagement with patients, carers and staff who provide services, a set of strategic objectives have been developed to achieve the strategic aims for the people of Sunderland.

- We will provide rehabilitation and reablement approaches appropriate to need
- We will place the individual and their carers at the centre of decision making
- We will facilitate timely access to good information and advice for individuals, carers and staff
- We will coordinate access to intermediate care services, ensuring a rapid response (within 2 hours) is available where appropriate
- We will increase individual and carers confidence and ability to cope
- We will facilitate increased joint working and streamlined pathways of care
- We will explore appropriate investment in assistive technology
- We will offer a range of bed based options as alternatives to hospital admission
- We will support a timely hospital discharge process by offering a range of intermediate care options
- We will ensure assessment and decision making about peoples long term care needs can only be made after they have had the opportunity for rehabilitation, reablement and recovery
- We will develop an integrated intermediate care workforce to ensure the ethos of rehabilitation and reablement is embedded in practice
- We will measure success by data analysis and seeking the experience of views of patients, carers and staff
- We will set out a clear accountability framework for delivery of the Strategic Direction

Appendix 1 details a case study example of what the achievement of these objectives will mean for a person in Sunderland

4.0 ENGAGEMENT

4.1 A range of engagement activities with service users, carers, families and members of the public have taken place throughout the development of the Strategic Direction and the early work on rehabilitation.



4.2 Engagement activities will continue throughout the Strategic Direction implementation plan

5.0 ACTIVITIES TO DATE

5.1 Ongoing shaping and development has taken place throughout the production of the Strategic Direction for Intermediate Care in Sunderland.

Examples include:

Facilitating Hospital Discharge:

- Interface team
- Hospital Discharge service (Age UK)
- Discharge Lounge
- Length of stay projects
- Pow Wows (Multi-disciplinary ward meetings)
- Complex Discharge Team
- Central Intermediate Care Hub

5.2 Preventing Admission

- Intermediate Care and Assessment Beds at Houghton PCC
- Pilots
  - Farmbrough Court Nursing beds
  - Care Home Time to Think beds
- Evaluation of impact
- Modelling of future demand

6.0 MEASURING SUCCESS

6.1 Our approach to measuring success is two-fold:

- A strategic "whole system" perspective on the model, reflecting on the expected outcomes of intermediate care beyond its delivery (e.g. its positive impact on health and social care systems), as well as the outcomes for individuals and carers themselves;

- An operational perspective exploring the management, impact and outcomes of specific parts of the model, particularly within the integrated pathway.

A balanced scorecard has been developed encompassing the following dimensions:

- Patient/Customer & Carer Outcomes
- Service Delivery
- Cost-Effectiveness
- Whole-System Dimension, including Capacity & Standards

7.0 ACCOUNTABILITY OF DELIVERY

7.1 Achievement of the strategic objectives and ongoing development of intermediate care services will be overseen by the Sunderland Joint Urgent Care/Intermediate Care Group.

Progress reports will also be provided to the Overview and Scrutiny Committee as part of the updates required for the Review of Rehabilitation and Early Supported Discharge from Hospital.

Updates will also provided as required for the Adult Partnership Board, Sunderland Clinical Commissioning Group and the Shadow Health and Wellbeing Board.

8.0 RECOMMENDATIONS

8.1 HWBB are requested to receive the Strategic Direction for Intermediate Care in Sunderland 2012 – 2015.

Appendix 1
Case study – Mrs V

Mrs V is 67 years old and was referred to the Reablement at Home team after a hospital stay due to a stroke. She returned home with the support of one member of staff and 4 visits throughout the day.

Mrs V also had the Sunderland Stroke Team visiting once/twice a week so both teams worked jointly to provide maximum input for Mrs V and ensure integrated provision across the teams.

Mrs V's stroke had left no physical, numbness or weakness but had affected her brain, her memory, communication skills, and difficulties recalling the correct words etc. The Reablement team first started with an assessment around her activities of daily living, and found out quite quickly Mrs V needed lots of prompts, guidance and instructions, but physically could carry out the tasks independently. Mrs V would lose her trail of thought and couldn't recall where items were in her own kitchen. Staff worked each visit alongside her to prepare her meals but only assisted and supported where necessary.

Mrs V also had been given a new system to enable her independence with her medication and staff worked each day prompting, and observing Mrs V with the long term goal that she would be able to complete herself. After a couple of weeks staff found Mrs V progressed very well and was managing kitchen activities independently, but had noticed the difficulty she was still having around reading the instructions on a packet or a microwave meal cooking instructions. Staff worked with the Occupational therapist and the Speech Therapist from the Stroke Team to plan how the team could support Ms V. Working with the Stroke team Mrs V was provided with a work booklet to complete and assist with development of independence.

The Reablement team suggested to Mrs V that they would help her complete once or maybe twice a day but during that first week Mrs V enjoyed this time so much that 3 out of 4 visits were now around these booklets, it reminded Mrs V about the class room, as she had been a primary teacher during her working days and she found it funny how she was going back to basics herself.

By the time the Stroke team visited the following week they were so surprised how far Mrs V had come from not been able to recognise letters to now attempting to spell and sound out small words.

Over a couple of more weeks her confidence grew in all areas, she was managing to wash, dress, and manage in kitchen (she still needed support if there was any reading material) and also remembering her own medication it was agreed to reduce visits to an evening call.

Once the service reached its 6 weeks it was agreed to extend for 2 more weeks due to her progress.
The 8th week came around very quickly Mrs V was now reading small words and recognizing pictures of items, and her communication skills had greatly improved. It was agreed, the stroke team would continue with their visits and Mrs V would continue with the work booklets, but now independently, and the Reablement at Home team would cease their visits.

Sunderland City Council

NHS
Sunderland Clinical Commissioning Group

NHS
South of Tyne and Wear

Sunderland Clinical Commissioning Group
Sunderland City Council
Sunderland Teaching Primary Care Trust

Strategic Direction for Intermediate Care in Sunderland 2012 – 2015

October 2012 – Version 22

Table of Contents

Foreword

We are delighted that we have reached the stage of 'launching' our joint Strategic Direction for intermediate care. Sunderland has a long history of partnership across health and social care. The introduction of the new landscape brought about by the Health and Social Care reforms has allowed our partnership working to be enhanced further. Through the Health and Wellbeing Board we are seeing the co-production of the City's Health and Wellbeing Strategy which sets the scene for us to drive integrated working at all levels.

This strategic direction has been developed collaboratively across the whole system and its delivery will ensure people in Sunderland will be able to access high quality, person centred, timely, intermediate care services.

Good intermediate care services ensure faster recovery from illness, prevent unnecessary admissions to hospitals and care homes, and therefore are extremely important to people and their families. This has driven the work in developing the Direction along with our determination to see services which are more personalised and support people's independence.

We are passionate in our ambition for the people of Sunderland and this Strategic Direction supports that ambition to see outcomes for people in Sunderland as good as the best anywhere.

Excellent intermediate care services require a seamless approach and integrated working which this Strategic Direction will deliver. The Strategic Direction describes a journey of continuous improvement and flexibility based on the experience of patients, carers, family members and all the staff involved. This will not only achieve the best possible outcomes for people but will also see the delivery of efficient, cost effective, fit for purpose services.

We, along with our partners, are greatly looking forward to implementing the Strategic Direction and seeing the improvement in the day to day work in our communities for the benefit of citizens across the City.

Dr Ian Pattison
Chair
Sunderland Clinical Commissioning Group

Neil Revely
Executive Director
Health, Housing and Adult Services
Sunderland City Council

Endorsements

This strategic direction is endorsed by the following partner organisations:

City Hospitals Sunderland NHS
NHS Foundation Trust

Gateshead Health NHS
NHS Foundation Trust

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

choose
South Tyneside NHS
NHS Foundation Trust

Executive Summary

This Strategic Direction has been developed jointly by Sunderland's City Council, Teaching Primary Care Trust, Clinical Commissioning Group, Intermediate Care Partnership and other key partners from the Sunderland Intermediate Care Strategy Group. (Membership detailed in Appendix 1).

It is a joint health and social care strategy which details how Sunderland intends to commission and redesign intermediate care, and within that, reablement services, over the next three years (2012-2015) to meet the needs of Sunderland residents. It outlines the principles that will guide development and implementation of the Strategic Direction and also sets out aims and objectives, and plans for delivery.

Commissioners from Health and Adult Services have worked with the key partners involved in the patient /user journey to analyse the current picture of service provision, review current and future needs, and learn from best practice elsewhere, to identify the changes necessary to improve quality, effectiveness and efficiency of future service provision throughout the city.

The Strategic Direction has been guided by local and national policy and by the priorities set out in Sunderland City Council, Health Housing and Adult Services', Delivering our Vision 2025, the 3 Year Delivery Plan, and Sunderland Clinical Commissioning Group's Clear and Credible Plan 2012-15.

Our vision for the future of intermediate care in Sunderland is:

To develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.

A set of high level aims have been developed that describe what our Intermediate Care Model will deliver for Sunderland. These closely align with the Department of Health guidance 'Intermediate Care - Half Way Home'.

Our aims are to:

- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to Long Term Residential Care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce
- Measure success from the view point of all

From our engagement with patients, carers and staff who provide services, we have developed a set of objectives and supporting activities, which we believe will help us to achieve the above aims for the people of Sunderland.

We have taken opportunities for engagement of individuals and carers throughout our journey to develop this Strategic Direction. However, it is essential that the Strategy Group establish an ongoing and genuine dialogue going forward. We will draw on current engagement mechanisms across the city such as the Sunderland Carers Centre and local Healthwatch to ensure co-production of the Model of Intermediate Care in the future.

We have incorporated the recommendations from the Health and Well-being Overview and Scrutiny Committee review of *Rehabilitation and Early Supported Discharge from Hospital* into the Strategic Direction and implementation plan, and therefore we will report on progress against this plan to the Overview and Scrutiny Committee.

The implementation of this Strategic Direction will become the key work plan for the Sunderland Intermediate Care and Reablement Strategy Group. We will review sub-group structure in light of this, providing opportunities for partner organisations to shape the delivery of key activities and ensuring full integration of the Third, Voluntary and Independent Sector in these arrangements.

We will also review the formal Sunderland Intermediate Care Partnership arrangements to facilitate achievement of the Strategic Direction.

Finally we intend to measure our success over the next three years by developing a suite of metrics and outcome measures, which will include engagement of individuals and their carers regarding their experience and views, which we believe is essential to the delivery and success of this Strategic Direction.

1. Introduction

Purpose

The purpose of this document is to:

- Set out the strategic direction for intermediate care and reablement services in Sunderland
- Outline the principles which will guide development and implementation of the strategic direction
- Share aims and objectives, and plans for delivery

This document has been developed by the Sunderland Intermediate Care Strategy Group, under the direction of Sunderland's Intermediate Care Partnership. *(see Appendix 1 for membership)*

Development of the Strategic Direction

The Strategy Group, assisted by a number of working groups, *(see Appendix 2 for working groups)* has worked throughout 2011/12 to develop this Strategic Direction for Intermediate Care in Sunderland.

This has been achieved through a series of workshops and time-limited projects to map existing intermediate care and reablement services in Sunderland; gather information on current and future needs, gain experiences of current services and examples of good practice from others areas. These in turn have helped to identify the changes necessary to ensure improved quality, effectiveness and efficiency of future service provision throughout the City, based on the principles described below.

The experiences and views of patients, carers, the public and staff providing health and social care services have helped to shape the Strategic Direction outlined in this document *(see Section 6*). It is essential, however, that the Strategy Group establishes an ongoing and real dialogue with individuals, carers and the staff to enable co-production of the Model of Intermediate Care in the future, and that the Model is able to adapt and change as individual's needs and experiences change.

The Strategy Group has agreed the following principles to guide development and implementation of the Strategic Direction, which states that intermediate care and reablement in Sunderland will be:

- Inclusive and personalised to meet individual needs
- Focused on achieving outcomes for individuals in a way that promotes equality and cultural diversity
- Delivered through a clear integrated pathway, which is flexible with easy access and provided in a range of settings
- Supportive of carers in their caring role, enabling them to continue caring

- Effective and efficient, integrating resources where this improves the customer journey and individual outcomes.
- Measurable by a standard set of performance and outcome metrics with an agreed governance framework that encompasses ongoing evaluation and review.

2. National Policy Context

Intermediate Care

To develop this strategic direction we have drawn on the original intermediate care guidance issued by the Department of Health in 2001[10] and subsequent updated guidance in 2009 'Intermediate Care – Halfway Home'[11], which sets out the national requirements for intermediate care. Whilst the 2009 update provided additional clarification relating to intermediate care the fundamental principles and definitions remained unchanged. The consistencies in the two documents are as follows:

> *"Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living"*

A more detailed definition is also contained in both publications. Intermediate care services can thus be defined as meeting the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

The updated guidance also added the following to the 2001 guidance:

- Inclusion of adults of all ages, such as young disabled people managing their transition to adulthood
- Renewed emphasis on those at risk of admission to residential care
- Inclusion of people with dementia or mental health needs

[10] Department of Health 2001. Intermediate Care Health service/local authority circular HSC 2001/001 LAC (2001)1 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012680.pdf

[11] Department of Health 2009. Intermediate Care – Halfway Home 2009 Updated Guidance for the NHS and Local Authorities http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

- Flexibility over the length of the time-limited period
- Integration with mainstream health and social care
- Timely access to specialist support as needed
- Joint commissioning of a wide range of integrated services to fulfil the intermediate care function, including social care re-ablement
- Governance of the quality and performance of services

Supporting Strategies

This Strategic Direction has been developed in response to and influenced by a range of national health and social care policies and strategies, including:

- Our Health Our Care Our Say: A New Direction for Community Services[12]
- The Local Government and Public Involvement Act 2007[13]
- Transforming Community Services: Enabling New Patterns of Provision[14]
- Think Local, Act Personal – Next Steps for transforming Adult Social Care [15]
- National Dementia Strategy[16]
- Valuing people now: a new three year strategy for people with learning disabilities [17]
- Healthcare for All [18]
- Recognised, valued and supported: Next steps for the Carers Strategy[19]
- Caring for our Future : reforming care and support[20]
- Equity and Excellence: Liberating the NHS[21]

'Think Local Act: Personal' provides a framework for partner agencies to develop a co-ordinated approach to the personalisation of services. Using this framework for intermediate care allows for the development of services that are tailored to meet individual needs, rather than provision of a range of targeted specialised services.

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[12] HM Government and Department of Health 2006. Our health, our care, our say: a new direction for community services. Health and Social Care Working in Partnership
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4130229.pdf

[13] The Local Government and Public Involvement in Health Act 2007
http://www.legislation.gov.uk/ukpga/2007/28/pdfs/ukpga_20070028_en.pdf

[14] Department of Health 2009. Transforming Community Services: enabling new patterns of provision
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf

[15] Department of Health November 2011. Think Local, Act Personal – Next Steps for transforming Adult Social Care
http://www.puttingpeoplefirst.org.uk/_library/PPF/NCAS/Partnership_Agreement_final_29_October_2010.pdf

[16] Department of Health 2009. Living well with dementia: A National Dementia Strategy
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf

[17] HM Government and Department of Health 2009. Valuing people now: a new three year strategy for people with learning disabilities
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf

[18] Department of Health July 2008. Health Care for All
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf

[19] Department of Health November 2008. Recognised, valued and supported: Next steps for the Carers Strategy.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122393.pdf

[20] Department of Health July 2012. Caring for our Future: reforming care and support
http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

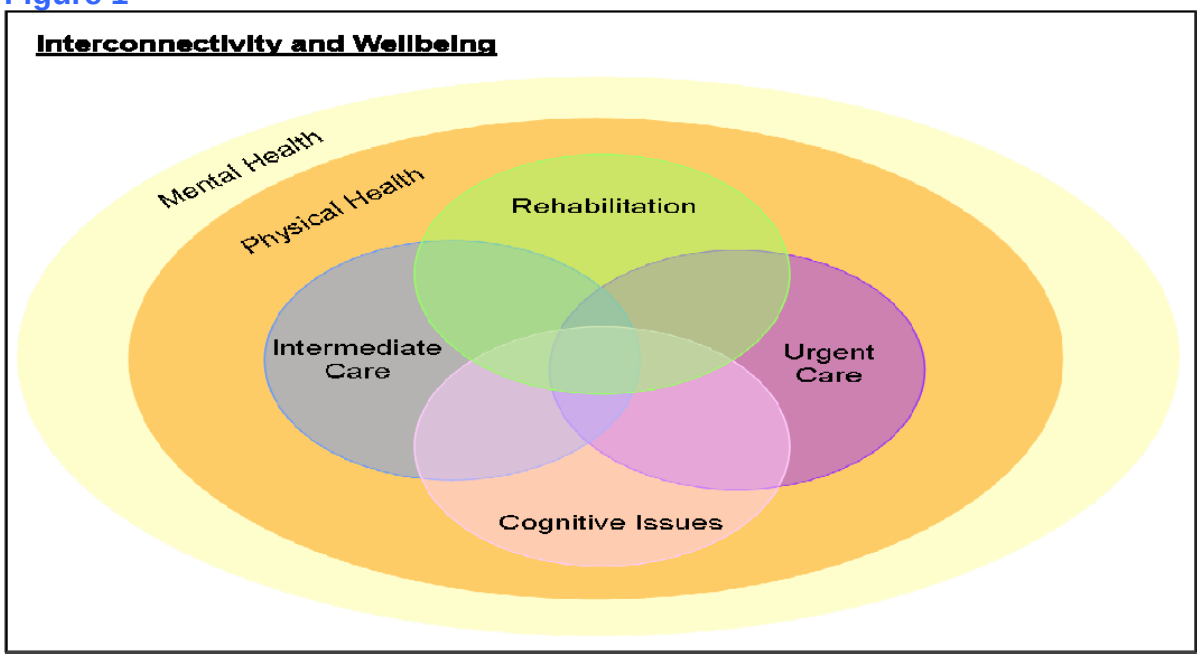
12 Department of Health December 2010. Equity and Excellence: Liberating the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

The overall aim is secure a shift to a position where as many people as possible are enabled to stay healthy and actively involved in their communities for longer and delaying or avoiding the need for targeted services. Those who do need help, however, should have maximum control over this, with the information, means (financial and practical) and confidence to make it a reality.

Adopting a universal approach to intermediate care can be achieved by ensuring that any services make the 'reasonable adjustments' that are needed to ensure accessibility for people identifying themselves under the Home Office six strands of diversity[22] (age, disability, gender, race, religion or belief, sexual orientation) with any particular needs, for example learning disabilities, sensory impairment, as they are to other people. For example support when a visit to hospital is needed; help to communicate; better information, and tighter inspection and regulation will all work to reduce inequalities in access to, and outcomes from, health and social care services.

Figure 1 below shows the inter-relationships between these supporting strategies, intermediate care and the wider prevention and well-being agenda.

Figure 1



Of particular importance to this Strategic Direction is the relationship between physical health and mental health and the need to ensure an inclusive strategy that addresses the needs of individuals holistically.

A range of mental health needs, including anxiety and depression, are likely to be identified through development of intermediate care and reablement services. It is understood that physical health needs predispose service users to development of mental health issues, and that those with mental health needs are more likely to develop physical health needs. Those with co-morbidities are more likely to be admitted to hospital and the care home population has particularly high levels of

[22] Equality Act 2010 | Home Office

physical and mental health co-morbidity. Addressing mental health needs such as anxiety and depression as part of intermediate care and reablement will reap dividends in terms of effectiveness and efficiency as well as improving service users quality of life.

In addition, through ensuring that all intermediate care and reablement services become accessible for those with dementia and their families, the potential for identifying mental health needs and providing interventions at all stages of the journey will be realised. The predicted demographic change for Sunderland over the next 20 years makes current practices for care of people with dementia, (which are acknowledged to be wanting), quite unaffordable. Thus identifying and intervening at an early stage in the journey of dementia, and promoting independence and wellbeing, keeping people in lower levels of care for longer, should allow for more effective and affordable services.

A key aspect of the national and local carers strategies are to ensure that the immense contribution made by carers every day is recognised and valued by society and that they are respected as an expert partner in the provision of support to the person they care for. They should have access to integrated and personalised services that support them in their caring role. Supporting carers to effectively care should be a key element of a successful intermediate care service, and the potential for providing services to carers needs to be fully explored.

3. Local Policy Context

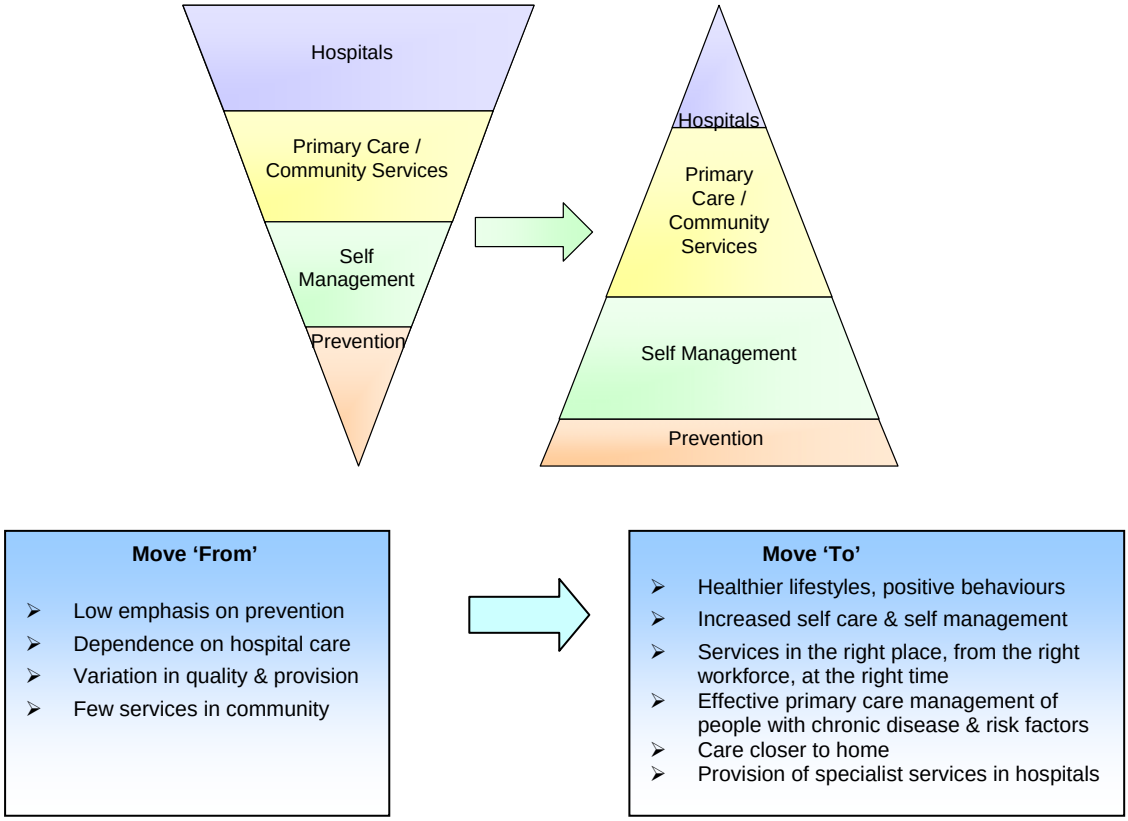
The national policy drivers outlined in Section 2 provide a framework for the further development of health and social care in Sunderland and the implementation of a coordinated approach to the personalisation of services across health, social care and partner agencies.

We aim to change the shape of health and social care services in the future to focus on:

- Prevention and promotion of health and wellbeing and away from an emphasis on ill health.
- Active identification of individuals at risk of developing illness, deterioration or crisis providing early intervention such as reablement and case management to support individuals to remain at home and avoid hospital admission.
- When people do need care and support, ensuring this is high quality and provided in the right setting at the right time, as close to home as possible
- Providing services that are personalised to meet needs so that individuals have choice, flexibility and control over the care and support they receive.

Figure 2 highlights the strategic shift in services and resources that we aim to achieve through implementation of our wider health and social care strategies.

Figure 2



4. What do we know about the needs of Sunderland's residents ?

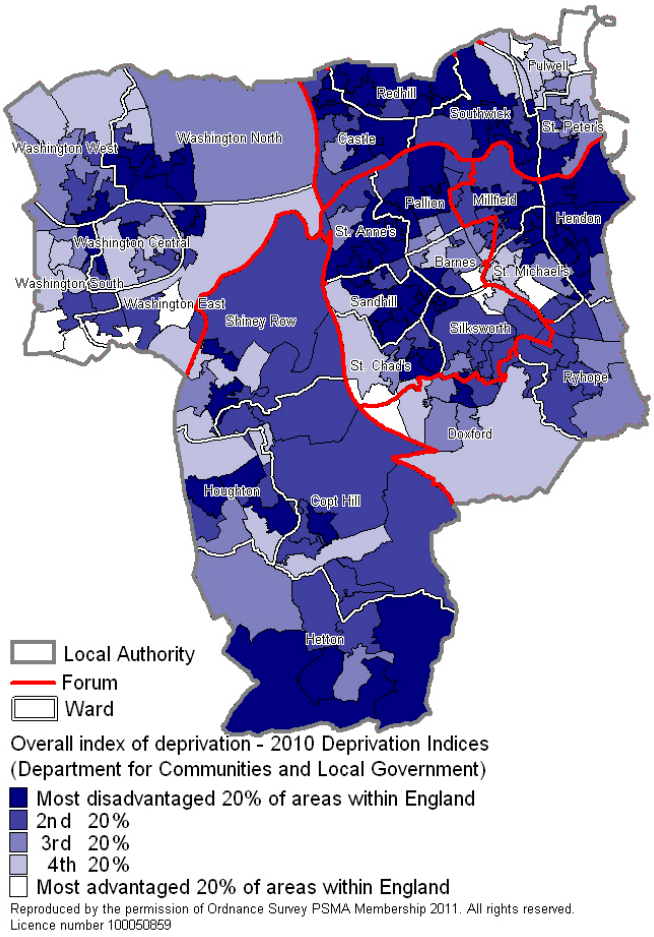
Sunderland is one of the largest cities in the North East with a population of around 283,000. There are approximately 46,800 people over 65 in Sunderland, representing around 16.7% of the population (POPPI)[23].

Population ('000s)[1]					
	Now	In the future			
Age(years)	2010	2020		2030	
All ages	284	285	↑	289	↑
0-14	46	47	↑	45	↓
65+	47	56	↑	68	↑

[23] Projecting Older People Population Information
www.poppi.org.uk

The map overleaf shows levels of deprivation across the 5 neighbourhood localities in Sunderland and super output areas, with 37% of the population of Sunderland living in areas that are among the 20% most disadvantaged across England[24]. 7% of the population of Sunderland are from BME groups, which whilst lower than the national average remains significant in terms of local needs to be addressed.

Population by ethnic group ('000s) [2]			
	White British	BME	% BME
Sunderland	262	19	7
England	42,900	8,900	17
BME = Black & minority ethnic groups			



Sunderland continues to have worse health outcomes than the England position in terms of life expectancy, mortality rates and the prevalence of specific conditions. This relatively poor health profile of the population leads to a higher level of need for those with resulting daily living problems and increased risks of admissions to hospital and long term care.

Early death from all cancers per 100,000 of the population in Sunderland is significantly worse than in England and continues to show a rising trend. The percentage of people diagnosed with heart disease / stroke and respiratory illness is also significantly worse than England. The percentage of people diagnosed with diabetes and the percentage of people who smoke is also increasing.

Currently 68,000 people or 24% of the population of Sunderland have a limiting long-term illness which is higher than that of the region or national average. National

[24] http://www.communities.gov.uk/documents/statistics/pdf/1871208.pdf

research shows that the majority of people aged 65 and over have two or more long term conditions (LTC), the majority over 75 have three.

Within the City's older person population there is also approximately 3,114 individuals with dementia, including 2043 aged 80 and over. The expected number of older people with dementia will increase by 40% (to 4,200) by 2025.

	Sunderland		England	
Male life expectancy[7]	76	↑	78	↑
Female life expectancy[7]	81	↑	82	↑
Early mortality rate, heart disease/stroke[8]	82	↓	71	↓
% and number diagnosed with heart disease[9]	5.2% 14,900	↓	3.4%	↓
Early mortality rate all cancers[10]	144	↑	112	↓
% and number diagnosed with diabetes[9]	5.6% 12,800	↑	5.4%	↑
% and number diagnosed with COPD[9]	2.9% 8,200	–	1.6%	↑
% and number diagnosed with dementia[9]	0.5% 1,500	↑	0.5%	↑
% of adults that smoke[11]	30% 39%	↑	21%	↓

Locally it is estimated that 37% of people aged 65 and over have problems with aspects of daily living, and this will rise by more than 25% to over 22,400 in the next 15 years, simply because there will be more, older people in the City, living for longer. In particular the number of people aged 85 and over, often those that tend to be the most vulnerable group of older people requiring the most support, is set to rise substantially in the next 20 years-from 5,200 to 12,800.

National research suggests that older people with 2 or more types of significant problems in daily living are particularly at risk of admission to hospital or care.

Informal 'carer fatigue' in supporting people in daily living as a result of long standing and life limited conditions is significant for public sector care and support particularly for those individuals with more significant dependencies. Without this informal care in place there is an increased risk of admission to hospital.

Sunderland has around 33,000 people reporting themselves to be a carer. However it is important to remember that many people do not consider themselves to be a carer, they are just looking after their mother, son, or best friend, just getting on with it and doing what anyone else would in the same situation. Many carers provide over 50 hours a week of unpaid care to the person they look after.

Approximately 17,550 people in Sunderland have a moderate physical disability, with a further 4,916 people having a serious physical disability. The total number of those with a physical disability is set to increase by 7.4% in 2025. This will be highly influenced by the number of people aged 50-64 years in the City. In particular, those people with "severe functional dependencies" are most at risk of admission to hospital because of the nature of their conditions.

It is estimated that around 2.4% of the overall population have learning disabilities. Children and adults with more significant learning disabilities, currently making up 0.43% of the population, are living longer that they once would have done, particularly into adulthood. It is expected that this number will increase to 1,500 people by 2021.

Sunderland has the highest prevalence of depression compared to the rest of the North East and is twice over the expected level. Depression occurs alongside anxiety in between 25% - 50% of people presenting with a common mental health problem.

In 2010/11 there were 33,613 emergency admissions to Sunderland hospital of which 14,531 (43%) were readmitted within 30 days. In March 2012 a joint audit of readmissions to the acute medical unit was undertaken which found that in 43% of cases the readmissions were thought to be avoidable. Moreover 22.92% of older people discharged from hospital in 2010/2011, and 13.65% in 2011/12 were no longer at home 3 months after discharge. This clearly highlights the need for greater focus on preventing avoidable hospital admissions by improving the support available to patients within the 30 days following discharge.

5. Intermediate Care and the links to Rehabilitation and Reablement

Different interpretations have emerged and evolved nationally and locally regarding the definition of 'intermediate care' and its links to 'rehabilitation' and 'reablement . In Sunderland, partners have worked together in order to review national guidance and agree a clear set of definitions for intermediate care, rehabilitation and reablement. These are as follows:

Rehabilitation Definition

'*The primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce)*

Rehabilitation usually requires a mixture of clinical , therapeutic and social interventions that also address issues relevant to a person's physical and social environment

And

Effective rehabilitation needs to be responsive to a user's needs and wishes, to be purposeful , involve a number of agencies and disciplines and be available when required.'

Audit Commission 2000. The Way to go Home – Rehabilitation and Remedial Services for Older People

Intermediate Care Definition

"Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living"

Department of Health 2009. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities

Reablement Definition

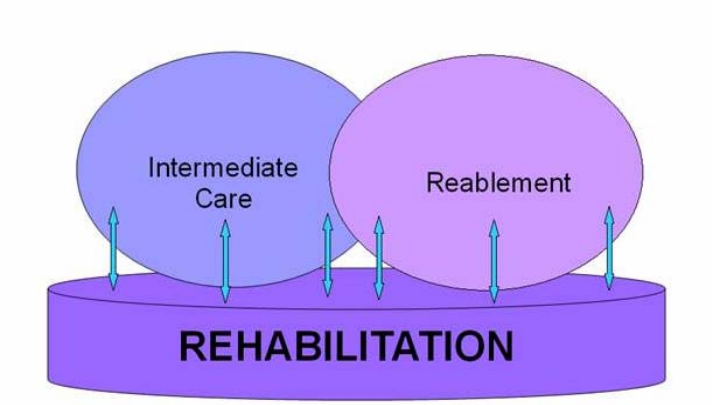
Reablement is an 'approach' or 'philosophy', which aims to help people 'to do things for themselves' rather than 'having things done for them'.

It is the use of timely, and time limited, focused support to improve choice and quality of life, so that people maximise their independence by regaining skills and confidence.

Developed by the Reablement and Accommodation Group on behalf of the Sunderland Intermediate Care Strategy Group, 2011

Therefore it is clear that many of the of the principles and functions of intermediate care fall within the spectrum of rehabilitation services, as stated in the local Rehabilitation Strategy (Transforming Rehabilitation – Achieving Synergy in South of Tyne and Wear 2011) which complements the development of a new intermediate care model for Sunderland. The Rehabilitation Strategy reiterates the clear connectivity between intermediate care and rehabilitation, with reablement being used to support individuals in order to encourage independence – see Figure 3 below. It is important to note that reablement is not limited to intermediate care and may be found in other areas such as mental health or long term conditions.

Figure 3



6. What does Intermediate Care look like now in Sunderland?

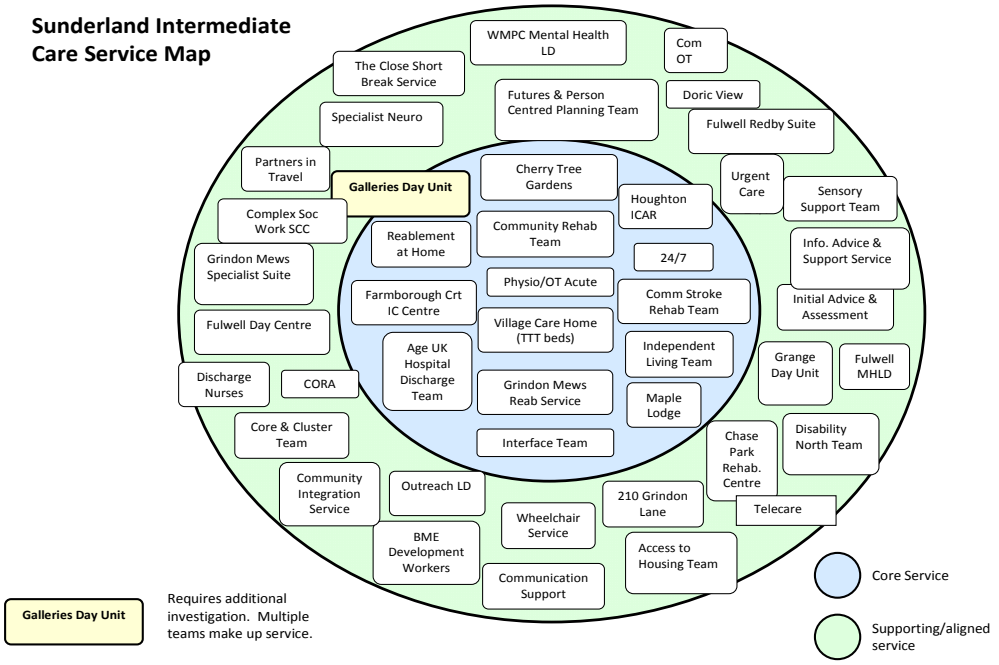
Sunderland Intermediate Care Service Partnership

Sunderland's Intermediate Care Service Partnership was established on 25 February 2005 and exists as a formal agreement between Sunderland City Council, Sunderland Teaching Primary Care Trust, City Hospitals Sunderland NHS Foundation Trust and Northumberland, Tyne and Wear NHS Trust. The Partnership has overseen the development of intermediate care services and managed the pooled budget for intermediate care, which currently is £2.2 million. It is acknowledged that significant new initiatives and service developments have recently emerged to support the population of Sunderland and new partners are also involved in this work such as South Tyneside NHS Foundation Trust and Gateshead Health NHS Foundation Trust. Given the changing landscape and also a lack of clarity regarding definitions of intermediate care, rehabilitation and reablement, it was agreed that a review of the overall intermediate care picture would be helpful, alongside a stock take of the budget for core intermediate care services both within and out with the pooled budget.

Current Services – Self Assessment

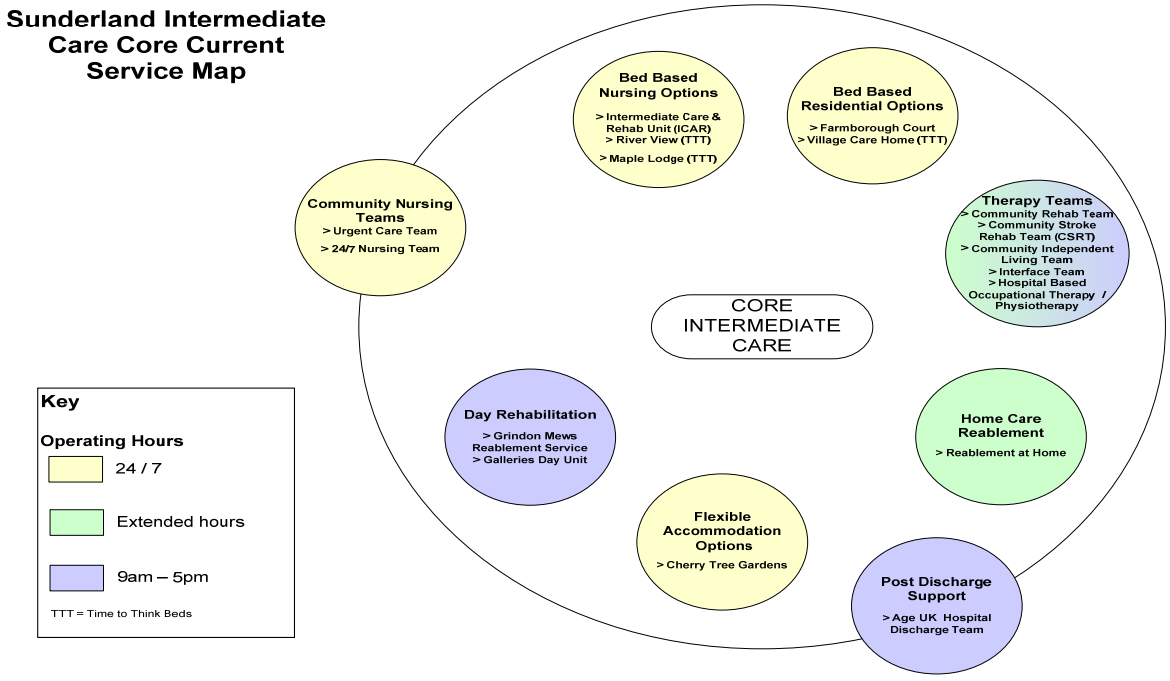
A self assessment exercise was initiated in Sunderland, with services believed to be providing intermediate care options in order to provide clarity and identify any gaps in provision. The outcome of the review resulted in the development of Figure 4 below, which depicts the feedback from the self assessment exercise in terms of a set of 'core' intermediate care options, with surrounding 'supporting services', reflecting the current picture in Sunderland. These services are delivered by a range of providers, within health, local authority and the third sector.

Figure 4



For the purposes of clarifying the functions of the teams and services identified in the core intermediate care service following the self assessment exercise, these have been grouped in Figure 5 as follows with an indication of their hours of service. It is important to note that whilst these services have been identified as core following the self assessment exercise of the current state, the emerging future model of intermediate care may need to incorporate other existing or new services as it develops therefore Figures 4 and 5 must be viewed collectively in order to understand the complexity and range of services in Sunderland.

Figure 5



The core services within the current state comprises of skilled staff from a variety of disciplines including:

- Physiotherapists
- Occupational Therapists
- Nurses
- Social Workers
- Support Workers

The review identified that the 'core' intermediate care services employ similar staff groups, whilst staff identified 'their team' as being their direct colleagues, they were less able to visualise the links between services and how their work could be complemented with the intervention of others. It was recognised that there had been little opportunity for planned shared learning and development.

As a result of their organic development over ten years, services are delivered at a variety of facilities or by various teams, and at times this can prove difficult to

navigate. It was noted that there are some duplications in function which is not conducive to a streamlined pathway. Services are working hard to deliver and support the intermediate care agenda, despite the mosaic of providers and teams and have developed strong links where possible, but few can describe the whole system or articulate how this is accessed.

This is emphasised for those responding to crisis situations, for example GPs identifying an individual in crisis in the community, faced with unclear pathways for care. In this environment and requirement for an immediate action, it is understandable that a hospital referral and admission is often the default option as opposed to the intermediate care services.

Current Services – Financial Stock Take

The current pooled budget for intermediate care is £2.2 million, however, via the self assessment exercise, a wide range of services were identified as providing a 'core' intermediate care function, which amounts to a total budget of £12.2 million. This is £10 million in excess of the formal pooled budget arrangements and demonstrates firstly the significant new investment that has been made in services for Sunderland, but also highlights the potential vulnerability of these services with funding sitting outwith the formal agreement. This is possibly a result of the lack of clarity that has already been described regarding definitions of what is or is not core intermediate care.

The development of clear definitions identifying core intermediate care services provides an ideal opportunity to review the formal pooled budget arrangements to ensure they are reflective of core intermediate care services which will enable a sustainable future model to be further developed.

Ideas for Change – A service provider and commissioner perspective

The self assessment undertaken by stakeholders has generated new and significant ideas for change. These include:

- To develop a central point for all referrals into intermediate care services
- To facilitate access to intermediate care services 24/7.
- Integrated working across a range of teams and services delivering intermediate care.
- Shared assessment frameworks.
- Workforce development strategies that promote shared learning and skills development across health and social care teams.
- To develop mechanisms to ensure services are shaped through user and carer engagement.
- To ensure services address the mental health as well as the physical needs of individuals.
- Increased support for carers within intermediate care services.
- To establish pathways that keep people at home safely when they are unwell and prevent hospital admission and readmission.

- To better understand and harness assistive technology in the individual's journey in order to support independence.
- To review the pooled budget arrangements to ensure they are reflective of core intermediate care services in the agreed future model.

These ideas combined with the views and ideas of the public, service users and carers have helped inform the development of objectives for this Strategic Direction.

Ideas for change – the views of public, service users and carers

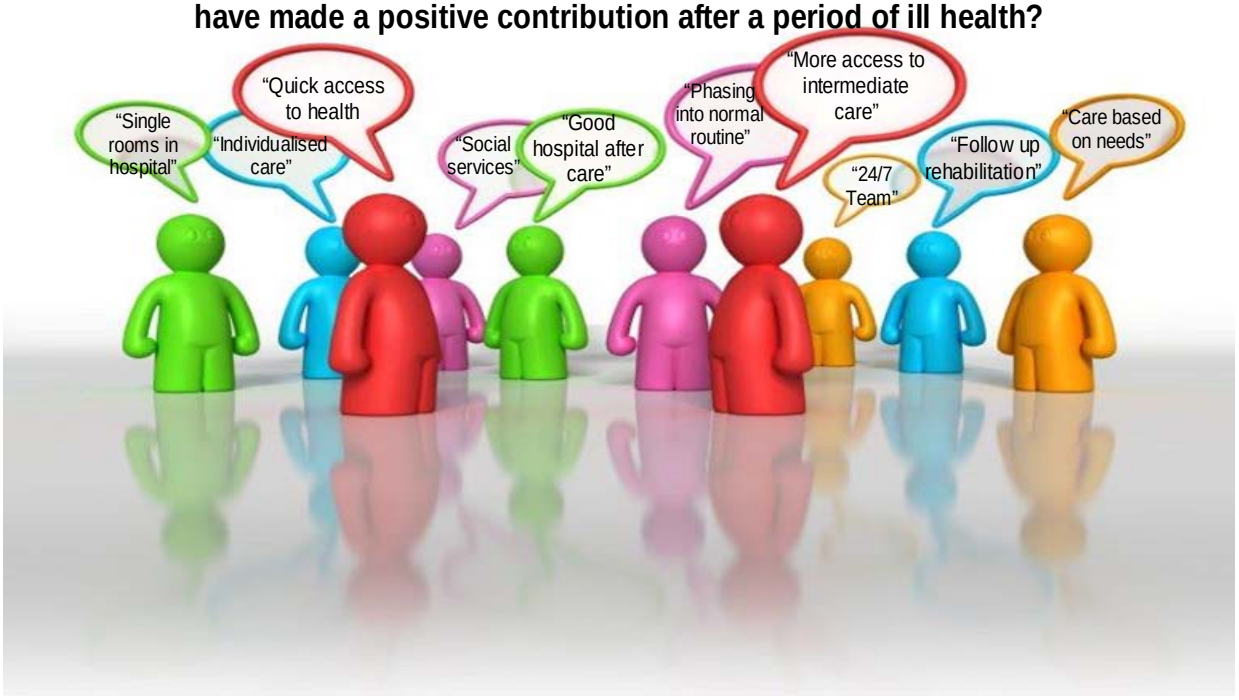
During 2009/10, a number of focus groups and 1-1 interviews on the topic of intermediate are took place with the public and carers, working with Age Concern (now Age UK), Sunderland Carers Centre, Farmborough Court Intermediate Care Centre, Sycamore Care Centre and City Hospitals Sunderland.

In addition in September 2010, a 'Positive Ageing' conference was held by Sunderland Teaching Primary Care Trust, in conjunction with Sunderland Council and Age UK. During the conference, more than 60 members of the public, users and carers participated in workshops on 'Staying Healthy for the Future', which included discussion around experiences and views on what works well and what could be better in relation to *'care and support available after a period of ill-health'*.

Due to the breadth of services that come under the heading of intermediate care, and its links with hospital discharge and wider community health and social care services, this led to a very varied content of discussion in the engagement work described above and subsequently very diverse comments and views. Key themes emerging have been summarised in the table below:

- *The need for person-centred care, focused on individual needs and promoting choice and control*
- *A social disability model which promotes independence and enablement not compensation*
- *Carers as partners in care, whose views, needs and expertise should be recognised and acted upon*
- *Care at home if possible, but availability of alternatives to hospital if recuperation and rehabilitation is required*
- *Need for quick access to health and social care services whether in the community or after a hospital stay such as: immediate post-op care, 24/7 Team, social services, equipment, follow up rehabilitation, respite*
- *Longer hospital stay to recover or more access to intermediate care i.e. Farmborough Court*
- *The need for good discharge planning and coordinated transfer of care*
- *GP to contact patients post discharge or periods of ill health*
- *Need for better information in the community and hospital*
- *Opportunities required for ongoing support so that the benefits of intermediate care are not lost once the services stop*

What have been your good experiences? Any ideas/thoughts on what else would have made a positive contribution after a period of ill health?



In February 2011, the Sunderland Health and Well-being Scrutiny Committee held a stakeholder engagement workshop as part of their *Review of Rehabilitation and Early Supported Discharge from Hospital*. The following is a summary of the key themes that emerged from the table-top discussions that relate to intermediate care:

Preventing admission to hospital

- *Lack of confidence in services available in the community – need to raise awareness of what is available – would result in possible reduction in admissions i.e. Break culture of 'when in doubt go to hospital'*
- *More education\information is required to encourage earlier contact with health services with better use/more awareness of screening services. This could help prevent admissions for chronic illness.*
- *More support to cares/families could result in fewer admissions*
- *Improve health education – People being made more aware of how to manage their health in the long term*
- *Much better understanding of services available to keep people out of hospital – people have no idea of what services/support is out there – Huge lack of knowledge of availability of support services.*
- *There is a need to tailor services for the individual. Need to be person-centred.*
- *After 5pm and on weekends access to services is reduced – need to plan in advance.*

My stay in hospital

- *Holistic approach to admissions needed – physical and mental health.*
- *Patients feel that the doctors are not listening when they are trying to tell them about any underlying or existing health problems – Not enough joined up thinking between departments, doctors etc.*
- *Treat patients with dignity courtesy and respect. Listen more to carers and respect patient's wishes*
- *Better awareness and ongoing promotion of what services are available through Community Health Services and Social Care and what their remit is. There needs to be a central contact / single point of entry that can provide this information for both patients and health professionals.*
- *The levels and services delivered by Community Health Services should be the same across the city. Numbers need to be increased to account for the increasing needs of an ageing population.*
- *Use of housing providers as a resource to promote health-related services, including preventative measures.*
- *Communication methods can be a barrier – internet and 0845 numbers are not accessible for all.*
- *Need for multi-agency planning and coordination.*
- *Training, support and inclusion of Carers. Give them information on patients' illness, treatment and care etc. and empower carers and help them and the patient make informed decisions etc*
- *Involvement of patients and carers in decision-making about their treatment and care*
- *Communication needs to be pitched at a level that everyone understands.*
- *Hospital staff need to make sure that they have an understanding of all health problems the patient is suffering from and not just the one they are presenting with.*
- *Need to give people more information on their treatment and care and listen to families too*

Hospital discharge process

- *Discharge process should be initiated when patient is admitted, with involvement of carers and Social Services if required from the beginning.*
- *Multi-agency discharge planning and links to follow up services*
- *Care plans shared across agencies – for everyone – needs to include whole process from admission to discharge.*
- *Delay in getting test results and medications so discharge can be delayed.*
- *Identifying a care coordinator for a patient to take responsibility for a patient's welfare / aftercare to ensure that the right level of care is being provided.*
- *Discharge navigator – communicator / coordinator – acts as a Lead / Mentor through the whole process.*
- *Delays in sending discharge information to GP can affect time in which practice are able to follow up with patient.*
- *Management of medications following discharge needs to be included as part of the package of care.*
- *Stronger links with housing providers – inform housing if people discharged so they can put in support if needed.*
- *Services need to be proactive and contact must be made with patients after discharge to find out how they are getting on. Regular reviews and follow ups are needed as a patient's need may change*
- *Evaluation after discharge - unclear who, if anyone, reviews the care plan after discharge – initially the patient may not need lots of support when discharged but circumstances could change re availability of carer/family member but this is not being taken into account but would be captured if regular reviews were undertaken.*

7. What does the future look like for the people of Sunderland ?

Our vision for the future of intermediate care in Sunderland is:

To develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.

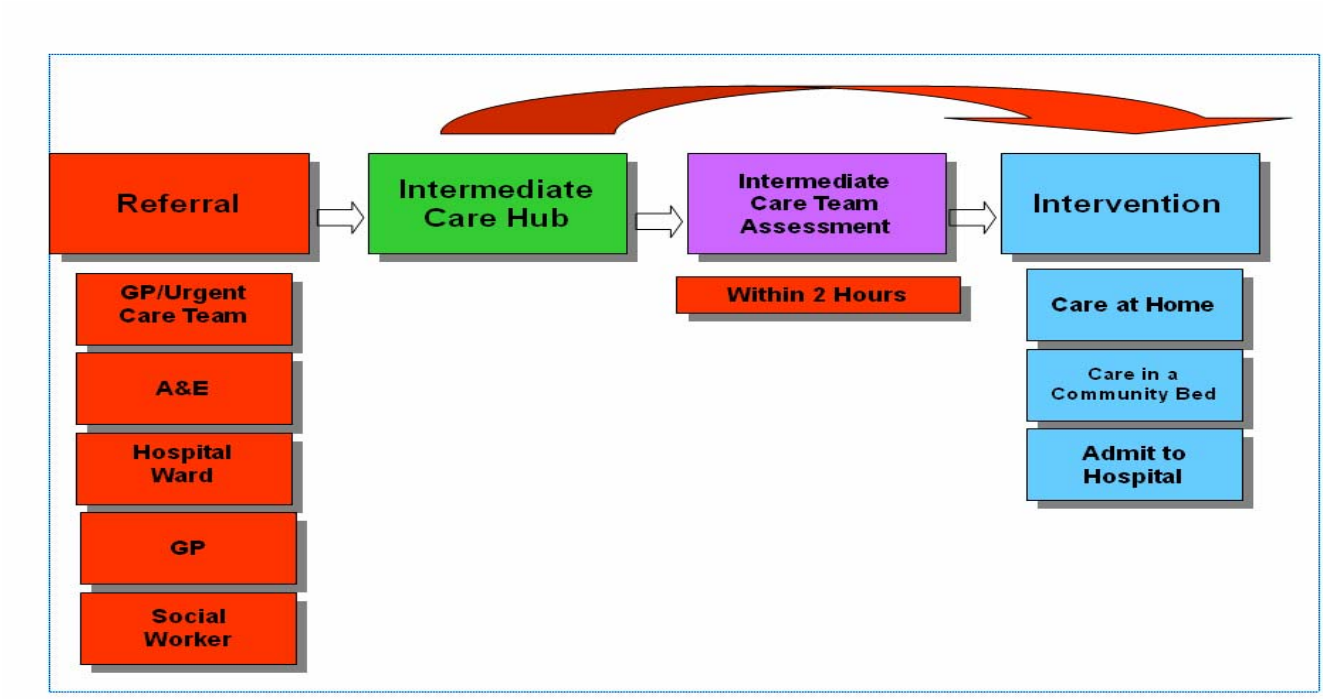
The overarching Model for Intermediate Care Services will be one where the emphasis is on delivering care closer to home as illustrated in the diagram below Figure 6.

Figure 6 – Future model for Intermediate Care in Sunderland

Reproduced with kind permission of Sheffield City Council/NHS Sheffield

Figure 7 shows the flow through the intermediate care services via the Intermediate Care Hub where multi-agency assessment takes place ensuring the person receives the right intervention in a timely manner.

Figure 7 – Flow through the Intermediate Care Services



A set of high level aims have been developed that describe what our Intermediate Care Model will deliver for Sunderland. These closely align with the Department of Health guidance 'Intermediate Care Half Way Home'.

Aims

- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to long term residential care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce
- Measure success from the view point of all

From our engagement with patients, carers and staff who provide services, we have developed a set of objectives which we believe will help us to achieve the above aims for the people of Sunderland.

Objectives

We will provide rehabilitation and reablement approaches appropriate to need
Key activities • Transition to an in-reach model of rehabilitation and reablement wherever the person is (eg. own home, care home, extra care, hospital) • Ensure needs are identified through therapy led assessment • Strengthen working relationship with specialist pathways and services (eg, stroke, falls, continence) • Greater integration and coordination with the spectrum of rehabilitation services in line with the new Rehabilitation Strategy • Ensure that individuals with complex needs (e.g. dementia, mental health, learning disabilities, long term conditions) have equity of access to the Intermediate Care Model which is sensitive and flexible to their specific needs • Explore linkages to the End of Life Strategy

We will place the individual and their carers at the centre of decision making
Key activities • The model of decision making will embrace the personalisation agenda with individuals and carers • Develop a person centred 'menu based' approach to service provision to offer choice and control to individuals

We will facilitate timely access to good information and advice for individuals, carers and staff
Key activities • Customer Service Centres will have access to a directory of services for staff and the public • Links with Healthwatch will continue to be maintained as it evolves • Individuals will have access to full and fair information, advice and support in order for them to make informed decisions

We will coordinate access to intermediate care services, ensuring a rapid response (within 2 hours) is available where appropriate

Key activities

- Development of an 'Intermediate Care Hub' to provide a single point of access and streamlined referral to intermediate care services
- Develop clear referral pathways into the Intermediate Care Hub with standard documentation, for hospital, community and primary care
- Review and further develop the rapid response component (within 2 hours) of the Intermediate Care Model to provide urgent community based assessment and intervention in peoples homes
- Develop a standard process for GP admissions, ensuring alternative pathways are readily available for individuals via the Intermediate Care Hub if a hospital admission can be prevented
- Analysis of the demand for intermediate care services over a 24 hour period to enable demand to be matched to capacity/availability

We will increase individual and carers confidence and ability to cope

Key activities

- People will be supported and empowered to manage their anxieties
- Carers will be actively identified by intermediate care services and signposted to appropriate support services
- Ensure robust support system for carers and explore opportunities for Reablement for carers
- The Intermediate Care Model will take into account the current Carers Strategy Review
- We will review the opportunities to support individuals to manage their medication

We will facilitate increased joint working and streamlined pathways of care

Key activities

- Establish joint working protocols and unified assessment documentation, trusted by all with appropriate information shared amongst partners
- Ensure documentation clearly indicates the individual's 'normal' level of functioning so that changes can be identified and appropriate goals set
- Re-model care management service in response to the Intermediate Care Model
- We will strengthen links with medical staff
- Reposition and strengthen prevention strategies within the model, this would include increased engagement with the third and voluntary sector
- Ensure that the model embraces the Memory Protection Service

We will explore appropriate investment in assistive technology

Key activities

- Invest and embed usage of assistive technology
- Ensure staff have access to appropriate training to maximise development opportunities in this area
- Develop 24 / 7 response to support people in any setting (eg. own home, care home, extra care, hospital)

We will offer a range of bed based options as alternatives to hospital admission

Key activities

- Drawing on current intelligence, jointly commission appropriate numbers and types of bed based provision to meet future need
- Ensure local commissioning arrangements are flexible to cope with surges in demand during episodes of peak activity

We will support a timely hospital discharge process by offering a range of intermediate care options

Key activities

- Ensure individuals have had the opportunity to access rehabilitation to meet their needs during their hospital stay to maximise recovery opportunities and independence
- Review the effectiveness of ward based multidisciplinary team discussions ('pow wows') to optimise effective communication and assessment of needs
- Ensure accurate and appropriate information regarding an individual's ongoing needs is shared with agreed services in a timely way, prior to hospital discharge
- Explore opportunities for access to rehabilitation and reablement for all those who could benefit post hospital discharge
- Review third and voluntary sector role in hospital discharge process

We will ensure assessment and decision making about peoples long term care needs can only be made after they have had the opportunity for rehabilitation, reablement and recovery

Key activities

- A period of rehabilitation and reablement will be part of the core offer to all individuals prior to decision making about their long term care needs, this includes individuals receiving care at home or in a care home
- We will agree a multi disciplinary approach to identifying and meetings individuals' long term care needs

We will develop an integrated intermediate care workforce to ensure the ethos of rehabilitation and reablement is embedded in practice

Key activities

- Develop virtual teams across health and social care to deliver the intermediate care model
- Ensure linkages with all teams for high / low risk patients
- Integration of therapy teams to reflect the intermediate care model
- Explore opportunities to secure dedicated medical support and input into intermediate care services
- Dedicated work to integrate the third and voluntary sector provision which contributes to intermediate care
- Align health and social care therapy workforce to the intermediate care model
- Develop social care Community Occupational Therapy work force to support reablement / rehabilitation journeys in addition to the statutory functions of the Council
- Profiling the workforce and ensuring they are equipped with the appropriate skills and knowledge
- All intermediate care workforce will receive core training in dementia
- Ensure the workforce is skilled to support individuals to manage anxiety or make behavioural changes

We will measure success by data analysis and seeking the experience of views of patients, carers and staff

Key activities

- Develop a suite of metrics and outcome measures that enable us to meet the desired outcomes of individual and their carers
- Establish mechanisms for capturing experience and views
- Commission a longitudinal study / evaluation

We will set out a clear accountability framework for delivery of the Strategic Direction

Key activities

- Review the Intermediate Care Partnership Agreement and pooled budget for Sunderland to incorporate all the elements of the new model and ensure ongoing governance across partners
- Develop a robust financial monitoring framework to deliver a cost effective service delivery
- Data collection for the key contracts relating to the intermediate care model will be aligned to produce a single data set
- Continually demonstrate accountability by establishing a process for continuous development of the model in response to metrics and experiential feedback

Outcomes for individuals

The following case studies provide some examples of what the achievement of these objectives will mean for the people of Sunderland.

Case study 1 – Mrs H

Mrs H is 94, a widow and living with her son and daughter-in-law.
She had a number of urinary infections and was constantly getting up in the night.
One night she fell and fractured her pelvis, ending up in Sunderland Royal Hospital.
Whilst in hospital Mrs H lost all her confidence, became depressed about her situation and began to feel that life wasn't worth living – her son became concerned that she would not be able to get back home.
Following treatment for her pelvis, the discharge team contacted the 'Intermediate Care Hub' a single point of access to all community services, who arranged for Mrs H to transfer to an Intermediate Care Assessment and Rehabilitation (ICAR) bed at the Houghton Primary Care Centre.
During her stay there, the team resolved the issues around her urinary infections and she had daily visits from the Occupational Therapist and Physiotherapist from the Community Rehabilitation Team to get her back on her feet. The team also worked with the Telecare service to install an alarm in her home to provide an alert to her family if she got up in the night and to prevent future falls.
After a short 2 week stay in ICAR, Mrs H went home feeling confident and well, and received a few weeks of additional support from the Reablement at Home team.
A few weeks later Mrs H was at the Stadium of Light cheering her favourite team, Sunderland Football Club, at their last match of the season.

Case study 2 – Mrs V

Mrs V is 67 years old and was referred to the Reablement at Home team after a hospital stay due to a stroke. She returned home with the support of one member of staff and 4 visits throughout the day.
Mrs V also had the Sunderland Stroke Team visiting once/twice a week so both teams worked jointly to provide maximum input for Mrs V and ensure integrated provision across the teams.
Mrs V's stroke had left no physical, numbness or weakness but had affected her brain, her memory, communication skills, and difficulties recalling the correct words etc. The Reablement team first started with an assessment around her activities of daily living, and found out quite quickly Mrs V needed lots of prompts, guidance and instructions, but physically could carry out the tasks independently. Mrs V would lose her trail of thought and couldn't recall where items were in her own kitchen. Staff worked each visit alongside her to prepare her meals but only assisted and supported where necessary.
Mrs V also had been given a new system to enable her independence with her medication and staff worked each day prompting, and observing Mrs V with the long term goal that she would be able to complete herself. After a couple of weeks staff found Mrs V progressed very well and was managing kitchen activities independently, but had noticed the difficulty she was still having around reading the instructions on a packet or a microwave meal cooking instructions. Staff worked with the Occupational therapist and the Speech Therapist from the Stroke Team to plan how the team could support Ms V.
Working with the Stroke team Mrs V was provided with a work booklet to complete and assist with development of independence.
The Reablement team suggested to Mrs V that they would help her complete once or maybe twice a day but during that first week Mrs V enjoyed this time so much that 3 out of 4 visits were now around these booklets, it reminded Mrs V about the class room, as she had been a primary teacher during her working days and she found it funny how she was going back to basics herself.
By the time the Stroke team visited the following week they were so surprised how far Mrs V had come from not been able to recognise letters to now attempting to spell and sound out small words.

Over a couple of more weeks her confidence grew in all areas, she was managing to wash, dress, and manage in kitchen (she still needed support if there was any reading material) and also remembering her own medication it was agreed to reduce visits to an evening call.
Once the service reached its 6 weeks it was agreed to extend for 2 more weeks due to her progress.
The 8th week came around very quickly Mrs V was now reading small words and recognizing pictures of items, and her communication skills had greatly improved. It was agreed, the stroke team would continue with their visits and Mrs V would continue with the work booklets, but now independently, and the Reablement at Home team would cease their visits.

Case study 3 – Mrs M

Mrs M is 70 years old and lives at home with her husband. She is in remission from bowel cancer and has other co morbidities including chronic obstructive pulmonary disease and diabetes. Mrs M was recently discharged from hospital after an extended stay post surgery. Recovery had been slow in hospital, complicated by immobility and a grade 4 sacral sore. She is now living downstairs with hoist for all transfers, other equipment and home care support services were in place for discharge. Her GP Visits 4 weeks post discharge after a call from patient's husband in crisis.

Mrs M's GP identifies Early Warning Score of 0 and feels patient may benefit from an Intermediate Care Assessment and Rehabilitation (ICAR) bed at the Houghton Primary Care Centre, however she wishes to remain at home. GP discusses needs with Intermediate Care Hub, who arrange same day assessment from Rapid Response Therapy and 24 7 Community Nursing Team.

A comprehensive multidisciplinary assessment and intensive rehabilitation/treatment takes place over the next six weeks. Mrs H made significant progress, her mood improved, she is now mobile with the aid of a walking frame, and supervision from husband/carers, her catheter has been removed, and her sacral sore is much improved.

Mrs M's future goals are to assess her ability to manage stairs.

Hospital admission/admission to Intermediate Care Bed was avoided.

8. Measuring our Success

This section sets out we intend to measure achievement of the aims and objectives of the Strategic Direction for Intermediate Care Model.

Our approach is two-fold:

- A strategic "whole system" perspective on the model, reflecting on the expected outcomes of intermediate care beyond its delivery (e.g. its positive impact on health and social care systems), as well as the outcomes for individuals and carers themselves;

- An operational perspective exploring the management, impact and outcomes of specific parts of the model, particularly within the integrated pathway. Clearly, some of the measures identified in the operational perspective will be reported upon (or aggregated across the pathway) for the 'whole systems' perspective.

For the purposes of this document we have outlined how the 'whole systems' perspective on the model will be measured.

Whole systems perspective

We have developed a Balanced Scorecard with four different dimensions:

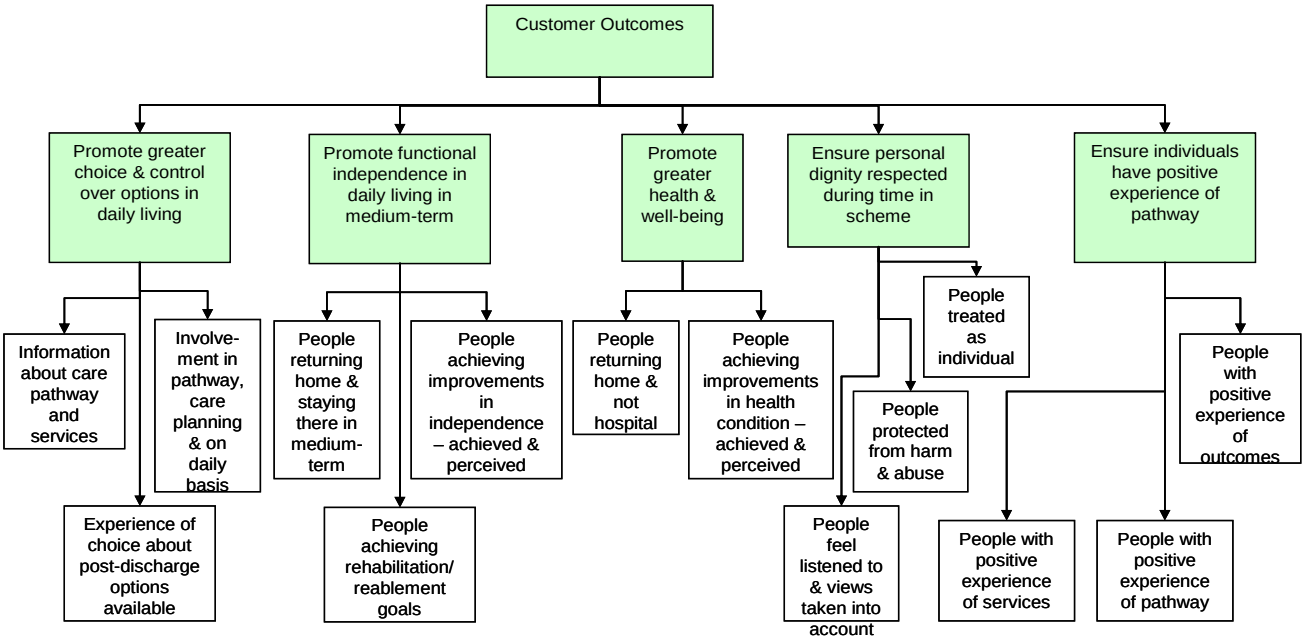
- Patient/Customer & Carer Outcomes
- Service Delivery
- Cost-Effectiveness
- Whole-System Dimension, including capacity & standards

Patient/Customer & Carer Outcomes

This first dimension seeks to determine whether the outcomes relating to individual customer/patients and carers are achieved – from a variety of different perspectives, but including those of individuals themselves and those of professionals in terms of improvements in the individual's condition or independence or their ability to better manage either.

The framework described in Figure 5 below shows the range of expected outcomes that will be measured. Intelligence will be gathered through a range of methods such as focus groups, research and audit, quantitative professional outcome measures (e.g. longitudinal studies – "before" and "after") and case studies. This intelligence is then combined to provide a coherent narrative about whether the stated outcomes are being achieved.

Figure 5



Service Delivery

This second dimension relates to outputs of delivery such as the number of clients accessing intermediate care and the logistics of this delivery, e.g. length of access etc. A range of quantitative performance metrics have been developed across the Intermediate Care Model to monitor this dimension. Clearly, these measures can also apply to individual elements of the Model in the operational Scorecard discussed above.

Cost-Effectiveness

This third dimension relates to outputs of cost-effectiveness on two levels:

- *Direct efficiency of delivery* of the intermediate care service, including monitoring where different partners' resources have been combined across the customer journey – which could be benchmarked against others' models of delivery;
- *Cost-Benefit analysis:* Understanding the (positive) impact the Intermediate Care Model would have on wider health and social care systems, translated into financial terms, but being careful to differentiate between "cashable" savings and "non-cashable" savings (i.e. savings would not be real; but if the Intermediate Care Model was not in place, there would be a greater spend on other parts of the system).

Whole-System Dimension, including Capacity & Standards

This fourth dimension relates to:

- *Partner Capacity & Standards:* This relates to the organisational capacity to deliver and improve an ongoing service, including "future proofing" delivery of services. As a partnership, this would include ongoing monitoring of training and development of staff and its positive impact in the service, quality assurance mechanisms such as case file audit and inspection and monitoring against standards and the management of safeguarding or risk issues;
- *Whole-System Impact:* Understanding the (positive) impact the Intermediate Care Model would have on wider health and social care systems, e.g. reducing emergency re-admission rates to hospital for certain conditions; or reductions in residential or nursing care. It will be important to understand the level of attribution between the Model's outcomes and the measures in this section, e.g. the Intermediate Care Model might be highly effective in reducing subsequent hospital re-admission rates for those patients it admits, but nonetheless, emergency re-admission rates in the city might continue to increase overall.

Governance

The scorecard is comprehensive and populated by a range of performance and outcome measures. However, we aim to reduce the burden on partners by using readily available information and monitoring of the separate dimensions of the Scorecard, which can then be aggregated up as required. e.g. partners would be expected to use their own monitoring tools and reporting arrangement in relation to Capacity & Standards rather than developing a common bespoke approach across partners for the Intermediate Care Model. Furthermore, some of the Customer Outcomes methods (e.g. case studies) could be collected over the period of a year to gradually build a holistic picture of progress in this area.

A short performance summary with recommendations for consideration using the above framework will be updated and prepared for the Intermediate Care Strategy Group (and for wider partners) on a quarterly basis, whilst a more in-depth evaluation with recommendations (together with progress against any quarterly recommendations made during the year) using the same framework will be presented to the Strategy Group annually.

9. Taking the Strategic Direction forward

Seeking Agreement

The next step for the Sunderland Intermediate Care and Reablement Strategy Group is to seek agreement and sign up to this strategic direction from all statutory partners via the appropriate internal mechanisms.

We have taken opportunities for engagement of individuals and carers through out our journey to develop this Strategic Direction however, it is essential that the Strategy Group establish an ongoing and genuine dialogue going forward. We will draw on current engagement mechanisms across the city such as the Sunderland Carers Centre and local Healthwatch to ensure co-production of the Model of Intermediate Care in the future.

We have incorporated the recommendations from the Health and Well-being Overview and Scrutiny Committee review of *Rehabilitation and Early Supported Discharge from Hospital* into the strategic direction and implementation plan, and therefore we will report on progress against this plan to the Overview and Scrutiny Committee.

The links between the Strategy Group and the development of the Sunderland Health and Wellbeing Strategy overseen by the Health and Wellbeing Board is also critical to its success ensuring democratic legitimacy from elected members, and therefore we will seek to ensure that this Strategic Direction document is acknowledged in the developing strategy.

Implementation

The implementation of this Strategic Direction will become the key work plan for the Sunderland Intermediate Care and Reablement Strategy Group. We will review sub-group structure in light of this, providing opportunities for partner organisations to shape the delivery of key activities and ensuring full integration of the third, voluntary and independent sector in these arrangements.

We will review the formal Sunderland Intermediate Care Partnership arrangements to facilitate achievement of the Strategic Direction.

As described above, continuous engagement of individuals and their carers is essential to delivery of this Strategic Direction.

Appendices

Appendix 1: Sunderland Intermediate Care Strategy Group Membership

Joint Chair:
Ailsa Nokes, Strategic Lead for Long Term Conditions, QIPP Reform Team, NHS SOTW
Jean Carter, Deputy Executive Director, Health Housing & Adult Services, Sunderland City Council

Members:
Dr Iain Gilmour, Board Member, Sunderland Clinical Commissioning Group
Philip Foster, Head of Service Care & Support, Health, Housing & Adult Services, Sunderland City Council
Philippa Corner, Head of Personalisation, Health, Housing & Adult Services, Sunderland City Council
Alan Caddick, Head of Service, Housing, Health Housing & Adult Services, Sunderland City Council
Graham King, Head of Service, Commissioning, Health Housing & Adult Services, Sunderland City Council
Mark Smith, Chief Operating Officer, City Hospitals Sunderland NHS FT
Bev Atkinson, Executive Director of Nursing and Patient Safety, South Tyneside NHS FT
Tim Docking, Group Director, Planned Care Group, Northumberland, Tyne and Wear NHS FT
Yvonne Ormston, Executive Director, Gateshead Health NHS FT
Wendy Kaiser, Strategic Lead, Mental Health Model of Care, Business Delivery Team, NHS SOTW
Helen Turnbull, Operational Reform Officer, QIPP Reform, NHS SOTW
Janette Oliver, Sunderland Intermediate Care & Reablement Co-ordinator, Health, Housing and Adult Services, Sunderland City Council

Appendix 2: Working Groups reporting to Sunderland Intermediate Care Strategy Group

Discharge Working Group

Chair:
Ailsa Nokes, Strategic Lead for Long Term Conditions, QIPP Reform Team, NHS SOTW
Vice Chair:
Jean Carter, Deputy Executive Director, Health Housing & Adult Services, Sunderland City Council

Members:
Philip Foster, Head of Service, Care & Support, Health, Housing & Adult Services, Sunderland City Council
Helen Turnbull, Operational Reform Officer, QIPP Reform, NHS SOTW
Anna Hargrave, Divisional General Manager, City Hospitals Sunderland NHS FT
Susan Martin, Divisional Discharge Co-ordinator, City Hospitals Sunderland NHS FT
Angus McLellan, Business Manager, South Tyneside NHS FT
Jill Graham, Occupational Therapy Manager, City Hospitals Sunderland NHS FT
John Padget, Service Manger, LD Inpatient Service, Urgent Care, Northumberland, Tyne and Wear NHS Foundation Trust
Norman Wilson, Team Manager, Health Housing and Adult Services, Sunderland City Council
Phil Hounsell, Service Development Manager, Personalisation Service, Health, Housing and Adult Services, Sunderland City Council
Gill Lawson, Service Development Manager, (Prevention Services) Care & Support, Health, Housing and Adult Services, Sunderland City Council
Pauline Forster, Commissioning Specialist, Commissioning Team, Health, Housing and Adult Services, Sunderland City Council
Anne De Cruz, Team Manager, Intermediate Care and Reablement at Home, Care and Support, Health, Housing and Adult Services, Sunderland City Council
Paul Allen, Intelligence Hub Lead Officer, Strategy, Policy & Performance Management, Office of the Chief Executive, Sunderland City Council
Rachael Forbister, Service Pathway Development Officer, Telehealth, Health, Housing and Adult

Services, Sunderland City Council
Janette Oliver, Sunderland Intermediate Care & Reablement Co-ordinator, Health, Housing and Adult Services, Sunderland City Council

Reablement & Accommodation Working Group

Chair:
Philip Foster, Head of Service Care & Support, Health, Housing and Adult Services, Sunderland City Council
Vice Chair:
Emma Anderson, Service Development Manager Reablement, Health, Housing and Adult Services, Sunderland City Council

Members:
Jean Carter, Deputy Executive Director, Health Housing & Adult Services, Sunderland City Council
Ailsa Nokes, Strategic Lead for Long Term Conditions, QIPP Reform, NHS SOTW
Helen Turnbull, Operational Reform Officer, QIPP Reform, NHS SOTW
Penny Davison, Senior Business and Contract Manager, NHS SOTW
Sharon Lowes, Lead Commissioner, Health, Housing and Adult Services, Sunderland City Council
Anne Prentice, Strategic Development Lead, Housing, Health, Housing and Adult Services, Sunderland City Council
Jim Usher, Service Transformation and Professional Lead Manager, Health, Housing and Adult Services, Sunderland City Council
Norman Wilson, Senior Team Leader, Hospital Social Work, Health, Housing and Adult Services, Sunderland City Council
Jill Graham, Occupational Therapy Manager, City Hospitals Sunderland NHS FT
Angus McLellan, Business Manager, South Tyneside NHS FT
Kerry Barclay, Team Lead Intermediate Care, South Tyneside NHS FT
Phil Hounsell, Service Development Manager, Personalisation Service, Health Housing & Adult Services, Sunderland City Council
Lynden Langman, Service Development Manager, Personalisation Service, Health Housing & Adult Services, Sunderland City Council
Rachael Forbister, Service Pathway Development Officer, Telehealth, Health, Housing and Adult Services, Sunderland City Council
Karen Wright, Rehabilitation Service Manager, Farmborough Court Intermediate Care Centre, Health, Housing and Adult Services, Sunderland City Council
Louisa Thompson, Community Support Manager, Social & Health Care Services, Health, Housing and Adult Services, Sunderland City Council
Sandra Begbie, Community Support Manager, Care & Support, Health Housing and Adult Services, Sunderland City Council
Anne De Cruz, Team Manager, Intermediate Care and Reablement at Home, Care and Support, Health, Housing and Adult Services, Sunderland City Council
Lesley Bainbridge, Business Manager, South Tyneside NHS FT
Anna Hargrave, Divisional General Manager, City Hospitals Sunderland NHS FT
Susan Martin, Divisional Discharge Co-ordinator, City Hospitals Sunderland NHS FT
Ron Todd, Directorate Manager, City Hospitals Sunderland NHS FT
Suzanne Miller, Service Manager, South Of Tyne Stepped Care Services, Planned Care Group, Northumberland, Tyne and Wear NHS FT
Angela Richardson, Network Development Officer, Tyne & Wear Care Alliance
Janette Oliver, Sunderland Intermediate Care & Reablement Co-ordinator, Health, Housing and Adult Services, Sunderland City Council

Item No. 7

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

SUNDERLAND HEALTH & WELLBEING STRATEGY – PROGRESS AND FORWARD PLAN

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

1. Purpose of the Report

At the Shadow Health and Wellbeing Board in September 2012, approval was given to the high level Health and Wellbeing Strategy (HWBS). Also approved was a forward plan detailing the process for further development and approval. This report is to provide the Board with an update on the progress to date and to provide more details of the process of engagement and participation that is planned.

2. Engagement and Approval

As detailed at the September Board, the strategy has been developed through a year long process of open engagement events that attracted representatives from the voluntary and community sectors, providers and public sector officers and members. The events established a broad understanding and acceptance of the content of the strategy.

To develop the broad acceptance of the strategy further into formal approval, it is proposed that the headline strategy (as approved by the Board) be taken for formal comment and sign off to the Boards and management organisations of partners throughout the whole health and social care system. This is to ensure that there is high level support and understanding for the strategy throughout the system; this will encourage the transition from strategic planning into delivery and performance management.

The list of organisations that will be included in the formal sign off process are the members of the Children's Trust and Adults Partnership Board alongside the management structures of individual Health and Wellbeing Board members and the Sunderland Partnership. This list is:

HWBB	Clinical Commissioning Group
HWBB	Sunderland LINK
APB	City Hospitals Sunderland
APB	Northumberland Tyne and Wear Mental Health Trust
APB	South Tyneside Foundation Trust

APB	Local Dental Committee
APB	Local Medical Committee
APB	Local Pharmaceutical Committee
APB	North East Ambulances
APB	Voice for Carers
APB	Age UK
APB	Headlight

APB	Housing Federation
CT	Gentoo
CT	City of Sunderland College
CT	Probation Service
CT	Job Centre Plus
CT	Tyne and Wear Fire Service

CT	Sunderland BME Network
CT	VCAS
CT	Northumbria Police
CT	SNCBC
	Sunderland Partnership

Alongside the formal sign off of the high level strategy, the process of developing actions and engaging broadly with partners regarding the strategy is progressing. It is proposed that the outline high level actions are taken to the various Boards at the same time as the strategy for comment and discussion and to identify actions that are currently progressing as part of business as usual and ensure these are accurately captured.

Further engagement and consultation sessions have been scheduled throughout November and December with Area People Boards and Area Committees, the Children's Trust Young Peoples Advisory Network and the various Stay Healthy/Healthy Lifestyles Partnerships. Sessions are planned with the Sunderland Partnership and Equality Forums. A large event is planned for the start of December and details will be circulated to the Board.

3. Performance Management

A two stage performance management framework is envisaged:

As part of the development of the strategic objectives into actions, there is a need to provide a framework to ensure a coordinated approach to their ownership and performance management. It is recognised that for the strategy to be embedded in the health and social care system, that the translation of strategic objectives into actions and their performance management needs to be integrated into the daily work of both commissioners and in service providers.

At a strategic level the Board's needs in terms of strategic transformational performance outcomes such as the change in commissioning decisions and extent of service integration will be balanced alongside the need for accurate and useful data on customer perceptions and experience and quality. Both performance management frameworks need to reflect nationally prescribed outcomes frameworks and locally defined commissioning criteria.

Following the completion of ongoing work into strategic actions, a report highlighting development of the performance management framework will be brought to the Board for discussion.

4. Recommendations

The Board is recommended to;

i) Note the approach to engaging organisations and individuals in the strategy
ii) Receive a future report on actions and performance management.

Item No. 9

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

REVIEW OF HEALTH VISITING SERVICES

Report of the Children's Trust

1 Purpose of the Report

1.1 This report has been produced in response to a request from the Health and Well-Being Board to consider the delivery of Health Visiting Services, specifically to include concerns about potential risks to safeguarding and communication issues as well as the developing service specification.

2. Introduction/background

2.1 In response to publication of the Health Visitor Implementation Plan 2011-2015: A Call to Action (February 2011) and NHS SoTW being one of twenty early implementer sites work has been undertaken, with colleagues from across the region, to develop a regional service specification for Health Visiting. To ensure engagement with this process across SoTW a Health Visitor Expansion Programme Early Implementer Stakeholder Group was established in 2011, with representation sought from local partners, including clinical commissioning groups. Membership has included 2 representatives of Sunderland CCG.

2.2 The working model for the Health Visiting Service has recently changed, following a Rapid Process Improvement Workshop. The outcome was a move to geographical based working across the Health Visiting Service, rather than a practice based working model. This has raised a number of concerns for primary care, particularly in relation to communication and safeguarding,

2.3 At a meeting of the Health and Well Being Board on 30th March 2012 the position as regards the future development of the Health Visiting service was considered. This report made reference to concerns raised in a recent survey of GP practices and also noted some concerns as to the level of influence the Sunderland Clinical Commissioning Group (SCCG) had been able to make in determining the new service specification.

2.4 The development of a new regional service specification has been taken forward by the designated leads for the national early implementer site leads across the North East, with representation sought from nominated children's leads (where identified) within Clinical Commissioning Groups. A draft service specification was taken to the SCCG Executive Committee in February 2012, after which further detailed discussions have been held and nominated leads have

represented SCCG on the South of Tyne and Wear Early Implementer Stakeholder Group.

2.5 Health Visiting is currently commissioned by NHS SoTW and delivered in Sunderland by South Tyneside Foundation Trust. This contract runs to March 2013, after which responsibility for the commissioning of Health Visiting Services will pass to the NHS Commissioning Board. It is anticipated commissioning responsibility for the Health Visiting service will pass to the Local Authority in 2015.

3. Current Position

3.1 As stated above the Health Visiting Service is currently commissioned by NHS SoTW and a regional service specification has been developed, to be implemented incrementally over the three year period 2012/13 to 2014/15 in line with the new National Health Visitor Model.

3.2 The development of the service model and regional service specification has been taken through the Early Implementer Stakeholder Group, led by commissioners and providers. In addition to this separate discussions have been held with CCG representatives, views from which have been fed into the ongoing process. An example of this is the need, in times of emergency, for health visitors to assist with emergency immunisation arrangements. As health visitors will not be routinely providing immunisation there are concerns amongst primary care about how health visitors will maintain skills and competency in immunisation to enable them to assist in such times of emergency. It is the expectation, under the service specification, that the provider of the Health Visiting Service will ensure arrangements are in place to support this.

3.3 Currently, although the service specification has been agreed at a regional level it is now with the provider, awaiting final approval. Some further negotiation may be needed in relation to outcome measures, although it is accepted the outcomes are incremental, as the health visiting workforce is expanded.

3.3.1 The specification, which describes the outcomes to be achieved but not the 'how to', includes 12 defined key service outcomes. These include:

- Liaise with Maternity services as set out within Department of Health Pathway No.1: health visiting and midwifery partnership – pregnancy and early years, this includes a targeted joint antenatal assessment where appropriate.
- To ensure a seamless, timely, high quality, accessible, efficient and comprehensive service that engages all children and families from conception to five years and which promotes social inclusion, equality and respects diversity.
- To provide a home visiting service to all families with children under the

age of five years with level of intensity based on assessed client need (following the 4 level model) utilising the skills of the health visiting team appropriately.

- The Health Visiting service will work in partnership through the delivery of evidence based programmes to keep all children healthy, happy, safe and ready to learn; improving early language development and school readiness.
- The Health Visiting service will contribute to the reduction of inequalities in infant mortality and child poverty, and improve outcomes in infant, maternal and child health.
- To co-ordinate and deliver a range of services to meet the outcomes required within the HCP.
- To signpost and support families to access service provision which will improve health and well being and reduce inequalities.
- To act as an interface between groups and individuals in the population and population based approaches to improving health and wellbeing. Health Visitors will be a catalyst in identifying and enabling action by local communities and individuals to enhance the community's capacity to improve health outcomes. The health visiting service will play a key role in enabling people and agencies to work together where necessary to influence policies (local or national) affecting health and wellbeing.
- To deliver specific additional care packages to vulnerable families as and when required in accordance with the Universal Plus Offer.
- To work with other agencies to co-ordinate / deliver of intensive care and support packages in accordance with the Universal Partnership Plus Offer.
- The Health visitor will lead the coordination of services across the four levels to ensure the right services are available at the right time to ensure that family needs are met.
- To ensure a seamless transition into school nursing services (DH pathway)

3.3.2 The specification has a separate section on safeguarding and makes it clear that safeguarding runs throughout service delivery and specifically notes this in regard to the 4 levels of the delivery model. It notes the requirement for engagement in MARAC and MAPPA processes and responsibilities as a partner of the SSCB.

3.3.3 The specification also includes a section in relation to how the Health Visiting Service works with GP's, noting the need for close working and regular contact including:

- Review of families with low service uptake and planning for improvement, for example immunisations
- Face to face meetings to share information, concerns regarding vulnerable families, make referrals and agree proposed provision of care for families with additional needs

- Face to face meetings by the Health Visitor involved with the family to share information where safeguarding concerns have been identified in attention to the information already shared through the Local Safeguarding Process
- Face to face meetings to share information on children identified as having a complex health need e.g. children discharged from specialist units
- Ongoing communication through a variety of methods to ensure the GP and Health Visitor are sharing information on families appropriately and effectively to improve outcomes
- The Health Visitor will be an active participant at regular relevant practice team meetings – an agreed schedule of attendance should be agreed by the GP practice and their named Health Visitor
- Health Visitors will record information electronically in the practice information system for each child detailing the responsible Health Visitor and contact details and other relevant information (subject to access being made available).
- The Health Visitor will provide professional development at least twice a year e.g. updates on relevant evidence based interventions to improve child health, trend information from their area in relation to injuries, common behavioural issues.

3.4 The Integrated Inspection of Safeguarding and Looked After Children's Services, carried out in February 2012 commented positively on the delivery of health visitor services and noted that health visitors and school nurses use skill mix effectively to deliver the full Healthy Child Programme up to age 5. The report also commented positively on the service in terms of appropriate packages of care to support vulnerable families, engagement in the CAF process, the use of risk assessment and the transfer from health visiting to school nursing services.

3.5 One of the biggest concerns raised by GPs centres on communication between GPs and health visitors. The survey conducted with GPs in February 2012 highlighted the following concerns:

- 44% of respondents did not know who the link visitor for the practice was;
- 78% did not know the team of health visitors working with their patients;
- 69% had not given the health visitor team even read only access to the Practice System;
- 43% never know who the named health visitor for individual patients is and 65% didn't think their patients knew;
- 52% rated the relationship between the practice and health visitor service as poor or very poor with 18% rating it as good or very good.

The survey captured positive aspects of the work but more than half of the respondents offered no response to this question. There were suggestions for improvement made and these have been considered. It is noted that many of the concerns would be addressed by the proper implementation of the specification noted in 3.3.1 above.

3.6 To help address concerns about communication a copy of the Health Visiting Directory has been shared with Practice Managers and again with the CCG for recirculation, detailing the named Health Visitor for each practice. This should also be made available on the Sunderland Information Portal. In relation to concerns regarding record keeping in practice information systems a Working Group across SoTW, currently looking at the development of a minimum data set for District Nurses, will also be asked to develop a minimum data set for Health Visitors, which could be used for this purpose. However, not all health visitors have access to practice information systems, an issue which will also need to be resolved to support the use of a minimum data set.

4. Recommendations

Partners are asked to:

- Note and discuss the contents of this report.
- Agree to the proposal of reviewing the implementation of the revised Health Visitor service specification after a period of time, informed by the views of commissioners, providers and SCCG. The time period for this is to be determined by the Shadow Health and Wellbeing Board, although a period of three months is suggested.

Item No. 10

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

TRANSFORMING HEALTH AND WELLBEING THROUGH INTEGRATING WELLNESS SERVICES

1. Purpose of the report

The Shadow Health and Wellbeing Board discussed the role of community resilience in transforming health and wellbeing in the City at its meeting in May. More integrated service delivery, based on a community resilience model building on local assets, was identified as a key opportunity to take this forward. This paper outlines the developing work stream to deliver this objective. Members of the board are asked to consider the contents of this paper and provide comments and/or approval in relation to the strategic direction and principles of this approach.

2. Background and drivers for change

Health inequalities in Sunderland have been apparent for many years. Recently there has been significant investment in "staying healthy" or "wellness" programmes such as physical activity, smoking cessation, slimming on referral and alcohol programmes. These programmes have often developed in isolation from each other largely due to the funding streams that were attached to investment. In spite of significant investment in these services, however, health inequalities remain. Local analysis has demonstrated the size of the gap in life expectancy experienced in some neighbourhoods of the city with the poorest life expectancy where men, on average, live for 16 years less than in the best PCT in England. This gap in relation to life expectancy is the outcome of a lifetime of inequalities which are demonstrated through many of the measures of the public health outcomes framework.

The persistence in health inequalities, despite investment, suggests that either there are other issues leading to poor health outcomes or services are not being accessed appropriately. The Marmot Review Team (2010) identifies the strong link between health inequalities and economic deprivation. At a time of economic downturn and public spending cuts, then, the need to address such inequalities becomes more urgent. There is, however, also evidence that the services are not being accessed in relation to need. Engagement with local communities has identified that many experience barriers in identifying and accessing services. This is borne out by a number of health equity audits that have been undertaken in relation to local services.

Available evidence suggests that many people have multiple lifestyle risk patterns. The 2012 Lifestyle Survey for Sunderland found that 24% of adults aged eighteen and over who are resident in Sunderland (some

55,000 people) exhibited three or more unhealthy behaviours, rising to 27% for those living in the most disadvantaged communities. In spite of this, however, users often find it difficult to navigate between services.

Finally, as with all public services, there is a duty to ensure that the commissioning of services to address lifestyle risks achieves value for money and in this case there is a clear responsibility to maximise health outcomes within available budgets. In particular, there are benefits associated with releasing funding for "invest to save" initiatives. As part of the transfer of responsibilities to local authorities, there has been a national process to identify a formula for allocating public health budgets going forward. For Sunderland, this will result in a significant reduction in the public health budget similar to other cost savings and efficiencies being experienced elsewhere in the local authority and the wider public sector. As a result there is a need to consider the commissioning of services as part of a cost-effective model.

Because of these drivers, there is a clear need to identify new ways of delivery, consistent with the previously identified aims of increasing community resilience through improved engagement leading to co-production alongside an asset-based approach.

3. Integration in the context of wellness services

The transfer of responsibility for public health from the NHS to local authorities provides new opportunities in service delivery, albeit at a time of funding constraints. National guidance has highlighted this opportunity as follows: -

" …tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs rather than commissioning a plethora of single issue services, and using new technologies to develop services that are easier and more convenient for users" and *"…making effective and sustainable use of all resources, using evidence to help ensure these are appropriately directed to areas and groups of greatest need and represent best possible value for money for local citizens."*

Having holistic services can, therefore, be seen as a key element of integration. This builds on the understanding that people's lifestyle choices are the result of many factors and so by responding to need in a more holistic way we are more likely to be successful in supporting them to make changes that will lead to improvements in health. To date, three elements to integration of wellness services in Sunderland have been identified: -

- "One stop shops" with integrated pathways into more specialised services where required. These services and pathways will be built with communities rather than being imposed upon them;

- Integration of wellness services with other services or developments e.g. use of green space when tackling obesity;
- Integration of information, with appropriate governance, to enable improved evaluation of the impact of new approaches.

The focus of this report is largely on the first element although implementation will need to consider all three.

4. Services to be Integrated

Members of the Board will be aware that there is a range of factors that impact on health. These range from risk factors that cannot be modified such as age and ethnic origin through to lifestyle factors, community networks, living and working conditions and finally more general socio-economic and environmental conditions. This final group is often referred to as the wider determinants of health.

Historically, the PCT has commissioned a number of services to address what are considered to be some of the more easily modifiable risk factors: those relating to individual and family lifestyles. Responsibility for the commissioning of most of these services will transfer to the local authority from 1st April 2013. These services sit alongside council services that also seek to support people in making healthier lifestyle choices, notably the city's Wellness Services which primarily aim to increase levels of physical activity with consequent improvements in health.

The integrated wellness model will initially aim to integrate those services which support people in adopting healthier lifestyles. In addition, they will recognise the fundamental impact of some of the wider health determinants that are likely to be a barrier to improving health by supporting and signposting to appropriate services.

The table below shows the services to be considered for integration.

Wellness services	*Brief advice and signposting*
• Stop smoking services • Physical activity • Nutrition • Weight management • Substance misuse • Sexual health • Emotional health & wellbeing • NHS Health Checks	• Financial support – benefit and debt advice • Support into employment • Education • Housing • Community safety e.g. domestic violence
Health Trainers Health Champions	

The two columns identify the main traditional wellness services and those wider determinants that have the greatest impact on health. These are underpinned by the Health Trainer Service which currently has a more

holistic approach and Health Champions who offer brief advice and signposting for a range of lifestyle issues.

5. Principles for integrating wellness

Development of services using approaches that will strengthen community resilience means that strategy development will be formative. It is, however, critical that the strategic direction is set by agreeing principles that will underpin services across the City. A working group has developed a set of principles which aim to encapsulate the model. Leeds Metropolitan University were then commissioned to cross-check these principles against public and user views gathered in recent years in relation to a number of preventative and early intervention services. Finally, as part of a recent public engagement session in relation to the Health Trainer service, the principles were endorsed by a group of stakeholders and residents. These principles together with user and public views identified by the thematic analysis undertaken by Leeds Metropolitan University are detailed below.

Choice

By this we mean that service users should, as far as is practicable, be able to have a choice as to where and when they access services. There may also be some choice of delivery model depending on local assets. Choice can be developed through use of appropriate social marketing techniques.

The data analysed showed that service users in a range of areas would like greater choice. Service users suggested changing locations of services to increase accessibility and extending open hours to account for work and other (e.g. school) commitments. Having services delivered in community locations was also suggested.

Needs led

Services will be developed to address individual and community need including having a holistic approach that helps to address the causes of unhealthy lifestyle choices.

The thematic data showed that some groups feel that their needs are not being met. For example, the LGBT community felt that services do not meet their needs in some areas e.g. in relation to emotional support and domestic violence. The BME community highlighted issues in relation to language barriers and cultural barriers. Young people were often unaware of what services they could access, and thus were not having their needs met.

Targeted

This relates to the Marmot principle of proportionate universalism. There will be a core service available to all but more to those who are in greatest

need. This might mean, for example, that some services are targeted towards those people living in neighbourhoods with the poorest life expectancy.

The data included in this area demonstrates that there needs to be targeting of services to deal with specific health problems as well as specific communities. Needs assessments included in this analysis show a variety of determinants of health, as well as specific needs in relation to communities such as BME, LGBT and young people.

Joined up

This principle is to address the current problem of fragmentation of services. It will also allow people to easily build on their successes when addressing unhealthy behaviours rather than losing the support that has helped them attain their success.

The thematic analysis also showed that partnership working is required in several ways

- To better provide services and reduce the number of points of contact
- To encourage learning from best practice in any area (local and indeed national)

Shared information (with appropriate governance)

Poor information sharing can result in fragmentation of service delivery. It also makes service evaluation extremely difficult. Improved choice without shared information could make services even more fragmented. It is, however, imperative that this principle is underpinned by the consent of users and appropriate levels of governance.

The thematic analysis showed that service users have concerns about stigma, the perceptions of them held by staff and confidentiality. Staff training can help to deal with changing perceived stigma. In addition, information sharing needs to be handled sensitively. This links into developing effective partnerships for service delivery.

Aims and outcome focused

Traditionally services have often been focused on process and throughput rather than outcomes. Service outcomes will also need to link to the public health outcomes framework to ensure that risks are shared across the system.

Whilst this was not highlighted by the thematic analysis, routine monitoring and evaluation can be used to assess how service provision is delivering the aims and outcomes of the integrated wellness model.

Life course

It is important that appropriate services are available across the life course and that they join up where appropriate for example for parents and young children and to allow for inter-generational cohesion. A key element of this will be a preventative approach that will reduce the number of people of all ages, but especially children and young people, from adopting less healthy behaviours. It is also important, however, that we do not neglect older people not only to ensure an equitable approach but also in recognition of the fact that it is often poor health in these groups that puts pressure on other parts of the system.

There are differential health needs across the life course and the thematic analysis shows that service users are concerned that these are not always recognised. For example, young people's needs are different to those of older people. Women's needs also change in relation to their reproductive health. Young men are more likely to smoke etc. Thus, services (wherever possible) should be designed to account for changing health across the life-course. Effective needs analyses should feed into the process of tailoring services appropriately across the life-course.

Local area/community of interest based approach

The importance of engagement and building on local assets has already been identified. It is proposed that this will largely be best achieved through working with area arrangements. It is, however, important to recognise that communities can be non-geographical and so for some communities it will be appropriate to have a city-wide approach.

The thematic analysis demonstrated that service users were interested in having more community located services and in capacity building. For example, the LGBT community suggested capacity building to improve engagement. BME communities also suggested working in collaboration with service providers to improve existing provision**.** Some services may also need to be increased in terms of their availability e.g. weight management services need to work with their community of interest for longer.

Cost effective

As financial pressures increase there will be major opportunity costs if best use is not made of available resources. It is therefore important that this remains a key principle for the commissioning and delivery of services.

The thematic analysis did not report findings related to cost effectiveness. However, increasing partnership working and reducing overlaps in service provision will be useful in increasing cost effectiveness. Some service provision could be broadened in scope to address more health needs. Regularly monitoring and evaluating service delivery will help to assess cost-effectiveness.

High quality

There are three main elements of quality: safety, service standards and user experience. Any funding or integration pressures should ensure that these elements are not compromised.

Identification of current barriers to the use of services can be used to inform quality developments. For example, in some areas the need for staff training and greater sensitivity to service user needs was identified (LGBT and young people). Engaging with communities and capacity building are also useful tools in achieving quality improvements. Change management strategies should also pay attention to staff motivation and attitudes as these are important in relation to quality.

Shared goals for providers

One of the current difficulties experienced when there is an element of choice or joining up of services is that providers may compete to maximise their own outcomes at the expense of other providers or, more importantly, service users.

The need for partnership working was clearly identified by the thematic analysis. Such partnership working can be facilitated via the provision of shared goals for providers, as well as routine monitoring of the effectiveness of current partnership mechanisms.

Diversity leading to new ways of engaging

This links strongly to the choice principle but also ensures that services reach out to potential users rather than only responding to effective demand.

A key theme around communication has emerged from several data sets. Thus strategies for engaging and promoting services need to be explored and diversified. Social marketing was suggested as one mechanism to engage. Communication needs to be sensitive, and tailored to different groups as approaches for young people, BME and LGBT communities should be different. Using the internet as a communication mechanism was suggested by young people. Working within communities should be used as a strategy to engage.

Transparent

Greater transparency in commissioning services will ensure that providers will understand the process and system, and their contribution to outcomes, to enable them to work better together.

The thematic analysis did not report any findings labelled as transparent but the theme of communication was identified throughout. Transparency

can be improved by changing communication methods and referral processes, identified via the thematic analysis. The suggested changes in communication and marketing of services identified by users are also important here in raising awareness of service availability, and thus increasing transparency. Changes made in relation to delivery related to rationing also need to be clearly communicated to users.

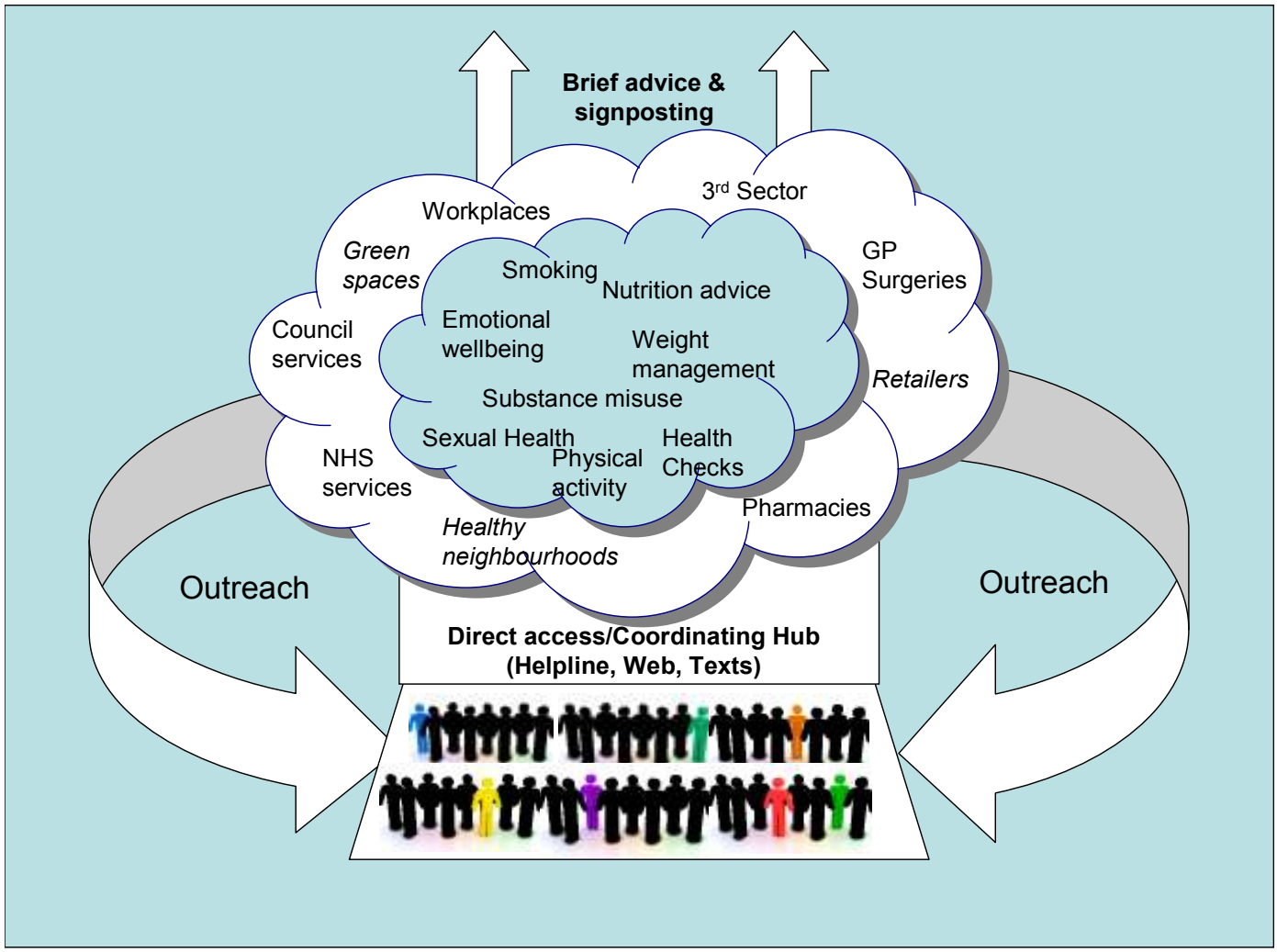
Fluidity of movement between services/interventions

This principle again relates to the difficulties experienced by users in accessing and navigating services. Fluidity will enable services to address multiple lifestyle issues and, where specialist standards means that a one stop shop is not cost effective, ensure that there are no organisational barriers to receiving help from another part of the system.

Increased partnership working can contribute to improved fluidity of movement between services, with effective sign-posting also important as part of this process. However, this needs to be achieved in a way which does not breach service user trust. Changes in delivery and referral should also be considered. For example, some service users suggested a one stop shop of community based provision, whilst others suggested a single point of referral to facilitate easier access.

Although there is a range of principles that will need to be taken forward, there are some that are key. In particular, if health outcomes are to be improved for the whole population and not just those who traditionally access services then addressing need and targeting services will be critical and this will inevitably mean that there should be some degree of choice for service users. Even more important, however, is the level of engagement with individuals, families and communities. This will run through from designing pathways, building services, service delivery and evaluation. This will be a key way in which the local health system can build individual and community resilience across the City.

Integrated Wellness Services



6. Foundations in place

Wellness services already have services and initiatives in place which provide strong foundations going forward. These are at different stages of development but offer opportunities for new ways of working.

Wellness Service

Sunderland's unique Wellness Service has continued to develop since 2005, with the primary aim to improve resident's health and well-being through the provision of physical activity opportunities, lifestyle advice and education. Since its conception Sunderland's Wellness Service has worked with a range of partners within in health promotion, sport and leisure services, adult and children's services to create a joined up approach to improving people's quality of life. This approach shifts emphasis away from focusing on illness and ill-health and instead concentrates on identifying how people can be encouraged and assisted to make themselves 'well'.

Prior to 2005 many preventative and intervention programmes were developed and delivered by Sunderland City Council (SCC) and Sunderland Teaching Primary Care Trust (STPCT) separately, and tended to be developmental, pilot based and reliant on short-term funding. To address this problem and to begin tackling health inequalities cohesively, a partnership was established in 2005 between STPCT and SCC. There was a clear recognition to have a shared vision, priorities, agendas and joint ways of working. The challenge was to be innovative and develop a new integrated service approach to meet the public health needs of our residents.

The Wellness Service was seen to be effectively supporting the integration of lifestyle change into programmes for the prevention and management of chronic diseases. It directly addressed lifestyle as a risk factor and lifestyle change as a 'treatment' to complement or compete with other treatment interventions. The key to the Wellness Service was then and continues to be now, supporting lifestyle change to prevent chronic diseases developing or worsening, and to keep people as fit and healthy as possible even when they have an established condition. A major advantage of the service is that the pathway to be embedded, from individuals participating in support programmes delivered by the Wellness Service within the facilities to the individuals becoming members and customers of the facilities when gradating from their support programme.

The Wellness Service works with both internal and external partners and partner organisations to ensure services are integrated, accessible and appropriate to the needs of those who are in greatest need of health improvements. Service development has taken place as a result of consultation, not only with existing service users to determine subtle programme changes, but more importantly with those individuals not yet engaged in physical activity to gain a greater understanding of the barriers to participation that exist. This knowledge has led to changes in service delivery that has enabled a greater impact to have been made with improved outcomes being achieved.

In 2008 SCC and STPCT were awarded Beacon status for its ground-breaking and successful work in Reducing Health Inequalities in the city's communities. The award was also in recognition of the Wellness Service's ability to deliver excellent services, demonstrating a clear vision and willingness to innovate. The programmes continue to develop to help 'close the health inequalities gap' Many of those who do not access provision are recognised as living within our areas of highest deprivation and much work still needs to be completed to ensure opportunities meet the needs of the residents.

Sunderland Health Champions

The Sunderland Health Champion programme was established in November 2010, led by the Washington Area Committee and West Area Committee, and has been delivered in line with Area Committee and Sunderland PCT priorities. The programme is overseen by Sunderland PCT and delivered in partnership with Sunderland City council and a range of third sector training providers. Health champions are community workers and volunteers as well as frontline staff as they are best placed in the heart of communities to offer support due to the long-established relationships with residents, who are comfortable talking to them. The training enables health champions to advise and signpost people to relevant services as part of their usual role.

To become a fully-fledged champion, individuals undertake five different training modules which take up to three and a half days. The modules include; understanding health improvement (level 2), emotional health and resilience, healthy money healthy you, smoking brief intervention (level 1) and alcohol brief intervention (level 2).

In March 2012 Leeds Metropolitan University carried out an independent evaluation of the health champion programme. The main findings included that health champions were effective in providing information and signposting, added value within communities through their accessibility and engagement and there was a potential for health champions to be expanded across other parts of Sunderland.

Health Trainers

The Health Trainer Service was established following the publication of the Public Health White Paper *Choosing Health: Making Healthy Choices Easier* in 2004.

Sunderland Health Trainers work with those with greatest health needs from disadvantaged communities, providing personal advice and support through the development of personal health plans, and signposting to appropriate services; and bringing these individuals into more effective contact with mainstream health improvement and other local services.

The Health Trainer Service specifically:

- Works with individuals from the target population to carry out a lifestyle health risk assessment;
- Informs each individual about possible risks to health as a result of their lifestyle;

- Enables these individuals to make changes in their behaviour to achieve a positive impact on their health by providing targeted advice and/or where appropriate bringing these individuals into more effective contact with mainstream health improvement and other local services such as Specialist Stop Smoking Services, weight management, opportunities for exercise, screening and wider health and social care services as deemed appropriate by the PCT; and
- Supports key national and local public health campaigns.

Health Trainers, therefore, potentially have a vital role in offering support in relation to a range of lifestyle issues that impact on health with a focus on those areas of greatest need.

Following a service review a decision was made by NHS South of Tyne and Wear to remodel and re-procure the Sunderland Health Trainer service. As part of this process an Equality Impact Assessment (EIA) was carried out in July 2012, alongside an engagement process. The aim of the EIA was to ensure that the Sunderland Health Trainer service meets the needs of the local population to ensure none are placed at a disadvantage. The main findings included:

- Health Trainers need to engage with more men, over 65 years and different community groups/ organisations (full recommendations included by group in the full EIA)
- Service operational times may need to be extended beyond 9am to 5pm to accommodate different working patterns
- Data needs to be better recorded.

Sunderland TPCT and Sunderland City Council are currently in discussion about the best future model of the health trainer service from April 2013 in the context of more integrated wellness services.

New Technologies

Sunderland TPCT is currently developing the use of a new text messaging service to support women and family members who are trying to stop smoking during pregnancy. Tele-health technology uses a computerised system called Florence (Flo) which is free to use in the UK and accessed via a mobile phone.

Once a woman has set a quit date she will start to get personalised motivational text messages that offer support and advice with regard to stopping smoking. This personalised service also offers an opportunity to raise awareness about other health issues such as secondhand smoke, breastfeeding, healthy eating and exercise.

This system is currently under development, with an anticipated date of 1st December 2012 to go live.

7. Next Steps

The next steps in developing this work stream fall into three main components: understanding, building and using.

Understanding

As identified to the Board in May 2012, complex system theory would suggest that if we are to achieve our goals of improving health we must work with people in a way that takes account of their values or working principles and the assets available to them. This means that we need to engage in a different way with local communities. It is proposed that this should be taken forward in the following ways: -

- The 2012 Health and Lifestyle Survey should be analysed further to identify the scale of health issues not only in relation to individual unhealthy lifestyles but also to estimate the proportion of people living in Sunderland who have multiple lifestyle related health risks. This should then be used with other information to identify population groups at greatest risk.
- Engagement with local people will take place in order to understand what support will help people to start to make the changes necessary to improve their health. This will be carried out in a way that recognises the differences between different socio-demographic groups using a tool such as Mosaic to segment the population. It can also have an asset based approach by focusing on people who have made the change to a healthier way of life and understanding what helped them to make the change.
- The knowledge of local people and community assets which is held by Elected Members will also be invaluable in understanding how services can target individuals and neighbourhoods of greatest need. It is proposed that the People Boards will be used to support the understanding of local communities.

Building

Engagement will continue as new pathways are built that take account of local needs and assets.

- The People Boards will oversee the development of models within each area of the City building on the information as described above. Elected Members can act as advocates for their communities and a local focus will enable services to build on local assets and community infrastructure.
- Guidance on best practice will form the basis of what is provided but services will need to be responsive to local need and build on local assets. The organisational and practitioner development that this will require should not be underestimated.
- There will be engagement with organizations in each area but also with current service providers and practitioners who will have experience of what works. Their views will the considered as pathways are built.

- As pathways are built they will be checked out with local people to ensure that their views are reflected in new services and initiatives.
- Again, Mosaic will be used to segment the population to support choice and ensure services are responsive.

Using

Once new services are implemented, engagement will continue. Health Champions will play a vital role in offering brief advice and then signposting into services. There will be a single point of contact to improve signposting although this will not form a barrier to those wishing to access services directly. Health Trainers will be fully integrated into services and embedded in the communities they serve offering additional support to those whose needs are greatest. Services will also have a responsibility to reach out into communities rather than merely responding to referrals into the system.

The information available in relation to population segments will be used to identify what the best information or service channels are to reach high risk groups. This approach has been taken by Heart of Birmingham PCT and enables tailored messaging and communications.

Because the lifestyle choices that people make are the results of such complex systems, services will need to be evaluated constantly in order to ensure that they are achieving the required outcomes and ensure that they are delivering services in a way that makes it easier for as many as possible to make positive choices in relation to their health.

8. Risks

The approach described in this report will lead to a transformation of wellness services in the City. As with all transformations there are risks – in this case there are risks that the required improvements in health will not be achieved due to: -

- The impact of the economic downturn and welfare reforms on the emotional health and wellbeing of the population;
- The impact of a reduced budget;
- Services not being sufficiently targeted;
- Insufficient engagement from community leaders and the wider community itself.

The principles of the model have been developed to diminish these risks but they will need to be monitored as the new approach is developed. Going forward, a risk register will be developed which will identify actions to mitigate emerging risks.

9. Recommendations

It is recommended that:

- The strategic direction described in this paper and the principles underpinning the development of integrated wellness services should be endorsed;
- The Health and wellbeing Board have oversight of the development of integrated wellness services with the potential to be supported by area arrangements as defined locally.

Victoria French
Assistant Head of Community Services (Sport & Leisure and Community Development)
Sunderland City Council

Gillian Gibson
Consultant in Public Health
Sunderland TPCT

Julie Parker
Public Health Lead
Sunderland TPCT

6 November 2012

Item No. 11

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

HEALTHWATCH AND NHS COMPLAINTS ADVOCACY UPDATE

Report of the Health Transition Lead

1.0 PURPOSE OF THE REPORT

1.1 To provide an update on the development of Healthwatch England.

1.2 To provide an update on the development of local Healthwatch and transition in Sunderland.

1.3 To provide an update on how the NHS Complaints Advocacy service will be commissioned, and who will be the lead authority, when it becomes the responsibility of local authorities from the 1st April 2013.

2.0 HEALTHWATCH ENGLAND

2.1 Background

2.1.1 Healthwatch was introduced by the Health and Social Care Act 2012. Healthwatch is the new consumer champion for health and social care in England. It will exist in two distinct forms - Healthwatch England, a national body, and local Healthwatch, a network of organisations representing people in their area.

2.1.2 Healthwatch England was launched on 1 October 2012. Anna Bradley was appointed Chair of Healthwatch England in July 2012. Further recruitment of staff for roles at Healthwatch England is ongoing.

2.1.3 Healthwatch England will gather and analyse information from local services, and take its findings to the national bodies which plan and run care services. It will tell them people's concerns, pass on and analyse information, and offer advice.

2.1.4 Through the Healthwatch network, Healthwatch England will make sure the voices of people who use health and social care services are heard by the Secretary of State, CQC, the NHS Commissioning Board, Monitor, and every local authority. By law, they will have to listen to Healthwatch and respond to its concerns.

2.1.5 The complete Healthwatch network, including local Healthwatch organisations, will be launched on 1 April 2013.

3.0 COMMISSIONING LOCAL HEALTHWATCH

3.1 Background

3.1.1 Local Healthwatch will replace the Local Involvement Network (LINk) as the mechanism for obtaining and promoting the voice of the public in commissioning and provision of health and social care services. It will retain the statutory functions of LINks, have a role to include the provision of information, advice and signposting and have a seat on the Health and Well-being Board.

3.1.2 Local Authorities have a duty to commission local Healthwatch which will become operational on the 1st April 2013 and will coincide with the commencement of the NHS Complaints Advocacy service.

3.1.3 The latest legislation states that Healthwatch should be a corporate body which is a social enterprise.

3.1.4 From April 2013/14 funding for local Healthwatch will have two different elements: The first is the on-going baseline funding for LINks; the second is new additional funding for the new service.

3.1.5 Whilst the precise funding for local Healthwatch is still under discussion, the following national information has been provided by the Department of Health:

Name	Route for Funding	Amount of Funding
LINKs funding	DCLG Business Rates Retention Scheme (BRRS)	£27 million
Additional local Healthwatch funding	To be determined	£11.5 million (with a minimum allocation of £20,000 for start up costs).

3.1.6 Current LINks funding will be transferred to become part of a single commissioning budget for local Healthwatch. The current LINKs budget is: £150,000 of which £133,500 was allocated.

3.1.7 An illustrative allocation of £76,437 has been calculated for Healthwatch Sunderland using data from the 2012/13 grant calculation, which will be updated prior to the 2013/14 settlement.

3.1.8 The LINks funding within formula grant is not ring-fenced and it is not possible to say how much each local authority will receive to commission their local Healthwatch services for the reason shown below:

3.1.9 Routine notifications of local government funding for the following financial year is notified at two stages. The provisional allocations are made known in November/ December of the current financial year; and

final allocations are made known in January/February prior to the start of the new financial year in April.

3.1.10 Decisions about funding for local Healthwatch will be made by each local authority as part of its overall responsibilities to fund services to meet the needs of local people and communities. The funding for local Healthwatch in Sunderland could be between £150 – 226K per annum.

3.1.11 National consultation is currently taking place on specific aspects of the Healthwatch Regulations. Final regulations are not yet available therefore certain aspects of the service specification have to remain flexible to allow for detail to be added once further information is available.

3.1.12 Whilst the funding and regulations are not yet clearly defined, in order to have a Local Healthwatch in place by April 2013 the commissioning and procurement process has by necessity commenced.

3.2 Current Position

3.2.1 As part of the commissioning of Local Healthwatch a number of activities have taken place. These are:

Consultation and Public Engagement

- A consultation event – this was held in November 2011 to obtain the views of the public about what Healthwatch should look like.

- A consultation questionnaire for adults – this was undertaken to complement the consultation event targeted at adults.

- A consultation questionnaire for children and young people – this was targeted at children and young people whose voice had not been heard in the previous consultation activities.

- Targeted consultation – using monies secured from the Strategic Health Authority, a SWITCH project has focused on engagement with a number of specific groups across the city, including children and young people; the Sunderland Men's Health Network; GP patient groups and people with learning disabilities to map the current engagement processes and to inform the engagement mechanisms of Healthwatch.

- Consultation with the current LINk volunteers to identify what they see as being important in commissioning and delivering a successful Local Healthwatch and to learn lessons from the last 5 years of LINK.

- Consultation with the wider VCS organisations to obtain their input into the development of Healthwatch, specifically about the values and principles of the organisation, staff and volunteer skills and competencies etc.

The feedback gathered from all of the consultation has been and will be used to shape the service specification for Healthwatch.

Developing a Service Specification

A service specification has been developed, taking into account consultation feedback.

Scoping the Market

Working collaboratively, Strategic Commissioning and Corporate Procurement have undertaken a scoping exercise to identify the current state of the market in relation to potential Healthwatch providers. 8 providers responded to the soft market testing, which consisted of national, regional and local third sector and private sector providers. There is sufficient competition in the market from a number of organisations that could reasonably be expected to be able to deliver the service.

3.2.2 It has now been agreed by Directorate Management Team to proceed with a procurement process. It is expected that the contract would be awarded in January with a 2 month setting up phase and transition of any relevant information from the current LINk host to the newly commissioned Local Healthwatch, ready for the1st April 2013 start date.

4.0 COMMISSIONING OF NHS COMPLAINTS ADVOCACY SERVICE

4.1 Background

4.1.1 The Department of Health currently commissions and manages the contract for NHS Complaints Advocacy, on behalf of the Secretary of State for Health. It is currently provided through a national contractual arrangement with three Independent Complaints Advocacy Services (ICAS), providing advocacy support to individuals wishing to complain about NHS services in England (which includes complaints to the Health Service Ombudsman). The Health and Social Care Act 2012 transfers the responsibility for commissioning this service to the Local Authority from 1 April 2013.

4.1.2 ICAS is a patient centred confidential service, delivering support ranging from provision of self-help information, through to the assignment of dedicated advocates to assist individuals with letter writing, form filling and attendance at meetings. ICAS aims to ensure

complainants have access to the support they need to articulate their concerns and navigate the complaints system.

4.1.3 The Carers Federation currently deliver ICAS for the Northern Region. The DH provided the indicative funding for NHS Complaints Advocacy allocations in June, which should be confirmed by the end of October 2012.

4.1.4 A number of Local Authorities (LAs) have met to discuss the possibility of a collaborative approach and the benefits that it might offer. There are 11 LAs interested in collaborating to progress this work:

- Darlington Borough Council
- Durham County Council
- Gateshead Council
- Hartlepool Borough Council
- Middlesbrough Council
- Newcastle City Council
- North Tyneside Council
- Redcar & Cleveland Borough Council
- South Tyneside Council
- Stockton-on-Tees Borough Council
- Sunderland City Council

4.1.5 Northumberland Council opted not to be part of the collaboration but have asked to be kept informed of progress.

4.2 Current Position

4.2.1 The Association of Directors of Adult Social Services support and agree to collaborative working and for Gateshead Council to be the lead commissioner for this service. The Director of NEPO (North East Purchasing Organisation) has confirmed NEPO do not have a direct resource to lead this work at the moment, but that he is agreeable to Gateshead taking this forward.

4.2.2 The costs associated with this arrangement were agreed by Cabinet in September 2012.

Gateshead Council will receive a one-off payment for pre-contract and post-contract work carried out on behalf of others (estimated to be in the region of £3,288 per LA)

4.2.3 As lead commissioner, Gateshead will be responsible for the pre and post contract work which includes administering the tender process and contract monitoring. Each LA will remain responsible for managing their individual budget commitment and it would be then up to each LA to manage the usage of the service to ensure they operate within their budget allocation.

4.2.4 All local authorities who are part of the collaborative approach, including Sunderland, are currently working with Gateshead to develop the service specification and the tender process.

4.2.5 The budget for NHS Complaints Advocacy Service is independent to that of Healthwatch and again we are working from estimates for the same reasons stated in 3.1.10. Sunderland anticipates receiving between £74 - £94K.

4.2.6 It is planned that the contract will be awarded by December 2012 for a start date of 1 April 2013.

5.0 RECOMMENDATIONS

5.1 It is recommended that the Shadow Health and Wellbeing Board receive this report for information.

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Item No. 13

SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD **16 November 2012**

HEALTH AND WELLBEING BOARD DEVELOPMENT PLAN

Report of the Head of Strategy, Policy and Performance Management

PURPOSE OF THE REPORT

This report sets out plans for the development programme of the Board until March 2013.

BACKGROUND

In the initial stages of Board Development, a development plan was established for the Health and Wellbeing Board to support it through the initial stages of development. Topics already covered include:

- Strategy, Vision and Values
- Joint decision making and setting priorities
- Joint commissioning
- The Health and Social Care System
- Engaging providers in the Health and Wellbeing Board

REVISED DEVELOPMENT PLAN

It is recognised that the development priorities of the Board have changed since the forward plan was agreed in February 2012 . In order to maximise the benefits of the development sessions, it is suggested that a revised programme be established to run through until the Board takes on its formal status on1st April 2013.

It is proposed that the sessions will be delivered in Thematic or Problem Solving workshops using a number of development tools and techniques to support the required outcomes/objectives. It is proposed that invitations be made to additional partners and experts for special sessions in order to maximise the value of the sessions for service improvement in the City as a whole.

To enable the workshops to be neutral, (in terms of agency representation and outcomes), it is proposed that independent specialist facilitators will lead on the majority of sessions.

RECOMMENDATIONS

The Board are requested to:

- Agree the thematic/problem solving topics identified in the plan
- Agree to the providers identifies in the plan
- Propose any additional development topics that the Board feel will benefit understanding and involvement.

Appendix 1

Health and Wellbeing Board Development Plan				
Session	**Date**	**Provider**	**Development Aims**	**Objectives & Products**
Problem Solving	Thursday 6 December 2012 10.00am - 12.00noon	Facilitated by Jean Carter & Ailsa Nokes	**Urgent & Intermediate Care Integration** ○ To build on the intermediate care strategic direction and work of the urgent care leadership group to explore the practice and process of urgent care & intermediate care ○ To establish challenges in urgent care & intermediate care being faced by the City ○ To agree a way forward in jointly dealing with urgent and intermediate care	○ Understand the issues surrounding urgent care & intermediate care in the city ○ Establish a joint view on dealing with urgent and intermediate care in the city ○ Establish a way forward for jointly dealing with urgent and intermediate care issues
Thematic Workshop	Thursday 7 February 2013 10.00am - 12.00noon	Specialist external facilitator- Mike Grady	**Influencing the wider determinants of health** ○ To make the links between Health and Wellbeing and broader services & activities ○ To identify service overlap and the impact on health and wellbeing in the city ○ To establish how the Board influences decisions on wider determinants	○ Understanding wider determinants of health and how they impact on health in the city. ○ Establishing a strategy on how the Board can influence and support decisions in wider arena
Thematic workshop	Date tbc (April)	Specialist external facilitator – Asset Based Consulting – Trevor	**How to deliver an assets based Health and wellbeing strategy** ○ To explore assets based approaches in the context of Health and Wellbeing ○ To identify the success factors in applying an assets based approach	○ Understanding of an assets based approach and how this relates to Health and Wellbeing in Sunderland ○ To approve a process for applying an assets based approach to delivering the Health and wellbeing Strategy

Health and Wellbeing Board Development Plan				
Session	**Date**	**Provider**	**Development Aims**	**Objectives & Products**
		Hopkins	○ To apply these to delivering the health and wellbeing strategy	
Thematic workshop	Date tbc (June)	tbc	**Engagement – Public and Patients** ○ To update the Board on HealthWatch developments ○ To define what engagement means to the Board, (e.g. level of engagement - awareness, active involvement etc) ○ To identify all the stakeholders that the board feel should be engaged. ○ Identify methods of engagement & communication that the board want to see.	○ Definition of what engagement is ○ Identified stakeholders/access routes ○ Established methods/levels of engagement & communication
Problem Solving	Date tbc (August)	Specialist external facilitator	**Personal Health Budgets/Personalisation budgets** ○ To understand personal health budgets ○ To understand personalisation budgets ○ To identify opportunities for aligning budgets ○ Participate in a scenario sessions to support thinking on options of dealing with any issues and problems presented	○ Understand Health Budgets/Personalisation budgets ○ Understand impact on the residents/city ○ Establish a way forward for dealing with potential Health budget issues